Trauma and Co-Occurring Disorders:
Understanding and Working with Youth and Their Caregivers

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Goals of This Training

• Understand the impact of child traumatic stress on the development and behavior of children.

• Understand the relationship between child traumatic stress and co-occurring disorders, primarily substance abuse.

• Learn about assessment and treatment strategies for youth affected by trauma and substance abuse.

• Learn about key components of integrated trauma-informed interventions for parents/caregivers.

• Identify strategies for managing personal and professional stress.
Trauma-Informed Versus Trauma-Specific Services
Trauma-Informed and Trauma-Specific Services

- The provision of “trauma-informed care” is a seminal concept in emerging efforts to address trauma in the lives of children, youth and adults.

- In a trauma-informed system, trauma is viewed as “a defining and organizing experience that forms the core of an individual’s identity.”

What are Trauma-Informed Services?

• Trauma-informed vs. trauma-specific
• Characteristics of trauma-informed services
  - Incorporate knowledge about trauma—prevalence, impact, and recovery—in all aspects of service delivery
  - Hospitable and engaging for survivors
  - Minimize re-victimization
  - Facilitate recovery and empowerment
Comparing Traditional and Trauma-Informed Paradigms

- Understanding of Trauma
- Understanding of the Consumer/Survivor
- Understanding of Services
- Understanding of the Service Relationship
Trauma-Informed Human Services Paradigm

• Understanding of **Trauma**
  
  - Traumatic events are not rare; experiences of life disruption are pervasive and common
  
  - The impact of trauma is seen in multiple, apparently unrelated life domains
  
  - Repeated trauma is viewed as a **core life event** around which subsequent development organizes
  
  - Trauma begins a **complex pattern of actions and reactions** which have a continuing impact over the course of one’s life
Truma-Informed Human Services Paradigm, cont’d

- Understanding of the Consumer/Survivor
  - An integrated, whole person view of individuals and their problems and resources
  - “Symptoms” are understood not as pathology but primarily as attempts to cope and survive; what seem to be symptoms may more accurately be solutions
  - A contextual, relational view of both problems and solutions
  - Appropriate and collaborative responsibility allocation
Understanding of **Services**

- Primary goals are empowerment and recovery
- Survivors are survivors; their strengths need to be recognized
- Service priorities are prevention driven
- Service time limits are determined by survivor self-assessment and recovery/healing needs
- Risk to the consumer is considered along with risk to the system and the provider
Understanding of the Service Relationship

- A collaborative relationship between the consumer and the provider of her or his choice
- Both the consumer and the provider are assumed to have valid and valuable knowledge bases
- The consumer is an active planner and participant in services
- The consumer’s safety must be guaranteed and trust must be developed over time
A Culture Shift: The Core Principles of a Trauma-Informed System

- **Safety**: Ensuring physical and emotional safety
- **Trustworthiness**: Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries
- **Choice**: Prioritizing consumer choice and control
- **Collaboration**: Maximizing collaboration and sharing of power with consumers
- **Empowerment**: Prioritizing consumer empowerment and skill-building
Trauma-Specific Interventions

• Services designed specifically to address violence, trauma, and related symptoms and reactions.

• The intent of the activities is to increase skills and strategies that allow survivors to manage their symptoms and reactions with minimal disruption to their daily obligations and to their quality of life, and eventually to reduce or eliminate debilitating symptoms and to prevent further traumatization and violence.
Ice Breaker: The Aftermath of Traumatic Events

• In pairs, discuss a client who you suspect has experienced trauma.

• Focus not on the event(s), but the behaviors exhibited by the client following the traumatic experience(s).

• Share: How did the client present? What behaviors did they exhibit?
Child Traumatic Stress and Co-Occurring Disorders
What Is Child Traumatic Stress?

- Traumatic stress in childhood involves *physical and emotional responses* to exposure to extreme threat, injury or death.
- Traumatic events overwhelm a child’s capacity to cope and elicit feelings of terror, powerlessness, and out-of-control physiological arousal.
What Is Child Traumatic Stress, cont'd

• A child’s response to a traumatic event may have a profound effect on his/her perception of self, the world, and the future.

• Traumatic events may affect children’s:
  – Ability to trust others
  – Sense of personal safety
  – Effectiveness in navigating life changes
Types of Traumatic Stress

- **Acute trauma** is a single traumatic event that is limited in time.
- **Chronic trauma** refers to the experience of multiple traumatic events.
- **Complex trauma** describes both exposure to chronic trauma—usually caused by adults entrusted with the child’s care—and the impact of such exposure on the child.
Variability in the Response to Stressors and Traumatic Events

- The impact of a potentially traumatic event is determined by both:
  - The objective nature of the event
  - The child’s subjective response to it
- Something that is traumatic for one child may not be traumatic for another.
• The impact of a potentially traumatic event depends on several factors, including:
  – The child’s age and developmental stage
  – The child’s perception of the danger faced
  – Whether the child was the victim or a witness
  – The child’s relationship to the victim or perpetrator
  – The child’s past experience with trauma
  – The adversities the child faces following the trauma
  – The presence/availability of adults who can offer help and protection

• When trauma is associated with the failure of those who should be protecting and nurturing the child, it has profound and far-reaching effects on nearly every aspect of the child’s life.
Effects of Trauma Exposure on Children

- **Attachment.** Traumatized children feel that the world is uncertain and unpredictable. They can become socially isolated and have difficulty relating to and empathizing with others.

- **Biology.** Traumatized children may experience problems with movement and sensation, including hypersensitivity to physical contact and insensitivity to pain. They may exhibit unexplained physical symptoms and increased medical problems.

- **Mood regulation.** Children exposed to trauma can have difficulty regulating their emotions, as well as difficulty knowing and describing their feelings and internal states.
Effects of Trauma Exposure, cont’d

- **Dissociation.** Some traumatized children experience a feeling of detachment or depersonalization, as if they are “observing” something happening to them that is unreal.

- **Behavioral control.** Traumatized children can show poor impulse control, self-destructive or risk-taking behavior, and aggression towards others.

- **Cognition.** Traumatized children can have problems focusing on and completing tasks, or planning for and anticipating future events. Some exhibit learning difficulties and problems with language development.

- **Self-concept.** Traumatized children frequently suffer from disturbed body image, low self-esteem, shame, and guilt.
Long Term Effects of Childhood Trauma

• In the absence of more positive coping strategies, children who have experienced trauma may engage in high-risk or destructive coping behaviors.

• These behaviors place them at risk for a range of serious mental and physical health problems, including:
  – Alcoholism
  – Drug abuse
  – Depression
  – Suicide attempts
  – Sexually transmitted diseases (due to high risk activity with multiple partners)
  – Heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease

Source: Felitti et al., 1998
Children who have experienced chronic or complex trauma frequently are diagnosed with PTSD.

