# Crisis and Trauma Counseling Continuing Education Course

(15 CEUs/Hours)

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1. Introduction and Definitions

According to SAMHSA’s Trauma and Justice Strategic Initiative, “trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” (SAMHSA). 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., posttraumatic 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 posttraumatic stress or other mental disorders but encounter significant trauma-related symptoms or culturally expressed symptoms of trauma (e.g., somatization, in which psycho logical 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 nonjudgmental stance, and develop intervention and coping strategies that are more likely to fit their strengths and resources. This view of trauma prevents further retraumatization by not defining traumatic stress reactions as pathological or as symptoms of pathology.

View Trauma in the Context of Individuals’ Environments

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

Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in the immediate and sustained response to the event(s), and in the short- and long-term effects of the traumatic
event(s), which may include housing availability, community response, adherence to or maintenance of family routines and structure, and level of family support. To more adequately understand trauma, you must also consider the contexts in which it occurred. Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences. Bronfenbrenner 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.

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

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

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. Understanding 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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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 chapter explores several main elements that influence why people respond differently to trauma. Using the social-ecological model outlined in Part 1, Chapter 1, 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.

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 re-viewed only once, even when they could fit in multiple
categories of trauma. Additionally, the order of appearance does not denote a
specific trauma’s importance or prevalence, and there is no lack of relevance
implied if a given trauma is not specifically addressed. The intent is to give a broad
perspective of the various categories and types of trauma to behavioral health
workers 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. 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.

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.

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 but also 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 unintentional, such as the technological accident of a bridge collapse. 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 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 to ERs 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.

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 counselor.

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 TIP briefly reviews two main groups as examples in the following sections: first responders and military service members. For more detailed information on the impact of trauma and deployment, refer to the planned TIP, Reintegration-Related Behavioral Health Issues in Veterans and Military Families (SAMHSA).

**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. 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.

**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 the Khmer 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. 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.

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 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 (refer to Part 3 of this TIP, available online, for more information highlighting the relationship between trauma and behavioral health problems). Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of pre-existing 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).

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 well-being 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 counselors 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. 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. 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 a new 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, & Frappe). Therefore, providers should expect to see trauma-related disorders among refugees who are seeking treatment for a substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

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. The following are examples of practices that ignite retraumatization:

- 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 counselor–client relationships by changing counselors’ 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.

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 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 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 this 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 with Rasheed’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.

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 two 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 three 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 four 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 two 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 eighteen 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 counselor 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 counselor 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 counselor for five additional visits, during which time a plan would be made for Rasheed to begin treatment for drug dependence and PTSD.

Was the trauma expected or unexpected?
When talking about a trauma, people sometimes say they didn’t see it coming. Being un-prepared, 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 over-seas 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 Red Cross. 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 not his 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.
Was the trauma experienced 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.

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.

**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.

**Cultural meaning of trauma**

Counselors 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, an Alaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic 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 counselors 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 counselors 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.

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 cheek bone 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 three 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.

For an inexperienced professional, her presentation may have ignited suspicions that she was beginning to present with psychotic features. However, it is common for trauma survivors to experience changes in core assumptions immediately after the event and to attach meaning to the trauma. Often, a key ingredient in the recovery process is first identifying the meaning of the event and the beliefs that changed following the traumatic experience. So when you hear a client say “I will never see life the same,” this expression should trigger further exploration into how life is different, what meaning has been assigned to the trauma, and how the
individual has changed his or her perception of self, others, and the future. Sometimes, reworking the altered beliefs and assumptions occurs with no formal intervention, as with Sonja. In her situation, a random stranger provided a moment that challenged an assumption generated from the trauma. For others, counseling may be helpful in identifying how beliefs and thoughts about self, others, and the world have changed since the event and how to rework them to move beyond the trauma. It is important to understand that the meaning that an individual attaches to the event(s) can either undermine the healing process (e.g., believing that you should not have survived, feeling shame about the trauma, continuing to engage in high-risk activities) or pave the road to recovery (e.g., volunteering to protect victim rights after being sexually assaulted). The following questions can help behavioral health staff members introduce topics surrounding assumptions, beliefs, interpretations, and meanings related to trauma:

- In what ways has your life been different since the trauma?
- How do you understand your survival? (This is an important question for clients who have been exposed to ACEs or cumulative trauma and those who survived a tragedy when others did not.)
- Do you believe that there are reasons that this event happened to you? What are they?
- What meaning does this experience have for you?
- Do you feel that you are the same person as before the trauma? In what ways are you the same? In what ways do you feel different?
- How did this experience change you as a person? Would you like to return to the person you once were? What would you need to do, or what would need to happen, for this to occur?
- Did the traumatic experience change you in a way that you don’t like? In what ways?
- How do you view others and your future differently since the trauma?
- What would you like to believe now about the experience?

**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 Psychiatric Association, 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
preexisting 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, African Americans experienced higher rates of overall violence, aggravated assault, and robbery than Whites 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 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 and Urban 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 the Homeless); 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).

**Overview of Common Trauma Responses**

The following includes an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short and long term responses to traumatic experiences in the context of individuals who may seek behavioral health services. This section 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 trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

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 (EMDR).

**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, & Cloture) 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.

**Case Illustration: Sadhanna**

Sadhanna is a 22-year-old woman mandated to outpatient mental health and substance abuse treatment as the alternative to incarceration. She was arrested and charged with assault after arguing and fighting with another woman on the street. At intake, Sadhanna reported a 7-year history of alcohol abuse and one depressive episode at age 18. She was surprised that she got into a fight but admitted that she was drinking at the time of the incident. She also reported severe physical abuse at the hands of her mother’s boyfriend between ages 4 and 15. Of particular note to the intake worker was Sadhanna’s matter-of-fact way of presenting the abuse history. During the interview, she clearly indicated that she did not want to attend group therapy and hear other people talk about their feelings, saying, “I learned long ago not to wear emotions on my sleeve.”

Sadhanna reported dropping out of 10th grade, saying she never liked school. She didn’t expect much from life. In Sadhanna’s first weeks in treatment, she reported feeling disconnected from other group members and questioned the purpose of the group. When asked about her own history, she denied that she had any difficulties and did not understand why she was mandated to treatment. She further denied having feelings about her abuse and did not believe that it affected her life now. Group members often commented that she did not show much empathy and maintained a flat affect, even when group discussions were emotionally charged.
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.

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 cultures approach emotional distress through the physical realm or view emotional and physical symptoms and well-being 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.

Using Information About Biology and Trauma

• Educate your clients:
  1. Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
  2. 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.
3. Discuss traumatic stress symptoms and their physiological components.
4. Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
5. 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.

- Support your clients and provide a message of hope—that they are not alone, they are not at fault, and recovery is possible and anticipated

**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 diseases and other physical illnesses, mental illnesses, substance-related disorders, and impairment in 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.

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.”

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 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.

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 pre- side 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. Many factors contribute to cognitive patterns prior to, during, and after a trauma.

**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 reexperiencing 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 reexperiencing 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 reexperience 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 re-grounded so that they can distinguish between what is happening now versus what had happened in the past. 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

**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.

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 sub-consciously 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 associate 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 reexperiencing the trauma in various ways. Reexperiencing 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, hyper-sexuality, 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.

**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.

**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. 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.

**Case Illustration: Marco**

Marco, a 30-year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soulmate and has had a difficult time understanding her actions or how he could have prevented them.

In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment.

In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. In this situation, the counselor will need to recognize the reenactment, explore the behavior, and examine how reenactments appear in other situations in Marco’s life.
Working With Clients Who Are Self-Injurious

Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should:

- Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment.
- Learn the client’s perspective on self-harm and how it “helps.”
- Understand that self-harm is often a coping strategy to manage the intensity of emotional and/or physical distress.
- Teach the client coping skills that improve his or her management of emotions without self-harm.
- Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming (e.g., intensive outpatient, partial hospitalization, residential treatment), or more frequent treatment sessions. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses.
- Consult with other team members, supervisors, and, if necessary, legal experts to determine whether one’s efforts with and conceptualization of the self-harming client fit best practice guidelines.
- Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior (e.g., alcohol disinhibits the client, who is then more likely to self-harm). In other cases, it can decrease the behavior (e.g., heroin evokes relaxation and, thus, can lessen the urge to self-harm). In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping.

Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her.
Counselors can also help the client prepare a safety card that the client can carry at all times. The card might include the counselor’s contact information, a 24-hour crisis number to call in emergencies, contact information for supportive individuals who can be contacted when needed, and, if appropriate, telephone numbers for emergency medical services. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences.

All professionals—and in some States, anyone—could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations.

**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 the New 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 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).
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.
**Subthreshold Trauma-Related Symptoms**

Many trauma survivors experience symptoms that, although they do not meet the diagnostic criteria for ASD or PTSD, nonetheless limit their ability to function normally (e.g., regulate emotional states, maintain steady and rewarding social and family relationships, function competently at a job, maintain a steady pattern of abstinence in recovery). These symptoms can be transient, only arising in a specific context; intermittent, appearing for several weeks or months and then receding; or a part of the individual’s regular pattern of functioning (but not to the level of DSM-5 diagnostic criteria). Often, these patterns are termed “subthreshold” trauma symptoms.

Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, or another mental illness. Likewise, clients who have experienced trauma may link some of their symptoms to their trauma and diagnose themselves as having PTSD, even though they do not meet all criteria for that disorder.

**Combat Stress Reaction**

A phenomenon unique to war, and one that counselors need to understand well, is combat stress reaction (CSR). CSR is an acute anxiety reaction occurring during or shortly after participating in military conflicts and wars as well as other operations within the war zone, known as the theater. CSR is not a formal diagnosis, nor is it included in the DSM-5 (APA, 2013a). It is similar to acute stress reaction, except that the precipitating event or events affect military personnel (and civilians exposed to the events) in an armed conflict situation. The terms “combat stress reaction” and “posttraumatic stress injury” are relatively new, and the intent of using these new terms is to call attention to the unique experiences of combat-related stress as well as to decrease the shame that can be associated with seeking behavioral health services for PTSD.

Although stress mobilizes an individual’s physical and psychological resources to perform more effectively in combat, reactions to the stress may persist long after the actual danger has ended. As with other traumas, the nature of the event(s), the reactions of others, and the survivor’s psychological history and resources affect the likelihood and severity of CSR. With combat veterans, this translates to the number, intensity, and duration of threat factors; the social support of peers in the veterans’ unit; the emotional and cognitive resilience of the service members; and the quality of military leadership. CSR can vary from manageable and mild to debilitating and severe. Common, less severe symptoms of CSR include tension, hypervigilance, sleep problems, anger, and difficulty concentrating. If left untreated, CSR can lead to PTSD.
Common causes of CSR are events such as a direct attack from insurgent small arms fire or a military convoy being hit by an improvised explosive device, but combat stressors encompass a diverse array of traumatizing events, such as seeing grave injuries, watching others die, and making on-the-spot decisions in ambiguous conditions (e.g., having to determine whether a vehicle speeding toward a military checkpoint contains insurgents with explosives or a family traveling to another area). Such circumstances can lead to combat stress. Military personnel also serve in noncombat positions (e.g., healthcare and administrative roles), and personnel filling these supportive roles can be exposed to combat situations by proximity or by witnessing their results.

**Case Illustration: Frank**

Frank is a 36-year-old man who was severely beaten in a fight outside a bar. He had multiple injuries, including broken bones, a concussion, and a stab wound in his lower abdomen. He was hospitalized for 3.5 weeks and was unable to return to work, thus losing his job as a warehouse forklift operator. For several years, when faced with situations in which he perceived himself as helpless and overwhelmed, Frank reacted with violent anger that, to others, appeared grossly out of proportion to the situation. He has not had a drink in almost 3 years, but the bouts of anger persist and occur three to five times a year. They leave Frank feeling even more isolated from others and alienated from those who love him. He reports that he cannot watch certain television shows that depict violent anger; he has to stop watching when such scenes occur. He sometimes daydreams about getting revenge on the people who assaulted him.

Psychiatric and neurological evaluations do not reveal a cause for Frank’s anger attacks. Other than these symptoms, Frank has progressed well in his abstinence from alcohol. He attends a support group regularly, has acquired friends who are also abstinent, and has reconciled with his family of origin. His marriage is more stable, although the episodes of rage limit his wife’s willingness to commit fully to the relationship. In recounting the traumatic event in counseling, Frank acknowledges that he thought he was going to die as a result of the fight, especially when he realized he had been stabbed. As he described his experience, he began to become very anxious, and the counselor observed the rage beginning to appear.

After his initial evaluation, Frank was referred to an outpatient program that provided trauma-specific interventions to address his subthreshold trauma symptoms. With a combination of cognitive–behavioral counseling, EMDR, and anger management techniques, he saw a gradual decrease in symptoms when he recalled the assault. He started having more control of his anger when memories of
the trauma emerged. Today, when feeling trapped, helpless, or overwhelmed, Frank has resources for coping and does not allow his anger to interfere with his marriage or other relationships.

Understanding the Nature of Combat Stress

Several sources of information are available to help counselors deepen their understanding of combat stress and post-deployment adjustment. Friedman explains how a prolonged combat-ready stance, which is adaptive in a war zone, becomes hypervigilance and overprotectiveness at home. He makes the point that the “mutual interdependence, trust, and affection” that are so necessarily a part of a combat unit are different from relationships with family members and colleagues in a civilian workplace. This complicates the transition to civilian life. *Wheels Down: Adjusting to Life After Deployment* (Moore & Kennedy) provides practical advice for military service members, including inactive or active duty personnel and veterans, in transitioning from the theater to home.

The following are just a few of the many resources and reports focused on combat-related psychological and stress issues:

- **Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery**
- **On Killing** (Grossman), an indepth analysis of the psychological dynamics of combat
- **Haunted by Combat** (Paulson & Krippner), which contains specific chapters on Reserve and National Guard troops and female veterans
- **Treating Young Veterans: Promoting Resilience Through Practice and Advocacy** (Kelly, Howe-Barksdale, & Gitelson)

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 over time is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated 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 pre-existing 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 or PTSD. 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.

**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:
  1. Directly experiencing the traumatic event(s).
  2. Witnessing, in person, the event(s) as it occurred to others.
  3. 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 violent or accidental.
  4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers
repeatedly exposed to details of child abuse). **Note:** This does not apply to exposure through electronic media, television, 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 intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

**Intrusion Symptoms:**

1. 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.

2. 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.

3. 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.

4. 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:**

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

**Dissociative Symptoms:**

6. An altered sense of the reality of one’s surroundings or oneself (e.g., seeing oneself from another’s perspective, being in a daze, time slowing).

7. 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).

**Avoidance Symptoms:**

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

**Arousal Symptoms:**

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

- Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

- 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 or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

**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 develop ASD will later be diagnosed with PTSD (Bryant & Harvey). Additionally, ASD is 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 of ASD 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 and PTSD 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.

**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.

**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 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 traumatic 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.

Case Illustration: Michael

Michael is a 62-year-old Vietnam veteran. He is a divorced father of two children and has four grandchildren. Both of his parents were dependent on alcohol. He describes his childhood as isolated. His father physically and psychologically abused him (e.g., he was beaten with a switch until he had welts on his legs, back, and buttocks). By age 10, his parents regarded him as incorrigible and sent him to a reformatory school for 6 months. By age 15, he was using marijuana, hallucinogens, and alcohol and was frequently truant from school.

At age 19, Michael was drafted and sent to Vietnam, where he witnessed the deaths of six American military personnel. In one incident, the soldier he was next to in a bunker was shot. Michael felt helpless as he talked to this soldier, who was still conscious. In Vietnam, Michael increased his use of both alcohol and marijuana. On his return to the United States, Michael continued to drink and use marijuana. He reenlisted in the military for another tour of duty.

His life stabilized in his early 30s, as he had a steady job, supportive friends, and a relatively stable family life. However, he divorced in his late 30s. Shortly thereafter, he married a second time, but that marriage ended in divorce as well. He was chronically anxious and depressed and had insomnia and frequent nightmares. He periodically binged on alcohol. He complained of feeling empty, had suicidal ideation, and frequently stated that he lacked purpose in his life.

In the 1980s, Michael received several years of mental health treatment for dysthymia. He was hospitalized twice and received 1 year of outpatient psychotherapy. In the mid-1990s, he returned to outpatient treatment for similar
symptoms and was diagnosed with PTSD and dysthymia. He no longer used marijuana and rarely drank. He reported that he didn’t like how alcohol or other substances made him feel anymore—he felt out of control with his emotions when he used them. Michael reported symptoms of hyperarousal, intrusion (intrusive memories, nightmares, and preoccupying thoughts about Vietnam), and avoidance (isolating himself from others and feeling “numb”). He reported that these symptoms seemed to relate to his childhood abuse and his experiences in Vietnam. In treatment, he expressed relief that he now understood the connection between his symptoms and his history.

**DSM-5 Diagnostic Criteria for PTSD**

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

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

1. Directly experiencing the traumatic event(s).

2. Witnessing, in person, the event(s) as it occurred to others.

3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to 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.

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

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s)
are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

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

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

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

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

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

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

1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.

2. Reckless or self-destructive behavior.

3. Hypervigilance.

4. Exaggerated startle response.

5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

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

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

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

Specify whether:

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

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one’s mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

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

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 to the trauma. Other triggers include returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

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.
Culture and posttraumatic stress

Although research is limited across cultures, PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 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 distress that he or she still bears.

Methods for measuring PTSD are also culturally specific. As part of a project begun in 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross cultural applicability of classification systems for various diagnoses. WHO and NIH identified apparently universal factors of psychological disorders and developed specific instruments to measure them. These instruments, the Composite International Diagnostic Interview and the Schedules for Clinical Assessment in Neuropsychiatry, include certain criteria from the DSM (Fourth Edition, Text Revision; APA) as well as criteria from the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10; Exhibit 1.3-5).

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 match PTSD 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 underdiagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

**People With Mental Disorders**

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al.).

Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

The relationship between PTSD and other disorders is complex. More research is now examining the multiple potential pathways among PTSD and other disorders and how various sequences affect clinical presentation.
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. 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.

People With Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders. Alcohol and drug use can be, for some, an effort to manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorders are at higher risk of developing PTSD than people who do not abuse substances. Counselors working with trauma survivors or clients who have substance use disorders have to be particularly aware of the possibility of the other disorder arising.

Timeframe: PTSD and the onset of substance use disorders

Knowing whether substance abuse or PTSD came first informs whether a causal relationship exists, but learning this requires thorough assessment of clients and access to complete data on PTSD; substance use, abuse, and dependence; and the onset of each. Much current research focuses solely on the age of onset of substance use (not abuse), so determining causal relationships can be difficult. The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms. Three other causal pathways described by Chilcoat and Breslau’s seminal work further explain the relationship between PTSD and substance use disorders:

1. The “self-medication” hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.
2. The “high-risk” hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.

3. The “susceptibility” hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.

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.
- 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.

**PTSD and substance abuse treatment**

PTSD can limit progress in substance abuse recovery, increase the potential for relapse, and complicate a client’s ability to achieve success in various life areas. Each disorder can mask or hide the symptoms of the other, and both need to be assessed and treated if the individual is to have a full recovery. There is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse
treatment; a counselor’s efforts to address substance abuse related behaviors in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled.

Sleep, PTSD, and substance use

Many people have trouble getting to sleep and/or staying asleep after a traumatic event; consequently, some have a drink or two to help them fall asleep. Unfortunately, any initially helpful effects are likely not only to wane quickly, but also to incur a negative rebound effect. When someone uses a substance before going to bed, “sleep becomes lighter and more easily disrupted,” and rapid eye movement sleep (REM) “increases, with an associated increase in dreams and nightmares,” as the effects wear off (Auerbach).

