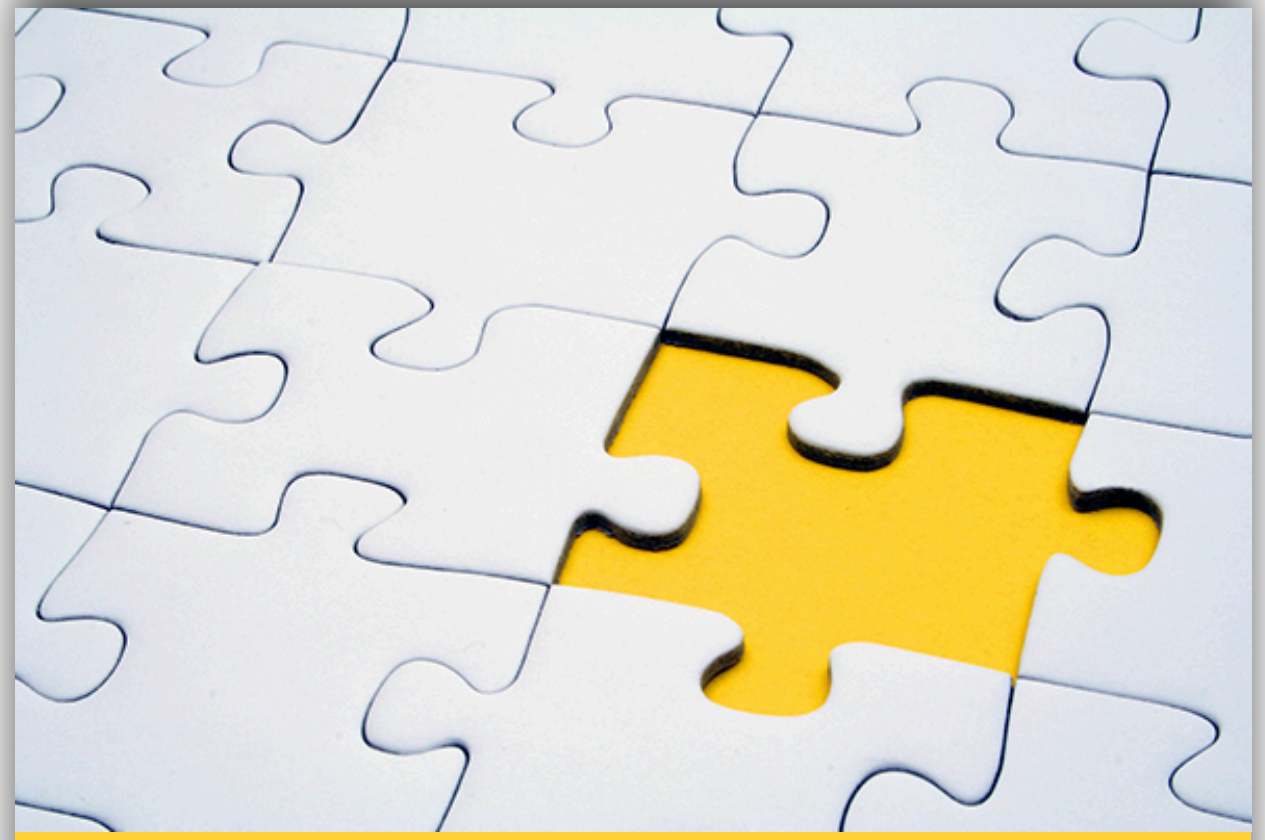

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Crisis and Trauma Counseling

15 Hours/Units

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Part I: Trauma Informed Care (TIC)

1. Introduction

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". 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 over whelms an individual's or community's re sources 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.

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 pro longed reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., post-traumatic stress and other anxiety disorders, sub stance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain). Others do not meet established criteria for post-traumatic 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.

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, bipolar disorder), impulse control disorders, and substance use disorders.

Traumatic stress increases the risk for mental illness, and findings suggest that traumatic stress increases the symptom severity of mental illness. 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.

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 detection.

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 non-judgmental 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.

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 and Ceci's 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). Here are the three main beliefs of a social-ecological approach (Stokols):

- 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.

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 in 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.

Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

2. Trauma Informed Care: A Sociocultural Perspective

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.

This section 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 section discusses the rationale for addressing

The Importance of TIC

The history of trauma raises various clinical issues. Many clinicians 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. Clinicians must be aware of trauma-related symptoms and disorders and how they affect clients in behavioral health treatment.

Clinicians 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, Ouimette, Ahrens, Moos, & Finney). In addition, assisting a client in achieving abstinence builds a platform upon which recovery from traumatic stress can proceed.

trauma in behavioral health services and reviews trauma-informed intervention and treatment principles.These principles serve as the section's conceptual framework.

Also emphasized is 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 section 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 course focuses on specific types of prevention (Institute of Medicine et al.): 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 course 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.

Specifically, this course 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 section, have all had experience as substance abuse and mental health counselors, prevention and peer specialists, seasoned clinicians, supervisors, clinical directors, researchers, or administrators working with individuals, families, and The material presented in this course 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.

Using a TIC framework, this course 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; program and administrative practices; and trauma resources.

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 individual providers. 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). 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.

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.

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

The Adverse Childhood Experiences Study (Centers for Disease Control and Prevention) 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) 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.

Trauma and Substance Use Disorders

Many people who have substance use disorders have experienced trauma as children or adults (Koenen, Stellman, Sommer, &Stellman, Ompad et al.). Substance abuse is known to predispose people to higher rates of traumas, such as dangerous situations and accidents, while under the influence (Stewart & Conrod, Zinzow, Resnick, Amstadter, McCauley, Ruggiero, &Kilpatrick) and as a result of the lifestyle associated with substance abuse (Reynolds et al.). In addition, people

who abuse substances and have experienced trauma have worse treatment outcomes than those without histories of trauma (Driessen et al., Najavits et al.). Thus, the process of recovery is more difficult, and the clinician'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, Najavits, Weiss, & Shaw). 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, Najavits et al.), and a significant number of clients in inpatient treatment also have subclinical traumatic stress symptoms or posttraumatic stress disorder (PTSD; Falck, Wang, Siegal, & Carlson, Grant et al., Reynolds etal.).

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.), impulse control disorders, and substance use disorders (Kessler, Chiu, Demler, & Walters).

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). 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.

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).

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 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.

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

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 clinician 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.

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.

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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.

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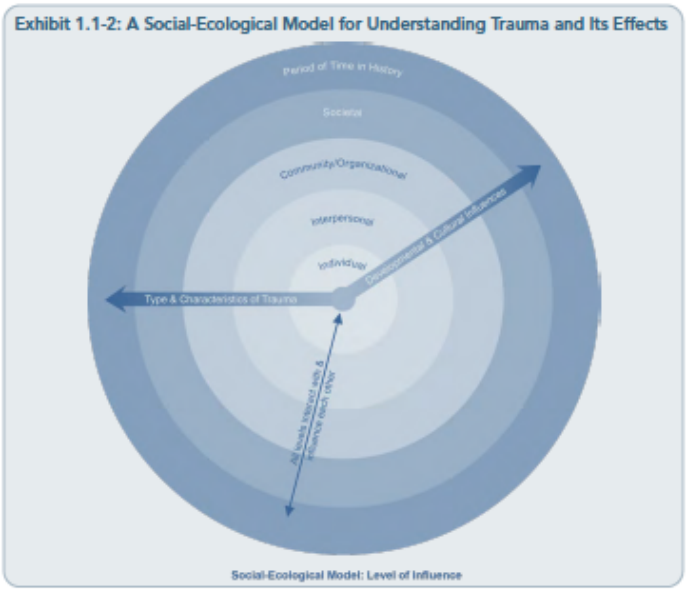
To more adequately understand trauma, you must also consider the contexts in which it occurred. Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences. Bronfenbrenner's and Bronfenbrenner and Ceci's 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). Here are the three main beliefs of a social-ecological approach (Stokols):

1. Environmental factors greatly influence emotional, physical, and social well-being.
2. 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.
3. Prevention, intervention, and treatment approaches integrate a combination of strategies targeting individual, interpersonal, and community systems.

This section uses a social-ecological model to explore trauma and its effects. 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 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, otherStates 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.

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.

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

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.

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).

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 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. Clinicians 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 wellbeing, behavioral health staff members may be more likely to seek support and supervision when needed and to comply with

Case Illustration: Jane

Jane, a newly hired female clinician, 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.

Collaboration

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.

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 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, 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.

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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.

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."

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 re-experiencing 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, clinicians 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?

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 non authoritarian 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.

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 ifa 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 in depth 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 abroad range of experiences typically considered traumatic and are flexible enough to allow for an individual's own interpretation of traumatic events.

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. 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 section 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.

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.

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.)

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,

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.

"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.,)

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 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 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.

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, Klinic CommunityHealth Centre). 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 clinician 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, post-traumatic stress, or adjustment, anxiety, or mood disorders (Bober & Regehr). 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).

Working daily with individuals who have been traumatized can be a burden for clinicians 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 two 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. Clinicians 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. Clinicians 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).

Essential components of TIC include organizational and personal strategies to address 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)

The Impact of Trauma

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 subsection has established the foundation and rationale of this section, 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. Clinicians, 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. 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.

3. Trauma Awareness

Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. This section explores several main elements that influence why people respond differently to trauma. Using the social-ecological model, this chapter explores some of the contextual and systemic dynamics that influence individual and community perceptions of trauma and its impact. The three main foci are: types of trauma, objective and subjective characteristics of trauma, and individual and

sociocultural features that serve as risk or protective factors.

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.

This section's main objective is to highlight the key characteristics of traumatic experiences. Trauma-informed behavioral health service providers understand that many influences shape the effects of trauma among individuals and communities—it is not just the event that determines the outcome, but also the event's context and the resultant interactions across systems.

Types of Trauma

The following section reviews various forms and types of trauma. It does not cover every conceivable trauma that an individual, group, or community may encounter. Specific traumas are reviewed only once, even when they could fit in multiple categories of trauma. The intent is to give a broad perspective of the various categories and types of trauma to clinicians, behavioral health workers, and other clinicians who wish to be trauma informed.

Natural or Human-Caused Traumas

The classification of a trauma as natural or caused by humans can have a significant impact on the ways people react to it and on the types of assistance mobilized in its aftermath (see Exhibit 1.2-1 for trauma examples). Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

Exhibit 1.2-1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrocution	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (e.g., returning to school or work, being able to do laundry, having products to buy in a local store). The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions as well as the recovery process.

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.

Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. Examples include the threat of others stealing what remains of personal property, restrictions on travel or access to property or living quarters, disruption of privacy within shelters, media attention, and subsequent exposure to repetitive images reflecting the devastation. Therefore, it isn't just the natural disaster or event that can challenge an individual or community; often, the consequences of the event and behavioral responses from others within and outside the community play a role in pushing survivors away from effective coping or toward resilience and recovery.

Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or

Working With Clients Who Have Experienced Individual Traumas

In working with clients who have histories of individual trauma, counselors should consider that:

- Empathy, or putting oneself in the shoes of another, is more potent than sympathy (expressing a feeling of sorrow for another person).
- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on reexperiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- It is helpful to examine how the trauma affects opportunities to receive substance abuse and/or mental health treatment as well as treatment for and recovery from the trauma itself (e.g., by limiting one's willingness to share in or participate in group counseling).
- Identifying and exploring strengths in the client's history can help the client apply those strengths to his or her ability to function in the present.

unintentional, such as the technological accident of a bridge collapse (as occurred in Minneapolis, Minnesota, U.S. Fire Administration). The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of

people is typically the target of the survivors' anger and blame. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the motives for performing the act, the calculated or random nature of the act, and the psychological makeup of the perpetrator(s).

Individual, Group, Community, and Mass Traumas

In recognizing the role of trauma and understanding responses to it, consider whether the trauma primarily affected an individual and perhaps his or her family (e.g., automobile accident, sexual or physical assault, severe illness); occurred within the context of a group (e.g., trauma experienced by first responders or those who have seen military combat) or community (e.g., gang-related shootings); transpired within a certain culture; or was a large-scale disaster (e.g., hurricane, terrorist attack). This context can have significant implications for whether (and how) people experience shame as a result of the trauma, the kinds of support and compassion they receive, whether their experiences are normalized or diminished by others, and even the kinds of services they are offered to help them recover and cope.

Individual Trauma

An individual trauma refers to an event that only occurs to one person. It can be a single event (e.g., mugging, rape, physical attack, work-related physical injury) or multiple or prolonged events (e.g., a life-threatening illness, multiple sexual assaults). Although the trauma directly affects just one individual, others who know the person and/or are aware of the trauma will likely experience emotional repercussions from the event(s) as well, such as recounting what they said to the person before the event, reacting in disbelief, or thinking that it could just as easily have happened to them, too.

Survivors of individual trauma may not receive the environmental support and concern that members of collectively traumatized groups and communities receive. They are less likely to reveal their traumas or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the trauma. Some survivors of individual traumas, especially those who have kept the trauma secret, may not receive needed comfort and acceptance from others; they are also are more likely to struggle with issues of causation (e.g.,a young woman may feel unduly responsible for a sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized.

Physical Injuries

Physical injuries are among the most prevalent individual traumas. Millions of emergency room (ER) visits each year relate directly to physical injuries. Most trauma patients are relatively young; about 70 percent of injury-related ER cases are people younger than 45 years old (McCaig & Burt). Dedicated ER hospital units, known as "trauma centers,"specialize in physical traumas such as gunshot wounds, stabbings, and other immediate physical injuries. The term "trauma" in relation toERs does not refer to psychological trauma, which is the focus of this TIP, yet physical injuries can be associated with psychological trauma. Sudden, unexpected, adverse health-related events can lead to extensive psychological trauma for patients and their families.

Acute stress disorder (ASD) prevalence among patients at medical trauma centers is very high, making trauma -related disorders some of the most common complications seen in physically injured patients. Clients who have sustained serious injuries in car crashes, fires, stabbings, shootings, falls, and other events have an increased likelihood of developing trauma -related mental disorders. Research suggests that PTSD and/or problem drinking is evident in nearly 50 percent of patients 1 year after discharge from trauma surgical units. (Zatzick, Jurkovich, Gentilello, Wisner, & Rivara)

Excessive alcohol use is the leading risk factor for physical injuries; it's also the most promising target for injury prevention. Studies consistently connect injuries and substance use (Gentilello, Ebel, Wickizer, Salkever, &Rivara); nearly 50 percent of patients admitted to trauma centers have injuries attributable to alcohol abuse and dependence (Gentilello et al.). One study found that two thirds of ambulatory assault victims presenting to an ER had positive substance use urinalysis results; more than half of all victims had PTSD 3 months later (Roy-Byrne et al.). Nearly 28 percent of patients whose drinking was identified as problematic during an ER visit for a physical injury will have a new injury within 1 year (Gentilello et al.).

Group Trauma

The term "group trauma" refers to traumatic experiences that affect a particular group of people. This section intentionally distinguishes group trauma from mass

trauma to highlight the unique experiences and characteristics of trauma-related reactions among small groups. These groups often share a common identity and history, as well as similar activities and concerns. They include vocational groups who specialize in managing traumas or who routinely place themselves in harm's way—for example, first responders, a group including police and emergency medical personnel. Some examples of group trauma include crews and their families who lose members from a commercial fishing accident, a gang whose members experience multiple deaths and injuries, teams of firefighters who lose members in a roof collapse, responders who attempt to save flood victims, and military service members in a specific theater of operation.

Survivors of group trauma can have different experiences and responses than survivors of individual or mass traumas. Survivors of group trauma, such as military service members and first responders, are likely to experience repeated trauma. They tend to keep the trauma experiences within the group, feeling that others outside the group will not understand; group outsiders are generally viewed as intruders. Members may encourage others in the group to shut down emotionally and repress their traumatic experiences—and there are some occupational roles that necessitate the repression of reactions to complete a mission or to be attentive to the needs at hand. Group members may not want to seek help and may discourage others from doing so out of fear that it may shame the entire group. In this environment, members may see it as a violation of group confidentiality when a member seeks assistance outside the group, such as by going to a clinician.

Group members who have had traumatic experiences in the past may not actively support traumatized colleagues for fear that acknowledging the trauma will increase the risk of repressed trauma-related emotions surfacing. However, groups with adequate resources for helping group members can develop a stronger and more supportive environment for handling subsequent traumas. These main group features influence the course of short-and long-term adjustments, including the development of traumatic stress symptoms associated with mental and substance use disorders.

Certain occupational groups are at greater risk of experiencing trauma—particularly multiple traumas. This section briefly reviews two main groups as examples in the following sections: first responders and military service members.

First Responders

First responders are usually emergency medical technicians, disaster management personnel, police officers, rescue workers, medical and behavioral health

professionals, journalists, and volunteers from various backgrounds.They also include lifeguards, military personnel, and clergy. Stressors associated with the kinds of traumatic events and/or disasters first responders are likely to experience include exposure to toxic agents, feeling responsible for the lives of others, witnessing catastrophic devastation, potential exposure to gruesome images, observing human and animal suffering and/or death, working beyond physical exhaustion, and the external and internal pressure of working against the clock.

Military Service Members

Military personnel are likely to experience numerous stressors associated with trauma. Service members who have repeatedly deployed to a war zone are at a greater risk for traumatic stress reactions (also known as combat stress reaction or traumatic stress injury), other military personnel who provide support services are also at risk for traumatic stress and secondary trauma. So too, service members who anticipate deployment or redeployment may exhibit psychological symptoms associated with traumatic stress. Some stressors that military service members may encounter include working while physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, fear of being struck by an improvised explosive device, and so forth.

Trauma Affecting Communities and Cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.

"The excitement of the season had just begun, and then, we heard the news, oil in the water, lots of oil killing lots of water. It is too shocking to understand. Never in the millennium of our tradition have we thought it possible for the water to die, but it is true."
–Chief Walter Meganack, Port Graham, 1989

Of all the groups negatively affected by the Exxon Valdez oil spill, in many ways Alaska Natives were the most devastated. The oil spill destroyed more than economic resources; it shook the core cultural foundation of Native life. Alaska Native subsistence culture is based on an intimate relationship with the environment. Not only does the environment have sacred qualities for Alaska Natives; their survival also depends on the well-being of the ecosystem and the maintenance of cultural norms of subsistence. The spill directly threatened the well-being of the environment, disrupted subsistence behavior, and severely disturbed the sociocultural milieu of Alaska Natives.

Source: Gill & Picou

Historical Trauma

Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and theKhmer Rouge in Cambodia are examples of historical trauma.

In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families. More recent literature has extended the concept of historical or generational trauma to the traumatic experiences of Native

Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities (Whitbeck, Chen, Hoyt, & Adams). Data are limited on the association of mental and substance use disorders with historical trauma among Native people, but literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Gone). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes.

Mass Trauma

Mass traumas or disasters affect large numbers of people either directly or indirectly. Mass traumas may involve significant loss of property and lives as well as the widespread disruption of normal routines and services. Responding to such traumas often requires immediate and extensive resources that typically exceed the capacity of the affected communities, States, or countries in which they occur.

Modern history examples of such large-scale catastrophes include:

- In January 2010, a massive earthquake hit Haiti, killing hundreds of thousands of people and leaving over a million homeless.
- A nuclear reactor meltdown in the Ukraine in 1986 resulted in a technological and environmental disaster that affected tens of millions of people.
- The tsunami in the Indian Ocean in 2005 left hundreds of thousands dead in nine countries.

One factor that influences an individual's response to trauma is his or her ability to process one trauma before another trauma occurs. In mass traumas, the initial event causes considerable destruction, the consequences of which may spawn additional traumas and other stressful events that lead to more difficulties and greater need for adjustments among survivors, first responders, and disaster relief agencies. Often, a chain reaction occurs. Take, for example, Hurricane Katrina and its impact on the people of Louisiana and other coastal states. After the initial flooding, people struggled to obtain basic needs, including food, drinking water, safe shelter, clothing, medicines, personal hygiene items, and so forth, all as concern mounted about the safety of children and other relatives, friends, and neighbors. In this and similar cases, the destruction from the initial flooding led to mass displacement of families and communities; many people had to relocate far from New Orleans and

Case Illustrations: Quecreek Mine Flood and Greensburg's Tornado

Quecreek Mine Flood

The year following the rescue of nine miners from the Quecreek mine in western Pennsylvania in 2002 was a difficult one for residents of Somerset County. The dazzle of publicity surrounding a handful of workers from a small town, tension between miners and rescuers, and animosity over money for movie and book deals, in addition to the trauma itself, resulted in a rescuer's suicide, a number of miners having trauma-related symptoms, and several rescuers needing to seek treatment for posttraumatic stress disorder (PTSD; Goodell).

Greensburg's Tornado

Greensburg, a small town in southern Kansas, was hit by a large tornado that killed 11 residents and leveled 95 percent of the town while causing severe damage to the remaining 5 percent. Families and community members experienced significant grief and traumatic stress after the disaster. Yet today, Greensburg is rebuilding with a focus on being "green"–that is, environmentally responsible–from design to construction and all the way through demolition. This town has the highest number of Leadership in Energy and Environmental Design-certified buildings in the world. A reality television show about the town's reinvention ran for three seasons, demonstrating the town's residents and business owners working with local government and various corporations to make their home an even better place than it was before the tornado.

other badly affected areas, while also needing to gain financial assistance, reinitiate work to generate income, and obtain stable housing. People could not assimilate one stressor before another appeared.

Nevertheless, mass traumas can create an immediate sense of commonality—many people are "in the same boat," thus removing much of the isolation that can occur

with other types of trauma. People can acknowledge their difficulties and receive support, even from strangers. It is easier to ask for help because blame is often externalized; large-scale disasters are often referred to as "acts of God" or, in cases of terrorism and other intentional events, as acts of "evil." Even so, survivors of mass trauma often encounter an initial rally of support followed by quickly diminishing services and dwindling care. When the disaster fades from the headlines, public attention and concern are likely to decrease, leaving survivors struggling to reestablish or reinvent their lives without much outside acknowledgment.

The experience of mass trauma can lead to the development of psychological symptoms and substance use at either a subclinical or a diagnostic level. Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of preexisting mental and co-occurring disorders, and individuals who are in early recovery from substance use disorders are at greater risk for such reactions as well. Nonetheless, people are amazingly resilient, and most will not develop long-term mental or substance use disorders after an event; in fact, most trauma-related symptoms will resolve in a matter of months (Keane & Piwowarczyk).

Interpersonal Traumas

Interpersonal traumas are events that occur (and typically continue to reoccur) between people who often know each other, such as spouses or parents and their children. Examples include physical and sexual abuse, sexual assault, domestic violence, and elder abuse.

Intimate Partner Violence

Intimate partner violence (IPV), often referred to as domestic violence, is a pattern of actual or threatened physical, sexual, and/or emotional abuse. It differs from simple assault in that multiple episodes often occur and the perpetrator is an intimate partner of the victim. Trauma associated with IPV is normally ongoing. Incidents of this form of violence are rarely isolated, and the client may still be in contact with and encountering abuse from the perpetrator while engaged in treatment.

Intimate partners include current and former spouses, boyfriends, and girlfriends. The majority of all nonfatal acts of violence and intimate partner homicides are committed against women; IPV accounts for over 20 percent of nonfatal violence against women but only 3.6 percent of that committed against men (Catalano). Children are the hidden casualties of IPV. They often witness the assaults or threats directly, within earshot, or by being exposed to the aftermath of the violence (e.g., seeing bruises and destruction of property, hearing the pleas for it to stop or the promises that it will never happen again).

Child Neglect

Child neglect occurs when a parent or caregiver does not give a child the care he or she needs according to his or her age, even though that adult can afford to give that care or is offered help to give that care. Neglect can mean not providing adequate nutrition, clothing, and/or shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or is not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments (e.g., exposure to domestic violence). It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can mean abandoning a child or expelling him or her from home. Lack of psychological care, including emotional support, attention, or love, is also considered neglect– and it is the most common form of abuse reported to child welfare authorities.

Substance abuse, particularly involving alcohol, is frequently associated with IPV. It is the presence of alcohol-related problems in either partner, rather than the level of alcohol consumption itself, that is the important factor.

Drinking may or may not be the cause of the violence; that said, couples with alcohol-related disorders could have more tension and disagreement within the relationship in general, which leads to aggression and violence.The consumption of alcohol during a dispute is likely to decrease inhibitions and increase impulsivity, thus creating an opportunity for an argument to escalate into a physical altercation.

Developmental Traumas

Developmental traumas include specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and

physical and mental health. Often, these traumas are related to adverse childhood experiences (ACEs), but they can also result from tragedies that occur outside an expected developmental or life stage (e.g., a child dying before a parent, being diagnosed with a life-threatening illness as a young adult) or from events at any point in the life cycle that create significant loss and have life-altering consequences (e.g., the death of a significant other in the later years that leads to displacement of the surviving partner).

Adverse Childhood Experiences

Some people experience trauma at a young age through sexual, physical, or emotional abuse and neglect. The Adverse Childhood Experiences Study (Felitti et al.) examined the effects of several categories of ACEs on adult health, including physical and emotional abuse; sexual abuse; a substance-dependent parent; an incarcerated, mentally ill, or suicidal household member; spousal abuse between parents; and divorce or separation that meant one parent was absent during childhood. The National Comorbidity Studies examined the prevalence of trauma and defined childhood adversities as parental death, parental divorce/separation, life-threatening illness, or extreme economic hardship in addition to the childhood experiences included in the Adverse Childhood Experiences Study (Green et al).

ACEs can negatively affect a person's wellbeing into adulthood. Whether or not these experiences occur simultaneously, are time-limited, or recur, they set the stage for increased vulnerability to physical, mental, and substance use disorders and enhance the risk for repeated trauma exposure across the life span. Childhood abuse is highly associated with major depression, suicidal thoughts, PTSD, and dissociative symptoms. So too, ACEs are associated with a greater risk of adult alcohol use. When a person experiences several adverse events in childhood, the risk of his or her heavy drinking, self-reported alcohol dependence, and marrying a person who is alcohol dependent is two to four times greater than that of a person with no ACEs (Dube,Anda, Felitti, Edwards, & Croft).

Political Terror and War

Political terror and war are likely to have lasting consequences for survivors. In essence, anything that threatens the existence, beliefs, well-being, or livelihood of a community is likely to be experienced as traumatic by community members. Whether clinicians are working with an immigrant or refugee enclave in the United States or in another country, they should be aware of local events, local history, and the possibility that clients have endured trauma. (For international information about the clinical, historical, and theoretical aspects of trauma and terrorism, see Danieli,Brom, & Sills). Terrorism is a unique subtype of human-caused disasters.

The overall goal of terrorist attacks is to maximize the uncertainty, anxiety, and fear of a large community, so the responses are often epidemic and affect large numbers of people who have had direct or indirect exposure to an event (Silver et al., Suvak, Maguen, Litz, Silver, & Holman).

Terrorism has a variety of results not common to other disasters, such as reminders of the unpredictability of terrorist acts; increases in security measures for the general population; intensified suspicion about a particular population, ethnicity, or culture; and heightened awareness and/or arousal.

Refugees

According to the World Refugee Survey, there are an estimated 12 million refugees and asylum seekers, 21 million internally displaced people, and nearly 35 million uprooted people (U.S. Committee for Refugees and Immigrants). Many of these people have survived horrendous ordeals with profound and lasting effects for individuals and whole populations. In addition to witnessing deaths by execution, starvation, or beatings, many survivors have experienced horrific torture. Refugees are people who flee their homes because they have experienced or have a reasonable fear of experiencing persecution. They differ from immigrants who willingly leave their homes or homeland to seek better opportunities. Although immigrants may experience trauma before migrating to or after reaching their new destination, refugees will often have greater exposure to trauma before migration. Refugees typically come from war-torn countries and may have been persecuted or tortured. Consequently, greater exposure to trauma, such as torture, before migrating often leads to more adjustment-related difficulties and psychological symptoms after relocation (Steel et al.).

Refugees typically face substantial difficulties in assimilating into new countries and cultures. Moreover, the environment can create anew set of challenges that may include additional exposure to trauma and social isolation (Miller et al.). These as well as additional factors influence adjustment, the development of mental illness (including PTSD), and the occurrence of substance use disorders. Additional factors that influence outcomes after relocation include receptivity of the local community, along with opportunities for social support and culturally responsive services.

Among refugee populations in the United States, little research is available on rates of mental illness and co-occurring substance use disorders and traumatic stress among refugee populations. Substance use patterns vary based on cultural factors as well as assimilation, yet research suggests that trauma increases the risk for substance use among refugees after war-related experiences (Kozarić-Kovačić,Ljubin, & Grappe). Therefore, providers should expect to see trauma-

related disorders among refugees who are seeking treatment fora substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

Torture and Captivity

Torture traumatizes by taking away an individual's personhood. To survive, victims have to give up their sense of self and will. They become the person the torturer designs or a nonperson, simply existing. Inevitably, the shame of the victim is enormous, because the focus of torture is to humiliate and degrade. As a result, victims often seek to hide their trauma and significant parts of their selfhood long after torture has ended and freedom has been obtained. According to Judith Herman, "the methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others."

System-Oriented Traumas: Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma.Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it, and sometimes clients themselves are not consciously aware that a clinical situation has actually triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

Staff and agency issues that can cause retraumatization include:

- Being unaware that the client's traumatic history significantly affects his or her life.
- Failing to screen for trauma history prior to treatment planning.

- ❖ Challenging or discounting reports of abuse or other traumatic events.
- ❖ Using isolation or physical restraints.
- ❖ Using experiential exercises that humiliate the individual.
- ❖ Endorsing a confrontational approach in counseling.
- ❖ Allowing the abusive behavior of one client toward another to continue without intervention.
- ❖ Labeling behavior/feelings as pathological.
- ❖ Failing to provide adequate security and safety within the program.
- ❖ Limiting participation of the client in treatment decisions and planning processes.
- ❖ Minimizing, discrediting, or ignoring client responses.
- ❖ Disrupting clinician–client relationships by changing clinicians' schedules and assignments.
- ❖ Obtaining urine specimens in a non private setting.
- ❖ Having clients undress in the presence of others.
- ❖ Inconsistently enforcing rules and allowing chaos in the treatment environment.
- ❖ Imposing agency policies or rules without exceptions or an opportunity for clients to question them.
- ❖ Enforcing new restrictions within the program without staff–client communication.
- ❖ Limiting access to services for ethnically diverse populations.
- ❖ Accepting agency dysfunction, including lack of consistent, competent leadership.

4. Characteristics of Trauma

The following section highlights several selected characteristics of traumatic experiences that influence the effects of traumatic stress. Objective characteristics are those elements of a traumatic event that are tangible or factual; subjective characteristics include internal processes, such as perceptions of traumatic experiences and meanings assigned to them.

Objective Characteristics

Was it a single, repeated, or sustained trauma? Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A *single trauma* is limited to a single point in time. A rape, an automobile accident, the sudden death of a loved one—all are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others—especially those with histories of previous trauma or mental or substance use

Addressing Retraumatization

- Anticipate and be sensitive to the needs of clients who have experienced trauma regarding program policies and procedures in the treatment setting that might trigger memories of trauma, such as lack of privacy, feeling pushed to take psychotropic medications, perceiving that they have limited choices within the program or in the selection of the program, and so forth.
- Attend to clients' experiences. Ignoring clients' behavioral and emotional reactions to having their traumatic memories triggered is more likely to increase these responses than decrease t hem.
- Develop an individual coping plan in anticipation of triggers that the individual is likely to experience in treatment based on his or her history.
- Rehearse routinely the coping strategies highlighted in the coping plan. If the client does not practice strategies prior to being triggered, the likelihood of being able to use them effectively upon triggering is lessened. For example, it is far easier to practice grounding exercises in the absence of severe fear than to wait for that moment when the client is reexperiencing an aspect of a traumatic event. (For more information on grounding exercises, refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*; Najavits.)
- Recognize that clinical and programmatic efforts to control or contain behavior in treatment can cause traumatic stress reactions, particularly for trauma survivors for whom being trapped was part of the trauma experience.
- Listen for the specific trigger that seems to be driving the client's reaction. It will typically help both the counselor and client understand the behavior and normalize the traumatic stress reactions.
- Make sure that staff and other clients do not shame the trauma survivor for his or her behavior, such a s through teasing or joking about the situation.
- Respond with consistency. The client should not get conflicting information or responses from different staff members; this includes information and responses given by administrators.

Case Illustration: Yourself

Think of a time that was particularly stressful (but not traumatic) in your life. Revisit this period as an observer watching the events unfold and then ask yourself, "What made this time particularly stressful?" It is likely that a part of your answer will include the difficulty of managing one situation before another circumstance came along demanding your time. Stressful times denote being bombarded with many things at one time, perceived or actual, without sufficient time or ability to address them emotionally, cognitively, spiritually, and/or physically. The same goes for trauma–rapid exposure to numerous traumas one after another lessens one's ability to process the event before the next onslaught. This creates a cumulative effect, making it more difficult to heal from any one trauma.

disorders, or those for whom the trauma experience is particularly horrific or overwhelming—a single trauma can result in traumatic stress symptoms and trauma-and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas. After the terrorist attacks on September 11, 2001—a significant single trauma—many Manhattan residents experienced intrusive memories and sleep disruption whether they were at the site of the attacks or watched television coverage of it (Ford & Fournier, Galea et al.).

A series of traumas happening to the same person over time is known as *repeated trauma*. This can include repeated sexual or physical assaults, exposure to frequent injuries of others, or seemingly unrelated traumas. Military personnel, journalists covering stories of mass tragedies or prolonged conflicts, and first responders who handle hundreds of cases each year typify repeated trauma survivors. Repetitive exposure to traumas can have a cumulative effect over one's lifetime. A person who was assaulted during adolescence, diagnosed with a life-threatening illness in his or her thirties, and involved in a serious car accident later in life has experienced repeated trauma.

Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include

Case Illustration: Rasheed

Rasheed was referred to an employee assistance program by his employer. He considered quitting his job, but his wife insisted he talk to a counselor. He is a 41-year-old auto mechanic who, 4 years ago, caused a head-on collision while attempting to pass another vehicle. A close friend, riding in the passenger's seat, was killed, and two young people in the other vehicle were seriously injured and permanently disabled. Rasheed survived with a significant back injury and has only been able to work sporadically. He was convicted of negligent homicide and placed on probation because of his physical disability. He is on probation for another 4 years, and if he is convicted of another felony during that time, he will have to serve prison time for his prior offense. While still in the hospital, Rasheed complained of feeling unreal, numb, and disinterested in the care he received. He did not remember the crash but remembers waking up in the hospital 2 days later. He had difficulty sleeping in the hospital and was aware of feelings of impending doom, although he was unaware of the legal charges he would later face. He was diagnosed with ASD.

He was discharged from the hospital with a variety of medications, including pain pills and a sleep aid. He rapidly became dependent on these medications, feeling he could not face the day without the pain medication and being unable to sleep without sleep medicine in larger doses than had been prescribed. Within 3 months of the accident, he was "doctor shopping" for pain pills and even had a friend obtain a prescription for the sleeping medication from that friend's doctor. In the 4 intervening years, Rasheed's drug use escalated, and his blunted emotions and detachment from friends became more profound. He became adept at obtaining pain pills from a variety of sources, most of them illegal. He fears that if he seeks treatment for the drug problem, he will have to admit to felony offenses and will probably be imprisoned. He also does not believe he can manage his life without the pain pills. In the past 2 years, he has had recurring dreams of driving a car on the wrong side of the road and into the headlights of an oncoming vehicle. In the dream, he cannot control the car and wakes up just before the vehicles crash. At unusual times—for instance, when he is just awakening in the morning, taking a shower, or walking alone—he will feel profound guilt over the death of his friend in the accident. He becomes very anxious when driving in traffic or when he feels he is driving faster than he should. His marriage of 18 years has been marked by increasing emotional distance, and his wife has talked about separating if he does not do something about his problem. He has been unable to work consistently because of back pain and depression. He was laid off from one job because he could not concentrate and was making too many mistakes.

The clinician in the employee assistance program elicited information on Rasheed's drug use, although she suspected Rasheed was minimizing its extent and effects. Knowledgeable about psychological trauma, the clinician helped Rasheed feel safe enough to talk about the accident and how it had affected his life. She was struck by how little Rasheed connected his present difficulties to the accident and its aftermath. The counselor later commented that Rasheed talked about the accident as if it had happened to someone else. Rasheed agreed to continue seeing the clinician for five additional visits, during which time a plan would be made for Rasheed to begin treatment for drug dependence and PTSD.

children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling his bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events. So too, early exposure to ACEs is associated with traumatic stress reactions and subsequent exposure to trauma in adult years.

People who have encountered multiple and longer doses of trauma are at the greatest risk for developing traumatic stress. For example, military reservists and other military service members who have had multiple long tours of duty are at greater risk for traumatic stress reactions. In addition, people are more likely to encounter greater impairment and distress from trauma if that trauma occurs with significant intensity and continues sporadically or unceasingly for extended periods.

Was there enough time to process the experience?

A particularly severe pattern of ongoing trauma, sometimes referred to as "cascading trauma," occurs when multiple traumas happen in a pattern that does not allow an individual to heal from one traumatic event before another occurs. Take, for example, California residents—they repeatedly face consecutive and/or simultaneous natural disasters including fires, landslides, floods, droughts, and earthquakes. In other cases, there is ample time to process an event, but processing is limited because people don't have supportive relationships or environments that model preventive practices. This can lead to greater vulnerability to traumas that occur later in life.

How many losses has the trauma caused?

Trauma itself can create significant distress, but often, the losses associated with a trauma have more far-reaching effects. For instance, a child may be forced to assume adult responsibilities, such as serving as a confidant for a parent who is sexually abusing him or her, and lose the opportunity of a childhood free from adult worries. In another scenario, a couple may initially feel grateful to have

escaped a house fire, but they may nevertheless face significant community and financial losses months afterward. In evaluating the impact of trauma, it is helpful to access and discuss the losses associated with the initial trauma. The number of losses greatly influences an individual's ability to bounce back from the tragedy.

In the case illustration on the next page, Rasheed's losses cause him to disconnect from his wife, who loves and supports him. Successful confrontation of losses can be difficult if the losses compound each other, as withRasheed's loss of his friend, his disability, his employment struggles, and the threats to his marriage and liberty. People can cite a specific event as precipitating their trauma, or, in other cases, the specific trauma can symbolize a series of disabling events in which the person felt his or her life was threatened or in which he or she felt emotionally overwhelmed, psychologically disorganized, or significantly disconnected from his or her surroundings. It will be important for Rasheed to understand how his losses played a part in his abuse of prescription medications to cope with symptoms associated with traumatic stress and loss, (e.g., guilt, depression, fear). If not addressed, his trauma could increase his risk for relapse.

Was the trauma expected or unexpected?

When talking about a trauma, people sometimes say they didn't see it coming. Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common components of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). People with substance use disorders, mental illness, and/or cognitive disabilities may be especially vulnerable in that they may attend less or have competing concerns that diminish attention to what is going on around them, even in high-risk environments. However, most individuals attempt to gain some control over the tragedy by replaying the moments leading up to the event and processing how they could have anticipated it.Some people perseverate on these thoughts for months or years after the event.

Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. Learning about what is likely to happen can reduce traumatization. For instance, training military personnel in advance of going to combat overseas prepares them to handle traumas and can reduce the impact of trauma.

Were the trauma's effects on the person's life isolated or pervasive?

When a trauma is isolated from the larger context of life, a person's response to it is more likely to be contained and limited. For instance, military personnel in combat situations can be significantly traumatized by what they experience. On

return to civilian life or non-combat service, some are able to isolate the traumatic experience so that it does not invade ordinary, day-to-day living. This does not mean that the combat experience was not disturbing or that it will not resurface if the individual encounters an experience that triggers memories of the trauma; it just means that the person can more easily leave the trauma in the past and attend to the present.

Conversely, people who remain in the vicinity of the trauma may encounter greater challenges in recovery. The traumatic event intertwines with various aspects of the person's daily activities and interactions, thus increasing the possibility of being triggered by surrounding cues and experiencing subsequent psychological distress. However, another way to view this potential dilemma for the client is to reframe it as an opportunity—the repetitive exposure to trauma-related cues may provide vital guidance as to when and which treatment and coping techniques to use in the delivery of trauma-informed and trauma-specific behavioral health services.

Who was responsible for the trauma and was the act intentional?

If the severity of a trauma is judged solely by whether the act was intentional or not, events that reflect an intention to harm would be a primary indicator in predicting subsequent difficulties among individuals exposed to this form of trauma. For most survivors, there is an initial disbelief that someone would conceivably intend to harm others, followed by considerable emotional and, at times, behavioral investment in somehow making things right again or in making sense of a senseless, malicious act. For instance, in the wake of the World Trade Center attacks in New York City, people responded via renewed patriotism, impromptu candlelight vigils, attacks on people of Arab and Muslim descent, and unprecedented donations and willingness to wait in long lines to donate blood to the RedCross. Each example is a response that in some way attempts to right the perceived wrong or attach new meaning to the event and subsequent consequences.

