# Trauma-Informed Care and Trauma-Specific Services: An Overview

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# Agenda

- What is Trauma Informed Care? Why do we need it?
  - Trauma 101
  - How do we become Trauma Informed?
- Think about Secondary Trauma
- What are some Trauma Specific Treatments

Understanding trauma is not just about acquiring knowledge.

*It's about changing the way you view the world.*

***Sandra Bloom, 2007***

# Shared Definitions

- Stress
  - Positive; Tolerable; Toxic; Traumatic
- Trauma
- Traumatization
- Traumatic Stress Disorders
- Trauma Informed Care
- Trauma Specific Services

# We create shared definitions …

… to create a common understanding and language

- With each other
  - consumers of service
  - providers of service
  - families
- In developing policies and practices
- Training and ongoing work with community partners

# Definitions of Stress

- Positive Stress Response
  - Normal/essential part of healthy development
    - Brief increases in heart rate and mild elevations in hormone levels
- Tolerable Stress Response
  - Activates the body's alert systems as a result of severe, longer lasting challenges
  - If activation is time limited and buffered by relationships with helping adult, full recovery possible
- Toxic Stress Response
  - After strong, frequent &/or prolonged adversity w/o adequate adult support

# Definition of Trauma

- Overwhelming event or events that render a person helpless, powerless, creating a threat of harm and/or loss
- The event or events continue to impact the person's perception of self, others, world and development.
- *Trauma is something which threatens one's physical or psychic integrity.*

# Traumatization

"Traumatization occurs when
both internal and external resources
are inadequate to cope
with external threat."

Bessel van der Kolk, 1989

# Traumatic Stress Disorders

Traumatic Stress Disorders are disorders related to and/or specifically a result of trauma exposure.

# Trauma Informed Care (TIC)

- An organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma on client well-being and behavior.
- TIC emphasizes physical, psychological, social and moral safety for both consumers and providers.
- TIC helps survivors rebuild a sense of control and empowerment.
- Additionally, a trauma-informed system of care also requires closely knit collaborative relationships with service system partners (e.g. child welfare, legal and substance abuse). The optimal situation is when partnering service systems/agencies offer TIC as well.

# Trauma Specific Services (TSS)

models designed to treat the psychological and behavioral consequences of trauma exposure.

Targeted to:

- time relative to trauma exposure (immediate, short term and delayed)
- type of reactions

# Trauma Informed Care

Trauma informed services are not specifically designed to treat the symptoms or syndromes related to trauma

Marsenich, L. 2010, CA Institute of Mental Health

Trauma Informed Care supports the delivery of Trauma Specific Services.

Hopper, E., Bassuk, L., Olivet, J., 2010

# Essentials of TIC

- Connect – Focus on Relationships
- Protect – Promote Safety and Trustworthiness
- Respect – Engage in Choice and Collaboration
- Redirect (Teach and Reinforce) – Encourage Skill-Building and Competence

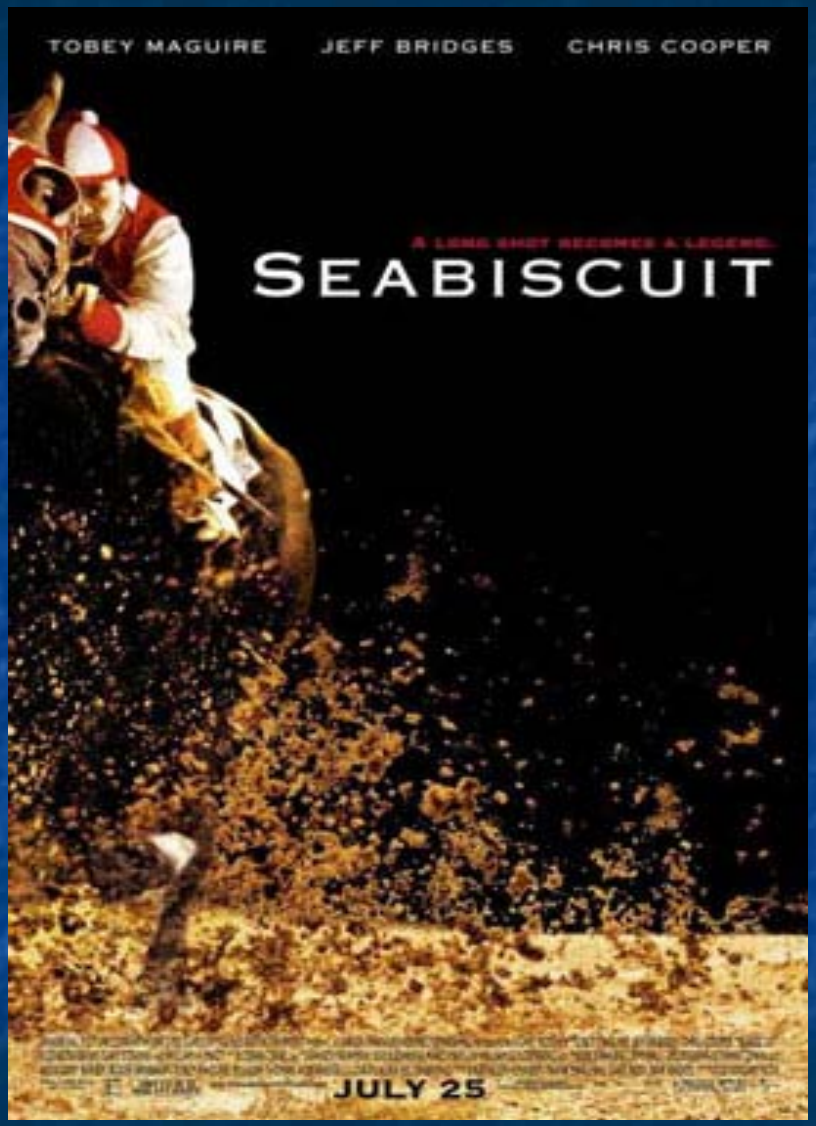
**Hummer, V., Crosland, K., Dollard, N., 2009**

# Trauma informed Care Systems demonstrate:

- An appreciation for the very high prevalence of traumatic experiences in persons who receive mental health, DV, child welfare, juvenile justice and adult corrections services
- A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual, and how these effects can translate into a person's everyday behavior
- Commitment to providing care that is collaborative, supportive and skill based

Marsenich, L. 2010, CA Institute of Mental Health

# Creating a Lens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CHRIS COOPER
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# Types of Traumatic Events

- Child abuse and maltreatment
- Domestic violence
- Community violence
- Criminal violence
- Rape or sexual assault
- Medical trauma- own or family members
- Traumatic or stigmatized loss
- Accidents/fires
- Disasters
- Terrorism
- War
- Genocide

# The Physiology of Stress

- The body's alarm system
- Shifts the body's priorities
- Puts on hold planning, learning, future-oriented responses
- Focuses on support of vigilance, focused attention, increased muscle tone and heart rate

# What does trauma do to the mind and body?

- Automatic and hard-wired
  - Fight
  - Flight
  - Freeze
- Evolutionary purpose is for survival in the face of a single event
- Biologically, PTSD is a broken feedback system. *PTSD is a missing "off switch."* The brain is not able to say that the danger is over.

