BASED ON TIP 57

Trauma-Informed Care in Behavioral Health Services

QUICK GUIDE
FOR CLINICIANS

Substance Abuse and Mental Health Services Administration
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This Quick Guide is based entirely on information contained in TIP 57, published in 2014. No additional research has been conducted to update this topic since publication of TIP 57.

Why a Quick Guide?

This Quick Guide accompanies the service improvement guidelines set forth in *Trauma-Informed Care in Behavioral Health Services,* Number 57 in the Treatment Improvement Protocol (TIP) series. It summarizes the how-to information in TIP 57 pertinent to behavioral health counselors and clinicians, focusing on principles, tools, and approaches in providing trauma-informed care.

Users of this Quick Guide are invited to consult the primary source, TIP 57, for more information on specific strategies that promote trauma-informed care. To order a copy or access the TIP online, see the inside back cover of this Quick Guide.

DISCLAIMER

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA) or the U.S. Department of Health and Human Services (HHS). No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described are intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

What Is a TIP?

The TIP series provides professionals in behavioral health and related fields with consensus-based, field-reviewed guidelines on behavioral health topics of vital current interest. The TIP series is published by SAMHSA and has been in production since 1991.

TIP 57, *Trauma-Informed Care in Behavioral Health Services*:

- Lays the groundwork for the implementation and provision of trauma-informed services.
- Describes trauma-informed treatment principles.
- Provides an overview of traumatic experiences, including types of trauma and trauma characteristics.
- Addresses the socioecological and cultural factors that influence the impact of trauma.
- Focuses on the impact of trauma, trauma-related stress reactions and associated symptoms, and common mental health and substance use disorders associated with trauma.
- Introduces screening and assessment as they relate to trauma.
- Covers clinical issues that behavioral health professionals may need to address when treating clients who have histories of trauma.

- Presents information on specific treatment models for trauma, distinguishing integrated models from those that treat trauma alone.

Other TIPs of interest to readers include:

- **TIP 25:** *Substance Abuse Treatment and Domestic Violence*
- **TIP 36:** *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*
- **TIP 48:** *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery*
- **TIP 51:** *Substance Abuse Treatment: Addressing the Specific Needs of Women*
- **TIP 59:** *Improving Cultural Competence*

Note: You may download TIPs and other related products for free through the SAMHSA Store at http://store.samhsa.gov.

Introduction

Guidelines for Readers

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

TIP 57 provides evidence-based and best practice information for behavioral health service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions. TIP 57 addresses trauma-related prevention, intervention, and treatment issues and strategies across behavioral health settings.

Terminology

Retraumatization. This term not only refers to the effect of being exposed to multiple traumatic events, but also implies the process of reexperiencing traumatic stress as a result of a current situation that mirrors or replicates in some way the prior traumatic experiences

(e.g., specific smells or other sensory input; interactions with others; responses to one's surroundings or interpersonal context, such as feeling emotionally or physically trapped).

Secondary trauma. This term describes trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all settings and among all professionals who provide services to people who have experienced trauma (e.g., healthcare providers, peer counselors, first responders, clergy, intake workers).

Substance abuse. This term refers to both substance abuse and substance dependence. This term was chosen partly because behavioral health professionals commonly use " substance abuse" to describe any excessive use of addictive substances. In this Quick Guide, the term refers to the use of alcohol as well as other substances of abuse. Attend to the context in which the term occurs to determine what possible range of meanings it covers; in most cases, it will refer to all varieties of substance-related disorders as found in the *Diagnostic and Statistical Manual of*

Mental Disorders, Fifth Edition (American Psychiatric Association, 2013[1]).

Trauma. "Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p. 7[2]). Although many individuals report a single specific traumatic event, others, especially those seeking mental health or substance abuse treatment services, have been exposed to multiple or chronic traumatic events.

Trauma-informed care (TIC). A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute

[1] American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders.* (5th ed.). Arlington, VA: American Psychiatric Association.

[2] Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

or chronic. TIC involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

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

Before You Begin

Individuals who have experienced trauma are at an elevated risk for substance use disorders, including abuse and dependence, mental disorders (e.g., depression and anxiety disorders, impairment in relational/ social and other major life areas, other distressing symptoms), and physical disorders and conditions, such as sleep disorders. TIP 57 endorses a trauma-informed model of care, which holds that behavioral health practitioners and organizations need to recognize the prevalence and pervasive impact of trauma on the lives of the people they serve and develop trauma-responsive services.

