Fundamentals of Trauma Processing

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Faculty

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Faculty Disclosure

Contributing faculty, Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This intermediate course is designed for psychologists who may encounter trauma-related disorders and their manifestations in professional settings.

Accreditations & Approvals

American Psychological Association

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Course Objective

The purpose of this course is to provide psychologists with the information necessary to assist clients to identify and process traumas that may be affecting their lives.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline concepts and definitions important to effective trauma work.
2. Identify various models of trauma and information processing.
3. Assess for the presence of clinically significant trauma in an individual.
4. Evaluate aspects of the first stage of trauma treatment with the three-stage consensus model.
5. Describe stages 2 and 3 of the three-stage consensus model and their use in the treatment of trauma-related disorders.
6. Determine one's own strengths and weaknesses in clinically addressing trauma and their various clinical manifestations.
7. Access the best possible referrals for enhanced client care.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

For decades, the helping professions have regarded the treatment of trauma as a "specialty." Many times, counselors and therapists will seek to refer any clients with trauma issues to a trauma specialist. The larger concern is that professionals do not feel equipped to handle such issues. At this stage in societal evolution, traumatic experiences and the ways that they affect people are so prevalent that trauma work can no longer afford to be labeled a specialty treatment in the helping professions. Rather, trauma competency is something that every professional should master, at least at a basic level.

This course will show that trauma competency is an essential characteristic for helping professionals in the modern era. To make this case, what trauma means and how to conceptualize it will first be explored. This demystification process is an essential component of moving trauma treatment from a specialty into the realm of routine clinical treatment. For many professionals and lay people, trauma has become synonymous with the formal diagnosis of post-traumatic stress disorder (PTSD), and this course will examine why that association is not practical in clinical care.

To achieve the task of defining and conceptualizing trauma, this course will examine various definitions, clinical models, and analogies. Then, strategies for assessment, recognizing the presence of clinically significant trauma, and developing an appropriate plan of action will be discussed. One of the simplest, most useful models available to guide trauma treatment is the three-stage consensus model, and this will offer the framework for the section on treatment. Next, the course delves into practical strategies for addressing the interaction between trauma-related disorders and addictive disorders and why developing an integrated treatment plan is vital.

In addition to these treatment-specific concepts, the course will cover a myriad of professional development issues that become very important in the context of effective trauma treatment. There is considerable evidence that a solid therapeutic alliance is essential for the implementation of effective trauma treatment, especially in the most severe cases of trauma. Thus, it is vital to consider the traits of a quality therapeutic alliance and to assess what personal qualities may contribute to or hinder this alliance. This personal assessment includes examining the ability to empower clients and implement skills to handle intense affect within sessions. Finally, the course will cover strategies for working in collaboration with other professionals in the community to increase clinicians' confidence about treating trauma and bolster clinical effectiveness.

FOUNDATIONS: CONCEPTUALIZING TRAUMA

DEFINING TRAUMA

Trauma is defined in many ways, but it is important to remember that it is a noun; it refers to an actual experience or wounding. Often, clinicians describe trauma based on its effects, not the actual experience. The word trauma is derived from the Greek word that literally means wound. By considering what physical wounds are and how they affect humans, the meaning of emotional trauma may be further understood. Basic principles of physical wounds and wound care include [1]:

- Wounds come in all shapes and sizes.
- Open wounds are usually visible to others and include incisions (e.g., from knives), lacerations (tears), abrasions (grazes), punctures, penetration wounds, and gunshot wounds.

- Closed wounds are usually not obvious to others and include contusions (bruises), hematomas (blood tumors), internal scar tissue, crush injuries, and slowly forming chronic wounds that can develop from conditions such as pressure ulcers.
- Wounds can form due to a variety of causes.
- Wounds can affect different people in different ways, depending on specific variables (e.g., medical issues, genetics, environmental factors, psychosocial considerations, economic issues, access to treatment).
- Wounds heal from the inside out.
- Wounds are usually obtained quickly but take time to thoroughly heal.
- Before wounds can begin to heal internally, steps must be taken to stop the initial bleeding (e.g., using bandages, gauze, stitches, sutures).
- Failure to receive the proper treatment after a wounding can complicate the healing process.
- Wounds can leave a variety of scars. Some are permanent, others are temporary. Many no longer hurt after the scarring has taken place, but some scarring can cause ongoing irritation.
- The skin around a healed scar is tougher than the rest of a person's skin.
- No two people wound in exactly the same way, even if they experience similar injuries.

This knowledge and logic regarding physical wounds can be applied to the emotional realm as well. Emotional traumas also come in various shapes and sizes, resulting from many possible causes. For some, a simple trauma (wound) can clear on its own, but for others with more complex emotional variables, the healing process may take longer. If a traumatized individual does not obtain the proper conditions to heal, it will likely take longer for the trauma to resolve. In the meantime, other symptoms can manifest. When drawing the parallels between physical and emotional trauma, understanding the concept of re-wounding is imperative. If the wound is continuously prodded, with insensitive comments and potentially re-traumatizing actions, the wound will worsen [1].

These comparisons between physical and emotional wounds are intended to begin the process of exploring the meanings of trauma. However, operational definitions of trauma, as officially supported by the psychologic professions, are also useful. According to the American Psychological Association's *Dictionary of Psychology*, trauma is [2]:

> Any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual's view of the world as a just, safe, and predictable place.

Helping professionals continue to debate whether certain types of trauma are "worse" than others. For instance, this definition goes on to propose that traumas caused by humans (e.g., rape, assault) often result in greater psychologic impact than those caused by nature (e.g., earthquakes, floods) [2]. Others, however, assert that trauma caused by people may be worse for certain people, but it depends on an individual's situation, constitution, and overall coping system in place to deal with the trauma. Because the human experience of trauma is fundamentally subjective, comparing traumas is difficult and generally not helpful.

ADVERSE LIFE EXPERIENCES AND POST-TRAUMATIC STRESS DISORDER

In 2001, Shapiro introduced the ideas of classifying trauma into one of two forms: large-T trauma and small-t trauma [3]. Large-T traumas are events that most people would experience as horrific or life-threatening. Examples of large-T traumas include assault, rape, military combat, or natural disasters. Essentially, whenever there is a life-threatening component or one perceives his or her life to be in danger, large-T trauma is involved. Large-T trauma is commensurate to what is called a Criterion A trauma in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) description of PTSD.

Although many clinicians still consider the large-T/small-t taxonomy useful, Shapiro has moved away from this original distinction, now opting for the term "adverse life experiences" [59]. These adverse life experiences may or may not qualify for a DSM-5 diagnosis of PTSD. It is important to note that it was never intended for people to use the large-T/small-t system as a value judgment; small-t trauma can be just as valid and just as clinically significant as large-T trauma [3]. The hope is that using the term adverse life experiences will keep inadvertent value judgments from taking place.

The DSM-5 includes full diagnostic criteria for PTSD, including qualifiers and specific symptoms. However, the following abbreviated definition of the PTSD diagnosis may be used as a general framework [5]:

- Exposure to actual or threatened death, serious injury, or sexual violence (Criterion A)
- Re-experiencing of the trauma (Criterion B)
- Persistent avoidance of stimuli associated with the trauma (Criterion C)
- Negative alterations in cognitions and mood associated with the trauma (Criterion D)
- Marked alterations in arousal and reactivity associated with the trauma (Criterion E)
- Duration of symptoms longer than one month (with anything less than one month falling under the category of acute stress disorder)
- Functional impairment due to disturbances
- Disturbances not attributable to the effects of a substance or medical condition

Criterion A Trauma

The PTSD diagnosis first appeared in the DSM-III in 1980, in response to cases stemming from the Vietnam War [4; 5]. However, PTSD certainly did not start in 1980. The notion of it has been recognized throughout the ages, being referred to by such names as combat neurosis, shell shock, and hysteria. According to the DSM-5, an individual must have experienced a Criterion A trauma for PTSD to be officially diagnosed [5]. The DSM-5 significantly expanded the definition of Criterion A trauma. In the DSM-IV-TR, Criterion A trauma required there to be some threat to physical integrity or life; many professionals used the colloquialism "threat to life or limb." In the DSM-5, witnessing a traumatic experience (real or threatened) happen to someone else also qualifies, as does violent or accidental death (real or threatened) to a family member or close friend. Sexual assault and certain cases of vicarious traumatization connected to work experiences also now qualify as Criterion A. Although the presence of a Criterion A trauma is a necessary qualification for a diagnosis of PTSD, not all persons who experience Criterion A trauma will develop PTSD.

Criterion B Symptoms

Criterion B encompasses symptoms related to the re-experiencing of the trauma. The classic examples include flashbacks, vivid dreams, and nightmares. Hallucinations of all types can also be a part of Criterion B. When an individual is experiencing hallucinatory symptoms, he or she is typically diagnosed with some type of psychotic disorder and placed on the corresponding medications. However, it is important to assess whether or not these voices or visions are connected to earlier trauma; if so, PTSD may be a more appropriate diagnosis than a psychotic disorder. Auditory hallucinations

may represent voices of an abuser or of a cruel parent, and visions may be flashbacks to an abusive episode. It becomes especially important to explore the content of these hallucinations in individuals who have experienced complex PTSD, which will be discussed in greater detail later in this course. Intense physiologic distress, often conceptualized as manifestations of a body memory, can also fall under Criterion B symptoms.