# PTSD Diagnostic Criteria

- Exposure to a traumatic event in which the person:
  - Experienced, witnessed or was confronted by death or serious injury to self and others AND
  - Responded with intense fear, helplessness or horror

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders, 4th Ed.

# PTSD Diagnostic Criteria

- PTSD is the only diagnosis in the DSM for which there is a known cause.
- In order to have PTSD, a person must have:
  - Been exposed to a traumatic event over 1 month ago
  - Have impairment in functioning
  - Have symptoms in the following three categories
    - Avoidance/numbing (3 symptoms required). This includes feeling distant or cut off from people, having trouble feeling love/anger, feeling numb, avoiding thoughts/feelings/people/places that remind one of the traumatic event, having a foreshortened sense of future
    - Re-experiencing (1 symptom required). This includes intrusive thoughts/images, flashbacks, feeling as though the event were happening again.
    - Hyperarousal (2 symptoms required). This includes feeling jumpy, easily startled, irritable, "on edge", and jittery.

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders, 4th Ed.

# Factors that Increase Risk of PTSD

- Event variables:
  - Perceived life threat
  - Intensity of stressor
  - Sudden
  - Act of man
  - Extent and duration of exposure
- Environmental variables:
  - Stressful life events in last year
  - Low income
  - Low social support
- Individual variables:
  - Anxious temperament
  - Chaotic family
  - Psychiatric history
  - Family psychiatric history
  - Early adversity

# Protective Factors

- Social support is a key mediating factor
  - Believing and validating the experience
- Feeling good about one's own actions in the face of danger
- Cognitive and self regulation abilities
- Positive belief about oneself
- Motivation to act effectively in environment

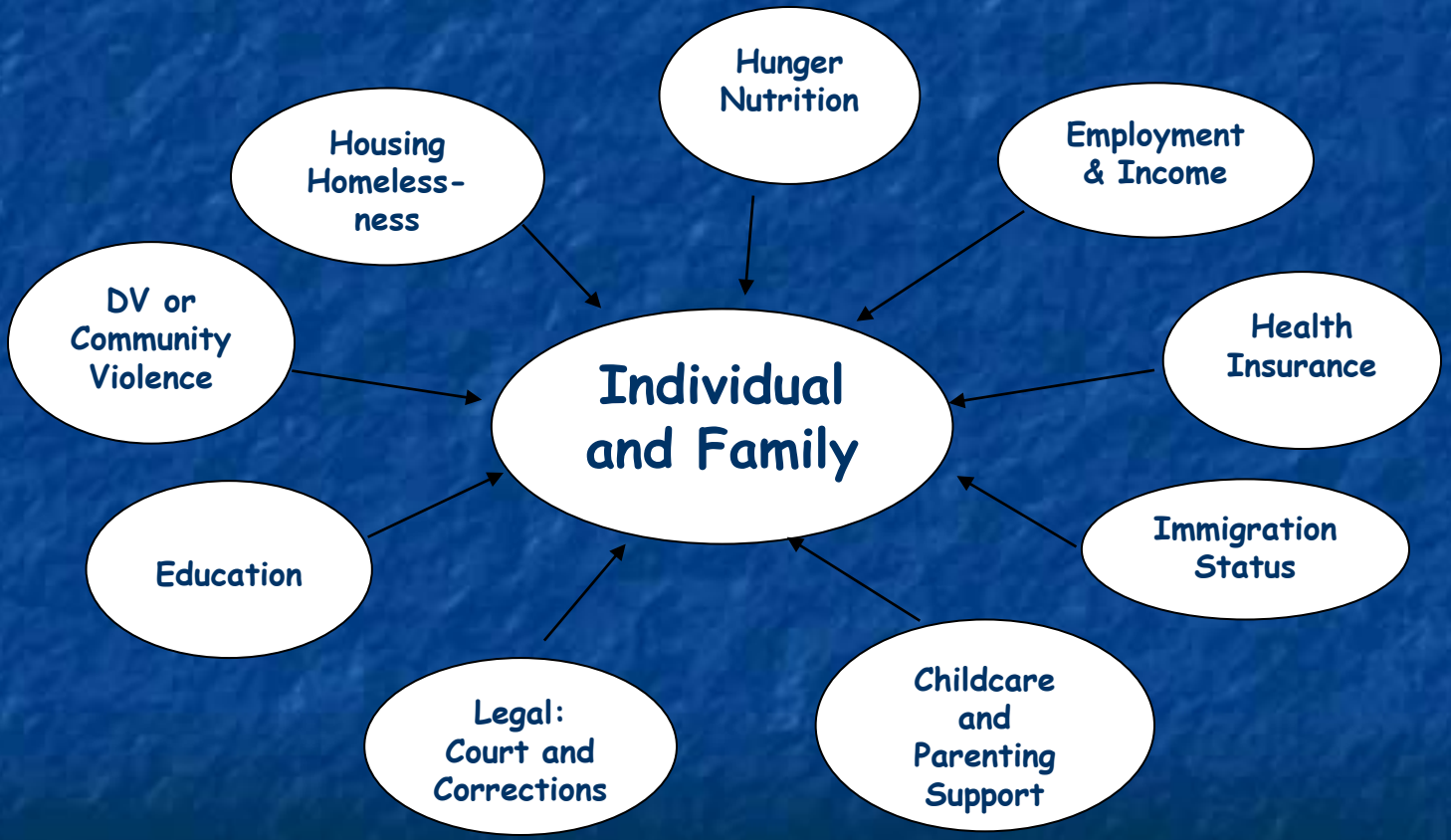
# Why is it Important to Ask Clients about Trauma?

- Trauma-related symptoms are generally not the initial problem brought up by clients. Presenting problems tend to be secondary symptoms, such as behavior problems, school problems, marital problems, work issues, etc.

# Comorbid Conditions

- Substance abuse or dependence
- Major depressive disorder
- Panic disorder
- Generalized anxiety disorder
- Obsessive compulsive disorder
- Social phobia
- Bipolar disorder

# Domains Affecting our Clients and Families:



# Trauma – PTSD Epidemiology

- Up to half of all people in the U.S. have been exposed to at least one traumatic event, even when the term trauma is used narrowly to denote a highly threatening and emotionally severe incident.

- About 1 person in 10 in the U.S. suffers from PTSD in his or her lifetime.

Mueser, K.T., Rosenberg, S. D., and Rosenberg, H. J. (2009) *Treatment of posttraumatic stress disorder in special populations: A cognitive restructuring program.* Washington, DC, US: American Psychological Association.