According to the American Psychiatric Association, PTSD may be diagnosed in children who have:

- Experienced, witnessed, or been confronted with one or more events that involved real or threatened death or serious injury to the physical integrity of themselves or others
- Responded to these events with intense fear, helplessness, or horror, which may be expressed as disorganized or agitated behavior

Source: American Psychiatric Association, 2000
• Key symptoms of PTSD
  – Re-experiencing the traumatic event (e.g. nightmares, intrusive memories)
  – Intense psychological or physiological reactions to internal or external cues that symbolize or resemble some aspect of the original trauma
  – Avoidance of thoughts, feelings, places and people associated with the trauma
  – Emotional numbing (e.g. detachment, estrangement, loss of interest in activities)
  – Increased arousal (e.g. heightened startle response, sleep disorders, irritability)

Source: American Psychiatric Association, 2000
Childhood Trauma and Other Diagnoses

- Other common diagnoses/misdiagnoses for children exposed to trauma include:
  - Reactive Attachment Disorder
  - Attention Deficit Hyperactivity Disorder
  - Oppositional Defiant Disorder
  - Bipolar Disorder
  - Conduct Disorder

- These diagnoses generally do not capture the full extent of the developmental impact of trauma.

- Many children with these diagnoses have a complex trauma history.
When faced with people, situations, places, or things that remind them of traumatic events, children may experience intense and disturbing feelings tied to the original trauma.

- These “trauma reminders” can lead to behaviors that seem out of place, but were appropriate—and perhaps even helpful—at the time of the original traumatic event.

Children who have experienced trauma may face so many trauma reminders in the course of an ordinary day that the whole world seems dangerous, and no adult seems deserving of trust.
• Trauma can have serious consequences for the normal development of children’s brains, brain chemistry, and nervous system.

• Trauma-induced alterations in biological stress systems can adversely effect brain development, cognitive and academic skills, and language acquisition.

• Traumatized children and adolescents display changes in the levels of stress hormones similar to those seen in combat veterans.
  - These changes may affect the way traumatized children and adolescents respond to future stress in their lives, and also influence their long-term health.¹

¹ Pynoos et al., 1997
The Influence of Culture on Trauma

- Many children seeking care are from groups that experience:
  - Discrimination
  - Negative stereotyping
  - Poverty
  - High rates of exposure to community violence

- Social and economic marginalization, deprivation and powerlessness can create barriers to service.

- These children can have more severe symptomatology for longer periods of time than their majority group counterparts.
• People of different cultural, national, linguistic, spiritual, and ethnic backgrounds may define “trauma” in many different ways and use different expressions to describe their experiences.

• Clinicians’ own backgrounds can influence their perceptions of child traumatic stress and how to intervene.

• Assessment of a child’s trauma history should always take into account the cultural background and modes of communication of both the assessor and the family.
Some components of trauma response are common across diverse cultural backgrounds. Other components vary by culture.

Strong cultural identity and community/family connections can contribute to strength and resilience in the face of trauma or they can increase children’s risk for and experience of trauma.

Some of these cultural resources can also serve as protective factors for substance abuse.
Case Example: Jenny

- Based on the initial referral information, describe possible diagnostic considerations and a preliminary treatment plan.
- How do challenges in Jenny’s peer and social world interfere with her functioning?
- Taking into consideration your knowledge of culturally competent services, how would you engage the family in treatment?
- How would you address the intergenerational and acculturation stressors that are exacerbating Jenny’s distress?
- How does the mother’s own trauma history play a role in this situation?
- How does additional information about the cultural and family context change the original diagnostic considerations and treatment plan you described earlier?
Being Culturally Informed

• Understand that social and cultural realities can influence children’s risk, experience and description of trauma.

• Recognize that strong cultural identity can also contribute to resilience of children, their families and communities.

• Adopt a “strength-based” approach that capitalizes on individual, family, and contextual factors that can serve to promote healthy coping and adjustment.
  – Family’s religious or spiritual beliefs
  – Extended families and available social support networks
  – Positive role models in the community
  – Opportunities for participating in positive recreational, artistic, or academic activities
  – Adolescent’s built-in capacity to grow and flourish in the midst of adversity
Cultural Competence

- Understanding and respect for diverse worldviews
- Staff who reflect the cultural diversity of the community served, and physical environment that reflects the diversity of communities served, including artwork, accessibility, and materials
- Use of interpreter services or, preferably, bilingual providers for clients with limited English proficiency
- Ongoing staff cultural competency education, training, and requirements

Sources: Anderson et al., 2003; Cross et al., 1989
Cultural Competence cont’d

- Use of linguistically and culturally appropriate educational materials
- Culturally relevant assessments
- Working within the family’s defined structure (e.g., the family may include elders or other relatives)
- Understanding and respect for the social mores related to interactions by gender and age
The Influence of Developmental Stage

- Child traumatic stress reactions vary by developmental stage.
- Children who have been exposed to trauma expend a great deal of energy responding to, coping with, and coming to terms with the event.
- This may reduce children’s capacity to explore the environment and master age-appropriate developmental tasks.
- The longer traumatic stress goes untreated, the further children tend to stray from appropriate developmental pathways.
The Influence of Developmental Stage cont’d

• **Young children** who have experienced trauma may:
  - Become passive, quiet, and easily alarmed
  - Become fearful, especially in regards to separations and new situations
  - Experience confusion about assessing threat and finding protection, especially in cases where parent or caretaker is the aggressor
  - Regress to recent behaviors (e.g., baby-talk, bed-wetting, crying)
  - Experience strong startle reactions, night terrors, or aggressive outbursts
School-age children with a history of trauma may:

- Become preoccupied with frightening moments from the traumatic experience
- Replay the traumatic event in their minds in order to figure out what could have been prevented or how it could have been different
- Develop intense, specific new fears linking back to the original danger
- Have thoughts of revenge
- Experience sleep disturbances that may interfere with daytime concentration and attention
The Influence of Developmental Stage cont’d

• In response to trauma, adolescents may feel:
  – That they are weak, strange, childish or “going crazy”
  – Embarrassed by their bouts of fear or exaggerated physical responses
  – That they are unique and alone in their pain and suffering
  – Anxiety and depression
  – Intense anger
  – Low self-esteem and helplessness
The Influence of Developmental Stage: Adolescents, cont’d

• These trauma reactions may in turn lead to:
  – Aggressive or disruptive behavior
  – Sleep disturbances masked by late night studying, television watching, or partying
  – Drug and alcohol use as a coping mechanism to deal with stress
  – Over- or under-estimation of danger
  – Expectations of maltreatment or abandonment
  – Difficulties with trust
  – Increased risk of revictimization, especially if the adolescent has lived with chronic or complex trauma
The Relationship Between Child Traumatic Stress and Substance Abuse
Prevalence of Trauma and Substance Abuse in Youth