Criterion C Symptoms

Criterion C refers to avoidance of stimuli associated with the trauma. These symptoms of avoidance may manifest to help a survivor steer clear of distress, real or perceived, connected to the Criterion A event/experience. Unlike in DSM-IV-TR, in which specific symptoms of avoidance were listed, no specific symptoms are mentioned in DSM-5; it is up to the clinician's discretion to determine which symptoms and presentations are signs of avoidance. Common examples of avoidance symptoms include isolation, agoraphobic tendencies, substance use, or other reinforcing behaviors. In the modern era, technology (e.g., texting, social media) may be used as an avenue for avoidance.

Criterion D Symptoms

Criterion D includes negative alterations in cognition and mood associated with the traumatic event(s). This is characterized mainly by negative self-image, self-blame, and/or negative beliefs about others or the world. An inability to remember an important aspect of the trauma (dissociative amnesia) is considered part of Criterion D. Additional Criterion D symptoms include [5]:

- Negative emotional state (e.g., fear, shame, anger)
- Diminished interest or participation in significant activities
- Detachment or estrangement
- Inability to experience positive emotions

These symptoms may be similar to those seen with depressive or dissociative disorders.

Criterion E Symptoms

Criterion E contains heightened arousal symptoms, which are also associated with psychologic pain. The two major symptoms associated with Criterion E are hypervigilance (e.g., always being on guard for something bad to happen) and an exaggerated startle response (i.e., a person is more "jumpy" than what would be considered normal). However, there are other major avoidance symptoms that are often attributed to other diagnostic categories without the trauma ever being examined. These other symptoms are [5]:

- Problems focusing or paying attention
- Sleep disturbance
- Increased irritability or outbursts of anger
- Reckless or self-destructive behavior

These symptoms are often misdiagnosed, and client care can suffer as a result. These misdiagnoses can occur due to simple misunderstanding of trauma and PTSD.

Problems with attention and focusing are Criterion E symptoms, but such symptoms are typically described as being part of an attention-deficit disorder. Sleep disturbance, which includes problems falling or staying asleep (without nightmares), is also a valid symptom under Criterion E. However, clients with sleeping difficulties are often prescribed medication without root causes ever being explored, particularly when treated solely by a non-mental health provider. Finally, symptoms of irritability, recklessness, and angry outbursts may be attributed to the bipolar spectrum, impulse control problems, or as part of an addiction. Clients struggling with symptoms of moodiness, irritability, and out-of-control anger may label themselves as bipolar due to the attention that the term has generated in recent decades. It is possible that the client has an issue with addiction or bipolar disorder, but it is vital to explore whether or not these symptoms can be better explained by trauma.

NON-CRITERION A ADVERSE LIFE EVENTS

Trauma does not necessarily need to be Criterion A for it to be clinically significant. This notion is the basis of Shapiro's concept of small-t trauma, now referred to as adverse life events not qualifying for PTSD [3]. This type of trauma includes all of the upsetting life events that may prove difficult to handle. Many clients may minimize small-t traumas, believing that if they did not survive a major disaster their trauma is somehow less legitimate or significant. Sadly, professionals and family members may further reinforce this devastating belief by comparing levels of trauma among clients or family.

Adverse life experiences can encompass a variety of events and issues, including verbal abuse, bullying, divorce, a medical crisis, and losing a pet, among many others. However, if an individual is unable to process or make sense of a small-t traumatic experience or series of experiences, it can cause just as much psychologic damage as a large-T trauma. Because of this subjectivity, the concepts of large-T and small-t traumas are controversial, as many argue that it is all trauma and it is all significant. It is true that small-t traumas can absolutely destroy people psychologically. However, due to the realities of clinical practice and the issues of diagnosis and billing, these separate constructs can be useful. Large-T traumas are those that we can diagnose (and thus bill) as PTSD. So, the question remains: How can these adverse life events be diagnosed and treated?

There is a wide variety of diagnoses that are either caused by or exacerbated by adverse life events. Depression is one diagnosis that may be the manifestation of or exacerbated by adverse life event(s). Other anxiety disorders, mood disorders, adjustments disorders, and even a variety of paraphilias and other problematic behaviors catalogued in the DSM-5 can fall into this spectrum of trauma-related disorders. For example, many personality disorders are being conceptualized as complicated manifestations of unhealed trauma that occurred at a developmentally vulnerable period. Because these disorders cover a wide range of the population, clinicians may be clinically interacting with traumatized individuals without being aware of it. For full practical purposes, clinicians should always diagnose according to symptoms. However, using the logic of adverse life events and the broader conceptualization of trauma, one may be able to honor the significant nature of all traumas and treat disorders using trauma-competent strategies, even if the diagnosis is not PTSD. The general principle to keep in mind is that trauma does not have to meet PTSD criteria to be clinically significant; it may manifest as something else entirely. The principles of trauma competency discussed in this course, however, may be used to enhance the treatment of other diagnoses.

Case Study

Client A is a young white man, 18 years of age, who grew up in a middle-class section of an affluent community. He presents for treatment because he is struggling with several identity and lifestyle issues, specifically how to attain a fulfilling romantic relationship. Client A recognizes that he struggles with having a "big ego," but he admits to disliking many things about himself, such as his "gut." (He is slightly overweight at the time of presentation.) The client has recently graduated from high school, where he had been successful in many activities, but he has always believed he was capable of performing better. He found himself in a deep depression after a girl in whom he was interested gave him mixed messages and, ultimately, rejected him. Client A has wanted to examine his issues for some time but grew especially concerned when, following the girl's rejection, he punched a wall and almost broke his hand.

Client A identifies that the main negative message he heard when the girl rejected him was, "I am worthless." Interestingly, some of the reasons the girl rejected the client existed long before she met him, including the fact that her conservative family pressures her not to date. However, Client A is unable to see this evidence. Using a series of questions, he and his therapist trace the negative message ("I am worthless") back to two instances that occurred

roughly around the same time. The first was when he was in elementary school and did not have many friends, and the second was when his parents made fun of him for being unpopular. When he was about 8 years of age, he overheard his parents talking in the kitchen one night when they thought he was in bed, mocking him for his "big ears" and for being an awkward kid. This absolutely devastated Client A and served as the small-t trauma that resulted in his pervasive, depression-provoking belief in his own worthlessness.

DISSOCIATION

It is irresponsible to present a course on trauma without covering dissociation. Although the dissociative disorders receive their own diagnostic attention in the DSM-5, it is important to consider that dissociation and severe trauma often co-occur. Dissociation is a numbing, detaching defense on which the mind may rely to cope with the intense disturbance of trauma. The most extreme forms of dissociation, such as dissociative identity disorder (formerly known as multiple personality disorder), dissociative amnesia, and depersonalization/derealization disorder, can be particularly baffling to even the most experienced clinicians.

However, dissociation is a part of the human experience. Whether we realize it or not, everyone engages in dissociation—daydreaming is a form of dissociation. In *The Dissociative Mind*, Howell demystifies the phenomenon [6]:

> The rising tide of trauma and dissociation studies has created a sea change in the way we think about psychopathology. Chronic trauma… that occurs early in life has profound effects on personality development and can lead to the development of dissociative identity disorder (DID), other dissociative disorders, personality disorders, psychotic thinking, and a host of symptoms such as anxiety, depression, eating disorders, and substance abuse. In my view, DID is simply an extreme version of the dissociative structure of the psyche that characterizes us all. Dissociation, in a general sense, refers to the rigid separation of parts of experience, including somatic experience, consciousness, affects, perception, identity, and memory.

Clinicians often fear dissociation, believing that if a client "drifts off" during a session, they will not be able to bring them back in a safe manner. Education about dissociation, like trauma, is becoming increasingly more important for clinicians as clients affected by it become more common. Part of this involves seeking peer consultation or supervision with clinicians who are comfortable handling dissociation.

THEORETICAL MODELS

Several models exist to explain trauma and how it affects the human experience, and this section will focus on three models commonly used in clinical practice. Different clinicians may find some of these models more useful than others in informing treatment, which is expected. This is why models, which are essentially trying to explain the same phenomenon, tend to develop independently over time. However, clinicians should have a grasp on several of these models because clients may respond to each model, used to guide treatment, differently.

PROCESSING AND REPROCESSING

There are many ways for humans to process and reprocess an experience. The models discussed in this section are intended to illuminate the reasons trauma affects people and offer an approach to addressing the problem by reprocessing the trauma.

Processing is the act of making sense of an experience or learning and can include achieving the resolution needed to move on from a traumatic experience or series of experiences. Processing can be equated to digesting an unsettling event. Thus, if some aspect of trauma is not processed (or digested) properly, it

will continue to cause problems until it can be dealt with and released, a process referred to as reprocessing. Reprocessing refers to consciously accessing the affected memory or experience (trauma) that has not been properly processed and striving to bring about a more adaptive experience. This term came into wider use with the advent of eye movement desensitization and reprocessing (EMDR) therapy. However, the term may be used with appreciation of the underlying logic even if EMDR therapy is not applied.

Returning to the wound metaphor, healthy processing is analogous to proper treatment given to a wound within an appropriate time frame, with the individual allowed the space necessary to heal. However, individuals who are not allowed to heal properly will continue to experience physical problems as a result of the body not being able to healthfully process, or heal, the wound. In these cases, reprocessing would involve allowing physicians to address the root cause of the wound and taking the necessary time to heal properly. If this reprocessing takes place successfully, the individual should no longer experience the physical sequelae from the original injury. This same basic process applies to healing from emotional or psychologic trauma.