# Trauma – PTSD Epidemiology

- In treatment seeking populations, the lifetime rate of PTSD is higher.
  - Psychiatric Outpatients: 20 – 30% (Howgego et al, 2005)
  - Urban Psychiatric Outpatients: ~40% (Switzer, 1999)
  - SMI populations: 29 – 43% (Mueser et al, 2002)
  - Female Drug Users: 55% (Burton et al, 1994)
  - SED: 30 – 40% (Mueser & Taub, 2008)
  - Others of note; Complex Medical procedures, Homeless, Homeless MI

# Youth in Foster Care

- 31.4% of all foster children had symptoms consistent with Serious Emotional Disturbance (20% of FBH population)
- 75% of all cases had some adjustment to trauma difficulties
  - **John Lyons, 2000, post an analysis of 33,000 New York City children in foster care**
- 25% had PTSD symptoms (vs. 12-15% of Iraq and Vietnam war veterans)
  - **The Northwest Foster Care Alumni Study published in 2005 based on 659 Washington and Oregon alumni**

# Impact of Client's Culture on the Response to Trauma

- What do we mean by culture?
  - religion
  - ethnicity
  - Race
  - Gender identity
  - Sexual orientation
  - philosophy
  - belief system
- Whose culture are we talking about?
  - individual
  - family
  - society

# Cultural Considerations

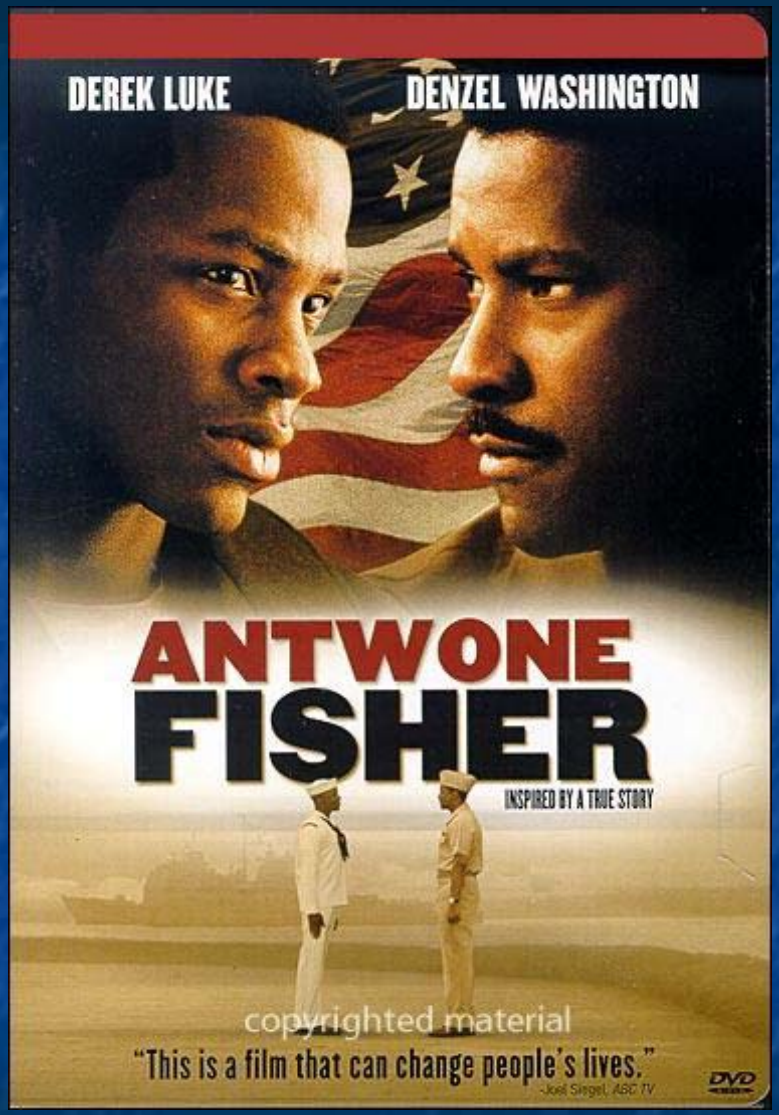
- How do we understand trauma from a cultural and racial perspective?
- What informs our thinking about normative or maladaptive reactions in this context?

# Cultural Formulations

- What must you consider
- During assessment phase
- For engagement and shared service planning
- In treatment selection and intervention monitoring
- External influences and biases including disproportionate representation of certain racial and ethnic groups in sub-sets of service

# Impact of Client's Culture on the Response to Trauma (cont'd)

- What are the cultural group's beliefs about what happened?
- What does the cultural group believe about appropriate emotional expression and integration of what happened?
- What are the gender rules for handling what happened?
- Are certain traumas particularly stigmatized for a cultural group?




# Trauma Exposure, Impact, Responses & Symptoms

# Trauma Exposure

- Specific information regarding the nature of the traumatic experience(s)
  - Severity, duration, frequency
- Circumstance of Disclosure
- Responses of family members
- Responses of relevant professionals
- Client's ability to express feelings about the traumatic experiences

# Trauma Impact

- How is it affecting the client now?
  - current symptoms
  - behavior problems
  - attachment problems
- What areas of functioning are impaired?
  - school, peer relationships, family interaction, play, social/community activities
- What trauma triggers can be identified?
  - sights, sounds, smells, sensations, persons, places, thoughts, feelings, etc.

# Trauma Responses

- Activation responses
  - Trigger response
  - Level of activation
- Avoidance responses
  - Underactivation
  - Emotional numbing, dissociation, denial, thought suppression, anxiolysis without obvious intoxication

Briere & Scott 2006

# Group Activity

**Assessment of Symptom Domains**

| | |
|---|---|
| **Cognitive Problems**<br>□ Maladaptive patterns of thinking about self, others, and situations<br>○ distortions or inaccurate thoughts<br>▪ self-blame for traumatic events<br>○ unhelpful thoughts<br>▪ dwelling on the worst possibilities | **Relationship Problems**<br>□ Difficulties getting along with peers<br>□ Poor problem-solving or social skills<br>□ Hypersensitivity in interpersonal interactions<br>□ Maladaptive strategies for making friends<br>□ Impaired interpersonal trust<br>□ Intimacy issues |
| **Affective Problems**<br>□ Sadness<br>□ Anxiety<br>□ Fear<br>□ Anger<br>□ Poor ability to tolerate or regulate negative affective states<br>□ Inability to self-soothe | **Family Problems**<br>□ Parenting skill deficits<br>□ Poor parent-child communication<br>□ Disturbances in parent-child bonding<br>□ Disruption in family function/ relationships due to familial abuse or violence |
| **Somatic Problems**<br>□ Sleep Difficulties<br>□ Triggers - physiological hyperarousal and hypervigilance toward possible trauma cues<br>□ Physical tension<br>□ Somatic symptoms<br>○ headaches<br>○ stomachaches | **Protective Factors**<br>Strengths<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |

# Assessment of Symptom Domains: Cognitive Problems

- Maladaptive patterns of thinking about self, others, and situations
  - distortions or inaccurate thoughts
    - self-blame for traumatic events
  - unhelpful thoughts
    - dwelling on the worst possibilities

Cohen,Mannarino, & Deblinger (2006). Treating Trauma and Traumatic Grief in Children and Adolescents.