- Traumatic stress and substance abuse problems frequently co-occur among adolescents
- Epidemiological studies show the overall rates of co-occurrence of PTSD and substance abuse can range from 13.5% to 29.7% \(^1\)
- However, the co-occurrence is even greater in treatment settings, with rates highest among females:
  - Lifetime prevalence rates of trauma exposure: 71-80\% \(^2, 3\)
  - Lifetime prevalence rates of PTSD: 24.3\% -45.3\% \(^2\)
  - Current prevalence rates of PTSD: 14\%- 40.0\% \(^2, 4\)

1. Kilpatrick et al., 2003; 2. Deykin & Buka, 1997;
3. Funk et al., 2003; 4. Diamond et al., 2006
Understanding Substance Abuse: Cues and Cravings

- A substance use "stimulus" (also known as a reminder, signal, cue or trigger) has been repeatedly associated with the preparation for, anticipation of, or the use of drugs and/or alcohol.
  - These stimuli include people, things, places, times of day, and emotional states.

- Substance use "craving" refers to the very strong desire for a psychoactive substance or for the intoxicating effects of that substance.
  - Cravings include thoughts (about the urge to use), physical symptoms (heart palpitations) and behaviors (pacing)
Common Reasons Given By Adolescents For Using Alcohol And Drugs

- **Reasons for starting:**
  - Social pressures
  - Experimentation
  - To cope with difficulties

- **Reasons for continuing**
  - Feels good
  - To cope with difficulties
  - To pass the time, deal with boredom
  - To manage withdrawal symptoms

- **Reasons for quitting**
  - No longer fits with lifestyle or to prevent adverse impact on anticipated future
  - Negative physical and psychological effects or outside pressures (probation, jail, drug testing)

Source: Titus et al., 2007
The Link Between Trauma and Substance Abuse

• The link between trauma and substance abuse:
  - **Self Medication:** Adolescents who experience trauma may turn to substances to alleviate distress. A reminder of past trauma or loss can elicit substance abuse cravings.
  - **Susceptibility:** Youth’s ability to appropriately cope with distressing and traumatic events may be decreased by ongoing substance use, leading to increased likelihood of traumatic stress symptoms.
  - **High Risk Behaviors:** Adolescents who use substances are more likely to engage in risky activities that could lead to experiencing trauma (e.g., driving under the influence, hanging out in unsafe neighborhoods).
Why are the Risks Greater for Adolescents?

• Disruption of normal brain development—not fully developed until age 24-25
  – Hippocampus (learning and memory)
  – Prefrontal cortex (critical thinking, planning, impulse control, and emotional regulation)¹

• Interference with many physiological processes that can destabilize mood (depression, aggression, violence, and suicide)

• Decision-making abilities are not fully developed

• The earlier the onset age of drinking, the greater the risk for lifetime alcohol abuse or dependence.²

¹ DeBellis, 2005; ² DeWit et al., 2000
Known Risk and Protective Factors

• Individual
  – Positive coping strategies (good decision-making skills, assertiveness, and cognitive mastery)
  – Avoidant stress coping and difficulty in managing temptations

• Family
  – Strong sense of attachment to parents
  – Parental attitudes about substance use

• School
  – Bonding with school
  – Having a strong commitment to doing well

• Peer
  – Associating with substance-using peers

• Community
  – Limited availability of needed services or quality educational and recreational opportunities
Recognizing Signs of Substance Use Problems In Adolescents

- Frequent intoxication
- Change in peer group, failing to introduce peers to parents
- Disruptive behavior
- Avoiding school
- Decline in academic performance
- Rapid changes in mood
- Hostile outbursts

- Dropping out of activities
- Change in physical appearance, poor hygiene
- Depression
- Anxiety
- Difficulty sleeping
- Secretive behavior (e.g., sneaking out, lying, locking doors (e.g., bedroom, bathroom)
DSM-IV Diagnoses: Substance Use Disorders (SUD’s)

- **Substance Abuse**
  - Use of drugs in a manner that is illegal or harmful to the individual and causes significant adverse consequences such as accidents or injuries, blackouts, legal problems, and risky sexual behavior.

- **Substance Dependence**
  - Continued substance abuse despite significant substance-related problems
  - Usually includes tolerance (requiring higher doses to achieve the same effect) and withdrawal (symptoms experienced when use of the drug is discontinued)
What Do We Mean By “Impairment”? 

• Inability to meet major role obligations 
• Leading to reduced functioning in one or more areas of life 
• Risk taking behavior 
• Increase in the likelihood of legal problems due to possession 
• Exposure to hazardous situations 
• A hallmark of Substance Use Disorders (SUD’s) in adolescents is impairment in psychosocial & academic functioning.\(^1\) Can include: 
  – Family conflict or dysfunction 
  – Interpersonal conflict 
  – Academic failure 

1. Martin & Winters, 1998
Case Example: Michael

- With the brief initial history, what additional history and/or assessments would you need to determine a diagnosis?
- How can your understanding of trauma reminders help you to determine whether they may have led to Michael’s current relapse?
- How would you help the parents understand the concept of trauma and substance abuse reminders, and how these might contribute to Michael’s relapse?
- List key issues that need to be addressed in Michael’s recovery environment in order to minimize his potential for future relapses.
Assessment Strategies and Treatment Interventions
Need for Comprehensive Assessment

• Assessment identifies potential risk behaviors (i.e. danger to self, danger to others) and aims to determine interventions that will ultimately reduce risk.

• Assessment also tells us why a child may be reacting this way, the behavior’s connection to his/her experiences of trauma, and whether substance use is a means to cope with distress.

• Assessment provides input for the development of treatment goals with measurable objectives designed to reduce the negative effects of trauma and substance use.
• Not all children who have experienced trauma need trauma-specific intervention.

• Unfortunately, many children exposed to trauma lack natural support systems and need the help of trauma-informed care.

• Many children who do not meet the full criteria for PTSD still suffer significant posttraumatic symptoms that can have a dramatic adverse impact on behavior, judgment, educational performance, and ability to connect with caregivers.

• These children need a comprehensive trauma assessment to determine which intervention will be most beneficial.
The Importance of Trauma Assessment

• Trauma assessment typically involves conducting a thorough trauma history.
  – Identify all forms of traumatic events experienced directly or witnessed by the child, to determine what is the best type of treatment for that specific child.