People with alcohol dependence report multiple types of sleep disturbances over time, and it is not unusual for clients to report that they cannot fall asleep without first having a drink. Both REM and slow wave sleep are reduced in clients with alcohol dependence, which is also associated with an increase in the amount of time it takes before sleep occurs, decreased overall sleep time, more nightmares, and reduced sleep efficiency. Sleep during withdrawal is “frequently marked by severe insomnia and sleep fragmentation...a loss of restful sleep and feelings of daytime fatigue. Nightmares and vivid dreams are not uncommon” (Auerbach).

Confounding changes in the biology of sleep that occur in clients with PTSD and substance use disorders often add to the problems of recovery. Sleep can fail to return to normal for months or even years after abstinence, and the persistence of sleep disruptions appears related to the likelihood of relapse. Of particular clinical importance is the vicious cycle that can also begin during “slips”; relapse initially improves sleep, but continued drinking leads to sleep disruption. This cycle of initial reduction of an unpleasant symptom, which only ends up exacerbating the process as a whole, can take place for clients with PTSD as well as for clients with substance use disorders. There are effective cognitive–behavioral therapies and nonaddictive pharmacological interventions for sleep difficulties.

3. Screening and Assessment

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

In addition, using screening tools needs to center on how and when to gather
relevant information after the screening is complete. Organizational policies and
procedures should guide clinicians on how to respond to a positive screening, such
as by making a referral for an indepth assessment of traumatic stress, providing the
client with an introductory psychoeducational session on the typical
biopsychosocial effects of trauma, and/or coordinating care so that the client gains
access to trauma-specific services that meet his or her needs. Screening tool
selection is an important ingredient in incorporating routine, universal screening
practices into behavioral health services. Many screening tools are available, yet
they differ in format and in how they present questions. Select tools based not just
on sound test properties, but also according to whether they encompass a broad
range of experiences typically considered traumatic and are flexible enough to
allow for an individual’s own interpretation of traumatic events.

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 dis- orders, 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.

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

**Screening**

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 “cut-off score”) for a particular potential problem. The screening procedures detail the actions to take after a client scores in the positive range. Clinical supervision is helpful—and sometimes necessary—in judging how to proceed.

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

- Trauma-related symptoms.
• Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences.

• Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders).

Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences).
• Substance abuse.
• Social support and coping styles.
• Availability of resources.
• Risks for self-harm, suicide, and violence.
• Health screenings.

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

Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other behavioral health professionals, and agencies. Qualifications for conducting assessments and clinical interviews are more rigorous than for screening. Advanced degrees, licensing or certification, and special training in administration, scoring, and interpretation of specific assessment instruments and interviews are often required. Counselors must be familiar with (and obtain) the level of training required for any instruments they consider using.
For people with histories of traumatic life events who screen positive for possible trauma-related symptoms and disorders, thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation or follow-up.

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

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

**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.

- At the end of the session, make sure the client is grounded and safe before leaving the interview room. 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.

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, 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 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.
Conduct Assessments Throughout Treatment

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

The Setting for Trauma Screening and Assessment
Advances in the development of simple, brief, and public domain screening tools mean that at least a basic screening for trauma can be done in almost any setting. Not only can clients be screened and assessed in behavioral health treatment settings; they can also be evaluated in the criminal justice system, educational settings, occupational settings, physicians’ offices, hospital medical and trauma units, and emergency rooms. Wherever they occur, trauma-related screenings and subsequent assessments can reduce or eliminate wasted resources, relapses, and, ultimately, treatment failures among clients who have histories of trauma, mental illness, and/or substance use disorders.

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

• **Clarify for the client what to expect in the screening and assessment process.** For example, tell the client that the screening and assessment phase focuses on identifying issues that might benefit from treatment. Inform him or her that during the trauma screening and assessment process, uncomfortable thoughts and feelings can arise. Provide reassurance that, if they do, you’ll assist in dealing with this distress—but also let them know that, even with your assistance, some psychological and physical reactions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal.

• **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.

- **Respect the client’s personal space.** Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client’s personal space, sitting neither too far from nor too close to the client; let your observations of the client’s comfort level during the screening and assessment process guide the amount of distance. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.

- **Adjust tone and volume of speech to suit the client’s level of engagement and degree of comfort in the interview process.** Strive to maintain a soothing, quiet demeanor. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been traumatized may be more reactive even to benign or well-intended questions.

- **Provide culturally appropriate symbols of safety in the physical environment.** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.

- **Be aware of one’s own emotional responses to hearing clients’ trauma histories.** Hearing about clients’ traumas may be very painful and can elicit strong emotions. The client may interpret your reaction to his or her revelations as disinterest, disgust for the client’s behavior, or some other inaccurate interpretation. It is important for you to monitor your interactions and to check in with the client as necessary. You may also feel emotionally drained to the point that it interferes with your ability to accurately listen to or assess clients. This effect of exposure to traumatic stories, known as secondary traumatization, can result in symptoms similar to those experienced by the client (e.g., nightmares, emotional numbing); if necessary, refer to a colleague for assessment (Valent).

- **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.
• **Use self-administered, written checklists rather than interviews when possible to assess trauma.** Traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer. Clients are more likely to report trauma when they use self-administered screening tools; however, these types of screening instruments only guide the next step. Interviews should coincide with self-administered tools to create a sense of safety for the client (someone is present as he or she completes the screening) and to follow up with more indepth data gathering after a self-administered screening is complete. The Trauma History Questionnaire (THQ) is a self-administered tool (Green). It has been used successfully with clinical and nonclinical populations, including medical patients, women who have experienced domestic violence, and people with serious mental illness (Hooper, Stockton, Krupnick, & Green).

• **Interview the client if he or she has trouble reading or writing or is otherwise unable to complete a checklist.** Clients who are likely to minimize their trauma when using a checklist (e.g., those who exhibit significant symptoms of dissociation or repression) benefit from a clinical interview. A trained interviewer can elicit information that a self-administered checklist does not capture. Overall, using both a self-administered questionnaire and an interview can help achieve greater clarity and context.

• **Allow time for the client to become calm and oriented to the present if he or she has very intense emotional responses when recalling or acknowledging a trauma.** At such times, avoid responding with such exclamations as “I don’t know how you survived that!” (Bernstein). 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.

**Barriers**

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

Concerning the first main barrier, some events will be experienced as traumatic by one person but considered nontraumatic by another. A history of trauma encompasses not only the experience of a potentially traumatic event, but also the person’s responses to it and the meanings he or she attaches to the event. Certain situations make it more likely that the client will not be forthcoming about traumatic events or his or her responses to those events. Some clients might not have ever thought of a particular event or their response to it as traumatic and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor whom they’ve only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or 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, counselors and other behavioral health service providers may lack awareness that trauma can significantly affect clients’ presentations in treatment and functioning across major life areas, such as relationships and work. In addition, some counselors may believe that their role is to treat only the presenting psychological and/or substance abuse symptoms, and thus they may not be as sensitive to histories and effects of trauma. Other providers may believe that a client should abstain from alcohol and drugs for an extended period before exploring trauma symptoms. Perhaps you fear that addressing a clients’ trauma history will only exacerbate symptoms and complicate treatment. Behavioral health service providers who hold biases may assume that a client doesn’t have a history of trauma and thus fail to ask the “right” questions, or they may be uncomfortable with emotions that arise from listening to client experiences and, as a result, redirect the screening or counseling focus.

**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:

2. **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?”

3. **Help the client decrease the intensity of affect.**
   - “Emotion dial”: A client imagines turning down the volume on his or her emotions.
   - Clenching fists can move the energy of an emotion into fists, which the client can then release.
   - Guided imagery can be used to visualize a safe place.
   - Distraction (see #3 below).
   - Use strengths-based questions (e.g., “How did you survive?” or “What strengths did you possess to survive the trauma?”).

4. **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.

5. **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.
Challenges

**Awareness of acculturation and language**

Acculturation levels can affect screening and assessment results. Therefore, indepth discussions may be a more appropriate way to gain an understanding of trauma from the client’s point of view. During the intake, prior to trauma screening, determine the client’s history of 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.

**Common Assessment Myths**

Several common myths contribute to underassessment of trauma-related disorders (Najavits):

- **Myth #1: Substance abuse itself is a trauma.** However devastating substance abuse is, it does not meet the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), criteria for trauma per se. Nevertheless, high-risk behaviors that are more likely to occur during addiction, such as interpersonal violence and self-harm, significantly increase the potential for traumatic injury.

- **Myth #2: Assessment of trauma is enough.** Thorough assessment is the best way to identify the existence and extent of trauma-related problems. However, simply identifying trauma-related symptoms and disorders is just the first step. Also needed are individualized treatment protocols and action to implement these protocols.

- **Myth #3: It is best to wait until the client has ended substance use and withdrawal to assess for PTSD.** Research does not provide a clear answer to the controversial question of when to assess for PTSD; however, Najavits and others note that underdiagnosis of trauma and PTSD has been more significant in the substance abuse field than overdiagnosis. Clinical experience shows that the PTSD diagnosis is rather stable during substance use or withdrawal, but symptoms can become more or less intense; memory impairment from alcohol or drugs can also cloud the symptom picture. Thus, it is advisable to establish a
tentative diagnosis and then reassess after a period of abstinence, if possible.

**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 Project Return Foundation, Inc. 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.

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). These symptoms need to be distinguished so that other presenting subclinical features or disorders do not go unidentified and untreated. To accomplish this, a comprehensive assessment of the client’s mental health is recommended.

**Misdiagnosis and underdiagnosis**

Many trauma survivors are either misdiagnosed (i.e., given diagnoses that are not accurate) or underdiagnosed (i.e., have one or more diagnoses that have not been identified at all). Such diagnostic errors could result, in part, from the fact that many general instruments to evaluate mental disorders are not sufficiently sensitive to identify posttraumatic symptoms and can misclassify them as other disorders, including personality disorders or psychoses. Intrusive posttraumatic symptoms, for example, can 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. 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.

**Culture-Specific Stress Responses**

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*

### Choosing Instruments

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

#### Purpose

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

#### Population

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

#### 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.
The DSM-5 and Updates to Screening and Assessment Instruments

The 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), has been eliminated; this criterion stated that the individual’s response to the trauma needs to involve intense fear, helplessness, or horror. There are now four cluster symptoms, not three: reexperiencing, avoidance, arousal, and persistent negative alterations in cognitions and mood. Changes to the DSM-5 were made to symptoms within each cluster. Thus, screening will need modification to adjust to this change (APA).

Key Areas of Trauma Screening and Assessment

**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; 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).

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

Sources: Antony et al.

Practical Issues

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

Trauma-Informed Screening and Assessment

The following sections focus on initial screening. For more information on screening and assessment tools, including structured interviews. Once a screening is complete and a positive screen is acquired, the client then needs referral for a more indepth assessment to ensure development of an appropriate treatment plan that matches his or her presenting problems.

Establish a History of Trauma

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

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

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

In addition to broad screening tools that capture various traumatic experiences and symptoms, other screening tools, such as the Combat Exposure Scale (Keane et al.) 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 counselor can ask such questions as, “Have you received any counseling or therapy? Have you ever been diagnosed or treated for a psychological disorder in the past? Have you ever been prescribed medications for your emotions in the past?” Screening is typically conducted by a wide variety of behavioral health service providers with different levels of training and education.

**Trauma-Informed Care in Behavioral Health Services**

**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?

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. 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.

**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 remind 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)

Another instrument that can screen for traumatic stress symptoms is the four-item self-report SPAN, 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 other measures, such as the Impact of Events Scale (r = 0.85) and the Sheehan Disability Scale (r = 0.87).

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.

**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).
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.

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
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience? 1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Trouble falling or staying asleep?

15. Feeling irritable or having angry outbursts?

16. Having difficulty concentrating?


18. Feeling jumpy or easily startled?

Source: Weathers et al.

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.

Preliminary research shows improvement of individual resilience through treatment interventions in other populations (Lavretsky, Siddarth, & Irwin.).

Resilience Scales
Properties that 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-, 15 item forms (Bartone, Roland, Picano)

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 assessment or to make an appropriate referral for an assessment, treatment planning processes that can easily incorporate additional trauma-informed care objectives and goals, and availability and access to trauma-specific services that match the client’s needs. Screening is only the first step!

**Common Stress Reactions**

The following includes a list of common stress reactions. Most people are resilient and experience mild or transient psychological disturbances from which they readily bounce back. The stress response becomes problematic when it does not or cannot turn off; that is, when symptoms last too long or interfere with daily life.

**Behavioral**

- Increase or decrease in activity level
- Substance use or abuse (alcohol or drugs)
- Difficulty communicating or listening
- Irritability, outbursts of anger, frequent arguments
- Inability to rest or relax
- Decline in job performance; absenteeism
- Frequent crying
- Hypervigilance or excessive worry
- Avoidance of activities or places that trigger memories
- Becoming accident prone

**Physical**

- Gastrointestinal problems
- Headaches, other aches and pains
- Visual disturbances
• Weight loss or gain
• Sweating or chills
• Tremors or muscle twitching
• Being easily startled
• Chronic fatigue or sleep disturbances
• Immune system disorders

Psychological/Emotional
• Feeling heroic, euphoric, or invulnerable
• Denial
• Anxiety or fear
• Depression
• Guilt
• Apathy
• Grief

Thinking
• Memory problems
• Disorientation and confusion
• Slow thought processes; lack of concentration
• Difficulty setting priorities or making decisions
• Loss of objectivity

Social
• Isolation
• Blaming
• Difficulty in giving or accepting support or help
• Inability to experience pleasure or have fun

(Adapted from CMHS)

First the brain sounds an alert to the adrenal glands. The adrenals answer by pouring out the first of the major stress hormones—adrenaline—for the classic fight-or-flight response.
The fight-or-flight response evolved with the prime directive of ensuring our safety and survival. The pulse begins to race as the adrenaline steps up the heart rate, sending extra blood to the muscles and organs. Oxygen rushes in as the bronchial tubes in the lungs dilate; extra oxygen also reaches the brain, which helps keep us alert. During this stage of the fight-or-flight response, the brain releases natural painkillers called endorphins. This phase, in which adrenaline plays a leading role, is the immediate response to stress.

When the stress response is active for a long period of time, it can damage the cardiovascular, immune, and nervous systems. People develop patterns of response to stress that are as varied as the individuals. These responses simply suggest a need for corrective action to limit their impact.

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

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

The goals of crisis intervention involve helping survivors regain some sense of control over their immediate situations and re-establish rational problem solving abilities. Crisis intervention typically involves four components:

1. Promote safety and security;
2. Identify current priority needs, problems, and possible solutions;
3. Assess functioning and coping; and
4. Provide reassurance, normalization, psychoeducation, and practical assistance.

1. Promote safety and security:

“May I get you something to drink?”
“Are you feeling comfortable/safe here?
Survivors need to feel protected from threat and danger. When given simple choices, many come to feel less powerless as they exercise some control over their situations—which is critical for engaging initial coping.

2. Identify current priority needs and problems and possible solutions:
“Describe the problems/challenges that you are facing right now.”
“Who might help you?”
Selecting and successfully addressing one solvable problem as most immediate can help bring back a sense of control and capability. Existing sources of assistance among friends, family, health care providers, or community resources may be helpful. Assist with accessing resources when necessary.

3. Assess functioning and coping:
“How are you doing?
How do you feel you are coping with this?”
“How have you coped with stressful life events in the past?”
Through observation, asking questions, and reviewing the magnitude of the survivor’s problems and losses, the worker develops an impression of the survivor’s capacity to address current challenges. Based on this assessment, the worker may make referrals, point out coping strengths, and facilitate the survivor’s engagement with social supports. The worker also may seek consultation from a medical or mental health professional. Discussion of individual disaster experiences must be carefully tailored to the person’s situation and coping style. For example, for those who are highly distressed, talking in much detail about their disaster experience and expressing related emotions might promote further destabilization.

Crisis counseling is designed to be brief and generally persists no longer than a few weeks. The emphasis is on a single or recurrent crisis that may produce traumatic symptoms. If a trauma or crisis is not resolved in a timely and/or effective therapeutic manner, the experience can lead to more lasting psychological, social and medical problems. The term “crisis” refers to the manner in which an individual responds to a traumatic or difficult situation. Various events may trigger the crisis response such as developmental hurdles (such as going through puberty), natural disasters, and the death of a loved one.
4. Family Trauma Assessment

Children depend on their families for support and reassurance. This is especially true following a traumatic event when a child’s belief in the safety and predictability of the world has been undermined. But trauma does not affect the child alone. The effects of any traumatic event reverberate throughout the family system. A child’s greatest need for love and support may come at a time when the trauma itself has compromised a family’s ability to provide it. This can happen for a variety of reasons:

- Other family members may have experienced the same traumatic event.
- Family members may have a history of trauma. The current event may bring back memories or feelings from the past.
- The traumatic event puts additional stress on a family whose current living situation is already stressful. They may lack the resources – emotional and material – to help the child recover.
- The family already interacts and communicates in negative, or even destructive, ways.

A trauma-specific, family centered assessment can provide valuable feedback to you and the family so that treatment can target the specific and interrelated needs of children and their families.

Begin by partnering with caregivers in the assessment process. Their collaboration can help you develop a treatment plan that is workable and acceptable to the entire family. Without the engagement and active participation of caregivers, it is much more difficult for a child’s individual therapy to succeed. The family assessment process will build collaboration with caregivers.

The assessment will reveal:

- Which family members are affected and how
- The family’s strengths and ways to utilize their natural sources of support
- Options for treatment

How do you get families to embrace the need for assessment? How you first introduce the assessment to the family is vital. Convey your confidence in the benefits of the process and clearly describe why the information you’ll gain is so important.
Here are some key points to make when framing the family trauma assessment for caregivers:

- Caregivers and family members are the most important people in the child’s life. They have the most intimate understanding of their child, and the child spends more time with them than anyone else. They are uniquely able to partner with the therapist in serving the best interest of the child and family.

- Research has shown time and time again that the support of family, peers, and community are essential elements in children’s recovery.

- It is normal for caregivers to be upset about a child’s having been exposed to a traumatic event. It is normal to find the child’s post-traumatic stress reactions distressing and challenging. A caregiver who understands how the trauma is affecting each member of the family and the family’s overall well being can seek out the kinds of supports that will be most helpful.

- Learning about the child’s immediate and extended family can help the clinician identify sources of support and aid in treatment/intervention recommendations.

- A clinician’s primary goal is to help the child and family feel better, and to make sure that they emerge from the traumatic event stronger and more capable of coping with life. Your goal is for the child to no longer need therapy.

To reach that goal, the family is an essential partner. If a family session is a standard part of assessments within a clinic, it becomes part of the culture. Clinicians and families will come to expect it as part of the treatment planning process.

What are best practices in family assessment? A comprehensive assessment should include an individual meeting with the child, an individual meeting with primary caregivers, and a family session. This family session should include everyone in the household: parents, stepparents, siblings, and other relatives living in the home. This provides you the chance to talk with the entire family as a group and observe interactions and communication styles. You’ll learn which members are on board with the idea of mental health treatment, which family members may provide the most support to the child, and any symptoms or behaviors that cause you concern as a clinician. Some family members may be reluctant to talk about their own histories right at the beginning of a clinical relationship. It might take a little time to get to know each other before moving to the bigger family picture. If in place, a peer to peer or family advocacy program can be used to educate and reassure family members, and make them more comfortable with the family assessment process.