When terrible things happen, it is human nature to assign blame. Trauma survivors can become heavily invested in assigning blame or finding out who was at fault, regardless of the type of trauma. Often, this occurs as an attempt to make sense of, give meaning to, and reestablish a sense of predictability, control, and safety after an irrational or random act. It is far easier to accept that someone, including oneself, is at fault or could have done something different than it is to accept the fact that one was simply in the wrong place at the wrong time.

For some trauma survivors, needing to find out why a trauma occurred or who is at fault can become a significant block to growth when the individual would be better served by asking, "What do I need to do to heal?" Behavioral health professionals

can help clients translate what they have learned about responsibility in recovery to other aspects of their lives. For instance, someone in treatment for co-occurring disorders who has internalized that becoming depressed or addicted was no this or her fault, but that recovery *is* a personal responsibility, can then apply the same principle to the experience of childhood abuse and thereby overcome negative judgments of self (e.g., thinking oneself to be a bad person who deserves abuse). The individual can then begin to reassign responsibility by attaching the blame to the perpetrator(s) while at the same time assuming responsibility for recovery.

Was the trauma experienced directly or indirectly?

Trauma that happens to someone directly seems to be more damaging than witnessing trauma that befalls others. For example, it is usually more traumatic to be robbed at gunpoint than to witness someone else being robbed or hearing someone tell a story about being robbed. Yet, sometimes, experiencing another's pain can be equally traumatic. For instance, parents often internalize the pain and suffering of their children when the children are undergoing traumatic circumstances (e.g., treatments for childhood cancer).

There are two ways to experience the trauma of others. An individual may witness the event, such as seeing someone killed or seriously injured in a car accident, or may learn of an event that happened to someone, such as a violent personal assault, suicide, serious accident, injury, or sudden or unexpected death.For many people, the impact of the trauma will depend on a host of variables, including their proximity to the event as eyewitnesses, the witnesses' response in the situation, their relationship to the victims, the degree of helplessness surrounding the experience, their exposure to subsequent consequences, and so on.

The effects of traumas such as genocide and internment in concentration camps can be felt across generations—stories, coping behaviors, and stress reactions can be passed across generational lines far removed from the actual events or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

What happened since the trauma?

In reviewing traumatic events, it is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, community events, behavioral health services, local stores, and recreational areas. There is typically an initial rally of services and support following a trauma, particularly if it is on a mass scale. However, the reality of the trauma's effects and their disruptiveness may have a more lasting impact. The deterioration of normalcy, including the disruption of day-to-day activities and the damage of

structures that house these routines, will likely erode the common threads that provide a sense of safety in individual lives and communities. Hence, the degree of disruption in resuming normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders. For example, adults displaced from their homes because of Hurricanes Katrina or Rita had significantly higher rates of past-month cigarette use, illicit drug use, and binge drinking than those who were not displaced (Office of Applied Studies).

Subjective Characteristics

Psychological Meaning of Trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event—that is, their beliefs and assumptions—contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or his or her family? How does the individual attach meaning to his or her survival? Does he or she believe that it is a sign of a greater purpose not yet revealed? People who attempt to share their interpretation and meaning of the event can feel misunderstood and sometimes alienated (Paulson & Krippner, Schein, Spitz, Burlingame, & Muskin). People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but his or her interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

> It is important to remember that what happened is not nearly as important as what the trauma means to the individual.

Case Illustration: Sonja

Sonja began to talk about how her life was different after being physically assaulted and robbed in a parking lot at a local strip mall a year ago. She recounts that even though there were people in the parking lot, no one came to her aid until the assailant ran off with her purse. She sustained a cheekbone fracture and developed visual difficulties due to the inflammation from the fracture. She recently sought treatment for depressive symptoms and reported that she had lost interest in activities that typically gave her joy. She reported isolating herself from others and said that her perception of others had changed dramatically since the attack.

Sonja had received a diagnosis of major depression with psychotic features 10 years earlier and received group therapy at a local community mental health center for 3 years until her depression went into remission. She recently became afraid that her depression was becoming more pronounced, and she wanted to prevent another severe depressive episode as well as the use of psychotropic medications, which she felt made her lethargic. Thus, she sought out behavioral health counseling.

As the sessions progressed, and after a psychological evaluation, it was clear that Sonja had some depressive symptoms, but they were subclinical. She denied suicidal thoughts or intent, and her thought process was organized with no evidence of hallucinations or delusions. She described her isolation as a reluctance to shop at area stores. On one hand, Sonja was self-compassionate about her reasons for avoidance, but on the other hand, she was concerned that the traumatic event had altered how she saw life and others. “I don’t see people as very caring or kind, like I used to prior to the event. I don’t trust them, and I feel people are too self-absorbed. I don’t feel safe, and this bothers me. I worry that I’m becoming paranoid again. I guess I know better, but I just want to have the freedom to do what I want and go where I want.”

Two months after Sonja initiated counseling, she came to the office exclaiming that things can indeed change. “You won’t believe it. I had to go to the grocery store, so I forced myself to go the shopping center that had a grocery store attached to a strip mall. I was walking by a coffee shop, quickly browsing the items in the front window, when a man comes out of the shop talking at me. He says, ‘You look like you need a cup of coffee.’ What he said didn’t register immediately. I looked at him blankly, and he said it again. ‘You look like you need a cup of coffee. I’m the owner of the shop, and I noticed you looking in the window, and we have plenty of brewed coffee left before we close the shop. Come on in, it’s on the house.’ So I did! From that moment on, I began to see people differently. He set it right for me—I feel as if I have myself back again, as if the assault was a sign that I shouldn’t trust people, and now I see that there is some goodness in the world. As small as this kindness was, it gave me the hope that I had lost.”

For Sonja, the assault changed her assumptions about safety and her view of others. She also attached meaning to the event. She believed that the event was a sign that she shouldn’t trust people and that people are uncaring. Yet these beliefs bothered her and contradicted how she saw herself in the world, and she was afraid that her depressive symptoms were returning.

Disruption of Core Assumptions and Beliefs

Trauma often engenders a crisis of faith (Frankl) that leads clients to question basic assumptions about life. Were the individual's core or life-organizing assumptions (e.g., about safety, perception of others, fairness, purpose of life, future dreams) challenged or disrupted during or after the traumatic event? (See the seminal work, *Shattered Assumptions*, by Janoff-Bulman). For example, some trauma survivors see themselves as irreparably wounded or beyond the possibility of healing.

Case Illustration: Frank

Frank entered substance abuse treatment with diagnoses of co-occurring PTSD and substance use disorder. While on a whitewater kayak trip with his wife, her kayak became pinned on a rock, and Frank could only watch helplessly as she drowned. His drinking had increased markedly after the accident. He acknowledged a vicious cycle of sleep disturbance with intrusive nightmares followed by vivid memories and feelings of terror and helplessness after he awoke. He drank heavily at night to quiet the nightmares and memories, but heavy alcohol consumption perpetuated his trouble sleeping. He withdrew from contact with many of his old "couple friends" and his wife's family, with whom he had been close. At treatment entry, he described his life as "going to work and coming home." The trauma occurred 3 years before he sought treatment, but Frank continued to feel numb and disconnected from the world. His only emotion was anger, which he tried to keep in check. Integrated treatment for PTSD and substance abuse helped him sleep and taught him coping skills to use when the memories arose; it fostered his engagement and retention in long-term care for both disorders.

Cultural Meaning of Trauma

Clinicians should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, anAlaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic

Resilience: Connection and Continuity

Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter studied the descendants of survivors of Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents directly affected by the purge experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. Whether the grandparents survived was less important than the connection the grandchildren felt to their pasts.

experience serves as a form of retribution. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture that has a strong belief in a positive afterlife. It is important for clinicians to recognize that their perceptions of a specific trauma could be very different from their clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system.

Individual and Sociocultural Features

A wide variety of social, demographic, environmental, and psychological factors influence a person's experience of trauma, the severity of traumatic stress reactions following the event, and his or her resilience in dealing with the short and long-term environmental, physical, sociocultural, and emotional consequences.This section addresses a few known factors that influence the risk of trauma along with the development of subclinical and diagnostic traumatic stress symptoms, such as mood and anxiety symptoms and disorders. It is not meant to be an exhaustive exploration of these factors, but rather, a brief presentation to make clinicians and other behavioral health professionals aware that various factors influence risk for and protection against traumatic stress and subsequent reactions.

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history as they

influence the person's experience and interpretation of, as well as his or her reactions to, trauma. However, many factors influence individual responses to trauma; it is not just individual characteristics. Failing to recognize that multiple factors aside from individual attributes and history influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

History of Prior Psychological Trauma

People with histories of prior psychological trauma appear to be the most susceptible to severe traumatic responses (Nishith, Mechanic, & Resick, Vogt, Bruce, Street, & Stafford), particularly if they have avoided addressing past traumas. Because minimization, dissociation, and avoidance are common defenses for many trauma survivors, prior traumas are not always consciously available, and when they are, memories can be distorted to avoid painful affects. Some survivors who have repressed their experiences deny a history of trauma or are unable to explain their strong reactions to present situations.

Remember that the effects of trauma are cumulative; therefore, a later trauma that outwardly appears less severe may have more impact upon an individual than a trauma that occurred years earlier. Conversely, individuals who have experienced earlier traumas may have developed effective coping strategies or report positive outcomes as they have learned to adjust to the consequences of the trauma(s).This outcome is often referred to as posttraumatic growth or psychological growth.

Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts.They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to attend to histories, adjust treatment to avoid retraumatization, and steer clear of labeling clients' behavior as pathological.

History of Resilience

Resilience—the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience.There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder,Charney, & Collins), flexibility in

adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions (Bonanno & Mancini).

History of Mental Disorders

The correlations among traumatic stress, substance use disorders, and co-occurring mental disorders are well known. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American PsychiatricAssociation, 2013a), traumatic stress reactions are linked to higher rates of mood, substance-related, anxiety, trauma, stress-related, and other mental disorders, each of which can precede, follow, or emerge concurrently with trauma itself. A co-occurring mental disorder is a significant determinant of whether an individual can successfully address and resolve trauma as it emerges from the past or occurs in the present. Koenen, Stellman, Stellman, and Sommer found that the risk of developing PTSD following combat trauma was higher for individuals with pre-existing conduct disorder, panic disorder, generalized anxiety disorder, and/or major depression than for those without preexisting mental disorders.

Sociodemographic Factors

Demographic variables are not good predictors of who will experience trauma and subsequent traumatic stress reactions. Gender, age, race and ethnicity, sexual orientation, marital status, occupation, income, and education can all have some influence, but not enough to determine who should or should not receive screening for trauma and traumatic stress symptoms. The following sections cover a few selected variables.

Gender

In the United States, men are at greater risk than women for being exposed to stressful events. Despite the higher prevalence among men, lifetime PTSD occurs at about twice the rate among women as it does in men. Less is known about gender differences with subclinical traumatic stress reactions. There are also other gender differences, such as the types of trauma experienced by men and women.Women are more likely to experience physical and sexual assault, whereas men are most likely to experience combat and crime victimization and to witness killings and serious injuries (Breslau, Kimerling, Ouimette, &Weitlauf, Tolin & Foa). Women in military service are subject to the same risks as men and are also at a greater risk for military sexual trauma. Men’s traumas often occur in public; women’s are more likely to take place in private settings. Perpetrators of traumas against men are often strangers, but women are more likely to know the perpetrator.

Age

In general, the older one becomes, the higher the risk of trauma—but the increase is not dramatic. Age is not particularly important in predicting exposure to trauma, yet at no age is one immune to the risk. However, trauma that occurs in the earlier and midlife years appears to have greater impact on people for different reasons. For younger individuals, the trauma can affect developmental processes, attachment, emotional regulation, life assumptions, cognitive interpretations of later experiences, and so forth (for additional resources, visit the National Child Traumatic Stress Network; http://www.nctsn.org). For adults in midlife, trauma may have a greater impact due to the enhanced stress or burden of care that often characterizes this stage of life—caring for their children and their parents at the same time. Older adults are as likely as younger adults to recover quickly from trauma, yet they may have greater vulnerabilities, including their ability to survive without injury and their ability to address the current trauma without psychological interference from earlier stressful or traumatic events. Older people are naturally more likely to have had a history of trauma because they have lived longer, thus creating greater vulnerability to the effects of cumulative trauma.

Race, Ethnicity, and Culture

The potential for trauma exists in all major racial and ethnic groups in American society, yet few studies analyze the relationship of race and ethnicity to trauma exposure and/or traumatic stress reactions. Some studies show that certain racial and ethnic groups are at greater risk for specific traumas. For example, AfricanAmericans experienced higher rates of overall violence, aggravated assault, and robbery thanWhites but were as likely to be victims of rape or sexual assault (Catalano). Literature reflects that diverse ethnic, racial, and cultural groups are more likely to experience adverse effects from various traumas and to meet criteria for posttraumatic stress (Bell).

Sexual Orientation and Gender Identity

Lesbian, gay, bisexual, and transgender individuals are likely to experience various forms of trauma associated with their sexual orientation, including harsh consequences from families and faith traditions, higher risk of assault from casual sexual partners, hate crimes, lack of legal protection, and laws of exclusion (Brown). Gay and bisexual men as well as transgender people are more likely to experience victimization than lesbians and bisexual women. Dillon reported a trauma exposure rate of 94 percent among lesbian, gay, and bisexual individuals; more than 40 percent of respondents experienced harassment due to their sexual orientation. Heterosexual orientation is also a risk for women, as women in

Resilience: Cultural, Racial, and Ethnic Characteristics

The following list highlights characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic groups:

- Strong kinship bonds
- Respect for elders and the importance of extended family
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers)
- Value in friendships and warm personal relationships
- Expression of humor and creativity
- Instilling a sense of history, heritage, and historical traditions
- Community orientation, activities, and socialization
- Strong work ethic
- Philosophies and beliefs about life, suffering, and perseverance

"Fortune owes its existence to misfortune, and misfortune is hidden in fortune."
-Lao-Tzu teaching, Taoism (Wong & Wong)

relationships with men are at a greater risk of being physically and sexually abused.

People who are Homeless

Homelessness is typically defined as the lack of an adequate or regular dwelling, or having a nighttime dwelling that is a publicly or privately supervised institution or a place not intended for use as a dwelling (e.g., a bus station). The U.S. Department of Housing andUrban Development (HUD) estimates that between 660,000 and 730,000 individuals were homeless on any given night (HUD). Two thirds were unaccompanied persons; the other third were people in families. Adults who are homeless and unmarried are more likely to be male than female.About 40 percent of men who are homeless are veterans (National Coalition for theHomeless); this percentage has grown,including the number of veterans with dependent children (Kuhn & Nakashima).

Rates of trauma symptoms are high among people who are homeless (76 to 100 percent of women and 67 percent of men; Christensen et al., Jainchill, Hawke, & Yagelka), and the diagnosis of PTSD is among the most prevalent non-substance use Axis I disorders (Lester et al., McNamara, Schumacher, Milby, Wallace, &

Usdan). People who are homeless report high levels of trauma (especially physical and sexual abuse in childhood or as adults) preceding their homeless status; assault, rape, and other traumas frequently happen while they are homeless. Research suggests that many women are homeless because they are fleeing domestic violence (National Coalition for the Homeless). Other studies suggest that women who are homeless are more likely to have histories of childhood physical and sexual abuse and to have experienced sexual assault as adults. A history of physical and/or sexual abuse is even more common among women who are homeless and have a serious mental illness.

Youth who are homeless, especially those who live without a parent, are likely to have experienced physical and/or sexual abuse. Between 21 and 42 percent of youth runaways report having been sexually abused before leaving their homes; for young women, rates range from 32 to 63 percent (Administration on Children, Youth and Families). Additionally, data reflect elevated rates of substance abuse for youth who are homeless and have histories of abuse.

More than half of people who are homeless have a lifetime prevalence of mental illness and substance use disorders. Those who are homeless have higher rates of substance abuse (84 percent of men and 58 percent of women), and substance use disorders, including alcohol and drug abuse/dependence, increase with longer lengths of homelessness (North,Eyrich, Pollio, & Spitznagel)

5. Understanding the Impact of Trauma

Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Providers need to understand how trauma can affect treatment presentation, engagement, and the outcome of behavioral health services. This chapter examines common experiences survivors may encounter immediately following or long after a traumatic experience. Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

This chapter begins with an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short-and longterm responses to traumatic experiences in the

context of individuals who may seek behavioral health services.This chapter discusses psychological symptoms not represented in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), and responses associated with trauma that either fall below the threshold of mental disorders or reflect resilience. It also addresses common disorders associated with traumatic stress. This chapter explores the role of culture in defining mental illness, particularly PTSD, and ends by addressing co-occurring mental and substance-related disorders.

Sequence of Trauma Reactions

Survivors' immediate reactions in the aftermath of trauma are quite complicated and are affected by their own experiences, the accessibility of natural supports and healers, their coping and life skills and those of immediate family, and the responses of the larger community in which they live. Although reactions range in severity, even the most acute responses are natural responses to manage trauma—they are not a sign of psychopathology. Coping styles vary from action oriented to reflective and from emotionally expressive to reticent. Clinically, a response style is less important than the degree to which coping efforts successfully allow one to continue necessary activities, regulate emotions, sustain self-esteem, and maintain and enjoy interpersonal contacts. Indeed, a past error in traumatic stress psychology, particularly regarding group or mass traumas, was the assumption that all survivors need to express emotions associated with trauma and talk about the trauma; more recent research indicates that survivors who choose not to process their trauma are just as psychologically healthy as those who do. The most recent psychological debriefing approaches emphasize respecting the individual's style of coping and not valuing one type over another.

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely.

Common Experiences and Responses to Trauma

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe

long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social supports, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

Foreshortened future: Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

The following sections focus on some common reactions across domains (emotional, physical, cognitive, behavioral, social, and developmental) associated with singular, multiple, and enduring traumatic events. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria.

Emotional

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's sociocultural history. Beyond the initial emotional reactions during the event, those most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying any of these feelings for various reasons. They might lack experience with or prior exposure to emotional expression in their family or community. They may associate strong feelings with the past trauma, thus believing that emotional expression is too dangerous or will lead to feeling out of control (e.g., a sense of "losing it" or going crazy). Still others might deny that they have any feelings associated with their traumatic experiences and define their reactions as numbness or lack of emotions.

Emotional Dysregulation

Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness ,and shame—this is more so when the trauma occurred at a young age (van der Kolk, Roth,Pelcovitz, & Mandel). In individuals who are older and functioning well prior to the trauma, such emotional dysregulation is usually short lived and represents an immediate reaction to the trauma, rather than an ongoing pattern. Self-medication—namely, substance abuse—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation (e.g.,substance-induced changes in affect during and after use). Other efforts toward emotional regulation can include engagement in high-risk or self-injurious behaviors, disordered eating, compulsive behaviors such as gambling or overworking, and repression or denial of emotions; however, not all behaviors associated with self-regulation are considered negative. In fact, some individuals find creative, healthy, and industrious ways to manage strong affect generated by trauma, such as through renewed commitment to physical activity or by creating an organization to support survivors of a particular trauma.

Traumatic stress tends to evoke two emotional extremes: feeling either too much (overwhelmed) or too little (numb) emotion.Treatment can help the client find the optimal level of emotion and assist him or her with appropriately experiencing and regulating difficult emotions. In treatment, the goal is to help clients learn to regulate their emotions without the use of substances or other unsafe behavior. This will likely require learning new coping skills and how to tolerate distressing emotions; some clients may benefit from mindfulness practices, cognitive restructuring, and trauma-specific desensitization approaches, such as exposure therapy and eye movement desensitization and reprocessing.

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. In the following case illustration, Sadhanna’s numbing is evidenced by her limited range of emotions associated with interpersonal interactions and her inability to associate any emotion with her history of abuse. She also possesses a belief in a foreshortened future. A prospective longitudinal study (Malta, Levitt, Martin, Davis, & Cloitre) that followed the development of PTSD in disaster workers highlighted the importance of understanding and appreciating numbing as a traumatic stress reaction. Because numbing symptoms hide what is going on inside emotionally, there can be a tendency for family members, counselors, and other behavioral health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Physical

Diagnostic criteria for PTSD place considerable emphasis on psychological symptoms, but some people who have experienced traumatic stress may present initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms.Moreover, there is a significant connection between trauma, including adverse childhood experiences (ACEs), and chronic health conditions. Common physical disorders and symptoms include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma

Immediate Emotional Reactions	Delayed Emotional Reactions
Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed	Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions	**Delayed Physical Reactions**
Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization	Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions	**Delayed Cognitive Reactions**
Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims	Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking
Immediate Behavioral Reactions	**Delayed Behavioral Reactions**
Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors	Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal

(Continued on the next page.)

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma (continued)

Immediate Existential Reactions	Delayed Existential Reactions
Intense use of prayer Restoration of faith in the goodness of others (e.g., receiving help from others) Loss of self-efficacy Despair about humanity, particularly if the event was intentional Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	Questioning (e.g., "Why me?") Increased cynicism, disillusionment Increased self-confidence (e.g., "If I can survive this, I can survive anything") Loss of purpose Renewed faith Hopelessness Reestablishing priorities Redefining meaning and importance of life Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, &

Somatization

Somatization indicates a focus on bodily symptoms or dysfunctions to express emotional distress. Somatic symptoms are more likely to occur with individuals who have traumatic stress reactions, including PTSD. People from certain ethnic and cultural backgrounds may initially or solely present emotional distress via physical ailments or concerns. Many individuals who present with somatization are likely unaware of the connection between their emotions and the physical symptoms that they're experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Some clients may insist that their primary problems are physical even when medical evaluations and tests fail to confirm ailments. In these situations, somatization may be a sign of a mental illness. However, various

Using Information About Biology and Trauma

Educate your clients:

- ➡ Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
- ➡ Communicate that treatment and other wellness activities can improve both psychological and physiological symptoms (e.g., therapy, meditation, exercise, yoga). You may need to refer certain clients to a psychiatrist who can evaluate them and, if warranted, prescribe psychotropic medication to address severe symptoms.
- ➡ Discuss traumatic stress symptoms and their physiological components.
- ➡ Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
- ➡ Normalize trauma symptoms. For example, explain to clients that their symptoms are not a sign of weakness, a character flaw, being damaged, or going crazy.

cultures approach emotional distress through the physical realm or view emotional and physical symptoms and wellbeing as one. It is important not to assume that clients with physical complaints are using somatization as a means to express emotional pain; they may have specific conditions or disorders that require medical attention.Foremost, counselors need to refer for medical evaluation.

Biology of Trauma

Trauma biology is an area of burgeoning research, with the promise of more complex and explanatory findings yet to come. Although a thorough presentation on the biological aspects of trauma is beyond the scope of this publication, what is currently known is that exposure to trauma leads to a cascade of biological changes and stress responses. These biological alterations are highly associated with PTSD, other mental illnesses, and substance use disorders. These include:

- ➡ Changes in limbic system functioning

- ➡ Hypothalamic–pituitary–adrenal axis activity changes with variable cortisol levels.
- ➡ Neurotransmitter-related, dysregulation of arousal and endogenous opioid systems.

As a clear example, early ACEs such as abuse, neglect, and other traumas affect brain development and increase a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseasesand other physical illnesses, mental illnesses,substance-related disorders, and impairmentin other life areas (Centers for Disease Control and Prevention).

Hyperarousal and Sleep Disturbances

A common symptom that arises from traumatic experiences is hyperarousal (also called hypervigilance). Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

Hyperarousal is a consequence of biological changes initiated by trauma. Although it serves as a means of self-protection after trauma, it can be detrimental. Hyperarousal can interfere with an individual's ability to take the necessary time to assess and appropriately respond to specific input, such as loud noises or sudden movements. Sometimes, hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Along with hyperarousal, sleep disturbances are very common in individuals who have experienced trauma. They can come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Sleep disturbances are most persistent among individuals who have trauma-related stress; the disturbances sometimes remain resistant to intervention long after other traumatic stress symptoms have been successfully treated.Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Cognitive

Traumatic experiences can affect and alter cognitions. From the outset, trauma challenges the just-world or core life assumptions that help individuals navigate daily life (Janoff-Bulman). For example, it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise. Belief that one's efforts and intentions can protect oneself from bad things makes it less likely for an individual to perceive

Case Illustration: Kimi

Kimi is a 35-year-old Native American woman who was group raped at the age of 16 on her walk home from a suburban high school. She recounts how her whole life changed on that day. "I never felt safe being alone after the rape. I used to enjoy walking everywhere. Afterward, I couldn't tolerate the fear that would arise when I walked in the neighborhood. It didn't matter whether I was alone or with friends–every sound that I heard would throw me into a state of fear. I felt like the same thing was going to happen again. It's gotten better with time, but I often feel as if I'm sitting on a tree limb waiting for it to break. I have a hard time relaxing. I can easily get startled if a leaf blows across my path or if my children scream while playing in the yard. The best way I can describe how I experience life is by comparing it to watching a scary, suspenseful movie–anxiously waiting for something to happen, palms sweating, heart pounding, on the edge of your chair."

personal vulnerability. However, traumatic events—particularly if they are unexpected—can challenge such beliefs.

Let's say you always considered your driving time as "your time"—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance. Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is eroded, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked. Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe. Still, many other individuals are able to return to organizing core beliefs that support their perception of safety.

Cognitions and Trauma

The following examples reflect some of the types of cognitive or thought-process changes that can occur in response to traumatic stress:

- **Cognitive errors:** Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma (e.g., a client overreacting to an overturned canoe in 8 inches of water, as if she and her paddle companion would drown, due to her previous experience of nearly drowning in a rip current 5 years earlier).
- **Excessive or inappropriate guilt:** Attempting to make sense cognitively and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.
- **Idealization:** Demonstrating inaccurate rationalizations, idealizations, or justifications of the perpetrator's behavior, particularly if the perpetrator is or was a caregiver. Other similar reactions mirror idealization; traumatic bonding is an emotional attachment that develops (in part to secure survival) between perpetrators who engage in interpersonal trauma and their victims, and Stockholm syndrome involves compassion and loyalty toward hostage takers (de Fabrique, Van Hasselt, Vecchi, & Romano).
- **Trauma-induced hallucinations or delusions:** Experiencing hallucinations and delusions that, although they are biological in origin, contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as child, because he wore shoes similar to those her father once wore).
- **Intrusive thoughts and memories:** Experiencing, without warning or desire, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while. For instance, individuals who inadvertently are retraumatized due to program or clinical practices may have a surge of intrusive thoughts of past trauma, thus making it difficult for them to discern what is happening now versus what happened then. Whenever counseling focuses on trauma, it is likely that the client will experience some intrusive thoughts and memories. It is important to develop coping strategies before, as much as possible, and during the delivery of trauma-informed and trauma-specific treatment.

Many factors contribute to cognitive patterns prior to, during, and after a trauma. Adopting Beck and colleagues' cognitive triad model, trauma can alter three main cognitive patterns: thoughts about self, the world (others/environment),and the future. To clarify, trauma can lead individuals to see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless—believing that personal suffering will continue, or negative outcomes will preside for the foreseeable future. Subsequently, this set of cognitions can greatly influence clients' belief in their ability to use internal resources and external support effectively. From a cognitive–behavioral perspective, these cognitions have a bidirectional relationship in sustaining or contributing to the development of depressive and anxiety symptoms after trauma. However, it is possible for cognitive patterns to help protect against debilitating psychological symptoms as well.

Feeling Different

An integral part of experiencing trauma is feeling different from others, whether or not the trauma was an individual or group experience. Traumatic experiences typically feel surreal and challenge the necessity and value of mundane activities of daily life. Survivors often believe that others will not fully understand their experiences, and they may think that sharing their feelings, thoughts, and reactions related to the trauma will fall short of expectations. However horrid the trauma may be, the *experience* of the trauma is typically profound.

The type of trauma can dictate how an individual feels different or believes that they are different from others. Traumas that generate shame will often lead survivors to feel more alienated from others—believing that they are"damaged goods." When individuals believe that their experiences are unique and incomprehensible, they are more likely to seek support, if they seek support at all, only with others who have experienced a similar trauma.

Triggers and Flashbacks

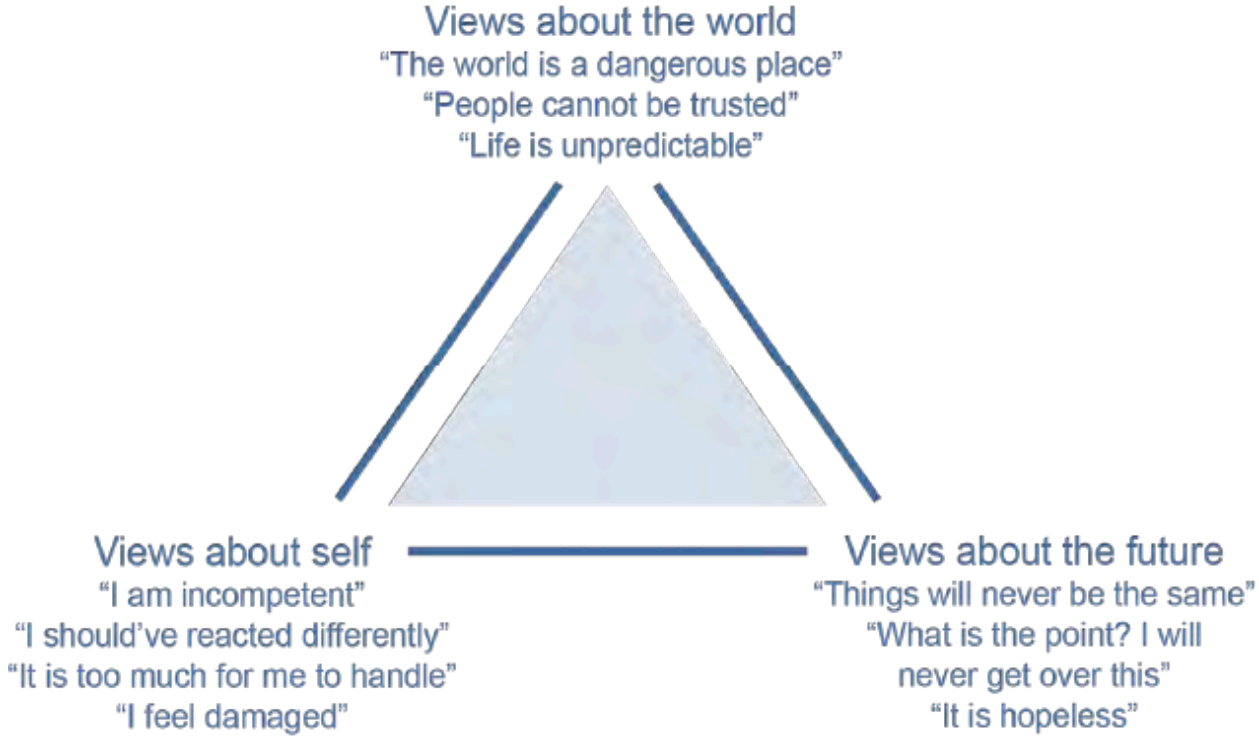
Triggers

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard. In treatment, it is important to help clients identify potential triggers, draw a connection between

strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs. A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback is re-experiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times, specific physical states increase a person's vulnerability to re-experiencing a trauma, (e.g., fatigue, high stress levels). Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people re-experience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.



Helping Clients Manage Flashbacks and Triggers

If a client is triggered in a session or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Behavioral health service providers should be prepared to help the client get regrounded so that they can distinguish between what is happening now versus what had happened in the past (See Covington, and Najavits, for more grounding techniques). Offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It often helps for the client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places him or her at higher risk for retraumatization and requires use of coping strategies, including seeking support.

Source: Green Cross Academy of Traumatology,

Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people re-experience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

Dissociation, Depersonalization, and Derealization

Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment. Dissociation can also occur during severe stress or trauma as a protective element whereby the individual

incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder).

According to the DSM-5, "dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013a, p. 291). Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors or victims of ongoing political imprisonment, torture, or long-term isolation. A mental health professional, preferably with significant training in working with dissociative disorders and with trauma, should be consulted when a dissociative disorder diagnosis is suspected.

Potential Signs of Dissociation

- Fixed or "glazed" eyes
- Sudden flattening of affect
- Long periods of silence
- Monotonous voice
- Stereotyped movements
- Responses not congruent with the present context or situation
- Excessive intellectualization

(Source: Briere)

The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through derealization, leading to a sense that what is taking place is unfamiliar or is not real.

If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-

term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process.

Behavioral

Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience.Some people reduce tension or stress through avoidant, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g.,high-risk behaviors), and/or self-injurious behaviors. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma.

Behavioral reactions are also the consequences of, or learned from, traumatic experiences. For example, some people act like they can't control their current environment, thus failing to take action or make decisions long after the trauma (learned helplessness). Other associated elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions.

Reenactments

A hallmark symptom of trauma is re-experiencing the trauma in various ways. Re-experiencing can occur through reenactments (literally, to "redo"), by which trauma survivors repetitively relive and recreate a past trauma in their present lives. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, 2001. Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: self-injurious behaviors, hypersexuality, walking alone in unsafe areas or other high-risk behaviors, driving recklessly, or involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent), to name a few.

Self-harm and Self-destructive Behaviors

Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often, self-harm is an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and"damaged" (Herman, Santa Mina &Gallop). Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. Thus, addressing self-harm requires attention to the client's reasons for self-harm. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways.

Among the self-harm behaviors reported in the literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair-pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide. Cutting and burning are among the most common forms of self-harm.

Self-harm tends to occur most in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse) rather than in those who have undergone a single adult trauma (e.g., a community-wide disaster or a serious car accident). There are strong associations between eating disorders, self-harm, and substance abuse (Claes &Vandereycken, for discussion, see Harned, Najavits, & Weiss). Self-mutilation is also associated with (and part of the diagnostic criteria for) a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders.

It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Most people who engage in self-harm are not doing so with the intent to kill themselves (Noll, Horowitz, Bonanno, Trickett, & Putnam)—although self-harm can be life threatening and can escalate into suicidality if not managed therapeutically. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors

in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term. However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persist—or worsen—without intervention.

Consumption of Substances

Substance use often is initiated or increased after trauma. Clients in early recovery —especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. In the first 2 months after September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, Galea, Ahern, Resnick, &Kilpatrick). A study by the Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Studies) used National Survey on Drug Use and Health data to compare the first three quarters of 2001 with the last quarter and reported an increase in the prevalence rate for alcohol use among people 18 or older in theNew York metropolitan area during the fourth quarter.

Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, 2001. Others, who lost their income and could no longer support their habit, enrolled in methadone programs (Weiss et al.). After the Oklahoma City bombing in 1995, Oklahomans reported double the normal rate of alcohol use, smoking more cigarettes, and a higher incidence of initiating smoking months and even years after the bombing (Smith,Christiansen, Vincent, & Hann).

Self-medication

Khantzian's self-medication theory suggests that drugs of abuse are selected for their specific effects. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression.

Avoidance

Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas (e.g., avoiding emotionally oriented conversations in an intimate relationship). For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area.Avoidance can come in many forms. When people can't tolerate strong affects associated with traumatic memories, they avoid, project, deny, or distort their trauma-related emotional and cognitive experiences. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidance—in essence, becoming desensitized to traumatic memories and associated symptoms.

Social/Interpersonal

A key ingredient in the early stage of TIC is to establish, confirm, or reestablish a support system, including culturally appropriate activities, as soon as possible. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. Relationships require emotional exchanges, which means that others who have close relationships or friendships with the individual who survived the trauma(s)are often affected as well—either through secondary traumatization or by directly experiencing the survivor's traumatic stress reactions. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned.

Survivors may readily rely on family members, friends, or other social supports—or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their

Neurobiological Development: Consequences of Early Childhood Trauma

Findings in developmental psychobiology suggest that the consequences of early maltreatment produce enduring negative effects on brain development (DeBellis, Liu, Diorio, Day, Francis, & Meaney, Teicher). Research suggests that the first stage in a cascade of events produced by early trauma and/or maltreatment involves the disruption of chemicals that function as neurotransmitters (e.g., cortisol, norepinephrine, dopamine), causing escalation of the stress response (Heim, Mletzko, Purselle, Musselman, & Nemeroff, Heim, Newport, Mletzko, Miller, & Nemeroff, Teicher). These chemical responses can then negatively affect critical neural growth during specific sensitive periods of childhood development and can even lead to cell death.

Adverse brain development can also result from elevated levels of cortisol and catecholamines by contributing to maturational failures in other brain regions, such as the prefrontal cortex (Meaney, Brake, & Gratton). Heim, Mletzko et al. found that the neuropeptide oxytocin– important for social affiliation and support, attachment, trust, and management of stress and anxiety–was markedly decreased in the cerebrospinal fluid of women who had been exposed to childhood maltreatment, particularly those who had experienced emotional abuse. The more childhood traumas a person had experienced, and the longer their duration, the lower that person's current level of oxytocin was likely to be and the higher her rating of current anxiety was likely to be.

Using data from the Adverse Childhood Experiences Study, an analysis by Anda, Felitti, Brown et al. confirmed that the risk of negative outcomes in affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased as scores on a measure of eight ACEs increased. The researchers concluded that the association of study scores with these outcomes can serve as a theoretical parallel for the effects of cumulative exposure to stress on the developing brain and for the resulting impairment seen in multiple brain structures and functions.

The National Child Traumatic Stress Network (http://www.nctsn.org) offers information about childhood abuse, stress, and physiological responses of children who are traumatized. Materials are available for counselors, educators, parents, and caregivers. There are special sections on the needs of children in military families and on the impact of natural disasters on children's mental health.

ability to use their support systems and resources adequately.

Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers. It is exceptionally difficult to override the feeling that someone is going to hurt you, take advantage of you, or, minimally, disappoint you. Early betrayal can affect one's ability to develop attachments, yet the formation of supportive relationships is an important antidote in the recovery from traumatic stress.

Developmental

Each age group is vulnerable in unique ways to the stresses of a disaster, with children and the elderly at greatest risk. Young children may display generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomachaches, headaches). School-age children may exhibit symptoms such as aggressive behavior and anger, regression to behavior seen at younger ages, repetitious traumatic play, loss of ability to concentrate, and worse school performance. Adolescents may display depression and social withdrawal, rebellion, increased risky activities such as sexual acting out, wish for revenge and action-oriented responses to trauma, and sleep and eating disturbances (Hamblen). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of alcohol or drugs. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe).

6. Specific Trauma-Related Psychological Disorders

Part of the definition of trauma is that the individual responds with intense fear, helplessness, or horror. Beyond that, in both the short term and the long term, trauma comprises a range of reactions from normal (e.g.,being unable to concentrate, feeling sad, having trouble sleeping) to warranting a diagnosis of a trauma-related mental disorder. Most people who experience trauma have no long-lasting disabling effects; their coping skills and the support of those around them are sufficient to help them overcome their difficulties, and their ability to function on a daily basis overtime is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated

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

Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been vio lent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to de tails of child abuse). **Note:** This does not apply to exposure through electronic media, televi sion, movies, or pictures, unless this exposure is work related.

Presence of nine (or more) of the following symptoms from any of the five categories of intru sion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
- Dissociative reactions (e.g., flashbacks), during which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.
- Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood:

- Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms:

- An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from an other's perspective, being in a daze, time slowing).
- Inability to remember an important aspect of the traumatic event(s) (typically due to dissocia tive amnesia and not to other factors, such as head injury, alcohol, or drugs).

Avoidance Symptoms:

- Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associat ed with the traumatic event(s).

Arousal Symptoms:

- Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
- Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
- Hypervigilance.
- Problems with concentration.
- Exaggerated startle response.

(Continued on the next page.)

with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of preexisting disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.

Acute Stress Disorder

ASD represents a normal response to stress.Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress. Most individuals who have acute stress reactions never develop further impairment orPTSD. Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress.

The primary presentation of an individual with an acute stress reaction is often that of someone who appears overwhelmed by the traumatic experience. The need to talk about the experience can lead the client to seem self-centered and unconcerned about the needs of others. He or she may need to describe, in repetitive detail, what happened, or may seem obsessed with trying to understand what happened in an effort to make sense of the experience. The client is often hypervigilant and avoids circumstances that are reminders of the trauma. For instance, someone who was in a serious car crash in heavy traffic can become anxious and avoid riding in a car or driving in traffic for a finite time afterward. Partial amnesia for the trauma often accompanies ASD, and the individual may repetitively question others to fill in details. People with ASD symptoms sometimes seek assurance from others that the event happened in the way they remember, that they are not “going crazy”or “losing it,” and that they could not have prevented the event. The next case illustration demonstrates the time-limited nature of ASD.