Trauma and Substance Use Disorders

- Many people who have substance use disorders have experienced trauma as children or adults.
- Substance abuse predisposes people to higher rates of traumas, such as dangerous situations and accidents, while under the influence and as a result of the lifestyle associated with substance abuse.
- People who abuse substances and have experienced trauma have worse treatment outcomes than those without histories of trauma.
- More than half of individuals who seek substance abuse treatment report one or more lifetime traumas, and a significant number of clients in inpatient treatment also have subclinical traumatic stress symptoms or posttraumatic stress disorder.

Trauma and Mental Disorders

- Individuals in 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 also meet criteria for posttraumatic stress disorder (PTSD).
- Individuals with serious mental illness who have histories of trauma often present with other psychological symptoms or disorders commonly associated with trauma, including anxiety, mood disorders (e.g., major depression, dysthymia, bipolar 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. Research suggests that trauma often precedes the development of mental disorders.
- Mental illness increases the risk of experiencing trauma, and trauma increases the risk of developing psychological symptoms and mental disorders.

Trauma-Informed Treatment Principles

1. Promote Trauma Awareness and Understanding

As a counselor, you must recognize the prevalence of trauma and its possible role in your clients' emotional, behavioral, cognitive, spiritual, and/or physical development and presentation. By being vigilant about the prevalence and potential consequences of traumatic events among clients, you can then tailor your style, approach, and strategies from the outset to plan for and be responsive to their specific needs. Although not every client has a history of trauma, it is important to know that those who have substance use and mental disorders are more likely to have experienced trauma.

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

Appreciating clients' perception of their presenting problems and viewing their responses to the impact of trauma as adaptive—even when you believe that their methods of dealing with trauma have been detrimental—are equally important elements of TIC. Once you begin to view your clients' behaviors as adaptive, your identification and classification of their presenting symptoms and behaviors can shift from a "pathology" mindset (i.e., defining clients strictly

through a diagnostic lens, 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. You will come to view traumatic stress reactions as normal reactions to abnormal situations.

3. View Trauma in the Context of Individuals' Environments

To understand trauma adequately, you must consider the contexts in which it occurred. Individual attributes, developmental factors (including protective and risk factors), life history, type of trauma, specific characteristics of the trauma, amount and length of trauma exposure, cultural meaning of traumatic events, number of losses associated with the trauma, available resources (internal and external, such as coping skills and family support), and community reactions are a few of the determinants that influence a person's responses to trauma across time. Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens.

4. Minimize the Risk of Retraumatization or Replicating Prior Trauma Dynamics

A trauma-informed approach begins with taking practical steps to reexamine treatment strategies, program procedures, and organizational polices that could solicit distress or mirror common characteristics

of traumatic experiences (e.g., loss of control, being trapped, feeling disempowered).

Potential Treatment Issues That Can Cause Retraumatization

- Using seclusion, restraint, or "time-out" practices that isolate individuals
- Mislabeling client symptoms as personality or other mental disorders, rather than as traumatic stress reactions
- Being overly authoritative when interacting with clients
- Giving treatment assignments that could humiliate clients (e.g., asking a client to wear a sign in group that reflects one of his or her treatment issues, even if the assignment centers on positive attributes of the client)
- Using a confrontational approach
- Presenting treatment as conditional on conformity to the counselor's beliefs and definitions of issues
- Challenging or discounting reports of abuse or other traumatic events
- Allowing the abusive behavior of one client toward another to continue without intervention
- Labeling client behavior/feelings as pathological
- Being unaware that the client's traumatic history significantly affects his or her life

Clients' experiences are unique to the specific traumas they have faced and the circumstances they experienced before, during, and after trauma, so remember that even seemingly safe and standard treatment policies and procedures may feel quite the contrary for clients if an element of those processes is reminiscent of their experience of trauma in some way. Trauma-informed providers anticipate and respond to practices that clients may potentially perceive as retraumatizing.

5. Create a Safe Environment

As a counselor, you need to be responsive in adapting the environment to establish and support clients' sense of physical and emotional safety. Beyond anticipating that various environmental stimuli within a program may generate strong emotions and reactions in trauma survivors and implementing strategies to help clients cope with triggers that evoke their experiences with trauma, other key elements in establishing a safe environment include consistency in client interactions and treatment processes, follow-through with what has been agreed on in sessions or meetings, and dependability. Creating safety is about how consistently and forthrightly you handle situations with clients when circumstances provoke feelings of being vulnerable or unsafe. Honest and compassionate communication that conveys a sense of handling the situation together generates safety.