Understanding and addressing any immediate safety concerns facing the family is an important first step in the assessment process. Assess the functioning of each
dyadic relationship within the family since each may be affected by trauma in different ways, and each may have an impact on the child’s recovery. Consider how parents interact with one another; how each parent interacts with each child; and how siblings interact with one another. By collecting information from multiple reporters (such as by asking both a parent and child about a parent’s behavior or family support) you may get a more complete picture of how well the family is functioning.

During the family session, you may choose to create a structured family history. As part of this history, you will work with the family to construct a genogram and family trauma timeline. This will allow you to observe how openly the family can describe their extended family situation and how able members are to talk about traumatic events in their past as well as those that brought them to therapy.

What are the appropriate domains of family trauma assessment? It is standard practice when a child presents for treatment to assess the child’s history, symptoms, and functioning. The family trauma assessment adds additional domains. The complexity of issues and how these issues interact can make a comprehensive assessment complicated. It is important to target those aspects of the family that need to be assessed and to identify the specific issues most relevant to the child’s recovery.

Assessment of Adult Caregiver Trauma History, Symptoms, and Functioning: Sometimes a child’s adaptation to trauma is affected by the trauma history, symptoms, and functioning of his/her caregiver. Ask caregivers if they have past experience with the same type of trauma that has recently occurred. For example, if the child was sexually abused, do caregivers have a past history with sexual abuse? Their history provides the context for their reaction to the recent event.

Also ask them about traumatic events that may not appear related. Even when past traumatic events differ from the current event, the current trauma may serve as a reminder of the past. Remember that how people experience, remember, and make meaning of traumatic events can be highly subjective. Understanding each family member’s subjective experience of prior traumas can help you to see the current traumatic event in a more complete light.

In addition to trauma history, other important areas for inquiry might include symptoms of physical and/or mental illness, including PTSD; indicators of substance abuse; intimate partnership issues; and caregivers’ ability to carry out activities of daily living, especially those involved with caregiving.

Assessment of Parenting: Aspects of parenting, including warmth, discipline style, and satisfaction are important for understanding a child’s daily life and the parent-child relationship. These factors can be assessed through interview questions and
observations, as well as through any of the myriad of parenting questionnaires available.

Assessment of Family Violence: Family violence includes physical abuse, sexual abuse, and psychologically aggressive interactions among family members. Screening and assessment for family violence should be routine practice. When asking about family violence, use behavioral descriptions, such as “Has your child ever been spanked or punished in a way that left a mark?” and “Do you or your spouse hit, shove, or throw things at each other?”

Assessment of Family Separations: Many children dealing with traumatic stress disorders are also dealing with losses of, or separations from, some family members. Domestic violence and intra-familial child abuse often result in a family member being removed or separated. Ask the family if children have ever lived outside the home and what other adults have lived in the home in the past.

How do you choose instruments and prioritize what to measure? Choosing instruments and prioritizing assessment needs can be daunting, especially with a highly traumatized, chaotic, and needy family. The first priority is understanding significant symptoms that may lead to self-harm or need immediate intervention. Since the family is bringing the child to treatment, assessing the severity of the child’s symptoms should have top priority; however, the child’s symptoms occur within the context of the family environment.

Assessing immediate safety concerns for the family is always a top priority.

Other assessment priorities:

- Child trauma history, symptoms/crisis issues
- Caregiver/family trauma history, symptoms/crisis issues
- Current or past domestic violence
- Changes in family constellation
- Relationships/communication within the family
- Resiliency and extended family support

Once you determine the domains to assess, other factors may influence your choice of instruments. These include:

- Cost (is the measure in the public domain?)
- Clinical utility (does it provide the information you need)
- Ease of administration and scoring and
- Assessment burden on both family and clinician
Finally, developmental level will influence a child’s ability to participate in the assessment. Most self-report measures of family functioning are not designed for children under 12.

How do you present the results to the family? It is important for families to understand that it is normal for trauma to stress the entire family system. Whatever problems preceded the trauma may be amplified by the added stress. The purpose of providing the family with feedback is to enable them to act as informed partners in making decisions about the best treatment for their child and family. Your feedback also helps them to conceptualize their baseline and track their own progress towards treatment goals.

Giving assessment results to families can be tricky. For example, there is the initial dilemma of who gets told what. Everyone in the family has a right to information about what the assessments have shown but every family member also has a right to privacy. Decisions about who receives what information have to be made on a case by case basis. Here are some important questions to consider:

- How should I handle information that might be perceived as negative, critical, or judgmental?
- Do I disclose information to caregivers individually and then repeat the disclosure with the family?
- Do I engage caregivers in deciding what children should be told or how they should be told?
- Have I identified the decision maker(s) in this family? How do I best structure the information to facilitate decision making?

Another tricky part of giving feedback is sharing the results in a developmentally sensitive manner. This is important so that family members of all ages understand the results. Everyone in the family is given an opportunity to ask questions about the results. Family members may not all agree on the results and important information can be gained from discussing any disagreements. What are some caveats and considerations? Responsibility when assessing all family members: A family assessment undertaken as part of the treatment of one family member may reveal that other family members are also in need of services. In this case, you need to be prepared to offer services either through your own agency or through partnerships with other agencies. It is imperative to become familiar and up to date on resources in your area. Establish connections with other agencies so that the referral process is as smooth and easy as possible.

Ethnocultural Factors: Ethnocultural background can influence a family’s participation in assessment. Some cultures have very strong prohibitions against discussing family problems.
MS. M AND HER FAMILY’S ASSESSMENT

Ms. M came for an assessment of her two children, who were 5 and 10 years old, after a long history of exposure to domestic violence and physical abuse by their father who is now in jail. During the assessment the family was asked to describe a typical day in their household. The 10-year reports that it is her job to get herself and her little sister ready for school and on the bus. Ms. M states that she is too tired in the mornings and is often still asleep when her daughters leave for school. Ms. M prepares dinner for the children when they return home but has difficulty implementing a homework or bedtime routine. She states, “The kids have been through so much, I just let them stay up as late as they want watching TV. Their father never let them watch and yelled at them all the time. I don’t want to yell at them, and I think the TV helps them get to sleep.” Ms. M and her children’s responses provide valuable information about family roles and structure and potential areas for intervention.

A “normal” pattern of interaction in your own culture may appear foreign or incomprehensible to your clients and vice versa. As in all clinical work, it is important to consider how a family’s ethnocultural background influences their participation in the assessment, response, and presentation. Understanding how a family’s behavior fits within their cultural norms helps build a more accurate picture of the family.

Family Structures: Families come in many shapes and sizes – two parent heterosexual, two parent homosexual, single parent, multigenerational, etc. When determining who to include in the assessment, ask the caregiver and child to name the important figures in the family.

Keep in mind that parents may not necessarily be the primary caregivers. In addition, extended family members may play a key role, even if they do not live in the same household. Finally, in separated families or children placed outside the home, any family member that the child interacts with regularly can be an important asset to the evaluation.

When NOT to do a family-based assessment: There are some circumstances in which a family-based assessment is contraindicated. These circumstances might include:

• Ongoing safety issues and risk for violence within the family: Before undertaking a family-based assessment, always determine whether there is a history of, or current pattern of family violence. Under such circumstances, family members may not feel safe sharing information, and actual or perceived disclosure of information by some family members may increase the risk of
violence. When there is any risk of family violence, even if all members appear to feel safe participating in a family-based assessment, first ensure that a safety plan is in place.

• Legal limitations on collecting family level information: In court-involved families, it is important to determine whether there are legal strictures that prevent an individual from providing information on other family members. In addition, consider the likelihood that records will be subpoenaed and for what purpose. That is not to say that family-based assessments should never be done with court-involved families, but rather a caution to consider the ramifications for all family members.

Summary
No child is an island – parental and family dynamics have significant influence on a child’s recovery from trauma. An assessment of the family provides valuable insights into both potential sources of support for the child as well as potential obstacles to therapeutic success. Armed with this knowledge, you and the family can plan a course of treatment with the best possible chance of success.

5. Crisis and Trauma Treatment Approaches

This section 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.

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

Some treatments discussed in this section 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. Although behavioral health counselors can prepare to help their clients, specialized training is necessary to provide treatment for co-occurring substance use and mental disorders related to trauma.

**Federal Agencies**

Both the American Red Cross and the Federal Emergency Management Agency (FEMA) respond to disasters. Behavioral health service providers should understand the basics about these major emergency response agencies. For example, the Red Cross can respond rapidly with funding for food, shelter, and immediate needs, whereas FEMA assistance requires a period of gearing up but provides for longer term needs. SAMHSA, along with other Federal agencies, assists FEMA in a number of areas of emergency response planning activities. See also SAMHSA’s Disaster Technical Assistance Center Web site (http://www.samhsa.gov/dtac) and Technical Assistance Publication, *Disaster Planning Handbook for Behavioral Health Treatment Programs* (SAMHSA) 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 Website.

**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 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 the
Terrorism and Disaster Branch of the National Child Traumatic Stress Network (http://www.nctsn.org/content/psychological-first-aid).

Core Actions in Preparing To Deliver Psychological First Aid
- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

Source: National Child Traumatic Stress Network & NCPTSD.

**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, & Emmelkamp). 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.

**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.

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 pre-trauma functioning (Bonanno).

The focus initially should be upon screening with follow-up as indicated.

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

Cognitive processing therapy
Cognitive processing therapy (CPT) is a manualized 12 session treatment approach that can be administered in a group or individual setting (Resick & Schnicke). 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 for Rape Victims: A Treatment Manual*.

**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, & Follette). 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]).

**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 during or following exposure treatments. Even so, the exacerbation may depend on counselor variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al.); a counselor unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen. Exposure therapy is recommended as a first line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al.).

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), and cognitive processing.
Steps for Introducing a Breathing Exercise

Use the following statements to lead clients through a breathing exercise:

• Place your hands on your stomach. As you inhale, breathe deeply but slowly so that your hands rise with your stomach. As you exhale slowly, practice breathing so that your hands drop with your stomach.

• Inhale slowly through your nose with your mouth closed; don’t rush or force in the air.

• Exhale slowly through your mouth with your lips in the whistling position.

• Breathe out for twice as long as you breathe in.

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 of Veterans Affairs (VA), the Royal College of Psychiatrists, 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 the EMDR 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.

A Brief Description of EMDR Therapy

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

• Phase 1: History and Treatment Planning (1-2 sessions)

• Phase 2: Preparation
• Phase 3: Assessment and Reprocessing
• Phase 4: Desensitization
• Phase 5: Installation
• Phase 6: Body Scan
• Phase 7: Closure
• Phase 8: Reevaluation Source: EMDR Network

Narrative therapy
Narrative therapy is an emerging approach to understanding human growth and change; it is founded on the premise that individuals are the experts on their own lives and can access their existing intrapsychic and interpersonal resources to reduce the impact of problems in their lives. Developed for the treatment of PTSD resulting from political or community violence, narrative therapy is based on CBT principles, particularly exposure therapy (Neuner, Schauer, Elbert, & Roth; 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, 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 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 whether DBT and exposure were both needed. Phase 1 therapeutic alliance and negative mood regulation skills predicted Phase 2 exposure success in reducing PTSD, suggesting the importance of establishing a strong therapeutic relation-ship and emotion regulation skills before conducting exposure work with people who have chronic PTSD.

STAIR Steps

Phase 1, tailored to individual clients, is called Skills Training in Affect Regulation and consists of the following components:

• Psychoeducation: Describe the symptoms of PTSD and explain the treatment rationale.

• Training in experiencing and identifying feelings, triggers, and thoughts, as well as training in mood regulation strategies.

• Learning history: Ask the client the following questions—How did the client deal with traumas past and present? How did the client’s family deal with feelings? How did the client’s family life affect his or her present difficulty experiencing and identifying feeling?

• Emotion regulation skills: Identify the cognitive, behavioral, and social support modalities for coping. Use data gathered with self-monitoring forms to identify strengths and weaknesses in each coping modality. Teach skills such as breathing retraining, self statements to reduce fear, and social skill training to improve social support.

• Acceptance and tolerance of negative affect: Motivate clients to face distressing situations related to the trauma that are important to them. Review negative repercussions of avoidance. Discuss tolerating negative affect as a step toward achieving specific goals.

• Schema therapy for improved relationships: Identify relevant schemas learned in childhood. Suggest alternative ways of viewing self and others in current relationships. Use role-playing to teach assertiveness, emphasizing response flexibility based on relative power in each relationship.

Once Phase 1 of STAIR is well learned, clients move to Phase 2, which involves exposure therapy, Source: Mollick & Spett.
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 of PTSD compared with waitlist controls and shows comparable efficacy to exposure therapy. At follow up (up to 12 months after treatment), gains were maintained (Foa et al.; Foa, Rothbaum, Riggs, & Murdock).

SIT Phases
Phase 1: Conceptualization and education. This phase has two main objectives. The initial goal is to develop a collaborative relationship that supports and encourages the client to confront stressors and learn new coping strategies. The next objective is to increase the client’s understanding of the nature and impact of his or her stress and awareness of alternative coping skills. Many cognitive strategies are used to meet these objectives, including self-monitoring activities, Socratic questioning, identifying strengths and evidence of resilience, and modeling of coping strategies.

Phase 2: Skill acquisition and rehearsal. This phase focuses on developing coping skills and using coping skills that the individual already possesses. This process includes practice across settings, so that the individual begins to generalize the use of his or her skills across situations through rehearsal, rehearsal, and more rehearsal.

Phase 3: Implementation and following through. The main objective is to create more challenging circumstances that elicit higher stress levels for the client. By gradually increasing the challenge, the client can practice coping strategies that mimic more realistic circumstances. Through successful negotiation, the client builds a greater sense of self-efficacy. Common strategies in this phase include imagery and behavioral rehearsal, modeling, role-playing, and graded in vivo exposure.
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. In contrast with integrated models, other model types include single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

Similar to single models, integrated treatment models are designed for use in a variety of settings (e.g., outpatient, day treatment, and/or residential substance abuse and mental health clinics/programs). Most models listed are manual-based treatments that address trauma-related symptoms, mental disorders, and substance use disorders at the same time. Additional approaches and further details on the selected approaches can be found at NREPP (http://www.nrepp.samhsa.gov).

Addiction and Trauma Recovery Integration Model

The Addiction and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry) 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 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-Occurring Disorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models (Morrissey et al.).

**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.

**Concurrent Treatment of PTSD and Cocaine Dependence**

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) is a 16-session, twice-weekly individual outpatient psychotherapy model designed to treat women and men with co-occurring PTSD and cocaine dependence (Coffey, Schumacher, Brimo, & Brady). CTPCD combines imagery and in vivo exposure therapy (in which the client becomes de-sensitized to anxiety-producing stimuli through
repeated exposure to them) for the treatment of PTSD with elements of CBT for substance dependence. To balance the dual needs of abstinence skill building and prompt trauma treatment, the first five sessions focus on coping skills for cocaine dependence. Session six transitions into exposure therapy, which begins in earnest in session seven and is combined with CBT for the treatment of substance abuse. CTPCD helps reduce substance use and PTSD symptoms. The use of any illicit drug, as measured by urine screens, was quite low during the 16-week treatment trial and didn’t escalate during the second half of treatment— when most exposure sessions occurred. PTSD symptoms dropped significantly over the course of treatment, as did self-reported depressive symptoms; however, the dropout rate was high (Coffey, Dansky, & Brady). CTPCD was reformulated into Concurrent Prolonged Exposure (COPE; Mills et al.), which was compared with treatment as usual in a high-complexity clinical sample of individuals who had PTSD and substance dependence. Both treatment conditions resulted in improvements in PTSD with no difference at 3 months (though COPE showed significantly greater improvement at 9 months); moreover, the two conditions did not differ in impact on substance use outcomes, depression, or anxiety.

**Integrated CBT**

Integrated CBT is a 14-session individual therapy model designed for PTSD and substance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber-Harris, Alterman, Xie, & Meier). 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 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 twenty-five topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client’s course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping
with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multisite trials representing various investigators and populations) provide the evidence base for this treatment model. For more information, see SAMHSA’s NREPP Web site (http://www.nrepp.samhsa.gov) as well as the “Outcomes” section of the Seeking Safety Web site (http://www.seekingsafety.org/3-03-06/studies.html). Study samples included people with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of settings (e.g., criminal justice, VA centers, adolescent treatment, homelessness services, public sector). Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available.

The five key elements of Seeking Safety are:

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

**Substance Dependence PTSD Therapy**

Substance Dependence PTSD Therapy (Triffleman) was designed to help clients of both sexes cope with a broad range of traumas. It combines existing treatments for PTSD and substance abuse into a structured, 40 session (5-month, twice-weekly) individual therapy that occurs in two phases. Phase I is “Trauma-Informed, Addictions-Focused Treatment” and focuses on coping skills and cognitive interventions as well as creating a safe environment. Phase I draws on CBT models, anger management, relaxation training, HIV risk reduction, and motivational enhancement techniques. Phase II, “Trauma- Focused, Addictions-
Informed Treatment,” begins with psychoeducation about PTSD followed by “Anti-Avoidance I,” in which a modified version of stress inoculation training is taught in two to four sessions. Following this is “Anti-Avoidance II,” lasting 6 to 10 sessions, in which in vivo exposure is used.

The Seven-Step FREEDOM Approach

Focus: Being focused helps a person pay attention and think about what’s happening right now instead of just reacting based on alarm signals tied to past trauma. This step teaches participants to use the SOS skill (Slow down, Orient, Self check) to pay attention to body signals and the immediate environment and to use a simple scale to measure stress and control levels.

Recognize triggers: Recognizing trauma triggers enables a person to anticipate and reset alarm signals as he or she learns to distinguish between a real threat and a reminder. This step helps participants identify personal triggers, take control, and short-circuit their alarm reactions.

Emotion self-check: The goal of this skill is to identify two types of emotions. The first are “alarm” or reactive emotions such as terror, rage, shame, hopelessness, and guilt. Because these emotions are the most noticeable after trauma, they are the alarm system’s way of keeping a person primed and ready to fend off further danger. The second type of emotion, “main” emotions, include positive feelings (e.g., happiness, love, comfort, compassion) and feelings that represent positive strivings (e.g., hope, interest, confidence). By balancing both kinds of emotions, a person can reflect and draw on his or her own values and hopes even when the alarm is activated.

Evaluate thoughts: When the brain is in alarm mode, thinking tends to be rigid, global, and catastrophic. Evaluating thoughts, as with identifying emotions, is about achieving a healthier balance of positive as well as negative thinking. Through a two-part process, participants learn to evaluate the situation and their options with a focus on how they choose to act—moving from reactive thoughts to “main” thoughts. This is a fundamental change from the PTSD pattern, which causes problems by taking a person straight from alarm signals to automatic survival reactions.

Define goals: Reactive goals tend to be limited to just making it through the immediate situation or away from the source of danger. These reactive goals are necessary in true emergencies but don’t reflect a person’s “main” goals of doing worthwhile things and ultimately achieving a good and meaningful life. This step teaches one how to create “main” goals that reflect his or her deeper hopes and values.
Options: The only options that are available when the brain’s alarm is turned on and won’t turn off are automatic “flight/fight” or “freeze/submit” reactive behaviors that are necessary in emergencies but often unhelpful in ordinary living. This step helps identify positive intentions often hidden by the more extreme reactive options generated by the alarm system. This opens the possibility for a greater range of options that take into consideration one’s own needs and goals as well as those of others.