# Assessment of Symptom Domains: Relationship Problems

- Difficulties getting along with peers
- Poor problem-solving or social skills
- Hypersensitivity in interpersonal interactions
- Maladaptive strategies for making friends
- Impaired interpersonal trust
- Intimacy issues

Cohen, Mannarino, & Deblinger (2006). Treating Trauma and Traumatic Grief in Children and Adolescents.

# Assessment of Symptom Domains: Affective Problems

- Sadness
- Anxiety
- Fear
- Anger
- Poor ability to tolerate or regulate negative affective states
- Inability to self-soothe

Cohen, Mannarino, & Deblinger (2006). Treating Trauma and Traumatic Grief in Children and Adolescents.

# Assessment of Symptom Domains: Family Problems

- Parenting skill deficits
- Poor parent-child communication
- Disturbances in parent-child bonding
- Disruption in family function/ relationships due to familial abuse or violence

Cohen, Mannarino, & Deblinger (2006). Treating Trauma and Traumatic Grief in Children and Adolescents

# Assessment of Symptom Domains: Somatic Problems

- Sleep Difficulties
- Triggers- physiological hyperarousal and hypervigilance toward possible trauma cues
- Physical tension
- Somatic symptoms
  - headaches
  - stomachaches
  - etc.

Cohen, Mannarino, & Deblinger (2006). Treating Trauma and Traumatic Grief in Children and Adolescents.

# Organizational Traumatic Stress

- Organizations, like individuals, are living, complex, adaptive systems and that being alive, they are vulnerable to stress, particularly chronic and repetitive stress.
- Organizations, like individuals, can be traumatized and the result of traumatic experience can be as devastating for organizations as it is for individuals.
- As a result, our helping systems frequently recapitulate the very experiences that have already proven to be so toxic for the people we are supposed to treat.

**Bloom, S. 2007**

# Parallel Processes

Bloom, S. 2007

| Staff | Clients | Organization |
|---|---|---|
| • Feel unsafe | • Feel unsafe | • Is unsafe |
| • Angry/aggressive | • Angry/aggressive | • Punitive |
| • Helpless | • Helpless | • Stuck |
| • Hopeless | • Hopeless | • Missionless |
| • Hyperaroused | • Hyperaroused | • Crisis Driven |
| • Fragmented | • Fragmented | • Fragmented |
| • Overwhelmed | • Overwhelmed | • Overwhelmed |
| • Confused | • Confused | • Valueless |
| • Demoralized | • Depressed | • Directionless |

# Organizational stress symptoms:

- Poor communication
- Working at cross purposes
- Blaming
- Overly rigid
- Avoid making decisions – failure to plan
- Client as scapegoat
- Attention to less meaningful details

# TIC takes organizational needs into account

Trauma Informed care (TIC)

An organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of trauma.

*It emphasizes physical, psychological and emotional safety for both consumers and providers,* and helps survivors rebuild a sense of control and empowerment.

# Steps towards * BECOMING * Trauma Informed

- Administrative Commitment to Change
- Universal Screening
- Staff Training and Education
- Hiring Practices
- Review of Policies and Procedures

Marsenich, L. 2010, CA Institute of Mental Health

# Trauma Informed Care Framework


Administrative Commitment to Change
Staff Training and Redirection
Universal Screening
Hiring Practices
Policy and Procedure

Created by Christina Grosso, JBFCS May 2012
Adapted from: *Hummer, V., Crosland, K., and Dollard, N., 2009*

# How is this important to your program?

# Administrative Commitment to Change

- Commitment to trauma informed services should become a part of an organization's mission statement
- A defining element of a trauma informed system is that an understanding of trauma is integrated into how staff understand and respond to those being served
  - JBFCS Lessons Learned

Marsenich, L. 2010, CA Institute of Mental Health

# Universal Screening

- Screening should occur routinely, as soon after admission as possible
- Screening need not be complex or threatening
- Screening conveys that histories of violence and victimization matter

Marsenich, L. 2010, CA Institute of Mental Health

# Staff Training and Education

- Since all staff interact with consumers at some level it is imperative that all receive introductory information on the impact of trauma
- The outcome should be an infusion of trauma informed responses to consumer behavior on the part of all staff

# Hiring and Evaluation Practices

- should incorporate three broadly based standards that incorporate the principles and practices of trauma informed care:
  - Values and beliefs
  - Job specific competencies including relationship building and de-escalation skills
  - Professional self awareness and self control

# Review of Policies and Practices

- Review all policies and practices in light of trauma informed care principles
- Ensure that there are not policies, practices and procedures that re-traumatize consumers

# What would it look like ...

- ... if my agency was fully trauma informed?
  - What is one thing we are doing now that is trauma informed and works well?
  - What is one thing we do that goes against trauma informed best practices?

# Promoting TIC

- Operate from your organization's points of strength, and have a plan for managing challenging areas.
- What are your needs/strengths/challenges?
- Provide clear structure, be open to listening, promote consensual decision making.

# Maintaining Trauma Informed Care

- Understanding Trauma: understanding the connections between trauma exposure and the client's symptoms and maladaptive behaviors
- Understanding the Consumer or Client: understanding the context of the client's life and understanding the styles of coping as they relate to survival
- Understanding Services: services should not simply decrease symptoms, but help develop autonomy in the patient, and should be strengths-based with an emphasis on skill-building and posttraumatic growth
- Understanding the Service Relationship: placing an emphasis on shared decision-making and development of trust
    - (From Hodas, G. (2006). Responding to Childhood Trauma: The Promise and Practice of Trauma-Informed Care)

# Self Care

- Energy
  - Depletion
  - Replenishment
- Healing Breath

  www.haveahealthymind.com

  The Healing Power of the Breath

  Brown & Gerbarg, 2012

# Secondary Traumatic Stress

- Secondary traumatic stress is a normal, natural, potential effect of empathetic engagement with a traumatized person. Doing our job puts us at risk for secondary trauma.