Differences Between ASD and PTSD

It is important to consider the differences between ASD and PTSD when forming a diagnostic impression. The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period. The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD also differs from PTSD in that the ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in

the following month. Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD, so the inclusion of dissociative symptoms makes it more likely that those who developASD will later be diagnosed with PTSD (Bryant & Harvey). Additionally, ASDis a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life. Over a lengthy period, PTSD can have profound effects on clients' perceptions of safety, their sense of hope for the future, their relationships with others, their physical health, the appearance of psychiatric symptoms, and their patterns of substance use and abuse.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD. There is some suggestion that, as with PTSD, ASD is more prevalent in women than in men (Bryant &Harvey). However, many people with PTSD do not have a diagnosis or recall a history of acute stress symptoms before seeking treatment for or receiving a diagnosis of PTSD.

Effective interventions for ASD can significantly reduce the possibility of the subsequent development of PTSD. Effective treatment ofASD can also reduce the incidence of other co-occurring problems, such as depression, anxiety, dissociative disorders, and compulsive behaviors (Bryant & Harvey). Intervention for ASD also helps the individual develop coping skills that can effectively prevent the recurrence of ASD after later traumas.

Although predictive science for ASD andPTSD will continue to evolve, both disorders are associated with increased substance use and mental disorders and increased risk of relapse; therefore, effective screening for ASD and PTSD is important for all clients with these disorders. Individuals in early recovery—lacking well-practiced coping skills, lacking environmental supports, and already operating at high levels of anxiety—are particularly susceptible to ASD. Events that would not normally be disabling can produce symptoms of intense helplessness and fear, numbing and depersonalization, disabling anxiety, and an inability to handle normal life events. Counselors should be able to recognize ASD and treat it rather than attributing the symptoms to a client's lack of motivation to change, being "dry drunk" (for those in substance abuse recovery), or being manipulative.

Posttraumatic Stress Disorder

The trauma-related disorder that receives the greatest attention is PTSD; it is the most commonly diagnosed trauma-related disorder, and its symptoms can be quite debilitating over time. Nonetheless, it is important to remember that PTSD

Helping Clients With Delayed Trauma Responses

Clients who are experiencing a delayed trauma response can benefit if you help them to:

- ✓ Create an environment that allows acknowledgment of the traumatic event(s).
- ✓ Discuss their initial recall or first suspicion that they were having a traumatic response.
- ✓ Become educated on delayed trauma responses.
- ✓ Draw a connection between the trauma and presenting trauma-related symptoms.
- ✓ Create a safe environment.
- ✓ Explore their support systems and fortify them as needed.
- ✓ Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- ✓ Identify their triggers.
- ✓ Develop coping strategies to navigate and manage symptoms.

symptoms are represented in a number of other mental illnesses, including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al.). The DSM-5 (APA, 2013a) identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks. Certain characteristics make people more susceptible to PTSD, including one's unique personal vulnerabilities at the time of the traumatic exposure, the support (or lack of support) received from others at the time of the trauma and at the onset of trauma-related symptoms, and the way others in the person's environment gauge the nature of the traumatizing event (Brewin, Andrews, & Valentine).

People with PTSD often present varying clinical profiles and histories. They can experience symptoms that are activated by environmental triggers and then recede

for a period of time. Some people with PTSD who show mostly psychiatric symptoms (particularly depression and anxiety) are misdiagnosed and go untreated for their primary condition. For many people, the trauma experience and diagnosis are obscured by co-occurring substance use disorder symptoms. The important feature of PTSD is that the disorder becomes an orienting feature of the individual's life. How well the person can work, with whom he or she associates, the nature of close and intimate relationships, the ability to have fun and rejuvenate, and the way in which an individual goes about confronting and solving problems in life are all affected by the client's trauma experiences and his or her struggle to recover.

Posttraumatic Stress Disorder: Timing of Symptoms

Although symptoms of PTSD usually begin within 3 months of a trauma in adulthood, there can be a delay of months or even years before symptoms appear for some people. Some people may have minimal symptoms after a trauma but then experience a crisis later in life. Trauma symptoms can appear suddenly, even without conscious memory of the original trauma or without any overt provocation. Survivors of abuse in childhood can have a delayed response triggered by something that happens to them as adults. For example, seeing a movie about child abuse can trigger symptoms related returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time.As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

Culture and Posttraumatic Stress

Although research is limited across cultures,PTSD has been observed in Southeast Asian,South American, Middle Eastern, and NativeAmerican survivors (Osterman & de Jong, Wilson & Tang). As Stamm and Friedman point out, however, simply observing PTSD does not mean that it is the"best conceptual tool for characterizing post-traumatic distress among non-Western individuals". In fact, many trauma-related symptoms from other cultures do not fit the DSM-5 criteria. These include somatic and psychological symptoms and beliefs about the origins and nature of traumatic events. Moreover, religious and spiritual beliefs can affect how a survivor experiences a traumatic event and whether he or she reports the distress. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it is harder for war veterans to come forward and

disclose that they are emotionally overwhelmed or struggling. It would be perceived as inappropriate and possibly demoralizing to focus on the emotional

Case Illustration: Sheila

Two months ago, Sheila, a 55-year-old married woman, experienced a tornado in her home town. In the previous year, she had addressed a long-time marijuana use problem with the help of a treatment program and had been abstinent for about 6 months. Sheila was proud of her abstinence; it was something she wanted to continue. She regarded it as a mark of personal maturity; it improved her relationship with her husband, and their business had flourished as a result of her abstinence.

During the tornado, an employee reported that Sheila had become very agitated and had grabbed her assistant to drag him under a large table for cover. Sheila repeatedly yelled to her assistant that they were going to die. Following the storm, Sheila could not remember certain details of her behavior during the event. Furthermore, Sheila said that after the storm, she felt numb, as if she was floating out of her body and could watch herself from the outside. She stated that nothing felt real and it was all like a dream.

Following the tornado, Sheila experienced emotional numbness and detachment, even from people close to her, for about 2 weeks. The symptoms slowly decreased in intensity but still disrupted her life. Sheila reported experiencing disjointed or unconnected images and dreams of the storm that made no real sense to her. She was unwilling to return to the building where she had been during the storm, despite having maintained a business at this location for 15 years. In addition, she began smoking marijuana again because it helped her sleep. She had been very irritable and had uncharacteristic angry outbursts toward her husband, children, and other family members.

As a result of her earlier contact with a treatment program, Sheila returned to that program and engaged in psychoeducational, supportive counseling focused on her acute stress reaction. She regained abstinence from marijuana and returned shortly to a normal level of functioning. Her symptoms slowly diminished over a period of 3 weeks. With the help of her counselor, she came to understand the link between the trauma and her relapse, regained support from her spouse, and again felt in control of her life.

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

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

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

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to de tails of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
- Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
- Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the

traumatic event(s) occurred, as evidenced by two (or more) of the following:

- Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
- Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
- Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
- Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
- Markedly diminished interest or participation in significant activities.
- Feelings of detachment or estrangement from others.
- 'Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

(Continued on the next page.)

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD (continued)

Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

- Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
- Reckless or self-destructive behavior.
- Hypervigilance.
- Exaggerated startle response.
- Problems with concentration.
- Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

- **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
- **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another med ical condition (e.g., complex partial seizures).

Specify whether:

- **With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.

distress that he or she still bears.

Complex Trauma and Complex Traumatic Stress

When individuals experience multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships, their reactions to trauma have unique characteristics (Herman). This unique constellation of reactions, called complex traumatic stress, is not recognized diagnostically in the DSM-5, but theoretical discussions and research have begun to highlight the similarities and differences in symptoms of posttraumatic stress versus complex traumatic stress (Courtois &Ford). Often, the symptoms generated from complex trauma do not fully matchPTSD criteria and exceed the severity of PTSD. Overall, literature reflects that PTSD criteria or sub-threshold symptoms do not fully account for the persistent and more impairing clinical presentation of complex trauma. Even though current research in the study of traumatology is prolific, it is still in the early stages of development. The idea

that there may be more diagnostic variations or subtypes is forthcoming, and this will likely pave the way for more client-matching interventions to better serve those individuals who have been repeatedly exposed to multiple, early childhood, and/or interpersonal traumas.

Other Trauma-Related and Co-Occurring Disorders

The symptoms of PTSD and other mental disorders overlap considerably; these disorders often coexist and include mood, anxiety, substance use, and personality disorders. Thus, it's common for trauma survivors to be under-diagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

> The term "**co-occurring disorders**" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including sub -stance abuse). Co -occurring disorders are common among individuals who have a history of trauma and are seeking help.

People With Mental Disorders

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al.). Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase

Co-Occurring PTSD and Other Mental Disorders
Individuals with PTSD often have at least one additional diagnosis of a mental disorder. The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.

Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, Waldrop, Back, Verduin, & Brady). Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment. Given the prevalence of traumatic events in clients who present for substance abuse treatment, counselors should assess all clients for possible trauma-related disorders.

vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

7. Screening and Assessment

Why screen universally for trauma in behavioral health services? Exposure to trauma is common; in many surveys, more than half of respondents report a history

of trauma, and the rates are even higher among clients with mental or substance use disorders. Furthermore, behavioral health problems, including substance use and mental disorders, are more difficult to treat if trauma-related symptoms and disorders aren't detected early and treated effectively. Not addressing traumatic stress symptoms, trauma-specific disorders, and other symptoms/disorders related to trauma can impede successful mental health and substance abuse treatment. Unrecognized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psychological symptoms or substance use, and worse outcomes. Screening can also prevent misdiagnosis and inappropriate treatment planning. People with histories of trauma often display symptoms that meet criteria for other disorders.

> Screening to identify clients who have histories of trauma and experience trauma -related symptoms is a prevention strategy.

Without screening, clients' trauma histories and related symptoms often go undetected, leading providers to direct services toward symptoms and disorders that may only partially explain client presentations and distress. Universal screening for trauma history and trauma-related symptoms can help behavioral health practitioners identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress.

Screening, early identification, and intervention serves as a prevention strategy. The chapter begins with a discussion of screening and assessment concepts, with a particular focus on trauma-informed screening. It then highlights specific factors that influence screening and assessment, including timing and environment. Barriers and challenges in providing trauma-informed screening are discussed, along with culturally specific screening and assessment considerations and guidelines. Instrument selection, trauma-informed screening and assessment tools, and trauma-informed screening and assessment processes are reviewed as well.

Screening

The first two steps in screening are to determine whether the person has a history of trauma and whether he or she has trauma-related symptoms. Screening mainly obtains answers to "yes" or "no" questions: "Has this client experienced a trauma in the past?" and"Does this client at this time warrant further assessment regarding trauma-related symptoms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are

present. However, the presence of such symptoms does not necessarily say anything about their severity, nor does a positive screen indicate that a disorder actually exists. Positive screens only indicate that assessment or further evaluation is warranted, and negative screens do not necessarily mean that an individual doesn't have symptoms that warrant intervention.

Screening procedures should always define the steps to take after a positive or negative screening. That is, the screening process establishes precisely how to score responses to screening tools or questions and clearly defines what constitutes a positive score (called a "cutoff score") for a particular potential problem.The screening procedures detail the actions to take after a client scores in the positive range.Clinical supervision is helpful—and sometimes necessary—in judging how to proceed.

Universal Screening and Assessment

Only people specifically trained and licensed in mental health assessment should make diagnoses; trauma can result in complicated cases, and many symptoms can be present, whether or not they meet full diagnostic criteria for a specific disorder. Only a trained assessor can distinguish accurately among various symptoms and in the presence of co-occurring disorders. However, behavioral health professionals without specific assessment training can still serve an important role in screening for possible mental disorders using established screening tools (CSAT). In agencies and clinics, it is critical to provide such screenings systematically–for each client–as PTSD and other co-occurring disorders are typically underdiagnosed or misdiagnosed.

Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process, but it is not an end in itself. Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them, whereas assessments for trauma-related disorders require a mental health professional trained in assessment and evaluation processes. The most important domains to screen among individuals with trauma histories include:

➡ Trauma-related symptoms

- Depressive or dissociative symptoms
- Sleep disturbances
- Intrusive experiences
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders)
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences)
- Substance abuse
- Social support and coping styles
- Availability of resources
- Risks for self-harm, suicide, and violence
- Health screenings

> Screening is often the first contact between the client and the treatment provider, and the client forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client.

Assessment

When a client screens positive for substance abuse, trauma-related symptoms, or mental disorders, the agency or counselor should follow up with an assessment. A positive screening calls for more action—an assessment that determines and defines presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement. Assessment determines the nature and extent of the client's problems; it might require the client to respond to written questions, or it could involve a clinical interview by a mental health or substance abuse professional qualified to assess the client and arrive at a diagnosis. A clinical assessment delves into a client's past and current experiences, psychosocial and cultural history, and assets and resources.

Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other behavioral health professionals, and agencies. Qualifications for conducting assessments and clinical interviews are more rigorous than for screening. Advanced degrees, licensing or certification, and special training in administration, scoring, and interpretation of specific assessment

instruments and interviews are often required. Clinicians must be familiar with(and obtain) the level of training required for any instruments they consider using.

For people with histories of traumatic life events who screen positive for possible trauma-related symptoms and disorders, thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation or follow-up.

Overall, assessment may indicate symptoms that meet diagnostic criteria for a substance use or mental disorder or a milder form of symptomatology that doesn't reach a diagnostic level—or it may reveal that the positive screen was false and that there is no significant cause for concern. Information from an assessment is used to plan the client's treatment.

The plan can include such domains as level of care, acute safety needs, diagnosis, disability, strengths and skills, support network, and cultural context. Assessments should reoccur throughout treatment. Ongoing assessment during treatment can provide valuable information by revealing further details of trauma history as clients' trust in staff members grows and by gauging clients' progress.

Timing of Screening and Assessment

As a trauma-informed counselor, you need to offer psychoeducation and support from the outset of service provision; this begins with explaining screening and assessment and with proper pacing of the initial intake and evaluation process. The client should understand the screening process, why the specific questions are important, and that he or she may choose to delay a response or to not answer a question at all. Discussing the occurrence or consequences of traumatic events can feel as unsafe and dangerous to the client as if the event were reoccurring. It is important not to encourage avoidance of the topic or reinforce the belief that discussing trauma-related material is dangerous, but be sensitive when gathering information in the initial screening. Initial questions about trauma should be general and gradual. Taking the time to prepare and explain the screening and assessment process to the client gives him or her a greater sense of control and safety over the assessment process.

Clients with Substance Use Disorders

No screening or assessment of trauma should occur when the client is under the influence of alcohol or drugs. Clients under the influence are more likely to give inaccurate information. Although it's likely that clients in an active phase of use (albeit not at the assessment itself) or undergoing substance withdrawal can

provide consistent information to obtain a valid screening and assessment, there is insufficient data to know for sure. Some theorists state that no final assessment of trauma or posttraumatic stress disorder (PTSD) should occur during these early phases (Read, Bollinger, & Sharkansky), asserting that symptoms of withdrawal can mimic PTSD and thus result in overdiagnosis of PTSD and other trauma-related disorders. Alcohol or drugs can also cause memory impairment that clouds the client's history of trauma symptoms. However, Najavits and others note that underdiagnosis, not overdiagnosis, of trauma and PTSD has been a significant issue in the substance abuse field and thus claim that it is essential to obtain an initial assessment early, which can later be modified if needed (e.g., if the client's symptom pattern changes). Indeed, clinical observations suggest that assessments for both trauma and PTSD— even during active use or withdrawal—appear robust (Coffey, Schumacher, Brady, & Dansky). Although some PTSD symptoms and trauma memories can be dampened or increased to a degree, their overall presence or absence, as assessed early in treatment, appears accurate (Najavits).

Conduct Assessments Throughout Treatment

Ongoing assessments let clinicians:

- ✓ Track changes in the presence, frequency, and intensity of symptoms.
- ✓ Learn the relationships among the client's trauma, presenting psychological symptoms, and substance abuse.
- ✓ Adjust diagnoses and treatment plans as needed.
- ✓ Select prevention strategies to avoid more pervasive traumatic stress symptoms.

The Setting for Trauma Screening and Assessment

Advances in the development of simple, brief, and public-domain screening tools mean that at least a basic screening for trauma can bed one in almost any setting. Not only can clients be screened and assessed in behavioral health treatment settings; they can also be evaluated in the criminal justice system, educational

settings, occupational settings, physicians' offices, hospital medical and trauma units, and emergency rooms. Wherever they occur, trauma-related screenings and subsequent assessments can reduce or eliminate wasted resources, relapses, and, ultimately, treatment failures among clients who have histories of trauma, mental illness, and/or substance use disorders.

Creating an Effective Screening and Assessment Environment

You can greatly enhance the success of treatment by paying careful attention to how you approach the screening and assessment process. Take into account the following points:

- ***Clarify for the client what to expect in the screening and assessment process.*** For example, tell the client that the screening and assessment phase focuses on identifying issues that might benefit from treatment.Inform him or her that during the trauma screening and assessment process, uncomfortable thoughts and feelings can arise. Provide reassurance that, if they do, you'll assist in dealing with this distress—but also let them know that, even with your assistance, some psychological and physical reactions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal.
- ***Approach the client in a matter-of-fact, yet supportive, manner.*** Such an approach helps create an atmosphere of trust, respect, acceptance, and thoughtfulness (Melnick &Bassuk). Doing so helps to normalize symptoms and experiences generated by the trauma; consider informing clients that such events are common but can cause continued emotional distress if they are not treated. Clients may also find it helpful for you to explain the purpose of certain difficult questions. For example, you could say, "Many people have experienced troubling events as children, so some of my questions are about whether you experienced any such events while growing up." Demonstrate kindness and directness in equal measure when screening/assessing clients (Najavits).
- ***Respect the client's personal space.*** Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client's personal space, sitting neither too far from nor too close to the client; let your observations of the client's comfort level during the screening and assessment process guide the amount of distance. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.
- ***Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process.*** Strive to maintain a soothing, quiet

Screening and Assessing Clients

- Ask all clients about any possible history of trauma; use a checklist to increase proper identification of such a history (see the online Adverse Childhood Experiences Study Score Calculator [http://acestudy.org/ace_score] for specific questions about adverse childhood experiences).
- Use only validated instruments for screening and assessment.
- Early in treatment, screen all clients who have histories of exposure to traumatic events for psychological symptoms and mental disorders related to trauma.
- When clients screen positive, also screen for suicidal thoughts and behaviors.
- Do not delay screening; do not wait for a period of abstinence or stabilization of symptoms.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- Focus assessment on how trauma symptoms affect clients' current functioning.
- Consider using paper-and-pencil instruments for screening and assessment as well as self-report measures when appropriate; they are less threatening for some clients than a clinical interview.
- Talk about how you will use the findings to plan the client's treatment, and discuss any immediate action necessary, such as arranging for interpersonal support, referrals to community agencies, or moving directly into the active phase of treatment. It is helpful to explore the strategies clients have used in the past that have worked to relieve strong emotions (Fallot & Harris).
- At the end of the session, make sure the client is grounded and safe before leaving the interview room (Litz, Miller, Ruef, & McTeague). Readiness to leave can be assessed by checking on the degree to which the client is conscious of the current environment, what the client's plan is for maintaining personal safety, and what the client's plans are for the rest of the day.

demeanor. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been traumatized may be more reactive even to benign or well-intended questions.

- ***Provide culturally appropriate symbols of safety in the physical environment.*** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.
- ***Be aware of one's own emotional responses to hearing clients' trauma histories*.** Hearing about clients' traumas may be very painful and can elicit strong emotions.The client may interpret your reaction to his or her revelations as disinterest, disgust for the client's behavior, or some other inaccurate interpretation. It is important for you to monitor your interactions and to check in with the client as necessary. You may also feel emotionally drained to the point that it interferes with your ability to accurately listen to or assess clients. This effect of exposure to traumatic stories, known as secondary traumatization, can result in symptoms similar to those experienced by the client (e.g., nightmares, emotional numbing); if necessary, refer to a colleague for assessment (Valent).
- ***Overcome linguistic barriers via an interpreter.*** Deciding when to add an interpreter requires careful judgment.The interpreter should be knowledgeable of behavioral health terminology, be familiar with the concepts and purposes of the interview and treatment programming, be unknown to the client, and be part of the treatment team. Avoid asking family members or friends of the client to serve as interpreters.
- ***Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic stress symptoms and related disorders.***There is no need to probe deeply into the details of a client's traumatic experiences at this stage in the treatment process. Given the lack of a therapeutic relationship in which to process the information safely, pursuing details of trauma can cause retraumatization or produce a level of response that neither you nor your client is prepared to handle. Even if a client wants to tell his or her trauma story, it's your job to serve as "gatekeeper" and preserve the client's safety. Your tone of voice when suggesting postponement of a discussion of trauma is very important. Avoid conveying the message, "I really don't want to hear about it." Examples of appropriate statements are: "Your life experiences are very important, but at this early point in our work together, we should start with what's going on in your life currently rather than discussing past experiences in detail. If you feel that certain past experiences are having a big effect on your life now, it would be helpful for us to discuss them as long as we focus on your safety and recovery right now." "Talking about your past at this point could arouse intense feelings—even more than you might be aware of right now. Later, if you choose to, you can talk with your counselor about how to work on exploring your past." "Often, people who have a history of trauma

want to move quickly into the details of the trauma to gain relief. I understand this desire, but my concern for you at this moment is to help you establish a sense of safety and support before moving into the traumatic experiences. We want to avoid retraumatization—meaning, we want to establish resources that weren't available to you at the time of the trauma before delving into more content."

- ***Give the client as much personal control as possible during the assessment by:*** Presenting a rationale for the interview and its stress-inducing potential, making clear that the client has the right to refuse to answer any and all questions. Giving the client (where staffing permits) the option of being interviewed by someone of the gender with which he or she is most comfortable. Postponing the interview if necessary (Fallot & Harris).
- ***Use self-administered, written checklists rather than interviews when possible to assess trauma.*** Traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer. Clients are more likely to report trauma when they use self-administered screening tools; however, these types of screening instruments only guide the next step. Interviews should coincide with self-administered tools to create a sense of safety f or the client (someone is present as he or she completes t he screening) and to follow up with more in depth data gathering after a self-administered screening is complete. The Trauma History Questionnaire (THQ) is a self-administered tool (Green). It has been used successfully with clinical and nonclinical populations, including medical patients, women who have experienced domestic violence, and people with serious mental illness (Hooper, Stockton).
- ***Interview the client if he or she ha s trouble reading or writing or is otherwise unable to complete a checklist.*** Clients who are likely to minimize their trauma when using a checklist (e.g., those who exhibit significant symptoms of dissociation or repression) benefit from a clinical interview. A trained interviewer can elicit information that a self-administered checklist does not capture. Overall, using both a self-administered questionnaire and an interview can help achieve greater clarity and context.
- ***Allow time for the client to become calm and oriented to the present if he or she has very intense emotional responses when recalling or acknowledging a trauma.*** At such times, avoid responding with such exclamations as "I don't know how you survived that!" (Bernstein). If the client has difficulty self-soothing, guide him or her through grounding techniques, which are particularly useful—perhaps even critical—to achieving a successful interview when a client has dissociated or is experiencing intense feelings in response to screening and/or interview questions.

- ***Avoid phrases that imply judgment about the trauma.*** For example, don't say to a client who survived Hurricane Katrina and lost family members, "It was God's will,"or "It was her time to pass," or "It was meant to be." Do not make assumptions about what a person has experienced. Rather, listen supportively without imposing personal views on the client's experience.
- ***Provide feedback about the results of the screening.*** Keep in mind the client's vulnerability, ability to access resources, strengths, and coping strategies. Present results in a synthesized manner, avoiding complicated, overly scientific jargon or explanations. Allow time to process client reactions during the feedback session. Answer client questions and concerns in a direct, honest, and compassionate manner. Failure to deliver feedback in this way can negatively affect clients' psychological status and severely weaken the potential for developing a therapeutic alliance with the client.
- ***Be aware of the possible legal implications of assessment.*** Information you gather during the screening and assessment process can necessitate mandatory reporting to authorities, even when the client does not want such information disclosed (Najavits). For example, you can be required to report a client's experience of child abuse even if it happened many years ago or the client doesn't want the information reported. Other legal issues can be quite complex, such as confidentiality of records, pursuing a case against a trauma perpetrator and divulging information to third parties while still protecting the legal status of information used in prosecution, and child custody issues (Najavits). It's essential that you know the laws in your state, have an expert legal consultant available, and access clinical supervision.

Barriers and Challenges to Trauma-Informed Screening and Assessment

Barriers

It is not necessarily easy or obvious to identify an individual who has survived trauma without screening. Moreover, some clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the occurrence of traumatic events. The two main barriers to the evaluation of trauma and its related disorders in behavioral health settings are clients not reporting trauma and providers overlooking trauma and its effects.

Concerning the first main barrier, some events will be experienced as traumatic by one person but considered non-traumatic by another. A history of trauma encompasses not only the experience of a potentially traumatic event, but also the person's responses to it and the meanings he or she attaches to the event. Certain

situations make it more likely that the client will not be forthcoming about traumatic events or his or her responses to those events.Some clients might not have ever thought of a particular event or their response to it as traumatic and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor whom they've only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or domestic violence). Still others may deny their history because they are tired of being interviewed or asked to fill out forms and may believe it doesn't matter anyway.

A client may not report past trauma for many reasons, including:

- Concern for safety (e.g., fearing more abuse by a perpetrator for revealing the trauma).
- Fear of being judged by service providers.
- Shame about victimization.
- Reticence about talking with others in response to trauma.
- Not recalling past trauma through dissociation, denial, or repression (although genuine blockage of all trauma memory is rare among trauma survivors; McNally).
- Lack of trust in others, including behavioral health service providers.
- Not seeing a significant event as traumatic.

Regarding the second major barrier, clinicians and other behavioral health service providers may lack awareness that trauma can significantly affect clients' presentations in treatment and functioning across major life areas, such as relationships and work. In addition, some clinicians may believe that their role is to treat only the presenting psychological and/or substance abuse symptoms, and thus they may not be as sensitive to histories and effects of trauma. Other providers may believe that a client should abstain from alcohol and drugs for an extended period before exploring trauma symptoms. Perhaps you fear that addressing a clients' trauma history will only exacerbate symptoms and complicate treatment. Behavioral health service providers who hold biases may assume that a client doesn't have a history of trauma and thus fail to ask the "right" questions, or they may be uncomfortable with emotions that arise from listening to client experiences and, as a result, redirect the screening or counseling focus.

Challenges

Awareness of Acculturation and Language

Acculturation levels can affect screening and assessment results. Therefore, in depth discussions may be a more appropriate way to gain an understanding of trauma from the client's point of view. During the intake, prior to trauma screening, determine the client's history of migration, if applicable, and primary language. Questions about the client's country of birth, length of time in this country, events or reasons for migration, and ethnic self-identification are also appropriate at intake. Also be aware that even individuals who speak English well might have trouble understanding the subtleties of questions on standard screening and assessment tools. It is not adequate to translate items simply from English into another language; words, idioms, and examples often don't translate directly into other languages and therefore need to be adapted. Screening and assessment should be conducted in the client's preferred language by trained staff members who speak the language or by professional translators familiar with treatment jargon.

Awareness of Co-occurring Diagnoses

A trauma-informed assessor looks for psychological symptoms that are associated with trauma or simply occur alongside it. Symptom screening involves questions about past or present mental disorder symptoms that may indicate the need for a full mental health assessment. A variety of screening tools are available, including symptom checklists. However, you should only use symptom checklists when you need information about how your client is currently feeling; don't use them to screen for specific disorders. Responses will likely change from one administration of the checklist to the next.

Basic mental health screening tools are available. For example, the Mental Health Screening Form-III screens for present or past symptoms of most mental disorders (Carroll & McGinley); it is available at no charge from ProjectReturn Foundation, Inc. and is also reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT). Other screening tools, such as the Beck Depression Inventory II and the Beck Anxiety Inventory (Beck, Wright, Newman, & Liese), also screen broadly for mental and substance use disorders, as well as for specific disorders often associated with trauma. For further screening information and resources on depression and suicide, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT), and TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*

Exhibit 1.4-1: Grounding Techniques

Grounding techniques are important skills for assessors and all other behavioral health service providers who interact with traumatized clients (e.g., nurses, security, administrators, clinicians). Even if you do not directly conduct therapy, knowledge of grounding can help you defuse an escalating situation or calm a client who is triggered by the assessment process. Grounding strategies help a person who is overwhelmed by memories or strong emotions or is dissociating; they help the person become aware of the here and now. A useful metaphor is the experience of walking out of a movie theater. When the person dissociates or has a flashback, it's like watching a mental movie; grounding techniques help him or her step out of the movie theater into the daylight and the present environment. The client's task is not only to hold on to moments from the past, but also to acknowledge that what he or she was experiencing is from the past. Try the following techniques:

Ask the client to state what he or she observes. Guide the client through this exercise by using statements like, "You seem to feel very scared/angry right now. You're probably feeling things related to what happened in the past. Now, you're in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, etc. What else can you do to feel okay in your body right now?"

Help the client decrease the intensity of affect.

- "Emotion dial": A client imagines turning down the volume on his or her emotions.
- Clenching fists can move the energy of an emotion into fists, which the client can then release.
- Guided imagery can be used to visualize a safe place.
- Use strengths-based questions (e.g., "How did you survive?" or "What strengths did you possess to survive the trauma?").

Distract the client from unbearable emotional states.

- Have the client focus on the external environment (e.g., name red objects in the room). Ask the client to focus on recent and future events (e.g., "to do" list for the day).
- Help the client use self-talk to remind himself or herself of current safety.
- Use distractions, such as counting, to return the focus to current reality.
- Somatosensory techniques (toe-wiggling, touching a chair) can remind clients of current reality.

Ask the client to use breathing techniques.

- Ask the client to inhale through the nose and exhale through the mouth.
- Have the client place his or her hands on his or her abdomen and then watch the hands go up and down while the belly expands and contracts.

Source: Melnick & Bassuk

(CSAT).

A common dilemma in the assessment of trauma-related disorders is that certain trauma symptoms are also symptoms of other disorders. Clients with histories of trauma typically present a variety of symptoms; thus, it is important to determine the full scope of symptoms and/or disorders present to help improve treatment planning. Clients with trauma-related and substance use symptoms and disorders are at increased risk for additional Axis I and/or Axis II mental disorders (Brady,Killeen, Saladin, Dansky, & Becker, Cottler, Nishith, & Compton). These symptoms need to be distinguished so that other presenting subclinical features or disorders do not go unidentified and untreated. To accomplish this, a comprehensive assessment of the client's mental health is recommended.

Misdiagnosis and Underdiagnosis

Many trauma survivors are either misdiagnosed (i.e., given diagnoses that are not accurate) or underdiagnosed (i.e., have one or more diagnoses that have not been identified at all). Such diagnostic errors could result, in part, from the fact that many general instruments to evaluate mental disorders are not sufficiently sensitive to identify posttraumatic symptoms and can mis-classify them as other disorders, including personality disorders or psychoses. Intrusive posttraumatic symptoms, for example, can show up on general measures as indicative of hallucinations or obsessions. Dissociative symptoms can be interpreted as indicative of schizophrenia. Trauma-based cognitive symptoms can be scored as evidence for paranoia or other delusional processes (Briere). Some of the most common misdiagnoses in clients with PTSD and substance abuse are:

- ***Mood and Anxiety Disorders.*** Overlapping symptoms with such disorders as major depression, generalized anxiety disorder, and bipolar disorder can lead to misdiagnosis.
- ***Borderline Personality Disorder.*** Historically, this has been more frequently diagnosed than PTSD. Many of the symptoms, including a pattern of intense interpersonal relationships, impulsivity, rapid and unpredictable mood swings, power struggles in the treatment environment, underlying anxiety and depressive symptoms, and transient, stress-related paranoid ideation or severe dissociative symptoms overlap. The effect of this misdiagnosis on treatment can be particularly negative; counselors often view clients with a borderline personality diagnosis as difficult to treat and unresponsive to treatment.
- ***Antisocial Personality Disorder.*** For men and women who have been traumatized in childhood, "acting out" behaviors, a lack of empathy and conscience, impulsivity, and self-centeredness can be functions of trauma and survival skills rather than true antisocial characteristics.

➡ ***Attention Deficit Hyperactivity Disorder (ADHD).*** For children and adolescents, impulsive behaviors and concentration problems can be diagnosed as ADHD rather than PTSD.

It is possible, however, for clients to legitimately have any of these disorders in addition to trauma-related disorders. Given the overlap of posttraumatic symptoms with those of other disorders, a wide variety of diagnoses often needs to be considered to avoid misidentifying other disorders as PTSD and vice versa. A trained and experienced mental health professional will be required to weigh differential diagnoses.

Cross-Cultural Screening and Assessment

Many trauma-related symptoms and disorders are culture specific, and a client's cultural background must be considered in screening and assessment (for review of assessment and cultural considerations when working with trauma, see Wilson & Tang). Behavioral health service providers must approach screening and assessment processes with the influences of culture, ethnicity, and race firmly in mind. Cultural factors, such as norms for expressing psychological distress, defining trauma, and seeking help in dealing with trauma, can affect:

- How traumas are experienced.
- The meaning assigned to the event(s).
- How trauma-related symptoms are expressed (e.g., as somatic expressions of distress, level of emotionality, types of avoidant behavior).
- Willingness to express distress or identify trauma with a behavioral health service provider and sense of safety in doing so.
- Whether a specific pattern of behavior, emotional expression, or cognitive process is considered abnormal.
- Willingness to seek treatment inside and outside of one's own culture.
- Response to treatment.
- Treatment outcome.

When selecting assessment instruments, counselors and administrators need to choose, whenever possible, instruments that are culturally appropriate for the client. Instruments that have been normed for, adapted to, and tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population are likely to contain cultural biases and produce misleading results. Subsequently, this can lead to misdiagnosis, overdiagnosis, inappropriate treatment plans, and ineffective interventions. Thus, it is important to interpret all test results cautiously and to discuss the limitations of instruments with clients from diverse ethnic populations and cultures.

The DSM-5 and Updates to Screening and Assessment Instruments

The recent publication of the DSM-5 (APA, 2013a) reflects changes to certain diagnostic criteria, which will affect screening tools and criteria for trauma-related disorders. Criterion A2 (specific to traumatic stress disorders, acute stress, and posttraumatic stress disorders), included in the fourth edition (text revision) of the DSM (DSM-IV-TR; APA, 2000a), has been eliminated; this criterion stated that the individual's response to the trauma needs to involve intense fear, helplessness, or horror. There are now four cluster symptoms, not three: re-experiencing, avoidance, arousal, and persistent negative alterations in cognitions and mood. Changes to the DSM-5 were made to symptoms within each cluster. Thus, screening will need modification to adjust to this change (APA).

Choosing Instruments

Numerous instruments screen for trauma history, indicate symptoms, assess trauma-related and other mental disorders, and identify related clinical phenomena, such as dissociation.One instrument is unlikely to meet all screening or assessment needs or to determine the existence and full extent of trauma symptoms and traumatic experiences. The following sections present general considerations in selecting standardized instruments.

Purpose

Define your assessment needs. Do you need a standardized screening or assessment instrument for clinical purposes? Do you need information on a specific aspect of trauma, such as history, PTSD, or dissociation? Do you wish to make a formal diagnosis, such as PTSD? Do you need to determine quickly whether a client has experienced a trauma? Do you want an assessment that requires a clinician to administer it, or can the client complete the instrument himself or herself? Does the instrument match the current and specific diagnostic criteria established in the DSM-5?

Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment

Trauma

Key question: Did the client experience a trauma?

Examples of measures: Life Stressor Checklist-Revised (Wolfe & Kimerling); Trauma History Questionnaire (Green); Traumatic Life Events Questionnaire (Kubany et al).

Note: A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

Acute Stress Disorder (ASD) and PTSD

Key question: Does the client meet criteria for ASD or PTSD?

Examples of measures: Clinician-Administered PTSD Scale (CAPS; Blake et al.); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel).

Note: A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

Other Trauma-Related Symptoms

Key question: Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

Examples of measures: Beck Depression Inventory II (Beck et al.); Dissociative Experiences Scale (Bernstein & Putnam, Carlson & Putnam); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, Weiss & Marmar); Trauma Symptom Inventory (Briere); Trauma Symptom Checklist for Children (Briere); Modified PTSD Symptom Scale (Falsetti et al.).

Note: These measures can be helpful for clinical purposes and for outcome assessment because they gauge *levels* of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

Other Trauma-Related Diagnoses

Key question: Does the client have other disorders related to trauma? These include mood disorders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

Examples of measures: Mental Health Screening Form III (Carroll & McGinley); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised); Structured Clinical Interview for DSMIV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised).

Note: For complex symptoms and diagnoses such as dissociation and dissociative disorders, interviews are recommended. Look for measures that incorporate DSM-5 criteria.

Sources: Antony et al., Najavits.

Population

Consider the population to be assessed (e.g.,women, children, adolescents, refugees, disaster survivors, survivors of physical or sexual violence, survivors of combat-related trauma, people whose native language is not English); some tools are appropriate only for certain populations. Is the assessment process developmentally and culturally appropriate for your client?

Instrument Quality

An instrument should be psychometrically adequate in terms of sensitivity and specificity or reliability and validity as measured in several ways under varying conditions. Published research offers information on an instrument's psychometric properties as well as its utility in both research and clinical settings. For further information on a number of widely used trauma evaluation tools, see Appendix D andAntony, Orsillo, and Roemer's paper.

Practical Issues

Is the instrument freely and readily available, or is there a fee? Is costly and extensive training required to administer it? Is the instrument too lengthy to be used in the clinical setting? Is it easily administered and scored with accompanying manuals and/or other training materials? How will results be presented to or used with the client? Is technical support available for difficulties in administration, scoring, or interpretation of results? Is special equipment required such as a microphone, a video camera, or a touch-screen computer with audio?

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or Slapped you?
2. Have you ever been in a relationship where your partner **Threatened** you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched **Things**?

Source: Paranjape & Liebschutz, Used

Trauma-Informed Screening and Assessment

The following sections focus on initial screening. Screening is only as good as the actions taken afterward to address a positive screen (when clients acknowledge that they experience symptoms or have encountered events highlighted within the screening). Once a screening is complete and a positive screen is acquired, the client then needs referral for a more in depth assessment to ensure development of

Culture-Specific Stress Responses

Culture-bound concepts of distress exist that don't necessarily match diagnostic criteria. Culture-specific symptoms and syndromes can involve physical complaints, broad emotional reactions, or specific cognitive features. Many such syndromes are unique to a specific culture but can broaden to cultures that have similar beliefs or characteristics. Culture-bound syndromes are typically treated by traditional medicine and are known throughout the culture. Cultural concepts of distress include:

- ***Ataques de nervios*.** Recognized in Latin America and among individuals of Latino descent, the primary features of this syndrome include intense emotional upset (e.g., shouting, crying, trembling, dissociative or seizure-like episodes). It frequently occurs in response to a traumatic or stressful event in the family.
- ***Nervios*.** This is considered a common idiom of distress among Latinos; it includes a wide range of emotional distress symptoms including headaches, nervousness, tearfulness, stomach discomfort, difficulty sleeping, and dizziness. Symptoms can vary widely in intensity, as can impairment from them. This often occurs in response to stressful or difficult life events.
- ***Susto*.** This term, meaning "fright," refers to a concept found in Latin American cultures, but it is not recognized among Latinos from the Caribbean. *Susto* is attributed to a traumatic or frightening event that causes the soul to leave the body, thus resulting in illness and unhappiness; extreme cases may result in death. Symptoms include appetite or sleep disturbances, sadness, lack of motivation, low self-esteem, and somatic symptoms.
- ***Taijin kyofusho*.** Recognized in Japan and among some American Japanese, this "interpersonal fear" syndrome is characterized by anxiety about and avoidance of interpersonal circumstances. The individual presents worry or a conviction that his or her appearance or social interactions are inadequate or offensive. Other cultures have similar cultural descriptions or syndromes associated with social anxiety.

Sources: APA, pp. 833-837; Briere & Scott

an appropriate treatment plan that matches his or her presenting problems.

Establish a History of Trauma

A person cannot have ASD, PTSD, or any trauma-related symptoms without experiencing trauma; therefore, it is necessary to inquire about painful, difficult, or overwhelming past experiences. Initial information should be gathered in a way that is minimally intrusive yet clear. Brief questionnaires can be less threatening to a client than face-to-face interviews, but interviews should be an integral part of any screening and assessment process.

If the client initially denies a history of trauma (or minimizes it), administer the questionnaire later or delay additional trauma-related questions until the client has perhaps developed more trust in the treatment setting and feels safer with the thoughts and emotions that might arise in discussing his or her trauma experiences.

The Stressful Life Experiences (SLE) screen is a checklist of traumas that also considers the client's view of the impact of those events on life functioning. Using the SLE can foster the client–clinician relationship. By going over the answers with the client, you can gain a deep understanding of your client, and the client receives a demonstration of your sensitivity and concern for what the client has experienced. The National Center for PTSD Web site offers similar instruments (http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp).