6. Identify Recovery From Trauma as a Primary Goal

It is important that you help clients bridge the gap between their mental health and substance-related issues and the traumatic experiences they may have had. All too often, trauma occurs before substance use and mental disorders develop; then, such disorders and their associated symptoms and consequences create opportunities for additional traumatic events to occur. If individuals engage in mental health and substance abuse treatment without addressing the role that trauma has played in their lives, they are less likely to experience recovery in the long run. For example, a person with a history of trauma is more likely to have anxiety and depressive symptoms, use substances to self-medicate, and/or relapse after exposure to trauma-related cues.

7. Support Control, Choice, and Autonomy

Gaining a sense of control and empowerment, along with an understanding of traumatic stress reactions, is pivotal to recovery. By creating opportunities for empowerment, you may help reinforce clients' sense of competence, which is often eroded by trauma and prolonged traumatic stress reactions. Keep in mind that treatment strategies and procedures that prioritize client choice and control need not focus solely on major life decisions or treatment planning. You can apply such approaches to common tasks and everyday interactions between staff and consumers.

8. Create Collaborative Relationships and Participation Opportunities

Individuals affected by trauma present an array of reactions, various levels of trauma awareness, and different degrees of urgency in their need to address trauma. By taking the time to understand the ways in which each client has perceived, adjusted to, and responded to traumatic experiences, providers are more likely to project the message that clients possess valuable personal expertise and knowledge about their own presenting problems. This shifts the viewpoint from, "We, the providers, know best," to the more collaborative, "Together, we can find solutions."

To achieve trauma-informed competence in an organization or across systems, clients need to play an active role. This starts with providing program feedback. It also means giving clients/consumers the chance to obtain state training and certification, as well as employment in behavioral health settings as peer specialists. Programs that incorporate peer support services reinforce a powerful message: that provider–consumer partnership is important, and that consumers are valuable.

9. Familiarize Clients With Trauma-Informed Services

Familiarizing clients with trauma-informed services extends beyond explaining program services or

treatment processes; it involves explaining the value and types of trauma-related questions that may be asked during an intake process, educating clients about trauma to help normalize traumatic stress reactions, and frequently discussing trauma-specific interventions and other available services (including explanations of treatment methodologies and of the rationale behind specific interventions).

10. Conduct Universal Routine Trauma Screening

Although most providers know that individuals can be affected by trauma, universal screening provides a reminder to be watchful for past traumatic experiences and their potential influence on clients' interactions and engagement with services across the continuum of care. Screening should guide treatment planning; it alerts 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 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).

11. View Trauma Through a Sociocultural Lens

To understand how a traumatic event affects an individual, family, or community, you must first

understand life experiences and cultural background as key contextual elements for that trauma. Many factors shape traumatic experiences and individual and community responses to them; one of the most significant factors is culture. Culture influences the interpretation of traumatic events, individual beliefs about personal responsibility for the trauma and subsequent responses, and the meaning and acceptability of symptoms, support, and help-seeking behaviors.

12. Use a Strengths-Focused Perspective To Promote Resilience

Fostering individual strengths is a key step in prevention when working with people who have been exposed to trauma. Knowledge of a client's strengths can help you understand, redefine, and reframe the client's presenting problems and challenges. By focusing and building on an individual's strengths, counselors and other behavioral health professionals can shift the focus from, "What is wrong with you?" to, "What has worked for you?"

13. Foster Trauma-Resistant Skills

Building trauma-resistant skills begins with normalizing the symptoms of traumatic stress and helping clients who have experienced trauma connect the dots between current problems and past trauma when appropriate. Developing trauma resistance focuses on developing self-care skills, coping strategies, supportive networks, and a sense of competence.

Using Strengths-Oriented Questions

Here are a few potential strengths-oriented questions:

- What behaviors have helped you survive during and after your traumatic experiences?
- What are some of the creative ways that you deal with painful feelings?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?

14. Show Organizational and Administrative Commitment to TIC

Becoming a trauma-informed organization requires administrative guidance and support. Agencies need to embrace specific strategies across each level of the organization to create trauma-informed services; this begins with staff education on the impact of trauma among clients. For more information on implementing TIC in organizations, see Part 2, Chapter 1 of TIP 57.