# Secondary Traumatic Stress, cont.

- Different Levels of Effects
- First order effects/lower level impact
  - Belief systems
  - Sense of personal control and invulnerability
  - Sense of personal competence
  - Belief in a just and benevolent world
  - Belief in the goodness of others
- Higher level – effects mimic typical PTSD symptoms
  - Re-experiencing
  - Numbing/avoidance
  - Hyperarousal

# Secondary Traumatic Stress, cont.

- Risk Factors
  - Degree of exposure (thought to be primary risk factor)
    - Quantitative and qualitative/cumulative
  - Intensity of work demand/stress overload
  - Personal history of trauma
  - Lack of social support/isolation
  - Punitive work environment
  - Lack of appropriate and supportive supervision
  - Exposure to acts of terrorism and violence outside of work

# Secondary Traumatic Stress, cont.

- Mitigating and protective factors
  - Self awareness
  - Self nurturance
  - Escape (not the same as avoidance!)
  - Humor
  - Active coping
  - Connection – support
  - Meaning making
  - Transformation
  - Rewards of work

# Secondary Traumatic Stress, cont.

- Personal Self-Care within the Workplace
  - Pacing – time management skills
  - Build in time to talk to colleagues and have a collegial support system in place
  - Build a personal sense of safety and de-stress
  - Take breaks – even for a few minutes at a time. Eat lunch, walk, breathe, don't answer every call
  - immediately, keep flowers in your office, listen to music
  - Utilize supervision and crisis help
  - Managing and tolerating the strong affects raised in the course of your work

# Secondary Traumatic Stress, cont.

- Personal Self-Care Outside the Workplace
  - Consider therapy for unresolved trauma that the therapeutic work may be activating
  - Practice stress management through meditation, prayer, conscious relaxation, deep breathing or exercise
  - Keep in contact with trusted others
  - Engage in hobbies and enjoyed activities
  - Get quiet time
  - Develop a written plan focused on maintaining work-life balance

# Trauma Specific Services (TSS)

- Trauma-Specific Services are models designed to treat the psychological and behavioral consequences of trauma exposure.
- TSS are targeted to the period of time relative to trauma exposure (immediate, short-term, and delayed) and to the type of reactions and pathology being addressed (e.g. supporting adaptive coping after a disaster or treating chronic PTSD).
- TSS are based upon a foundation of evidence for effective interventions.

# Phases of Trauma Treatment

- Historically, treatment of PTSD has been conceptualized as occurring in three phases:
- Safety and Stabilization
- Remembrance and Mourning (resolution of traumatic memory)
- Reconnection (integration and future focus)

# Phases of Trauma Treatment

- Phase One focuses on ensuring client safety, providing psychoeducation, and actively assisting the client in building skills for effectively coping with trauma-related symptoms.

- Phase Two consists of exposure to traumatic material through imaginal or in vivo exposure and often includes the creation of a detailed trauma narrative. Cognitive processing is used to restructure trauma-related maladaptive thoughts and beliefs. A number of trauma-focused treatments use prolonged gradual exposure throughout all three phases of treatment.

- Personality integration and rehabilitation are the focus of Phase Three. The goal is to help the client return to fully functional daily living and enhance future safety.

# Phase One: Safety and Stabilization

- Preparatory phase: purpose is to restore and/or strengthen client's sense of safety and coping skills. Elements, which may be repeated and reinforced throughout the next two phases, include:
  - Skills for affect and interpersonal regulation
  - Learning and practice of coping, relaxation and grounding techniques
  - Psychoeducation
    - Specific information about the traumatic events the client has experienced
    - Information about the impact of trauma
    - Information about treatment
  - Cognitive coping techniques, thought stopping and attention shifting
  - Provides opportunity for client and clinician to build therapeutic alliance

# Phase One: Safety & Stabilization

- Feeling Identification
  - Labeling feelings
  - Identify Intensity
  - Identification of connection between feeling, thoughts and behaviors
  - Identification of how the client experiences distress, such as:
    - Body: where the distress is located in their bodies. (Those who dissociate don't necessarily experience distress this way.) Sense of their body in space
    - Racing thoughts
- Regulation of Feelings and Impact of Feelings
  - Breathing Training; Progressive Muscle Relaxation
  - Containment & Distraction
  - Grounding Techniques
    - Necessary first step for affect regulation and active coping
    - Early, temporary way to manage and contain overwhelming feelings by focusing on a specific sensory pathway for containment

# Phase Two: Remembrance and Mourning

- Provides some form of exposure therapy whereby traumatic events are recalled and cohesively assembled. Can include the following:
  - Creation of trauma narrative
  - Desensitization through repeated telling of trauma story, exposure to fears/aspects avoided
  - Addressing primary and secondary cognitions and distortions
  - Processing and integration of trauma experience

# Phase Three: Reconnection

- Emotions and cognitions revealed during the exposure phase are examined; treatment moves beyond trauma experience and is connected to client's interpersonal life. This phase includes:
  - Addressing losses, relationships, permanent changes, traumatic growth
  - Meaning making
  - Preparation for returning to daily life
  - Solidification of trauma processing

# Evidence-Based/Supported Treatments Commonly Used with Traumatized Clients

- Alternatives for Families-Cognitive-Behavioral Therapy
- Attachment, Self-Regulation, and Competency
- Child-Parent Psychotherapy
- Cognitive-Behavioral Therapy
- Cognitive Processing Therapy
- Eye Movement Desensitization Reprocessing
- Prolonged Exposure
- Seeking Safety
- Skills Training in Affective and Interpersonal Regulation/ Narrative Story-Telling
- Structured Psychotherapy for Adolescents Responding to Chronic Stress
- Trauma Focused-Cognitive Behavioral Therapy
- Trauma Focused-Cognitive Behavioral Therapy for Child Traumatic Grief
- Trauma Recovery and Empowerment Model
- Trauma Systems Therapy

# Alternatives for Families-Cognitive-Behavioral Therapy (AF-CBT) (Kolko, 1996)

- Description
  - Formerly known as Abuse-Focused Cognitive Behavioral Therapy
  - Consists of 3 phases:
    - Phase 1: Psychoeducation and Engagement
    - Phase 2: Individual and Family Skills Training
    - Phase 3: Family Applications
  - Treatment is designed for working with physically abused children and their offending caregivers and is based on principles/procedures from learning/behavioral theory, family-systems therapy, cognitive therapy, and developmental victimology
  - Treatment emphasizes instruction in specific intrapersonal (e.g., cognitive, affective) and interpersonal (e.g., behavioral) skills designed to promote the expression of pro-social behavior and discourage the use of coercive/abusive behavior at both the individual and family levels
- Population
  - Children and their offending caregiver
- Modality
  - Treatment is provided in the home or clinic setting and typically involves parallel individual and family sessions. Can also be done in a group format.
- Intervention Function
  - Present-based: Present-based refers to treatments that focus on increasing client stability and assisting the client in building coping skills. Present-based treatments do not focus on direct exposure to trauma-related material and do not include a narrative component. Narrative work refers to the resolution of traumatic memory through writing or storytelling about traumatic events.
- http://www.afcbt.org (training and manual available for purchase); Learning Collaboratives through NCTSN