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to? YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? YES NO
3. Were constantly on guard, watchful, or easily startled? YES NO
4. Felt numb or detached from others, activities, or your surroundings? YES NO

Source: Prins et al. Material used is in the public domain.

In addition to broad screening tools that capture various traumatic experiences and symptoms, other screening tools, such as the Combat Exposure Scale (Keane et al.) and the Intimate Partner Violence Screening Tool, focus on acknowledging a specific type of traumatic event.

Screen for Trauma-Related Symptoms and Disorders in Clients With Histories of Trauma

This step evaluates whether the client's trauma resulted in subclinical or

diagnosable disorders. The clinician can ask such questions as,"Have you received any counseling or therapy? Have you ever been diagnosed or treated for a psychological disorder in the past? Have you ever been prescribed medications for your emotions in the past?" Screening is typically conducted by a wide variety of behavioral health service providers with different levels of training and education; however, all individuals who administer screenings, regardless of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained. Exhibit 1.4-5 is an example of a screening instrument for trauma symptoms, the Primary Care PTSD (PC-PTSD) Screen. Current research (Prins et al.) suggests that the optimal cutoff score for the PC-PTSD is 3. If sensitivity is of greater concern than efficiency, a cutoff score of 2 is recommended.

Exhibit 1.4-6: The SPAN

The SPAN instrument is a brief screening tool that asks clients to identify the trauma in their past that is most disturbing to them currently. It then poses four questions that ask clients to rate the frequency and severity with which they have experienced, in the past week, different types of trauma-related symptoms (startle, physiological arousal, anger, and numbness).

To order this screening instrument, use the following contact information: Multi-Health Systems, Inc. P.O. Box 950 North Tonawanda, NY 14120-0950 Phone: 800-456-3003
Source: Meltzer-Brody et al.

Another instrument that can screen for traumatic stress symptoms is the four-item self-report SPAN, summarized in Exhibit 1.4-6, which is derived from the 17-item Davidson Trauma Scale (DTS). SPAN is an acronym for the four items the screening addresses: startle, physiological arousal, anger, and numbness. It was developed using a small, diverse sample of adult patients (N=243; 72 percent women;17.4 percent African American; average age =37 years) participating in several clinical studies, including a family study of rape trauma, combat veterans, and Hurricane Andrew survivors, among others.

The SPAN has a high diagnostic accuracy of 0.80 to 0.88, with sensitivity (percentage of true positive instances) of 0.84 and specificity (percentage of true negative instances) of 0.91(Meltzer-Brody, Churchill, & Davidson). SPAN scores correlated highly with the full DTS (r = 0.96) and

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when some thing reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being “super-alert” or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Source: Weathers et al. Material used is in the public domain.

other measures, such as the Impact of Events Scale ($r = 0.85$) and the Sheehan Disability Scale ($r = 0.87$).

Exhibit 1.4-8: Resilience Scales

A number of scales with good psychometric properties measure resilience:

- Resilience Scale (Wagnild & Young)
- Resilience Scale for Adults (Friborg, Hjemdal, Rosenvinge, & Martinussen)
- Connor Davidson Resilience Scale, 25-,10-, and 2-Item (Connor & Davidson, Campbell-Sills & Stein, Vaishnavi, Connor, & Davidson, respectively)
- Dispositional Resilience Scale, 45-,30-, 15item forms (Bartone, Roland, Picano, &Williams)

The PTSD Checklist, developed by the National Center for PTSD, is in the public domain. Originally developed for combat veterans of the Vietnam and Persian Gulf Wars, it has since been validated on a variety of noncombat traumas (Keane, Brief,Pratt, & Miller). When using the checklist, identify a specific trauma first and then have the client answer questions in relation to that one specific trauma.

Other Screening and Resilience Measures

Along with identifying the presence of trauma-related symptoms that warrant assessment to determine the severity of symptoms as well as whether or not the individual possesses subclinical symptoms or has met criteria for a trauma-related disorder, clients should receive other screenings for symptoms associated with trauma (e.g., depression, suicidality). It is important that screenings address both external and internal resources (e.g., support systems, strengths, coping styles). Knowing the client's strengths can significantly shape the treatment planning process by allowing you to use strategies that have already worked for the client and incorporating strategies to build resilience (Exhibit 1.4-8). Preliminary research shows improvement of individual resilience through treatment interventions in other populations (Lavretsky,Siddarth, & Irwin).

Screen for Suicidality

All clients—particularly those who have experienced trauma—should be screened for suicidality by asking, "In the past, have you ever had suicidal thoughts, had intention to commit suicide, or made a suicide attempt? Do you have any of those feelings now? Have you had any such feelings recently?" Behavioral health service providers should receive training to screen for suicide. Additionally, clients with substance use disorders and a history of psychological trauma are at heightened risk for suicidal thoughts and behaviors; thus, screening for suicidality is indicated.

Concluding Note

Screenings are only beneficial if there are follow-up procedures and resources for handling positive screens, such as the ability to review results with and provide feedback to the individual after the screening, sufficient resources to complete a thorough assess mentor to make an appropriate referral for an assessment, treatment planning processes that can easily incorporate additional trauma-informed care objectives and goals, and availability and access to trauma-specific services that match the client's needs. Screening is only the first step!

8. Clinical Issues Across Services

Many clients in behavioral health treatment may have histories of trauma, so counselors should be prepared to help them address issues that arise from those histories. This chapter begins with a thorough discussion of trauma-informed prevention and treatment objectives along with practical clinical strategies. Specific treatment issues related to working with trauma survivors in a clinical setting are discussed as well, including client engagement, pacing and timing, traumatic memories, and culturally appropriate and gender-responsive services. The chapter ends with guidelines for making referrals to trauma-specific services.

Trauma-Informed Prevention and Treatment Objectives

Trauma-informed care (TIC) not only focuses on identifying individuals who have histories of trauma and traumatic stress symptoms; it also places considerable effort in creating an environment that helps them recognize the impact of trauma and determine the next course of action in a safe place. For some individuals, psychoeducation and development or reinforcement of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions. Although research is limited in the area of building resilience to prevent exacerbation of trauma symptoms and traumatic stress disorders, TIC also focuses on prevention strategies to avoid retraumatization in treatment, to promote resilience, and to prevent the development of trauma-related disorders. The following sections highlight key trauma-informed prevention and treatment objectives.

Establish Safety

Beyond identifying trauma and trauma-related symptoms, the initial objective of TIC is establishing safety. Borrowing from Herman's conceptualization of trauma

recovery, safety is the first goal of treatment. Establishing safety is especially crucial at the outset of trauma-informed treatment and often becomes a recurrent need when events or therapeutic changes raise safety issues, such as a change in treatment staffing due to vacations.

In the context of TIC, safety has a variety of meanings. Perhaps most importantly, the client has to have some degree of ***safety from trauma symptoms***. Recurring intrusive nightmares; painful memories that burst forth seemingly without provocation; feelings of sadness, anger, shame, or being overwhelmed; or not having control over sudden disconnections from others make moment-to-moment living feel unsafe. Clients might express feeling unsafe through statements such as, "I can't control my feelings," or, "I just space out and disconnect from the world for no reason," or,"I'm afraid to go to sleep because of the nightmares." The intense feelings that accompany trauma can also make clients feel unsafe.They may wake up in the morning feeling fine but become immobilized by depression as the day progresses. Clients with histories of trauma may experience panicky feelings of gain more control over trauma symptoms (and be able to label them as such) by learning more about the client and helping him or her develop new coping skills to handle symptoms when they arise and stay more grounded when flooded with feelings or memories.

A second aspect is ***safety in the environment***. Trauma reactions can be triggered by sudden loud sounds (e.g., television at high volume, raised voices), tension between people, certain smells, or casual touches that are perceived as invasions of physical boundaries. The vulnerability of exposing one's history in the treatment setting can manifest in the client as feeling physically vulnerable and unsafe in the treatment environment. Sudden or inadequately explained treatment transitions, such as moving from one level of treatment to another or changing counselors, can also evoke feelings of danger, abandonment, or instability. Early in treatment, trauma survivors generally value routine and predictability. The counselor should recognize these needs and respond appropriately by offering information in advance, providing non shaming responses to a client's reactions to stimuli in his or her environment, and helping the client build a daily structure that feels safe.

A third aspect of safety is ***preventing a recurrence of trauma***. People with histories of trauma and substance abuse are more likely to engage in high-risk behaviors and to experience subsequent traumas. Early treatment should focus on helping clients stop using unsafe coping mechanisms, such as substance abuse, self-harm, and other self-destructive behaviors, and replacing them with safe and healthy coping strategies. Helping clients learn to protect themselves in reasonable ways is a positive goal of treatment.

Strategies To Promote Safety

Strategy #1: Teach clients how and when to use grounding exercises when they feel unsafe or overwhelmed.
Strategy #2: Establish some specific routines in individual, group, or family therapy (e.g., have an opening ritual or routine when starting and ending a group session). A structured setting can provide a sense of safety and familiarity for clients with histories of trauma.
Strategy #3: Facilitate a discussion on safe and unsafe behaviors. Have clients identify, on paper, behaviors that promote safety and behaviors that feel unsafe for them today.
Strategy #4: Refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits). This menu-based manual covers an array of treatment topics, including the core concept of safety. Each topic consists of several segments, including preparing for the session, session format, session content, handouts, and guidelines.
Strategy #5: Encourage the development of a safety plan. Depending on the type of trauma, personal safety can be an issue; work with the client to develop a plan that will help him or her feel in control and prepared for the unexpected. If the trauma was a natural or human-caused disaster, encourage thinking about how family and friends will respond and connect in the event of another crisis. If sexual abuse or rape was the event, encourage thinking about future steps that could help make the client safer. There is a delicate balance between preparation and the realization that one cannot prepare for all possible traumatic events. Nonetheless, an action plan can help the client regain a sense of environmental balance.

Prevent Retraumatization

A key objective in TIC is to prevent retraumatization generated by intervention and treatment practices and policies. Unfortunately, treatment settings and clinicians

Strategies To Prevent Retraumatization

Strategy #1: Be sensitive to the needs of clients who have experienced trauma regarding behaviors in the treatment setting that might trigger memories of the trauma.

Strategy #2: Do not ignore clients' symptoms and demands when clients with trauma histories act out in response to triggered trauma memories; doing so may replicate t he original traumatic experience.

Strategy #3: Be mindful that efforts to control and contain a client's behaviors in treatment can produce an abnormal reaction, particularly for trauma survivors for whom being trapped was part of the trauma experience.

Strategy #4: Listen for specific triggers that seem to be driving the client's reaction. An important step in recovery is helping the client identify these cues and thereby reach a better understanding of reactions and behaviors.

can unintentionally create retraumatizing experiences (for a review of traumas that can occur when treating serious mental illness, see Fruehet al.). For instance, compassionate inquiry into a client's history can seem similar to the interest shown by a perpetrator many years before. Direct confrontation by clinicians about behaviors related to substance abuse can be seen, by someone who has been repeatedly physically assaulted, as provocation building up to assault. Clinician and program efforts to help clients constrain destructive behaviors can be interpreted as efforts to control and dominate the individual. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Some staff and agency issues that can result in retraumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.
- Discounting a client's report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling intense rage and other feelings as pathological.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting clinician–client relationships by changing clinicians' schedules and assignments.

- Obtaining urine specimens in a non private and/or disrespectful manner.
- Having clients undress in the presence of others.
- Being insensitive to a client's physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including alack of consistent, competent leadership.

Provide Psychoeducation

Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders as well as the related consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, to highlight potential short-term and long-term consequences of trauma and various paths to recovery, and to underscore the message that recovery is possible. Education frequently takes place prior to or immediately following an initial screening as a way to prepare clients for hearing results or to place the screening and subsequent assessment findings in proper context. Education in and of itself, however, does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals who have histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance recognition of symptoms and ease the path of seeking treatment.

Some clients do not recognize the link between their current difficulties and their trauma histories; education can help them understand the possible origin of their difficulties. Psychoeducation presents trauma-related symptoms that follow a trauma as normal reactions. By identifying the source of clients' current difficulties and framing them as normal thoughts, emotions, and behaviors in response to trauma, many trauma survivors report a reduction in the intensity of the difficulties or symptoms. Often, a client will express relief that his or her reactions are normal. You may find the U.S. Department of Veterans Affairs (VA) National Center onPTSD's educational handouts on traumatic stress reactions useful.

Psychoeducation goes beyond the identification of traumatic stress symptoms and/or learning about the psychological, cognitive, and physical impacts of trauma. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies

Strategies To Implement Psychoeducation

Strategy #1: Remember that this may be the client's first experience with treatment. It's easy to use program or clinical jargon when you're around it every day, but most individuals who seek help are unfamiliar with clinical language, how the program works, and treatment objectives. Psychoeducation begins with understanding the client's expectations and reasons for seeking help, followed by educating the client and other family members about the program. Remember that this is all new for them.
Strategy #2: After obtaining acknowledgment of a trauma history, provide an overview of common symptoms and consequences of traumatic stress, regardless of whether the client affirms having trauma-related symptoms. It is equally important to educate the client on resilience factors associated with recovery from trauma (Wessely et al.). A trauma-informed perspective provides a message that trauma reactions are normal responses to an abnormal situation.
Strategy #3: Develop a resource box that provides an array of printed or multimedia educational materials that address t he program, specific symptoms and tools to combat trauma-related symptoms, treatment options and therapy approaches, advantages of peer support, and steps in developing specific coping strategies.
Strategy #4: Develop a rotating educational group that matches services and client schedules to complement treatment. Remember that education can play a pivotal role in enhancing motivation, in normalizing experiences, and in creating a sense of safety as individuals move further into treatment. For some survivors, education can be a powerful intervention or prevention strategy.

in key areas, including safety, emotional regulation, help-seeking, avoidant behavior, and so forth. An example is S.E.L.F.,a trauma-informed psychoeducational group curriculum with educational components related to trauma recovery in the following areas: creating **S**afety, regulating **E**motions, addressing **L**oss, and redefining the **F**uture (Bloom, Foderaro, & Ryan,)

Offer Trauma-Informed Peer Support

Living with a history of trauma can be isolating and consuming. The experience of trauma can reinforce beliefs about being different, alone, and marred by the

Strategies To Enhance Peer Support

Strategy #1: Provide education on what peer support is and is not. Roles and expectations of peer support can be confusing, so providing clarification in the beginning can be quite useful. It is important to provide initial education about peer support and the value of using this resource.

Strategy #2: Use an established peer support curriculum to guide the peer support process. For example, *Intentional Peer Support: An Alternative Approach* (Mead) is a workbook that highlights four main tasks for peer support: building connections, understanding one's worldview, developing mutuality, and helping each other move toward set desires and goals. This curriculum provides extensive materials for peer support staff members as well as for the individuals seeking peer support.

experience. At times, behavioral health treatment for trauma-related effects can inadvertently reinforce these beliefs. Simply engaging in treatment or receiving specialized services (although warranted) can further strengthen clients' beliefs that there is something wrong with them. Formalized peer support can enhance the treatment experience. Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress (e.g., believing that one is permanently damaged; that nobody could understand; that no one should or could tolerate one's story). Peer support provides opportunities to form mutual relationships; to learn how one's history shapes perspectives of self ,others, and the future; to move beyond trauma; and to mirror and learn alternate coping strategies. Peer support defines recovery as an interactive process, not as a definitive moment wherein someone fixes the "problem."

"This might not sound like a big deal, but for many people relationships have become all about getting: telling your problem story and then getting help with it. There is little, if any, emphasis placed on giving back. That's a big deal!!! Service relationships are like a one -way street and both people's roles are clearly defined. But in 'regular' relationships in your community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling ok about being vulnerable (needing help) as well as confident about what they're offering. For many of us, being the role of 'getter' all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. Peer support breaks that all down. It gets complicated somewhat when one of us is paid, but modeling this kind of relationship in which both of us learn, offers us the real practice we need to feel like a 'regular' community member as opposed to an 'integrated mental patient'." -Mead

Normalize Symptoms

Symptoms of trauma can become serious barriers to recovery from substance us e and mental disorders, including trauma-related ones. Clinicians should be aware of how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique

Strategies To Normalize Symptoms

Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress.
Strategy #2: Research the client's most prevalent symptoms specific to trauma, and then provide education to the client. For example, an individual who was conscious and trapped during or as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution (e.g., feeling stuck in a work environment where the boss is emotionally abusive).
Strategy #3: First, have the client list his or her symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom. Remember that symptoms serve a purpose, even if they may not appear to work well or work as well as they had in the past. Focus on how the symptoms have served the client in a positive way (see Case Illustration: Hector). This exercise can be difficult, because clients as well as counselors often don't focus on the value of symptoms.

and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

Identify and Manage Trauma-Related Triggers

Many clients who have traumatic stress are caught off guard with intrusive thoughts, feelings, sensations, or environmental cues of the trauma. This experience can be quite disconcerting, but often, the individual does not draw an immediate connection between the internal or external trigger and his or her reactions. At other times, the trigger is so potent that the individual is unable to discern the present trigger from the past trauma and begins to respond as if the trauma is reoccurring.

> The Subjective Units of Distress Scale (SUDS) uses a 0 -10 rating scale, with 0 representing content that causes no or minimal distress and 10 representing content that is exceptionally distressing and overwhelming.

Key steps in identifying triggers are to reflect back on the situation, surroundings, or sensations prior to the strong reaction. By doing so, you and your client may be able to determine the connections among these cues, the past trauma(s), and the client's reaction. Once the cue is identified, discuss the ways in which it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say "I love you"in a significant relationship as an adult and connecting this to an abuser who said the same thing prior to a sexual assault). Other cues will not be as obvious. With practice, the client can begin to track back through what occurred immediately before an emotional, physical, or behavioral reaction and then examine how that experience reminds him or her of the past.

Draw Connections

Mental health and substance abuse treatment providers have historically underestimated the effects of trauma on their clients for many reasons. Some held a belief that substance abuse should be addressed before attending to any co-occurring conditions. Others did not have the knowledge and training to evaluate trauma issues or were uncomfortable or reluctant to discuss these sensitive issues with clients (Ouimette & Brown). Similarly, in other behavioral health settings, clinicians sometimes address trauma-related symptoms but do not have experience or training in the treatment of substance abuse.

Strategies To Help Clients Draw Connections

Strategy #1: Writing about trauma can help clients gain awareness of their thoughts, feelings, and current experiences and can even improve physical health outcomes (Pennebaker, Kiecolt-Glaser, & Glaser, Smyth, Hockemeyer, & Tulloch). Although this tool may help some people draw connections between current experiences and past traumas, it should be used with caution; others may find that it brings up too much intense trauma material (especially among vulnerable trauma survivors with co-occuring substance abuse, psychosis, and current domestic violence). Journal writing is safest when you ask clients to write about present-day specific targets, such as logging their use of coping strategies or identifying strengths with examples. Writing about trauma can also be done via key questions or a workbook that provides questions centered upon trauma experiences and recovery.

Strategy #2: Encourage clients to explore the links among traumatic experiences and mental and substance use disorders. Recognition that a mental disorder or symptom developed after the trauma occurred can provide relief and hope that the symptoms may abate if the trauma is addressed.

Ways to help clients connect substance use with trauma histories include (Najavits, Najavits, Weiss, & Shaw):

- ✓ Identifying how substances have helped "solve" trauma or PTSD symptoms in the short term (e.g., drinking to get to sleep).
- ✓ Teaching clients how trauma, mental, and substance use disorders commonly co-occur so that they will not feel so alone and ashamed about these issues.
- ✓ Discussing how substance abuse has impeded healing from trauma (e.g., by blocking feelings and memories).
- ✓ Helping clients recognize trauma symptoms a s triggers for relapse to substance use and mental distress.
- ✓ Working on new coping skills to recover from trauma and substance abuse at the same time.

So too, people who have histories of trauma will often be unaware of the connection between the traumas they've experienced and their traumatic stress reactions.They may notice depression, anger, or anxiety, or they may describe themselves as "going crazy" without being able to pinpoint a specific experience that produced the trauma symptoms. Even if clients recognize the events that precipitated their trauma symptoms, they may not understand how others with similar experiences can have different reactions. Thus, a treatment goal for trauma survivors is helping them gain awareness of the connections between their histories

of trauma and subsequent consequences. Seeing the connections can improve clients' ability to work on recovery in an integrated fashion.

Teach Balance

You and your clients need to walk a thin line when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session whereby the client dissociates, shuts down, or becomes emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma. Several trauma-specific theories offer guidelines on acceptable levels of distress associated with the traumatic content that the therapy addresses. For example, some traditional desensitization processes start at a very low level of subjective distress, gradually working up through a hierarchy of trauma memories and experiences until those experiences produce minimal reactions when paired with some coping strategy, such as relaxation training. Other desensitization processes start at a higher level of intensity to provide more rapid extinction of traumatic associations and to decrease the risk of avoidance—a behavior that reinforces traumatic stress.

Strategy To Teach Balance

Strategy #1: Teach and use the SUDS in counseling. This scale can be useful from the outset as a barometer for the client and counselor to measure the level of distress during and outside of sessions. It provides a common language for the client and counselor, and it can also be used to guide the intensity of sessions. SUDS can tangibly show a client's progress in managing experiences. Without a scale, it is more difficult to grasp that a distressing symptom or circumstance is becoming less and less severe without some repeated measure.

Working with trauma is a delicate balancing act between the development and/or use of coping strategies and the need to process the traumatic experiences. Individuals will choose different paths to recovery; it's a myth that every traumatic experience needs to be expressed and every story told. For some individuals, the use of coping skills, support, and spirituality are enough to recover. Regardless of theoretical beliefs, counselors must teach coping strategies as soon as possible. Retraumatization is a risk whenever clients are exposed to their traumatic histories without sufficient tools, supports, and safety to manage emotional, behavioral, and physical reactions.

Build Resilience

Resilient Responses to Trauma

Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include:

✓ Increased bonding with family and community.
✓ Redefined or increased sense of purpose and meaning.
✓ Increased commitment to a personal mission.
✓ Revised priorities.
✓ Increased charitable giving and volunteerism.

Strategies To Build Resilience

Strategy #1: Help clients reestablish personal and social connections. Access community and cultural resources; reconnect the person to healing resources such as mutual-help groups and spiritual supports in the community.

Strategy #2: Encourage t he client to take action. Recovery requires activity. Actively taking care of one's own needs early in treatment can evolve into assisting others later on, such as by volunteering at a community organization or helping military families.

Strategy #3: Encourage stability and predictability in the daily routine. Traumatic stress reactions can be debilitating. Keeping a daily routine of sleep, eating, work, errands, household chores, and hobbies can help the client see that life continues. Like exercise, daily living skills take time to take hold as the client learns to live through symptoms.

Strategy #4: Nurture a positive view of personal, social, and cultural resources. Help clients recall ways in which they successfully handled hardships in the past, such as the loss of a loved one, a divorce, or a major illness. Revisit how those crises were addressed.

Strategy #5: Help clients gain perspective. All things pass, even when facing very painful events. Foster a long-term outlook; help clients consider stress and suffering in a spiritual context.

Strategy #6: Help maintain a hopeful outlook. An optimistic outlook enables visions of good things in life and can keep people going even in the hardest times. There are positive aspects to everyone's life. Taking time to identify and appreciate these enhances the client's outlook and helps him or her persevere.

Strategy #7: Encourage participation in peer support, 12-Step, and other mutual-help programs.

Survivors are resilient! Often, clinicians and clients who are trauma survivors focus on the negative consequences of trauma while failing to recognize the perseverance and attributes that have helped them survive. It is natural to focus on what's not working rather than what has worked. To promote growth after trauma and establish a strengths-based approach, focus on building on clients' resilience. Current resilience theories claim that building or reinforcing resilience prevents further development of trauma-related symptoms and disorders.

Build Trust

Some traumatic experiences result from trusting others (e.g., interpersonal trauma). In other cases, trust was violated during or after the traumatic experience, as in cases when help was late to arrive on the scene of a natural disaster. This lack of trust can leave individuals alienated, socially isolated, and terrified of developing relationships. Some feel that the trauma makes them different from others who haven't had similar experiences. Sometimes, a client's trust issues arise from a lack of trust in self—for instance, a lack of trust in one's perceptions, judgment, or memories. People who have also experienced severe mental or substance use disorders may have difficulty trusting others because, during the course of their illness, they felt alienated or discriminated against for behaviors and emotions generated by or associated with the disorders.

Some client groups (e.g., gay, lesbian, and bisexual clients; people from diverse cultures; those with serious mental illness) evidence significant mistrust because their trust has been repeatedly violated in the past. Traumatic experiences then compound this mistrust. Mistrust can come from various sources, is usually unstated, and, if left unaddressed, can impede treatment. For example, some clients leave treatment early or do not engage in potentially beneficial treatments. Others avoid issues of trust and commitment by leaving treatment when those issues begin to arise.

Establishing a safe, trusting relationship is paramount to healing—yet this takes time in the counseling process. Clinicians and other behavioral health professionals need to be consistent throughout the course of treatment; this includes maintaining consistency in the parameters set for availability, attendance, and level of empathy.

Trust is built on behavior shown inside and outside of treatment; you should immediately address any behavior that may even slightly injure the relationship (e.g.,being 5 minutes late for an appointment, not responding to a phone message in a timely manner, being distracted in a session).

Strategies To Build Trust

Strategy #1: Clients can benefit from a support or counseling group composed of other trauma survivors. By comparing themselves with others in the group, they can be inspired by those who are further along in the recovery process and helpful to those who are not faring as well as they are. These groups also motivate clients to trust others by experiencing acceptance and empathy.

Strategy #2: Use conflicts that arise in the program as opportunities. Successful negotiation of a conflict between the client and the counselor is a major milestone (van der Kolk, McFarlane, & Van der Hart). Helping clients understand that conflicts are healthy and inevitable in relationships (and that they can be resolved while retaining the dignity and respect of all involved) is a key lesson for those whose relationship conflicts have been beset by violence, bitterness, and humiliation.

Strategy #3: Prepare clients for staff changes, vacations, or other separations. Some clients may feel rejected or abandoned if a counselor goes on vacation or is absent due to illness, especially during a period of vulnerability or intense work. A phone call to the client during an unexpected absence can reinforce the importance of the relationship and the client's trust. You can use these opportunities in treatment to help the client understand that separation is part of relationships; work with the client to view separation in a new light.

Strategy #4: Honor the client-counselor relationship, and treat it as significant and mutual. You can support the development of trust by establishing clear boundaries, being dependable, working with the client to define explicit treatment goals and methods, and demonstrating respect for the client's difficulty in trusting you and the therapeutic setting.

Support Empowerment

Strong feelings of powerlessness can arise in trauma survivors seeking to regain some control of their lives. Whether a person has survived a single trauma or chronic trauma, the survivor can feel crushed by the weight of powerlessness. Mental illness and substance abuse, too, can be disempowering; clients may feel that they've lost control over their daily lives, over a behavior such as drug use, or over powerful emotions such as fear, sadness, oranger. Empowerment means helping clients feel greater power and control over their lives, as long as such control is within safe and healthy bounds. A key facet of empowerment is to help

Strategies To Support Empowerment

Strategy #1: Offer clients information about treatment; help them make informed choices. Placing appropriate control for treatment choices in the hands of clients improves their chances of success.
Strategy #2: Give clients the chance to collaborate in the development of their initial treatment plan, in the evaluation of treatment progress, and in treatment plan updates. Incorporate client input into treatment case consultations and subsequent feedback.
Strategy #3: Encourage clients to assume an active role in how the delivery of treatment services occurs. An essential avenue is regularly scheduled and structured client feedback on program and clinical services (e.g., feedback surveys). Some of the most effective initiatives to reinforce client empowerment are the development of peer support services and the involvement of former clients in parts of the organizational structure, such as the advisory board or other board roles.
Strategy #4: Establish a sense of self-efficacy in clients; their belief in their own ability to carry out a specific task successfully–is key. You can help clients come to believe in the possibility of change and in the hope of alternative approaches to achieving change. Supporting clients in accepting increasing responsibility for choosing and carrying out personal change can facilitate their return to empowerment (Miller & Rollnick)

clients build on their strengths. Empowerment is more than helping clients discover what they "should" do; it is also helping them take the steps they feel ready to take.

Acknowledge Grief and Bereavement

The experience of loss is common after traumas, whether the loss is psychological (e.g., no longer feeling safe) or physical (e.g., death of a loved one, destruction of community, physical impairment). Loss can cause public displays of grief, but it is more often a private experience. Grieving processes can be emotionally overwhelming and can lead to increased substance use and other impulsive behaviors as a way to manage grief and other feelings associated with the loss. Even for people who experienced trauma years prior to treatment, grief is still a common psychological issue. Delayed or absent reactions of acute grief can cause exhaustion, lack of strength, gastrointestinal symptoms, and avoidance of emotions.

Strategies To Acknowledge and Address Grief

Strategy #1: Help the client grieve by being present, by normalizing the grief, and by assessing social supports and resources.
Strategy #2: When the client begins to discuss or express grief, focus on having him or her voice the losses he or she experienced due to trauma. Remember to clarify that losses include internal experiences, not just physical losses.
Strategy #3: For a client who has difficulty connecting feelings to experiences, assign a feelings journal in which he or she can log and name each feeling he or she experiences, rate the feeling's intensity numerically, and describe the situation during which the feeling occurred. The client may choose to share the journal in an individual or group session.
Strategy #4: Note that some clients benefit from developing a ritual or ceremony to honor their losses, whereas others prefer offering time or resources to an association that represents the loss.

Risk factors of chronic bereavement (grief lasting more than 6 months) can include:

- Perceived lack of social support.
- Concurrent crises or stressors (including reactivation of PTSD symptoms).
- High levels of ambivalence about the loss.
- An extremely dependent relationship prior to the loss.
- Loved one's death resulting from disaster: unexpected, untimely, sudden, and shocking (New South Wales Institute of Psychiatry & Centre for Mental Health).

Monitor and Facilitate Stability

Stability refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli (Briere & Scott). It's common for individuals to have an increase in symptoms, distress, or impairment when dealing with the impact of their trauma or talking about specific aspects of their trauma. There is a thin line that the client and counselor need to negotiate and then walk when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session that causes the client to dissociate, shut down, or become emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Managing Destabilization

When a client becomes destabilized during a session, you can respond in the following manner: "Let's slow down and focus on helping you be and feel safe. What can we do to allow you to take care of yourself at this moment? Then, when you feel ready, we can decide what to focus on next."

Clients should have some psychological stability to engage in trauma-related work. An important distinction can be made between a normative increase in symptoms (e.g., the typical up-and-down course of traumatic stress reactions or substance abuse) and destabilization (dangerous, significant decrease in functioning). Signs of destabilization include (Green Cross Academy of Traumatology, Najavits):

- Increased substance use or other unsafe behavior (e.g., self-harm).
- Increased psychiatric symptoms (e.g., depression, agitation, anxiety, withdrawal, anger).
- Increased symptoms of trauma (e.g., severe dissociation).
- Helplessness or hopelessness expressed verbally or behaviorally.

- Difficulty following through on commitments (e.g., commitment to attend treatment sessions).
- Isolation.
- Notable decline in daily activities (e.g.,self-care, hygiene, care of children or pets,going to work).

9. Treatment Issues

The treatment environment itself can significantly affect how clients experience traumatic stress and how the client responds to treatment. Some specific issues related to working with trauma survivors in a clinical setting are discussed in the following sections.

Client Engagement

A lack of engagement in treatment is the client's inability to make progress toward treatment goals, deal with important topics in treatment, or complete treatment. Clients who have histories of trauma will express ambivalence about treatment similarly to others, except that clients who have traumatic stress can feel more "stuck" and perceive themselves as having fewer options. In addition, clients maybe avoiding engagement in treatment because it is one step closer to addressing their trauma.You should attend to the client's motivation to change, implement strategies that address ambivalence toward treatment, and use approaches that help clients overcome avoidant behavior.

Pacing and Timing

Although your training or role may prohibit you from providing trauma-specific services, you must still be prepared for the fact that clients are not as focused on when or where it is most appropriate to address trauma—they want relief, and most lay and professional people have been taught that the only path to recovery is disclosure. Some clients are reluctant to talk about anything associated with their histories of trauma. Other clients immediately want to delve into the memories of their trauma without developing a safe environment. The need to gain any relief for the traumatic stress pushes some individuals to disclose too quickly, without having the necessary support and coping skills to manage the intensity of their memories. Clients who enter treatment and immediately disclose past trauma often don't return because the initial encounter was so intense or because they experienced considerable emotional distress for several days afterward and/or in anticipation of the next session.

Proper pacing of sessions, disclosure, and intensity is paramount. Clients who immediately disclose without proper safety nets are actually retraumatizing

Exhibit 1.5-1: The OBSERVATIONS Coping Strategy

- Take a moment to just ***Observe*** what is happening. Pay attention to your body, your senses, and your environment.
- Focus on your ***Breathing***. Allow your feelings and sensations to wash over you. Breathe.
- Name the ***Situation*** that initiated your response. In what way is this situation familiar to y our past? How is it different?
- Remember that ***Emotions*** come and go. They may be intense now, but later they will be less so. Name your feelings.
- ***Recognize*** that this situation does not define you or your future. It does not dictate how things will be, nor is it a sign of things to come. Even if it is familiar, it is only one event.
- ***Validate*** your experience. State, at least internally, what you are feeling, thinking, and experiencing.
- ***Ask*** for help. You don't have to do this alone. Seek support. Other people care for you. Let them!
- ***This*** too shall pass. Remember: There are times that are good and times that are not so good. This hard time will pass.
- ***I*** can handle this. Name your strengths. Your strengths have helped you survive.
- Keep an ***Open*** mind. Look for and try out new solutions.
- ***Name*** strategies that have worked before. Choose one and apply it to this situation.
- Remember you have survived. You are a ***Survivor!***

themselves by reliving the experience without adequate support—often placing themselves in the same circumstances that occurred during the actual traumas they experienced. Although you should not adamantly direct clients not to talk about what happened, it is important to discuss with the clients, even if you have to interrupt them empathically and respectfully, the potential consequences of disclosing too soon and too fast. Ask whether they have done this before ,and then inquire about the outcome. Reinforce with clients that trauma heals when there are support, trust, and skills in place to manage the memories of the traumatic experiences. Ideally, disclosure begins after these elements are secured, but realistically, it is a balancing act for both the counselor and client as to when and

how much should be addressed in any given session. Remember not to inadvertently give a message that it is too dangerous to talk about trauma; instead, reinforce the importance of addressing trauma without further retraumatization.

Length of Treatment

Many factors influence decisions regarding the length of treatment for a given client. Severity of addiction, type of substance abused, type of trauma, age at which the trauma occurred, level of social support, and the existence of mental disorders all influence length of treatment. External factors, such as transportation and childcare, caps on insurance coverage, and limitations in professional resources, can also affect length of treatment. In general, longer treatment experiences should be expected for clients who have histories of multiple or early traumas, meet diagnostic criteria for multipleAxis I or Axis II diagnoses, and/or require intensive case management. Most of the empirically studied and/or manual-based models described in the next chapter are short-term models (e.g., lasting several months); however, ongoing care is indicated for clients with more complex co-occurring trauma disorders.

Memories of Trauma

Points for clinicians to remember are:

- Some people are not able to completely remember past events, particularly events that occurred during high-stress and destabilizing moments.
- In addition to exploring the memories themselves, it can be beneficial to explore how a memory of an event helps the client understand his or her feeling, thinking, and behaving in the present.
- Persistently trying to recall all the details of a traumatic event can impair focus on the present.

Traumatic Memories

One of the most controversial issues in the trauma field is the phenomenon of "recovered memories" or "traumatic amnesia" (Brewin). Practitioners working with traumatized individuals are particularly concerned about the possibility of new memories of the traumatic event emerging during the course of therapy and the possibility of these memories being induced by the clinician. Scientific reviews indicate that people can experience amnesia and delayed recall for some memories of a wide variety of traumas, including military combat and prisoner of war experiences, natural disasters and accidents, childhood sexual abuse, and political torture (Bowman & Mertz, Brewin, Karon & Widener, McNally). In some cases, the survivor will not remember some of what happened, and

the clinician may need to help the client face the prospect of never knowing all

Strategies To Manage Traumatic Memories

Strategy #1: Most people who were sexually abused as children remember all or part of what happened to them, although they do not necessarily fully understand or disclose it. Do not assume that the role of the clinician is to investigate, corroborate, or substantiate allegations or memories of abuse (American Psychiatric Association [APA]).

Strategy #2: Be aware that forgotten memories of childhood abuse can be remembered years later. Clinicians should maintain an empathic, nonjudgmental, neutral stance toward reported memories of sexual abuse or other trauma. Avoid prejudging the cause of the client's difficulties or the veracity of the client's reports. A counselor's prior belief that physical or sexual abuse, or other factors, are or are not the cause of the client's problems can interfere with appropriate assessment and treatment (APA).

Strategy #3: Focus on assisting clients in coming to their own conclusions about t he accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help clients understand the impact of the memories or abuse experiences on their lives and to reduce their detrimental consequences in the present and future (APA).

Strategy #4: Some clients have concerns about whether or not a certain traumatic event did or did not happen. In such circumstances, educate clients about traumatic memories, including the fact that memories aren't always exact representations of past events; subsequent events and emotions can have the effect of altering the original memory. Inform clients that it is not always possible to determine whether an event occurred but that treatment can still be effective in alleviating distress.

Strategy #5: There is evidence that suggestibility can be enhanced and pseudomemories can develop in some individuals when hypnosis is used as a memory enhancement or retrieval strategy. Hypnosis and guided imagery techniques can enhance relaxation and teach self-soothing strategies with some clients; however, use of these techniques is not recommended in the active exploration of memories of abuse (Academy of Traumatology).

Strategy #6: When clients are highly distressed by intrusive flashbacks of delayed memories, help them move through the distress. Teach coping strategies and techniques on how to tolerate strong affect and distress (e.g., mindfulness practices)

Case Illustration: Abby

Abby, a 30-year-old, nervous-looking woman, is brought by her parents to a community mental health clinic near their home in rural Indiana. During the intake process, the counselor learns that Abby is an Army Reservist who returned from 12 months of combat duty 3 years ago. The war experience changed her in many ways. Her deployment pulled her away from veterinary school as well as the strong emotional support of family, friends, and fellow classmates. She got along with her unit in Iraq and had no disciplinary problems. While there, she served as a truck driver in the Sunni Triangle. Her convoy was attacked often by small arms fire and was once struck by an improvised explosive device. Although Abby sustained only minor injuries, two of her close friends were killed. With each successive convoy, her level of fear and foreboding grew, but she continued performing as a driver.

Since returning to the United States, she has mostly stayed at home and has not returned to school, although she i s helping out o n the farm with various chores. Abby has isolated herself from both family members and lifelong friends, saying she doesn't think others can understand what she went through and that she prefers being alone. She reports to her parents and the therapist that she is vaguely afraid to be in cars and feels most comfortable in her room or working alone, doing routine tasks, at home. Abby also says that she now understands how fragile life can be.

She has admitted to her parents that she drinks alcohol on a regular basis, something she did not do before her deployment, and that on occasion, she has experienced blackouts. Abby feels she needs a drink before talking with strangers or joining in groups of friends or family. She confided to her father that she isolates herself so that she can drink without having to explain her drinking to others.

The therapist recognizes Abby's general sense of lacking internal control and feeling powerless over what will happen to her in the future. He adopts a motivational interviewing style to establish rapport and a working alliance with Abby. During sessions, the counselor asks Abby to elaborate on her strengths; he reinforces strengths that involve taking action in life, positive self-statements, and comments that deal with future plans. He also introduces Abby to an Iraq War veteran who came home quite discouraged about putting his life together but has done well getting reintegrated. The counselor urges Abby go to the local VA center so that she can meet and bond with other recently returned veterans. He also encourages Abby to attend Alcoholics Anonymous meetings, emphasizing that she won't be pressured to talk or interact with others more than she chooses to.

The therapist continues to see Abby every week and begins using cognitive-behavioral techniques to help her examine some of her irrational fears about not being able to direct her life. He asks Abby to keep a daily diary of activities related to achieving her goals of getting back to school and reestablishing a social network. In each session, Abby reviews her progress using the diary as a memory aid, and the counselor reinforces these positive efforts. After 4 months of treatment, Abby reenrolls in college and is feeling optimistic about her ability to achieve her career plans.

there is to know about the past and accept moving on with what is known.

Legal Issues

Legal issues can emerge during treatment. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for domestic violence) or to sue for damages sustained in an accident or natural disaster. The counselor's role is not to provide legal advice, but rather, to offer support during the process and, if needed, refer the client to appropriate legal help. A legal matter can dominate the treatment atmosphere for its duration. Some clients have difficulty making progress in treatment until most or all legal matters are resolved and no longer act as ongoing stressors.

Forgiveness

Clients may have all sorts of reactions to what has happened to them. They may feel grateful for the help they received, joy at having survived, and dedication to their recovery. At the other extreme, they may have fantasies of revenge, a loss of belief that the world is a good place, and feelings of rage at what has happened. They may hold a wide variety of beliefs associated with these feelings.