THE THREE-STAGE CONSENSUS MODEL

There is a general consensus in the traumatic stress literature that addressing trauma should occur in three stages [14; 15; 16; 17]. The three-stage consensus model, with origins tracing back to the French psychiatrist Pierre Janet in the 1880s, is an important tool to place the discussion of processing and reprocessing into some context. Within the consensus model, reprocessing experiences is part of stage 2, or working through the trauma. Clinicians often err by jumping right into the processing or working through of the trauma without some stabilization strategies in place, which can make treatment more difficult. This three-stage consensus model will be explored in depth later in this course.

The three stages originally proposed by Janet were [60]:

- Stabilization, symptom-oriented treatment, and preparation for liquidation of traumatic memories
- Identification, exploration, and modification of traumatic memories
- Relapse prevention, relief of residual symptomatology, personality reintegration, and rehabilitation

The simplicity of the model suggests that treatment has a beginning, middle, and end (perhaps better conceptualized as maintenance). Naturally, there is space for clinicians to apply their preferred theoretical frameworks. However, treatment planning, regardless of theoretical approaches or interventions, should follow this three-stage model as a guide.

One of the greatest misconceptions about trauma counseling is that it is all about catharsis, or the second stage (i.e., identification, exploration, and modification of traumatic memories). However, if a patient or clinician jumps into catharsis without having a foundation of stabilization, including a therapeutic alliance and a set of coping or affect regulation skills, further damage can result [13].

Another misconception about trauma counseling is that once trauma is processed or cleared, then it is gone. This mindset promotes the idea that trauma can be cured. A healthier approach is to view trauma as a wound that may be healed. Even after a person has a major catharsis or breakthrough in counseling, there is still work to be done with his or her adjustment [12].

Consider how the consensus model fits with the wound metaphor addressed earlier in this course. Stabilization is the immediate attention to a wound. For example, stabilization might mean cleaning out the wound and disinfecting the area. Then, a dressing is generally applied to stop the bleeding and prevent infection or contamination. However, the wound needs to be exposed to the light and air in order to fully heal. Healing occurs from the inside

and can take a great deal of time. This process is stage two. After a wound heals, it generally leaves a scar. In cases of relatively benign wounding, that scar may resolve completely. With more significant injuries, a person may live with a scar or whatever aftermath is left after the wound heals.

In 2012, an expert consensus panel of the International Society for Traumatic Stress Studies issued their recommendations for addressing complex posttraumatic stress. The panel still recommends the general sequence of the three-stage consensus model as the standard for trauma care [9]. The 2013 World Health Organization report on treating trauma also makes reference to similar themes, particularly the importance of psychologic first aid (or stabilization) as a standard of care for PTSD [8].

THE TRIUNE BRAIN MODEL

To further the role of processing, it is vital to review some basic biology. MacLean's triune brain model suggests that the human brain actually operates as three separate minds, each with its own special role and its own respective senses of time, space, and memory [10]. While this model's use in terms of neuroanatomic evolution is considered by some to be outdated or oversimplified, it is useful as a purely explanatory tool. It describes the brain structure in a manner that is easy to understand and use as a conceptualization for treatment planning.

- The R-complex brain (reptilian brain): Includes the brainstem and cerebellum. It controls reflex behaviors, muscle control, balance, breathing, and heartbeat, and is very reactive to direct stimulation.
- The limbic brain: Contains the amygdala, hypothalamus, and hippocampus. It is the source of emotions and instincts within the brain, including attachment and survival. When this part of the brain is activated, emotion is activated. According to MacLean, everything in the limbic system is either agreeable (pleasure) or disagreeable (pain/distress), and survival is based on the avoidance of pain and the recurrence of pleasure.
- The neocortex (or cerebral cortex): Contains the frontal lobe and is unique to primates. The more evolved brain, it regulates executive functioning, which can include higher-order thinking skills, reason, speech, meaning, and sapience (e.g., wisdom, calling on experience).

Humans rely on all three brains to function. Thus, optimal processing of information would require all three brains to harmoniously operate to facilitate this essential processing.

Application to Cognitive Interventions

Cognitive therapies are designed to activate and work with higher-order thinking. However, for clients who have unprocessed trauma symptoms, the three brains are not fully communicating. During periods of intense emotional disturbance, the functions of the frontal lobe cannot be optimally accessed because the limbic brain, or "survival brain," is in control [11]. Moreover, if a person is triggered into a fight, flight, or freeze response at the limbic level, one of the quickest ways to alleviate that pain after the distress is to feed the pleasure potential in the R-complex. Alcohol, drugs, food, sex, gambling, shopping, hoarding, or other reinforcing activities are particularly effective at managing the pain [1].

Traumatized individuals are often stuck in a survival mode. The limbic region of the brain is activated during the original trauma to help the traumatized person survive. Because the left and right frontal lobes are abandoned during the experience (resulting in awareness but lack of ability to process), the individual is never able to link the limbic activation to the frontal lobe. Thus, in developing treatment plans for traumatized individuals, using cognitive strategies that primarily target the frontal lobe may not be effective.

One reason trauma may remain unprocessed is due to a misunderstanding of what processing involves. In many Western cultures, clinicians tend to assume that talking is the best way to process trauma; however, in other cultures, the approaches can vary from spiritual interventions to physical treatments. In many mental health and addiction treatment settings, talking is synonymous with processing. Although talking can help a person process, it is primarily a function of the frontal lobe. A person can talk about the trauma extensively, but until it is addressed at the limbic level, the trauma will likely remain a problem [13]. Other healthy modalities of processing can include exercise, breath work, imagery, journaling, drawing, prayer, or dreaming. These experiential modalities are more likely to address limbic-level activity when compared to the classic "talking it out" strategies [13].

PROPOSALS FOR THE FUTURE OF TRAUMA DIAGNOSIS AND TREATMENT

From the time that it was introduced in 1980, some have criticized the PTSD diagnosis as being too one-dimensional. The criteria generally only apply to those who experienced a single, catastrophic trauma, and they were written primarily with combat veterans (primarily men) in mind. Individuals who experienced prolonged trauma over time, be it subtle or overt, are generally excluded. For example, children who grow up in dysfunctional homes and seem to be affected by that trauma may not have a single Criterion A event on which a PTSD diagnosis can be made.

In response to these criticisms, the concept of complex PTSD has been introduced [18]. Essentially, complex PTSD refers to conditions of prolonged trauma or trauma that occurs at developmentally vulnerable times, resulting in effects more significant than is believed possible with standard PTSD. In its most updated definition, complex PTSD manifests from conditions that [15]:

- Are repetitive or prolonged
- Involve direct harm and/or neglect or abandonment by caregivers or ostensibly responsible adults
- Occur at developmentally vulnerable times in the victim's life, such as early childhood
- Have great potential to severely compromise a child's development

In the DSM-5, modifications to the PTSD diagnosis were made to acknowledge some of the potential developmental manifestations of trauma [5; 19]. The revised DSM includes separate criteria for children younger than 6 years of age, and the former Criterion A symptom of subjective reaction to the trauma has been removed [5]. Although it was considered for inclusion, the DSM-5 does not include a separate category for complex PTSD. Furthermore, the category Disorders of Extreme Stress Not Otherwise Specified, which was another term for complex PTSD, has been removed. Additional subtypes of PTSD with dissociative symptoms or delayed manifestation (six months or longer after trauma exposure) have been added. Although this along with the established preschool criteria may encompass some (or even many) cases of complex PTSD, critics believe the DSM-5 does not account for the developmental nature of trauma enough.

Although not an official DSM-5 diagnosis, complex traumatic stress disorders are real to many clients and clinicians. The label of complex PTSD suggests that the healing of original traumatic wounds can be further complicated due to a variety of conditions [13].

Santoro suggests that borderline personality disorder is a manifestation of complex PTSD, and upon closer examination, many of the Cluster B personality disorders (e.g., borderline personality disorder, antisocial personality disorder) occur in individuals who have experienced profound trauma in childhood [20]. If a clinician is treating personality disorders, it is likely that his or her clients may be displaying complex PTSD in some form. Therefore, knowledge about trauma and PTSD can help to enhance understanding of these complicated and relatively common personality conditions.

ASSESSING FOR TRAUMA-RELATED DISORDERS

CLINICAL INTERVIEWING STRATEGIES

Clinicians often view assessment as the first session in which a clinician gets to know a client and gathers enough data to make a diagnosis. However, it is important to think of assessment as an ongoing process, starting before diagnosis and continuing throughout treatment, whereby data are gathered to inform the course of treatment based on the client's goals. A good initial assessment is important to ensure that an appropriate clinical snapshot is obtained and treatment is begun on the most appropriate footing. However, especially with traumatized clients who may be hesitant to disclose too much too soon, it is vital to remember that more may be revealed throughout the treatment process. Just because there were no obvious red flags for trauma in the initial session does not necessarily mean that trauma is not a factor. The client may be testing boundaries or a clinician's trustworthiness before revealing his or her most painful, private material.

The American Psychiatric Association recommends that the initial psychiatric evaluation of a patient include review of the patient's trauma history.

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Strength of Recommendation: 1C (Recommended based on low-quality evidence)

This section will focus on several best practices to use for questioning during initial clinical interviews. These best practices may seem like good common sense regardless of a client's history, and they are especially helpful guidelines when assessing a client with a possible trauma issue.