Make a contribution: When the brain’s alarm is turned on and reacting to ordinary stressors as if they were emergencies, it is very difficult for a person to come away from experiences with a feeling that they have made a positive difference. This can lead to feelings of alienation, worthlessness, or spiritual distress. The ultimate goal of TARGET is to empower adults and young people to think clearly enough to feel in control of their alarm reactions and, as a result, to be able to recognize the contribution they are making not only to their own lives, but to others’ lives as well. (Source: Advanced Trauma Solutions).

Trauma Affect Regulation: Guide for Education and Therapy
Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford & Russo; Frisman, Ford, Lin, Mallon, & Chang) uses emotion and information processing in a present-focused, strengths-based approach to education and skills training for trauma survivors with severe mental, substance use, and co-occurring disorders across diverse populations. TARGET helps trauma survivor understand how trauma changes the brain’s normal stress response into an extreme survival based alarm response that can lead to PTSD, and it teaches them a seven step approach to making the PTSD alarm response less distressing and more adaptive (summarized by the acronym FREEDOM: Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution). TARGET can be presented in individual therapy or gender-specific psychoeducational groups, and it has been adapted for individuals who are deaf; it has also been translated into Spanish and Dutch. TARGET is a resilience building and recovery program not limited to individual or group psychotherapy; it is also designed to provide an educational curriculum and milieu intervention that affects all areas of practice in school, therapeutic, or correctional programs. TARGET is listed in SAMHSA’s NREPP (http://www.nrepp.samhsa.gov).

Trauma Recovery and Empowerment Model
The trauma recovery and empowerment model (TREM) of therapy (Fallot & Harris, Harris & Community Connections Trauma Work 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 thirty-three topics, are informed by the role of gender in women’s experience of and coping with trauma.

TREM can be adapted for shorter-term residential settings and outpatient substance abuse treatment settings, among others. Adaptations of the model for men and adolescents are available. The model was used in SAMHSA’s Women, Co-Occurring Disorders and Violence Study for three of the nine study sites and in SAMHSA’s Homeless Families program, and it is listed in SAMHSA’s NREPP. This model has been used with clients in substance abuse treatment; research by Toussaint, VanDeMark, Bornemann, and Graeber shows that women in a residential substance abuse treatment program showed significantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.

**TREM Program Format**

Each session includes an experiential exercise to promote group cohesiveness. The thirty-three 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 sub-groups 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

**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. Numerous applications are available and evolving.

**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 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: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness*. For clinical applications of mindfulness, see *Mindfulness- Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (Segal et al.) and *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Donovan).

**Becoming The Observer**

The following exercise, “leaves floating on a stream,” is a classic. Many clinicians and authors provide renditions of this mindfulness practice. The main objectives are to stand back and observe thoughts rather than get caught up in them. Simply stated, thoughts are just thoughts. Thoughts come and go like water flowing down a stream. We don’t need to react to the thoughts; instead, we can just notice them. Conduct the mindfulness exercise for about ten minutes, then process afterward. Take time to allow participants to visualize each sense as they imagine themselves sitting next to the stream. For example, what does it look like? What do they hear as they sit next to the stream? Don’t rush the exercise. As you slowly make the statements detailed in the following two paragraphs, take time in between each statement for participants to be in the exercise without interruption; simply offer gentle guidance.

Begin to sit quietly, bringing your attention to your breath. If you feel comfortable, close your eyes. As you focus on breathing in and out, imagine that you are sitting next to a stream. In your imagination, you may clearly see and hear the stream, or you may have difficulty visualizing the stream. Follow along with the guided exercise; either way, it will work just as well.

Now begin to notice the thoughts that come into your mind. Some thoughts rush by, while others linger. Just allow yourself to notice your thoughts. As you begin to notice each thought, imagine putting those words onto a leaf as it floats by on the stream. Just let the thoughts come, watching them drift by on the leaves. If your thoughts briefly stop, continue to watch the water flow down the stream. Eventually, your thoughts will come again. Just let them come, and as they do, place them onto a leaf. Your attention may wander. Painful feelings may arise. You may feel uncomfortable or start to think that the exercise is “stupid.” You may hook onto a thought—rehashing it repeatedly. That’s okay; it’s what our minds do.
As soon as you notice your mind wandering or getting stuck, just gently bring your focus back to your thoughts, and place them onto the leaves. Now, bring your attention back to your breath for a moment, then open your eyes and become more aware of your environment.

Facilitated Questions:

- What was it like for you to observe your thoughts?
- Did you get distracted? Stuck?
- Were you able to bring yourself back to the exercise after getting distracted?
- In what ways was the exercise uncomfortable?
- In what ways was the exercise comforting?

**Pharmacological Therapy**

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

**Concluding Note**

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

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

6. 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 population 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.

In the wake of rare but highly publicized tragedies attributed to people with mental illnesses, there is often a temporary surge in political concern about mental healthcare and expanding crisis interventions. Sadly, the more commonplace crises endured every day by many thousands of adults, older adults and children with serious mental or emotional problems tend to generate neither media attention nor political concern.
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

Individually 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:

- where the intervention occurs,

- at what time of day it 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 experienced by the individual,

- interventional 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:

1. Ensuring that mental health crisis interventions are guided by standards consistent with recovery and resilience and
2. 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
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 gatekeeping 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.”

From the website of Projects to Empower and Organize the Psychiatrically Labeled (PEOPLE, Inc.) at: [http://www.projectstoempower.org](http://www.projectstoempower.org)

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.

7. **Crisis and Trauma Counseling Clinical Issues**

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

**Trauma-Informed Prevention and Treatment Objectives**

Trauma-informed care (TIC) not only focuses on identifying individuals who have histories of trauma and traumatic stress symptoms; it also places considerable effort in creating an environment that helps them recognize the impact of trauma and determine the next course of action in a safe place. For some individuals, psychoeducation and development or reinforcement of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions. 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 being trapped or abandoned. An early effort in trauma treatment is thus helping the client 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*. 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 re-gain 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 can unintentionally create retraumatizing experiences. For instance, compassionate inquiry into a client’s history can seem similar to the interest shown by a perpetrator many years before. Direct confrontation by counselors about behaviors related to substance abuse can be seen, by someone who has been repeatedly
physically assaulted, as provocation building up to assault. Counselor and program efforts to help clients constrain destructive behaviors can be interpreted as efforts to control and dominate the individual. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Some staff and agency issues that can result in retraumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.
- Discounting a client’s report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling intense rage and other feelings as pathological.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors’ schedules and assignments.
- Being insensitive to a client’s physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including a lack of consistent, competent leadership.

**Strategies To Prevent Retraumatization**

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

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

**Strategy #3:** Be mindful that efforts to control and contain a client’s behaviors in treatment can produce an abnormal reaction, particularly for trauma survivors for whom being trapped was part of the trauma experience.
Strategy #4: Listen for specific triggers that seem to be driving the client’s reaction. An important step in recovery is helping the client identify these cues and thereby reach a better understanding of reactions and behaviors.

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 prep for hearing results or to place the screening and subsequent assessment findings in proper context. Education in and of itself, however, does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals who have histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance recognition of symptoms and ease the path of seeking treatment.

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

Psychoeducation goes beyond the identification of traumatic stress symptoms and/or learning about the psychological, cognitive, and physical impacts of trauma. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies in key areas, including safety, emotional regulation, help seeking, avoidant behavior, and so forth.
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. A trauma-informed perspective provides a message that trauma reactions are normal responses to an abnormal situation.

**Strategy #3:** Develop a resource box that provides an array of printed or multimedia educational materials that address the program, specific symptoms and tools to combat trauma-related symptoms, treatment options and therapy approaches, advantages of peer support, and steps in developing specific coping strategies.

**Strategy #4:** Develop a rotating educational group that matches services and client schedules to complement treatment. Remember that education can play a pivotal role in enhancing motivation, in normalizing experiences, and in creating a sense of safety as individuals move further into treatment. For some survivors, education can be a powerful intervention or prevention strategy.

Case Illustration: Linda

Linda served as an Army nurse in an evacuation hospital in Vietnam. She reported her post-deployment adjustment as difficult and isolating but denied any significant symptoms of traumatic stress throughout her life. Four years ago, Linda sought treatment for alcohol dependence; during the intake, she recalls denying trauma-related symptoms. “I distinctly remember the session,” she recounts. “The counselor first took my history but then gave information on typical symptoms and reactions to trauma. I thought, ‘Why do I need to hear this? I’ve survived the worst trauma in my life.’ I didn’t see the value of this information. Then 3 weeks ago, I began to have recurrent nightmares, the same graphic type I occasionally had when I was in Vietnam. Since then, I’ve been very anxious, reliving horrible scenes that I’d experienced as a nurse and postponing going to bed in fear of having the dreams again. I didn’t understand it. I am 70 years old, and the war happened a
long time ago. Then I began putting it together. Recently, the emergency helicopter flight pattern and approach to the area’s hospital changed. I began hearing the helicopter periodically in my living room, and it reminded me of Vietnam. I knew then that I needed help; I couldn’t stop shaking. I felt as if I was losing control of my emotions. I remembered how the intake counselor took the time to explain common symptoms of trauma. That’s why I’m here today.”

**Offer Trauma-Informed Peer Support**

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

**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.

**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.

**Normalize Symptoms**

Symptoms of trauma can become serious barriers to recovery from substance use and mental disorders, including trauma-related ones. Counselors should be aware of how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

**Case Illustration: Hector**

Hector was referred to a halfway house specializing in co-occurring disorders after inpatient treatment for methamphetamine dependence and posttraumatic stress disorder (PTSD). In the halfway house, he continued to feel overwhelmed with the frequency and intensity of flashbacks. He often became frustrated, expressing anger and a sense of hopelessness, followed by emotional withdrawal from others in the house. Normalization strategy #3 was introduced in the session. During this exercise, he began to identify many negative aspects of flashbacks. He felt that he couldn’t control the occurrence of flashbacks even though he wanted to, and he realized that he often felt shame afterward. In the same exercise, he was also urged to identify positive aspects of flashbacks. Although this was difficult, he realized that flashbacks were clues about content that he needed to address in trauma specific treatment. “I realized that a flashback, for me, was a billboard advertising what I needed to focus on in therapy.”

**Identify and Manage Trauma-Related Triggers**

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

Key steps in identifying triggers are to reflect back on the situation, surroundings, or sensations prior to the strong reaction. By doing so, you and your client may be able to determine the connections among these cues, the past trauma(s), and the client’s reaction. Once the cue is identified, discuss the ways in which it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say “I love you” in a significant relationship as an adult and connecting this to an abuser who said the same thing prior to a sexual assault). Other 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.

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. 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-occurring 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:

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

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

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

Teach Balance

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

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.

**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.

**Build Resilience**

Survivors are resilient! Often, counselors and clients who are trauma survivors focus on the negative consequences of trauma while failing to recognize the perseverance and attributes that have helped them survive. It is natural to focus on what’s not working rather than what has worked. To promote growth after trauma and establish a strengths-based approach, focus on building on clients’ resilience. Current resilience theories claim that building or reinforcing resilience prevents further development of trauma-related symptoms and disorders. The following *Advice to Counselors* box is adapted from the American Psychological Association’s statement on resilience.

**Strategies To Build Resilience**

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

**Strategy #2:** Encourage the client to take action. Recovery requires activity. Actively taking care of one’s own needs early in treatment can evolve into assisting others later on, such as by volunteering at a community organization or helping military families.

**Strategy #3:** Encourage stability and predictability in the daily routine. Traumatic stress reactions can be debilitating. Keeping a daily routine of sleep, eating, work, errands, household chores, and hobbies can help the client see that life continues. Like exercise, daily living skills take time to take hold as the client learns to live through symptoms.
Strategy #4: Nurture a positive view of personal, social, and cultural resources. Help clients recall ways in which they successfully handled hardships in the past, such as the loss of a loved one, a divorce, or a major illness. Revisit how those crises were addressed.

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

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

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

Source: American Psychological Association,

Address Sleep Disturbances

Sleep disturbances are one of the most enduring symptoms of traumatic stress and are a particularly common outcome of severe and prolonged trauma. Sleep disturbances increase one’s risk of developing traumatic stress; they significantly alter physical and psychological processes, thus causing problems in daytime functioning (e.g., fatigue, cognitive difficulty, excessive daytime sleepiness). People with sleep disturbances have worse general health and quality of life. The cardiovascular and immune systems, among others, may be affected as well. Sleep disturbances can worsen traumatic stress symptoms and interfere with healing by impeding the brain’s ability to process and consolidate traumatic memories.

Sleep disturbances vary among trauma survivors and can include decreased ability to stay asleep, frequent awakenings, early morning unintentional awakening, trouble falling asleep, poor quality of sleep, and disordered breathing during sleep. Most traumatic stress literature focuses on nightmares, insomnia, and frequent awakenings. These disturbances are connected to two main symptoms of traumatic stress: hyperarousal (which causes difficulty in falling and remaining asleep) and reexperiencing the trauma (e.g., through recurrent nightmares). Other sleep disturbances trauma survivors report include sleep avoidance or resistance to sleep (see Case Illustration: Selena), panic awakenings, and restless or unwanted body movements (e.g., hitting your spouse unintentionally in bed while asleep).

Strategies To Conduct a Sleep Intervention

Strategy #1: Conduct a sleep history assessment focused first on the client’s perception of his or her sleep patterns. Assess whether there is difficulty initiating
or staying asleep, a history of frequent or early morning awakenings, physically restless sleep, sleepwalking, bedtime aversion, and/or disruptive physical and emotional states upon awakening (e.g., confusion, agitation, feeling unrested). Also determine total sleep time, pattern of nightmares, and use of medications, alcohol, and/or caffeine.

**Strategy #2:** Use a sleep hygiene measure to determine the presence of habits that typically interfere with sleep (e.g., falling asleep while watching television). The National Sleep Foundation Web site (http://www.sleepfoundation.org) provides simple steps for promoting good sleep hygiene.

**Strategy #3:** Provide education on sleep hygiene practices. Introduce clients to the idea that practicing good sleep hygiene is one step toward gaining control over their sleep disturbances.

**Strategy #4:** Reassess sleep patterns and history during the course of treatment. Sleep patterns often reflect current client status. For example, clients who are struggling are more likely to have disturbed sleep patterns; sleep disturbances significantly influence clients’ mental health status.

**Strategy #5:** Use interventions such as nightmare rehearsals to target recurrent nightmares. There are numerous examples of imagery-based nightmare rehearsals. Clients may be instructed to rehearse repetitively the recurrent nightmare a few hours before bedtime. In this instruction, the client either rehearses the entire nightmare with someone or visualizes the nightmare several times to gain control over the material and become desensitized to the content. Other strategies involve imagining a change in the outcome of the nightmare (e.g., asking the client to picture getting assistance from others, even though his or her original nightmare reflects dealing with the experience alone).

**Case Illustration: Selena**

Selena initially sought treatment for ongoing depression (dysthymia). During treatment, she identified being sexually assaulted while attending a party at college. At times, she blames herself for the incident because she didn’t insist that she and her girlfriends stay together during the party and on the way back to their dorm afterward. Selena reported that she only had two drinks that night: “I could never manage more than two drinks before I wanted to just sleep, so I never drank much socially.” She was assaulted by someone she barely knew but considered a “big brother” in the brother fraternity of her sorority. “I needed a ride home. During that ride, it happened,” she said. For years afterward, Selena reported mild bouts of depression that began lasting longer and increasing in number. She also reported nightmares and chronic difficulty in falling asleep. In therapy, she noted avoiding her bed until she’s exhausted, saying, “I don’t like going to sleep; I know
what’s going to happen.” She describes fear of sleeping due to nightmares. “It’s become a habit at night. I get very involved in playing computer games to lose track of time. I also leave the television on through the night because then I don’t sleep as soundly and have fewer nightmares. But I’m always exhausted.”

**Build Trust**

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

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

Establishing a safe, trusting relationship is paramount to healing—yet this takes time in the counseling process. Counselors and other behavioral health professionals need to be consistent throughout the course of treatment; this includes maintaining consistency in the parameters set for availability, attendance, and level of empathy. Trust is built on behavior shown inside and outside of treatment; you should immediately address any behavior that may even slightly injure the relationship (e.g., being 5 minutes late for an appointment, not responding to a phone message in a timely manner, being distracted in a session).

**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. Helping clients understand that conflicts are healthy and inevitable in relationships (and that they can be resolved while retaining the dignity and respect of all involved) is a key lesson for those whose relationship conflicts have been beset by violence, bitterness, and humiliation.

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

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

Support Empowerment

Strong feelings of powerlessness can arise in trauma survivors seeking to regain some control of their lives. Whether a person has survived a single trauma or chronic trauma, the survivor can feel crushed by the weight of powerlessness. Mental illness and substance abuse, too, can be disempowering; clients may feel that they’ve lost control over their daily lives, over a behavior such as drug use, or over powerful emotions such as fear, sadness, or anger. Empowerment means helping clients feel greater power and control over their lives, as long as such control is within safe and healthy bounds. A key facet of empowerment is to help clients build on their strengths. Empowerment is more than helping clients discover what they “should” do; it is also helping them take the steps they feel ready to take.

Case Illustration: Abby

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

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

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

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

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

**Acknowledge Grief and Bereavement**

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

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

- Perceived lack of social support.
- Concurrent crises or stressors (including reactivation of PTSD symptoms).
- High levels of ambivalence about the loss.
• An extremely dependent relationship prior to the loss.
• Loved one’s death resulting from disaster: unexpected, untimely, sudden, and shocking.

Strategies To Acknowledge and Address Grief

**Strategy #1:** Help the client grieve by being present, by normalizing the grief, and by assessing social supports and resources.

**Strategy #2:** When the client begins to discuss or express grief, focus on having him or her voice the losses he or she experienced due to trauma. Remember to clarify that losses include internal experiences, not just physical losses.

**Strategy #3:** For a client who has difficulty connecting feelings to experiences, assign a feelings journal in which he or she can log and name each feeling he or she experiences, rate the feeling’s intensity numerically, and describe the situation during which the feeling occurred. The client may choose to share the journal in an individual or group session.

**Strategy #4:** Note that some clients benefit from developing a ritual or ceremony to honor their losses, whereas others prefer offering time or resources to an association that represents the loss.

**Monitor and Facilitate Stability**

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

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

• 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).

**Treatment Issues**

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

**Client Engagement**

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

**Pacing and Timing**

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

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

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.

Strategies To Establish Appropriate Pacing and Timing

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

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

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

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

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

Source: Strategies 1–6: Green Cross Academy of Traumatology

Length of Treatment

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

Traumatic Memories

One of the most controversial issues in the trauma field is the phenomenon of “recovered memories” or “traumatic amnesia”. 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. In some cases, the survivor will not remember some of what happened, and the counselor may need to help the client face the prospect of never knowing all there is to know about the past and accept moving on with what is known.

Memories of Trauma

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.

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.

**Strategies To Manage Legal Proceedings**

**Strategy #1:** If you’re aware of legal proceedings, you can play a key role in helping your client prepare emotionally for their impact, such as what it might be like to describe the trauma to a judge or jury, or how to cope with seeing the perpetrator in court. When helping a client prepare, however, be careful not to provide legal advice.

**Strategy #2:** Help clients separate a successful legal outcome from a successful treatment outcome. If clients connect these two outcomes, difficulties can arise. For example, a client may discontinue treatment after his or her assailant is sentenced to serve prison time, believing that the symptoms will abate without intervention.

**Strategy #3:** If clients express interest in initiating a civil or criminal suit, encourage them to consider the ways in which they are and are not prepared for this, including their own mental states, capacity for resilience, and inevitable loss of confidentiality. Inform clients coping with legal issues that involvement in the legal process can be retraumatizing.