• Supplement trauma history with trauma-specific standardized clinical measures to assist in identifying the types and severity of symptoms the child is experiencing.
Examples of Trauma Assessment Tools

- **UCLA PTSD Reaction Index**: Youth self-report screen for exposure to traumatic events and DSM-IV PTSD symptoms.
  - Sample item: “I try to stay away from people, places, or things that make me remember what happened.”

- **The Trauma Symptom Checklist for Children**: Youth self-rating measure used to evaluate both acute and chronic posttraumatic stress symptoms.
  - Sample item: “How often do you have bad dreams or nightmares?”

For more information go to www.nctsn.org/measures.
Assessment of Co-Occurring Substance Abuse Problems

- *If you don’t ask, they won’t tell.* Trauma and substance abuse screening should happen at the beginning and throughout treatment.

- Youth with this co-occurrence experience difficulties with emotional and behavioral regulation, and thus find it hard to stop using.

- The presence of one of these problems can—and often does—exacerbate the other.

- Therefore, assessment strategies should look at the extent of substance use as well as the level of impairment and interference with emotional and behavioral functioning.
Substance Abuse Assessment Tools

Screening and Assessing Adolescents for Substance Use Disorders: Treatment Improvement Protocol (TIP) Series 31

• Free guide that provides information about screening and assessment of adolescents with substance use disorders including descriptions of specific assessment instruments.

• This guide can be downloaded or ordered for free at the National Clearinghouse for Alcohol and Drug Information

For more information go to http://ncadi.samhsa.gov/ or www.health.org.
Substance Abuse Assessment Tools

CRAFFT

- Six-item measure that assesses for problematic substance use among adolescents (reasons for drinking or other substance use, risky behavior associated with substance use, peer and family behavior surrounding substance use, whether the adolescent has ever been in trouble as a result of his or her substance use).

- This measure is very short and can be given as a standard part of an initial assessment to screen for likelihood of a substance use disorder.

- Two or more “yes” responses are suggestive of a probable substance use disorder and should be followed up with a more in-depth assessment.
Adolescent Substance Abuse Screening: CRAFFT

1. Have you ever ridden in a Car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to Relax, feel better about yourself, or fit in?
3. Do you ever use alcohol/drugs while you are by yourself, Alone?
4. Do your Family or Friends ever tell you that you should cut down on your drinking or drug use?
5. Do you ever Forget things you did while using alcohol or drugs?
6. Have you gotten into Trouble while you were using alcohol or drugs?

*2 or more yes answers suggests risk for substance use disorder

Developed by The Center for Adolescent Substance Use Research (CeASAR).
Permissions/use email: info@CRAFFT.org
Case Example: Karen

- What screening and assessment instruments might be helpful at this juncture to learn more about the causes of Karen’s emotional turmoil?

- What kind of information must you obtain to discern between mental health and substance abuse/dependence problems?

- What has been the likely impact of Karen’s earlier trauma exposure on her current behavior and functioning?

- In your treatment plan, what would you address first—Karen’s traumatic stress symptoms, her substance abuse, risky behaviors, or the needs within the family?
Evidence-Based Treatments
Examples of Evidence-Based Treatments For Trauma In Children

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)
- Child Parent Psychotherapy (CPP)
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

There are many different evidence-based trauma-focused treatments. A trauma-informed mental health professional should determine which treatment is most appropriate for a given case.

See http://www.nctsn.com/nccts/nav.do?pid=ctr_top_trmnt_prom#q4 for factsheets on treatments.
Common Elements of Evidence-Based Trauma and Substance Abuse Treatments

• Starting treatment
  – Psychoeducation
  – Strategies to promote family and youth engagement

• Cognitive behavioral approaches
  – Skill building to improve ability to cope with distress
  – Skill building to improve ability to cope with cravings

• Family interventions
  – Improve parental monitoring and limit setting
  – Improve communication
Core Components of Trauma-Informed Evidence-Based Treatment

Trauma-informed approaches incorporate some or all of the following elements:

• Building a strong therapeutic relationship
• Psychoeducation about normal responses to trauma
• Parent support, conjoint therapy, or parent training
• Emotional expression and regulation skills
• Anxiety management and relaxation skills
• Cognitive processing or reframing
Additional elements of trauma-informed treatment:

- Construction of a coherent trauma narrative
- Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child’s experience
- Personal safety training and other important empowerment activities
- Resilience and closure
Elements of parental involvement during trauma-informed treatment:

• Psychoeducation about the impact of trauma
• Parent skill building to manage behavior problems (e.g., labeled praise, active ignoring, time out, rewarding good behavior)
• Stress inoculation techniques
• Cognitive processing
• Joint parent/child sessions to facilitate open communication about trauma
Cognitive Processing Strategies

• Traumatized youth may show negative patterns of thinking as a result of their negative experiences
  – Mistrust in others or expectations that they might be harmed by others
  – Overestimation of danger
  – Low self esteem and self blame (feeling responsible for the trauma or what happened as a result)
  – Helplessness and hopelessness about the future
  – Shame or stigma
  – Negative perceptions about the body or personal safety

• Through cognitive processing, clinicians can help youth identify these faulty patterns of thinking and practice using healthier cognitive coping strategies.
Steps to Cognitive Processing
(Cognitive Coping, Reframing, Restructuring)

• Learn about thoughts, feelings, and behavior.
  – Distinguish between accurate and inaccurate cognitions, or helpful and unhelpful cognitions
  – Understand relationship between feelings, thoughts, and behavior
• Learn how to identify and correct unhelpful thoughts.
  – Identify: Identifying the thought behind the emotion
  – Challenge: Evaluating the thought based on the evidence and logic
  – Replace: Choosing alternative, more accurate, adaptive or helpful thoughts. Trying to change the way you feel and act by changing the way you think.
Exposure to the Trauma Narrative

• Exposure to the trauma narrative involves
  – Reviewing details of traumatic experience to achieve habituation to distress (reduce association between memories and overwhelming emotion)
  – Identifying and challenging distortions in thinking associated with the trauma

• Generating a trauma narrative helps a child to:
  – Control intrusive and upsetting trauma-related imagery
  – Reduce avoidance of trauma-related cues and reminders
  – Identify unhelpful cognitions about traumatic events
  – Recognize and prepare for reminders of trauma
Steps to the Trauma Narrative

• Occurs over the course of several sessions (usually done after emotion regulation and coping skills have been taught).

• Parent and child should receive a clear rationale for going over memories that the child finds distressing.

• Can take the form of a book, song, or poem, or a series of pictures.

• Child describes details about what happened before, during and after the traumatic event.

• Child identifies thoughts and feelings during these times. This may be hard to do, but it is important to try to create the narrative as realistic and “in the moment” as possible.