15. Develop Strategies To Address Secondary Trauma and Promote Self-Care

Secondary trauma is a normal occupational hazard for mental health and substance abuse professionals,

particularly those who serve populations that are likely to include survivors of trauma. The demands of providing care to trauma survivors cannot be ignored. Symptoms of secondary trauma may include physical or psychological reactions to traumatic memories that clients have shared; avoidance behaviors during client interactions or when recalling emotional content in supervision; numbness, limited emotional expression, or diminished affect; somatic complaints; heightened arousal, including insomnia; negative thinking or depressed mood; and detachment from family, friends, and others. Symptoms may or may not meet diagnostic thresholds for acute stress, posttraumatic stress, or anxiety or mood disorders.

16. Provide Hope—Recovery Is Possible

Providing hope involves projecting an attitude that recovery is possible. This attitude also involves viewing clients as competent to make changes that will allow them to deal with trauma-related challenges, providing opportunities for them to practice dealing with difficult situations, and normalizing discomfort or difficult emotions and framing these as manageable rather than dangerous. If you convey this attitude consistently to your clients, they will begin to understand that discomfort is not a signal to avoid, but a sign to engage—and that behavioral, cognitive, and emotional responses to cues associated with previous traumas are a normal part of the recovery process.

Decreasing the Risk of Secondary Trauma and Promoting Self-Care Among Counselors

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

Types of Trauma: Natural or Human-Caused

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).

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 a bridge collapse due to structural deterioration. The reactions to these traumas often depend on the intentionality of the trauma. 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 oversight. After intentionally 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).

Characteristics of Trauma

Objective characteristics are the tangible or factual elements of a traumatic event; subjective characteristics include internal processes, such as determining the personal meaning of the trauma.

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 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 survivors of repeated trauma. Repetitive exposure to traumas can also have a cumulative effect over an individual's lifetime. 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; individuals 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.

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. In other cases, there is ample time to process an event, but processing is limited due to a lack of supportive relationships or environments. This can lead to greater vulnerability to traumas that occur further down the road.

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.

Was the trauma expected or unexpected?

Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common ingredients of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. 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 individuals perseverate on these thoughts for months or years after the event.

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

When individuals remain in the vicinity of the trauma, they are more likely to encounter greater challenges in recovery (e.g. living in close proximity of a murdered family member). 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.

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.

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.

Was the trauma experienced directly or indirectly?

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 to the situation, their relationship to the victims, the degree of helplessness surrounding the experience, their exposure to subsequent consequences, and so on.

Historical Trauma

The effects of traumas like genocide, slavery, and internment in concentration camps can stretch across generations. Stories, coping behaviors, and stress reactions can cross generational lines far removed from the actual event(s) or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

What has happened since the trauma?

It is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, daily routines, community, behavioral health services, housing, local stores, and recreational areas. Such losses will likely erode the sense of safety in individual lives and communities. Hence, the inability to resume normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders.

Subjective Characteristics

The psychological meaning of trauma

An important clinical issue in gauging the impact of trauma is understanding the meaning that the survivor has attached to the traumatic experience. For example, what does the trauma mean? How does the individual

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

attach meaning to his or her survival? Does he or she believe that the trauma is a sign of a greater purpose not yet revealed? People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience.

Disruption of core assumptions and beliefs

Often, individuals report that they no longer see life the same way after a traumatic experience. Trauma can alter core beliefs and assumptions about life—beliefs and assumptions that provide meaning and a way to organize one's life and one's interactions with the world and others. Consider asking whether a client's core beliefs about life (e.g., about safety, perception of others, fairness, purpose of life, future dreams) were challenged or disrupted during or after the traumatic event.

The following questions can help you address assumptions, beliefs, interpretations, and meanings related to trauma:

- In what ways has your life been different since the trauma?
- What does the trauma mean to you?

- How do you understand your survival?
- Do you believe that there are reasons that this event happened to you? What are they?
- 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? How so?
- Do you view others and your future differently since the trauma? How so?

Cultural meaning of trauma

Culture strongly influences perceptions of trauma. You must recognize that your perceptions of a specific trauma could be very different from your clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system. For more information on culture and how to achieve cultural competence in providing behavioral health services, see TIP 59, *Improving Cultural Competence.*

Common Experiences of and Responses to Trauma

Emotional

Beyond initial emotional reactions during traumatic event(s), the symptoms most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying emotional reactions for various reasons.