**Strategy #4:** Emphasize, for trauma survivors who are involved in legal proceedings against an assailant, that “not guilty” is a legal finding—it is based on the degree of available evidence and is not a claim that certain events in question did not occur. They should also receive, from an attorney or other qualified individual, information on:

- The nature of the legal process as it pertains to the clients’ specific cases.
- The estimated duration and cost of legal services, if applicable.
- What to expect during police investigations.
- Court procedures.
- Full information on all possible outcomes.
- What to expect during cross-examination.

**Strategy #5:** Counselors can be called on to assist with a legal case involving trauma. The court may require you to provide treatment records, to write a letter
summarizing your client’s progress, or to testify at a trial. Always seek supervisory and legal advice in such situations and discuss with the client the possible repercussions that this might have for the therapeutic relationship. As a general rule, it is best practice to avoid dual roles or relationships.

Forgiveness

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

One issue that comes up frequently among counselors is whether to encourage clients to forgive. The issue of forgiveness is a very delicate one. It is key to allow survivors their feelings, even if they conflict with the counselor’s own responses. Some may choose to forgive the perpetrator, whereas others may remain angry or seek justice through the courts and other legal means. Early in recovery from 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. 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, mental illness, and substance use disorders and recovery, requires behavioral health practitioners to consider the complicated interactions between culture, personality, mental illness, and substance abuse in adapting treatment protocols. This section offers some general guidelines for working with members of cultures other than one’s own. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive.

The U.S. Department of Health and Human Services has defined the term “cultural competence” as follows:

“Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.”

Cultural competence is a process that begins with an awareness of one’s own culture and beliefs and includes an understanding of how those beliefs affect one’s attitudes toward people of other cultures. It is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one’s own. For a thorough review of cultural competence, see the planned TIP, Improving Cultural Competence (Substance Abuse and Mental Health Services Administration [SAMHSA], planned c).

Cultural Competence
Cultural competence includes a counselor’s knowledge of:

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

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

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

• How to differentiate PTSD, trauma-related symptoms, and other mental disorders in the culture.
In some cultures, an individual’s needs take precedence over group needs 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. 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 in Bangladesh displaces thousands of people each year, yet few believe that it is a serious problem or that the displacement will be permanent. 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.

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

Importance of the trauma aftermath

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

Treatment strategies

Many traditional healing ways have been damaged, forgotten, or lost—yet much wisdom remains. Drawing on the best traditional and contemporary approaches to human distress and defining culturally competent curricula regarding identity and healing 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.

Community-Based Treatment for Native American Historical Trauma

Key beliefs in community healing:

• Clients carry childhood pain that has led to adult dysfunction.
• Childhood pain must be confronted, confessed, and addressed, if relief is to be obtained.
• Cathartic expression is the initial step in the healing journey toward a lifelong pursuit of introspection and self-improvement.
• The healing journey entails reclamation of indigenous heritage, identity, spirituality, and practices to remedy the pathogenic effects of colonization and other sources of historical trauma.

Source: Gone

Working With Clients From Diverse Cultures: Trauma and Substance Abuse

• In socially appropriate ways, educate clients, their loved ones, and possibly members of their extended community about the relationship between substance abuse and PTSD, how substance abuse is often used to cope with trauma, and what treatment entails.
• Make serious efforts to connect clients to supportive and understanding people (preferably within culturally identified groups).

• Help clients understand that many who have not experienced trauma or do not have substance use disorders will not understand the psychological, spiritual, and interpersonal insights that they have gained during their recovery processes.

Gender

Gender differences exist in traumatic stress, mental disorders, and substance use disorders. For example, women have higher rates of PTSD, whereas men have higher rates of substance abuse.

The types of interpersonal trauma experienced by men and by women are often different. A number of studies indicate that men experience more combat and crime victimization and women experience more physical and/or sexual assault—implying that men’s traumas often occur in public, whereas the traumatization of women is more likely to take place in a private setting, such as a home. Men’s abusers are more often strangers. Those who abuse women, on the other hand, are more often in a relationship with them. Women (and girls) often are told, “I love you,” during the same time period when the abuse occurs. However, women now serve in the military and thus are increasingly subject to some of the same traumas as men and also to military sexual trauma, which is much more common for women to experience. Similarly, men can be subject to domestic violence or sexual abuse.

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

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Beyond the complexities of gender considerations, one must also consider whether clients should be given the choice of working with a male or a female counselor. Some clients who have been traumatized have no preference, particularly if their trauma wasn’t associated with gender (e.g., a natural disaster, act of terrorism, fire, serious accident). If gender did play a role in trauma (e.g., childhood sexual abuse), clients can have strong fears of working with a counselor who is the same gender as the perpetrator. Many women who experienced sexual abuse (whose perpetrators are typically men) feel uncomfortable being treated by men because of the intense emotions that can be evoked (e.g., anger, fear). Men who experienced sexual abuse (whose perpetrators are also typically men) can feel uncomfortable for the same reasons, or they may feel shame when talking to men due to feelings evoked about masculinity, homosexuality, and so forth. However, not all clients with trauma histories prefer female therapists.

Discuss with clients the possible risks (e.g., initial emotional discomfort) and benefits of being treated by a woman or man (e.g., developing a therapeutic relationship with a man might challenge a client’s belief that all men are dangerous), and, if possible, let them choose the gender of their counselor. Tell them that if they experience initial emotional discomfort, and the discomfort does not decrease, they can switch to a counselor of the opposite gender. For group therapy that focuses on trauma, similar considerations apply. Generally, gender-specific groups are recommended when possible, but mixed gender groups also work. Gender also comes into play in substance abuse treatment. Research and clinical observation indicate that significant gender differences occur in many facets of substance abuse and its treatment. For example, men and women experience different physical repercussions of substance use (e.g., women have more health problems), different trajectories (e.g., women become addicted more quickly), and different treatment considerations (e.g., traditional substance abuse treatment was designed for men).
Sexual orientation

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

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

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:

- 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.
8. Child and Adolescent Exposure to Trauma: Comparative Effectiveness of Interventions

Approximately two-thirds of children and adolescents will experience at least one traumatic event, creating a critical need to identify effective child trauma interventions. While most children exposed to trauma do not experience long-term negative sequelae in terms of psychological and social functioning, some go on to develop traumatic stress syndromes, including post-traumatic stress disorder (PTSD). Studies have indicated that childhood traumatic stress syndromes are associated with a high degree of impairment that can carry into adolescence and adulthood. For example, childhood PTSD increases the risk for developing co-morbid mental disorders, such as depression, substance abuse, and conduct disorder.

Suicidality is a particular concern for children with PTSD. Decreased social, home, school (lower academic achievement), and relational functioning have also been observed in children and adolescents with PTSD. Although several guidelines on the treatment of PTSD during childhood and adolescence exist, the recommendations have not been largely based on evidence resulting from Comparative Effectiveness Reviews. Furthermore, the guidelines offer inconsistent recommendations for interventions.

Scope

This review addresses the treatment of children exposed to traumatic events other than child maltreatment or family violence, some of whom are already experiencing symptoms. Interventions for children exposed to family violence (i.e., intimate partner violence and other forms of violence exposure in the home) are not covered by either review given the heterogeneity in this population and the interventions used to treat family violence exposure. That is, children who witness but do not directly experience interpersonal violence represent different clinical populations in terms of the nature of the relationship disturbance and implications for treatment. For the sake of brevity, we refer to children and adolescents as “children” for the remainder of this report. The review also seeks to understand whether evidence exists for differences in the efficacy of interventions by specific child or treatment characteristics or by setting of the delivered intervention. Finally, the review attempts to identify adverse events associated with the interventions reviewed.

Key Questions

**Key Question 1:** What is the comparative effectiveness of different types of pharmacotherapy, psychotherapy, complementary and alternative therapy, or other
therapy, such as combined, for children ages 0 to 17 years exposed to trauma other than maltreatment?

**Key Question 2:** What is the comparative effectiveness of different types of pharmacotherapy, psychotherapy, complementary and alternative therapy, or other therapy, such as combined, for children ages 0 to 17 years with traumatic stress symptoms from trauma other than maltreatment who are already experiencing symptoms?

**Key Question 3:** Do interventions targeting children who were exposed to trauma and are already experiencing symptoms vary in their effectiveness by characteristics of the child, treatment, or setting?

**Key Question 4:** What are the harms (e.g., low adherence/dropouts, side effects, retraumatization) associated with specific types of therapies targeting children exposed to trauma or targeting children who were exposed to trauma and are already experiencing symptoms?

**Key Question 1: Treatment Based on Exposure**

We sought evidence on the effectiveness of interventions targeting children exposed to trauma according to traumatic stress, mental health, physical health, and other outcomes. These outcomes included the following:

- Prevention of traumatic stress symptoms or syndromes (e.g., PTSD, acute stress disorder, developmental trauma disorder [DTD])
- Prevention of or reduction in mental health conditions or symptoms (e.g., depression, anxiety)
- Prevention of or reduction in physical health conditions or symptoms (e.g., sleep disorders, eating disorders, pain, overweight or obesity, asthma, cardiovascular problems, gastrointestinal problems, headaches)
- Reduction in risk-taking behaviors, including substance use; reduction in behavioral problems, including conduct disorder and attention deficit hyperactivity disorder (ADHD); or reduction in criminal activities
- Healthy development, including improvements in interpersonal and social functioning or reductions in developmental regression
- School-based functioning
- Improvements in quality of life
- Decreased suicidality
Summary of Findings by Intervention

Seven studies (in eight articles) on six different interventions provided information on a subset of these outcomes. Five interventions evaluated a variety of psychotherapeutic approaches compared with waitlist controls, no treatment, usual care, or supportive therapy; the sixth intervention evaluated the efficacy of propranolol compared with placebo. The propranolol study and the early psychological intervention study found no improvement in any outcomes. All other interventions reported some improvement in one or more outcomes. Three of four interventions showing evidence of benefit (trauma-focused cognitive behavioral therapy [TF-CBT] and both mixed school group interventions--ERASE Stress and Overshadowing the Threat of Terrorism) compared outcomes from interventions with outcomes from wait-list controls or no intervention. The Child and Family Traumatic Stress Intervention (CFTSI) trial was the only study showing evidence of benefit with an active group comparator.

Summary of Findings Across Interventions

Five studies (four treatment types) evaluated PTSD diagnosis; of these, three studies (two treatment types, CFTSI and mixed school group ERASE Stress) found evidence of improvement favoring intervention arms. Four studies (three treatment types) evaluated severity of PTSD symptoms; three studies representing two treatments found evidence of improvement favoring intervention arms (both school-based interventions). Three studies (one study presented in two publications) evaluating PTSD symptoms found evidence of improvement; the early intervention study found no benefit (early psychological intervention). Six studies evaluated mental health outcomes, specifically anxiety, depression, and dissociative symptoms. Both studies evaluating anxiety reported improvement in anxiety; three studies (four publications) evaluating depression reported improvement in depression; the early psychological intervention found no improvement in depressive symptoms; and one study found no improvement in dissociative symptoms. Four studies evaluated physical health outcomes. All three studies that evaluated somatic complaints found evidence of benefit favoring the intervention arm. A single study evaluating physiological reactivity found no evidence of benefit. Regarding other outcomes, all three studies that evaluated functional impairment found evidence of benefit. The single study that evaluated behavior problems found no evidence of benefit.
Key Question 2: Treatment of Traumatic Stress Symptoms

As in KQ 1, we sought evidence of the effectiveness of interventions designed to treat traumatic stress symptoms in children on a variety of traumatic stress, mental health, physical health, and other outcomes. Specifically, these included:

- Remission of PTSD
- Reduction in severity or number of traumatic stress syndromes or symptoms
- Prevention of or reduction in co-occurring mental health conditions or symptoms (e.g., depression, anxiety)
- Prevention of or reduction in co-occurring physical health conditions or symptoms (e.g., sleep disorders, eating disorders, pain, overweight or obesity, asthma, cardiovascular problems, gastrointestinal problems, headaches)
- Reduction in risk-taking behaviors, including substance use; reduction in behavioral problems, including conduct disorder and ADHD; or reduction in criminal activities
- Healthy development, including improvements in interpersonal/social functioning, or reductions in signs of developmental regression
- School-based functioning
- Improvements in quality of life
- Decreased suicidality

As with KQ 1, at least one outcome from each included study had to relate to the assessment of trauma symptoms or syndromes. We also included findings that showed non beneficial outcomes associated with the intervention (e.g., no significant changes in outcomes between groups or significantly worse outcomes in the intervention group).

Summary of Findings Across Interventions

Four studies evaluated PTSD diagnosis; of these, two found evidence of improvement favoring intervention arms (TF-CBT, EMDR). Fifteen studies evaluated PTSD symptoms, but only four interventions were graded as having low SOE of improvement. One study suggested evidence of worse outcomes for the sertraline intervention arm, compared with the placebo arm, for parent rated PTSD symptoms and clinician-rated PTSD severity.

Twelve studies representing 10 interventions evaluated mental health outcomes, specifically anxiety, depression, and internalizing symptoms. Six studies reported no improvement in one or all outcomes evaluated. One of 5 interventions reported in 6 studies evaluating anxiety symptoms reported improvements; 4 interventions
reported in 5 studies out of 10 interventions reported in 12 studies reported improvement in depression; and 2 studies found no improvement in internalizing behaviors. Two studies evaluated physical symptoms or general health outcomes; Neither found evidence of benefit. Seven studies evaluated a range of other outcomes, including functional symptoms, psychosocial dysfunction, acting out or aggression, shyness/anxiety, learning problems, quality of life, externalizing/conduct problem behaviors, global distress, anger, and supernatural complaints. One study suggested evidence of no benefit for quality of life for the intervention arm, sertraline, compared with the placebo arm. Two of three studies evaluating general functioning did not find evidence of benefit. A third study found mixed results. One study found evidence of benefit for the intervention arm on psychosocial dysfunction. One of three studies found evidence of benefit for the intervention arm on externalizing/conduct problem behavior. No studies found any evidence of benefit for acting out or aggression, shyness, learning problems, quality of life, externalizing/conduct problem behaviors, global distress, anger, and supernatural complaints.

Key Question 3: Treatment Subgroup Comparisons for Interventions Targeting Children Exposed to Trauma, Some of Whom Already Have Symptoms: Our review found only two studies that examined subgroup characteristics that moderated the effect of the intervention tested by an interaction term. We elected not to summarize findings that merely presented results stratified by subgroups because of the risk of over interpreting results from underpowered subsamples. Both studies that examined subgroup characteristics that moderated the effect of an intervention on an outcome were school based. The first intervention examined the effect of trauma-focused cognitive behavioral therapy (TF-CBT) targeting children exposed to trauma.The second intervention examined the effect of CBT targeting children exposed to trauma who already have symptoms. Both studies examined sex subgroups; in addition, one study evaluated age group and exposure to violence.

The TF-CBT study did not find any differences in relationship between intervention and PTSD symptoms or depression. The CBT study found no significant differences by age group or exposure to violence with respect to PTSD symptoms or functional impairment. The study did, however, find significant differences by sex, suggesting that the intervention effect on PTSD symptoms and functional impairment were greater for girls than boys.

Key Question 4: Harms Associated With Targeting Children Exposed to Trauma, Some of Whom Already Have Symptoms:
Five studies reported harms associated with interventions. One study examined harms of TF-CBT versus wait-list control and found no adverse events in either group. No mention was made of how harms were assessed or evaluated. A second study examined harms of trauma and grief component therapy (TGCT) for adolescents with classroom based psychoeducation and skills training versus classroom based psychoeducation and skills training alone. The study used a Reliable Change Index (RCI) for post-traumatic stress, depression, traumatic grief, and existential grief in order to quantify the number of reliably deteriorated cases. The authors found no significant differences in reliable deterioration for post-traumatic stress, depression, traumatic grief, and existential grief by study arm at post-treatment or at the 4-month followup.

One study found no increase in several types of adverse events associated with sertraline compared with placebo, including disturbed sleep, agitation, headache, abdominal pain, nausea, pharyngitis, vomiting, accidental injury, respiratory tract infections, diarrhea, dizziness, hyperkinesis, and rhinitis. However, the study reported some incidents of other types of serious adverse events (undefined), dry mouth, and dysmenorrhea among patients taking sertraline compared with none for patients in the placebo arm. The study reported higher incidents of dropouts because of adverse events, increased suicidality ratings, and active suicidality in the sertraline arm compared with the placebo arm but did not report the results of statistical significance tests.

**Key Findings**

No pharmacotherapy intervention demonstrated effectiveness. Studies demonstrating improvement in outcomes generally compared results of interventions with waitlist controls. With a single exception, studies comparing interventions with active controls did not show benefit. Some psychotherapy interventions targeting children exposed to trauma appeared promising based on the magnitude and precision of effects found. These interventions were school based treatments with elements of CBT. There was less compelling evidence regarding potentially promising interventions targeting already existing symptoms; each also had elements of CBT.

The study authors typically evaluated short-term outcomes. The body of available evidence provided no insight into how interventions targeting children exposed to trauma, some of whom already have symptoms, might influence healthy long-term development. We found little evidence on how effectiveness might vary by child characteristics; and we found no evidence on how effectiveness might vary by treatment characteristics or setting. We also found little evidence addressing possible harms associated with psychological treatments. Only pharmacological interventions attempted to assess harms in this vulnerable population.
Traumatic events are common in childhood. In one longitudinal study of more than 1,400 children 9 to 16 years of age, 68 percent of children reported at least one traumatic event (with 37 percent experiencing more than one event); 13.4 percent of those experiencing trauma developed some post-traumatic symptoms. In a survey of adolescents 12 to 17 years of age, the 6-month prevalence for PTSD was 6.3 percent in girls and 3.7 percent in boys. The prevalence of PTSD in younger children is largely unknown; however, several studies have assessed the prevalence of PTSD in young children exposed to various types of violence (abuse, car crashes, and natural disasters) with high reported rates of PTSD. The rates of PTSD vary considerably in such studies and may be related to the severity, chronicity, and type of trauma.

**Types of Trauma**

Children can be exposed to many types of trauma, including inflicted trauma, unintentional trauma, natural disasters, war, and neighborhood violence. One longitudinal study reported that 25 percent of its sample was exposed to or victimized by violence (excluding sexual trauma), 11 percent was exposed to sexual trauma, and 32 percent was exposed to other types of trauma (diagnosed with a physical illness, 11%; serious accident, 11.6%; natural disaster, 11.1%; fire, 5.9%). The Adverse Childhood Experiences Study showed high rates of childhood trauma exposure in a large adult population. In this population, 65 percent recalled adverse childhood experiences, many of which could be defined as traumatic events. These experiences included emotional abuse (11%), physical abuse (28%), sexual abuse (21%), battered mother (13%), household drug/alcohol abuse (27%), household mental illness (17%), parent separation or divorce (23%), and incarcerated household member (5%). PTSD rates vary by type of traumatic exposure, with 35 percent of children exposed to community violence and half those affected by interpersonal violence. Road crashes, another common form of childhood trauma, were associated with rates of PTSD ranging from 13 to 25 percent between 4 and 12 months after a road crash. Children with agency-reported abuse had much higher rates of PTSD when compared with children without reported abuse. Trauma from natural disasters frequently leads to PTSD; for example, one study reported a PTSD rate of 35 percent for children surviving an earthquake.