# Attachment, Self-Regulation, and Competency (ARC)
## (Kinniburgh, Blaustein, Spinnazola & van der Kolk, 2005)

- Description
  - ARC targets children who have experienced chronic trauma such as sexual abuse, physical abuse, neglect, domestic violence, and community violence
  - Interventions focus on building secure attachments, enhancing self regulatory capabilities, and increasing competencies across multiple domains
  - Appropriate interventions are chosen from a menu
  - ARC utilizes psychodynamic, cognitive, behavioral, relaxation, art/expressive, and movement techniques, and focuses on psychoeducation, relationship strengthening, social skills, and parent-education training
- Population
  - Children, adolescents, and their caregiver(s)
- Modality
  - Can include individual and group therapy for children, education for caregivers, parent-child sessions, and parent workshops
- Intervention Function
  - Present-based: Focused on stability and skill building, no exposure or narrative work
- http://www.traumacenter.org/research/ascot.php (manual and training available for purchase); Learning Collaboratives through NCTSN

# Child-Parent Psychotherapy (CPP)
## (Lieberman & Van Horn, 2005)

Description

- Focuses on how trauma has affected the parent-child relationship and the family's connection to their culture and cultural beliefs, spirituality, intergenerational transmission of trauma, historical trauma, immigration experiences, parenting practices, and traditional cultural values
- Based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories
- Focus is on family violence and child maltreatment
- Components of treatment focus on safety, affect regulation, improving the child-caregiver relationship, normalization of trauma-related response, and joint construction of a trauma narrative, with the goal of returning the child to a normal developmental trajectory

- Population
  - Children up to age 6 and their primary caregiver(s)
- Modality
  - Dyadic parent-child sessions
- Intervention Function
  - Integrated: Includes present-based work and construction of a trauma narrative
- Manual available for purchase: Lieberman & Van Horn (2005) Don't Hit My Mommy: A manual for child-parent psychotherapy with young witnesses of family violence

# Cognitive-Behavioral Therapy (CBT)

- Description
  - Widely used, empirically studied
  - Based upon the recognition that thoughts, feelings and behavior all influence each other
  - Change can be brought about by intervening in any of the following domains:
    - emotions, through the introduction of regulation skills
    - cognitions, through the identification and correction of maladaptive beliefs
    - behavior
    - interpersonal, through relationship skills building
- Population
  - Children, adolescents, and adults
- Modality
  - Individual or group
- Intervention Function
  - Integrated: includes present-based work, exposure to and processing of trauma-related material, and integration of new thoughts and beliefs related to the trauma

# Cognitive Processing Therapy (CPT)
## (Resick & Schnicke, 1992)

- Description
  - Developed to specifically treat PTSD among adults who have experienced a sexual assault
  - Adapted for general trauma and Veterans- Veteran/Military Version
  - Could be adapted for group treatment
  - Approximately 12 sessions
  - Combination of cognitive therapy and exposure therapy
- Population
  - Adults
- Modality
  - Individual or adapted for group
- Intervention Function
  - Integrated: Focus on cognitive processing of trauma related material and exposure through the creation of a written "trauma account."
- http://cpt.musc.edu/index (manual and web-based training available for free)

# Eye Movement Desensitization Reprocessing (EMDR) (Shapiro, 1989)

- Description
  - An 8-stage treatment focused on assessment, stabilization and skill building, desensitization, reprocessing of trauma related material, and replacement of cognitions
  - Includes “dual stimulation” accomplished using bilateral eye movements, tones, or taps
- Population
  - Children, adolescents, and adults
- Modality
  - Individual
- Intervention Function
  - Integrated: Includes present-based work, exposure to and processing of trauma related material, and integration of new thoughts and beliefs related to the trauma
- http://www.emdr.com/index.htm (manual, training and supervision available for purchase)

# Prolonged Exposure (PE)
## (Foa, Hembree, & Dancu, 1999)

- Description
  - Comprised of four main components
    - Education about trauma and trauma reactions
    - Training in breathing techniques
    - Imaginal exposure to memories of the traumatic event(s)
    - In vivo exposure to trauma reminders, usually as homework
  - Includes processing after each imaginal exposure in order to promote integration of new information and insights
- Population
  - Children, adolescents, and adults
- Modality
  - Individual
- Intervention function
  - Integrated: Includes present-based work, exposure to trauma related material, and processing and integration of new thoughts and beliefs related to the trauma
- Manual available for purchase: Foa, Hembree, & Rothbaum (2007) Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences Therapist Guide

# Seeking Safety (Najavits, 1992)

- Description
  - Present-focused therapy to help people attain safety from trauma/PTSD and substance abuse
  - Consists of 25 topics that can be conducted in any order
  - Can be used for general trauma by omitting substance abuse modules
  - The key principles of Seeking Safety are:
    - Safety
    - Integrated treatment
    - A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse
    - Four content areas: cognitive, behavioral, interpersonal, case management
    - Attention to clinician processes focusing on countertransference, self-care, and other issues
- Population
  - Adolescents and adults, clients with co-occurring substance abuse
- Modality
  - Individual or group
- Intervention Function
  - Present-based: Focused on stability and skill building, no exposure or narrative work
- http://www.seekingsafety.org (manual and training available for purchase)

# Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR)
(Cloitre, 2005)

- Description
  - Consists of 8 STAIR sessions focused on improving emotion regulation and enhancing interpersonal relationships
  - And 8 NST sessions focused on narrative processing of trauma
  - Life Skills/Life Story (LSLS): The adult STAIR model adapted for use with adolescent girls
  - Skills training – 10 sessions with 2 optional sessions
    - Teaching and coaching to support emotion regulation and enhance coping strategies
  - Narrative storytelling – 6 sessions
    - Modified prolonged exposure
    - Telling about the trauma directly, repeatedly, and specifically
    - Changes view of self and traumatic experiences
    - Decreases the prevalence of past trauma

- Population
  - STAIR: Adults, LSLS: Adolescent girls (ages 12-21)

- Modality
  - Individual or group

- Intervention Function
  - Integrated: Includes present-based work, exposure to trauma related material through narrative storytelling, and processing and integration of new thoughts and beliefs related to the trauma

- STAIR manual available for purchase: Cloitre, Cohen, & Koenen (2006) Treating Survivors of Childhood Abuse. No LSLS manual currently available for purchase.

# Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

(Labruna & Habib, 2006)

- Description
  - 16 sessions, 1 hour in length
  - For chronically traumatized adolescents living with ongoing stress, difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance
  - Goals :
    - cope more effectively in the moment,
    - enhance self-efficacy,
    - connect with others
    - establish supportive relationships
    - cultivate awareness,
    - create meaning
- Population
  - Adolescents (ages 12-19)
- Modality
  - Individual or group
- Intervention Function
  - Present-Based: Focused on stability and skill building. Not focused on exposure and includes no narrative work.
- Manual available for purchase with training: DeRosa, Habib, et al. (2005) Structured Psychotherapy for Adolescents Responding to Stress: A Trauma-Focused Guide. Learning Collaboratives through NCTSN

# Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)

(Cohen, Mannarino & Deblinger, 1996)

- Description
  - 12-16 weeks, 1 hour individual, parallel parent sessions
  - 10 "PRACTICE" components
    - Psychoeducation/Parenting skills
    - Relaxation
    - Affective expression & modulation
    - Cognitive coping and processing I: The cognitive triangle
    - Trauma narrative
    - Cognitive coping and processing II: Processing the traumatic experience
    - In vivo mastery
    - Conjoint child-parent sessions
    - Enhancing future safety and development
- Population
  - Children and adolescents
- Modality
  - Individual therapy, parent sessions, and joint child-parent sessions
- Intervention Function
  - Integrated: Includes present-based work, exposure to trauma related material through the development of a written narrative, and processing and integration of new thoughts and beliefs related to the trauma
- www.musc.edu/tfcbt (manual and web-based training available for free); Learning Collaboratives through NCTSN

# Trauma Focused-Cognitive Behavioral Therapy for Child Traumatic Grief (TG-CBT)

(Cohen, Mannarino & Deblinger, 1996)

- Description
  - A modified version of TF-CBT focused specifically on traumatic grief
  - Consists of all 10 components of TF-CBT followed by 4 grief-focused components
    - Grief Psychoeducation
    - Grieving the loss and resolving ambivalent feelings about the deceased
    - Preserving positive memories of the deceased
    - Redefining the relationship with the deceased and committing to present relationships
- Population
  - Children and adolescents
- Modality
  - Individual therapy, parent sessions, and joint child-parent sessions
- Intervention Function
  - Integrated: Includes present-based work, exposure to trauma related material through the development of a written narrative, and processing and integration of new thoughts and beliefs related to the trauma
- http://ctg.musc.edu/ (manual and web-based training available for free)

# Trauma Recovery and Empowerment Model (TREM)

(Harris, 1998)

- Description
  - Originally developed as a manualized group-based intervention to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse
  - Now includes M-TREM, a modified version for male survivors of trauma, and G-TREM, an adapted version for adolescent girls
  - TREM uses cognitive restructuring, psychoeducational, and skills-training techniques, and emphasizes the development of coping skills and social support
  - TREM has been used in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations
- Population
  - Adult men and women, adolescent girls (12-18)
- Modality
  - Group therapy
- Intervention Function
  - Integrated: Includes present-based work and some exposure to trauma-related material but no narrative or storytelling component
- http://www.communityconnectionsdc.org/web/page/657/interior.html (Training and manuals for TREM, M-TREM, and G-TREM available for purchase)

# Trauma Systems Therapy (TST)

(Saxe et al., 2006)

- Description
  - TST conceptualizes child traumatic stress as the interface between two conceptual axes:
    - The degree of emotional and behavioral dysregulation when a child is triggered by overt and subtle reminders of a trauma
    - The capacity of the child's social-ecological environment/system-of-care to protect the child from these reminders, or help the child to regulate emotions in the face of such reminders
  - Multi-disciplinary team based treatment proceeds in phases depending on the child's degree of emotional/behavioral regulation and environmental stability.
  - Specific intervention modalities
    - Home-based care, legal advocacy, emotional regulation skills training, cognitive processing skills, and psychopharmacology
    - TST is both a way of organizing services as well as a set of specific clinical interventions
- Population
  - Children and adolescents (ages 6-19)
- Modality
  - Services are delivered using multiple modalities including individual, family, community and systems-based interventions
- Intervention Function
  - Present-based: Focused on stability and skill building. Not focused on exposure and includes no narrative work.
- Manual available for purchase: Saxe, Ellis, & Kaplow (2007) Collaborative Treatment of Traumatized Children and Teens: The Trauma Systems Therapy Approach

# Treatments Used for Trauma-Related Disorders (with an Evidence Base Established for Non-Trauma-Related Disorders)

- Dialectical Behavior Therapy
- Multisystemic Therapy
- Parent-Child Interaction Therapy

# Dialectical Behavior Therapy (DBT)

(Linehan, 1993)

- Description
  - A cognitive-behavioral treatment approach for Borderline Personality Disorder with two key characteristics:
    - A behavioral, problem-solving focus blended with acceptance-based strategies
    - An emphasis on dialectical processes
  - "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies
  - DBT has five components:
    - capability enhancement (skills training)
    - motivational enhancement (individual behavioral treatment plans)
    - generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment)
    - structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors)
    - capability and motivational enhancement of therapists (therapist team consultation group)
  - DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients
  - Therapists follow a detailed procedural manual
- Population
  - Adolescents and adults
- Modality
  - Individual, group, and family interventions
- Manual available for purchase: Linehan (1993) Skills Training for Treating Borderline Personality Disorder

# Multisystemic Therapy (MST)

(Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009)

- Description
  - Developed for working with juvenile offenders; addresses the multidimensional nature of behavior problems in troubled youth
  - Treatment focuses on those factors in each youth's social network that are contributing to his or her antisocial behavior
  - The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and achieve these outcomes at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization
  - The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources
  - MST involves systemic interventions and is delivered in the natural environment (in the home, school, or community)
- Population
  - Children and adolescents
- Modality
  - Family therapy and systems level interventions
- http://www.mstservices.com/
- Manual and training available for purchase: Henggeler, Schoenwald, Borduin, Rowland, & Cunningham (2009) Multisystemic Therapy for Antisocial Behavior in Children and Adolescents, Second Edition

# Parent-Child Interaction Therapy (PCIT) (Eyberg, Nelson, & Boggs, 2008)

- Description
  - PCIT is an evidenced-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child
  - PCIT emphasizes changing negative parent/caregiver child patterns
  - In PCIT, therapists generally sit behind a one-way mirror and use a transmitter and receiver system to coach parents/caregivers as they interact in specific play with their child
  - PCIT is used to address interpersonal complex traumas (i.e., physical, sexual, and emotional abuse and neglect)
- Population
  - Children (ages 2-12)
- Modality
  - Caregiver-child coaching sessions, can be done in group format
- http://pcit.phhp.ufl.edu/
- Manual and training available for purchase: Bodiford McNeil & Hembree-Kigin (2010) Parent-Child Interaction Therapy: Second Edition

# Treatments Used for Trauma-Related Disorders – No Current Evidence Base

- Narrative Therapy
- Sensorimotor Psychotherapy
- Systems Training for Emotional Predictability and Problem Solving
- Expressive Arts Therapies
- Accelerated Experiential-Dynamic Psychotherapy
- Trauma Sensitive Yoga
- Brainspotting