Emotional dysregulation

Some trauma survivors have difficulty regulating emotions, especially when the trauma occurred at a younger age. Traumatic stress tends to evoke two emotional extremes: feeling either too much or too little emotion. 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 helping them learn how to use new coping skills and how to tolerate distressing emotions. Some clients may benefit from mindfulness and cognitive–behavioral strategies.

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. Because numbing symptoms hide what is going on inside emotionally, there can be a tendency on the part of family members, counselors, and other behavioral

health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Physical

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, and chronic health conditions. Common physical disorders and symptoms related to trauma include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Somatization

Somatization is the process of focusing on bodily symptoms or dysfunctions as a way to express emotional distress. Many individuals who present with somatization are unaware of the connection between their emotions and the physical symptoms they are experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Somatic symptoms are more likely to occur with individuals

who have traumatic stress reactions, including PTSD. So too, individuals from certain ethnic and cultural backgrounds may initially or solely present emotional distress through physical ailments or concerns. However, you should not 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. Be sure to refer them for medical evaluation.

Hyperarousal

Hyperarousal (also called hypervigilance) is a consequence of biological changes initiated by trauma. It is the body's way of remaining prepared. Hyperarousal is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses, and it can persist for years after trauma occurs. 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. Hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Sleep disturbances

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. Sleep disturbances come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Triggers or cues

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. 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. 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 represents a previous trauma. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback occurs when one reexperiences a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble one'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, but not necessarily, initiated by a trigger. 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). Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

If a client is triggered or has a flashback in a ses sion or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Offer edu cation about the experience of triggers and flash backs, and then normalize these events as common traumatic stress reactions.

Trauma-induced hallucinations or delusions

Trauma-induced hallucinations and delusions contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as a child, because he wears shoes similar to those her father once wore).

Cognitive

Traumatic experiences can alter cognitions. 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 that negative outcomes will persist for the foreseeable future.

Foreshortened future

Trauma can affect beliefs about the future. Some clients may experience loss of hope about the future, limited expectations about life, suspicion that life will end abruptly or early, or anticipation that normal life events will not occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

Disruption of core beliefs

Trauma challenges the concept of a just world and the core life assumptions that help individuals navigate daily life. It would be difficult to leave the house if you believed that the world were not safe, that all people were dangerous, or that life held no promise. Belief that one's efforts and intentions can protect against bad things lessens perceive personal vulnerability. Traumatic events—particularly if they are unexpected—can challenge such beliefs.

Cognitions and Trauma

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

- **Cognitive errors:** Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma.
- **Excessive or inappropriate guilt:** Attempting to make sense of and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.
- **Intrusive thoughts and memories:** Involuntarily experiencing, without warning, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. Intrusions can come rapidly, known as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while.

Perceptions of self and others

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. Traumas that generate shame will often lead survivors to feel more alienated from others, sometimes through believing that they are "damaged goods." Often, survivors 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.

Dissociation

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. Disassociation is a mental process that severs connections amongst 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 to 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. However, 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.

Behavioral

Often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of a 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 attempt to gain control over their experiences by being aggressive or subconsciously reenacting an aspect of the trauma.

Reenactments

A hallmark symptom of trauma is reexperiencing the trauma in various ways. Reexperiencing can occur through reenactments, by which traumatized individuals 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 9/11. 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: walking alone in unsafe areas, driving recklessly, or involving oneself repeatedly in destructive relationships.

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.
- Increased commitment to a personal mission.
- Revised priorities.
- Increased charitable giving and volunteerism.

Self-destructive and self-harming behaviors

Self-destructive behaviors include substance abuse, restrictive or binge eating, reckless driving, or high-risk impulsive behavior. 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." 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.

It is important to distinguish self-harm that is suicidal from self-harm that is nonsuicidal 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—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.

Substance use and abuse

Substance use often begins or increases after trauma. Clients who are in early recovery—especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. 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.

Avoidance

Avoidance often coincides with anxiety. 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). Avoidance can come in many forms. When people cannot tolerate strong affect associated with traumatic memories, they may avoid, project, deny, or distort their trauma-related emotional and cognitive experiences.