**Risk and Protective Factors of Traumatic Stress in Children**

Not all trauma-exposed children develop traumatic stress syndromes. Several risk and protective factors play a role in the development of syndromes such as PTSD. In one study of terrorism exposure, children more directly affected by terrorism were more likely to report PTSD. Likewise, those with more frequent reminders of traumatic experiences were more likely to experience PTSD, and those with
support seeking behavior were less likely to report PTSD. The severity of injuries resulting from motor vehicle accidents has been shown to be associated with the development of PTSD. Previous trauma and preexisting anxiety disorders increase the risk of PTSD. A variety of genetic and neurobiological factors play a role in the development of PTSD. The developmental age, number of trauma exposures, family systems, and neighborhood factors may play a role in the development of PTSD after trauma.

Clinical Presentation of Post-Traumatic Stress Disorder and Associated Impairment

Clinicians often face several challenges in recognizing and diagnosing PTSD in children. Because misdiagnosis of PTSD as other psychiatric conditions such as bipolar disorder is common, clinicians need to be careful in assessing children for several key features of PTSD. To establish the diagnosis, a clinician needs to establish that a traumatic event preceded onset of the disorder, which he or she can determine either through compelling evidence or by reports given by the child or the child’s caregiver. This conclusion might be difficult given that avoidance of the trauma is a core feature of PTSD in children, and a parent might deny the trauma if he or she is the perpetrator, is ashamed or embarrassed about the trauma, or is unaware of it. In some instances, referral of the child for a forensic evaluation might be necessary.

Clinical diagnosis of PTSD in children also requires the presence of three distinct symptom clusters: (1) symptoms of re-experiencing the trauma, (2) emotional numbing and persistent avoidance of trauma reminders, and (3) persistent symptoms of hyperarousal. Young children might exhibit different behaviors, such as oppositionalism, fears unrelated to the traumatic event itself, and separation anxiety. Although acute stress disorder (ASD) can be diagnosed in children as soon as 2 days after the traumatic event, at least 1 month is required to make a PTSD diagnosis in children.

Intervention Strategies

The continued uncertainties of trauma identification and PTSD diagnosis increase the clinical challenges of addressing this population appropriately. Interventions designed to prevent or treat traumatic stress symptoms exist within the domains of psychotherapy, pharmacotherapy, complementary and alternative treatments, and other therapies such as systems or combination therapies. To provide a comprehensive review, we include all intervention domains for questions of treatments targeting children exposed to trauma, some of whom are already experiencing symptoms. Some of the intervention examples specified below focus solely on interventions for children exposed to trauma without requiring the
presence of any traumatic syndromes (treatment based on exposure), and others focus on interventions for children exposed to trauma and already experiencing traumatic symptoms or syndromes that exceed a predetermined threshold (treatment based on symptoms). For children who have been exposed to trauma but have not yet developed symptoms or syndromes, interventions are intended to prevent the onset of traumatic stress syndromes or PTSD. For children already experiencing such symptoms, treatments are intended to result in remission of PTSD, a reduction of symptoms, and improved functioning.

We also note settings when relevant. Interventions other than pharmacotherapy may be carried out at an individual, family, or group level. They may be carried out in various settings (including the outpatient versus inpatient setting) or in communities, schools, or classrooms. Many programs attempt to bring one of a variety of psychotherapeutic techniques into the home. In these circumstances, the training that parents and children receive differs very little from general psychotherapeutic techniques. The goal of these interventions, rather, is to improve access and outcomes in populations that are traditionally harder to reach such as ethnic minorities, rural populations, or people of low socioeconomic status. In addition to attempting to prevent PTSD or traumatic stress symptoms, these interventions are often directed at associated symptoms such as aggression or delinquency.

**Psychotherapy:** Interventions for Preventing or Treating Post-Traumatic Stress Disorder or Traumatic Stress Symptoms in Children Following a Potentially Traumatic Event

Several different psychotherapeutic interventions have been designed to prevent or treat PTSD or traumatic stress symptoms in children. Most of the approaches incorporate elements of cognitive behavioral interventions, and many include the caregiver(s) as an important component of the treatment. School-based interventions are unlikely to involve the primary caregivers in the treatment but have the advantage of intervening with larger numbers of children through group treatment. Cognitive behavioral components of these treatments may include psychoeducation, cognitive restructuring, relaxation training, and exposure therapy/desensitization (often through development of a trauma narrative). Interventions also vary in degree of structure, with the intervention manualized with specific concepts or techniques reviewed or taught during specific sessions. These manualized interventions may have the advantage of easier replication and may offer more guidance to the clinician. These time limited approaches may be especially advantageous when used in groups (e.g., school based interventions); at an individual level, more flexibility in the number of sessions and material covered in each session may be beneficial.
The following interventions have cognitive behavioral components and are used in both the prevention and treatment of traumatic stress symptoms: cognitive behavioral therapy (CBT), trauma-focused cognitive behavioral therapy (TF-CBT), cognitive processing therapy (CPT), child-parent psychotherapy (CPP), Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST), trauma and grief component therapy (TGCT), and Cognitive Behavioral Intervention for Trauma in Schools (CBITS).

CBT is a form of psychotherapy used to treat many psychiatric problems, including depression, anxiety, and PTSD. CBT combines elements of cognitive therapy and behavioral therapy. In CBT, maladaptive thought patterns are identified and targeted through cognitive restructuring, and maladaptive behaviors are targeted through behavioral techniques that may include exposure/desensitization, relaxation skills, and stress inoculation training or teaching an individual how to reduce anxiety. In addition to the more traditional use of CBT with individuals who are experiencing symptoms of traumatic stress, its components may be appropriate for use with children exposed to traumatic events.

TF-CBT is a psychotherapeutic technique that has specifically adapted CBT for use with children exposed to trauma and those presenting symptoms of traumatic stress. In TF-CBT, children and parents learn skills to help process thoughts and feelings related to traumatic life events and to manage and resolve distressing thoughts, feelings, and behaviors also related to those same events. Components of treatment include psychoeducation about trauma; parenting skills; relaxation skills; coping skills to deal with trauma-related thoughts, feelings, and behaviors; and child exposure tasks via narratives, drawings, or other imaginal methods. Safety and social skills training may also be a component of treatment.

CPT is a manualized 12-session cognitive behavioral treatment for PTSD that has a primary focus on challenging and modifying maladaptive beliefs related to the trauma but also includes a written exposure component. Clients are asked to write about the impact and content of the traumatic event. Associated problems such as depression, guilt, and anger are also addressed in CPT.

CPP is a relationship based treatment that integrates modalities derived from psychodynamic, attachment, trauma, cognitive behavioral, and social learning theories. The child-parent relationship is used to target the child’s improvement in emotional, cognitive, and social domains of functioning. The interventions focus on promoting affect regulation in the child and parent; changing maladaptive behaviors in the child, the mother, and their interaction; supporting and encouraging developmentally appropriate interactions and activities; and assisting the child and the mother in creating a joint trauma narrative. CPP has more traditionally been implemented with populations in which there were clinical
concerns about the child’s behavior or the mother’s parenting after the child witnessed or overheard marital violence and also with maltreating families. However, this intervention may also be appropriate for children soon after exposure to other traumatic events.

STAIR/NST is a two-module treatment focused on reducing symptoms of PTSD and other trauma-related symptoms (including depression and dissociation) and on building and enhancing specific social and emotional competencies that are frequently disturbed in youths who have experienced multiple traumas and/or sustained trauma. This intervention might also be used to prevent the development of traumatic stress symptoms when implemented after exposure to a traumatic event. STAIR/NST includes 10 treatment sessions conducted in group or individual format that target social and emotional competency building. The sessions focus on developing emotional regulation and social skills, positive self-definition exercises, and goal setting and achievement. The NST phase of treatment is conducted in 6 individual sessions that focus on the emotional processing of traumas in detail while developing a positive life narrative and future plan.

TGCT is a group treatment program for traumatically bereaved older school-aged children and adolescents. The target population includes youths affected by community violence, school violence, gang violence, war/ethnic cleansing, and natural and manmade disasters. TGCT has several areas of focus, including the processing of traumatic experiences, coping with reminders of trauma and loss, coping with post-traumatic adversities, managing traumatic grief, and resuming developmental progression. This intervention may be appropriate for children exposed to traumatic events and for those experiencing traumatic stress symptoms. Psychotherapeutic interventions have also been developed specifically for use in schools.

CBITS is a skills-based, group intervention for children exposed to trauma who are typically between the ages of 10 and 15 years; it may be appropriate not only for intervening early after exposure to a traumatic event but also for treating traumatic stress symptoms. The CBITS program consists of 10 group sessions designed to provide education about reactions to trauma, teach relaxation skills, provide cognitive therapy to challenge upsetting thoughts, teach social problem solving, and work on processing traumatic memories and grief. These skills are learned through the use of drawings and by talking in both individual and group settings. Between sessions, children complete assignments and participate in activities that reinforce the skills they have learned. Parent and teacher education sessions are also included.

Cognitive behavioral approaches are less applicable when working with younger children because of developmental issues, though the caregiver may benefit from
cognitive behavioral treatment. For this population, intervention approaches tend to be relationship based, and the primary focus of the intervention is centered around supporting the caregiver-child relationship as a strategy for treating traumatic stress in the young child.

In addition, psychotherapy treatment is sought traditionally when an individual is already experiencing symptoms of distress. However, professionals recognize that an effective strategy for reducing traumatic stress symptoms and disorders in children can be to intervene soon after an exposure to a potentially traumatic event but prior to the development of symptoms or a traumatic stress disorder. One intervention developed specifically to treat children exposed to a potentially traumatic event is the Child and Family Traumatic Stress Intervention (CFTSI). CFTSI is a four-session caregiver-child early intervention and secondary prevention model that focuses on increasing communication between children and their caregivers about feelings, symptoms, and behaviors with the goal of increasing the caregivers’ support of the child and teaching specific behavioral skills to both caregiver and child to assist the child in coping with symptoms. CFTSI’s focus is informed by findings that indicate the role of family support as a primary protective factor for children exposed to a potentially traumatic event.

Other psychotherapy approaches that may be beneficial in the treatment of children presenting with traumatic stress symptoms and disorders include dialectical behavior therapy (DBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), parent-child interaction therapy (PCIT), eye movement desensitization and reprocessing (EMDR), and trauma systems therapy (TST).

DBT is a psychotherapeutic approach that helps clients learn to both regulate and tolerate their emotions and may be appropriate for treating traumatic stress symptoms. Concrete skills are taught and practiced, including mindfulness practices from Eastern medicine. DBT combines standard cognitive behavioral techniques for emotion regulation with concepts of distress tolerance, acceptance, and mindfulness.

SPARCS is based on DBT. SPARCS is a group intervention designed to address the needs of chronically traumatized adolescents who may be living with ongoing stress and is intended to take place in a variety of settings, including schools, agencies, and residential treatment centers; it has been shown to decrease PTSD symptoms. These adolescents may experience problems in several areas of functioning, including difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing, and avoidance. SPARCS is predominantly cognitive behavioral; key components of the program include mindfulness, problem solving, relationship building/communication skills, and distress tolerance.
PCIT is a treatment that targets improvement in the quality of the parent-child relationship. Parents are taught skills that facilitate the establishment of a nurturing and secure relationship with their child while increasing the child’s prosocial behavior and decreasing negative behavior. The treatment includes a child-directed interaction that is similar to play therapy, with the goal of strengthening the parent-child relationship, and a parent-directed interaction, in which parents learn to use behavior management techniques as they play with their child. PCIT has been adapted for children who have experienced trauma and is most appropriate as a treatment of traumatic stress symptoms rather than as prevention of traumatic stress symptoms after exposure to a traumatic event.

EMDR is a psychotherapeutic approach in which the patient attends to past memories, present triggers, or anticipated future experiences while simultaneously moving his or her eyes back and forth following the therapist’s fingers as they move across the patient’s field of vision. Graduated imaginal exposure to the traumatic event(s) is combined with having the child visually track the therapist’s hand movements. The theoretical basis for EMDR is that PTSD symptoms result from insufficient processing or integration of sensory, cognitive, and affective components of the traumatic memory, and the eye movements are proposed to facilitate information processing and integration, thereby allowing patients to fully process traumatic memories. EMDR is an intervention that targets individuals who experience symptoms of traumatic stress.

TST is targeted toward children and adolescents who are having difficulty regulating their emotions as a result of the interaction between the traumatic experience and stressors in the social environment. TST is appropriate for individuals who are experiencing traumatic stress symptoms, but it might also be relevant for preventing traumatic stress symptoms when implemented after exposure to a traumatic event. Interventions include a focus on both the emotional regulation capacities of the traumatized child and the ability of the child’s social environment and system of care to help the child manage his or her emotions or to protect the child from threat. Treatment modules include home and community-based services, services advocacy, emotional regulation skills training, cognitive processing, and psychopharmacology.

*Pharmacotherapy*: Interventions for Preventing Post-Traumatic Stress Disorder or Traumatic Stress Symptoms in Children

Medication use in children who have experienced acute trauma or during their exposure to trauma to prevent the development of PTSD is intended to target memory consolidation and physiologic hyperarousal. A similar rationale supports use of the opioid analgesic morphine in the acute care setting in the prevention of PTSD, especially in the pediatric intensive care setting. In addition to treating the
pain from invasive medical procedures, morphine diminishes the memory consolidation that may accompany this pain. In addition, other medications, such as the alpha-agonist clonidine, are intended to diminish the physiologic symptoms of hyperarousal immediately following or during a traumatic event. Other medications that target physiologic hyperarousal and memory consolidation may also be used to prevent PTSD in exposed children.

Selective serotonin-reuptake inhibitors, or SSRIs, are a class of antidepressants that are among the most studied medications for PTSD treatment in children. SSRIs work by inhibiting the reuptake of serotonin and, therefore, increase the amount of serotonin in the synaptic cleft available to receptors on the postsynaptic neuron. Because they are the first line treatments for PTSD in adults, they are some of the most common medications used to treat PTSD in children as well. However, there has been no clear indication established for SSRI use as monotherapy (i.e., without psychotherapy) in children with PTSD.

Some studies conducted with the SSRIs sertraline and citalopram have indicated some therapeutic benefit in children and adolescents. In contrast, there have been few studies of fluoxetine or other SSRIs aimed at improving PTSD in children.

Other Antidepressants

Atypical antidepressants, such as bupropion, venlafaxine, and mirtazapine, are also commonly used to treat PTSD symptoms or PTSD associated symptoms. Imipramine is a tricyclic antidepressant that has shown promise as a PTSD treatment and was used frequently before the development of the SSRIs; however, cardiac side effects have significantly limited its use. In addition, the restricted diet that patients on monoamine oxidase inhibitors (MAOIs) must follow has also limited the use of MAOIs as a PTSD treatment.

Other Medications

Because childhood PTSD is so often associated with other comorbid mental conditions, numerous other medications are used to treat PTSD and have been studied. These medications are thought to work through various mechanisms.

- **Stimulants** such as methylphenidate and its derivatives and amphetamine preparations are used to treat PTSD-related symptoms of inattention and externalizing behaviors that are often confused with or misdiagnosed as attention deficit hyperactivity disorder (ADHD). Because PTSD often causes hyperarousal and associated physiologic changes, medications that treat these physiologic effects have also been studied in patients with PTSD. As mentioned earlier, the alpha agonist clonidine is thought to mainly target hyperarousal symptoms in PTSD. Propranolol, a beta-adrenergic blocking agent, has also had promising results as a treatment for PTSD in childhood.
• *Antipsychotics* have also been studied as a PTSD treatment because of their effects on comorbid aggression or psychotic symptoms. These medications include risperidone and quetiapine. In addition, clozapine has been shown to reduce both hallucinations and flashbacks to a traumatic event while reducing the number of medications required to treat children with PTSD. Because PTSD can often be accompanied by severe behavior problems and mood fluctuations, the mood stabilizers valproic acid, carbamazepine, and lithium have been studied in children with PTSD and are frequently used clinically.

• *Benzodiazepines*, another class of medication, have also been used to treat the severe anxiety that often accompanies PTSD. Medications in this class include clonazepam, diazepam, alprazolam, and lorazepam. The American Association of Child and Adolescent Psychiatry (AACAP) has advocated that these medications not be used to treat PTSD in children because of the risk for long-term cognitive effects, sedation, and the potential for tolerance and addiction.

**Complementary and Alternative Interventions for Preventing or Treating Post-Traumatic Stress Disorder or Traumatic Stress Symptoms in Children**

*Equine-assisted psychotherapy* is a specialized experiential approach to psychotherapy that uses a horse as a therapeutic tool. The goal is to encourage client insight through horse examples, addressing self-esteem and personal confidence; communication and interpersonal effectiveness; trust, boundaries, and limit setting; and group cohesion. Work is performed through the horse and supports and encourages the identification and expression of emotions.

**Other Interventions for Preventing Post-Traumatic Stress Disorder and Traumatic Stress Symptoms in Children**

Given that many traumatic events such as natural disasters or acts of terrorism can affect whole communities, community-based approaches have been developed to combat PTSD at its source or where chronic harm may be occurring. These approaches are outside of the traditional clinic setting and often allow clinicians an inside view of the context of the problem, which the patient is often unable to express during a clinic visit. These can be home- or school-based intervention programs or programs that partner with first responders or law enforcement to attempt to prevent or improve PTSD. Interventions may also encompass system-level, multicomponent, or other approaches (e.g., Web based). Two interventions designed to intervene early after exposure to traumatic events are critical incident stress debriefing (CISD) and Child Development-Community Policing (CD-CP). CISD is an intervention that targets individuals who have recently been exposed to a traumatic event. CISD is one of the first interventions created for police officers, first responders, and emergency medical technicians to use in the field with a
survivor of a traumatic event during the first 72 hours. The CD-CP program is a collaborative early intervention program that targets individuals exposed to violence and is the product of a partnership between mental health professionals at the Yale University Child Study Center and the New Haven Police Department. The goals of the program are to help children cope with traumatic events and prevent the development of traumatic stress symptoms.

**Current Child Traumatic Stress Guidelines**

Although there are no existing guidelines for other syndromes of childhood traumatic stress, three organizations—the AACAP, the International Society for Traumatic Stress Studies (ISTSS), and the National Institute for Health and Clinical Excellence (NICE)—have published guidelines on the treatment of PTSD during childhood and adolescence. These guidelines largely stem from expert consensus based on existing evidence and clinical practice rather than on formal Comparative Effectiveness Reviews. These guidelines use different categories of interventions to summarize evidence and offer inconsistent recommendations for some treatment categories or interventions. For instance, the AACAP notes that SSRIs can be considered as a treatment for children with PTSD; NICE concludes that there is insufficient evidence to recommend the use of any medication in young people with PTSD. Similarly, ISTSS considers the evidence on EMDR to be insufficient to make a definitive recommendation for the acute period; NICE suggests that EMDR shows promise despite the lack of rigorous testing in randomized controlled trials. The guidelines do suggest agreement on some issues. For example, both AACAP and ISTSS agree on the importance of considering comorbid psychiatric conditions and school-based treatment approaches. These guidelines are summarized below.

**American Academy of Child and Adolescent Psychiatry**

The Practice Parameter for the Assessment and Treatment of Children and Adolescents with Post-Traumatic Stress Disorder recommends early identification of PTSD, stresses the importance of gathering information from both children and parents to make valid diagnostic decisions, and highlights the importance of assessing and treating comorbid conditions of PTSD in children. Based on published randomized controlled trials (RCTs) conducted on children with PTSD, AACAP made seven recommendations regarding best treatment practices in accordance with the strength of the empirical evidence or clinical support for each treatment type. Recommendations based on rigorous empirical evidence and/or overwhelming clinical consensus (minimum standard) are as follows:
• Treatment planning should consider a comprehensive treatment approach that includes consideration of the severity and degree of impairment of the child’s PTSD symptoms.