Although every agency or office uses its own assessment form (and some states incorporate standardized forms), some will not include questions or sections about trauma. In these cases, the trauma questions should be worked into other potentially pertinent areas, like sexual history, grief and loss, or childhood/family constellation issues. A form's failure to include questions about trauma does not excuse the clinician from exploring, at a basic level, whether any major traumatic events occurred. Use the major sections on the form as a guide and follow-up with some additional questions. If appropriately placed, this can invite clients to provide more in-depth history about their experiences. For example, the following questions could be incorporated into various sections of an assessment:

What were things like for you growing up? This is a relatively benign, open-ended question that falls into the family constellation section. It can allow clients to provide as much or as little detail as they would like at the time it is asked. If they give a short, simple answer, one may follow-up. If asked in a friendly enough tone, the client may crack a joke that breaks the ice and leads to a fruitful discussion.

Tell me about any significant losses that you've had in your life that you had difficulty dealing with. This question could be incorporated into the grief/loss section. It is important not to use the word "death" specifically, because loss, especially traumatic loss, can come in many forms (e.g., pets, marriage, career). After the client identifies the loss, follow up by asking the open question of what impact those losses had on his or her life. If done carefully and compassionately, this strategy can also open up further dialogue.

Have you ever been the victim of any abuse that you can identify in your life—physical, emotional, sexual? In this case, a closed question is used, because it is important not to convey to clients an automatic assumption that they were abused; this question gives them a chance to say no. If the answer is yes, one can follow-up with more open-ended questions (e.g., What are you able to tell me today about that abuse? How did that affect you?)

Is there anything you can think of today that I missed? Anything about your life or experiences that really affected you? Is there anything we didn't cover here today that you feel I need to know in order to help you? These questions can be included as a part of a general wrap-up at the end of an initial assessment. If something comes up, it can be explored immediately or at the next appointment.

Just as some mandatory forms are very vague, other facilities' assessment forms may be extensively detailed. For instance, forms may require very specific questions to be asked about the nature of clients' sexual experiences, but clinicians may find that there is not sufficient rapport established for the client to feel comfortable answering such questions. Regardless of the scenario, following guidelines can be very effective for conducting the best possible assessments, especially with clients who may be struggling about whether or not to disclose their trauma histories [1]:

- Do not re-traumatize. Well-intentioned clinicians can re-traumatize clients if they ask questions in an interrogatory manner, minimize clients' experiences, or ask clients to talk about some aspect of their life or trauma before they are ready to talk about it. Be careful how you ask the questions. If you simply read down the list in a cold manner, the client may feel interrogated. On the other hand, you also want to avoid coming across as too saccharine and sweet in your questioning, or the client may perceive this as being disingenuous, placating, or pitying. Be the best version of yourself, and think of how you would feel if you were being asked such difficult questions about your life.
- Consider the role of shame in complex presentations. Shame is defined as the belief that who one is, at the core, bad or defective. Shame is pervasive in many survivors of abuse or other traumatic experiences and in people who feel they are defective because they have not been able to "get better" from the disorder that brought them into treatment. From the initial history-taking session, you have the power to reinforce this shame (through re-traumatizing behaviors) or to begin dispelling it by edifying the client during the initial assessment.
- Be genuine and build rapport from the first greeting. Edifying a client does not mean being fake and phony with goodness. Be yourself, but be attuned to how you present yourself. Always show the client dignity and respect.
- Ask open-ended questions. One of the basics of counseling is using open-ended questions (e.g., typically those starting with what or how). These tend to be less interrogatory. For example, questions like "What were things like for you growing up?" or "How did that experience affect you?" allow clients to steer the interview in a direction commensurate with their comfort level. There are exceptions to this rule, but it is best to

generally avoid using leading or closed-ended questions, like "Was that experience traumatic for you?" or others that can be answered with a simple yes or no. Be mindful of where the client is steering the interview. Using open-ended questions is a good way to accomplish this task.

- Make use of the "stop sign technique." In this technique, the client may be instructed to give a "stop" signal (e.g., a hands up, or simply saying stop) if the assessment begins to enter into an area the client is not yet ready to discuss. At the beginning of sessions, let clients know that if they are not comfortable answering any questions they can indicate their unwillingness to continue by saying so or giving a stop sign.
- Do not be judgmental. This should be a given for clinicians who are embarking on doing any type of trauma work. However, it is an area that requires constant self-assessment. Interpretations and diagnostic proclamations, for instance, may come across as judgmental. Remember that you may be dealing with a person with a high degree of shame-based baggage; how he or she interprets things may be different from how you would.
- Assure clients that they may not be alone in their experiences, if appropriate. This is a strategy to use with caution, but it can be effective if used appropriately. Many clients present for treatment bogged down with shame, feeling they are uniquely bad or crazy for feeling a certain way or engaging in a certain behavior. In some cases, the simple assurance that they are not alone can make a world of difference. Only attempt this practice if you can be genuine about it. Be careful not to make it sound like you are minimizing their experience.
- Send the client away with a quick affect regulation technique or assignment, if appropriate. If, during the first session, the client has addressed a significant amount of trauma-related issues or engaged in an unexpected catharsis, it is important to ensure that her or she is comfortable leaving. Consider teaching clients a quick breathing exercise or other body-based coping technique (e.g., pressure points, muscular clench and release, mindfulness) to effectively "shut down" the session. It is vital not to arouse client emotions with questioning unless you have a way to guide him or her back to calmness before leaving.

SCREENING TOOLS AND OTHER RESOURCES

In addition to these clinical interviewing strategies, assessment tools may also be used to provide additional structure to the interview process. This section will outline available tools, how to use them, and where to obtain additional screening/assessment resources.

Primary Care PTSD Screen

The Primary Care PTSD Screen was developed not as a diagnostic tool, but as an effective screening tool [21; 61]. This screening tool was initially validated with Veterans Affairs primary care patients, but its use has been demonstrated for nonveteran clients as well [22; 23]. If a client answers yes to any three of the following questions, the results of the screening should be considered positive:

In the past month, have you had an experience in your life that was so frightening, horrible, or upsetting that you:

- Had nightmares about it or thought about it when you didn't want to?
- Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
- Were constantly on guard, watchful, or easily startled?

- Felt numb or detached from others, activities, or your surroundings?
- Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

Further interviewing should be conducted to determine whether or not PTSD could be diagnosed. For a copy of the Primary Care PTSD Screen and instructions for incorporating it into clinical settings, visit https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp.

The Primary Care PTSD Screen may be administered in print or verbally. If administered verbally, the screening tool allows for follow-up questions and inquiring for more detail about any yes answers. These answers should give the information necessary to make an appropriate diagnosis.

Negative Cognitions Lists

Another very simple screening tool that can be employed is a negative cognitions list (***Table 1***). With a negative cognitions list, clinicians are able to identify any faulty cognitions and use those to determine the history. Sample negative cognition lists appear in manuals on cognitive-behavioral therapy and online. These lists are often subdivided into the categories of responsibility, safety, power, and value, or the general classifications of how humans interpret stress [24].

A negative cognitions list screen is easy to conduct [1]. Clients are given the list and asked to check off the negative beliefs they struggle with, with assurance that there is no specific number of items they should check off. A client may return the list with 2, 5, or 20 items marked. A client's beliefs may be concentrated in one of the categorical areas (i.e., responsibility, safety, power, or value), or they may span across categories. There is semantic overlap between certain items on the list, but that is good. One client may connect with an idea worded in one way (e.g., "I am worthless"), while another client may experience it in a different way (e.g., "I am a bad person").

NEGATIVE COGNITIONS LIST

Domain	Statements
Responsibility	I should have known better. I should have done something. I did something wrong. I am to blame. I cannot be trusted.
Value	I am not good enough. I am a bad person. I am permanently damaged. I am defective. I am terrible. I am worthless/inadequate. I am insignificant. I am not important. I deserve to die. I deserve only bad things. I am stupid. I do not belong. I am different. I am a failure I am ugly. My body is ugly. I am alone. I have to be perfect. I have to please everyone.
Safety	I cannot trust myself. I cannot trust anyone. I am in danger. I am not safe. I cannot show my emotions.
Power	I am not in control. I am powerless/helpless. I am weak. I am trapped. I have no options. I cannot get what I want. I cannot succeed. I cannot stand up for myself. I cannot let it out.

Source: Compiled by Author *Table 1*

The list is then returned to the client, who is asked to rank the top three most disturbing cognitions. For example, a client could rank his or her negative cognitions as:

1. I am worthless.
2. I cannot show my emotions.
3. My body is ugly.

Starting with "I am worthless," ask what is referred to as a "floatback question," designed to get to the root of the traumatic disturbance [3]. Typical wording of a floatback question is, "Thinking back over the course of your life, when is the first time you remember getting the message 'I am worthless'?" If the client is unable to remember the first time, adjust the floatback question to, "When was the time in your life when that message, 'I am worthless,' felt the worst?" Asking specifically about the first or the worst experience will provide useful information about where the problematic cognitions started, and this experience may fit the definition of trauma (small-t or large-T). Assessments using this process are often used to obtain information to guide treatment, to honor the client's dignity, and help the client regulate affect before leaving the session.

For further sources for screening PTSD, consider visiting the National Center for PTSD (https://www.ptsd.va.gov) or Integrative Trauma Treatment (http://www.trauma101.com). Networking with local colleagues who are known to be competent in trauma may also be useful. These colleagues can share strategies they find most effective when assessing for trauma.

TRAUMA TREATMENT IN THE THREE-STAGE CONSENSUS MODEL

LAYING THE GROUNDWORK

Following the initial assessment session(s), the next step is typically the formulation of a treatment plan. A well-devised treatment plan documents specific, measurable goals that reflect what the client wants to get out of treatment and how the clinician will be able to therapeutically assist the client in reaching those goals. There are two main best practices at this stage of treatment planning: determine what the client really wants to get out of treatment and assess the client's willingness to change.