Screening and Assessment

Why screen universally for trauma in behavioral health services? Exposure to trauma is common; in many surveys, more than half of respondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders. Moreover, behavioral health problems, including substance use and mental disorders, are harder to treat if trauma-related symptoms and disorders aren't detected early and treated effectively.

Unrecognized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psychological symptoms or substance use, and poorer outcomes. Trauma screening can also prevent misdiagnosis and inappropriate treatment planning, given that people with histories of trauma often display symptoms that meet criteria for other disorders.

Screening

The most important areas to screen among individuals with trauma histories include:

- Trauma-related symptoms.
- Depressive symptoms.
- Sleep disturbances.
- Past and present mental disorders, including trauma-related disorders.

- Type and characteristics of trauma.
- Substance abuse.
- Social support, coping styles, and availability of resources.
- Risks for self-harm, suicide, and violence.
- Health screenings.

Ten General Guidelines in Screening and Assessing Clients With Trauma

1. Ask all clients about any possible history of trauma.

2. Use only validated instruments for screening and assessment.

3. Early in treatment, screen all clients who have histories of exposure to traumatic events for psychological symptoms and mental disorders related to trauma.

4. When clients screen positive for trauma, also screen for suicidal thoughts and behaviors.

5. Do not delay screening for trauma; do not wait for a period of abstinence or stabilization of symptoms.

6. 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).

7. Do not require clients to describe emotionally overwhelming traumatic events in detail.

PC-PTSD Screen

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

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

Scoring: 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.

Source: Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., et al. (2004). The Primary Care PTSD Screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry*, *9*, 9 -14. Material used is in the public domain.

8. Focus assessment on how trauma symptoms affect clients' current functioning.

9. Consider using paper-and-pencil instruments for screening and assessment as well as self-report measures when appropriate, as they can be less threatening for some clients than a clinical interview.

10. Talk with each client about how you will use findings to plan the client's treatment, and at the end of the session, make sure the client is grounded and safe before leaving the interview room.

Assessment

A positive screening calls for further action—an assessment that evaluates 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. Assessments can require more than a single session to complete and should also use multiple avenues to obtain 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.

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.
- Approach the client in a matter-of-fact, yet supportive, manner.
- Respect the client's personal space.
- Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process.
- Provide culturally appropriate symbols of safety in the physical environment.
- Overcome linguistic barriers by using an interpreter.
- Only elicit information necessary to determine a history of trauma and the possible existence/extent of traumatic stress symptoms and related disorders.
- When possible, use self-administered, written instruments to assess trauma.
- An interview is best if a client has trouble reading or writing or is otherwise unable to complete a written instrument. If a client has intense emotional responses when recalling or acknowledging a

trauma, give the client time to become calm and oriented to the present.

- Provide feedback about the results of the screening.
- Be aware of the possible legal implications of assessment.

Trauma-Informed Treatment Objectives and Strategies

The following material highlights key trauma-informed treatment objectives and strategies. For some individuals, psychoeducation and development of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions.

Establish Safety

Beyond the identification of trauma and trauma-related symptoms, the initial objective is establishing safety. 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.

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. 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.

Prevent Retraumatization

Treatment settings and clinicians can unintentionally create retraumatizing experiences.

Strategies To Prevent Retraumatization

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

Strategy #2: When clients with trauma histories act out in response to triggered trauma memories, ignoring their symptoms and demands is likely to 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 in 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/behavior.

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.

Strategies for Implementing Psychoeducation

Strategy #1: Psychoeducation begins with understanding the client's expectations and reasons for seeking help, followed by educating the client and his or her family members about the program.

Strategy #2: After obtaining acknowledgment of a trauma history, it is good practice to provide an overview of common symptoms and consequences of traumatic stress, regardless of whether the person affirms having trauma-related symptoms.

Strategy #3: Develop a resource box that provides an array of printed or multimedia educational materials that address the program, specific trauma-related symptoms and tools to combat them, 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.

Offer Trauma-Informed Peer Support

The experience of trauma can reinforce beliefs about being different, alone, and marred by the experience. Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress. Peer support provides opportunities to form mutual relationships, to move beyond trauma, and to mirror and learn alternate coping strategies. Peer support defines recovery as an interactive process.

Strategies To Enhance Peer Support

Strategy #1: Provide education on what peer support is and is not. 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.

Normalize Symptoms

A significant step in addressing symptoms is normalizing them. Specifically, individuals with traumatic stress symptoms need to understand that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms provides considerable relief to clients.