One issue that comes up frequently among clinicians is whether to encourage clients to forgive. The issue of forgiveness is a very delicate one. It is key to allow survivors their feelings, even if they conflict with the clinician's own responses. Some may choose to forgive the perpetrator, whereas others may remain angry or seek justice through the courts and other legal means. Early in recovery from trauma, it is best to direct clients toward focusing on stabilization and a return to normal functioning; suggest that, if possible, they delay major decisions about forgiveness until they have a clearer mind for making decisions (Herman). Even in later stages of recovery, it's not essential for the client to forgive in order to recover. Forgiveness is a personal choice independent of recovery. Respect clients' personal beliefs and meanings; don't push clients to forgive or impose your own beliefs about forgiveness onto clients.

In the long-term healing process, typically months or years after the trauma(s), forgiveness may become part of the discussion for some people and some communities. For example, in South Africa, years after the bitter and bloody apartheid conflicts, a Truth and Reconciliation Commission was established by the Government. Public hearings created dialog and aired what had been experienced as a means, ultimately, to promote forgiveness and community healing. By addressing very difficult topics in public, all could potentially benefit from the discourse. Similarly, a parental survivor of the Oklahoma City bombing was, at first, bitter about his daughter's early, unfair, and untimely death. Today, he gives talks around the world about the abolition of the death penalty. He sat with

convicted bomber Timothy McVeigh's father while the man's son was executed in Indiana at a Federal prison several years after the bombing. For this man, forgiveness and acceptance helped him attain personal peace. Other trauma survivors may choose never to forgive what happened, and this, too, is a legitimate response.

Culturally and Gender Responsive Services

Culture is the lens through which reality is interpreted. Without an understanding of culture, it is difficult to gauge how individuals organize, interpret, and resolve their traumas.The challenge is to define how culture affects individuals who have been traumatized.

Increased knowledge of PTSD (Wilson &Tang), mental illness, and substance use disorders and recovery (Westermeyer) requires behavioral health practitioners to consider the complicated interactions between culture, personality, mental illness, and substance abuse in adapting treatment protocols. This section offers some general guidelines for working with members of cultures other than one's own. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive.

The U.S. Department of Health and HumanServices has defined the term "cultural competence" as follows:

> *Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families*

Cultural Competence

Cultural competence includes a counselor's knowledge of:

Whether the client is a survivor of cultural trauma (e.g., genocide, war, government oppression, torture, terrorism).

How to use cultural brokers (i.e., authorities within the culture who can help interpret cultural patterns and serve as liaisons to those outside the culture).

How trauma is viewed by an individual's sociocultural support network.

How to differentiate PTSD, trauma-related symptoms, and other mental disorders in the culture.

receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Cultural competence is a process that begins with an awareness of one's own culture and beliefs and includes an understanding of how those beliefs affect one's attitudes toward people of other cultures. It is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one's own.

Strategies To Foster Engagement

Strategy #1: According to Mahalik, the standard method of handling clients' lack of engagement is exploring it with them, clarifying the situation through discussion with them, reinterpreting (e.g., from "can't" to "won't" to "willing"), and working through the situation toward progress.

Strategy #2: To improve engagement into treatment, try motivational interviewing and enhancement techniques.

In some cultures, an individual's needs take precedence over group needs (Hui & Triandis), and problems are seen as deriving from the self. In other cultures, however, complex family, kin, and community systems take precedence over individual needs. Considerable heterogeneity exists within and across most ethnic subcultures and across lines of gender, class, age, and political groups (CSAT). Subcultures abound in every culture, such as gangs; populations that are homeless or use substances; orphaned or disenfranchised people; religious, ethnic, and sexual minorities; indigenous people; and refugee and immigrant populations. Some subcultures have more in common with similar subcultures in other countries than with their own cultures (e.g., non heterosexual populations).

Trauma and substance abuse can themselves be a basis for affiliation with a subculture. De Girolamo reports that "disaster subcultures" exist within many cultures. These cultures of victimization, like all subcultures, have unique world views, codes of conduct, and perceptions of the larger society. In a disaster subculture, people are, to some extent, inured to disaster and heedless of warnings of impending disaster. For example, riverbank erosion inBangladesh displaces thousands of people each year, yet few believe that it is a serious problem or that the displacement will be permanent (Hutton). Israelis who have lived with

unpredictable violence for many years behave differently in public areas and have adapted to different norms than people who don't commonly experience violence (Young).

Many people identify with more than one subculture. Some identify with a particular culture or subculture, but not with all of its values. Individual identities are typically a mosaic of factors, including developmental achievements, life experiences, behavioral health histories, traumatic experiences, and alcohol and illicit drug use; levels of acculturation and/or assimilation vary from one individual to the next as well.

Importance of the Trauma Aftermath

Clinicians working in the immediate aftermath of trauma—whether individual, group, or community in nature—face many challenges. For example, survivors may be forced to adjust without access to other health services, employment, support, or insurance. In these instances, clinicians must often work with individuals and communities coping with the trauma while struggling daily to meet basic needs. Research suggests that re-establishing ties to family, community, culture, and spiritual systems can not only be vital to the individual ,but can also influence the impact of the trauma upon future generations. For example, Baker and Gippenreiter studied the descendants of people victimized by Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents affected by the purge experienced fewer negative effects than did those who were emotionally or physically severed from their grandparents. The researchers also found that whether the grandparents survived was less important than the connection the grandchildren managed to keep to their past. Ties to family and community can also have an adverse effect, especially if the family or community downplays the trauma or blames the victim. Clinicians need to have a full understanding of available support before advocating a particular approach.

Treatment Strategies

Many traditional healing ways have been damaged, forgotten, or lost—yet much wisdom remains. Drawing on the best traditional and contemporary approaches to human distress and defining culturally competent curricula regarding identity and healing (Huriwai, Wilson & Tang) both require respect and appreciation for the many ways in which various people characterize and resolve trauma and how they use addictive substances to bear the burdens of human distress.

It is not yet known how well existing PTSD treatments work for individuals who identify primarily with cultures other than mainstream American culture. It is

possible that such treatments do work for clients of other cultures, though some cultural adaptation and translation may be required. For example, some PTSD treatments that have been used with subculture groups without adaptation other than language translation and that appear to be effective across cultures include eye movement desensitization and reprocessing (Bleich, Gelkopf, & Solomon,) andSeeking Safety (Daouest et al).

Gender

Gender differences exist in traumatic stress, mental disorders, and substance use disorders. For example, women have higher rates ofPTSD, whereas men have higher rates of substance abuse (Kessler, Chiu, Demler, Merikangas, & Walters, Stewart, Ouimette, & Brown, Tolin & Foa). The types of interpersonal trauma experienced by men and by women are often different. A number of studies (Kimerling, Ouimette, &Weitlauf) indicate that men experience more combat and crime victimization and women experience more physical and/or sexual assault—implying that men's traumas often occur in public, whereas the traumatization of women is more likely to take place in a private setting, such as a home. Men's abusers are more often strangers. Those who abuse women, on the other hand, are more often in a relationship with them. Women (and girls) often are told, "I love you," during the same time period when the abuse occurs. However, women now serve in the military and thus are increasingly subject to some of the same traumas as men and also to military sexual trauma, which is much more common for women to experience. Similarly, men can be subject to domestic violence or sexual abuse.

In treatment, gender considerations are relevant in a variety of ways, including, but not limited to, the role and impact of societal gender stereotypes upon assessment processes, treatment initiation, and engagement of services (e.g., peer support systems); the selection and implementation of gender-specific and gender-responsive approaches for both men and women at each level of intervention; and the best selection of trauma-related interventions that account for gender-specific differences related to traumatic stress.

Beyond the complexities of gender considerations, one must also consider whether clients should be given the choice of working with a male or a female clinician. Some clients who have been traumatized have no preference, particularly if their trauma wasn't associated with gender (e.g., a natural disaster, act of terrorism, fire, serious accident). If gender did play a role in trauma (e.g., childhood sexual abuse), clients can have strong fears of working with a clinician who is the same gender as the perpetrator. Many women who experienced sexual abuse (whose perpetrators

Strategies To Establish Appropriate Pacing and Timing

Strategy #1: Frequently discuss and request feedback from clients about pacing and timing. Moving too quickly into discussion of the trauma can increase the risk of dissociation, over-activation of memories, and feeling overwhelmed.

Strategy #2: Use the SUDS as a barometer of intensity to determine the level of work.

Strategy #3: Slowly increase the speed of interventions and continually adjust the intensity of interventions; move in and out of very intense work, or use strategies that decrease the intensity when necessary. One approach that typically decreases the intensity of traumatic memories is to ask the individual to imagine that he or she is seeing the scene through a window or on a television screen. This helps decrease intensity and the risk of dissociation. It provides an opportunity for the client to view the trauma from a different perspective and a strategy to use outside of treatment to shift f rom reliving the trauma to observing it from a neutral position.

Strategy #4: Monitor clients to ensure that treatment does not overwhelm their internal capacities, retraumatize them, or result in excessive avoidance; make sure therapy occurs in the "therapeutic window" (Briere & Scott).

Strategy #5: Be alert to signs that discussions of trauma, including screening, assessment, and intake processes, are going too fast. Mild to moderate signs are:

- Missing counseling appointments after discussions of important material.
- Periods of silence.
- Dissociation.
- Misunderstanding what are usually understandable concepts.
- Redirecting the focus of the discussion when certain issues arise.

Strategy #6: Observe the client's emotional state. Slow down; seek consultation if the client exhibits:

- Persistent resistance to addressing trauma symptoms.
- Repetitive flashbacks.
- Increase in dissociation.
- Regression.
- Difficulty in daily functioning (e.g., trouble maintaining everyday self-care tasks).
- Substance use relapses.
- Self-harm or suicidal thoughts/behaviors (e.g., talking about suicide).

Strategy #7: Use caution and avoid (Briere):

- Encouraging clients to describe traumatic material in detail before they can deal with the consequences of disclosure.
- Using overly stressful interventions (e.g., intensive role-plays, group confrontation, guided imagery).
- Confrontations or interpretations that are too challenging given the client's current functioning.
- Demanding that the client work harder and stop resisting.

are typically men) feel uncomfortable being treated by men because of the intense emotions that can be evoked (e.g., anger, fear). Men who experienced sexual abuse (whose perpetrators are also typically men) can feel uncomfortable for the same reasons, or they may feel shame when talking to men due to feelings evoked about masculinity, homosexuality, and so forth. However, not all clients with trauma histories prefer female therapists. Discuss with clients the possible risks (e.g.,initial emotional discomfort) and benefits of being treated by a woman or man (e.g., developing a therapeutic relationship with a man might challenge a client's belief that all men are dangerous), and, if possible, let them then choose the gender of their clinician.

For group therapy that focuses on trauma, similar considerations apply. Generally, gender-specific groups are recommended when possible, but mixed-gender groups also work. Gender also comes into play in substance abuse treatment. Research and clinical observation indicate that significant gender differences occur in many facets of substance abuse and its treatment. For example, men and women experience different physical repercussions of substance use (e.g., women have more health problems), different trajectories (e.g., women become addicted more quickly), and different treatment considerations (e.g., traditional substance abuse treatment was designed for men).

Sexual Orientation

Lesbian, gay, bisexual, and transgender (LGBT) clients face specific issues in behavioral health treatment settings, including histories of abuse and discrimination relating to sexual orientation, homophobia in treatment on the part of clinicians or other clients, potential difficulty addressing traumatic experiences related to their sexuality or sexual orientation, and often, a significant lack of trust toward others. LGBT people sometimes think that others can't understand them and their specific needs and thus are reluctant to engage in treatment programs in which the clientele is predominantly heterosexual. Some clients react with judgment, anger, or embarrassment when an LGBT client attempts to describe sexual trauma relating to homosexual behavior, making it even harder for LGBT clients to describe their experiences.

Often, individual counseling can address issues the LGBT client isn't comfortable discussing in group treatment. "Providing one-on-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood that heterosexism or homophobia will become an issue" (CSAT).

Making Referrals to Trauma-Specific Services

Many people who experience trauma do not exhibit persistent traumatic stress symptoms.In fact, people do recover on their own. So how do you determine who is at higher risk for developing more persistent symptoms of traumatic stress, trauma-related disorders, and traumatic stress disorders? One main factor is the severity of symptoms at the time of screening and assessment. Other factors, beyond trauma characteristics and pre-trauma individual characteristics, to consider in making referrals include (Ehlers & Clark):

- Cognitive appraisals that are excessively negative regarding trauma sequelae, including consequences, changes after the event(s), responses of other people to the trauma, and symptoms.
- Acknowledgment of intrusive memories.
- Engagement in behaviors that reinforce or prevent resolution of trauma, including avoidance, dissociation, and substance use.
- History of physical consequences of trauma(e.g., chronic pain, disfigurement, health problems).
- Experiences of more traumas or stressful life events after the prior trauma.
- Identification of co-occurring mood disorders or serious mental illness.

The next chapter provides an overview of trauma-specific services to complement this chapter and to provide trauma-informed clinicians with a general knowledge of trauma-specific treatment approaches.

10. Trauma-Specific Services

This chapter covers various treatment approaches designed specifically to treat trauma-related symptoms, trauma-related disorders, and specific disorders of traumatic stress. The models presented do not comprise an exhaustive list, but rather, serve as examples.These models require training and supervised experience to be conducted safely and effectively. The chapter begins with a section on trauma-specific treatment models, providing a brief overview of interventions that can be delivered immediately after a trauma, as well as trauma-specific interventions for use beyond the immediate crisis. The second segment focuses on integrated care that targets trauma-specific treatment for mental, substance use, and co-occurring disorders. Even though entry-level, trauma-informed behavioral health service providers are unlikely to be in a position to use these interventions, having some knowledge of them is nevertheless important. Currently, more research is needed to tease out the most important ingredients of early interventions and their role in the prevention of more pervasive traumatic stress

symptoms. More science-based evidence is available for trauma-specific treatments that occur and extend well beyond the immediate reactions to trauma. The last part of the chapter provides a brief review of selected emerging interventions.

Introduction

Trauma-specific therapies vary in their approaches and objectives.Some are present focused, some are past focused, and some are combinations (Najavits). Present-focused approaches primarily address current coping skills, psychoeducation, and managing symptoms for better functioning. Past-focused approaches primarily focus on telling the trauma story to understand the impact of the trauma on how the person functions today, experiencing emotions that were too overwhelming to experience in the past, and helping clients more effectively cope in the present with their traumatic experiences. Clients participating in present-focused approaches may reveal some of their stories; past-focused approaches emphasize how understanding the past influences current behavior, emotion, and thinking, thereby helping clients cope more effectively with traumatic experiences in the present. The distinction between these approaches lies in the primary emphasis of the approach. Depending on the nature of the trauma and the specific needs of the client, one approach may be more suitable than the other. For instance, in short-term treatment for clients in early recovery from mental illness and/or substance abuse, present-focused, cognitive–behavioral, or psychoeducational approaches are generally more appropriate. For clients who are stable in their recovery and have histories of developmental trauma where much of the trauma has been repressed, a past-focused orientation may be helpful. Some clients may benefit from both types, either concurrently or sequentially.

This chapter discusses a number of treatment models, general approaches, and techniques. A treatment model is a set of practices designed to alleviate symptoms, promote psychological well-being, or restore mental health. Treatment techniques are specific procedures that can be used as part of a variety of models. Some models and techniques described in this chapter can be used with groups, some with individuals, and some with both. This chapter is selective rather than comprehensive; additional models are described in the literature. See, for example, the PILOTS database on the Web site of the National Center for PTSD (NCPTSD; http://www.ptsd.va.gov) for treatment literature related to trauma and posttraumatic stress disorder (PTSD). For an overview of models for use with both adult and child populations, refer to *Models for Developing Trauma-Informed Behavioral HealthSystems and Trauma-Specific Services* (Center for Mental Health Services).

Some treatments discussed in this chapter are described as evidence based. Because research on integrated treatment models is so new, many have only been examined in a few studies. Given these circumstances and the fact that an outcome study provides only limited evidence of efficacy, the term "evidence based" should be interpreted cautiously. Additional scientific study is needed to determine whether some treatments discussed herein are, in fact, evidence based. A good resource for evaluating evidence-based, trauma-specific treatment models is *Effective Treatments for PTSD* (Foa, Keane, Friedman, & Cohen). Although evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with symptoms of trauma that co-occur with mental and substance use disorders, other factors must also be weighed, including the specific treatment needs of the client; his or her history of trauma, psychosocial and cultural background, and experiences in prior trauma treatment; the overall treatment plan for the client; and the competencies of the program's clinical staff.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created the National Registry of Evidence-Based Pro-grams and Practices (NREPP) as a resource for reviewing and identifying effective treatment programs. Programs can be nominated for consideration as co-occurring disorders programs or substance abuse prevention or treatment programs, and their quality of evidence, readiness for dissemination, and training considerations are then reviewed. For more detailed information, including details about several evidence-based co-occurring trauma treatment programs, visit the NREPP Web site (http://www.nrepp.samhsa.gov). Program models for specialized groups, such as adolescents, can also be found on the NREPP Web site.

Trauma-Specific Treatment Models

Immediate Interventions

Intervention in the First 48 Hours

The acute intervention period comprises the first 48 hours after a traumatic event. In a disaster, rescue operations usually begin with local agencies prior to other organizations arriving on the scene. Law enforcement is likely to take a primary role on site. Whether it is a disaster, group trauma, or individual trauma (including a trauma that affects an entire family, such as a house fire), a hierarchy of needs should be established: survival, safety, security, food, shelter, health (physical and mental), orientation of survivors to immediate local services, and communication with family, friends, and community (National Institute of Mental Health). In this crucial time, appropriate interventions include educating survivors about resources; educating other providers, such as faith-based organizations and social service

Evidence Related to Immediate Interventions

Evidence related to immediate interventions suggests that:

- Early, brief, focused psychotherapeutic intervention provided in an individual or group format can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive-behavioral approaches may help reduce the incidence, duration, and severity of acute stress disorder (ASD), PTSD, and depression in trauma survivors.
- A one-session individual recital of events and expression of emotions evoked by a traumatic event does not consistently reduce risk of later developing PTSD. In fact, it may increase the risk for adverse outcomes. Perhaps CISD hinders the natural recovery mechanisms that restore pretrauma functioning (Bonanno).
- The focus initially should be upon screening with follow-up as indicated.

groups, to screen for increased psychological effects including use of substances; and use of a trauma response team that assists clients with their immediate needs. No formal interventions should be attempted at this time, but a professionally trained, empathic listener can offer solace and support (Litz & Gray).

Basic Needs

Basic necessities, such as shelter, food, and water, are key to survival and a sense of safety.It is important to focus on meeting these basic needs and on providing a supportive environment. Clients' access to prescribed medications may be interrupted after a trauma, particularly a disaster, so providers should identify clients' medication needs for preexisting physical and mental disorders, including methadone or other pharmacological treatment for substance use. For example, after September 11, 2001, substance abuse treatment program administrators in New York had to seek alternative methadone administration options (Frank, Dewart, Schmeidler, & Demirjian).

Psychological First Aid

The psychological first aid provided in the first 48 hours after a disaster is designed to ensure safety, provide an emotionally supportive environment and activities, identify those with high-risk reactions, and facilitate communication, including strong, reassuring leadership immediately after the event. The primary helping response of psychological first aid is to provide a calm, caring, and supportive environment to set the scene for psychological recovery. It is also essential that all those first responding to a trauma—rescue workers, medical professionals, behavioral health workers (including substance abuse

counselors), journalists, and volunteers—be familiar with relevant aspects of traumatic stress. Approaching survivors with genuine respect, concern, and knowledge increases the likelihood that the caregiver can (NCPTSD):

- ➡ Answer questions about what survivors may be experiencing.
- ➡ Normalize their distress by affirming that what they are experiencing is normal.
- ➡ Help them learn to use effective coping strategies.
- ➡ Help them be aware of possible symptoms that may require additional assistance.
- ➡ Provide a positive experience that will increase their chances of seeking help if they need it in the future.

Clinical experience suggests that care be taken to respect a survivor's individual method of coping; some may want information, for example, whereas others do not. Similarly, some may want to talk about the event, but others won't. An excellent guide to providing psychological first aid is available online from theTerrorism and Disaster Branch of the National Child Traumatic Stress Network (http://www.nctsn.org/content/psychologicalfirst-aid).

Critical Incident Stress Debriefing

Initially developed for work with first responders and emergency personnel, critical incident stress debriefing (CISD; Mitchell & Everly) is now widely used and encompasses various group protocols used in a variety of settings. This facilitator-led group intervention is for use soon after a traumatic event with exposed people. The goal is to provide psychological closure by encouraging participants to talk about their experiences and then giving a didactic presentation on common stress reactions and management.

The widespread use of CISD has occurred despite the publication of conflicting results regarding its efficacy. Claims that single-session psychological debriefing can prevent development of chronic negative psychological sequelae are not empirically supported (van Emmerik, Kamphuis, Hulsbosch, & Emmel kamp). Some controlled studies suggest that it may impede natural recovery from trauma (McNally, Bryant, & Ehlers). Other research suggests emphasizing screening to determine the need for early interventions. Mitchell and Everly point out that many of the studies showing negative results were not conducted with first responders; that is, CISD may be appropriate for some, but not all, groups. A recent study of 952 U.S. peacekeepers and CISD by the U.S.Army Research Unit–Europe (Adler et al.) found mixed results.

Interventions Beyond the Initial Response to Trauma

In the interest of increasing your overall familiarity with relevant approaches, the following sections review several traumatic stress treatment approaches that counselors will most likely encounter when collaborating with clinicians or agencies that specialize in trauma-specific services and treating traumatic stress.

Cognitive–behavioral Therapies

Most PTSD models involve cognitive–behavioral therapy (CBT) that integrates cognitive and behavioral theories by incorporating two ideas: first, that cognitions (or thoughts) mediate between situational demands and one's attempts to respond to them effectively, and second, that behavioral change influences acceptance of altered cognitions about oneself or a situation and establishment of newly learned cognitive–behavioral interaction patterns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush, Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address various populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many others. CBT has also been expanded to include various techniques, coping skills, and approaches, such as dialectical behavior therapy (DBT; Linehan), Seeking Safety (Najavits), and mindfulness (Segal, Williams, & Teasdale). Traditional CBT emphasizes symptom reduction or resolution, but recent CBT approaches have also emphasized the therapeutic relationship, a particularly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre).

CBT has been applied to the treatment of trauma and has also been widely and effectively used in the treatment of substance use. Areview of efficacy research on CBT for PTSDis provided by Rothbaum, Meadows, Resick,and Foy. Najavits and colleagues and O'Donnell and Cook offer an overview of CBT therapies for treatingPTSD and substance abuse. In addition, a free online training resource incorporating CBT for traumatized children within the community, Trauma-Focused CBT, is available from the Medical University of South Carolina(http://tfcbt.musc.edu/).

Cognitive Processing Therapy

Cognitive processing therapy (CPT) is a manualized 12-session treatment approach that can be administered in a group or individual setting (Resick & Schnicke). CPT

was developed for rape survivors and combines elements of existing treatments for PTSD, specifically exposure therapy (see the "Exposure Therapy" section later in this chapter) and cognitive therapy. The exposure therapy component of treatment consists of clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes identified by McCann and Pearlman: safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs.

Results from randomized, placebo-controlled trials for the treatment of PTSD related to interpersonal violence (Resick, Resick,Nishith, Weaver, Astin, & Feuer) support the use of CPT. CPT and prolonged exposure therapy models are equally and highly positive in treating PTSD and depression in rape survivors; CPT is superior in reducing guilt (Nishith, Resick, & Griffin, Resick et al., Resick, Nishith, &Griffin). CPT has shown positive outcomes with refugees when administered in the refugees' native language (Schulz, Marovic-Johnson, & Huber) and with veterans (Monson et al.). However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. CPT requires a 3-day training plus consultation (Karlin et al.). Resick and Schicke published a CPT treatment manual, *Cognitive Processing Therapy forRape Victims: A Treatment Manual*.

Exposure Therapy

Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retraumatization (clients can become conditioned to fear the trauma-related material even more). Clients must have ample time to process their memories and integrate cognition and affect, so some sessions can last for 1.5 hours or more. For simple cases, exposure can work in as few as 9 sessions; more complex cases may require 20 or more sessions (Foa, Hembree, &Rothbaum). Various techniques can expose the client to traumatic material. Two of the more common methods are exposure through imagery and in vivo ("real life") exposure.

The effectiveness of exposure therapy has been firmly established (Rothbaum et al.); however, adverse reactions to exposure therapy have also been noted. Some individuals who have experienced trauma exhibit an exacerbation of symptoms

Relaxation Training, Biofeedback, and Breathing Retraining Strategies

Relaxation training, biofeedback, and breathing retraining strategies may help some clients cope with anxiety, a core symptom of traumatic stress. However, no evidence supports the use of relaxation and biofeedback as effective standalone PTSD treatment techniques (Cahill, Rothbaum, Resick, & Follete). Both are sometimes used as complementary strategies to manage anxiety symptoms elicited by trauma-related stimuli. Breathing retraining uses focused or controlled breathing to reduce arousal. Breathing retraining and relaxation, along with other interventions when necessary, can help clients with ASD. An important caution in the use of breath work with trauma clients is that it can sometimes act as a trigger–for example, given its focus on the body and its potential to remind them of heavy breathing that occurred during assault. Biofeedback, which requires specialized equipment, combines stress reduction strategies (e.g., progressive muscle relaxation, guided imagery) with feedback from biological system measures (e.g., heart rate, hand temperature) that gauge levels of stress or anxiety reduction. Relaxation training, which requires no specialized equipment, encourages clients to reduce anxiety responses (including physiological responses) to trauma-related stimuli; it is often part of more comprehensive PTSD treatments (e.g., prolonged exposure and stress inoculation training [SIT]).

during or following exposure treatments. Even so, the exacerbation may depend on clinician variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al.) a clinician unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen.

Exposure therapy is recommended as a first-line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental

A Brief Description of EMDR Therapy

Treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases. Counselors may work with several phases in one session. Each phase is meant to be revisited either in every session or when appropriate (e.g., the closure process is meant to be conducted at the end of every session, in preparation for the next).

Phase 1: History and Treatment Planning (1-2 sessions)
Phase 2: Preparation
Phase 3: Assessment and Reprocessing
Phase 4: Desensitization
Phase 5: Installation
Phase 6: Body Scan
Phase 7: Closure
Phase 8: Reevaluation

illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al.).

Prolonged exposure therapy for PTSD is listed in SAMHSA's NREPP. For reviews of exposure therapy, also see Najavits and Institute of Medicine. In addition to prolonged exposure therapy, other therapies incorporate exposure and desensitization techniques, including eye movement desensitization and reprocessing (EMDR; Shapiro), cognitive processing, and systematic desensitization therapies (Wolpe).

Eye Movement Desensitization and Reprocessing

EMDR (Shapiro) is one of the most widely used therapies for trauma and PTSD. The treatment protocols of EMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision.EMDR draws on a variety of theoretical frameworks, including psychoneurology, CBT, information processing, and nonverbal representation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an effective treatment for PTSD (Seidler &Wagner) and is accepted as an evidence-based

practice by the U.S. Department ofVeterans Affairs (VA), the Royal College ofPsychiatrists, and the International Society for Traumatic Stress Studies (Najavits); numerous reviews support its effectiveness (e.g., Mills et al.). EMDR values the development of "resource installation" (calming procedures) and engages in exposure work to desensitize clients to traumatic material, using external tracking techniques across the visual field to assist in processing distressing material. Training in EMDR, available through theEMDR Institute, is required before counselors use this treatment. It is listed in SAMHSA's NREPP (EMDR Network). Thus far, there is no study examining the use of EMDR with clients in substance abuse treatment.

Narrative Therapy

Narrative therapy is an emerging approach to understanding human growth and change; it is founded on the premise that individuals are the experts on their own lives and can access their existing intrapsychic and interpersonal resources to reduce the impact of problems in their lives. Developed for the treatment ofPTSD resulting from political or community violence, narrative therapy is based on CBT principles, particularly exposure therapy (Neuner, Schauer, Elbert, & Roth, Neuner, Schauer, Klaschik, Karunakara, & Elbert). This approach views psychotherapy not as a scientific practice, but as a natural extension of healing practices that have been present throughout human history.For a trauma survivor, the narrative, as it is told and retold, expresses the traumatic experience, puts the trauma in the context of the survivor's life, and defines the options he or she has for change. Narrative structure helps clients connect events in their lives, reveals strings of events, explores alternative expressions of trauma, evokes explanations for clients' behaviors, and identifies their knowledge and skills. The use of stories in therapy, with the client as the storyteller, generally helps lessen suffering (McLeod, 1997; White).

Skills Training in Affective and Interpersonal Regulation

Skills training in affective and interpersonal regulation (STAIR) is a two-phase cognitive–behavioral model that adapts therapies developed by others into a new package (Cloitre, Koenen, Cohen, & Han). Phase 1 consists of eight weekly sessions of skills training in affect and interpersonal regulation derived from general CBT and DBT (Linehan) and adapted to address trauma involving childhood abuse. Session topics are labeling and identifying feelings, emotion management, distress tolerance, acceptance of feelings, identifying trauma-based interpersonal schemas, identifying conflict between trauma-generated feelings and current interpersonal goals, role-plays on issues of power and control, and role-plays on developing flexibility in interpersonal situations. Phase 2 features eight sessions of modified prolonged exposure using a narrative approach. Cloitre and

SIT has been used to help individuals cope with the aftermath of exposure to stressful events and on a preventative basis to "inoculate" individuals to future and ongoing stressors (Meichenbaum). This practice as a preventive strategy is similar to promoting disease resistance through immunizations.

colleagues assigned women with PTSD related to childhood abuse randomly to STAIR or a minimal attention wait-list, excluding clients with current substance dependence as well as other complexities. STAIR participants showed significantly greater gains in affect regulation, interpersonal skills, and PTSD symptoms than the control participants. These gains were maintained through follow-up at 3 and 9 months. However, it is not clear from this study whetherDBT and exposure were both needed. Phase 1therapeutic alliance and negative mood regulation skills predicted Phase 2 exposure success in reducing PTSD, suggesting the importance of establishing a strong therapeutic relationship and emotion regulation skills before conducting exposure work with people who have chronic PTSD.

Stress Inoculation Training

SIT was originally developed to manage anxiety (Meichenbaum, Meichenbaum & Deffenbacher). Kilpatrick, Veronen, and Resick modified SIT to treat rape survivors based on the idea that the anxiety and fear that rape survivors experience during their trauma generalizes to other objectively safe situations. SIT treatment components include education, skills training (muscle relaxation training, breathing retraining, role-playing, guided self-talk, assertiveness training, and thought stopping [i.e., actively and forcefully ending negative thoughts by thinking "STOP" and then redirecting thoughts in a more positive direction]), and skills application. The goal is to help clients learn to manage their anxiety and to decrease avoidant behavior by using effective coping strategies.Randomized controlled clinical trials have indicated that SIT reduces the severity ofPTSD compared with waitlist controls and shows comparable efficacy to exposure therapy.At follow-up (up to 12 months after treatment), gains were maintained (Foa et al., Foa, Rothbaum, Riggs, & Murdock).

Other Therapies

Numerous interventions introduced in the past 20 years focus on traumatic stress. For some interventions, the evidence is limited, and for other others, it is evolving. One example is the traumatic incident reduction (TIR) approach. This brief memory-oriented intervention is designed for children, adolescents, and adults who have experienced traumatic stress (Valentine & Smith). Listed in SAMHSA's

NREPP, the intervention is designed to process specific traumatic incidents or problematic themes related to the trauma, including specific feelings, emotions, sensations, attitudes, or pain. It involves having clients talk through the traumatic incident repeatedly with the anticipation that changes in affect will occur throughout the repetitions.TIR is a client-centered approach.

Integrated Models for Trauma

This section covers models specifically designed to treat trauma-related symptoms along with either mental or substance use disorders at the same time. Integrated treatments help clients work on several presenting problems simultaneously throughout the treatment, a promising and recommended strategy (Dass-Brailsford & Myrick, Najavits, Nixon & Nearmy). Thus far, research is limited, but what is available suggests that integrated treatment models effectively reduce substance abuse, PTSD symptoms, and other mental disorder symptoms. Similar to single models, integrated treatment models are designed for use in a variety of settings (e.g., outpatient, day treatment, and/or residential substance abuse and mental health clinics/programs). Most models listed are manual-based treatments that address trauma-related symptoms, mental disorders, and substance use disorders at the same time. Additional approaches and further details on the selected approaches can be found atNREPP (http://www.nrepp.samhsa.gov).

Addiction and Trauma Recovery Integration Model

The Addiction and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry) integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for individuals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. It helps clients explore anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. It was designed primarily for women and focuses on developmental (childhood) trauma and interpersonal violence, but it recognizes that other types of traumatic events occur.

The ATRIUM model consists of three phases of treatment. The first stage, or "outer circle,"consists of the counselor collecting data from the client about his or her trauma history, offering psychoeducation on the nature of trauma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trauma events in this phase. The second stage, or"middle circle," allows clients and counselors to address trauma symptoms more directly and specifically encourages clients to reach out to and engage with support

resources in the community. The middle circle also emphasizes learning new information about trauma and developing additional coping skills. The third stage of the program, the "inner circle," focuses on challenging old beliefs that arose as a result of the trauma. For instance, the concept of "non-protecting bystander" is used to represent the lack of support that the traumatized person experienced at the time of the trauma.This representation is replaced with the "protective presence" of supportive others today.

ATRIUM was used in one of the nine study sites of SAMHSA's Women, Co-OccurringDisorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models (Morrissey et al). There has not yet been a study of ATRIUM per se, however. A manual describing the theory behind this model in greater depth, as well as how to implement it, is published under the title *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit* (Miller & Guidry).

Beyond Trauma: A Healing Journey for Women

Beyond Trauma (Covington) is a curriculum for women's services based on theory, research, and clinical experience. It was developed for use in residential, outpatient, and correctional settings; domestic violence programs; and mental health clinics. It uses behavioral techniques and expressive arts and is based on relational therapy. Although the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme throughout. Beyond Trauma has a psychoeducational component that defines trauma by way of its process as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). Coping skills are emphasized; specific exercises develop emotional wellness.

Integrated CBT

Integrated CBT is a 14-session individual therapy model designed for PTSD and substance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber-Harris, Alterman, Xie, & Meier). A randomized controlled trial showed that both integrated CBT and individual addiction treatment achieved improvements in substance use and other measures of psychiatric symptom severity with no difference between the treatments.

Seeking Safety

Seeking Safety is an empirically validated, present-focused treatment model that helps clients attain safety from trauma and substance abuse (Najavits). The Seeking

Safety manual (Najavits) offers clinician guidelines and client handouts and is available in several languages.Training videos and other implementation materials are available online (http://www.seekingsafety.org). Seeking Safety is flexible; it can be used for groups and individuals, with women and men, in all settings and levels of care, by all clinicians, for all types of trauma and substance abuse.

Seeking Safety covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client's course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multi-site trials representing various investigators and populations) provide the evidence base for this treatment model. For more information, see SAMHSA's NREPP Web site (http://www.nrepp.samhsa.gov) as well as the"Outcomes" section of the Seeking Safety Web site (http://www.seekingsafety.org/3-0306/studies.html). Study samples included people with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of settings (e.g., criminal justice, VA centers, adolescent treatment, homelessness services, public sector). Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available.

The five key elements of Seeking Safety are:

- ➡Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
- ➡ Integrated treatment (working on trauma and substance abuse at the same time).
- ➡A focus on ideals to counteract the loss of ideals in both trauma and substance abuse.
- ➡ Four content areas: cognitive, behavioral, interpersonal, and case management.
- ➡Attention to clinician processes (addressing countertransference, self-care, and other issues).

Trauma Recovery and Empowerment Model

The trauma recovery and empowerment model (TREM) of therapy (Fallot & Harris, Harris & Community Connections TraumaWork Group) is a manualized group intervention designed for female trauma survivors with severe mental disorders. TREM addresses the complexity of long-term adaptation to trauma and attends to a range of difficulties common among survivors of sexual and physical abuse. TREM focuses mainly on developing specific recovery skills and current functioning and uses techniques that are effective in trauma recovery services. The model's content and structure, which cover 33 topics, are informed by the role of gender in women's experience of and coping with trauma.

TREM Program Format

Each session includes an experiential exercise to promote group cohesiveness. The 33 sessions are divided into the following general topic areas:

- **Part I–empowerment** introduces gender identity concepts, interpersonal boundaries, and self-esteem.
- **Part II–trauma recovery** concentrates on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and relational patterns and issues.
- **Part III–advanced trauma recovery issues** addresses additional trauma issues, such as blame and the role of forgiveness.
- **Part IV–closing rituals** allows participants to assess their progress and encourages them to plan for their continued healing, either on their own or as part of a community of other survivors.
- **Part V–modifications or supplements for special populations** provides modifications for subgroups such as women with serious mental illness, incarcerated women, women who are parents, women who abuse substances, and male survivors.

Source: Mental Health America Centers for Technical Assistance,

TREM can be adapted for shorter-term residential settings and outpatient substance abuse treatment settings, among others. Adaptations of the model for men and adolescents are available. The model was used in SAMHSA's Women, Co-Occurring Disorders and Violence Study for three of the nine study sites and in SAMHSA's Homeless Families program, and it is listed in SAMHSA's NREPP.

This model has been used with clients in substance abuse treatment; research by Toussaint, VanDeMark, Bornemann, and Graeber shows that women in a residential substance abuse treatment program showed significantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.

Triad Women's Project

The Triad Project was developed as a part of SAMHSA's Women, Co-Occurring Disorders and Violence Study. It is a comprehensive, trauma-informed, consumer-responsive integrated model designed for female trauma survivors with co-occurring substance use and mental disorders who live in semi-rural areas. Triad integrates motivational enhancement for substance use disorders, DBT, and intensive case management techniques for co-occurring mental disorders. This program is a 16-week group intervention for women that uses integrated case management services, a curriculum-based treatment group, and a peer support group (Clark & Fearday).

Emerging Interventions

New interventions are emerging to address traumatic stress symptoms and disorders. The following sections summarize a few interventions not highlighted in prior chapters; this is not an exhaustive list. In addition to specific interventions, technology is beginning to shape the delivery of care and to increase accessibility to tools that complement trauma-specific treatments.

Couple and Family Therapy

Trauma and traumatic stress affects significant relationships, including the survivor's family. Although minimal research has targeted the effectiveness of family therapy with trauma survivors, it is important to consider the needs of the individual in the context of their relationships. Family and couples therapy may be key to recovery. Family members may experience secondary traumatization silently, lack understanding of traumatic stress symptoms or treatment, and/or have their own histories of trauma that influence their willingness to support the client in the family or to talk about anything related to trauma and its effects. Family members can engage in similar patterns of avoidance and have their own triggers related to the trauma being addressed at the time. A range of couple and family therapies have addressed traumatic stress and PTSD, but few studies exist that support or refute their value. Current couple or family therapies that have some science-based evidence include behavioral family therapy, behavioral marital therapy, cognitive–behavioral couples treatment, and lifestyle management courses (Riggs, Monson, Glynn, & Canterino).

Mindfulness Interventions

Mindfulness is a process of learning to be present in the moment and observing internal experience (e.g., thoughts, bodily sensations) and external experience (e.g., interactions with others) in a nonjudgmental way. Mindfulness challenges limiting beliefs that arise from trauma, quells anxiety about future events, and simply helps one stay grounded in the present. It plays a significant role in helping individuals who have been traumatized observe their experiences, increase awareness, and tolerate uncomfortable emotions and cognitions.

To date, mindfulness-based interventions appear to be valuable as an adjunct to trauma-specific interventions and in decreasing arousal (Baer). It may also help individuals tolerate discomfort during exposure-oriented and trauma processing interventions. Overall, mindfulness practices can help clients in managing traumatic stress, coping, and resilience.In a study of firefighters, mindfulness was associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when controlling for other variables (Smith et al.)
For clients and practitioners who want to develop a greater capacity for mindfulness, see Kabat-Zinn's books *Wherever You Go, There You Are: Mindfulness Meditation In Everyday Life* and *Full Catastrophe Living: Usingthe Wisdom of Your Body and Mind to FaceStress, Pain, and Illness*. For clinical applications of mindfulness, see *Mindfulness-Based Cognitive Therapy for Depression: A NewApproach to Preventing Relapse* (Segal et al) and *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Donovan).