Determine Client Goals

It is important to ascertain clients' preferences as part of ethical treatment. If a client is only looking for coping skills to deal with stress, it is unethical to forge ahead with an intense trauma-resolution treatment plan. Although clinicians can discuss the advantages and disadvantages of certain trauma treatment strategies, it is vital to keep the sessions about the client and his or her preferences.

Stages of Change

Part of treatment planning involves determining how a client feels about change and how much work/commitment he or she is ready to put into the process. Prochaska and DiClemente's stages of change model, very popular in the medical and addiction fields, applies to trauma treatment [25]. The stages are as follows:

- Precontemplation: The person is not prepared to take any action at this time or in the foreseeable future.
- Contemplation: The person is intending to change soon.

- Preparation: The person is intending to make a change in the immediate future.
- Action: The person is making significant changes in his or her lifestyle.
- Maintenance: The person is working to prevent relapse.
- Termination: The person has achieved 100% self-efficacy, and the relapse potential is near zero. (There are those in the drug and alcohol field who will, of course, argue that a recovering addict is always in maintenance.)

Stage-appropriate treatment is critical when working with complicated clinical presentations. It may sound simple, but the clinician must truly commit to honoring the therapeutic alliance to adhere to this principle. Meeting clients where they are becomes the imperative.

Some clients will enter treatment completely precontemplative (having no desire to change any time soon) and will be barraged with action-oriented interventions. It is important to gauge where the client is in the stages of change, regardless of whether he or she has an addiction problem. In terms of trauma, stage 1 stabilization work can be initiated with clients who are precontemplative, contemplative, and in preparation; however, stage 2 trauma processing work should be done only with clients who are in the action or maintenance stage of change.

Clients at lower stages of change (e.g., precontemplative) should not be bombarded with the possibility of trauma resolution all at once. Start with the basics (e.g., rapport building; discussions about problems, solutions, and treatment options; motivational enhancement) and work up from there. The basics of counseling and rapport building become even more vital with traumatized populations because of the trust factor; these relational imperative strategies are discussed in greater detail later in this course.

STAGE 1: STABILIZATION

Some clinicians feel an urge to get clients talking about the trauma so the treatment process can begin as soon as possible. Although this approach can sound like common sense, the neurologic concepts covered in the first section of this course suggest otherwise. First, an individual might not be able to easily talk about a traumatic experience because of the way that it is stored in the brain. Secondly, in some cases, talking about the trauma can do more harm than good, such as if the client does not have skills in place to cope with the intense, body-level disturbance that recalling the trauma can stir up. There are two primary tasks that must be accomplished during the stabilization phase of treatment: facilitate coping skills training and affect regulation strategies, and assess/help build recovery capital, or the "good" material that a client has to draw upon, before major trauma processing work can commence.

Coping Skills and Affect Regulation Strategies

Coping skills and affect regulation skills are utilized in trauma treatment to ensure clients' safety. If a client is seriously triggered during sessions, it will be necessary to have the skills to be able to calm him- or herself down, leave the office safely, and stay safe in the interim between sessions. This issue of safety can be more precarious with certain types of clients, such as those who self-injure, who have a tendency toward suicidal or harming behaviors, or who abuse substances. When a client has a history of dangerous coping behaviors, incorporation of coping skills and affect regulation training becomes even more vital. It also means more time will be spent in stage 1 stabilization with clients of this nature. There are several techniques that can be incorporated into stage 1 stabilization therapy, including breathing exercises, guided imagery, pressure points, yoga, and music therapies.

Grounding Strategies

Basic grounding strategies consist of clients practicing their awareness in space and connecting to the present in the space they occupy. One of the most basic grounding skills involves asking the client to name and describe five things he or she sees. A more multi-sensory approach may include describing sounds, smells, tastes, and sensations. This technique allows clients to return back to the room if they have left their affective window of tolerance during therapy, and it is an especially effective regrounding tool at the end of a session.

Breathing Exercises

The simplest place to start with body-based stabilization skills is with breathing. Teaching a client how to breathe seems simple; however, breathing mindfully is so simple that people, including clinicians, often dismiss it. According to Dr. Andrew Weil, "Practicing regular, mindful breathing can be calming and energizing and can even help with stress-related health problems ranging from panic attacks to digestive disorders" [26]. Mindful breathing simply means to focus only on one's breath in a nonjudgmental fashion. According to Weil, practicing mindful breathing for as few as three minutes per day can yield significant long-term benefits [26].

Although it may be easy to dismiss breathwork as too simplistic, it is a good place to start. Teaching clients a series of breathing exercises may offer them a new, radical approach to stabilization because they may have never thought about breathing before. Moreover, once a client has a strong sense of how to regulate his or her breath, other sensory skills can be practiced more effectively. For instance, those who are able to regulate their breath will likely derive more benefit from a guided imagery exercise than persons whose breathing is uncontrolled [13].

In the spirit of grounding and easing clients into stabilization strategies, before launching into instructing specific breathing strategies, it is often wise to have them take a specified period of time (as little as 15 seconds) to notice their breath (without judgement) as it naturally flows. This practice may be used as an avenue to teach clients that there is no wrong way to do these exercises. If the critical mind starts to wander during the breath awareness exercise, simply invite the attention back to the breath. As a major trauma-informed caution, clients should be informed that they can keep their eyes open at all times during breath work (or any of these exercises) if they choose. For many, panic may ensue when they start to get relaxed and the eyes are closed, perhaps creating a sense of lost control or claustrophobia.

Three basic breath exercises that may be incorporated into a treatment plan are diaphragmatic breathing, complete breathing, and ujjayi breathing:

- Diaphragmatic breathing (or belly breathing): Instruct the client to breathe in through the nose and out through the mouth, focusing only on the rise and fall of the belly (not the whole rib cage). Challenge the client to expand the belly as far as possible as he or she inhales. It may help for the client to put his or her hand on the belly to concentrate on this motion.
- Complete breathing: For this exercise, the client should begin with the belly breath. When the stomach expands as far as it will go, teach the client to inhale through the nose again and concentrate on the air coming into and fully expanding the rib cage. There are two variations on the release: either a slow, steady release, which helps promote tranquility and mindfulness, or a sudden, rapid release, which can help the client experience how good "letting go" can feel.

- Ujjayi breathing ("ocean breathing" or "Darth Vader breathing"): This breath, which is effective as an affect regulator during moments of high stress or intensity, is a noisy in-through-the-nose, out-through-the-nose technique. The mouth should stay closed, although it should also feel as if one is sucking through a straw. This allows for a greater flow of oxygen into the lungs, which can stimulate a relaxation response. For clients who are not used to mindful breathing, it is especially important to start slow with this exercise, doing no more than 5 breaths at a time. Let the client know that the louder this breath sounds (even if he or she feels self-conscious at first), the better it is likely to work.

This list is by no means exhaustive; there are many other techniques that may be utilized at this stage of treatment. The major benefit of breathing exercises is that it can be accessed by clients at any time after they leave the office.

Pressure Points

Many clinicians also use pressure points from the acupuncture/acupressure tradition and energy psychology tapping points to help enhance relaxation responses. The two points that may be useful for trauma clients are the "sea of tranquility point" (on the breastbone), and the "letting go points" (on the collarbones). While clients hold these pressure points, it is important that they maintain steady, concentrated breathing to achieve optimal impact in relaxation and regulation.

Yoga and Embodiment

Breath and body-based skills have been used for millennia by those who practice yoga. Yoga has different connotations for different people. For example, some see it as Eastern, blasphemous, and New Age, whereas others simply associate yoga with a class offered at the gym. Yoga, which literally means union, refers to a series of breath exercises and physical poses that are designed to build mental discipline and foster a greater sense of connectedness among body, mind, and spirit. Many see yoga as an ideal adjunct to treatment for mental health disorders, because those who suffer from many of these disorders (including PTSD) experience disconnectedness [1]. In the stabilization phase of trauma work, taking a yoga class or doing yoga practice at home may be recommended.

Therapists interested in building their skills on using yoga and embodiment clinically may seek additional research or classes. Even if the techniques will not be used in sessions, it is helpful to have knowledge of the yoga studios or teachers equipped to deal with mental health and trauma issues for referral purposes. Other practices related to yoga, like conscious dance, tai chi, or qi gong, may also be good fits for clients to supplement their treatment plan.

Visual Skills

Guided imagery is often the first thought that comes to mind when discussing visually based coping skills. The purpose of guided imagery as a stabilization exercise is to provide the client with a safe, healthy mental escape that he or she can access when needed. At first, the clinician's voice is the guide to take the client to this place. If a clinician feels uncomfortable developing guided imagery scenarios, there are many good free scripts available online, including hundreds of variations on the standard calm, happy, or safe place [1].

The biggest concern when doing guided imagery as part of trauma stabilization is to screen for the image or place the client would view as calm, happy, or safe (or any other positive emotion) prior to starting. If the client says that he or she feels safe locked in the closet, that is probably not the most adaptive place to use for an exercise, although it may be a starting point. Some traumatized clients may have no conception of what the word safety means or have a safe place. An alternative construct, such as a calm or happy place, could work. With a few

exceptions, it is also advisable to give clients a general orientation to imagery and to let them know that it is typically best not to have other people involved in their image, especially at first, because this can complicate the image.

If an early guided imagery exercise takes a bad turn for the client, there are options. One is to ask the client if he or she would feel more comfortable using another place instead and start over (with imagery or another stabilization exercise). Yet another option is to ask the client if he or she would like to talk about what came up. If a solid therapeutic alliance has been established, the talking approach will likely be effective, and if handled well, it can help assure the client that he or she will not be pushed into an area that is scary or uncomfortable [1].