# Narrative Therapy
## (White and Epston)

- Description
  - Puts individuals as the experts in their own lives and views problems as separate from people
  - Emphasizes the stories of people's lives and the differences that can be made through particular tellings and retellings of these stories
  - Involves ways of understanding the stories of people's lives, and ways of re-authoring these stories in collaboration between the clinician and the consumer
  - The evidence base for Narrative Therapy is slim
- Population
  - Children, adolescents, and adults
- Modality
  - Individual, group, or family
- http://www.narrativetherapycentre.com/index.htm

# Sensorimotor Psychotherapy
(Ogden)

- Description
  - Developed to resolve the somatic symptoms of unresolved trauma
  - Bodily experience becomes the primary entry point for intervention
  - Sensorimotor process works from the bottom up rather than the top down; it aims to address the more primitive, automatic, and involuntary functions of the brain that underlie traumatic and post-traumatic responses
  - Very little information on the evidence for sensorimotor psychotherapy can be found in the literature
- Population
  - Children, adolescents, and adults
- http://www.sensorimotorpsychotherapy.org/home/index.html

# Systems Training for Emotional Predictability and Problem Solving (STEPPS)

(Blum, Bartels, St. John, & Pfohl, 2002)

- Description
  - Manual-based group treatment program for outpatients with borderline personality disorder
  - STEPPS combines cognitive behavioral elements with skills training
  - STEPPS has three main components: 1) psychoeducation about borderline personality disorder; 2) emotion management skills training; and 3) behavior management skills training
  - The literature on the efficacy of STEPPS is not terribly extensive.
- Population
  - Adults
- Modality
  - Group
- http://steppsforbpd.com/

# Expressive Arts Therapies

- Description
  - Expressive Arts Therapy includes not only verbal language, but also visual language, body language, and all of the senses to communicate with a larger range of potential for healing
  - Based on the premise that clients can access trauma related material in a less threatening format and from a different perspective than one can access through speech and analysis
  - Working with art materials creates a forum for self-soothing and self-care activities and practices
- Population
  - Children, adolescents, and adults
- Modality
  - Individual or group

# Accelerated Experiential-Dynamic Psychotherapy (AEDP)

## (Fosha & Slowiaczek, 1997)

- Description
  - Grounded in attachment theory, affective neuroscience, and body-focused approaches including Winnicott's Object Relations theory, David Malan's Brief Psychotherapy, Les Greenberg's Emotion-Focused Therapy (EFT), and Habib Davenloo's Intensive Short-Term Dynamic Psychotherapy (ISTDP)
  - Goal is to foster the emergence of new and healing experiences through the in-depth processing of difficult emotional and relational experiences
  - AEDP also aims to activate naturally occurring, adaptive change processes

# Trauma Sensitive Yoga

- Description
  - A traditional practice originating in India comprised of physical and mental disciplines and meditative practice
  - There are numerous branches of yoga including Rāja Yoga, Karma Yoga, Jnana Yoga, Bhakti Yoga, and Hatha Yoga
  - Traditional yoga practice has been adapted to be more sensitive to trauma.
    - Includes psychoeducation about the relationship between trauma and the body
    - Practitioner creates a modified yoga program comprised of physical and mental disciplines designed to meet the individual needs of the client
- Population
  - Children, adolescents, and adults
- Modality
  - Individual or group

# Brainspotting
(Grand, 2003)

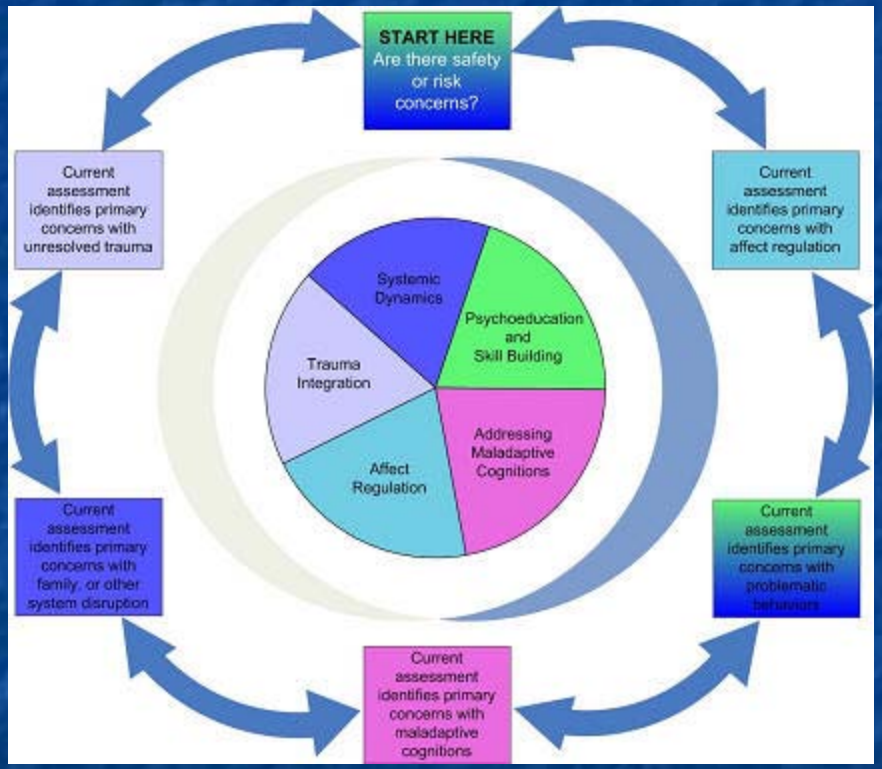
- Description
  - Brainspotting is a focused treatment method that works by identifying, processing and releasing neurophysiological sources of emotional/body pain, trauma, dissociation and other challenging symptoms
  - Helps the client to neurobiologically locate, focus, process, and release experiences and symptoms that are typically out of reach of the conscious mind and its cognitive and language capacity
  - Brainspotting works with the deep brain and the body through its direct access to the autonomic and limbic systems within the body's central nervous system
  - A "Brainspot" is the eye position which is related to the energetic/emotional activation of a traumatic/emotionally charged issue within the brain, most likely in the amygdala, the hippocampus, or the orbitofrontal cortex of the limbic system
  - Brainspotting can be useful as a complement to various body-based therapies including advanced bodywork, chiropractic, acupuncture, somatic therapies, physical therapy, nursing, medicine, and other specialized approaches to physical healing

- http://www.brainspotting.pro/

# Notes on Treatment Selection: Assessment Tools

- Assessment Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP)
- Description
  - Comprised of 3 components
    - Assessment
    - Triage
    - Treatment
  - Utilizes standardized assessment measures at intake and ongoing throughout treatment
  - Guides clinical team in determining the most appropriate evidence supported treatment intervention based on the unique presentation and assessment of each client
- Population
  - Children and adolescents

# Assessment Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP) (Kletzka, Gilbert, Ryan, & Mann)




http://www.taptraining.net

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