• After each portion of the narrative is completed, child should read what they have done so far.
Steps to the Trauma Narrative, cont’d

- Sequence of the trauma narrative:
  - The child should be involved in the sequence of events reviewed.
  - Exposure should be gradual, starting from details that elicit low levels of anxiety and progressing to more difficult memories.
  - The narrative should include the worst moment or most distressing memory.
  - Narrative should continue until the child no longer experiences extreme anxiety, distress, avoidance, numbing or detachment.
  - Narrative should end with a positive or optimistic outlook by noting how the child is not defined only by what happened, how he/she sees things differently now, what he/she has learned, how he/she has grown, and how he/she can offer advice to other children with similar experiences.
  - If possible, it is often helpful to share the narrative with the caregivers once it is completed.
Steps to the Trauma Narrative, cont’d

• Cognitive processing techniques to address cognitive distortions/errors or unhelpful thoughts can be used during the exposure and after the trauma narrative is completed.

• Stress management techniques may be used in session to address any emotional and physical reactions to the trauma narrative.
  – For youth with substance abuse history, this should include management of cravings and a review of drug refusal strategies.

• Encouragement of child with praise, rewards and positive event scheduling (e.g., games or fun activities) should take place at the end of each session.
Case Example: Karen

• Briefly describe how you would employ specific therapy skills to help Karen overcome her difficulties.
  
  – What kind of negative cognitions might Karen (and her parents) be experiencing as a result of her trauma, and what might “cognitive processing” look like?
  
  – What should be kept in mind when planning the exposure to the trauma narrative for someone like Karen who is actively using substances?
Examples of Evidence-Based Substance Abuse Treatments for Adolescents

- Matrix Model\textsuperscript{1,2}
- Cognitive-Behavioral Therapy (CBT)
- Motivational Interviewing (MI) or Motivational Enhancement plus CBT (MECBT)
- Multidimensional Family Therapy (MDFT)
- Brief Strategic Family Therapy (BSFT)
- Multisystemic Therapy (MST)
- Adolescent Community Reinforcement Approach (ACRA)

\textsuperscript{1} Rawson et al., 2005; \textsuperscript{2} CSAT, 2006a, 2006b
Core Components of Evidence-Based Substance Abuse Treatment

- Psychoeducation (for youth and their families)
  - Providing information about substance use (cues/cravings), coping with distress (which can include trauma reminders) and the interaction between the two
- Helping youth identify triggers and manage cravings
  - Help youth formulate constructive ways to handle symptoms, cravings, and distress without substance use
• Random urine drug screenings (with contingency management)
• Drug refusal skills and assertiveness training
• Relapse prevention
  – Acknowledge and prepare for the role of stress and trauma on relapse
Core Components, cont’d

- Motivational interviewing strategies
  - Taking an empathic, non-judgmental stance and listening reflectively
  - Developing discrepancy between the adolescent’s goals and their current behavior
  - Rolling with the client’s resistance and avoiding argumentation
  - Supporting self-efficacy for change.

Source: Miller & Rollnick, 2002
Core Components, cont’d

- Family Interventions
  - Collaborative/team approach: Inclusion of family in treatment planning and goal setting
  - Relationship building: Improving family interactions, communication & conflict resolution skills
  - Parent training: Improve caregiver ability to manage behavior problems
Using Motivational Interviewing with Adolescents

- Substance abusing youth often do not come to treatment voluntarily.
- With this approach, it is not necessary for adolescents to admit to having a problem to start treatment (in contrast to more traditional approaches—such as AA).
- Experimentation is normative during adolescence. MI can be applied to varying degrees of “readiness for change.”
- This technique places an emphasis on avoiding argumentation and hostile confrontation vs. lecturing or telling them what to do (e.g., “rolling with resistance”).
- MI strategies can be employed to encourage participation in treatment, to enhance motivation for change (when engaging in risky and harmful behaviors), and to facilitate adoption of learned skills.
Stages of Change

Source: Prochaska & DiClemente, 1982
Motivational Interviewing Techniques: Empathic Style-Reflective Listening

• Simple reflection
  – Repeating what the client says to convey that the therapist understands the client and that the intention is not to get into an argument with them.

• Amplified reflections
  – Slightly exaggerating the client’s statement to the point where the client may disavow or disagree with it. It is important that the counselor not overdo it, because if the client feels mocked or patronized, he/she is likely to respond with anger.

• Double-sided reflections
  – Require the therapist to reflect both the current, resistant statement, and a previous, contradictory statement that the client has made.
Motivational Interviewing Techniques:
Developing a Discrepancy

• Eliciting individual’s short term and long term goals
• How does current behavior hinder or prevent achievement of goals?
• Providing normative feedback
  – How does youth behavior compare to that of most teens
• Ask youth to describe what life would be like without behavior in question
• Decisional balance exercise
  – Evaluating costs and benefits of no change vs. change
### Motivational Interviewing Techniques: Decision Balance Exercise

<table>
<thead>
<tr>
<th>Good things about no change</th>
<th>Less good things about no change</th>
</tr>
</thead>
<tbody>
<tr>
<td>(continuing to use)</td>
<td>(continuing to use)</td>
</tr>
<tr>
<td>I don’t have to deal with my problems.</td>
<td>I feel guilty or ashamed.</td>
</tr>
<tr>
<td>I feel more confident.</td>
<td>I don’t like the way I look and feel after use.</td>
</tr>
<tr>
<td>I have something to do when I am bored.</td>
<td>It is a source of conflict between me and my family.</td>
</tr>
<tr>
<td>I use to fit in with my friends.</td>
<td>It is a source of conflict between me and my friends.</td>
</tr>
<tr>
<td>I have more fun at parties.</td>
<td>I will have money problems.</td>
</tr>
<tr>
<td>It helps me calm down and relax.</td>
<td>I will continue to feel anxious and depressed.</td>
</tr>
<tr>
<td></td>
<td>I will harm my health.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Less good things about changing</th>
<th>Good things about changing</th>
</tr>
</thead>
<tbody>
<tr>
<td>(reducing or stopping use)</td>
<td>(reducing or stopping use)</td>
</tr>
<tr>
<td>I will feel more depressed and/or anxious.</td>
<td>I will feel more in control over my life.</td>
</tr>
<tr>
<td>I won’t have anything to do when I’m bored.</td>
<td>I will gain more self-esteem.</td>
</tr>
<tr>
<td>I won’t have any way to relax.</td>
<td>It will improve my relationship with my family.</td>
</tr>
<tr>
<td>I will have to change my social life.</td>
<td>I will have more money.</td>
</tr>
<tr>
<td>I won’t fit in with some friends.</td>
<td>I will have fewer problems at work and/or school.</td>
</tr>
<tr>
<td>I don’t know if I can make change stick.</td>
<td>It will make it easier to achieve life goals.</td>
</tr>
</tbody>
</table>
Recommendations for Integrated Treatment For Both Trauma and Substance Abuse

- Cross train in mental health and substance abuse.
- Utilize screening and assessment tools that identify needs in both areas.
- Provide more intense treatment options to address the magnitude of difficulties often experienced by this population.
- Emphasize management and reduction of both substance use and PTSD symptoms early in the recovery process.
- Address the negative affect common to both substance use disorders and PTSD to help prevent relapse of both.
- Provide relapse prevention efforts, targeting both substance and trauma-related cues, early in treatment.