Pharmacological Therapy

Pharmacotherapy for people with mental, substance use, and traumatic stress disorders needs to be carefully managed by physicians who are well versed in the treatment of each condition. Medications can help manage and control symptoms; however, they are only apart of a comprehensive treatment plan. There are no specific "anti-trauma" drugs; rather, certain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need careful assessment. Some clients with pre-existing mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden withdrawal from a pattern of self-administered substances can not only lead to dangerous levels of physical distress, but also exacerbate the emergence of more severe PTSD symptoms. Distress after trauma often lessens over time, which can sometimes make the use of medications unnecessary for some individuals. Some trauma survivors do not develop long-term psychological problems from their experiences

that require medication; others may simply refuse the initiation of pharmacotherapy or the use of additional medications.

Concluding Note

Behavioral health providers can best serve clients who have experienced trauma by providing integrated treatment that combines therapeutic models to target presenting symptoms and disorders. Doing so acknowledges that the disorders interact with each other. Some models have integrated curricula; others that address trauma alone can be combined with behavioral health techniques with which the counselor is already familiar.

In part, the choice of a treatment model or general approach will depend on the level of evidence for the model, the clinician's training, identified problems, the potential for prevention, and the client's goals and readiness for treatment. Are improved relationships with family members a goal? Will the client be satisfied if sleep problems decrease, or is the goal resolution of broader issues? Are there substance use or substance-related disorders? Is the goal abstinence? Collaborating with clients to decide on goals, eliciting what they would like from treatment, and determining what they expect to happen can provide some clues as to what treatment models or techniques might be successful in keeping clients engaged in recovery.

Part II: Crisis Counseling

11. Core Elements for Responding to Mental Health Crises

Crises have a profound impact on people with serious mental health or emotional problems. Adults, children and older adults with a serious mental illness or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization.

Homelessness, police contact, institutionalization and other adverse events are in themselves crises, and may also contribute to further crises. The statistics below paint a sobering picture of how crises affect the lives of people who have mental or emotional disabilities:

- From one third to one half of homeless people have a severe psychiatric disorder.

- Approximately 7 percent of all police contacts in urban settings involve a person believed to have a mental illness.
- The likelihood of mental illness among people confined in state prisons and local jails is three to four times higher than in the general population3 and, compared with other inmates, it is at least twice as likely that these individuals will be injured during their incarceration.
- About 6 percent of all hospital emergency department visits reflect mental health emergencies.
- Due to a lack of available alternatives, 79 percent of hospital emergency departments report having to "board" psychiatric patients who are in crisis and in need of inpatient care, sometimes for eight hours or longer.
- Almost one in 10 individuals discharged from a state psychiatric hospital will be readmitted within 30 days; more than one in five will be readmitted within 180 days.
- About 90 percent of adult inpatients in state psychiatric hospitals report histories of trauma.
- About three quarters of youth in the juvenile justice system report mental health problems and one in five has a serious mental disorder.
- Mothers with serious mental illnesses are more than four times as likely as other mothers to lose custody of their children.
- People with serious mental illnesses die, on average, 25 years earlier than the general population.

These statistics are incomplete; they reflect just a sampling of scenarios that, while commonplace, constitute significant life crises for individuals with serious mental illnesses. Many such individuals experience a cascade of crisis events that place them in more than one of these statistical groups. For instance, readmission to a psychiatric institution—a high probability for adults who have been discharged from a state psychiatric hospital, based on these data—may feature a series of crisis events for the individual: the psychiatric emergency itself; forcible removal from one's home; being taken into police custody, handcuffed and transported in the back of a police car; evaluation in the emergency department of a general hospital; transfer to a psychiatric hospital; a civil commitment hearing; and so on. And at multiple points in this series of interventions, there is a likelihood that physical restraints, seclusion, involuntary medication or other coercion may be used. Intense feelings of disempowerment are definitional of mental health crises, yet as the individual becomes the subject of a "disposition" at each juncture, that person may experience a diminishing sense of control.

While no one with a mental or emotional disorder is immune from crises, people

with what are termed serious mental illnesses—defined as schizophrenia, bipolar disorder and major depression—may be most reliant on public systems. They also may be at great risk of recurrent crises and interventions that exacerbate their clinical and social problems. These guidelines focus most specifically on individuals with serious mental or emotional problems who tend to encounter an assortment of governmental or publicly funded interveners when they are in crisis. Nevertheless, the values, principles and strategies embedded in the guidelines that follow are applicable to all individuals with mental healthcare needs, across populations and service settings.

Individuals whose diagnoses do not fit "serious mental illnesses" may be vulnerable to serious mental health crises that can have devastating outcomes. Interventions on their behalf are more likely to occur within the private healthcare sector, which mirrors public mental health systems' problems in providing early and meaningful access to help. Within these parallel systems, crisis services are provided in a broad array of settings that ultimately will require translation of the guidelines presented here into specific protocols that break cycles of crises and advance the prospects of recovery for people with mental illnesses.

What It Means to be In a Mental Health Crisis

Too often, public systems respond as if a mental health crisis and danger to self or others were one and the same. In fact, danger to self or others derives from common legal language defining when involuntary psychiatric hospitalization may occur—at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated.

While behaviors that represent an imminent danger certainly indicate the need for some sort of an emergency response, these behaviors may well be the culmination of a crisis episode, rather than the episode in its entirety. Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).

Because only a portion of real-life crises may actually result in serious harm to self or others, a response that is activated only when physical safety becomes an issue is often too little, too late or no help at all in addressing the root of the crisis. And a response that does not meaningfully address the actual issues underlying a crisis may do more harm than good.

The Need for Crisis Standards

Individuals experiencing mental health crises may encounter an array of professionals and non-professionals trying to intervene and help: family members, peers, healthcare personnel, police, advocates, clergy, educators and others. The specific crisis response offered is influenced by a number of variables, among them:

✓At what time of day it occurs
✓Where the intervention occurs
✓When it occurs within the course of the crisis episode
✓The familiarity of the intervener with the individual or with the type of problem
✓Interveners' training relating to crisis services
✓Resources of the mental health system and the ready availability of services and supports, and professional, organizational or legal norms that define the nature of the encounter and the assistance offered.

The guidelines presented here define appropriate responses to mental health crises across these variables. They were developed by a diverse expert panel that includes individuals with and without serious mental illnesses who are leaders within mental health professions and mental health advocacy.

These crisis guidelines promote two essential goals:

✓Ensuring that mental health crisis interventions are guided by standards consistent with recovery and resilience and
✓Replacing today's largely reactive and cyclical approach to mental health crises with one that works toward reducing the likelihood of future emergencies and produces better outcomes.

Responding to a Mental Health Crisis Ten Essential Values

Ten essential values are inherent in an appropriate crisis response, regardless of the nature of the crisis, the situations where assistance is offered or the individuals providing
assistance:

1. Avoiding harm. Sometimes mental health crises place the safety of the person, the crisis responders or others in jeopardy. An appropriate response establishes physical safety, but it also establishes the individual's psychological safety. For instance, restraints are sometimes used in situations where there is an immediate risk of physical harm, yet this intervention has inherent physical and psychological risks that can cause injury and even death. Precipitous responses to individuals in mental health crises—often initiated with the intention of establishing physical safety—sometimes result in harm to the individual. An appropriate response to mental health crises considers the risks and benefits attendant to interventions and whenever possible employs alternative approaches, such as controlling danger sufficiently to allow a period of "watchful waiting." In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address an immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimize the duration and negative impact of interventions used.

2. Intervening in person-centered ways. Mental health crises may be routine in some settings and, perhaps, have even come to be routine for some people with serious mental health or emotional problems. Nevertheless, appropriate crisis assistance avoids rote interventions based on diagnostic labels, presenting complaint or practices customary to a particular setting. Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated in the crisis response.

"To promote patient-centered care, all parties involved in health care for mental or substance-use conditions should support the decision-making abilities and preferences for treatment and recovery of persons with mental/substance use problems and illnesses" Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders.

3. Shared responsibility. An acute sense of losing control over events or feelings is a hallmark of mental health crises. In fact, research has shown "feeling out of control" to be the most common reason consumers cite for being brought in for psychiatric emergency care. An intervention that is done to the individual— rather than with the individual—can reinforce these feelings of helplessness. One of the principal rationales for person-centered plans is that shared responsibility promotes engagement and better outcomes. While crisis situations may present challenges to implementing shared, person-centered plans, ultimately an intervention that

considers and, to the extent possible, honors an individual's role in crisis resolution may hold long-term benefits. An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in—rather than a passive recipient of—services.

4. Addressing trauma. Crises, themselves, are intrinsically traumatic and certain crisis interventions may have the effect of imposing further trauma—both physical and emotional. In addition, people with serious mental illness have a high probability of having been victims of abuse or neglect. It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual's relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available (for instance, by executing advance directives).

5. Establishing feelings of personal safety. An individual may experience a mental health crisis as a catastrophic event and, accordingly, may have an urgent need to feel safe. What is regarded as agitated behavior may reflect an individual's attempts at self-protection, though perhaps to an unwarranted threat. Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (perhaps contained in a crisis plan or personal safety plan previously formulated by the individual) and what interventions increase feelings of vulnerability (for instance, confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively.

6. Based on strengths. Sharing responsibility for crisis resolution means understanding that an individual, even while in crisis, can marshal personal strengths and assist in the resolution of the emergency. Individuals often understand the factors that precipitated a crisis as well as factors that can help ameliorate their impact. An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.

7. The whole person. For individuals who have a mental illness, the psychiatric label itself may shape—even dominate—decisions about which crisis interventions

are offered and how they are made available. An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may—or may not—be immediately paramount. That the individual may have multiple needs and an adequate understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty. An individual's emergency may reflect the interplay of psychiatric issues with other health factors. And while the individual is experiencing a crisis that tends to be addressed as a clinical phenomenon, there may also be a host of seemingly mundane, real world concerns that significantly affect an individual's response: the whereabouts of the person's children, the welfare of pets, whether the house is locked, absence from work, and so on.

8. The person as credible source. Assertions or complaints made by individuals who have been diagnosed with a serious mental illness tend to be viewed skeptically by others. Particularly within the charged context of mental health crises, there may be a presumption that statements made by these individuals are manifestations of delusional thinking. Consequently, there is a risk that legitimate complaints relating to such matters as medical illness, pain, abuse or victimization will go unheeded. Even when an individual's assertions are not well grounded in reality and represent obviously delusional thoughts, the "telling of one's story" may represent an important step toward crisis resolution. For these reasons, an appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information—factual or emotional—that is important to understanding the person's strengths and needs.

9. Recovery, resilience and natural supports. Certain settings, such as hospital emergency departments, may see individuals only transiently, at a point when they are in acute crisis and in a decidedly high-stress environment. Even when not occurring within hospitals, mental health emergency interventions are often provided in settings that are alien to the individual and the natural supports that may be important parts of his or her daily life. It is important not to lose sight of the fact that an emergency episode may be a temporary relapse and not definitional of the person or that individual's broader life course. An appropriate crisis response contributes to the individual's larger journey toward recovery and resilience and incorporates these values. Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.

10. Prevention. Too often, individuals with serious mental illnesses have only temporary respite between crises. An appropriate crisis response works to ensure

that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements.

The National Consensus Statement on Mental Health Recovery identifies recovery as an individual's journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. It also cites 10 fundamental components for systems:

➡Self-Direction
➡Individualized and Person-Centered
➡Empowerment
➡Holistic
➡Non-Linear
➡Strengths-Based
➡Peer Support
➡Respect
➡Responsibility
➡Hope

Principles for Enacting the Essential Values

Several principles are key to ensuring that crisis intervention practices embody these essential values:

1. Access to supports and services is timely. Ready access to assistance is important not only because it holds the promise of reducing the intensity and duration of the individual's distress, but also because as a crisis escalates, options for interventions may narrow. Timely access presupposes 24-hour/7-days-a-week availability and a capacity for outreach when an individual is unable or unwilling to come to a traditional service site.

2. Services are provided in the least restrictive manner. Least restrictive emergency interventions not only avoid the use of coercion, but also preserve the individual's connectedness with his or her world. Individuals should not be unnecessarily isolated from their routine networks of formal and natural supports and should be encouraged to make contact with outside professionals, family and friends who can provide assistance through the crisis event and beyond.

3. Peer support is available. Services should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first hand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis.

4. Adequate time is spent with the individual in crisis. In settings such as hospital emergency departments, there may be intense pressure to move patients through quickly. People who provide assistance must have an adequate understanding of the crisis situation, not only objectively, but also as it is being experienced by the individual who is in crisis. Unfortunately, individuals in acute crisis—particularly following involuntary transport to an evaluation setting—may not be in a position to discuss their presenting complaints clearly and concisely. Personnel in healthcare and similar settings must regard face-to-face time with the individual not as a distraction, but as a core element of quality crisis care. Settings that cannot accommodate the individual in this way may not be appropriate venues for psychiatric crisis intervention; as is discussed elsewhere in these guidelines, such a determination should be regarded as a problem in care and drive performance improvement at both the organizational and systemic levels.

Staff behaviors that consumers feel Are most important to individuals in a mental health crisis:
• Having the staff listen to me, my story and my version of events
• Being asked about what treatment I want
• Trying to help me calm down before resorting to forced treatment
• Being asked about what treatments were helpful and not helpful to me in the past.

5. Plans are strengths-based. It may be fairly routine for professional staff to concentrate on clinical signs and other deficits to be addressed, particularly when an individual is in a crisis state and, therefore, “symptomatic.” Yet appropriate crisis intervention gives at least equal attention to the individual’s immediately available and potentially available assets. A strengths based plan helps to affirm the individual’s role as an active partner in the resolution of the crisis by marshalling his or her capabilities. A strengths based approach also furthers the goals of building resilience and a capability for self managing future crises.

6. Emergency interventions consider the context of the individual’s overall plan of services. Many individuals with serious mental illnesses go into mental health crises while receiving some sort of services and supports. Appropriate crisis

services consider whether the crisis is, wholly or partly attributable to gaps or other problems in the individual's current plan of care and provide crisis measures in ways that are consistent with services the individual receives (or should receive) in the community. In addition, appropriate crisis services place value on earlier efforts by the individual and his or her service providers to be prepared for emergencies, for instance, by having executed psychiatric advance directives or other crisis plans. Incorporating such measures in a crisis response requires that interveners be knowledgeable about these approaches, their immediate and longer-term value, and how to implement them. Appropriate crisis interventions also include post-event reviews that may produce information that is helpful to the individual and his or her customary service providers in refining ongoing services and crisis plans.

7. Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented. Crisis intervention may be considered a high end service, that is high-risk and demanding a high level of skill. Within the course of a psychiatric emergency, various types of crisis interventions may occur—some by healthcare professionals, some by peers and some by personnel (such as police) who are outside of healthcare. Throughout, the individual experiencing a mental health crisis should be assured that all interveners have an appropriate level of training and competence. What that means may vary considerably between scenarios. For instance, a significant number of instances of police involvement with individuals in mental health crises result in injuries or even death. Accordingly, some police departments have taken special measures to train officers in identifying and de-escalating mental health crises. Many have also established links with mental health professionals who can provide timely on-site assistance. These efforts have required police and health care professionals to connect across traditional bureaucratic boundaries.

8. Individuals in a self-defined crisis are not turned away. People who seek crisis services but do not meet the service criteria of an organization should receive meaningful guidance and assistance in accessing alternative resources. This is particularly applicable in organizations or programs that carry out a screening or gatekeeping function. For instance, it is not sufficient, upon determining that an individual fails to meet the criteria for hospitalization, to tell the individual or family members to make contact again if the situation worsens. Such practices tacitly encourage the escalation of crises. Individuals and their families should be assisted in accessing services and supports that resolve issues early on, and an organization providing screening or gate keeping services should be fluent with alternatives for when service thresholds are not met. When these alternatives are

lacking, the organization should consider this a problem in care and take action accordingly. Likewise, an organization providing early intervention that routinely receives referrals from hospital gatekeepers might consider improving its outreach so that individuals seeking help are more likely to access their services directly, without placing demands on programs designed for late-stage emergencies.

An Alternative Approach "The Hospital Diversion Program at the Rose House is currently available to residents of Orange and Ulster counties [New York State]. This peer-operated house is designed to assist fellow peers in diverting from psychiatric distress, which may lead to a hospitalization. The program is located in a three-bedroom home set up and furnished for comfort. The house is equipped with a variety of traditional self help and proactive tools to maintain wellness. Trained peer companions are the key ingredients in helping others learn self help tools. Peer companions are compassionate, understanding and empowering. We exist to fill a gap in the mental health system that can break the cycle of going from home to crisis to hospital. The ROSE HOUSE offers a stay of up to five days to take control of your crisis or potential crisis and develop new skills to maintain your wellness. Peer companions staff the house 24 hours a day to address the needs of guests as they arise. Participation in the program is completely voluntary and free of charge. You are free to come and go as you please. We also will maintain contact and support for you, at your request, after you finish your stay. We have found that occasional calls and visits reinforce recovery and self determination."

9. Interveners have a comprehensive understanding of the crisis. Meaningful crisis response requires a thorough understanding of the issues at play. Yet, for people with serious mental illnesses, interventions are commonly based on a superficial set of facts: behaviors are seen to present a safety issue, the individual has reportedly failed to take medications as prescribed, or an encounter with the police has occurred. An appropriate understanding of the emergency situation not only includes an appreciation for what is happening at the moment, but also why it is happening and how an individual fares when he or she is not in crisis. Crises—particularly recurrent crises—likely signal a failure to address underlying issues appropriately. When crisis intervention occurs outside of the individual's customary setting, such as in a hospital emergency department or a psychiatric inpatient unit, it may be challenging to gain a good picture of the individual's circumstances.

10. Helping the individual to regain a sense of control is a priority. Regaining a sense of control over thoughts, feelings and events that seem to be spinning out of control may be paramount for an individual in mental health crisis. Staff

interventions that occur without opportunities for the individual to understand what is happening and to make choices among options (including the choice to defer to staff) may reinforce feelings that control is being further wrested away. The individual's resistance to this may be inaccurately regarded as additional evidence of his or her incapacity to understand the crisis situation. Incorporating personal choice in a crisis response requires not only appropriate training, but also a setting with the flexibility to allow the exercise of options. Informed decision-making in this context is not a matter of simply apprising the individual of the empirically derived risks and benefits associated with various interventions; it also includes an understanding among staff that an ostensibly sub-optimal intervention that is of the individual's choosing may reinforce personal responsibility, capability and engagement and can ultimately produce better outcomes. The specific choices to be considered are not limited to the use of medications, but also include the individual's preferences for what other approaches are to be used where crisis assistance takes place, involving whom and with what specific goals. While the urgency of a situation may limit the options available, such limitations may also highlight how earlier interventions failed to expand opportunities to exercise personal control. Post-crisis recovery plans or advance directives developed by the individual with assistance from crisis experts are important vehicles for operationalizing this principle.

11. Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served. Given the importance of understanding how an individual is experiencing a crisis and engaging that individual in the resolution process, being able to effectively connect with the individual is crucial. A host of variables reflecting the person's identity and means of communicating can impede meaningful engagement at a time when there may be some urgency. Establishing congruence requires more than linguistic proficiency or staff training in cultural sensitivity; it may require that to the extent feasible, an individual be afforded a choice among staff providing crisis services.

12. Rights are respected. An individual who is in crisis is also in a state of heightened vulnerability. It is imperative that those responding to the crisis be versed in the individual's rights, among them: the right to confidentiality, the right to legal counsel, the right to be free from unwarranted seclusion or restraint, the right to leave, the right for a minor to receive services without parental notification, the right to have one's advance directive considered, the right to speak with an ombudsman and the right to make informed decisions about medication. It is critical that appropriately trained advocates be available to provide needed

assistance. Correctly or not, many individuals with serious mental illnesses have come to regard mental health crisis interventions as episodes where they have no voice and their rights are trampled or ignored. Meaningfully enacting values of shared responsibility and recovery requires that the individual have a clear understanding of his or her rights and access to the services of an advocate. It is also critical that crisis responders not convey the impression that an individual's exercise of rights is a hostile or defiant act.

13. Services are trauma-informed. Adults, children and older adults with serious mental or emotional problems often have histories of victimization, abuse and neglect, or significant traumatic experiences. Their past trauma may be in some ways similar to the mental health crisis being addressed. It is essential that crisis responses evaluate an individual's trauma history and the person's status with respect to recovery from those experiences. Similarly, it is critical to understand how the individual's response within the current crisis may reflect past traumatic reactions and what interventions may pose particular risks to that individual based on that history. Because of the nature of trauma, appropriately evaluating an individual requires far more sensitivity and expertise than simply asking a series of blunt, potentially embarrassing questions about abuse and checking off some boxes on a form. It requires establishing a safe atmosphere for the individual to discuss these issues and to explore their possible relationship to the crisis event.

"Confounding and complicating the prevalence of trauma in public mental health service recipients is the fact that mental health services themselves are often experienced as traumatic. The use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment vs. empowerment and choice often cause unintentional re-traumatization in already vulnerable populations." (National Association of State Mental Health Program Directors NASMHPD Position Statement on Services and Supports to Trauma Survivors).

The American Psychiatric Association (APA) played an important role in redefining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's. National trauma research and practice centers have conducted significant work in the past few decades, further remaining the concept of trauma, and developing effective trauma assessments and treatments. With the advances in neuroscience, a bio-psychosocial approach to traumatic experiences

has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the lifespan.

12. Disaster Crisis Counseling

12A. Disaster Phases and Responses

Survivors' reactions to and recovery from a disaster are influenced by a number of factors, including:

- The disaster's unique characteristics, such as its size and scope, and whether it was caused by human or natural factors;
- The affected community's unique characteristics, including its demographic and cultural make-up and the presence of pre-existing structures for social support and resources for recovery; and
- The individual's personal assets and vulnerabilities that either reduce or exacerbate stress (DHHS).

Despite the differences in disasters, communities, and individuals, survivors' emotional responses to disaster tend to follow a pattern of seven "disaster phases" (National Institute of Mental Health):

➡Warning or threat; Impact;

➡Rescue or heroic;

➡Remedy or honeymoon;

➡Inventory;

➡Disillusionment; and

➡Reconstruction or recovery.

The characteristics of the disaster, as well as those of the community and its individual residents, affect the duration and nature of the each phases. The phases do not necessarily move forward in linear fashion; instead, they often overlap and blend together. Furthermore, individuals may experience a given phase in different ways (DHHS), and different cultural groups may respond differently during these phases. Below are brief descriptions of each phase, including examples of responses of different cultural groups during each phase.

Warning or Threat Phase

The warning or threat phase occurs with hurricanes, floods, and other disasters for which there is warning hours or days in advance. Lack of warning can make

TABLE 1 - 3

Characteristics of Disasters

Researchers have identified several common characteristics of disasters that are particularly important when discussing emotional distress and recovery. These characteristics are as follows:

- ***Intensity of the impact:*** Disasters that wreak intense destruction within a short period of time are particularly likely to cause emotional distress among survivors than are disasters that work their effect more slowly.
- ***Impact ratio (i.e., the proportion of the community sustaining personal losses):*** When a disaster affects a significant proportion of a community's population, few individuals may be available to provide material and emotional to support survivors.
- ***Potential for recurrence or other hazards:*** The real or perceived threat of recurrence of the disaster or of associated hazards can lead to anxiety and heightened stress among survivors.
- ***Cultural and symbolic aspects:*** Changes in survivors' social and cultural lives and routine activities can be profoundly disturbing. Both natural and human-caused disasters can have symbolic implications.
- ***Extent and types of loss sustained by survivors:*** Property damage or loss, deaths of loved ones, injury, and job loss all affect emotional recovery.

survivors feel vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

Racial and ethnic groups sometimes differ in the ways in which they receive information about risks and in the credence they place on such information. For example, Hispanics are more likely than non-Hispanics to use social networks for disaster information and to believe information obtained through these networks than are members of other groups. Furthermore, some marginalized communities do not have adequate or functioning warning systems. When disaster warning information is not provided in multiple languages or is not closed-captioned, people who do not understand English or who are deaf or hard of hearing may not receive adequate warning.

Impact Phase

The impact phase occurs when the disaster actually strikes. This phase can vary from the slow, low-threat buildup associated with some types of floods to the violent and destructive outcomes associated with tornadoes and explosions.

Depending on the characteristics of the disaster, reactions range from confusion, disbelief, and anxiety (particularly if family members are separated) to shock or hysteria.

Rescue or Heroic Phase

In the rescue or heroic phase, individuals' activity levels are typically high and oriented toward rescue operations, survival, and perhaps evacuation. People generally work together to save lives and property; pre-existing tensions between racial and ethnic or cultural groups are set aside. However, if family members are separated, anxiety may be heightened.

Remedy or Honeymoon Phase

During this phase, optimism may reign as the community pulls together and government and volunteer assistance become available. The interactions between relief workers and survivors from different cultures can be very important and can influence people's long-term perceptions of the disaster relief effort. Perceptions and beliefs about how healing occurs also may influence recovery. Frequently, however, disaster workers who have had no orientation to local cultures and lack sensitivity to them are brought in to help out during this phase. Such workers may exacerbate, rather than mitigate, cultural differences.

Inventory Phase

During the inventory phase, survivors recognize the limits of help and begin to assess their futures. They become exhausted because of multiple demands, financial pressures, and the stress of relocation or living in a damaged home. Initial optimism may give way to discouragement and fatigue. This also is a time characterized by high levels of grief and loss. Families who lose loved ones will grieve and cope in different ways.

Disillusionment Phase

The disillusionment phase occurs when survivors recognize the reality of loss and the limits of outside relief. This phase is characterized by a high level of stress that may be manifested in personally destructive behavior, family discord, and community fragmentation. Obtaining assistance from relief agencies can be extremely difficult, and survivors may feel helpless and angry. Hostility between neighbors and among groups is common, and tensions may erupt among different cultural, racial, and ethnic groups.

Reconstruction or Recovery Phase

The final phase, reconstruction or recovery, may last for years. This phase involves the structural rebuilding of the community as well as the integration of changes occasioned by the disaster into one's community and one's life. A common problem is a lack of housing, particularly if the disaster destroyed much of the low-income housing stock. In such situations, the private market typically hinders rebuilding of low- and moderate-income rental units. Therefore, housing shortages and rent increases disproportionately affect racial and ethnic minority groups. It is not unusual for local political issues to create friction and fragmentation in the impacted community during the disparate reconstruction progress and buyouts between neighboring counties.

12B. Disaster Crisis Counseling Techniques

Disaster counseling involves both listening and guiding. Survivors typically benefit from both talking about their disaster experiences and being assisted with problem-solving and referral to resources. The following section provides "nuts-and-bolts" suggestions for workers.

Establishing Rapport

Survivors respond when workers offer caring eye contact, a calm presence, and are able to listen with their hearts. Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and being nonjudgmental are necessary ingredients for building rapport.

Active Listening

Workers listen most effectively when they take in information through their ears, eyes, and "extrasensory radar" to better understand the survivor's situation and needs. Some tips for listening are:

❖Allow silence - Silence gives the survivor time to reflect and become aware of feelings. Silence can prompt the survivor to elaborate. Simply "being with" the survivor and their experience is supportive.

❖Attend nonverbally - Eye contact, head nodding, caring facial expressions, and occasional "uh-huhs" let the survivor know that the worker is in tune with them.

❖Paraphrase - When the worker repeats portions of what the survivor has said, understanding, interest, and empathy are conveyed. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: "So you are saying that . . . " or "I have heard you say that . . . "

❖Reflect feelings - The worker may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, "You sound angry, scared etc., does that fit for you?" This helps the survivor identify and articulate his or her emotions.

❖Allow expression of emotions - Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. Workers should stay relaxed, breathe, and let the survivor know that it is OK to feel.

SOME DO'S AND DON'T'S

Do say:

✓These are normal reactions to a disaster.

✓It is understandable that you feel this way.

✓You are not going crazy.

✓It wasn't your fault, you did the best you could.

✓Things may never be the same, but they will get better, and you will feel better.

Don't say:

•It could have been worse.

•You can always get another pet/car/house.

•It's best if you just stay busy.

•I know just how you feel.

•You need to get on with your life.

The human desire to try to fix the survivor's painful situation or make the survivor feel better often underlies the preceding "Don't say" list. However, as a result of receiving comments such as these, the survivor may feel discounted, not understood, or more alone. It is best when workers allow survivors their own experiences, feelings, and perspectives.

12C. Disaster, Crisis Counseling, and Culture

Since its founding, the United States has been a nation of diversity. In the years to come, fertility and mortality rates, immigration patterns, and age distributions within subgroups of the population will contribute to an increasingly diverse national population. Data from the U.S. Census reveal that Hispanics have replaced African Americans as the second largest ethnic group after whites.[2] Because of higher birth and immigration rates, the Hispanic population is growing faster than

any other ethnic minority group *(DHHS)*. The population of Asian Americans is also growing and is projected to continue growth throughout the first half of the 21st century, primarily because of immigration *(DHHS)*.

These demographic changes have given the United States the benefits and richness of many cultures, languages, and histories. At the same time, the Nation's growing diversity has made it more important than ever for health and human service providers—including disaster mental health service providers—to recognize, understand, and respect the diversity found among cultural groups and subgroups. Service providers must find ways to tailor their services to individuals' and communities' cultural identities, languages, customs, traditions, beliefs, values, and social support systems. This recognition, understanding, respect, and tailoring of services to various cultures is the foundation of cultural competence.

Cultural and socioeconomic factors contribute to both individual and community responses to the trauma caused by disaster. The culture of the community provides the lens through which its members view and interpret the disaster, and the community's degree of cohesion helps determine the level of social support available to survivors. In other words, a community that is disrupted and fragmented will be able to provide less support than a cohesive community.

A classic example is presented by sociologist Kai Erikson, who studied the impact of the devastating 1972 flood in Buffalo Creek, West Virginia. The flood led to relocation of the entire community. Erikson describes a "loss of community," in which people lost not only their sense of connection with the locale but also the support of people and institutions. Results of this community's fragmentation included fear, anger, anxiety, and depression.

Other studies have emphasized positive effects that can result from disaster experiences in communities that perform a protective role and cushion the stress of the disaster. Compared with non disaster-related suffering, which is isolating and private, the suffering of disaster survivors can be collective and public. However, devastating disasters can have positive outcomes. They can bring a community closer or reorient its members to new priorities or values. Individuals may exhibit courage, selflessness, gratitude, and hope that they may not have shown or felt before the disaster.

Community often is extremely important for racial and ethnic minority groups, and it may dramatically affect their ability to recover from disaster. For example, a racial or ethnic minority community may provide especially strong social support functions for its members, particularly when it is surrounded by a hostile society. However, its smaller size may render it more fragile and more subject to dispersion and destruction after a disaster. Members of some racial and ethnic minority

groups, such as refugees, previously have experienced destruction of their social support systems, and the destruction of a second support system may be particularly difficult.

Racism and Discrimination

As a result of past or present experiences with racism and discrimination, racial and ethnic minority groups may distrust offers of outside assistance at any time, even following a disaster. They may not be accustomed to receiving support and assistance from persons outside of their own group in non-disaster circumstances. Therefore, they may be unfamiliar with the social and cultural mechanisms of receiving assistance and remain outside the network of aid.

REPORT

Damage from Mississippi Tornadoes Unequal

In the late 1950s, several tornadoes struck rural Mississippi. The only persons killed were black. A subsequent study found that many people in the black community had great difficulty in coming to terms with this disaster. They did not understand how a just God could discriminate in such a fashion between white and black.

Perry and Perry

Particularly during the "disillusionment phase" of the disaster, when intra-group tensions are typically high, racial and ethnic minority groups can face the brunt of anger and even blame from members of the larger culture. Such psychological assaults and experiences with racism and discrimination can result in increased stress for individuals and groups.

Social and Economic Inequality

Social and economic inequality leads to reduced access to resources, including employment; financial credit; legal rights; and education, health, and mental health services. Poor neighborhoods also have high rates of homelessness, substance abuse, and crime (DHHS).

Poverty makes people more susceptible than others to harm from disaster and less able to access help. Low-income individuals and families typically lose a much larger part of their material assets and suffer more lasting negative effects from disaster than do those with higher incomes. Often, disadvantaged persons live in the least desirable and most hazardous areas of a community, and their homes may be older and not as sound as those in higher income areas. For example, many low-income people live in apartment buildings that contain unreinforced masonry, which is susceptible to damage in a disaster.

Although disaster relief activities can help ameliorate some of the damage rendered by a disaster, some groups cannot readily access such services. Negative perceptions derived from pre-disaster experiences may serve as a barrier to seeking care. Lack of familiarity with sources of community support or lack of transportation are common barriers for many immigrants and unwillingness to disclose their immigration status is a major barrier.

Middle-class disaster survivors are more likely than lower-income people—including those from other cultures—to know how to complete forms, communicate adequately, talk to the "right" people, or otherwise maneuver within the system. Thus, they may be more likely to receive aid than survivors with fewer means or those from different cultures. On the other hand, affluent groups may find it difficult to accept assistance from mental health and social service agencies. They may fear a loss of control and find it humiliating to accept emergency assistance such as clothing, food, loans, and emotional support from disaster workers.

In some instances, people of lower socioeconomic status exhibit strong coping skills in disaster situations because they have seen difficult times before and have survived. In other instances, the loss of what little one had may leave an individual feeling completely hopeless.

Cultural Competence and Disaster Mental Health Planning

Providing culturally competent mental health services to survivors requires action before, during, and after a disaster. The disaster mental health plan, which should be part of a State or community emergency management plan, can help ensure an efficient, coordinated response to the mental health needs of the affected population (DHHS, Rev. ed., in press). These plans specify roles, responsibilities, and relationships among agencies and organizations in responding to a community's mental health needs following a disaster (DHHS, Rev. ed., in press).

Well-designed disaster mental health plans enhance coordination and minimize chaos, thereby helping to ensure that survivors receive assistance in a timely, helpful, and culturally sensitive manner should a disaster occur. Disaster mental health plans that identify and address diverse needs within a community can save valuable time and avert many problems. In the absence of such planning, disaster relief is disorganized, especially in the immediate aftermath. Confusion and inefficiency can prevail when survivors attempt to gain access to services.

Successful program planners recognize that creating culturally competent environments requires more than recruiting bilingual and bicultural mental health workers, sponsoring a single diversity management class, sending a few employees to a cultural competence workshop, or hiring a "token" racial or ethnic minority

group representative. Rather, cultural competence must be a part of the program values; included in the program's mission statement; and encouraged in attitudes, policies, and practices at every level.

To develop a culturally competent disaster mental health plan, planners must:

❖Assess and understand the community's composition;

❖Identify culture-related needs of the community;

❖Be knowledgeable about formal and informal community institutions that can help meet diverse mental health needs;

❖Gather information from and establish working relationships with trusted organizations, service providers, and cultural group leaders and gatekeepers; and

❖Anticipate and identify solutions to cultural problems that may arise in the event of a disaster.

Table 1-4 presents questions that should be addressed in the mental health plan. For further information about disaster mental health planning, refer to *Disaster Response and Recovery: A Strategic Guide* (DHHS, Rev. ed., in press).

Guiding Principles and Recommendations

Developing cultural competence requires a concerted effort by disaster mental health planners and front-line workers. Successful programs share common practices that are defined by nine guiding principles. These principles, listed here, have been identified by CMHS.

This section discusses each of the guiding principles and suggests ways to integrate them into disaster mental health planning and crisis counseling programs. The guiding principles, in many ways, overlay the Key Concepts of Disaster Mental Health (DHHS).

Recognize the Importance of Culture and Respect Diversity

Culture is one medium through which people develop the resilience that is needed to overcome adversity. Following a disaster, culture provides validation and influences rehabilitation. However, when daily rituals, physical and social environments, and relationships are disrupted, life becomes unpredictable for survivors. Disaster mental health workers can help reestablish customs, rituals, and social relationships and thereby help survivors cope with the impact of a disaster. When doing so, these workers need to recognize that diversity exists within as well as across cultures (Cross et al). In disasters, individuals within a given cultural group may respond in very different ways; some will be receptive to disaster relief efforts, while others will not. Older adults and young people within a particular

culture may react to losses or seek help in different ways, depending on their

REPORT

Indigenous Outreach Workers Provide Community-Appropriate Services in Guam

In the aftermath of the 1997 super-typhoon, Paka, the Territory of Guam partnered with the University of Guam College of Life Sciences to provide culturally appropriate crisis counseling services. Strategies such as paying special attention to racial tensions, matching workers to the population served, and providing training on culturally respectful interactions helped the outreach workers gain entry to the island's diverse population.

The demographics of the staff mirrored that of the community, and the mental health providers were an integral part of the community. Culture-specific training provided a forum for interacting with representatives of helping agencies on the island and from neighboring Saipan. Outreach tools and strategies included a monkey hand puppet used to engage children, a program for hotel workers, and a program for seniors that used symbolism and activities to encourage recovery. Broadcast and print media, as well as personal conversations, were used to educate the public about the project and the emotional effects of disaster.

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degree of acculturation. Disaster mental health workers also must be aware of and sensitive to issues stemming from biculturalism; these issues include conflict and ambivalence related to identity and the need to function in cross-cultural environments (Hernandez and Isaacs).

Recognizing the importance of culture and respecting diversity require an institution-wide commitment. To meet this commitment, disaster mental health workers must understand their own cultures and world views; examine their own attitudes, values, and beliefs about culture; acknowledge cultural differences; and work to understand how cultural differences affect the values, attitudes, and beliefs of others. Table 2-2 examines important considerations mental health workers should keep in mind when dealing with people from other cultures.

Cultural Composition of the Community

No one knows when or where disaster will strike. For this reason, a pre-disaster assessment of a community's composition and familiarity with cultural traditions and customs during times of loss, trauma, and grief can provide invaluable knowledge in the event of a disaster. The range of cultural diversity—ethnic, religious, racial, and language differences among subgroups—should be assessed and described in a comprehensive profile of the community. A comprehensive community profile describes the community's composition in terms of:

- ✓ Race and ethnicity;
- ✓ Age;
- ✓ Gender;
- ✓ Religion;
- ✓ Refugee and immigrant status;
- ✓ Housing status (i.e., number of single-parent households, type of housing, rental versus ownership, number of persons per household);
- ✓ Income and poverty levels;
- ✓ Percentage of residents living in rural versus urban areas;
- ✓ Unemployment rate;
- ✓ Languages and dialects spoken;
- ✓ Literacy level;
- ✓ Number of schools; and
- ✓ Number and types of businesses.

Information about the values, beliefs, social and family norms, traditions, practices, and politics of local cultural groups, as well as the history of racial relations or ethnic issues in the community, should be included in the community profile, because these cultural characteristics may take on additional significance in times of stress (DeVries). This information should be gathered with the assistance of and in consultation with community cultural leaders ("key informants") who represent and understand local cultural groups.

Other sources of data incorporated in the community profile include the city hall or the county commissioner's office, as well as the resources listed in Appendix C. Finally, information included in the community profile should be updated frequently, because such data can change rapidly.

Recruit Disaster Workers who are Representative of the Community or Service Area

Disaster mental health programs are most effective when individuals from the community and its various cultural groups are involved in service delivery as well as in program planning, policy, and administration and management. Recruiting staff whose cultural, racial, and ethnic backgrounds are similar to those of the survivors helps ensure a better understanding of both the survivors and the community and increases the likelihood that survivors will be willing to accept

assistance. For example, if American Indian or Alaska Native populations have experienced a disaster, tribal leaders, elders, medicine persons, or holy persons might be recruited to serve as counselors or in some other capacity. The community profile can be reviewed when recruiting disaster crisis counseling workers to ensure that they are representative of the community or service area.

If indigenous workers are not immediately available, coordinators can attempt to recruit staff with the required racial or ethnic background and language skills from other community agencies or jurisdictions (DHHS, Rev. ed. in press).

Recruitment based solely on race, ethnicity, or language, however, may not be sufficient to ensure an effective response. People who are racially and ethnically representative of the community are not necessarily culturally or linguistically competent. The ability to speak a particular language is not necessarily associated with cultural competence. For example, a well-educated, Spanish-speaking Hispanic professional may not understand the problems and cultural nuances of an immigrant community whose members are living in poverty (DHHS).

Table 2-3 highlights the attributes, knowledge, and skills essential to development of cultural competence that should be considered.

Ongoing Cultural Competence Training

Cultural competence is an essential component of disaster mental health training. Training should be acquired ignorer to develop the values, knowledge, skills, and attributes needed to communicate and work in a sensitive, nonjudgmental, and respectful way in cross-cultural situations.

Cultural competence training programs work particularly well when they are provided in collaboration with community-based groups that offer expertise or technical assistance in cultural competence or in the needs of a particular culture. Involving such groups not only enables program staff to gain firsthand knowledge of various cultures, but also opens the door for long-term partnerships (Hernandez and Isaacs).

Training should cover basic cultural competence principles, concepts, terminology, and frameworks. For example, training should include discussion of:

- Cultural values and traditions;
- Family values;
- Linguistics and literacy;
- Immigration experiences and status;
- Help-seeking behaviors;
- Cross-cultural outreach techniques and strategies; and

- Avoidance of stereotypes and labels (DHHS).