Although there is a variety of guided imagery exercises for trauma stabilization, it may be easiest to start with a light stream exercise, which is the most benign while also being effective. The essential principle of light stream imagery is to have the client imagine a bright, healing light of any color or with any characteristic. If the client is spiritual, this light may emerge from a spiritual source. As the guide, the clinician describes the light entering through the client's body (typically through the top of the head, but this can vary) and then moving through the rest of the body. The exercise can be enhanced with slow, bilateral stimulation at various points (e.g., "back-and-forth" tapping on the legs) [1].

To really make the exercise effective, it helps to have a client start with a disturbance and have him or her describe the disturbance in his or her body. Then, introduce the concept of the bright and healing light and guide its passage through the client's body. After observing some type of affective shift, ask the client what happened to the original disturbance. If the client is still experiencing some level of disturbance, invite him or her to turn up the intensity of the light or to think about the light being refreshed with every breath [1].

Visual images can be used as part of stabilization, even without formal guided imagery scripts. One option is to ask the client if he or she has any pictures that he or she finds especially calming or edifying. Sometimes, a client has a picture of himself or herself as a small child that represents a state of freedom that he or she would like to access, or a recovering addict may carry pictures of family and children for motivation. Any picture that represents something positive to the client can be used as a resource, and such pictures are easy to carry around for the purposes of affective regulation.

Music and Sound

Guided imageries can be effective, but not everyone is good at visualization. Music has been used as a coping skill for centuries, and many great historical figures have written about its healing effects [27]. In stabilization work, an image may be replaced with a piece of music that is determined to be relaxing, healing, or empowering for the client. Many clients will have a portable music source (e.g., an mp3 player) when they arrive for sessions, which can be a great resource. Assist clients in helping to find what works for them.

Taste and Smell

Just as a virtual sanctuary can be created with music, a sense of safety can also be constructed with the senses of smell and taste. Determine which smells and tastes a client finds pleasurable and calming. If a person has compulsive eating habits, taste should most likely be avoided because it can reinforce the notion of eating as self-soothing. However, individuals without eating disorders may report that chewing on a piece of gum or sucking on their favorite candy can be calming. If this is not maladaptive, an exercise can be formed in which the client slowly and mindfully eats this substance, noticing the body-level responses as he or she does [1].

Aromatherapy is another useful approach. Scented candles and other pleasantly scented items, such as lotions and body sprays, may be sampled by a client to determine if any are particularly relaxing or soothing. If so, have him or her light the candle or spread the lotion on his or her hands and smell, noting how the body feels when engaging with those scents. Practice the cuing component by bringing up a disturbance and testing whether the client can use the scent to return to this restful state. The nice thing about aromatherapy is that the client can typically purchase a scented candle or lotion in the same fragrance inexpensively and keep it at strategic places around the house or carry it to access the calming cue at any time [13].

Blended Senses Exercises

Three useful stabilization exercises tap into a blend of the senses: focusing on positive memories, imagining hopeful future scenarios, and journaling. Installing positive memories, when carefully done, can be a tremendously healing resource, especially as a frontloading strategy. With this technique, the clinician helps the client take a positive memory or experience and use it as a safe place image. Elicit the memory in detail and have the client give that experience a cue name. If appropriate, the cue name can be a positive self-belief that the client associates with the memory.

Just as past scenarios can be used for stabilization, a future scenario can also be used. Have the client bring to mind a goal that he or she has for the future. For instance, the client could imagine what it will look like down the road to be in his or her own apartment, away from an abusive parent. Have the client describe, in as much detail as possible, what it will be like to live apart from his or her family. Then, have the client focus on that healthy, future projection.

Some clients never consider the benefits of journaling until the clinician mentions it, and the stabilization stage is an appropriate time to suggest this exercise. If clients can get into the habit of journaling, it can prove to be a useful supplement to any trauma therapy. It is important to teach clients that there is no wrong way to journal. If clients are afraid of someone finding their work, advise them to rip it up or destroy it after they have finished writing. The point is not to keep the work and bring it into sessions for analysis, but to release the troublesome emotional baggage [1].

Dissociation-Specific Strategies

Careful stabilization with clients who have a tendency to dissociate must include multisensory grounding strategies, or keeping the client in the present. Visual-only strategies are rarely the best for grounding, or bringing the client back to a mindful state of awareness and reality; essentially, guided imagery exercises are a form of controlled dissociation. Clearly, dissociation can be an inherently positive self-soothing mechanism. However, like many other self-soothing mechanisms, when it is used to an excessive degree and impairs functioning, it can be problematic [1].

Stabilization is a critical period for determining which coping skills or affect regulation strategies will work best to keep the client in a place of dual awareness (i.e., staying oriented in the present even while reflecting back on the past). For some clients, grounding exercises in which they envision their feet rooted into the earth like trees may be effective. Add a multisensory component by inviting the client to press his or her feet into the ground and feel that sensation. Consider having the client give a cue word to this experience (e.g., tree, roots). Other experiences, such as smelling a specific scent, feeling a certain tactile sensation (e.g., wool, cotton, rubber), listening to a certain piece of music, or tasting a certain candy, may also make the client feel present, alert, and aware. Use the stabilization period to experiment and find what works. If dissociation then happens during stage 2 trauma processing and it becomes imperative to bring a client back to the present, a strategy or group of strategies will be in place to do so.

Recovery Capital and Knowing When to Progress to Stage 2

Recovery capital is a term that comes from the addiction treatment field, but it has broad application to trauma work as well, whether or not addiction is part of the picture. The term is defined as the "quality and quantity of internal and external resources that one can bring to bear on the initiation and maintenance of recovery" [28; 29]. Recovery capital can also be conceptualized as the tangible and intangible resources that an individual possesses to make recovery successful. Recovery capital can include a support group, 12-step meetings, a sponsor, a church group, a job, hobbies, supportive family, motivation, or a place to live—essentially, whatever positive influences a person has. In assessing whether a client is a candidate for proceeding with stage 2 processing work, it is important to evaluate the depth of his or her recovery capital [1]. If a client is without recovery capital, it does not necessarily rule out progressing to stage 2 trauma processing, but the client may require more time to build capital as part of stabilization.

The following questions should be asked before moving to stage 2 trauma processing work [1]:

- *Have I assessed for secondary gains?* Secondary gains are benefits a person obtains or maintains from staying sick. These gains can be as tangible as procuring a government disability check due to a diagnosis or as subtle as maintaining an excuse for irresponsible behavior. Be direct with clients about exploring secondary gains, and if they are holding on to reasons for staying stuck in maladaptive behavior(s), discuss these reasons in the context of the therapeutic alliance. Doing trauma processing work with clients who have not fully considered their secondary gains can result in more surprises or give them more excuses for poor behavioral choices. If the past is not examined at in the context of larger recovery, it can do more harm than good.
- *What is the client's motivation for wanting to do trauma processing work?* Trauma processing work with a client, especially a complex one prone to destructive behaviors, can be difficult when a client's motivation for seeking treatment is unclear, especially if no effort has been made to embrace lifestyle change (e.g., if the client is in a precontemplative or contemplative stage of change) and he or she feels that a simple explanation for his or her problems lies in the past.
- *Does the client understand what may happen if change results and the effects of the trauma on his or her life start to shift?* If trauma processing works for the client, there is a good chance he or she will change and adopt healthier lifestyle patterns. It is important that this possibility is discussed with clients ahead of time to ensure they are aware of what is to come, especially if people in their life are used to the client being sick or unhealthy.
- *Does the client have emotional support resources, including but not limited to, a 12-step program sponsor, a support network, a church group, or access to healthy friends and family?* It is essential that if the client has an emotionally draining trauma processing session and has some disturbance after leaving, he or she has someone healthy and supportive (beside the clinician) on whom he or she can call. Encourage clients to let at least one person in their life know they are going through intense therapy. The absence of a support system does not necessarily rule out doing trauma processing with a client, but it does mean more time should be spent on stabilization. If a client is genuinely without any positive social support, explore whether there are 24-hour on-call services in the community or on-call mental health professionals available during a client's trauma processing.

- *Is the client able to reasonably calm and/or relax himself or herself when distressed?* Of course, it is not necessary for a client to be able to perfectly calm himself or herself when distressed. But, it is important for clients to be able to use one or more coping skills to self-soothe. Skills can include imagery exercises, music, somatic techniques, or talking to someone. Practicing these exercises and building an arsenal of options for self-soothing is critical. Moreover, it becomes vital for clients to do these exercises on their own if disturbance from processing emotional material emerges between sessions.
- *Is there a sufficient amount of adaptive, healthy material in the client's life?* Positive material can include everything from acquisition of the basic needs (e.g., food, water, shelter) to work, hobbies, a supportive family, life goals, and healthy friends. The absence of such positive material does not rule out trauma processing, but does necessitate more advanced preparation in the realm of resource development.

STAGE 2: TRAUMA PROCESSING

Principles of Trauma Processing

If the stabilization stage is completed successfully, the next stage, trauma processing, will be less daunting. As a quick review, processing is making sense of an experience or learning; it can be equated to digesting an unsettling event. Reprocessing refers to consciously accessing the affected memory or experience that was not processed properly and striving to bring about a more adaptive experience. The two terms will be used interchangeably in this section.