Sources: Back et al., 2000; Giaconia, et al., 2003; Ouimette & Brown, 2003
Coordinating Services with Other Agencies

- Offer case management for youth involved with multiple systems of care (schools, juvenile justice, child welfare, other substance abuse/MH treatment providers)

- Access available resources and develop partnerships
  - Integrate available services
  - Increase communication between providers
  - Develop local solutions (e.g., organizing multiple services across multiple systems)

- Foster use of evidence based practices that are trauma-informed and substance use informed

- Outreach efforts: School-based programs may represent an important means of reaching at-risk youth
Case Example: Lamont

• Describe possible challenges in developing a preliminary treatment plan, given Lamont’s history of acute trauma.

• What motivational interviewing strategies could you use to engage him in treatment to address his gang affiliation and/or substance use?

• How would you gain Lamont’s trust and address his concerns about confidentiality?

• How would you coordinate care between the juvenile court system, child welfare services and the school district in order to develop a comprehensive treatment plan?
Working with Caregivers
Case Example: Jenny

• Page 20 in your Participant Guide

• Jenny, a 15-year-old Hispanic girl, attends an inner-city high school where she was recently the victim of a beating. Formerly a good student, Jenny has now been refusing to go to school. Her school counselor calls the house and learns that Jenny is often agitated and has been having frequent nightmares. She refers Jenny to the school-based mental health provider.

• Suspecting that Jenny is experiencing posttraumatic stress from the beating incident, the therapist asks Jenny whether she and her mother could come in to school for an appointment. Jenny is very hesitant, explaining that she is afraid to go to school. Jenny also discloses that her father was killed as a result of political affiliations in El Salvador, and she is doubtful that her mother will trust enough to come into the office. It appears that Jenny’s experience at school has also shaken up her mother.
Case Example: Michael

- Page 30 in your Participant Guide
- Michael, a 14-year-old Caucasian boy, successfully completed a substance abuse residential treatment program. His mother recently complained to his probation officer that Michael was coming home past his curfew with bloodshot eyes, and was acting excessively irritable. He is referred to an outpatient treatment program for further assessment and possible treatment.
- Michael’s parents admit that they have been arguing, but deny any current violence.
- Michael’s father has a history of actively using and also dealing marijuana, and is once again under police scrutiny for suspicion of current problems with the law.
Case Example: Karen

• Page 36 in your Participant Guide

• Karen, a 17-year-old Korean American girl, has been referred by a local free clinic which offers testing for STDs. She has been sexually acting out and apparently abusing alcohol and drugs.

• During a home visit, the clinician discovers that Karen and her parents have also been experiencing stress and economic hardship. As first-generation immigrants, the parents work long hours and rely on their children to help them with household chores. The clinician learns that when Karen was little, a Korean neighbor babysat the girl. The parents found out that the woman’s husband had repeatedly abused their daughter. The abuse continued for about three years and the parents felt bad about not being around when Karen was younger. This also caused more hardship for them because they had to find a new babysitter.
Trauma-informed care refers not only to the recognition of the pervasiveness of trauma, but also to a commitment to identify and address it early, whenever possible.
What is COJAC?

In the summer of 2005, the State Co-Occurring Disorders Workgroup/COD Policy Academy members, along with representatives from the County Alcohol and Drug Program Administrators Association of California (CADPAAC) and the California Mental Health Directors Association (CMHDA), formed the Co-Occurring Joint Action Council (COJAC) to develop and implement the State’s COD Action Plan.
The COJAC Screening Committee

- One of the major objectives of the COJAC State Action Plan was to identify screening protocols designed to meet the needs of a variety of populations served by both AOD and Mental Health Systems, including adolescents, women with children, adults, and transition age youth with trauma.

- The Screening Committee was established; chair of the committee is Dr. Vivian Brown.
• The Committee was charged with identifying the best screening tool(s) for COD.

• The Screening Committee identified all instruments being utilized across the country; we found that the most widely used instruments were those designed either for identification of substance abuse or identification of mental illness.
The COJAC Screening Committee, therefore, decided to design a California screening tool that not only would identify COD, but would integrate trauma, be short enough to not burden clients nor staff, and simple enough to be utilized in a wide range of community service sites (including emergency rooms).
Co-Occurring Disorders Screening Instrument

Step 1 – Ask The Primary Screening Questions

3 Questions for Mental Health:
- Have you ever been worried about how you are thinking, feeling, or acting?
- Has anyone ever expressed concerns about how you were thinking, feeling, or acting?
- Have you ever harmed yourself or thought about harming yourself?

3 Questions for Alcohol & Drug Use (Health Canada Best Practice Report):
- Have you ever had any problem related to your use of alcohol or other drugs?
- Has a relative, friend, doctor, or other health worker been concerned about your drinking or other drug use or suggested cutting down?
- Have you ever said to another person, “No, I don’t have (an alcohol or drug problem,)” when around the same time you questioned yourself and felt, maybe I do have a problem?

3 Questions for Trauma/Domestic Violence:
- Have you ever been in a relationship where your partner has pushed or slapped you?
- Before you were 13, was there any time when you were punched, kicked, choked, or received a more serious physical punishment from a parent or other adult?
- Before you were 13, did anyone ever touch you in a sexual way or make you touch them when you did not want to?

Step 2 – If participant answers two questions Yes (1 mental health and 1 substance abuse or 1 substance abuse and 1 trauma), complete:
- GAIN Short Screener (SS) or other assessment tool.
The COJAC Screener

- The COJAC Screener is being implemented in a number of counties in California, including Los Angeles.

- At the same time, the state Alcohol and Drug Program is implementing an expanded two-year pilot test of the Screener.

- The COJAC Screener can be used with any parent/caregiver at the time of the child’s intake.
Parents/caregivers who have COD and trauma require help to:

- Identify the nature of the problems that they face
- Participate in interventions to help themselves and their family
- Accept referrals for more intensive treatment
Provide Feedback

• Use the screening form to provide feedback:
  – “It appears that you may be experiencing a number of problems.”
  - “These issues not only impact you, but also may have impact on your child.”
  - “We have a discussion group for parents that you might want to attend.”
Identifying and Recognizing Family Strengths

• It is important that the strengths of parents/caregivers of children with trauma-related symptoms also be identified and supported.