Even if the initial training period is of limited duration, participants should have an opportunity to examine and assess values, attitudes, and beliefs about their own and other cultures. Self-assessment helps identify areas where skills need to be developed (DHHS). Training should stress that people of a given cultural group may react quite differently to disaster, depending on their level of acculturation.

Cultural competence training is a developmental process. Ongoing education is essential.

Ensure that Services are Accessible, Appropriate, and Equitable

Survivors are not always receptive to offers of support. For example, some members of cultural groups may be reluctant to take advantage of services because of negative past experiences. Undocumented immigrants may not seek services because they fear deportation. Such individuals may be reluctant or refuse to move to temporary shelters, to accept State or Federal assistance, or to discuss information that they think could be used against them.

Inequitable treatment following disasters may reinforce mistrust of the public services and disaster assistance systems. Following the 1989 Loma Prieta earthquake in California, shelter services in the more affluent neighborhoods had more community volunteers than survivors. The mayor visited the disaster site in these areas. Less affluent neighborhoods had fewer volunteers, and some volunteers made remarks that the survivors felt were offensive. The mayor did not visit these areas (Dhesi). Moreover, food and meal preparation in shelters was not culturally appropriate following the earthquake, and many Latinos reported that they became sick from eating the food prepared by the Anglo relief workers (Phillips).

In studies of Hurricane Andrew's aftermath, racial and ethnic minority group survivors were less likely to have insurance than were white survivors because of practices that exclude certain communities from insurance coverage at affordable rates. Survivors from minority groups were also more likely to receive insufficient settlement amounts (Peacock and Girard). Concerns related to gender also were investigated after Hurricane Andrew. Many non-English-speaking women of color, especially single women, were subjected to dishonest practices of construction contractors (Enarson and Morrow).

The delivery of appropriate services is a frequent problem. Racial and ethnic discrimination, language barriers, and stigma associated with counseling services have a negative effect on many individuals' access to and utilization of health and mental health services (Denboba et al.). Families who participated in focus groups reported problems with cultural and ethnic biases and stereotypes, offensive

REPORT

Hurricane Response Designed to Be Culturally Competent

Hurricane Hortense struck Puerto Rico with devastating impact. The disaster crisis counseling program was designed to be particularly sensitive to the Puerto Rican culture. For example, recognizing that this culture encourages strong ties with friends and neighbors, the program provided group debriefing sessions.

The project also used cultural celebrations to advance its goals. For example, the festival of the Three Kings Day, which occurs in early January, was used as an opportunity for special outreach in which project staff went door to door "giving asaltos"—a tradition of singing Christmas carols and giving donated gifts—as a way to identify needs and provide information and social support. The project also used dramatization to inform persons in the community about disaster phases and disaster planning.

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communication and interactions based on such biases and stereotypes, lack of cross-cultural knowledge, and lack of understanding of the values of various cultural groups (Malach et al.).

Disaster mental health programs must take special care to exercise culturally competent practices. They should make efforts to ensure that staff members speak the language and understand the values of the community. Providing food that has cultural significance can be important. Involving cultural group representatives in disaster recovery committees and program decision making (for example, as members of planning boards or other policy-setting bodies) can help ensure that disaster services are accessible, appropriate, and equitable.

Culturally sensitive outreach techniques also can help ensure that services are accessible and appropriate to all survivors. For example, outreach workers should:

- Allow time for and devote energy to gaining acceptance, take advantage of associations with trusted organizations, and be wary of aligning their efforts with those of agencies and organizations that are mistrusted by cultural groups;
- Determine the most appropriate ways to introduce themselves;
- Recognize cultural variations in expression of emotion, manifestation and description of psychological symptoms, and views about counseling; and

- Assist in eliminating barriers by carefully interpreting facts, policies, and procedures.

Table 2-4 addresses special considerations that should be taken into account when counseling refugees.

Recognize the Role of help Seeking Behaviors, Customs and Traditions, and Natural Support Networks

Culturally competent disaster mental health services proactively respond to the culturally defined needs of the community. Disruption of many aspects of life and the need to adapt to difficult circumstances cause stress and anxiety in many survivors. In some cases, these problems can be as difficult as the disaster itself. Effective response requires familiarity with help-seeking behaviors; customs and traditions related to healing, trauma, and loss; and use of natural support networks of various cultural groups.

Help-Seeking Behaviors

Different cultures exhibit different help-seeking behaviors. In many cultures, people turn to family members, friends, or cultural community leaders for help before reaching out to government and private-sector service systems. They may prefer to receive assistance from familiar cultural community leaders or groups rather than unfamiliar service systems. In most communities, churches and other places of worship play a role similar to that of an extended family, and survivors turn to them first for assistance.

Many survivors may be reluctant to seek help or may reject disaster assistance of all types. Some people feel shame in accepting assistance from others, including the government, and equate government assistance with "welfare." Members of racial and ethnic minority groups, including refugees and immigrants, also may be reluctant or afraid to seek help and information from service systems because of historical mistrust of the health, mental health, and human services systems or because of fear of deportation (Aponte, Rivers, and Wohl). Other groups may prefer to suffer or even perish rather than seek help from people they mistrust. Therefore, building trusting relationships and rapport with disaster survivors is essential to effective crisis counseling.

Those who do seek help may find relief procedures confusing. Feelings of anger and helplessness and loss of self-esteem can result from survivors' encounters with relief agencies. These feelings result from the survivors' lack of understanding of the disaster relief system as well as government and private agencies' often bureaucratic procedures.

Customs and Traditions in Trauma and Loss

Religious and cultural beliefs are important to survivors as they try to sort through their emotions in the aftermath of traumatic events. Beliefs may influence their perceptions of the causes of traumatic experiences. For example, in many cultures, people believe that traumatic events have spiritual causes. These beliefs can affect their receptivity to assistance and influence the type of assistance that they will find most effective. Different populations may elaborate on the cultural meaning of suffering in different ways, but suffering itself is a defining characteristic of the human condition in all societies. In most major religions, including Christianity, Judaism, Islam, Hinduism, and Buddhism, the experience of human misery—resulting from sickness, natural disasters, accidents, violent death, and atrocity—also is a defining feature of the human condition.

Different cultural groups also handle grief in different ways. Family customs, beliefs, and degree of acculturation affect expressions of grief. Disaster mental health workers must recognize that grief rituals, although diverse in nature, can help people return to a reasonable level of functioning. For example, Western tradition holds that grief should be "worked through." This process includes acceptance of the loss; extinction of behaviors that are no longer adaptive; acquisition of new ways of dealing with others; and resolution of guilt, anger, and other disruptive emotions.

REPORT

Shamans Counter Bad Luck

In 1995, northern California experienced a series of storms that led to flooding, landslides, and mud debris flow. The State implemented a FEMA-funded crisis counseling program for the victims of the storms. One group affected were Hmong immigrants, persons with a history of war and severe losses. In serving the Hmong population, the program utilized the color red in many printed materials and supplies because Hmong culture includes a belief that red symbolically wards off evil spirits. Another consideration involved the Hmong belief that floods are an omen of doom and that shaman cleansing rituals are needed to counter the bad luck that this omen portends. As a way of acknowledging and respecting this belief, the staff developed and provided a referral list of shamans in the local area.

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If a community remains intact after a disaster, cultural norms, traditions, and values determine the strategies that the survivors use to deal with the effects. When the

entire community is affected, however, cultural mechanisms may be overwhelmed and unable to fulfill their customary functions of regulating emotions and providing identity, support, and resources (DeVries). Disaster mental health workers can support the healing process by helping rebuild the community's cultural support system. Workers will be most effective when they recognize and understand the importance of culture in the lives of disaster survivors and the beliefs, rituals, and level of acculturation of the community in which they work.

Customs and Traditions for Healing

Many cultural groups hold beliefs about illness and healing that differ sharply from those held by Western society. People in every culture share beliefs about the causes of illness and ideas about how suffering can be mitigated. For example, members of some cultures believe that physical and emotional problems result from spiritual wrongdoings in this life or a previous one. They believe that healing requires forgiveness from ancestors or higher spirits. Some people believe that suffering cannot be ameliorated. Others demonstrate stress and emotional conflict through complaints about their physical health.

13. Addressing the Unique Needs of Diverse Populations in Crisis Counseling

Crisis Services: Addressing Unique Needs of Diverse Populations

Crisis services constitute an array of activities, from phone or text lines to crisis assessment centers outside of emergency rooms and include emergency services embedded in more traditional hospital and emergency department settings. These services employ and treat a diverse population withunique individual needs that warrant consideration. The Substance Abuse and Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit issued in early 2020 calls for crisis services to be ready to serve anyone who needs the services. The National Association of State Mental Health Program Directors (NASMHPD) has focused its technical assistance papers in 2020 on crisis services and has similarly called attention to critical issues related to access to care for diverse populations encountering crisis services.

As crisis services receive increased attention and expand, considerations for diversity among populations served and among the workforce needs to be at the forefront of the minds of program leaders and policy makers. Although most crisis services treat adults ranging from 18 to 65 years of age,youth and older adults frequently present in crisis settings. Additionally, individuals with neurodevelopmental disabilities, complex and co-occurring substance use and

REPORT

Disaster Strikes a Highly Diverse Community

On January 17, 1994, a major earthquake struck Los Angeles and Ventura Counties. The Northridge earthquake was the largest and most violent to hit an urban area in the United States since the 1906 San Francisco quake. The post-disaster recovery effort provided mental health services to 1.9 million persons, representing myriad ethnic groups, special populations, and lifestyles.

The size and scope of the two affected counties, as well as the ethnic diversity of their residents, constituted a challenge to disaster mental health providers. For example, Ventura County is home to many undocumented migrant farm workers, the majority of whom do not speak English and are mistrustful of government at any level. Language and cultural barriers had to be overcome for persons from several Asian cultures as well. The diverse population in the affected areas also included other special populations, such as physically challenged persons and runaway youth, two groups that required special outreach strategies.

The disaster mental health program staff recognized from the beginning of the project the need to develop and provide culturally relevant and linguistically appropriate services, covering a multitude of cultures and languages.

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medical conditions, and other characteristics must also navigate the crisis mental health and substance use system. Racial, ethnic, and sexual minorities experience barriers to mental health and substance use care in crisis settings just as they do in their daily lives. Structural racism, discrimination, stigma, and racialized legal statuses including criminal justice involvement and immigration also require special consideration. With the lens of experience during the COVID-19 pandemic, these issues have been further highlighted.

This chapter discusses the considerations, challenges, and implications of treating these diverse populations in any of the varied crisis settings. Older adults from racially and ethnically oppressed groups, younger adults with intellectual and developmental disabilities, and immigrant groups with language barriers are some of the ways in which these intersecting identities pose unique challenges for ensuring a robust and comprehensive crisis services system that continues to promote equity and quality care to all individualsin a person-centered manner. With that in mind, the following recommendations stem from this chapter's review of extant literature and practices related to crisis services.

Recommendations

- ✓ Crisis services must employ a systems-based approach to focus on early intervention with individuals of all ages, including youth at risk of mental

TABLE 1 - 4
Questions to Address in the Disaster Mental Health Plan

Community demographic characteristics

- Who are the most vulnerable persons in the community? Where do they live?
- What is the range of family composition (i.e., single-parent households)?
- How could individuals be identified and reached in a disaster?
- Are policies and procedures in place to collect, maintain, and review current and emergent demographic data for any area that might be affected by a disaster?

Cultural groups

- What cultural groups (ethnic, racial, and religious) live in the community?
- Where do they live, and what are their special needs?
- What are their values, beliefs, and primary languages?
- Who are the cultural brokers in the community?

Socioeconomic factors

- Does the community have any special economic considerations that might affect people's vulnerability to disaster?
- Are there recognizable socioeconomic groups with special needs?
- How many live in rental property? How many own their own homes?

Mental health resources

- What mental health service providers serve the community?
- What skills and services does each provider offer?
- What gaps, including lack of cultural competence, might affect disaster services?
- How could the community's mental health resources be used in the event of different types of disasters?

Government roles and responsibilities in disaster

- What are the Federal, State, and local roles in disaster response?
- How do Federal, State, and local agencies relate to one another?
- Who would lead the response during different phases of a disaster?
- How can mental health services be integrated into the government agencies' disaster response?
- What mutual aid agreements exist?
- Do any subgroups in the community harbor any historical or political concerns that affect their trust of government?

Nongovernmental organizations' roles in disaster

- What are the roles of the American Red Cross, interfaith organizations, and other disaster relief organizations?
- What resources do nongovernment agencies offer, and how can local mental health services be integrated into their efforts?

health crises and older adults.Services must be available at every level of the crisis system in order to support youth in school, community, residential, or hospital settings, while simultaneously considering the multiple complex needs

including coordination with referring programs and facilities for older adult populations. This approach to individuals across the lifespan should have as a goal to minimize the crisis, prevent suicideand other negative outcomes and link individuals to other care as needed.

- ✓ Clinicians may provide more culturally competent care by demonstrating an awareness of historical trauma in racial, ethnic and experiential minority populations. By encouraging patients' narratives in crisis settings, clinicians may foster a welcoming and supportive environment for patients from historically marginalized communities.
- ✓ Clinicians should consider mental health stigma in communities of color, while identifying and addressing barriers to psychiatric care for racially and ethnically oppressed persons. Stigma remains high in many communities of color. A biopsychosocial approach to assessment and treatment that explores the roles of family, culture and religious beliefs may be helpful in addressing barriers to mental health services.
- ✓ Crisis services should be familiar with their state's immigration policies and available systems of support and potential funding mechanisms to promote the health of undocumented persons with mental illness and substance use challenges. This includes addressingundocumented persons' fears about their legal status and the institutions duty to privacy and confidentiality under state and federal guidelines.
- ✓ Clinicians providing crisis services should consider sexual identity as part of their biopsychosocial assessment in order to provide equitable treatment for a diverse population and understand personal narratives.
- ✓ Clinical examination should include a broad assessment of individuals' functionalstrengths and limitations to provide individualized person-centered treatment.
- ✓ A biopsychosocial approach is essential in determining the appropriate treatmentfor persons with complex needs who present in crisis. This includes consideration of how staff and physical environments may provide healing and supportive environments for persons with intellectual and developmental disabilities.
- ✓ Crisis services must collaborate with community stakeholders to ensure early intervention for individuals with mental health and substance use needs and those at risk of suicide. These partnerships may help divert emergency department visits, focus on preventive and lifesavingcare, and build alliances with other stakeholders.
- ✓ Crisis mental health systems must assess for underlying medical comorbidities, and take lessons learned from the COVID-19 pandemic to ensure individuals served receive adequate treatment and medical care when needed, and

TABLE 2 - 1

Key Concepts of Disaster Mental Health

The following concepts should be adopted by all disaster mental health providers, including those serving culturally diverse survivors. The concepts can also help administrators and service providers set program priorities. The concepts deviate in some ways from those on which mental health work has traditionally been based. However, their validity has been confirmed again and again in disasters of various types that have affected a broad range of populations (DHHS).

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma—individual and community.
- Most people pull together and function adequately during and after a disaster, but their effectiveness is diminished by the effects of the event.
- Stress and grief in disasters are normal reactions to abnormal situations.
- Many emotional reactions of disaster survivors stem from problems of daily living brought about by the disaster.
- Disaster relief assistance may be confusing to some survivors. They may experience frustration, anger, and feelings of helplessness related to Federal, State, and private-sector disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be tailored to the culture of communities where they are provided.
- Mental health workers should set aside traditional methods, avoid mental health labels, and use an active outreach approach to intervene successfully in disaster.

collaborate with vulnerable patients' families, healthcareproviders, and other support systems to provide appropriate care. In this way, as part of the continuum of care, crisis services should partner with local medical systems and vice versa to help patients access the best door to care as needed.

✓ In order to account for the various structural barriers to accessing services, crisismental health systems should emphasize the unique needs and differences among diverse populations to encourage individuals to engage in care, even as structural barriers may otherwise limit their access to such care.

Over 55 million Americans suffer from mental health or substance use disorders in the United States and account for nearly 10 million hospitalizations annually.

TABLE 2 - 2

Important Considerations When Interacting with People of Other Cultures

Giger and Davidhizar's "transcultural assessment and intervention model" was developed to assist in the provision of transcultural nursing care. It is currently used by several other health and human services professions. The model identifies five issues that can affect the interactions of providers and service recipients. These issues, adapted below to apply to disaster crisis counseling, illustrate the importance of acknowledging culture and of respecting diversity. A complete description of the model can be found in *Transcultural Nursing: Assessment and Intervention* (Giger and Davidhizar).

Communication: Both verbal and nonverbal communication can be barriers to providing effective disaster crisis counseling when survivors and workers are from different cultures. Culture influences how people express their feelings as well as what feelings are appropriate to express in a given situation. The inability to communicate can make both parties feel alienated and helpless.

Personal Space: "Personal space" is the area that immediately surrounds a person, including the objects within that space. Although spatial requirements may vary from person to person, they tend to be similar among people in a given cultural group (Watson). A person from one subculture might touch or move closer to another as a friendly gesture, whereas someone from a different culture might consider such behavior invasive. Disaster crisis counselors must look for clues to a survivor's need for space. Such clues may include, for example, moving the chair back or stepping closer.

Social Organization: Beliefs, values, and attitudes are learned and reinforced through social organizations, such as family, kinships, tribes, and political, economic, and religious groups. Understanding these influences will enable the disaster crisis counselor to more accurately assess a survivor's reaction to disaster. A survivor's answers to seemingly trivial questions about hobbies and social activities can lead to insight into his or her life before the disaster.

Time: An understanding of how people from different cultures view time can help avoid misunderstandings and miscommunication. In addition to having different interpretations of the overall concept of time, members of different cultures view "clock time"—that is, intervals and specific durations—differently. Social time may be measured in terms of "dinner time," "worship time," and "harvest time." Time perceptions may be altered during a disaster. Crisis counselors acting with a sense of urgency may be tempted to set timeframes that are not meaningful or realistic to a survivor. The result may be frustration for both parties.

Environmental Control: A belief that events occur because of some external factor—luck, chance, fate, will of God, or the control of others—may affect the way in which a survivor responds to disaster and the types of assistance needed. Survivors who feel that events and recovery are out of their control may be pessimistic regarding counseling efforts. In contrast, individuals who perceive that their own behavior can affect events may be more willing to act (Rotter). Disaster crisis counselors need to understand beliefs related to environmental control because such beliefs will affect survivors' behavior.

Of the many types of crisis mental health services, emergency psychiatric hospitalization represents the highest level of clinical care for individualswith acute mental health needs. The National Association of State Mental Health Program Directors has called for the need to look “Beyond Beds” and consider an array of services across a continuum of psychiatric care to meet the needs of individuals with mental health conditions, including an examination of the crisis services continuum.

In recent years, communities have established and utilized a broad range of crisis services suchas walk-in and free community clinics, crisis line telephone and texting services, mobile treatment centers, crisis stabilization units, observation, crisis residential services, and hospitalization. The Substance Abuse and Mental Health Services Administration introduced in early 2020 the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, in which it is articulated that crisis services must be available for anyone, anywhere, anytime. This means that such crisis services must address the needs of a large, diverse, and growing population. Individuals with complex care needs, including older adults, those with intellectual and developmental disorders (IDD), dementia and neurocognitive disorders, co-occurring medical and physical issues, and even infectious diseases as highlighted in the COVID-19 context, all can present themselves for crisis services. These individuals represent particularly vulnerable populations in the mental health system. Here we discuss the unique challenges and considerations for ensuring equity in providing crisis services for diverse populations in crisis mental health care.

As with any health care service—from primary care to advanced specialty care—person- centered care is critical to address the unique challenges of meeting complex care needs. To provide effective individualized treatments, mental health clinicians must:

- Recognize the characteristic signs, symptoms and natural history of psychiatric illness;
- Appreciate the diversity of psychological differences among individuals across mental disorders;
- Account for the range of behaviors among individuals;
- Understand how individuals' trauma and life-stories influence their illness experienceand expression.

By appreciating these perspectives in all mental health services, the mental health and substance use systems may better provide evidence-supported treatments

alongside psychosocial interventions that account for patients' unique genetic, behavioral, and environmental characteristics.

Special Age-cohort Populations in Crisis Settings

Youth, Children and Younger Adults

Crisis services are a “continuum of services” provided to individuals experiencing psychologicaldistress across the life-course. Crisis mental health systems, however, are most adept at delivering services to adults between the ages of 18 and 65. There are unique challenges for community health systems caring for younger children and older populations requiring crisis services.

There is a growing number of children seeking psychiatric emergency care in the United States. Although the details of child and adolescent crisis services is beyond the scope of this chapter, it is important to highlight that although many communities may have robust crisis systems for adults, they may be less likely to have well-developed systems that meet the needs of a growing pediatric population. Like adults, children may exhibit symptoms of psychological distress, including suicidal ideation, mood disorders, behavioral changes, and the effects of substance use. Because of this growing need, communities and stakeholders must have a vested interest in expanding the range of crisis services to provide the most appropriate level and type of care for youth in crisis. Studies suggest that afull continuum of crisis services, including prevention, early intervention, response, and stabilization services, can divert youth from psychiatric emergency rooms, which may be associated with poorer clinical outcomes and increased cost of services. Community stakeholders providing crisis services must be familiar with available funding mechanisms to appropriate financial, clinical, and material resources to support the mental health workforce and patient populations with psychiatric needs.

Knowledge of available resources, which include funding, community partners, schools, and referringinstitutions, is essential in ensuring a robust crisis services system for children and younger adults. Sharon Hoover and Jeff Bostic have provided a more detailed review about crisis services for childrenand adolescents.

Older Adult Populations

There is also a large and growing older adult population in the United States. Older adults over the age of 65 are expected to account for 1 out of every five individuals in the United States by 2030. For mental health services, there is an expected two-fold increase in geriatric patients with mental health disorders.

TABLE 2 - 3

Attributes, Knowledge, and Skills Essential to Development of Cultural Competence

Personal Attributes

- Genuineness, empathy, and a capacity to respond flexibly to a range of possible solutions
- Acceptance and awareness of cultural differences and cross-cultural dynamics
- Willingness to work with survivors of different cultures
- Ability to articulate one's own values, stereotypes, and biases and to identify how they may accommodate or conflict with the needs of culturally diverse disaster survivors
- Openness to learning about the cultures of diverse groups

Knowledge

- History, tradition, values, artistic expressions of culturally diverse disaster survivors
- Help-seeking behaviors, informal helping supports, and natural healing practices of survivors of various cultures
- Role of language, speech patterns, and communication styles in culturally distinct communities
- Psychosocial stressors relevant to diverse groups (e.g., migration, acculturation stress, legal and illegal discriminatory patterns, racism, and socioeconomic status)
- Community resources (agencies, informal helping networks) and their availability for special populations

Skills

- Ability to discuss cultural issues and to respond to culturally-based cues
- Ability to assess the meaning of culture for the disaster survivor
- Ability to interview and assess survivors on the basis of their personal, psychological, social, cultural, political, or spiritual models

Adapted from: Benedetto; DHHS

Despite this increase in the elderly population, geriatric populations have a disproportionately low rate of utilization of mental health and crisis resources. Older adult patients withmental health diagnoses such as schizophrenia are particularly

underrepresented among individuals utilizing public mental health systems. Some of this may relate to funding, policy and program architecture. This is especially true for many individuals who first present with mental health symptoms in their older years but may already be in care for medical conditions, as opposed to older adults who “grew up” in the public mental health system.

The American Association of Geriatric Psychiatry has characterized the shortage of geriatric mental health specialists as “a national crisis”. Older adults often have more complicated mood and affective disorders and are more likely to have comorbid medical and psychiatric illnesses that require careful coordination with other medical providers. Older individuals with chronic mental illness may also be less likely to achieve full symptom remission early in treatment. Moreover, they may require combinations of medications and other therapies that increase other risks such as drug interactions, shifts in mood states, or the risk of development of conditions like delirium or other medical complications. Suicide rates are highest among white males with increased risk among older adults with concomitant physical illness. Substance use significantly increases the risk of morbidity and mortality, with a two-fold increase in the risk of suicide among older adults with dual diagnoses. Rural and unmarried elder persons may be particularly less likely to utilize crisis services. Despite these complex treatment and demographic considerations, treatment of older adults may be associated with low reimbursement rates for clinicians, creating a paradox that imposes additional barriers to accessing mental health care in the community. As crisis services expand across the country, it will be important to identify the unique needs of the older adult population and address barriers to their use of crisis services.

Older adults tend to have higher medical complexity than younger patients. It can be challenging to distinguish medical symptoms from psychiatric symptoms in this complex population. Comorbid physical conditions may be more prominent than underlying psychiatric symptoms in geriatricpopulations. These medical comorbidities also lead to higher risks related to polypharmacy, which may contribute to worsening medical and psychiatric symptoms, especially in geriatric populations. In treating mental health disorders among geriatric populations, clinicians must also focus on the "competing demands" of underlying medical comorbidities that may simultaneously erect barriers to psychiatric treatment. Comorbidities may include diabetes, hypertension, obstructive and other respiratory illness, cardiovascular diseases, cancer, immunologic and rheumatologic conditions, chronic pain, as well as vision and hearing deficits, to name a few. These conditions may require more coordination and accommodations to ensure individuals have access to their physical aids for ambulation,

equipment, medications, and other supplies necessary to support the individuals with theseconditions.

Additionally, in the array of crisis services where individuals spend time (as opposed to text linesor phone lines), regulatory requirements include minimum standards for patient census, safety, staffing, training, and medical personnel. There may be increased licensing requirements to provide services for older adult populations, with many of the facilities limiting treatment to patients who can attend to their own basic needs. Thus, functional impairment in activities of daily living and self-care, which is often more prevalent among geriatric populations, is an additional barrier to eligibility and access to crisis services. This is especially true if the crisis service is outside of a more traditional medical setting. Given these considerations may pose barriers to caring for aging populations frequently need additional medical services (e.g., care for medical, psychiatric, cognitive, and physical impairment), the current mental health system must continue to develop social and structural interventions that ensure access to high-quality crisis services to all individuals across the life course.

Older persons are considered a protected population and may require additional psychosocial support and case management needs. The increased vulnerability of elderly patients to undue influence and abuse may be due to the physical and cognitive changes associated with late-life. Elder abuse affects over 4.3 million persons each year and accounts for an estimated $36 billion in losses to elderly individuals. Older individuals are at increased risk of physical and sexual abuse, neglect, and financial and material exploitation by strangers and individuals in positions of trust. Crisis mental health systems must be prepared to not only recognize the warning signs of different types of abuse but also be equipped to take the necessary steps to appropriately identify, support, reduce, and mitigate these issues. Minimally staffed crisis services serving more acute psychiatric patient populations may be less able to care for this population without further education, training and guidance. As crisis services evolve, careful collaboration with referring facilities to coordinate care during treatment and upon discharge will be essential for ensuring elderly patients receive appropriate care upon recovery.

Racially, Ethnically, and Experientially Diverse Populations in Crisis Settings

Racially and Ethnically Diverse Populations

To date, barriers to access to care for racially and ethnically diverse populations has been a major concern. Disparities in health care resources and outcomes

among these populations create and maintain racial inequities in mental health care. For example, African American men are more likely to be diagnosed with personality disorders such as antisocial personality disorder despite evidence that the incidence of these disorders is relatively consistent across populations. Black men are 13 times more likely to be routed to the criminal justice system for substance use issues than the general population, contributing to increased criminalization of mental illness and substance use particularly among oppressed populations. Black youth are 2.5 times more likely to be diagnosed with conduct disorder and five times more likely to be diagnosed with adjustment disorder than ADHD compared to their white counterparts. These disparities may influence whether patients receive behavioral, pharmacotherapy, or are routed to criminal/juvenile legal systems. Disparities in mental health outcomes in other population such as American Indians and Native Alaskans, are also well-documented. Thus, blacks and other minority or non-dominant populations may receive inappropriate treatments when presenting in crisis, further contributing to disparate health and social outcomes.

Indeed, in nearly every domain heretofore discussed (i.e., youth, geriatric, intellectually challenged, dual diagnosis, persons with disabilities, or the medically complex), racially and ethnically oppressed identifying persons face increased barriers to mental health and substance use services with consequent poorer health care outcomes. Black youth are less likely to seek care or be referred to psychiatric care. They receive suboptimal therapeutic and psychopharmacological treatments compared to their white counterparts.

As the current data is equivocal on the relative estimates of health services utilization among racial and ethnic subpopulations, further research is needed to fully understand use patterns across populations. Although African Americans face several barriers to mental health care, some studies estimate that they are half as likely to utilize professional mental health services irrespective of differences in class or access to resources. Some studies suggest that stigma, reduced access to care and family structure may explain the underutilization of mental health resources, while others suggest that discrimination and implicit bias may be at play. In a recent audit study, middle-class black clients were “considerably less likely than whites to be offered an appointment” for psychotherapy and psychologicalservices compared to their white counterparts. Such barriers to regular care may account for emergency and crisis mental health services utilization among African Americans.

A legacy of abuse and exploitation in medicine may also contribute to distrust in the health care system. Physicians and clinicians who demonstrate an awareness of such historical trauma while encouraging patients' narratives are more likely to provide culturally competent care and engage effectively with these patients, particularly in crisis settings. Clinicians must try to understand how cultural differences in stigma, religion, coping styles, mistrust of the medical system, and family influence the willingness of oppressed populations to seek mental health resources. These differences may explain why African Americans are more likely to find care from general physicians or religious figures. Still, the evolution of more racially and ethnically conscious approaches to care may allow for expansion of more adept and racially-attuned crisis services. Indeed, there are opportunities to considerearly examples of successful approaches to crisis services. For example, some researchers have found considerable success in "comprehensive, community-based, mobile-crisis intervention[s]" among indigent African American populations. Clinicians should identify and address barriers that prevent racially and oppressed persons from accessing and benefitting from psychiatric care. Stigma remains high in many communities of color. A biopsychosocial approach to assessment and treatment, includingsocial and religious history, may be helpful in addressing barriers and stigma related to mental health services.

Immigrant Populations

Racialized legal status is an under-recognized social determinant of health. Immigrants and undocumented persons comprise a vulnerable population that often appears in crisis mental health settings. Certainly, not all immigrants are treated similarly. Immigrants' health status varies by ethnicity and citizenship, with undocumented immigrants experiencing a higher risk of affective and other mental health disorders. These outcomes may reflect social and political stressors, decreased access to health care, and fears of deportation. Moreover, fears of legal consequences have both direct and indirect effects on immigrant health status: undocumented individuals are at increased risk of affective disordersand are less likely to interface with the health system if they feel their family's legal status may be criminalized. Undocumented persons may fear involvement with the health system due to fears of detainment and deportation. Thus, when an acute mental health situation erupts, it is likely that individuals would be brought into contact with the crisis service system. Even among immigrants and undocumented persons who seek access to care, mental health services are generally underfunded in the United States. In addition to reluctance to access traditional healthcare services of immigrants, undocumented immigrants have historically been ineligible for federal benefits and resources at the state and national level.

Crisis services should become familiar with their state's immigration policies and identify and utilize available funding mechanisms to promote the health of undocumented persons with mental illness. Moreover, they should address undocumented patients' fears about their legal status and protect patient's privacy and confidentiality under state andfederal guidelines, given that individuals in crisis care may be concerned about a host of legal repercussions for a variety of reasons.

Linguistic Diversity

Lack of language concordance can present another potential barrier to accessing crisis services. In order for a crisis system to function as intended, meeting the unique needs of individuals across various community settings, demographics, clinical needs, and other contexts, it must be able to communicate effectively with the populations that seek crisis support. As with any hospital, clinic, or other healthcarefacility, crisis programs along the crisis continuum should be accessible to individuals who may not speakthe dominant language of the region. Moreover, various states and jurisdictions have enacted policies that require healthcare facilities to provide translation services for threshold languages. In California, for example, threshold languages are defined as languages spoken by 3,000 individuals within a county or that comprise at least 5% of the spoken languages in that locale. Threshold languages typically vary by region, and include Spanish, Russian, Vietnamese, Mandarin Chinese, Vietnamese, Korean, Tagalog,Russian, Arabic, Farsi, Hmong, and others. Although these may be encompassed in legally mandated requirements, a robust crisis system should strive to meet the basic needs of all of its constituents in order to serve anyone who accesses these services. These minimum requirements are also federally mandated for many facilities; the Civil Rights Act of 1964 requires federally-funded facilities to provide linguistic services, whether in-person or remote aids, to its constituents.[70] Nevertheless, these policies may not be frequently enforced and represent only a minimum requirement. As a true crisis system must meaningfully respond to the needs of its community, all crisis systems arguably must be able to provide culturally competent care and interpreterservices. This should be available to facilitate care for individuals across the continuum of crisis services.

Sexual Minorities

Experiential minorities, including individuals who identify as lesbian, gay, bisexual, transgender, queer, asexual, intersex, and non-binary individuals (LGBTQAI2+) or other sexual minorities also face unique challenges navigating crisis and non-crisis settings. Existing data has not yet included these various

TABLE 2 - 4

Special Considerations When Working with Refugees

Refugees may differ from each other and from native populations on several dimensions, including:

Language: Refugees frequently do not speak English well, if at all. This presents communication challenges throughout all phases of a disaster.

Culture: Refugees have their own cultures. Because they are new to the United States, they usually are less well-versed in Western culture than are immigrants, who have had more time to understand it.

Economic marginalization and differences: When they arrive in the United States, many refugees can barely manage economically. Many are supporting relatives left at home. On the other hand, some refugees—especially those with education and highly sought skills—find well-paying jobs quickly. Thus, although poverty is common among refugees, not all refugees are poor.

Fractured social relations: The communities of origin of many refugees have failed to provide needed security. In addition, many refugees have experienced personal attacks by representatives of their community or the larger society. Some become so disillusioned by this experience that they are reluctant to form new community bonds. In addition, refugees often face within-group schisms. Preexisting ethnic, religious, and political divisions of the society of origin are frequently reinstituted in refugee communities formed in the new country.

Some refugees solve the problem by restricting new relationships to the safest ones, for example, by forming or joining small groups of people who emigrated from the same geographic area. When a disaster forces relocation, it can break up this small community and make recovery more problematic (Athey and Ahearn).

The negative experiences of many refugees also make them suspicious of government. They may be reluctant to seek out or accept assistance following disaster. Undocumented migrants may fear deportation, but even refugees who have achieved legal status may fear that accepting of assistance following a disaster will put them at risk of deportation. Thus, refugees often are the last group to obtain assistance following disaster.

Experience of traumatic stressors and of loss: Refugees often have experienced horrific events that cause symptoms of Post-Traumatic Stress Disorder. They may have lost family members, their homes, and their possessions, and some have been deprived of sufficient food or water, lacked medical care, or lived in inadequate housing for long periods of time. A disaster can lead to the emotional re-experiencing of these events (Van der Veer). On the other hand, some refugees may have gained strength and resilience from their previous experiences and bring that strength to the new disaster.

Family dynamics and role changes: Another challenge for many refugee families is that of new family dynamics upon resettlement. Children may have seen their parents fearful, helpless, and stressed during the flight and—upon resettlement—anxious, powerless, and exhausted. Children may come to believe that adults are not to be trusted because they have not seen adults playing a protective and nurturing role.

identities, yet it does point to concerning trends that are relevant to crisis contexts. For example, LGBT populations are more likely to suffer from affective, anxiety, and substance use challenges than the heterosexual population and approximately twice as likely to attempt suicide. Actual suicide rates for LGBTQAI2+-identifying individuals are not available given sexual orientation is not reported at death, but studies suggest that sexual minorities are four to six times more likely to attempt suicide resulting in injury that requires medical treatment.

LGBTQ-identifying individuals may face overt and implicit discrimination based on their sexual identity including discrimination in the clinical setting. There may be additional concerns about safety and privacy for sexual minorities in crisis residential settings, issues which remain difficult to fully assessgiven the extent of variation across systems and institutions. Nevertheless, research suggests that crisis services tailored to LGBT populations may help mitigate suicidal behavior and other symptoms.

Clinicians and health systems should consider sexual identity as part of their biopsychosocial assessment in order to address the needs of this diverse population, improve access to care for experientially oppressed persons, and provide equitable treatment for a diverse population of individuals in need of crisis services.

Persons with Neurodevelopmental Disorders in Crisis Settings

Intellectual developmental disorder (IDD) encompasses a spectrum of disorders that limit intellectual functioning such as reasoning, learning, and integration (e.g., problem-solving), and adaptive behavior(conceptual, social and practical skills). Autism spectrum disorder is one of the most common neurodevelopmental disorders, characterized by impairments in social communication, restricted and repetitive behaviors, and abnormal language development and ability, and may or may not be accompanied by intellectual developmental disorder.

Neurodevelopmental disorders frequently co- occur with mental health disorders. Psychiatric disorders such as major depressive disorder, bipolar disorder, and neurocognitive disorders may be three to four times more prevalent in the IDD population. Individuals with autism spectrum disorders are at an increased risk of presenting with psychiatric emergencies. Moreover, while inadequate bed availability has led to prolonged boarding times and delays in care for many individuals with mental illness, individuals with IDD are at increased risk of longer emergency department boarding times. Individuals with IDDs often have more varied and complex presentations when compared to the general population.

Individuals with deficits in communication may have anxiety, mood, or psychotic experiences that manifest in aggressive, externalizing, or disruptive behaviors that may be poorly understood when presenting to crisis service providers less familiar with these underlyingconditions or the individuals themselves. Deaf and other hard of hearing individuals also face additional barriers to crisis care and may be misdiagnosed as having intellectual or developmental disabilities.

Given the rate of psychiatric comorbidities in the IDD population and the eligibility restrictions for developmental disability services (these state agencies have different names in different states), persons with IDD may also be inappropriately referred for psychiatric treatment. In these cases, psychiatric treatments for functional or adaptive behaviors where there is no mental illness may be ineffective at best and potentially harmful at worst. However, cognitive symptoms may often overshadow psychiatric symptoms among IDD populations presenting for crisis services, especially among individuals with a more severe cognitive disability. Individuals with more significant cognitive symptoms may be less adept at communicating the burden of their affective and psychotic symptoms, leading to crisis assessments that may not fully capture symptom severity. Individuals with mild intellectual disabilities may often display a "cloak of competence," demonstrating functional and adaptive skills that may mask underlying cognitive and psychiatric impairment. Crisis services must work with community mental health providers to create partnerships that divert emergency department(ED) visits, enable other care providers to recognize and intervene in crises, and build alliances with school systems. Additionally, individuals with IDD may be particularly vulnerable to psychosocial stressors. For example, self-injury may be a symptom of a psychiatric disorder or functional behavior in individuals with IDD to communicate pain, discomfort, and unhappiness. Similarly, aggressive behaviors may result from disinhibition that is seen in many psychiatric disorders or "escape-avoidance" behaviors commonlyused in IDD populations to avoid activity. In delivering crisis services, it is important to differentiate whether behaviors in individuals are employed to serve a purpose (i.e., functional) or are the result of some interactional environment and processing component. For example, environmental stimuli may include lighting, small spaces, and noise. Crisis services, which often treat patients with acute mental health needs, may be particularly overstimulating for this population. Additionally, since often behavior is the focus of attention for individuals with neurodevelopmental disorders, underlying mental health and medical conditions may be overlooked. Thus, clinicians' psychiatric evaluations should include a broad assessment of individuals' functional strengths and limitations to provide individualized patient- focused treatment. A biopsychosocial approach is essential

in determining the appropriate treatment for patients with complex needs. Crisis services must provide healing environments with appropriately trained staff to meet the needs of patients with IDD.

Many individuals with IDD may not be embedded in the systems designed to address their unique needs. Because of system structure and funding streams, individuals with mild to moderate disability, or disabilities that developed after adulthood, may not meet eligibility criteria for state developmental disability services, yet they are still likely to require psychiatric consultation and emergency services. Given these trends, it is not surprising that individuals with IDD are more likely touse psychiatric emergency services compared to the general population, and could benefit from an expanded crisis service continuum that is adept at understanding their needs.

Infectious Diseases in Crisis Settings with Lessons Learned from COVID-19

Crisis services provide care for patients with increased risks of transmission of infectious and communicable diseases. Many individuals with severe persistent mental illness and serious substance use disorders are un-domiciled, may live in congregate living environments, residential settings, boardand care facilities, multiple unit dwellings, dormitories, and other arrangements that may bring them into close contact with other individuals with high-risk for communicable disease. Moreover, mental health and substance use care is often provided in shared spaces and groups that bring individuals in close proximity. While the global spread of the coronavirus disease 2019 (COVID-19) arising from severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has changed the landscape for all types and levels of medical care, its effect on mental health and substance use services has been dramatic. Crisis services sites and even mobile crisis services vary widely in their funding, specific practices, state and local restrictions, and access to resources and supplies needed to provide infection-related safe care andlimit the spread of communicable disease.