• Treatment planning should incorporate appropriate interventions for comorbid psychiatric disorders.

• Trauma-focused psychotherapies should be considered first line treatments for children and adolescents with PTSD.

Recommendations that are acceptable based on emerging empirical evidence or clinical opinion but lack strong empirical evidence and/or strong clinical consensus (option) are as follows:

• SSRIs can be considered for the treatment of children and adolescents with PTSD.

• Medications other than SSRIs may be considered for children and adolescents with PTSD.

The recommendation based on strong empirical evidence and/or strong clinical consensus (clinical guideline) is as follows:

• Treatment planning may consider school-based accommodations.

The recommendation known to be ineffective or contraindicated (not endorsed) is as follows:

• The use of restrictive rebirthing therapies and other techniques that bind, restrict, withhold food or water, or are otherwise coercive is not endorsed.

International Society for Traumatic Stress Studies
Six guidelines for the treatment of PTSD in children and adolescents were published in “Effective Treatments for PTSD, Second Edition”:

• Acute interventions: Current evidence is insufficient to make a definitive recommendation regarding intervention selection or timing for systemic approaches, art and massage therapies, EMDR, debriefing, or cognitive behavioral approaches in the acute period.

• CBT: Several effective forms of CBT are available for clinicians to use with traumatized children and adolescents of diverse cultures. Trauma-focused forms of CBT effectively decrease PTSD symptoms and improvements with comorbid mental problems (e.g., depression and anxiety), behavioral problems, shame, grief, and adaptive functioning.
• Psychopharmacology: No medications are currently Food and Drug Administration (FDA)-approved for PTSD treatment in children. Studies testing the effectiveness of psychopharmacologic agents on children lag behind studies of adults; however, medication use in children has become the standard of care. Some evidence suggests that medication can help reduce PTSD symptoms. SSRIs appear to be a good first choice of agent. Severe comorbid psychiatric conditions might improve with the selection of an agent that can treat both PTSD and the comorbid condition.

• School based treatment: A handful of trauma-focused school based interventions have been empirically tested and shown to reduce corresponding PTSD symptoms and improve behavior. These programs are particularly helpful for children with limited access to clinic based treatment.

• Psychodynamic therapy: There is growing evidence for psychodynamic, relationship based therapy involving caregivers in treating childhood PTSD. Studies have indicated associated reduction in PTSD symptoms as well as improved developmental trajectories over time.

• Creative arts therapies: These therapies are currently under development and empirical testing has not occurred to enable a definitive recommendation. Despite this limitation, however, arts therapies appear to be promising.

National Institute for Health and Clinical Excellence
These guidelines make the following recommendations for psychological interventions for children with PTSD:

• Among children and young people who have been sexually abused, psychological interventions (specifically trauma-focused cognitive–behavioral psychotherapy) can be effective for the treatment of PTSD symptoms.

• There is very little evidence from RCTs for the efficacy of any psychological interventions for children or young people who suffer from PTSD arising from other forms of trauma.

• EMDR shows promise despite lack of rigorous testing in RCTs.

• Evidence examining the effectiveness and efficacy of PTSD treatment in children less than 7 years of age is weak, and conclusions about best practices cannot be made.

• Single-session debriefing is not recommended.
• With respect to pharmacological interventions for childhood PTSD, the NICE guidelines conclude that there is insufficient evidence to recommend the use of any medication in young people.

**Trauma**

**Key Question 1: Trauma-Focused Cognitive Behavioral Therapy**

This study identified four schools in a single city severely affected by an earthquake. Children in the sixth and seventh grades were selected for therapy 1.5 years after the earthquake. The method of selecting children was not reported. The mean age was 13.2 years. All children were exposed to serious direct threats to life, including witnessing mutilating injuries, agonizing screams of distress, and cries for help. Children were selected based on exposure to therapy, not on diagnosis or symptom score. No children were on psychotropic medicine or other mental health treatment. For the 1.5-year follow-up study, two schools closest to the study staff’s clinics were chosen for treatment, and two other schools served as the control condition. Children participated in four group sessions (30 minutes) and two individual sessions (60 minutes) of TF-CBT over 3 weeks. Outcome measures included traumatic stress symptoms (University of California-Los Angeles [UCLA] Post-Traumatic Stress Disorder Index [PTSD-RI scores] and depressive symptoms [Children’s Depression Scale])

**Key Points**

- **PTSD symptoms:** Participants in TF-CBT had greater decreases in PTSD symptoms than those in usual care in a single prospective cohort study (low SOE).
- **Depression symptoms:** Participants in TF-CBT had greater decreases in depression symptoms than those in usual care in a single prospective cohort study (low SOE).

**Key Points**

We found three studies that tested two school-based interventions that addressed KQ 1.

**ERASE Stress Versus Wait-List Control**

- **PTSD severity:** Participants in the ERASE Stress group had significantly greater decreases in PTSD symptom severity than wait-list group participants between baseline and follow up assessments in both studies (low SOE).
- **PTSD diagnosis:** Participants in the ERASE Stress group had significantly greater decreases in PTSD diagnosis in one study than waitlist group participants. The statistical significance of the comparison between ERASE
Stress group participants and wait-list control participants was unknown in the second study (low SOE).

- **Depression symptoms**: Participants in the ERASE Stress group had significantly greater decreases in depression symptoms than waitlist controls between baseline and follow-up assessments in both studies (low SOE).

- **Somatic complaints**: Participants in the ERASE Stress group had significantly greater decreases in somatic complaints than wait-list controls in one study. The differences in the second study are reported as significant, but the magnitude of the difference is unknown because of a data reporting error in the publication (low SOE).

- **Functional impairment**: Participants in the ERASE Stress group had significantly greater decreases in functional impairment than waitlist controls between baseline and follow-up assessments in both studies (low SOE).

Overshadowing the Threat of Terrorism Versus Wait-List Control, Study Characteristics

- **PTSD symptoms**: Participants in the OTT group had significantly greater reduction in PTSD symptoms between baseline and follow up than waitlist control participants (low SOE).

- **PTSD severity**: Participants in the OTT group had significantly greater reduction in PTSD severity between baseline and followup than waitlist control participants (low SOE).

- **PTSD diagnosis**: The statistical significance of the comparison of reduction in PTSD diagnosis between OTT and wait-list group participants is not reported (insufficient SOE).

- **Generalized anxiety symptoms**: Participants in the OTT group had significantly greater reduction in generalized anxiety symptoms between baseline and followup than waitlist control participants (low SOE).

- **Separation anxiety symptoms**: Participants in the OTT group had significantly greater reduction in separation anxiety between baseline and follow up than wait-list control participants (low SOE).

- **Somatic complaints**: Participants in the OTT group had significantly greater reduction in somatic complaints between baseline and follow up than waitlist control participants (low SOE).

- **Functional impairment**: Participants in the OTT group had significantly greater reduction in functional impairment between baseline and followup than waitlist control participants (low SOE).
Standardized instruments were used to assess acute stress disorder (ASD), PTSD (the German version of the CAPS-CA), depressive symptoms (using the German version of the Child Depression Inventory [CDI]) and behavioral problems.

- **PTSD symptoms**: Participants in early psychological intervention group had no difference in changes in PTSD symptoms pre to post-treatment than those in usual care in a single RCT (insufficient SOE).
- **Depression symptoms**: Participants in early psychological intervention group had no difference in changes in depressive symptoms pre to post-treatment than those in usual care in a single RCT (insufficient SOE).
- **Behavioral problems**: Participants in early psychological intervention group had no difference in changes in behavioral problems pre to post-treatment than those in usual care in a single RCT (insufficient SOE).

**Description of Included Studies**

Authors found one study conducted to evaluate beta-blocker medication’s effect targeting children exposed to trauma. We rated this study as having a low risk of bias.

The study recruited children ages 10 to 18 years who had been involved in multiple types of accidents, presented to an emergency room with injury in the United States, and were screened to have a high risk of developing PTSD. The population was recruited based on exposure to trauma but were all found to be “at risk” of developing PTSD at screening. Study participants were screened and enrolled in an emergency department in the midwestern United States. Medication was administered during admissions and as outpatients for 10 days.

**Key Points**

We found one study that tested beta-blocker medication that addressed KQ 1.

- **PTSD diagnosis and symptoms**: No differences between groups were found for changes in PTSD diagnosis or symptoms. We rated the SOE as insufficient for the efficacy of beta-blocker medication to decrease PTSD diagnosis and symptoms based on the conclusion of one study with imprecise estimates.
- **Physiologic reactivity**: No differences between groups were found for changes in heart rate reactivity. We rated the SOE as insufficient for the efficacy of propranolol to reduce the physiologic reactivity to trauma triggers based on the results of a single study.
Key Question 2: Trauma-Focused Cognitive Behavioral Therapy

Description of Included Studies

We found one RCT comparing trauma-focused cognitive behavioral therapy (TF-CBT) to waitlist control for the treatment of PTSD in children. This study was rated as having a low risk of bias.

Key Points

- **PTSD severity**: Participants in the TF-CBT intervention demonstrated significantly less PTSD symptomatology compared with waitlist control (low SOE).
- **PTSD diagnoses**: At post-treatment, a significantly greater number of TF-CBT participants were free of diagnosis compared with the waitlist control (low SOE).
- **Anxiety**: Participants in the TF-CBT group scored lower than the wait-list control group on anxiety measures (low SOE).
- **Depression**: Participants in the TF-CBT group scored lower than the wait-list control group on depression measures (low SOE).

Key Points

- **PTSD severity**: Participants in the CBITS intervention reported significantly lower symptoms of PTSD following intervention than wait-list control participants in one study and nonsignificant differences in the other study (low SOE).
- **Depression**: Participants in the CBITS intervention reported significantly lower levels of depression following intervention compared with waitlist control participants (low SOE).
- **Psychosocial dysfunction**: Parents of participants in the CBITS intervention group reported significantly less psychosocial dysfunction following intervention compared with parents of students in the wait-list control group (low SOE).
- **Acting out behaviors**: No differences in teacher-reported classroom acting out behavior in participants following CBITS intervention compared with waitlist controls (insufficient SOE).
• **Shyness/anxiousness**: No differences in teacher-reported shyness/anxiety in participants following CBITS intervention compared with waitlist controls (insufficient SOE).

• **Learning problems**: No differences in teacher-reported learning problems in participants following CBITS intervention compared with waitlist controls (insufficient SOE).

• **Problem behaviors (parent-rated)**: No differences in parent-reported problem behaviors in participants following CBITS intervention compared with waitlist controls (insufficient SOE).

• **Problem behaviors (teacher-rated)**: No differences in teacher-reported problem behaviors in participants following CBITS intervention compared with waitlist controls (insufficient SOE).

**Key Question 2: Cognitive Processing Therapy**

**Key Points**

• **PTSD severity**: Incarcerated male youth reported significantly fewer symptoms of PTSD after CPT treatment compared with wait-list controls (low SOE).

• **Depression**: Incarcerated male youth reported significantly lower levels of depression after CPT treatment compared with waitlist controls (low SOE).

**Key Points**

• **PTSD diagnosis**: Participants in the KIDNET (narrative exposure therapy) group did not have significantly different improvements in PTSD diagnoses at 1- or 6-month followups than participants in the MED-RELAX (active comparison) group (insufficient evidence).

• **Post-traumatic stress symptoms**: Participants in the KIDNET (narrative exposure therapy) group did not have significantly different improvements in PTSD symptoms at 1- or 6-month followups than participants in the MED-RELAX (active comparison) group (insufficient evidence).

• **Physical symptoms**: Participants in the KIDNET (narrative exposure therapy) group did not have significantly different improvements in physical symptoms at 1- or 6-month followups than participants in the MED-RELAX (active comparison) group (insufficient evidence).

• **Functioning problems**: Participants in the KIDNET (narrative exposure therapy) group did not have significantly different improvements in functioning problems 1- or 6-month followups than participants in the MED-RELAX
Key Question 2: Grief- and Trauma-Focused Interventions
Description of Included Studies
This study identified 56 children ages 7 to 12 years 4 months after exposure to Hurricane Katrina enrolled at a single elementary school. The subjects had to be identified from a single school as having experienced loss of home or loved one and experiencing at least moderate levels of post-traumatic stress symptoms. Children were excluded if they were less than 1 month from loss, actively suicidal, or considered inappropriate for group therapy. The study compared individual with group trauma and grief-focused therapy. The interventions used a manualized approach incorporating CBT and narrative exposure therapy. Each arm was designed with 10 1-hour weekly sessions and one parent meeting. Outcome measures included the PTSD symptom scores (UCLA PTSD Index), depressive symptoms (MFQ-C—Mood & Feelings Questionnaire), traumatic grief (Traumatic Grief Subscale of the UCLA Grief Inventory Revised), and global distress (single project-derived item). These outcomes did not vary by intervention group. The outcomes were assessed at the end of the intervention and at followup, which occurred an average of 20 days post-treatment. The treatment was delivered in the school. See Table 38 for study characteristics.

Key Points
• Post-traumatic stress symptoms: Participants in the individual therapy group did not have significantly different improvements in PTSD symptoms at the 20-day followup than participants in the group intervention (insufficient evidence).
• Depressive symptoms: Participants in the individual therapy group did not have significantly different improvements in depressive symptoms at the 20-day followup than participants in the group intervention (insufficient evidence).

Key Question 2: Eye Movement Desensitization and Reprocessing
Description of Included Studies
We found one study addressing eye movement desensitization and reprocessing (EMDR). This study was a randomized controlled trial (RCT) with waitlist control. This study identified 27 children ages 6 to 12 years an average of 8 months after admission to a hospital emergency room after a motor vehicle accident. The children had to have at least moderate post-traumatic stress symptoms. Children
were excluded if they were on psychotropic medicine, had concurrent psychological conditions, a past history of abuse or neglect, or a serious head injury. Children were randomized to active treatment with EMDR or a 6-week wait-list control. Participants participated in four 60-minute sessions of EMDR over 4 weeks. Outcomes measured included traumatic stress symptoms and diagnostic criteria for PTSD (PTSD Revised Index [RI] scores), depressive symptoms (Children’s Depression Scale), parent-reported internalizing and externalizing symptoms (Child Behavior Checklist), and parent-reported traumatic stress symptoms (Parent PTS Reaction Index [RI]).

Key Points

- **Children meeting two or more DSM criteria**: Significantly greater reduction in PTSD diagnosis (two or more DSM criteria for PTSD) in the EMDR group than in the wait-list control group (low strength of evidence [SOE]).
- **Reduction in PTSD symptoms**: Participants in the EMDR group had significant reductions in PTSD symptoms reported by the child and parent compared with the wait-list control group (low SOE).

**Key Question 2: School-Based Interventions**

Key Points

Trauma and Grief Component Therapy for Adolescents Plus Classroom-Based Psychoeducation and Skills Training Versus Classroom-Based Psychoeducation and Skills Training

- **PTSD symptoms**: Participants in the trauma and grief component therapy (TGCT) plus classroom-based psychoeducation and skills training group had significantly greater improvements in PTSD symptoms between baseline and followup than participants in the classroom-based psychoeducation and skills training only group (low SOE).
- **Depression symptoms**: Participants in the TGCT plus classroom-based psychoeducation and skills training group had significantly greater improvements in depression symptoms between baseline and followup than participants in the classroom-based psychoeducation and skills training only group (low SOE).
Cognitive Behavioral Therapy/Creative Expressive School-Based Group Intervention Versus Wait-List Control

- **PTSD symptoms:** Participants in the CBT/creative expressive school-based group had significantly greater reduction in PTSD symptoms between baseline and followup than wait-list control participants in one study and no significant difference in the other study (insufficient SOE).

- **Depression symptoms:** Participants in the CBT/creative expressive school-based group did not have significantly different changes in depression symptoms than wait-list control participants in either study (insufficient SOE).

- **Anxiety symptoms:** Participants in the CBT/creative expressive school-based group did not have significantly different decreases in anxiety symptoms than wait-list control participants in either study (insufficient SOE).

- **Functional impairment:** Participants in the CBT/creative expressive school-based group did not have significantly different changes in child-rated functional impairment than wait-list control participants in either study (insufficient SOE).

- **Functional impairment (parent-rated):** Participants in the CBT/creative expressive school-based group did not have significantly different changes in parent-rated functional impairment than waitlist control participants in one study. We found the evidence insufficient to draw a conclusion about the efficacy of CBT/creative expressive school-based group therapy versus waitlist control (insufficient SOE).

- **Aggression (parent-rated):** Participants in the CBT/creative expressive school-based group did not have significantly different changes in parent-rated aggression than waitlist control participants in one study. We found the evidence insufficient to draw a conclusion about the efficacy of CBT/creative expressive school-based group therapy versus waitlist control (insufficient SOE).

- **Psychological difficulties:** Participants in the CBT/creative expressive school-based group did not have significantly different changes in psychological difficulties than wait-list control participants in a single study (insufficient SOE).

- **Prosocial behaviors:** Participants in the CBT/creative expressive school-based group did not have significantly different changes in prosocial behaviors than wait-list control participants in a single study (insufficient SOE).
• **Supernatural complaints**: Participants in the CBT/creative expressive school-based group did not have significantly different changes in supernatural complaints than waitlist control participants in a single study (insufficient SOE).

• **Conduct problems**: Participants in the CBT/creative expressive school-based group had significantly greater decreases in conduct problems as compared with wait-list control participants in a single study (low SOE).

### Key Question 3: Subgroup Differences in Efficacy of Interventions Targeting Children Exposed to Trauma, Some of Whom Already Have Symptoms

#### Key Points

To address KQ 3, we found two studies that examined subgroup differences in the effectiveness or efficacy of interventions targeting exposure to trauma (n=1) and exposed to trauma and already experiencing symptoms (n=1).

**Trauma-Focused Cognitive Behavioral Therapy Versus No Treatment**

We identified one prospective cohort study comparing the effectiveness of a TF-CBT school-based intervention versus no treatment. This study targeted children in the sixth and seventh grades (mean age=13.2 years) 1.5 years after exposure to an earthquake resulting in serious direct threats to life, including witnessing mutilating injuries, agonizing screams of distress, and cries for help. Two schools closest to the study staff’s clinics were chosen for treatment and two other schools served as the control condition. The effectiveness of the intervention on outcomes was compared for girls versus boys.

• PTSD symptoms: – **Sex**: There were not significant differences in the effectiveness of the intervention on PTSD symptoms by sex (insufficient SOE).

• Depression symptoms: – **Sex**: There were not significant differences in the effectiveness of the intervention on PTSD symptoms by sex (insufficient SOE).

**Cognitive Behavioral Therapy /Creative Expressive School-Based Group Intervention Versus Wait-List Control**

We identified one RCT comparing the efficacy of a CBT/creative expressive school-based group intervention with that of a wait-list control. This study targeted children exposed to poverty or political violence/instability war who had significant PTSD and anxiety symptoms. Subgroup differences examined included age, exposure to violence, and sex.

• PTSD symptoms: – **Age**: There were no significant differences in efficacy of the intervention on PTSD symptoms by age (insufficient SOE). – **Exposure to...**
There were no significant differences in efficacy of the intervention on PTSD symptoms by exposure to violence (insufficient SOE).

− **Sex:** Intervention effect on reducing PTSD symptoms was significantly greater for female than male students (low SOE).

- **Functional impairment:**
  - **Age:** There were no significant differences in efficacy of the intervention on functional impairment by age (insufficient SOE).
  - **Exposure to violence:** There were no significant differences in efficacy of the intervention on functional impairment by exposure to violence (insufficient SOE).
  - **Sex:** Intervention effect on reducing functional impairment was significantly greater for female than male students (low SOE).