Strategies To Normalize Symptoms

Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress.

Strategy #2: Provide education to the client that addresses his or her most prevalent symptoms.

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 more on how the symptoms have served the client in a positive way. This exercise can be difficult, because clients as well as counselors often don't focus on the value of symptoms.

Identify and Manage Trauma-Related Triggers

Many clients who have traumatic stress are caught off guard by intrusive thoughts, feelings, sensations, or

environmental cues related to the trauma. Often, clients will not draw immediate connections between the internal or external trigger and their reactions.

Strategies To Identify and Manage Trauma-Related Triggers

Strategy #1: Use the "Cognitive Realignment" technique to help separate the current situation from the past trauma. Identify one trigger at a time, and then discuss the following questions:

- When and where did you begin to notice a reaction?
- How does this situation remind you of your past history or past trauma?
- How are your reactions to the current situation similar to your past reactions to the trauma(s)?
- How was this current situation different from the past trauma?
- How did you react differently to the current situation than to the previous trauma?
- How are you different today (e.g., factors such as age, abilities, strength, level of support)?
- What choices can you make that are different from those you made in the past and that can help you address the current situation (trigger)?

Strategy #2: After the client identifies the trigger and connects the trigger to past trauma, work with him or her to establish responses and coping strategies to

deal with triggers as they occur. Initially, the planned responses will not occur right after a trigger, but with practice, the planned responses will move closer to the time of the trigger.

Strategy #3: Use self-monitoring by asking the client to record each time a trigger occurs, along with describing the trigger and its intensity level (using a scale from 1–10). Clients and counselors will gain an understanding of the type of triggers present and the level of distress that each one produces.

OBSERVATIONS: A 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

A goal of treatment for trauma survivors is helping them become more aware 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.

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. However, use writing with caution, as some may find that it brings up too much intense trauma material too soon. Journal writing is safest when you ask clients to write about the present, such as logging their use of coping strategies or identifying strengths with supporting examples.

Strategy #2: Encourage clients to explore the links among traumatic experiences and mental and substance use disorders.

Teach Balance

Working with trauma is a balancing act between the development and/or use of coping strategies and the need to process traumatic experiences. People 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.

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.

You and your clients need to negotiate a thin line when addressing trauma. Too much work focused on highly distressing content can cause clients to dissociate, shut down, or become emotionally overwhelmed. Conversely, too little on trauma can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Strategy To Teach Balance

Strategy #1: Teach and use the Subjective Units of Distress Scale (SUDS) in counseling. It provides a common language for the client and counselor, and it can also be used to guide the intensity of sessions. SUDS can show a client's progress in managing experiences. SUDS uses a 0–10 rating scale, with 0 representing content that causes no or minimal distress and 10 representing content that is exceptionally distressing and overwhelming.

Build Resilience

Survivors are resilient! Establish a strengths-based approach by building clients' resilience.

Strategies To Build Resilience

Strategy #1: Help clients reestablish personal and social connections.

Strategy #2: Encourage clients to take action. Recovery requires activity.

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

Strategy #4: Help clients recall how they successfully handled hardships in the past, such as the loss of a loved one, a divorce, or a major illness.

Strategy #5: Help keep things in perspective. Even when facing painful events, all things pass.

Strategy #6: Help maintain hope. 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.

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

Address Sleep Disturbances and Disorders

Sleep disturbances are among the most enduring symptoms of traumatic stress and are particularly common with severe and prolonged trauma. Sleep disturbances also increase one's risk of developing traumatic stress. In general, people with sleep disturbances have worse general health and quality of life. Sleep disturbances vary among clients with trauma histories and can include decreased ability to stay asleep, frequent awakenings, early morning or unintentional awakening, sleep aversion, nightmares, trouble falling asleep, poor quality of sleep, and disordered breathing during sleep.

Strategies for Sleep Intervention

Strategy #1: Conduct a sleep history assessment focused first on the client's perception of his or her sleep patterns. 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.

Strategy #4: Reassess sleep patterns and history during treatment. Sleep patterns often reflect clients' current status, and sleep disturbances can significantly influence clients' mental health.

Build Trust

Some traumatic experiences result from trusting others (e.g., interpersonal trauma). In other cases, trust was violated during or after trauma, as in cases when help was late to arrive on the scene of a natural disaster. Some client groups (e.g., gay, lesbian, and bisexual individuals; people from diverse cultures; those with serious mental illness) have significant mistrust because their trust has been repeatedly violated in the past. Traumatic experiences then compound this mistrust.