In general, crisis services must meet various Food and Drug Administration (FDA), Occupational Safety and Health Administration (OSHA), Centers for Disease Control and Prevention (CDC), and other regulatory requirements and local and institutional policies regarding infection control. They must also be prepared as a critical part of a community's disaster response to help address the emotional needs ofindividuals who are dealing with trauma, shifting economics, substance use and a host of other factors. Yet the COVID-19 pandemic created an urgent need to re-tool practices to meet these requirements.

The care provided throughout behavioral health systems including crisis services has undergone dramatic shift in the context of COVID-19, with telecare becoming more widely used. Physical distancingis endorsed when care via video or telephonic interface can be provided safely and effectively. Strategies for acute psychiatric bed availability have ranged from reduced census levels to minimize the number of potential exposures to allocating beds for general medical use to meet the demands of potential surges in infections.

With regard to infection control, residential based facilities have long required screening documentation for tuberculosis. Now, more work will need to be added related to management of otherinfectious conditions. Given frequently evolving standards and requirements, the challenge of meeting new standards will require adapting to new information resulting in shifting expectations. These include identifying the types of resources needed and available, including sanitation practices and supplies, personal protective equipment (PPE), testing and laboratory access, and other materials.

The lessons of COVID-19 are many, and highlight the social, structural and infrastructural inequalities in various health systems. Many underfunded, understaffed and overtaxed systems have had difficulty providing services with greater need despite fewer resources. The burden of physical illness has had a disproportionate impact on ethically and racially oppressed persons, who as have been discussed earlier, face a number of barriers and systemic disadvantages when navigating the mental health care system. Perhaps more importantly, the health system's challenges in mounting a timely and effective response highlighted the vulnerabilities in behavioral health systems including crisis services. Logistical challenges in managing COVID-19 in settings that were not as readily geared toward infectious disease spread prevention, as well as persistent disparities in access to resources and health outcomes raised increased awareness of the community. Through advocacy and leadership, state and local behavioral health leaders have been able to respond to evolving trends in these areas. As crisis services develop, their ability to nimbly continue to operate, to use tele-practices as appropriate and still to be able to adequately assess individuals in need wherever they are will continue to be critical. Crisis service supports will continue to necessitate certain instances when a face-to-face encounter is required in the crisis context, and when that happens, the providers will need to ensure proper protection from viral spread for staff and the person being assessed. As part of the care continuum, crisis services will undoubtedly continue to take lessons learned from this pandemic and apply them to the program design of the future.

Although public health and community mental health systems cannot solve structural violence, poverty, and discrimination alone, crisis mental health and substance use systems need to help foster integrated systems of care that recognize these disparities and create safeguards against further perpetuating existing inequalities. As such, providers working within them must be aware of these unique threats and develop and implement strategies to mitigate the risk of worsening the risk factors that vulnerable populations already face. Finally, with the lessons learned from the COVID-19 pandemic, it is clear that crisis services will also need to be adept at dealing with infectious disease and partnerships with local health services with evolving policy and practice.

10. Legal Issues

Key Points

- ➡ Providers of crisis services offer necessary and critical aid to individuals and the communityin times of behavioral health emergencies.
- ➡ For mental health providers of such services, it is important to understand the legal and regulatory issues pertinent to practicing in these settings.
- ➡ Issues discussed in this chapter include civil commitment treatment orders, the role of guardians, restraint and seclusion, confidentiality, the criminal justice system, EMTALA, redflag laws, risk management, and how these important topics relate specifically to crisis services. This paper will also discuss the COVID-19 pandemic and its potential implications for legal issues related to crisis services.
- ➡ Understanding such key topics will aid the mental health provider in navigating the everevolving and complex landscape of crisis services.

Introduction

National efforts from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Directors (NASMHPD) are inspiringsystems to examine and develop the availability of robust crisis services.

It is becoming increasingly clear that expanded crisis services are a critical part of the psychiatriccare continuum for individuals and communities. Although they are important at any time, in the wake of recent events, such as various mass

shootings, political unrest, and the COVID-19 pandemic, the needfor these mental health crisis services is even more apparent. While the types of crisis services available in a community can vary, the advantages to a robust crisis response system are numerous. Such a system can provide time-sensitive and efficient care for an individual in crisis and be an integral part of preventing harm that an individual may intend to themselves or others. Crisis services can be successful in diverting individuals from emergency departments when not needed and from entering a higher level of care, such as an inpatient setting, or from entering the criminal justice system. Effective crisis systems can also link individuals to community providers, connecting them to necessary resources that can help them stabilize with long-term supports. Navigating complex legal and regulatory issues, however, is an important element in crisis service delivery. In this paper, the authors describe key legal issues relevant to providers working in crisis settings as well as discuss implications for systems considering policies and practices related to crisis services. Although crisis services can start with a call or a text, this paper will describe legal and regulatory issues focused on crisis contacts that involve clinical assessments of individuals in crisis.

Emergency Involuntary Holds, Civil Commitment, and Assisted Outpatient Treatment Orders and Crisis Services

Providers of crisis services may encounter patients with a clear need for psychiatric treatment for mental illness. However, providing such treatment is not always simple. At times, individuals maybeunwilling to engage in recommended care, and this may result in risks to themselves or others. It may also be that the individual is not unwilling but unable to engage in treatment, due economic barriers, lack of transportation to appointments, or cognitive limitations. Whatever the reason, individuals with mental illness with continued treatment non-adherence can be caught in a problematic pattern. Such individuals may present to crisis centers or emergency rooms with acute symptoms. They may experience improvement in their crisis symptoms and be stabilized with treatment in an acute setting such as an inpatient hospital. However, such individuals may then relapse after discharge due to withdrawal or non-adherence to treatment, prompting their symptoms to return, the cycle to restart, and mental health providers to see them in a crisis setting once again.

While the majority of mental health services should be and are provided on a voluntary basis, civil commitment laws, including inpatient hospitalization and mandated outpatient treatment (also frequently referred to as Outpatient Commitment or Assisted Outpatient Treatment [AOT]), provide legal authorization

for involuntary psychiatric treatment for individuals with mental illness who also meet certain other criteria. These criteria vary from state to state, though every state in the United States utilizes some form of involuntary treatment authorized by civil commitment statutes. Although some states have separate civil commitment laws for substance use, many are not used and they raise other complicated issues beyond the scope of this paper. As such, civil commitment in this chapter will therefore refer to those laws related to mental illness. A broad outline of common civil commitment criteria for mental illness can be seen in Figure 1.

Figure 1: Examples of Mental Illness Civil Commitment Criteria

Civil commitment laws typically take hold across three broad points in a time continuum. A behavioral health crisis may trigger the need for an emergency "hold" or hospitalization for evaluation,typically for a short period of time (e.g.., 72 hours, though the duration varies across jurisdictions).

These clinical, involuntary holds for evaluation differ from "police holds", in which law enforcement officers can place an individual who appears to be publicly incapacitated into protective custody for the purpose of taking them to an emergency room or appropriate facility. A second time point of referencecan be inpatient civil commitment, where a judge orders involuntary hospitalization for an

individual who meets the state's civil commitment criteria. The court-ordered inpatient commitment will be permissible for the period of time available by statute, and subject to renewals for individuals who continue to meet those criteria. A third time point or form can be outpatient civil commitment, or AOT,which is a method of providing involuntary, court-ordered mental health treatment in the community. Despite utilizing civil commitment statutes, national surveys shows that clinicians involved with civil commitments may lack knowledge about statutory criteria. This may be especially problematic and relevant for providers of crisis services, where, due to the emergent nature of crises, involuntary detention or treatment may be considered necessary to mitigate risk.

Some crisis settings allow for involuntary detention under these types of laws, while others do not. If they do not, and if the individual appears to require a higher level of care but does not choose to accept it on a voluntary basis, the crisis provider may need to initiate a civil commitment process. The individual in crisis then might need to be transported to an emergency department on a petition (also called an application for hospitalization), which is a document that can be completed by any involved person detailing the basis for bringing an individual in for evaluation. Here again states vary, but in general there is broad authority to petition for evaluation, followed by process either through the courtsor, if petitioned by allowable parties with special relationships to the individual (e.g., clinicians, law enforcement), to have the individual directly transported to the evaluation site. Often this is an emergency room or a designated crisis evaluation site. As crisis services evolve, part of that evolution will include whether crisis hub sites are able and appropriately staffed to manage involuntary patients. Regardless, once at the evaluation site, a clinical review would certify that the person still meets involuntary commitment criteria. Civil commitment laws require periodic reviews, and at any time the individual may consent to services voluntarily, negating the need for civil commitment. Individuals undergoing court-ordered inpatient commitment are also usually entitled certain due process protections under state and federal law, including the right to an attorney and the right to challenge their commitment before a judge or judicial authority.

Regarding outpatient civil commitment, in general, AOT orders could be appropriate for individuals described above, particularly those with mental illness who have a history of persistent non- adherence to treatment and who therefore continue to pose some risk of harm. AOT programs, authorized by law in 47 states and the District of Columbia, were designed to motivate an individual, viathe courts' authority, to participate in treatment. Research has noted that AOT programs may be ableto break the problematic pattern of treatment non-adherence

for certain individuals. AOT programs, when continued for at least six months, appear to increase treatment engagement while significantly reducing hospitalization rates as well as re-arrest for select participants when compared with similar community services provided without court oversight. Much of AOT's effectiveness is thought to be secondary to the presence of a court order and the intensive community supervision. The American Psychiatric Association's position statement on AOT notes that not all individuals are appropriate for AOT, but that involuntary outpatient treatment programs have demonstrated their effectiveness when "systematically implemented, linked to intensive outpatient services, and prescribed or extended periods of time" for persons clinically evaluated and identified as appropriate for this type of court-ordered treatment. Crisis services provide an integral role for the individual on an AOT. An individual on an AOT who is in crisis may encounter a variety of crisis service providers. For example, law enforcement officers often act as first responders and extensions of the court when the provisions of an AOT order have been violated. They can be responsible for executing "pick up" orders on an individual who has been court-ordered to receive community-based services. These orders from the court can authorize anindividual's transport and even temporary hold in a crisis center or psychiatric facility for evaluation.

Individuals on an AOT may also encounter providers in a crisis center or psychiatric emergency room after a symptom relapse. Ensuring robust collaboration between law enforcement, providers of crisis services, and an individual's community-based AOT providers is essential, and may help in averting repeat hospitalizations, criminalization, and even in improving treatment engagement. Importantly, providers of crisis services considering involuntary outpatient treatment for their patient should also be cognizant of potential racial and ethnic disparities in practices. One study explored racial disparities in outpatient civil commitments, noting that African Americans are more likely than whites to be involuntarily committed for outpatient care in New York. The authors note that depending on perspective, some providers could see this overrepresentation as positive, given it provides a potentiallyunderserved population more access to treatment, while others could perceive this as negative, given the aspect of coercion and loss of an individual's autonomy. Other issues regarding disparities in the public mental health system as a whole, and access to voluntary services in particular, are also relevant to interpreting this study's findings. Providers of crisis services considering involuntary commitment should therefore be vigilant in their awareness of potential racial disparities and bias, as well as other pre-existing social determinants such as poverty and how public mental health care is structured and financed. Furthermore, with all this in mind, clinicians should work

to provide culturally sensitive practices during patient interactions with a goal of maximizing engagement voluntarily before involuntary treatment is recommended. Voluntary engagement should always be the first priority.

Of note, providers of crisis services should also be mindful that Psychiatric Advance Directives (PADs) for an individual may be present. These directives, laid out by individuals with mental illness during a time of stability, outline their preferences for treatment and may help preserve an individual's autonomy in a time of crisis. Such advance instructions may be a method of communication of choice when an individual is deemed to lack decision-making capacity and may include the identification of a proxy decision-maker. Although they are still relatively new, PADs may allow other opportunities for accessing treatment without court involvement.

The Role of Guardians in Crisis Services

Mental health providers working in crisis services may come across individuals who cannot legally make their own treatment decisions, such as individuals with designated court-appointed guardians who are authorized to make such decisions on their behalf. These "incapacitated persons"require careful consideration when it comes to all manner of mental health services that require informed voluntary consent, which usually would require the person to have capacity to provide it. Providers should therefore be mindful of several considerations when an individual under guardianshippresents in crisis. For example, asking an individual to sign a release of information in order to obtain collateral information is common practice in psychiatric settings. A mental health provider must be cognizant of the individual's guardianship status when asking for record releases, however, as theguardian's consent may be required. As noted, guardians also have potential roles to play when inpatient psychiatric hospitalization isrecommended for an individual in crisis. Generally, for people not under guardianship, the individual would be evaluated and, if inpatient psychiatric hospitalization was recommended, an assessment of theindividual's competency to voluntarily consent to hospitalization would be conducted. Following such an assessment, the individual, if deemed to have decision-making capacity, would be offered a voluntaryadmission with informed consent. However, the process can be more complicated with someone who is not authorized to make their own treatment decisions. The ability of a guardian to provide the necessary consent to psychiatric hospitalization or treatment varies from state to state. If a state's statute does not permit the guardian to consent to voluntary hospitalization on behalf of the incapacitated person and involuntary commitment is pursued, it may make it

difficult to locate an inpatient setting for an individual who would benefit from treatment, but does not meet involuntary state commitment criteria.
In contrast to the states that do not allow a guardian to authorize an individual's psychiatric admission, other states allow the guardian to consent for the individual's psychiatric admission (or restrictions on consenting to psychiatric facilities are not specifically addressed in statute). Still other states allows the guardian to consent as long as the individual under guardianship also assents to hospitalization. Variations continue, with some states allowing a guardian to consent to an incapacitated person's hospitalization but only after obtaining a specific court authorization. With allthis taken into account, a mental health provider recommending voluntary hospitalization for an individual under guardianship should be familiar with the relevant state statute in which they practice.

Restraint/Seclusion in Crisis Services

Providers in crisis services can be faced with the scenario of caring for an individual in crisis who is acting in an imminently dangerous or agitated manner. Jurisdictional practices differ with regard to whether seclusion or restraint is legally authorized in particular crisis settings. In cases of acute agitation where there is concern that an individual could imminently harm themselves or others, where permitted, restraint or seclusion might be considered, though use of restraint and seclusion is controversial and must only be utilized as a last resort when less restrictive interventions fail. Numerous studies have pointed to the dangers of seclusion and restraint, including serious injury or death, loss of dignity, and psychological trauma to patients, as well as psychological and physical injuries to staff. As a result, non-coercive de-escalation strategies should be first line and could begin upstream even with improving the therapeutic milieu to decrease potential precipitants to agitation. Studies are beginningto identify specific strategies that may be key to reducing or eliminating seclusion or restraint, including strong leadership, procedural changes, staff training on specific issues, consumer debriefing, regular progress feedback using data to inform policy, and changes to organizational culture. It is also critically important that crisis services be designed to be trauma-informed with staff training on seclusion/ restraint prevention.

Making every effort to prevent seclusion and restraint and manage agitation with less restrictive strategies should be a core feature of a successful crisis service. If those interventions fail, there are many considerations regarding seclusion and restraint that a crisis setting must first deliberate. First, whether a crisis setting is authorized to utilize restraint or seclusion varies. State licensure and laws will

generally dictate whether a crisis site is eligible or ineligible for any hands-on holds of patients or any other type of restraint or seclusion. Hospitals and emergency rooms, in contrast, will be authorized to utilize these interventions and this may be one of the factors that is assessed when determining the level of care needed for the safest management of an individual's symptoms. That said, as previously noted, de-escalation and seclusion/restraint prevention can significantly reduce the use of these coercive and traumatizing strategies across the crisis continuum.

Where seclusion or restraint is allowable, regulatory structures must be followed. Restraint and seclusion in inpatient psychiatric treatment settings are among the most highly regulated practices in mental health, as the risks to patients can be severe with use, though failure to use restraint or seclusionin emergency situations can also result in adverse outcomes. Providers should be mindful that seclusion or restraint is not a treatment per se, and as such, there should be every effort to minimize time in seclusion or restraint. Providers should also be mindful that certain racial or ethnic groups may be viewed as more violent, and that such misconceptions about racial groups could have serious repercussions related to the use of seclusion or restraint in particular populations. Once a patient has gained control, implementing multiple strategies can be helpful at improving outcomes in managing future aggressive behavior. These strategies could include, but are not limited to, patient and staff debriefings and review processes aimed at examining the behavior leading to seclusion or restraint, as well as quality improvement initiatives examining overall seclusion and restraint utilization patterns. A detailed exploration of possible preconceived notions in providers and education about cultural awareness and sensitivity could also be performed in order to help identify and eliminate racial or ethnicbias in the use of seclusion or restraint.

Confidentiality and Duty to Protect Others in Crisis Services

Confidentiality in patient encounters can be a complex issue for mental health providers. Mental health providers are usually aware of major regulations governing confidentiality and privacy which stem from codes of professional practice, state statutes, and the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law passed with the intent to protect individual health information. It requires a patient to authorize release of medical information prior to any distribution and necessitates that patients be informed how their medical information will be utilized. Ifan individual is in a crisis service for substance use needs, then the federal law, 42 C.F.R. Part 2 is the prevailing federal statute that requires strict maintenance of confidentiality. It is considered more

restrictive than HIPAA for many reasons, including that it has criminal sanctions attached. Despite these laws and regulations surrounding privacy and confidentiality, however, providers of crisis services may find themselves in acute situations where these tenets conflict with a patient's safety or the safety of others. For example, an individual may be brought to a crisis center by law enforcement after makinghomicidal or suicidal statements but refuse to answer provider questions or authorize a release for collateral information. The provider is then left without an adequate understanding of the circumstances and may be unable to make an informed risk assessment or provide appropriate treatment recommendations. In such situations, a mental health provider must weigh the patient and public's safety with the consequences of violating that person's privacy.

Providers of crisis services should be aware of potentially mandatory disclosures for threats of serious and imminent harm made by the patient. There is state to state variation on whether such "duty to warn" disclosures are required or simply allowed. The reference to the "duty to warn" statutes arose from the 1974 landmark case *Tarasoff v. Regents of the University of California,* in which the California Supreme Court determined that a provider may have the duty to break confidentiality and warn a potential third party under certain circumstances, such as when the patient reveals ideas about harming the third party. The Court revisited this ruling two years later in 1976. At that time, they noted that mental health professionals had a "duty to protect" an identifiable victim, and that warning the intended victim might be only one way to fulfill the duty to protect. While the *Tarasoff* cases and subsequent California legislation only applies to practitioners in California, states have adopted variations on these themes. Crisis service providers should be aware of their state statute and provisions when an individual enters their care. If threats are identified, the crisis provider may need to take steps that can reasonably lead to protection of a third party or the public at large, which can include warning the identified third party, voluntarily or involuntarily hospitalizing the individual if clinically indicated, or notifying law enforcement of the threat under appropriate circumstances. Crisis service providers would do well to have policies and procedures for handling these types of situations and may need to seek legal counsel or clinical consultation on a case by case basis.
Crisis service providers should also be aware of other exceptions to confidentiality. For example, notable exceptions exist for disclosures required by law, such as mandated reporting of childabuse, disabled persons abuse or elder abuse. Mandated reporters are spelled out in state statutes, but typically include professionals working in crisis services, including social workers, physicians, nurses, therapists, law enforcement officers, and other health-care workers.

Role of Crisis Service Providers in States with Red Flag or Extreme Risk Protection Orders

A mental health provider working in crisis services may come across individuals who are thought to present a risk of harm to themselves or others. Access to a firearm for such individuals may increase their risk. What, then, should crisis services providers do when confronted with such an individual who owns guns? Although the answer requires a case by case multifactorial analysis and would likely involve a careful firearms-related risk assessment, obtaining collateral information, or a potential inpatient hospitalization to allow such risk assessment to be done in a higher level of care, several states have alsorecently passed laws allowing the permissible, temporary removal of firearms from an individual during a crisis. These laws, variably called gun violence restraining orders (GVROs), dangerous persons firearmsseizure, risk-based gun removal, extreme risk protection orders, or "red flag" laws, allow for the temporary confiscation of firearms from an individual when there is a "red flag" raised by others. These "red flags", or concerns, center around the belief that the individual in question presents a risk of harm to themselves or others and that having access to a firearm could result in elevating that risk.

"Red flag" laws are currently implemented in some form in seventeen states and the District of Columbia, and have the benefit of addressing risk while ensuring that those with mental illness are notunfairly stigmatized, as these laws are not directly connected to mental illness or a previous civil commitment. In other words, anyone who presents the requisite "red flag" of risk could be subject to firearm removal provisions in those states where such laws exist.

Providers practicing in crisis settings should be familiar with their state procedures, allowances, and prohibitions regarding high risk individuals who have access to firearms. Depending on the state in which they practice, crisis providers should know whether it is permissible to report their concerns to police to initiate the firearm removal process or whether they can encourage family members or others to do so (including the patient themselves). According to Connecticut and Indiana data regarding their risk-based gun removal laws, the most frequent circumstance that led to firearm removal involved self- harm, with less frequent circumstances involving concerns about harm to others or a combination of the two. Data indicates that in both the aforementioned states, the most common action taken by police at the time of firearm removal was transport to the hospital for psychiatric evaluation. Thus, these situations were not likely initiated by crisis services, but resulted in crisis assessments. While the goal of these laws is to

decrease the risk of violence toward self or others by removing the tools by which the individual might harm themselves or others—a so called "means reduction"—often they provide an opportunity for the individual to connect with treatment services as well. A review of the clinician's role in this topic is summarized by Kapoor et al.

Crisis Centers and EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by the United States Congress in 1986. The intent of EMTALA was to guarantee nondiscriminatory public access toemergency medical care regardless of an individual's ability to pay. This in turn was to prevent the practice of patient "dumping", defined as the "denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere." In short, EMTALA aimed to prevent hospitals from transferring patients who could not pay without consideration of their medicalstability. EMTALA requires all hospitals receiving Medicare funds to screen, examine, and stabilize a patient prior to a transfer taking place. In addition, EMTALA notes the receiving hospital must agree to the transfer and have facilities to provide the necessary treatment.

There are three criteria that must be met before a facility could be held liable for an EMTALA violation. First, the facility must be licensed as a hospital under state law. Second, it must participate in Medicare. Finally, it must operate a dedicated emergency department (DED). Although it is usually readily apparent if a facility is licensed as a hospital and if it participates in the Medicare program, the third criteria could be less clear. The Centers for Medicare and Medicaid Services (CMS) define a DED asa department that is licensed as an emergency department, a department that presents itself to the public as a provider of emergency services, or a department that sees at least one-third of its visits for the treatment of emergency medical conditions on an urgent basis without a previously scheduled appointment. This includes ambulatory outpatients who may present on an unscheduled basis to psychiatric intake centers. Thus, while Medicare-participating hospitals are required to comply with EMTALA requirements, a freestanding, walk-in Crisis Center or Crisis Stabilization Unit (CSU) could also potentially qualify.

Mental health providers working in psychiatric crisis services, including at freestanding Crisis Centers or CSUs, should be aware of EMTALA mandates and how they related to state licensing authorities. Although many walk-in crisis

services focus on resolving a crisis in a less intensive setting onan urgent basis, at times, hospitalization may be recommended as necessary given the severity of the patient's crisis. If so, providers should be mindful of issues related to patient stability and transfer. Carefully considering the transport of the patient in crisis is also important, and assuring the safest method available (i.e., ambulance vs. patient car) should be the goal.

Covid-19 Related Legal Issues Relevant to Crisis Services

COVID-19 has presented numerous challenges to health care systems around the world. While the medical complications related to COVID-19 are often prominently discussed, the mental health impact of COVID-19 also has critical bearing on individuals and communities. More than one-third of Americans noted that the COVID-19 pandemic was having a "serious impact" on their mental health, according to a survey by the American Psychiatric Association released March 25, 2020. Given ongoing implications related to the global pandemic, providers of behavioral health services, particularly crisis services, should be cognizant of COVID-19 related mental health issues that they may be encountering inindividuals presenting in a behavioral health crisis. Such issues include social isolation resulting from quarantines, economic and financial concerns secondary to lockdowns, and stress related to job-loss or food insecurity. Behavioral health providers should also be aware of COVID-19 specific implications for policies and practices related to crisis services. The full impact of COVID-19 on legal issues related to crisis services is not yet known, though there are many potential repercussions. For example, individuals presenting to a walk-in crisis center or psychiatric emergency room may require hospitalization or a transfer to a higher level of care given the severity of their crisis. However, arranging a safe and expedient transfer to a psychiatric bed may not be simple when factoring in COVID-19. It is possible thatcrisis providers may be asked to test individuals and consequently wait for COVID-19 test results prior to transferring patients to another facility in order to prevent possible transmission of the virus. This couldresult in longer emergency room boarding times in an era when some states are already being sued overbed waits.

Crisis providers may also, as previously noted, be evaluating and treating individuals who arestill actively involved in the criminal justice system. Jail and prison populations may be particularly vulnerable during this pandemic, given close living quarters, the potential for overcrowding, the difficulties with social distancing, and this population's increased rate of chronic medical comorbidities compared to the general population. It is not yet clear at the time of this writing

whether persons withsevere mental illness in a behavioral health crisis, who are also positive for COVID-19, will be more likely to be retained in jails instead of eligible for diversion into the community. Providers of crisis services should continue to communicate regularly with liaisons in the community who are aware of a patient's physical and mental health as well as legal status.

In addition, although many crisis services moved to video, it remains important that in-person services be available, and that proper PPE and infectious disease protections and protocols be implemented. This is critical as crisis services must ensure proper staffing and evaluation capabilities to mitigate the risk of liability in those assessments. Another potential example of COVID-19 impacting legal issues related to crisis services arises when considering the management of an acutely agitated patient in a crisis setting. While some crisis facilities may be allowed to utilize restraints as noted above,attempting to restrain an agitated and likely un-masked patient—especially one with an unknown COVID-19 test status —could put both the patient and the crisis staff at significant risk. It is also important to note that public health codes, such as those outlined by the Centers for Disease Control and Prevention, define isolation and quarantine differently than restraint and seclusion.[65] Restraint and seclusion are regulated by Centers for Medicare & Medicaid Services and require least restrictive alternatives to be addressed, as opposed to isolation and quarantine, where infection control is the key concern. Overall, in the COVID-19 context, crisis providers should work not only toward the first-line de- escalation strategies discussed above in this paper but should also be diligent in practices such as mask- wearing for all involved.

Risk Management and Liability with Crisis Centers

Working with individuals in crisis can be a positive and rewarding clinical experience in that crises can typically resolve with thoughtful communication and timely intervention. However, issues of liability can be an area of ongoing concern for providers who work in crisis settings. Issues of liability are particularly relevant when deciding to discharge a patient from a crisis setting. The decision to discharge should only occur after a determination of the appropriate level of care the individual needs, decided after a careful risk assessment based on the available information. Carefully and thoroughly documenting the decision, the considerations that went into the decision, and the recommendations made is of utmost importance and can help protect the mental health provider against liability should there be an unfortunate event after discharge, such as a patient suicide.

In general, several elements must be present for the plaintiff in a case to prove medical malpractice. These elements are commonly referred to as the “four Ds”. They include duty, dereliction, damages, and direct causation. Duty is established from the doctor-patient relationship, and dereliction, often cited as negligence or deviation from the standard of care, must directly lead to the damages.[68] In addition, for the plaintiff’s case to prevail, there is also the condition that the suicide should have been foreseeable. Thus, the issue of liability will often hinge on whether the mental health provider appropriately assessed the risk that a suicide would occur, emphasizing again the importance of thorough clinical documentation. A clinician should therefore weigh the available information and use their professional judgment combined with clinical practice guidelines, while clearly documenting their reasoning and considerations in order to best protect themselves from liability.

Providers in crisis settings offer necessary and critical services to individuals and the community. While working in such high-stakes settings can be emotionally taxing, it can also be rewarding. Crisis services provide opportunities for early intervention and treatment during a behavioral health crisis prior to more severe consequences occurring. Providers should be aware of key legal issues relevant to crisis service evaluations, with focus specifically on statute in the state in which they practice. These legal issues are also ever evolving, as highlighted with recent events related to COVID-19 and a renewedattention to racial and ethnic disparities. Although the work is complex, being mindful of the current legal landscape can help a crisis service provider protect themselves from liability while working to achieve the best outcome for the individual in crisis.

15. Additional Resources

Disaster Distress Helpline: People affected by any disaster or tragedy can call the Disaster Distress Helpline to receive immediate counseling. Calling 1-800-985-5990 or texting TalkWithUs to 66746 will connect you to a trained professional from the closest crisis counseling center within the network. The hotline is sponsored by the Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA).

Crisis Text Line : help is available 24 hours a day throughout the US by texting START to 741741

National Suicide Prevention Lifeline : If you or someone you know is in a crisis, get help immediately. You can call 911 or the National Suicide Prevention Line at 1-800-273-TALK (8255). The lifeline is a free 24-hour, confidential suicide prevention hotline available to anyone in crisis or emotional distress. By calling the

hotline number, you'll be connected to a skilled, trained counselor at a crisis center in your area 24/7.

Veterans Chat (confidential), text to 838255 (part of the Veterans Crisis Line)

Other Hotlines and Resources

National Suicide Hotlines USA
United States of America

Toll-Free / 24 hours a day / 7 days a week

1-800-SUICIDE

1-800-784-2433

1-800-273-TALK

1-800-273-8255

Hotlines USA: Boy's Town (*Not* just for boys): 1-800-448-3000 Childhelp USA National Hotline: 1-800-422-4453.

Hotline / Crisis Numbers

Veteran Crisis Line

1.800.273.TALK (8255) – Veterans Press '1

National Veterans Foundation Hotline

1.888.777.4443

Rape, Abuse, and Incest National Network (RAIN) (24 Hours)

1.800.656.4673

National Domestic Violence Hotline

1.800.799.7233

National Council on Alcoholism and Drug Dependence Hope Line

1.800.622.2255

Gulf War Veterans' Hotline
1.800.796.9699

National Hotlines and Helpful Links
VictimConnect
National Hotline for Crime Victims
1-855-4-VICTIM (1-855-484-2846)

Office for Victims of Crime, Directory of Crime Victim Services
[links to programs and services available to crime victims]

National Suicide Prevention Lifeline
1-800-273-TALK (8255) [24/7 hotline]
1-888-628-9454 (Spanish)
1-800-799-4889 (TTY)

Disaster Distress Helpline [24/7 hotline]
1-800-985-5990

FINRA Securities Helpline for Seniors
844-57-HELPS

Gift from Within (Not a hotline. A helpful link for survivors of trauma and victimization)
207.236.8858

Jennifer Ann's Group
Free resources on teen dating violence

MADD (Mothers Against Drunk Driving)
1-800-438-6233

National Alliance on Mental Illness
1-800-950-6264

National Association of Crime Victim Compensation Boards
[links to every state's compensation program]

National Center on Elder Abuse

National Child Abuse Hotline
1-800-422-4453

National Coalition of Anti-Violence Programs,
National Advocacy for Local LGBT Communities
1-212-714-1141

National Domestic Violence Hotline
1-800-799-7233 or 1-800-787-3224 (TTY)

National Indigenous Women's Resource Center
406-477-3896

National Runaway Switchboard
1-800-786-2929

National Sexual Assault Hotline
1-800-656-4673 [24/7 hotline]
[hosts an online hotline]

National Teen Dating Abuse Helpline
1-866-331-9474 or 1-866-331-8453 (TTY)

Overseas Citizens Services
1-888-407-4747
1-202-501-4444 (from overseas)

Parents of Murdered Children
1-888-818-7662

Adolescent Suicide Hotline
800-621-4000

Adolescent Crisis Intervention & Counseling Nineline
1-800-999-9999

AIDS National Hotline
1-800-342-2437

CHADD-Children & Adults with Attention Deficit/Hyperactivity Disorder
1-800-233-4050

Child Abuse Hotline
800-4-A-CHILD

Cocaine Help Line
1-800-COCAINE (1-800-262-2463)

Domestic Violence Hotline
800-799-7233

Domestic Violence Hotline/Child Abuse
1-800-4-A-CHILD (800 422 4453)

Drug & Alcohol Treatment Hotline
800-662-HELP

Ecstasy Addiction
1-800-468-6933

Eating Disorders Center
1-888-236-1188

Family Violence Prevention Center
1-800-313-1310

Gay & Lesbian National Hotline
1-888-THE-GLNH (1-888-843-4564)

Gay & Lesbian Trevor HelpLine Suicide Prevention
1-800-850-8078

Healing Woman Foundation (Abuse)
1-800-477-4111

Help Finding a Therapist
1-800-THERAPIST (1-800-843-7274)

Incest Awareness Foundation
1-888 -547-3222

Learning Disabilities - (National Center For)

1-888-575-7373

Missing & Exploited Children Hotline
1-800-843-5678

National Alliance on Mental Illness (NAMI)
1-800-950-NAMI (6264)

Panic Disorder Information Hotline
800- 64-PANIC

Post Abortion Trauma
1-800-593-2273

Project Inform HIV/AIDS Treatment Hotline
800-822-7422

Rape (People Against Rape)
1-800-877-7252

Rape, Abuse, Incest, National Network (RAINN)
1-800-656-HOPE (1-800-656-4673)

Runaway Hotline
800-621-4000

Self-Injury (Information only)
(NOT a crisis line. Info and referrals only)
1-800-DONT CUT (1-800-366-8288)

Sexual Assault Hotline
1-800-656-4673

Sexual Abuse - Stop It Now!
1-888-PREVENT

STD Hotline
1-800-227-8922

Suicide Prevention Lifeline
1-800-273-TALK

Suicide & Crisis Hotline
1-800-999-9999

Suicide Prevention - The Trevor HelpLine
(Specializing in gay and lesbian youth suicide prevention).
1-800-850-8078

IMAlive-online crisis chat
Teen Helpline
1-800-400-0900

Victim Center
1-800-FYI-CALL (1-800-394-2255)

Youth Crisis Hotline
800-HIT-HOME

Non-Profit Groups for Illnesses & Disorders Government Agencies

AASK America/Aid to Adoption of Special Kids
(800) 232-27511
http://www.aask.org/

The International Center for Disability Resources on the Internet
(919) 349-6661
http://www.icdri.org/

Children's Hospice International
(800) 242-4453
www.chionline.org

HEALTHSOUTH Rehabilitation Corporation
Check the website for your state's contact numbers
http://www.healthsouth.com/

Job Accommodation Network
(800) 526-7245, (800)-ADA-WORK
www.jan.wvu.edu

National Autism Hotline
(304) 525-80144

National Center for Stuttering
(800) 221-2483
www.stuttering.com

National Easter Seal Society
(800) 221-6827

http://www.easterseals.com/

Mental Health America
(Formerly National Mental Health Association)
(800) 969-6MHA (6642)

In crisis? Call: 1-800-273-TALK
http://www.mentalhealthamerica.net

Office for Civil Rights, U.S. Department of Education
1-800-USA-LEARN (1-800-872-5327)
http://www.ed.gov/about/offices/list/ocr/index.html

PsychINFO American Psychological Association
(800) 374-2722
http://www.apa.org/psycinfo/

Social Security Administration
(800) 772-1213
Medicare (800) 638-6833
http://www.ssa.gov/

TRIPOD GRAPEVINE
(800) 352-8888, (800) 287-4763

"For More Info" by Subject-Telephone List:

AIDS

National Association of People with AIDS
202-247-0880

http://www.napwa.org/

NPIN National Prevention Information Network
800-458-5231
http://www.cdcnpin.org

Centers for Disease Control and Prevention
1-800-CDC-INFO
http://www.cdc.gov/hiv/

AIDS Clinical Trials Info Service
800-HIV-0440
http://www.aidsinfo.nih.gov/

ALCOHOL

American Council on Alcoholism
800-527-5344
http://www.aca-usa.org/

National Council on Alcoholism and Drug Dependence
800-622-2255
http://www.ncaddnj.org/

National Council on Alcohol and Drugs
1-800-NCA-CALL
http://www.ncadd.org/

ALZHEIMER'S DISEASE

Alzheimer's Association

800-272-3900.
http://www.alz.org/

Alzheimer's Disease Education and Referral Center
800-438-4380
http://www.nia.nih.gov/Alzheimers/

BIPOLAR

Depression and Bipolar Support Alliance (DBSA)
(800) 826 -3632
http://www.dbsalliance.org/

CHRONIC PAIN

American Chronic Pain Association
1-800-533-3231
http://www.theacpa.org/

DEPRESSION

Depression and Bipolar Support Alliance (DBSA)
(800) 826 -3632
http://www.dbsalliance.org/

DOMESTIC VIOLENCE

National Domestic Violence Hotline
Info & Referrals for women who are abused verbally, mentally or physically.
1-800-799-SAFE (24 hrs)
http://www.ndvh.org/

DRUG ABUSE

National Council on Alcoholism and Drug Dependence
800-622-2255
http://www.ncaddnj.org/

National Council on Alcohol and Drugs
1-800-NCA-CALL
http://www.ncadd.org/

800-COCAINE
800-262-2463

888-MARIJUANA
888-627-4582

EATING DISORDERS

National Eating Disorder Referral and Information Center
International treatment referrals and prevention information
1-858-481-1515
http://www.edreferral.com/
edreferral@edreferral.com

National Eating Disorders Association
1-800-931-2237
International treatment referrals and information
http://www.nationaleatingdisorders.org/

4Therapy.com Network

National database of thousands of mental health professionals including psychiatrists, psychologists, social workers, marriage and family therapists, and pastoral counselors.

http://www.4therapy.com/

Anorexia Nervosa and Associate Disorders (ANAD)

1-847-831-3438

Referrals to treatment and Information

http://www.anad.org/

Massachusetts Eating Disorder Association, Inc Helpline

1-617-558-1881

Staffed by trained/supervised individuals. M-Friday 9:30-5:00pm. Wednesday evenings until 8:00pm

http://www.medainc.org/

Eating Disorders Association (UK)

Adult Helpline: 011-44-8456-341414 (open 8:30 to 20:30 weekdays)

Youthline: 011-44-8456-347650 (open 16:00 to 18:30 weekdays)

http://www.edauk.com/

Bulimia and Self-Help Hotline

1-314-588-1683

(24 hours crisis line)

Food Addicts In Recovery Anonymous

http://www.foodaddicts.org/

GRIEF & LOSS

Grief Recovery Institute

818-907-9600

http://www.grief.net/

MENTAL HEALTH

Mental Health America (Formerly National Mental Health Association)
(800) 969-6MHA
In crisis? Call: 1-800-273-TALK
http://www.nmha.org/

National Alliance on Mental Illness
1-800-950-NAMI (950-6264)
http://www.nami.org/

OBSESSIVE-COMPULSIVE DISORDER

National OCD Information Hotline
800-NEWS-4-OCD

PAIN

American Chronic Pain Association
Telephone: 1-800-533-3231
http://www.theacpa.org/

Missing Children

Vanished Children's Alliance
Helps victims; conducts investigations; training & materials, registry; counselors; listening.
1-800-VANISHED (sightings)
www.vca.org

Child Find of America

Prevention and resolution of child abduction

1-800-I AM LOST

www.childfindofamerica.org

National Center for Missing & Exploited Children

Hotline: 1-800-THE-LOST (1-800-843-5678)

703-235-3900

www.missingkids.com

National Runaway Switchboard

Keeps America's runaway and at-risk kids safe and off the streets

1-800-RUNAWAY

Youth Issues/Problem Parenting

Covenant House NineLine

Referrals for youth or parents re: drugs, homelessness, runaways, etc. Message relays, reports of abuse. Helps parents with problems with their kids. If all counselors are busy, stay on line & one will be with you as soon as possible.

1-800-999-9999 (24 hrs)

National Dissemination Center for Children with Disabilities

Check the website for your state's resources

Telephone: 800-695-0285

www.nichcy.org

Non-Profit Groups for Illnesses & Disorders Government Agencies

AASK America/Aid to Adoption of Special Kids

(800) 232-27511
http://www.aask.org/

The International Center for Disability Resources on the Internet
(919) 349-6661
http://www.icdri.org/

Children's Hospice International
(800) 242-4453
www.chionline.org

HEALTHSOUTH Rehabilitation Corporation
Check the website for your state's contact numbers
http://www.healthsouth.com/

Job Accommodation Network
(800) 526-7245, (800)-ADA-WORK
www.jan.wvu.edu

National Autism Hotline
(304) 525-80144

National Center for Stuttering
(800) 221-2483
www.stuttering.com

National Easter Seal Society
(800) 221-6827
http://www.easterseals.com/

Mental Health America

(Formerly National Mental Health Association)
(800) 969-6MHA (6642)
In crisis? Call: 1-800-273-TALK
http://www.mentalhealthamerica.net

Office for Civil Rights, U.S. Department of Education
1-800-USA-LEARN (1-800-872-5327)
http://www.ed.gov/about/offices/list/ocr/index.html

PsychINFO American Psychological Association
(800) 374-2722
http://www.apa.org/psycinfo/

Social Security Administration
(800) 772-1213
Medicare (800) 638-6833
http://www.ssa.gov/

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