There are significant cognitive implications of stage 2 work. If a client has experienced a trauma as a child (e.g., physical abuse by parent) and received a stern negative message as a result of that experience (e.g., the parent constantly said to the child, "You're no good" while being abusive), then that negative cognition becomes ingrained; it is the filter through which the child sees the world. Just as trauma can differ in its intensity and after-effects, so can the pervasiveness of the cognitive schema in filtering through experiences. The essential goal of stage 2 work is to holistically move a negatively experienced belief (e.g., "I'm not good enough") to a healthier, more adaptive belief (e.g., "I am good enough"). To be holistic, the client will move beyond simply stating an affirmative belief to finally believing it at the level of body, mind, and soul.

There are many approaches to transmuting a traumatic experience. The reality is that cognitive-behavioral strategies and just about every approach to psychotherapy have the potential to help a client reprocess traumatic experience; the key is finding the one best suited to the client's personal style and view of the change process [30].

Evaluating Best Possible Treatments for Trauma Processing

Although research in this area is relatively scarce, there are a few meta-analyses exploring which treatment is most effective for trauma processing. In a review of more than 30 studies, Bisson and Andrew found that trauma-oriented PTSD treatments were far superior to coping-skill-only PTSD treatments. In other words, those treatments that began stage 2 processing by asking clients to examine their pasts were more likely to have an effect than those that focused on stage 1 coping-skill work only [31]. Past-oriented or trauma-oriented treatments can include trauma-focused cognitive-behavioral therapy, exposure therapy, hypnosis, or EMDR. In its 2013 guideline on the management of trauma-related conditions, the World Health Organization listed cognitive-behavioral and EMDR therapy as the preferred treatments following stabilization [8].

Another meta-analysis examined all studies on "bona fide" treatments for PTSD that compared two or more treatment interventions (e.g., desensitization, hypnotherapy, psychologic debriefing, trauma treatment protocol, EMDR, stress inoculation, exposure, thought field therapy, imaginal exposure) [32]. No statistically significant differences in effect size among the various treatment modalities were noted. The authors ultimately concluded that, although there is strong evidence that the treatments studied work for PTSD compared with no treatment, no one therapy should be considered the best option for PTSD clients. They noted, "having several psychotherapies to choose from may enable a better match of patients to type of psychotherapy that fits the patient's worldview and is more tolerable to that particular patient" [32].

Although this meta-analysis is not without its critics, specifically over what constitutes a "bona fide treatment," the authors' conclusion resonates with clinicians who do not subscribe to a one-size-fits-all approach to therapy [33]. Of course, this does not mean that one should take a haphazard approach to trauma treatment, but it affirms that clinicians have choices when treating PTSD. If one modality does not work or goes awry for whatever reason, there are other options to help the client meet his or her goals within a trauma-sensitive model of treatment.

At present, there are many popular therapies being used for the treatment of PTSD and trauma-related disorders, all of which have some level of research to support their efficacy. Of course, the legitimacy of each therapy is weighted differently by respective clinical organizations based on how much research exists to support it. These therapies include:

- Accelerated experiential dynamic psychotherapy
- Acceptance and commitment therapy
- Cognitive-behavioral therapy
- Cognitive processing therapy
- Dialectical behavioral therapy
- The Developmental Needs Meeting Strategy (DNMS)
- Emotional Freedom Technique (EFT)
- EMDR therapy
- Energy psychology
- Experiential therapy
- Exposure therapy
- Expressive arts (e.g., music, dance, drama)
- Focusing
- Gestalt therapy
- Graduated exposure therapy
- Hakomi therapy
- Hypnosis and hypnotherapy
- Internal family systems therapy
- Interpersonal neurobiology
- Logotherapy
- Mindfulness-based cognitive therapy
- Narrative therapy
- Neurofeedback
- Neurolinguistic programming
- Play therapy
- Progressive counting
- Psychoanalysis
- Psychodrama
- Psychomotor psychotherapy
- Sensorimotor psychotherapy
- Somatic experiencing
- Stress inoculation
- Trauma-focused cognitive-behavioral therapy
- Traumatic incidence reduction
- Yoga therapy

According to the Australian Centre for Post-Traumatic Mental Health, adults with PTSD should be offered trauma-focused cognitive-behavioral interventions or eye movement desensitization and reprocessing.

(https://www.phoenixaustralia.org/wp-content/uploads/2015/03/Phoenix-ASD-PTSD-Guidelines.pdf. Last accessed March 29, 2022.)

Level of Evidence: A (Body of evidence can be trusted to guide practice)

Most clinicians have familiarity with at least two of these approaches to trauma therapy. As such, clinicians already have some of the basics to complete stage 2 trauma processing work. Each type of therapy can be further researched at various websites and through books detailing the specific approaches. However, it is important to remember that it is unnecessary to have training in all of these techniques in order to do stage 2 trauma processing work. If it is clear that certain approaches are not working for a client, one may either research and familiarize oneself with another variation or refer the client to a colleague who may offer one of the other therapies. All of these therapies have the potential to achieve the goal of stage 2 processing work: to holistically move that negative experience of trauma to a more adaptive place in the client's brain, ultimately resulting in improved life functioning.

Likewise, clinicians who subscribe to a particular school of therapeutic approach may attempt to justify their position with research and past experiences, while ignoring some basic, common sense principles of honoring the therapeutic relationship [1]. In all cases, allow the client and his or her responses to guide treatment.

Stage 2 processing trauma work is not within the comfort level of every clinician, especially with certain populations. However, if one feels comfortable and competent working with a specific population (e.g., children), then doing stage 2 trauma processing work with this group will not be as daunting. It is important to remember that working with a population that is outside one's scope of competency can have serious ethical and legal consequences, and reflecting on strengths with specific populations is an element to consider when preparing for stage 2 work.

STAGE 3: REINTEGRATION

Reintegration is perhaps the most logical stage of the entire consensus model, yet it is one that is often missed. The purpose of reintegration is to help clients transition into living their lives without the sequelae of trauma. When clients manage to eliminate the emotional burden of a traumatic experience during stage 2 treatment, they may feel lighter and freer. Because this catharsis is so positive, it can be tempting to stop treatment at this point, with the client feeling "cured." However, it is important to remember that, after carrying a weight for such a long time, it may feel strange or even uncomfortable to maneuver through life without it [1]. For example, if a client has released the burden of guilt over his father's death, he can begin to live his life with the new knowledge that he is a good person. But if the people in his life had grown so used to his negative self-image that they took advantage of his low self-esteem, his new outlook on life could change the whole family dynamic. These changes will require adjustments in the client's way of living. These adjustments and adaptations are not necessarily bad, but they may feel strange and new. The care and concern of a therapist who helped a client release the burden can be an invaluable asset to help him or her reintegrate into ordinary life. Essentially, reintegration work is similar to providing physical therapy or other rehabilitation following a major surgery.

Keep in mind that there will likely be overlap of work completed in stages 3, 2, and 1, especially if the trauma work is being conducted in an outpatient setting. In fact, many clinicians argue that reintegration occurs throughout the treatment process and is not a unique stage. This is true to an extent because, regardless of the stage of therapy, the strategies covered help clients to live their lives integrated into society. However, these supportive strategies take on a new dimension of importance following the stage 2 work because relieving the burden of trauma can be a major adjustment. Clinicians should be available to help clients with those adjustments using existing clinical skills.

TRAUMA AND ADDICTION

It is difficult to pinpoint the exact prevalence of trauma and addiction comorbidity for several reasons. To begin, the term trauma usually only refers to the wounding event itself; the effects of the trauma can be multifarious, ranging from diagnosable PTSD as defined by the DSM-5 to instances of depression or panic symptoms that may result from adverse life experiences [14]. Thus, different studies may define trauma-related sequelae in different ways. This makes comparing studies a rather difficult task, as the use of operational definitions and inconsistent use of constructs (e.g., addictive disorders versus substance dependence versus substance use disorders, which can include both abuse and dependence) occur among the studies. Additionally, the inaccuracy in study participant reporting due to memory gaps or fear of stigmatization may also be a factor in some of the disparity among reports. Taking this into consideration, some connections have been gathered about the links between substance use disorders and trauma-related disorders.

An estimated 46.4% of clients with lifetime PTSD meet the criteria for substance use disorder [34]. Various studies have found a disproportionately higher number of abuse, neglect, or trauma histories in substance abusers than in the general population [35; 36; 37; 38; 39]. Of patients in substance disorder treatment, 12% to 34% have a diagnosis of PTSD; these numbers can be as high as 33% to 59% in certain subgroups, including women [37; 40; 41]. Brown and Gilman reported that nearly 65% of persons found eligible for county drug court were affected by trauma in some way [42]. Further categorized, 26% met the criteria for PTSD, 35% reported some PTSD symptoms connected to a trauma but did not meet full criteria for PTSD as defined by the DSM-IV-TR, and 3.9% had experienced a Criterion A trauma at some point in their life but had no PTSD symptoms.

Individuals with a history of PTSD are more likely to have a history of other psychiatric disorders, alcohol dependence, and other significant psychosocial impairments [43]. Furthermore, substance abuse increases the likelihood of victimization, which can further promulgate the cycle of coping with trauma-related stress and self-medicating with addictive substances [14; 44; 45; 46; 47].

The authors of the Addiction and Trauma Recovery Integration Model (ATRIUM) assert that traditional models of addiction recovery and relapse prevention do not consider the significant role that unresolved trauma can play in an addicted individual's attempt at recovery [48]. They further contend that these traditional approaches tend to marginalize addicted, traumatized women more than their male counterparts. Though the authors do not discredit the merit of traditional models, such as 12-step facilitation or cognitive-behavioral therapy, they suggest that these approaches do not sufficiently address the role that trauma has played. Ultimately, these approaches can set individuals up to fail. Though these ideas

are compatible with common themes on relapse risk factors in the literature (e.g., poor self-efficacy, high volume of negative emotion coupled with poor coping skills), an integrated, more holistic approach is needed to promote long-term recovery and prevent relapse. This type of an approach would extend beyond the cognitive interventions that have traditionally been used in relapse prevention counseling or in 12-step-related interventions [13].