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. 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, being unable to respond to a phone

message in a timely manner, becoming inadvertently distracted in a session).

Strategies To Build Trust

Strategy #1: Clients can benefit from a support or counseling group composed of other trauma survivors. These groups can motivate clients to trust others by allowing them to experience acceptance and empathy.

Strategy #2: Use conflicts that arise in the program as opportunities. 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 major 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.

Strategy #4: Support the development of trust by establishing clear boundaries, being dependable, working with clients to define explicit treatment goals and methods, and demonstrating respect for clients who have difficulty trusting you and the therapeutic setting.

Support Empowerment

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.

Strategies To Support Empowerment

Strategy #1: Offer clients information about treatment, and help them make informed choices.

Strategy #2: Collaborate with clients to develop their initial treatment plan, to evaluate treatment progress, to update treatment plans, and to gather program feedback.

Strategy #3: Clients should assume an active role in how the delivery of treatment services occurs. Some of the most effective initiatives to reinforce client empowerment are the development of peer support services and the involvement of prior clients in parts of the organizational structure, such as the advisory board or other board roles.

Strategy #4: Establishing a sense of self-efficacy—clients' belief in their ability to carry out specific coping strategies successfully—is key.

Acknowledge Grief and Bereavement

The experience of loss is common after most traumas, whether the loss is psychological (e.g., no longer feeling safe), physical (e.g., death of a loved one, destruction of community, physical impairment), or spiritual (e.g., loss of hope).

Strategies To Acknowledge and Address Grief

Strategy #1: Initially, you can help clients grieve by being present, by normalizing the grief, and by assessing social supports and resources.

Strategy #2: When clients begin to talk about or express grief, focus on having them voice the losses that they experienced because of the trauma. Remember to clarify that losses include internal experiences, not just physical losses.

Strategy #3: For individuals who have difficulty connecting their feelings to experiences, assign a feelings journal in which they log and name each feeling they experience, assign a number to rate the intensity of the feeling, and describe the situation during which the feeling occurred.

Strategy #4: Some individuals benefit from developing a ritual or ceremony to honor their losses. Others prefer contributing time or resources to an association that represents the loss.

Use 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. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive. For more information on culturally responsive treatment, refer to TIP 59, *Improving Cultural Competence*.

Strategies To Enhance Culturally and Gender Responsive Services

Strategy #1: Determine if the client is a survivor of cultural trauma (e.g., genocide, war, government oppression, torture, terrorism).

Strategy #2: Use cultural brokers (i.e., authorities within the culture who can help interpret cultural patterns and serve as liaisons to people outside the culture).

Strategy #3: Determine how an individual's sociocultural support network views trauma.

Strategy #4: Understand how the culture manifests PTSD, trauma-related symptoms, and other mental disorders.

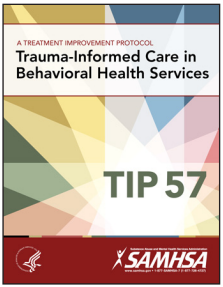
Making Referrals From Trauma-Informed to Trauma-Specific Services

Many people who experience trauma do not exhibit persistent traumatic stress symptoms. In fact, some individuals 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 indicator is symptom severity at the time of screening and assessment. Other individual psychological factors, outside of trauma characteristics and pretrauma individual characteristics, that warrant consideration for referral include:

- Excessively negative cognitions regarding the aftermath of the trauma, including consequences, changes after the event(s), responses of other people to the trauma, and symptoms.
- Presence of intrusive memories.
- Behaviors that reinforce or prevent resolution of trauma, including avoidance, dissociation, and substance use.
- Physical consequences of trauma (e.g., chronic pain, disfigurement, health problems).
- Additional traumas or stressful life events in the aftermath of the prior trauma.
- Comorbid mood disorder(s) or serious mental illness.

Ordering Information

TIP 57
Trauma-Informed Care in Behavioral Health Services



TIP 57-Related Products:
KAP Keys for Clinicians Based on TIP 57

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Other Treatment Improvement Protocol (TIPs) that are relevant to this Quick Guide:

TIP 25: Substance Abuse Treatment and Domestic Violence

TIP 36: Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues

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

TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women

TIP 59: Improving Cultural Competence

See the inside back cover for ordering information for all TIPs and related products.

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