Cognitive Behavioral Therapy/Creative Expressive School-Based Group Intervention Versus Wait-List Control

**Key Points**

- **Attrition for psychotherapy interventions:** Because attrition may be an indicator of undetected harms, we evaluated the retention rates in intervention and control groups for nine psychotherapy interventions. The studies reported small or nonsignificant differences in retention between intervention and control groups. The small sample sizes and absence of information on reasons for attrition in many included studies makes it challenging to interpret this evidence as suggesting equivalence: we therefore grade the evidence as insufficient because the studies do not always attribute reasons for discontinuation.

- **Overall adverse events for TF-CBT:** Participants in the TF-CBT in both intervention and control groups did not exhibit any adverse events. We rated the evidence as insufficient because the small sample size was not likely to be powered adequately to test for equivalence in adverse events.

**Key Question 4: Harms in Interventions Targeting Children Exposed to Trauma: School-Based Interventions**

**Harms in School-Based Interventions**

We found nine studies examining KQ 1 and KQ 2 with school-based interventions. This trial evaluated an intervention of TGCT with classroom-based psychoeducation and skills training versus the classroom-based psychoeducation and skills training alone and addressed KQ 4.
Key Points

- **Adherence for school-based interventions**: Because adherence may be an indicator of undetected harms, we evaluated the adherence rates in intervention and control groups for six school-based interventions. The studies reported small differences in adherence between intervention and control groups. The small sample sizes and absence of information on reasons for low adherence in many included studies makes it challenging to interpret this evidence as suggesting equivalence: we therefore grade the evidence as insufficient because the studies do not all always attribute reasons for discontinuation or low adherence.

- **Posttraumatic stress for TGCT**: Participants in the TGCT intervention group did not exhibit any significant increase in reliable deterioration in post-traumatic stress. Because of the small sample size with wide confidence intervals, we graded the strength of evidence (SOE) as insufficient for the results of one study with imprecise estimates.

- **Depression for TGCT**: Participants in the TGCT intervention group did not exhibit any significant increase in reliable deterioration in depression. Because of the small sample size with wide confidence intervals, we graded the SOE as insufficient for the results of one study with imprecise estimates.

- **Traumatic grief for TGCT**: Participants in the TGCT intervention group did not exhibit any significant increase in reliable deterioration in traumatic grief. Odds ratios and confidence intervals were unable to be calculated owing to lack of participants with reliable deterioration. We graded the SOE as insufficient for the results of one study with imprecise estimates.

- **Existential grief for TGCT**: Participants in the TGCT intervention group did not exhibit any significant increase in reliable deterioration in existential grief. Odds ratios and confidence intervals were unable to be calculated owing to lack of participants with reliable deterioration. We graded the SOE as insufficient for the results of one study with imprecise estimates.

**Key Question 4: Harms in Interventions Targeting Children Exposed to Trauma: Medication Interventions**

Key Points: Imipramine Versus Chloral Hydrate or Placebo

- **Retention**: The studies did not report differential dropout rates; we graded the evidence as insufficient.

- **Overall adverse events or harms**: Participants in the imipramine intervention group did not exhibit any adverse events or harms in two studies. Because of
the small sample sizes of each study, short duration of treatment, no
significance given, and imprecise estimates, we graded the SOE as insufficient
for the results.

Key Points: Fluoxetine Versus Placebo

- **Retention:** The study reported a 5.3 percent difference in dropouts; we graded
the evidence, based on a single small study, as insufficient.

- **Overall adverse events or harms:** Participants in the fluoxetine intervention
group did not exhibit any adverse events or harms in the study; we graded the
evidence, based on a single small study, as insufficient.

Key Points: Sertraline Versus Placebo

A single study comparing sertraline to placebo reported numerous adverse events
but no significant differences between study arms. As a result, we graded the
following outcomes as insufficient for:

- Any adverse events
- Disturbed sleep
- Agitation
- Headache/abdominal pain
- Nausea
- Pharyngitis
- Vomiting
- Accidental injury
- Respiratory tract infections
- Diarrhea
- Dizziness
- Hyperkinesis
- Rhinitis

The study also reported some incidents of severe adverse events (undefined),
serious adverse events (undefined), dry mouth, and dysmenorrhea among patients
taking sertraline compared with none for patients in the placebo arm. The authors
did not run statistical tests that adjusted for zero-cell counts in the placebo arm. The study reported higher incidents of dropouts due to adverse events, increased suicidality ratings, and active suicidality in the sertraline arm compared with the placebo arm but did not report the results of statistical significance tests. We rated these outcomes also as insufficient.

**Key Findings and Strength of Evidence**

**Overview**

**Key Question 1: Treatment Based on Trauma Exposure**

We sought evidence on the effectiveness of interventions targeting children exposed to trauma on a range of traumatic stress, mental health, physical health, and other outcomes. These included the following:

- Prevention of and reduction in traumatic stress symptoms or syndromes (e.g., post-traumatic stress disorder [PTSD], acute stress disorder [ASD], developmental trauma disorder [DTD])
- Prevention of or reduction in mental health conditions or symptoms (e.g., depression, anxiety)
- Prevention of or reduction in physical health conditions or symptoms (e.g., sleep disorders, eating disorders, pain, overweight or obesity, asthma, cardiovascular problems, gastrointestinal problems, headaches)
- Reduction in risk-taking behaviors (including substance use), behavioral problems (including conduct disorder and attention deficit hyperactivity disorder [ADHD]), or criminal activities
- Healthy development, including improvements in interpersonal/social functioning or reductions in signs of developmental regression
- School-based functioning
- Improvements in quality of life
- Decreased suicidality

At least one outcome from each included study had to relate to the assessment of trauma symptoms or syndromes. We also included findings that showed non-beneficial outcomes associated with the intervention (e.g., no significant changes in outcomes between groups or significantly worse outcomes in the intervention group).
Already Having Symptoms
As in KQ 1, we sought evidence of the effectiveness of interventions designed to treat children exposed to trauma who were already experiencing symptoms on a variety of traumatic stress, mental health, physical health, and other outcomes. These included the following:

- Remission of PTSD
- Reduction in severity or number of traumatic stress syndromes or symptoms
- Prevention of or reduction in co-occurring mental health conditions or symptoms (e.g., depression, anxiety)
- Prevention of or reduction in co-occurring physical health conditions or symptoms (e.g., sleep disorders, eating disorders, pain, overweight or obesity, asthma, cardiovascular problems, gastrointestinal problems, headaches)
- Reduction in risk-taking behaviors (including substance use), behavioral problems (including conduct disorder and ADHD), or criminal activities;
- Healthy development including improvements in interpersonal/social functioning or reductions in signs of developmental regression
- School-based functioning
- Improvements in quality of life
- Decreased suicidality

As with KQ 1, at least one outcome from each included study had to relate to the assessment of trauma symptoms or syndromes. We also included findings that showed non-beneficial outcomes associated with the intervention (e.g., no significant changes in outcomes between groups or significantly worse outcomes in the intervention group).

Summary of Findings by Intervention
Fifteen studies reported on a subset of outcomes for 13 different interventions. Ten

Summary of Findings by Outcome

**Key Question 3**: Treatment Subgroup Comparisons for Interventions Targeting Children Exposed to Trauma, Some of Whom Already Have Symptoms

Our review found only two studies that examined subgroup characteristics that moderated the effect of the interventions tested by an interaction term. The TF-CBT study did not find any differences in relationship between intervention and PTSD symptoms or depression. The CBT study found no significant differences by
age group or exposure to violence with respect to PTSD symptoms or functional impairment. The study did, however, find significant differences by sex suggesting that the intervention effect on PTSD symptoms and functional impairment were greater for girls than boys.

**Key Question 4: Harms Associated With Interventions Targeting Children Exposed to Trauma, Some of Whom Already Have Symptoms**

Five studies reported harms associated with interventions. One study examined harms of TF-CBT versus waitlist control and found no adverse events in study group or control. No mention was made of how harms were assessed or evaluated.

A second study examined the harms of trauma and grief component therapy (TGCT) for adolescents with classroom-based psychoeducation and skills training versus the classroom- based psychoeducation and skills training alone. The study used a Reliable Change Index (RCI) for post-traumatic stress, depression, traumatic grief, and existential grief in order to quantify the number of reliably deteriorated cases. The authors found no significant differences in reliable deterioration for post-traumatic stress, depression, traumatic grief, and existential grief by study arm at post-treatment or at 4-month followup.

Three studies evaluated the harms of medications. Two studies found no adverse events for imipramine compared with chloral hydrate or placebo, or for imipramine compared with fluoxetine. These studies did not, however, report how adverse events or harms were assessed. One study found no significantly increased adverse events with sertraline in any adverse events, disturbed sleep, agitation, headache, abdominal pain, nausea, pharyngitis, vomiting, accidental injury, respiratory tract infections, diarrhea, dizziness, hyperkinesis, rhinitis, or by study arm. The study also reported some incidents of severe adverse events (undefined), serious adverse events (undefined), dry mouth, and dysmenorrhea among patients taking sertraline compared with none for patients in the placebo arm. The study reported higher incidents of dropouts due to adverse events, increased suicidality ratings, and active suicidality in the sertraline arm compared with the placebo arm but did not report the results of statistical significance tests.

**Findings in Relation to What Is Already Known**

Few systematic reviews have evaluated the treatment of traumatic stress in children; those that have done so have generally combined maltreatment as a form of trauma with single-episode exposure to trauma and trauma other than maltreatment. Because of the complicated relationship dynamics between a child and an abusive or neglectful parent, interventions might impact these groups differently. Generalizing the results of treatments found to be effective with a maltreated population to children with other types of trauma may mislead
clinicians and policymakers. In addition, the focus or essential components of treatments targeting maltreated children with traumatic stress may differ significantly. This review attempts to decrease the heterogeneity of the population, thereby increasing the specificity of results, by examining interventions targeting children exposed to potentially traumatic events other than child maltreatment.

Our view of the heterogeneity of this population reflects ongoing debates about diagnostic classification. Van der Kolk notes that a child who experiences trauma as a single isolated exposure may be more likely to present with a discrete conditioned or behavioral response.

Both CPP and PCIT include treatment components that may offer assistance to families with a child with traumatic stress other than maltreatment, particularly because they involve close collaboration with the caregiver. We found no evidence of these interventions that met our study criteria. In addition, the companion review that evaluated treatment of maltreated children found a few studies that tested interventions such as CPP or PCIT on outcomes such as recidivism and healthy caregiver-child relationships. The companion review found similar limitations as our review in volume and type of evidence: it found sparse evidence on interventions targeting maltreated children, with most trials being single studies that could not be combined, with low sample sizes and few head-to-head comparisons. Both reviews conclude that strong recommendations cannot be made based on the findings. Differences in interventions, outcomes, and patient characteristics across the two reviews precluded additional synthesis of the findings.

Symptoms of depression and anxiety are common among children with PTSD. Pharmacological interventions such as SSRIs and psychotherapy such as CBT that are effective in the treatment of depression and anxiety in children may also be found to be effective with children exposed to traumatic stress. TF-CBT is one such treatment that has been modified for use with children with traumatic stress.

Intervention

The evidence base reflects the diverse range of intervention approaches in the field. Several interventions noted in the evidence base were not found in this review. Only 4 interventions (2 ERASE Stress school-based mixed intervention trials and 2 CBITS trials) addressing KQ 2 were able to be combined in the evidence table. Most interventions varied in intensity as well, with delivery ranging from 4 to 20 sessions for the psychotherapies and from 1 to 10 weeks for medication administration in the pharmacotherapeutic interventions.

Conclusions
Our review uncovered a modest and heterogeneous body of evidence, marked by numerous interventions with a single study. We did not find studies that attempted to replicate findings of effective interventions; rather, studies tested unique interventions. No pharmacotherapy intervention demonstrated effectiveness; in one study of sertraline, children in the intervention arm tended to fare worse than those in the placebo arm. Studies demonstrating improvement in outcomes generally compared results of interventions with wait-list controls. With a single exception, studies comparing interventions with active controls did not show benefit. Some psychotherapy interventions targeting children exposed to trauma appear promising based on the magnitude and precision of effects found. These interventions were school-based treatments with elements of CBT. There was less compelling evidence regarding potentially promising interventions targeting children exposed to traumatic events already experiencing symptoms; each such intervention also had elements of CBT.

The body of evidence provides no insight on how interventions targeting children exposed to trauma or already experiencing traumatic stress symptoms might influence healthy long-term development. We found very little evidence on how effectiveness might vary by child characteristics and no evidence on how effectiveness might vary by treatment characteristics or setting. We also found almost no evidence on harms associated with psychological treatments. Only pharmacological interventions attempted to assess harms in this vulnerable population.

Our findings may be interpreted as a call to action: psychotherapeutic intervention may be beneficial relative to no treatment, but far more research is required to produce definitive guidance on the comparative effectiveness of psychotherapeutic or pharmacological interventions targeting children exposed to trauma, some of whom already have symptoms.

9. Disaster Crisis Counseling

9A. 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 (see Table 1-3);
- 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).

### 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 support to 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.

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.

For further information about disaster characteristics and phases, refer to the *Training Manual for Mental Health and Human Service Workers in Major Disasters* (DHHS).

**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 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.
9B. 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.

9C. Culture and Disaster

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.

Particularly during the “disillusionment phase” of the disaster, when intragroup 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.

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_

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.
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.

California Final Report

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).

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<td>Questions to Address in the Disaster Mental Health Plan</td>
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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?
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), presented in Table 2-1. The Cultural Competence Checklist for Disaster Crisis Counseling Programs, presented in Appendix F, summarizes key content in a convenient form for use in program planning.
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.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of disaster.
- Social support systems are crucial to recovery.

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 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).

REPORT

Concerns About Child Care Heightened by Bombing

Following the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, local mental health agencies mobilized to provide services to the survivors. One Latino child perished in the Murrah Building and several Latino children were wounded at the YMCA day care center. Mental health workers realized that they would have to address the concerns and guilt of Latino parents regarding child care because in this culture individuals generally resist using babysitters or placing their children in day care.

Oklahoma Application

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.

Guam Site Visit Report, 1998
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.
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, 1966). Disaster crisis counselors need to understand beliefs related to environmental control because such beliefs will affect survivors' behavior.
MAINTAIN A CURRENT PROFILE OF THE 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 when recruiting disaster mental health staff.

**TABLE 2 - 3**  
Staff 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,)*

**PROVIDE ONGOING CULTURAL COMPETENCE TRAINING TO DISASTER MENTAL HEALTH STAFF**

Cultural competence is an essential component of disaster mental health training programs. Training should be provided to help mental health workers acquire the values, knowledge, skills, and attributes needed to communicate and work in a
sensitive, nonjudgmental, and respectful way in cross-cultural situations. Such training should be provided to direct services staff, administrative and management staff, language and sign-language interpreters, and temporary staff.

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, 1998).

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—through in-service training and regularly scheduled meetings with project staff to discuss cultural competence issues—is essential (Hernandez and Isaacs).
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).

REPORT

Innovative Program Developed for Seniors

Following civil unrest in Los Angeles in 1993, a crisis counseling program was developed to assist the community. One element of this program was peer counseling with senior adults, including a group of elderly Samoans. No mental health professionals from the Samoan population could be found to help address the needs of these monolingual older adults in South Bay. Project staff worked with the head of the Samoan Council of Chiefs to offer a first-of-its-kind peer counselor training delivered via simultaneous translation. It worked beautifully. Twenty Samoans became deeply committed to counseling seniors in their community.

California Final Report,
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 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.

### REPORT

**Hurricane Response Designed to Be Culturally Competent**

Hurricane Hortense struck Puerto Rico in 1996 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.

*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.
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
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.

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.

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.

California Final Report
*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.

10. 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/

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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-COCAINEx
800-262-2463

888-MARIJUANAX
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/

GAMBLING

National Council on Problem Gambling
800-522-4700
http://www.ncpgambling.org/

GAY & LESBIANS

GLBT National Help Center
Gay, lesbian, bisexual and transgender national hotline
1-888-THE-GLNH (1-888-843-4564)
GRIEF & LOSS

Grief Recovery Institute
818-907-9600
http://www.grief.net/

HOMOSEXUALITY

GLBT National Help Center
Gay, lesbian, bisexual and transgender national hotline
1-888-THE-GLNH (1-888-843-4564)

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

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http://www.ed.gov/about/offices/list/ocr/index.html

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(800) 374-2722
http://www.apa.org/psycinfo/

Social Security Administration
(800) 772-1213
Medicare (800) 638-6833
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1-800-CDC-INFO
http://www.cdc.gov/hiv/

AIDS Clinical Trials Info Service
800-HIV-0440
http://www.aidsinfo.nih.gov/

Mental Health America State List:

MHA Arizona
Telephone: 1-800-642-9277
www.mhaarizona.org

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MHA California
Telephone: 916-557-1167
www.mhac.org

MHA Colorado
Telephone: 1-800-456-3249
www.mhacolorado.org

MHA Connecticut
Telephone: 1-800-842-1501
www.mhact.org

MHA Delaware
Telephone: 1-800-287-6423
www.mhainde.org

MHA DC
Telephone: 202-265-6363
www.mhadc.org

MHA Georgia
Telephone: 800-933-9896
www.mhageorgia.org

MHA Hawai'i
Telephone: 808-521-1846
www.mentalhealth-hi.org

MHA Illinois
 Telephone: 312-368-9070
www.mhai.org

MHA Indiana
Telephone: 1-800-555-MHAI(6424)
www.mentalhealthassociation.com

MHA Kentucky
Telephone: 888-705-0463
www.mhaky.org

MHA Louisiana
Telephone: 1-800-241-6425
www.mhal.org

MHA Maryland
Telephone: 800-572-MHAM(6426)
www.mhamd.org

MHA Michigan
Telephone: 248-647-1711
www.mha-mi.com

MHA Mississippi
Telephone: 228-385-1119
www.msmentalhealth.org

MHA for Eastern MO
(in St. Louis)
www.mha-em.org
MHA Montana
Telephone: 1-877-927-6642
www.montanamentalhealth.org

MHA Nebraska
Telephone: 888-902-2822
www.mha-ne.org

MHA New Jersey
Telephone: 973-571-4100
www.mhanj.org

MHA New Mexico
Telephone: 866-425-7030

MHA New York
Telephone: 1-800-766-6177
www.mhanys.org

MHA North Carolina
Telephone: 800-897-7494
www.mha-nc.org

MHA North Dakota
Telephone: 1-800-472-2911
www.mhand.org

MHA Oregon
Telephone: 503-725-5953
www.mhaoforegon.com
MHA Pennsylvania
Telephone: 866-578-3659
www.mhap.org

MHA Rhode Island
Telephone: 401-726-2285
www.mhari.org

MHA South Carolina
Telephone: 866-929-6145
www.mha-sc.org

MHA Tennessee
Telephone: 615-371-6116

MHA Texas
Telephone: 512-454-3706
www.mhatexas.org

MHA Virginia
Telephone: 1-866-400-6428
www.mhav.org

MHA Wisconsin
Telephone: 877-642-4630
www.mhawisconsin.org/
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Mental Health America Centers for Technical Assistance. (2012). *Trauma recovery and empowerment model (TREM)*. Alexandria, VA: Mental Health America Centers for Technical Assistance.


National Child Traumatic Stress Network, Child Sexual Abuse Task Force and Research & Practice Core. (2004). *How to implement trauma-focused cognitive*


Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA’s working definition of trauma and principles and guidance for a trauma-informed approach [Draft]*. Rockville, MD: Substance Abuse and Mental Health Services Administration.


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