• Three C’s (caring, capable, challenged) posit that families are fundamentally caring and capable in many respects.

• Nevertheless, at present the family is challenged and uncertain about how to best help their child.

Source: Hodas, G.R., 2006
Creating Safety: Culture

• Understanding the influence of the parents’/caregivers’ culture(s) is essential to making an effective therapeutic alliance.

• One of the issues regarding culture is assisting the parent to express any traumatic experience related to his/her race and/or ethnicity.
Case Example: Debbie

• Please form pairs, with one person playing the part of the parent and the other of the therapist/clinician.

• The therapist is to screen the parent (using the COJAC Screener) to identify any trauma, mental health, and/or substance use problem.

• Be sure to introduce the topic before moving to the form.

• Then, after the screening, the therapist is to give feedback to the parent.
Debbie is a 30-year old divorced African American woman who presents her story speaking quite rapidly. She acknowledges a history of childhood sexual abuse and describes her many unsatisfactory attempts to get help since she has been experiencing disturbing memories and panic attacks for more than a year. She finds relief with alcohol and marijuana.

Debbie states that she would have given up on getting help, but she is worried about her 12-year old son. He has been failing in school and is “hanging out” with the wrong kind of friends.
Linking Caregivers to Appropriate Supports

- Evidence-Based Practices for Parents with COD and Trauma
  - Seeking Safety
  - Other CBT Curricula
- Evidence-Based Practices for Parenting Skills
  - Nurturing Parent Training
- Promising Practice from Women with Co-Occurring Disorders and Violence Study and its Children’s Subset Study
  - Prevention/Skills Building Group for Children
Evidence-Based Practices for Parents with COD and Trauma
Seeking Safety: A Training Manual for PTSD & Substance Abuse

Developed by:

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150 South Huntington, 1168-3
Belmont, MA 02130
E-Mail: Lnajavits@hms.harvard.edu or lisa.najavits@va.gov
www.seekingsafety.org

Source: Najavits, L.M., 2002
Seeking Safety: A Training Manual for PTSD & Substance Abuse

• Evidence-based, present-focused therapy designed to promote safety and recovery for individuals with trauma histories.

• Relevant for individuals with PTSD and those with trauma histories who do not meet criteria for PTSD.

• Based on 4 key content areas: cognitive, behavioral, interpersonal and case management.

• Able to be delivered in a variety of settings (inpatient, outpatient, field-based) and formats (group, individual).

• Integrates both Trauma and Substance Abuse

Source: Najavits, L.M., 2002
Treatment Topics

• Introduction to Treatment and Case Management
• Safety
• PTSD: Taking Back Your Power
• Detaching from Emotional Pain (Grounding)
• When Substances Control You
• Asking for Help
• Taking Good Care of Yourself
• Compassion
• Red and Green Flags
Treatment Topics, cont’d

- Honesty
- Recovery Thinking
- Integrating the Split Self
- Commitment
- Creating Meaning
- Community Resources
- Setting Boundaries in Relationships
- Discovery
Treatment Topics, cont’d

- Getting Others to Support Your Recovery
- Coping with Triggers
- Respecting Your Time
- Healthy Relationships
- Self-Nurturing
- Healing From Anger
- Life Choices Game (review)
- Termination
The Session Format

- **Check-in**
  - How are you feeling?
  - What safe coping have you done?
  - Any substance use or unsafe behavior?
  - Did you do your commitment?
  - Community resource update

- **Quotation**

- **Relate the topic (1 of the 25) to the women’s lives**

- **Closing**
  - Name one thing you learned from this session
  - What is your commitment for the next session?
  - What community resource will you call?
Adapting Seeking Safety to Different Contexts

12 Sessions (CTN Study)
• Introduction to Treatment
• Safety
• PTSD: Taking Back Your Power
• Detaching from Emotional Pain (Grounding)
• When Substances Control You
• Taking Good Care of Yourself
• Compassion
• Red and Green Flags
• Honesty
• Integrating the Split Self
• Creating Meaning
• Setting Boundaries in Relationships
• Healing from Anger

5 Sessions:
• Safety
• PTSD: Taking Back Your Power
• When Substances Control You
• Detaching from Emotional Pain (Grounding)
• Asking for Help

NCTSN The National Child Traumatic Stress Network
Seeking Safety
Grounding Demonstration
Seeking Safety
5-Session Module
Session 1: SAFETY

“Although the world is full of suffering, it is full also of the overcoming of it.”

- Safety as the first stage of healing from PTSD and SA
  - empower the patient to regain control
  - Help the patient to identify cues (who, what, when) are safe
  - Teach coping skills that may never have been learner in childhood
  - Assess the impact of SA and develop a plan for abstinence
  - Provide psychoeducation about SA and PTSD
Session 1: SAFETY

**DO:**
- Be active and directive
- Give the patient control
- Seek to understand the patient’s self-destructive behaviors as “symbolic or literal reenactment of the initial abuse.”

**DO NOT:**
- Do not offer dynamic interpretations
- Do not confront defenses
- Do not focus on therapist-patient relationship
Session 2: PTSD: Taking Back Your Power

“You are not responsible for being down, but you are responsible for getting up”

• Define PTSD
• Explore the relationship between PTSD and SA
• Help the patient to take back their power by viewing PTSD and SA with compassion
• Help patient understand the long-term impact of severe trauma

Handouts available for all of the above topics
**Session 3: When Substances Control You**

“Not to laugh, not to lament, not to judge, but to understand”

- Help patients honestly evaluate whether they have a substance use disorder
- Raise patient’s awareness of how substance abuse prevents healing from PTSD
- Identify an immediate plan to relinquish substance use that is REALISTIC and ACCEPTABLE to the patient (Quit at once, Try an experiment, Cut down gradually)
- Conduct an imaginative exercise, Climbing Mount Recovery, to help patients realistically prepare substances
- Help patients recognize that it is normal to have mixed feelings about giving up substances, as long as their actions remain safe
- Discuss the role of self-groups and encourage patients to attend them
- Help patients make sense of confusing messages they may hear about recovery from PTSD and SA
Session 4: Detaching from Emotional Pain (Grounding)

“No feeling is final”

• Teach grounding as a set of simple but powerful techniques to detach from emotional pain

• Conduct an in-session experiential exercise on grounding (record for patients to take home)

• Explore how grounding can be applied to patients’ day-to-day problems
Session 5: Asking for Help

“And the trouble is, if you don’t risk anything, you risk even more”

- Discuss effective ways to ask for help
- Rehearse how to ask for help
- Explore patient’s experiences in asking for help
Cognitive Behavior Therapy (CBT)
Cognitive Theory

• CBT is designed to be a short-term approach suited to the resource capabilities of many delivery systems.

• It focuses on immediate problems and is structured and goal-oriented.

• It is a flexible, individualized approach that can be adapted to a wide range of clients, settings (both inpatient and outpatient), and formats, including groups.
Key Ingredients of CBT Therapies

• The identification and debriefing of past and future high-risk situations

• The encouragement and review of extra-session implementation of skills

• Practice of skills within sessions
Antecedents are activating situations or life events (something happens or is about to happen—situations about which the individual has strong feelings). Cognitions represent the individual’s opinions, thoughts, or attitudes that serve to filter and distort the perception of the antecedents. Behavior is the individual’s observable actions and emotional reactions that result from his/her beliefs and emotions (how someone thinks or feels and the behavior resulting from those thoughts).
Key Ingredients of CBT Therapies, cont’d

- **Polarized thinking**—thinking of things as black or white, good or bad, perfect or failures, with no middle ground.

- **Control fallacies**—feeling externally controlled as helpless or a victim of fate or feeling internally controlled, responsible for the pain and happiness of everyone around.

- **Blaming**—holding other people responsible for your pain or blaming yourself for every problem.
Key Ingredients of CBT Therapies, cont’d

- **Fallacy of change**—expecting that other people will change to suit you if you pressure them enough; having to change people because your hopes for happiness seem to depend on them.

- **Being right**—proving that your opinions and actions are correct on a continual basis; thinking that being wrong is unthinkable; going to any lengths to prove that you are correct.
A Cognitive-Behavioral Model of the Relapse Process

Confronts a high-risk situation

CLIENT

Chooses and makes use of appropriate coping response

Response does not use adequate coping

Experiences decrease in self-efficacy, with a resulting sense of helplessness or passivity and decreased self control

Experiences a sense of mastery and an ability to cope with the situation

Has expectation that a drink would help the situation (positive outcome expectancies)

These perceptions and expectancies lead to initial use of alcohol

Results in “abstinence violation effect”

Feels guilt and loss of control

These feelings increase the probability of relapse

These perceptions decrease the likelihood of relapse

Source: Adapted from Alan & Kadden, 1995
How the Trauma-Informed Team Works with the Family
A Trauma-Informed Approach
Includes a Trauma-Informed Team

• A trauma-informed team integrates mental health, substance abuse, and trauma work.

• A trauma-informed team integrates child interventions and parent/family interventions.

• A trauma-informed team integrates work with the multiple systems affecting the child and family.

• A trauma-informed team integrates the parent, who is a consumer-survivor or person with lived experience, as a full member.
The Team Approach is Essential to Effective Service Provision

- It allows us to assemble “expertise packages” to provide the highest quality services (i.e., we can assemble the best group of individuals with varying expertise, including trauma work).

- It allows us to use staffing patterns that permit backup and sharing of clinical responsibilities and coverage.

- It allows us to treat the child(ren) and parents/caregivers and, at the same time, work with the multiple systems affecting the child and family.
Managing Professional and Personal Stress
Professional Stress

- The provision of mental health services for traumatized children can increase the potential for secondary traumatic stress. Clinicians may be confronted with danger, threats, or violence.

- Clinicians may empathize with their clients’ experiences; feelings of helplessness, anger, and fear are common.

- Clinicians who are parents—or who have their own histories of childhood trauma—may be at particular risk for experiencing such reactions.
Personal Stress

• Clinician self-care is an important aspect of a trauma-informed system.

• Working with trauma survivors reminds us of our own vulnerability to traumatic events, the dangerousness of the world we live in, and the way in which the things that matter to us (e.g., our loved ones, our health, our sense of meaning) can be suddenly affected.

• The term “vicarious traumatization” was first used in 1990 to describe secondary traumatic stress (in the helper).
Personal and Professional Stress

• When we helpers ignore our own stress and emotional experiences in working with trauma survivors, we are more likely to respond in ways (both direct and indirect) that create distance and disconnection from our clients.

• When the work is with children who have experienced interpersonal traumas, the pain for the helper is deeper and another level of vulnerability is touched.

• Another issue occurs when the clinician is a survivor of abuse and is dealing with his/her own abuse issues while delivering care to other survivors.

• As a result of their experiences, survivor-clinicians have the potential to bring a unique understanding to their work. However, this capacity, can pose difficulties for survivor-clinicians, who may overextend themselves in order to help everyone.

Source: Saakvitne et al., 2000
Impact of Working with Victims of Trauma

- Trauma experienced while working in the role of helper has been described as:
  - Compassion fatigue
  - Countertransference
  - Secondary traumatic stress (STS)
  - Vicarious traumatization

- Unlike other forms of job “burnout” STS is precipitated not by work load and institutional stress, but by exposure to clients’ trauma.

- STS can disrupt clinicians’ lives, feelings, personal relationships and overall view of the world.
Recognizing Signs of Secondary Traumatic Stress

• Secondary traumatic stress shows up in strong reactions of grief, rage, and outrage, which grow as we repeatedly hear about and see people’s pain and loss. It is also evident in our emotional numbing and our wishes not to know.

• Other signs include:
  – Feeling off balance
  – Being easily flooded by negative feelings and having to limit exposure to violence (e.g., by avoiding TV or movies)
  – Being easily moved to tears
  – Feelings of “burn-out”
  – Feelings of despair and hopelessness
  – Reduced productivity
Managing Personal and Professional Stress: What Clinicians Can Do

- Request and expect regular supervision and supportive consultation.
- Utilize peer support.
- Consider therapy for unresolved trauma, which the child therapy work may be activating.
- Practice stress management through meditation, prayer, conscious relaxation, deep breathing, and exercise.
- Develop a written plan focused on work-life balance.
- Participate in community-building activities and system change. We need to collaborate with our clients, our co-workers, and our communities in order to truly make a difference and transform our feelings of isolation.
Managing Personal Stress: What Clinicians Can Do

- Attend to your health: physical, emotional, psychological, and spiritual
- Eat healthily
- Exercise
- Take mini-vacations
- Practice receiving from others
- Spend time with important people in your life
- Identify comforting activities
- Take time to eat lunch and chat with co-workers
Self-Care/Coping

• Three essential tools in coping with secondary traumatic stress are awareness, balance, and connection.
  – **Awareness**: Being attuned to your needs, limits, emotions, and resources.
  – **Balance**: Maintaining balance among work, play, and rest.
  – **Connection**: Connections to oneself, to loved ones, to colleagues, and to the larger community.

Source: Saakvitne et al., 2000
Brainstorming
About Organizational Change