STRATEGIES FOR ADDRESSING INTERACTION

The three-stage consensus model described throughout this course can be applied to addiction treatment as well. In stage 1 stabilization, the only caveat is that many of the skills, tools, and strategies that are taught to the client to facilitate coping must be geared toward achieving sobriety. In essence, stage 1 stabilization is for teaching addicted individuals new, healthy coping strategies to replace substance abuse or other potentially addictive behaviors. Many conventional treatment centers and programs already do this type of work. However, conventional methods often then jump to stage 3 reintegration without doing the vital processing work of stage 2. If stage 1 has been executed thoroughly and the client is able to access some very basic skills to muster safety and equilibrium, stage 2 processing can be conducted with an addict in relatively early sobriety.

Evans and Sullivan proposed a five-tenet model that can be a useful guide [49]. The five essential components of this model are [49]:

- A large portion of clients presenting for treatment in any setting have a history of childhood trauma. Respecting this history enhances treatment.
- Successful treatment of the trauma must include working through memories of the trauma in an experiential way, after the clinician and client have established a foundation of safety and coping skills.
- Substance use disorders are a significant part of the clinical picture for many survivors of trauma. Thus, treatment of the abuse issues that does not address the substance use issues will be ineffective, and treating only the addiction in those with survivor issues will likely be ineffective.
- The disease model of addiction and conventional 12-step approaches to treatment are productive in treating the addicted survivor of trauma.
- Treatment models for addicted survivors of trauma must be integrated and must address the synergism of trauma and addiction. A two-track approach is generally ineffective.

Using the three stages of the consensus model, together with some of the addiction principles inherent to this five-tenet model, can be a powerful combination.

Clinicians, including many traditional treatment providers, often worry that getting into trauma work too soon may threaten an addict's recovery, with some suggesting that trauma processing should not be attempted with addicts until they have been sober for at least two years. Unfortunately, a history of unresolved trauma can be a risk factor for relapse, and many of these clients will be unable to maintain sobriety for one or two years without relapsing. The three-stage consensus model of treatment offers an opportunity for balance. It provides a framework for equipping the individual with tools that he or she needs before doing the essential work of reconciling the past.

EVALUATING PERSONAL ROADBLOCKS TO ADDRESSING TRAUMA

QUALITIES OF AN EFFECTIVE TRAUMA THERAPIST

General traumatic stress studies indicate that the therapeutic alliance is an important mechanism in facilitating meaningful change for clients with complex PTSD [50; 51; 52]. This idea is really common sense; the client will only feel comfortable sharing traumatic secrets with someone he or she believes to be trustworthy, compassionate, and understanding.

A seminal volume of empirical research studies and chapters from various psychotherapeutic professions demonstrated that the therapy relationship, together with discrete method, influences treatment outcomes [53]. Furthermore, it concluded that therapists can hone these relational elements and that it is their responsibility to tailor these skills to the needs of individual patients. The therapeutic relationship should drive the theory, not the other way around [1].

Theory and technique are clearly important and should not be dismissed. However, clinicians may be focused on technical elements of treatment (possibly as a result of over-reliance on manual-based approaches) at the expense of the relationship, which can negatively affect treatment. Ultimately, clinicians' knowledge of themselves and how they interact with clients is absolutely vital in the execution of effective trauma treatment.

The traits of an effective trauma therapist are perhaps best described using the constructs of the classic psychology theorists/writers Rogers and Yalom. Rogers' basic constructs of empathy, genuineness, congruence, and unconditional positive regard are absolutely foundational, even for clinicians utilizing more directive approaches than a classic Rogerian approach would dictate. Yalom stresses that the therapeutic process should be relationship driven, not theory driven [54].

There are several qualities that have been identified as lending themselves to ensuring that an EMDR therapist is effective and accepted by clients [55]. However, these qualities are also positive traits of good trauma therapists in general. The following list and questions can be applied to clinical practice, regardless of approach. These questions should serve as a form of self-evaluation, allowing for the identification of strengths and weaknesses:

Good Clinical Skills

- What abilities or special skills do I have as a clinician?
- How comfortable am I with implementing the most basic clinical strategies for safety (e.g., risk assessment, contracting for safety, seeking outside help when necessary)?
- If trauma processing sessions do not go as planned, what other clinical skills may I utilize to ensure that the client is not harmed?

Ability to Develop Rapport with Clients

- What effective strategies do I have to establish rapport at the first meeting with a client?
- What are my struggles with forging a solid therapeutic relationship?
- Are there certain populations with whom I find it especially difficult to connect?
- If it becomes clear that the client and I are not connecting after several sessions, am I willing to explore the potential problems and solutions? Would I be willing to make a referral?

Comfort with Trauma and Intense Affect

- How do I feel when a client enters a state of extreme emotional catharsis in my office (e.g., intense crying, screaming, or lashing out at a figure from the past who is not in the office, such as a past abuser)?
- What personal issues do clients seem to provoke the most in me?

- What aspects of trauma and its sequelae might I still find hard to grasp clinically or personally?

Spacious

- Have I ever forced a client to work on an area that he or she might not be ready to handle?
- What might my motives be for pushing a client to work on traumatic material that he or she is not yet ready to address?

Well-Grounded

- Have I worked on my own issues when it comes to trauma, addiction, and mental health?
- What are my motives for helping people deal with their traumas?
- Do I let the client lead the session, or am I usually the leader?

Attuned to Clients

- What issues may keep me from staying present with my client during sessions?
- At what times might I find myself drifting off or distracted during sessions?
- Am I able to read my clients nonverbal and paraverbal cues?

Client perception and comfort can also affect treatment outcomes. One small study with clients who had attained a period of extended addiction sobriety (one to six years) and had been treated with EMDR found that client-identified clinician qualities that resulted in greater satisfaction with care included [13]:

- Caring
- Trustworthy
- Intuitive
- Natural
- Connected
- Comfortable with trauma work
- Skilled
- Accommodating
- Commonsensical
- Validating
- Gentle
- Nurturing
- Facilitating
- Smart
- Consoling

Likewise, traits associated with ineffective therapists were [13]:

- Rigid
- Scripted
- Detached
- Not comfortable with trauma work
- Anxious
- Unclear

Of course, this list is not all-inclusive, and the study assessed only female clients, which may have affected the types of responses. It may be helpful to reflect on both lists and ask which of these qualities may enhance your effectiveness and which you may need to address.

SELF-CARE

Mastering the arts of self-care and self-improvement are vital for any clinician, but for a clinician doing quality trauma work, they are essential. Self-care must be pre-emptive to be effective; it is not enough to initiate interventions after the weight of trauma work is taking its toll [56]. Clinicians doing any trauma work must constantly evaluate and care for themselves first. This can be difficult, as clinicians are trained to care for others and clients' needs may seem more urgent. But it is important to recognize that self-care is not selfish—it is essential to ensuring that the client continues to receive the best possible care from a healthy clinician.

There are many screening tools available to assess compassion fatigue and satisfaction, including the Compassion Satisfaction and Fatigue Test and the Professional Quality of Life Compassion Satisfaction and Fatigue (ProQOL) subscale, both of which are available online. It is good practice to complete one of these self-evaluation measures every three to four months as a preventative self-care measure. Again, the better a clinician takes care of him- or herself, the more effective the clinical work will be [1].

Lack of time is possibly the most common excuse professionals give when they are not engaging in self-care activities, and this excuse is certainly a problem. In the modern era, when productivity equals survival, it can be too easy to justify not having the time or resources to take care of oneself. However, it is important for individuals who are experiencing symptoms of stress and/or burnout to consider the costs of not making time to reduce stress. Persons who are burned out have difficulty engaging in all aspects of their lives and being there for family and friends. As discussed, stress and burnout also negatively impact productivity. This is particularly important for professionals whose relentless quest to complete tasks is affecting their work and personal lives.

As behavioral health professionals, it is also important to consider the negative influence that stress and burnout can have on clients. If, as Yalom suggests, the effective therapist should never force discussions of any content area, but should allow sessions to be relationship driven, attentiveness in all therapeutic sessions is necessary [57]. A heightened sensibility to existential issues influences the nature of the relationship of the therapist and patient and affects every therapy session. Professionals who are stressed or burned out will most likely be less attentive to clients. As such, failure to engage in effective self-care can be a client care issue.

Making the time to take care of oneself is a personal decision. For some, spending a few minutes each day practicing breathing or imagery may be a good place to start. When individuals start to see the benefits, they are often inspired to expand their self-care regimen.

HANDLING ABREACTIONS AND INTENSE AFFECT

Before initiating stage 2 trauma processing work with clients, it is important to assess one's comfort with handling abreaction and intense affect. Abreaction is defined as "the therapeutic process of bringing forgotten or inhibited material (e.g., experiences, memories) from the unconscious into consciousness, with concurrent emotional release and discharge of tension and anxiety" [2]. In simpler terms, an abreaction is a massive emotional reaction to accessing long-repressed experiences and emotions and may be evidenced by crying, screaming, foaming at the mouth, vomiting, or catatonia in extreme circumstances. Although it can be upsetting, these reactions can be part of a healthy resolution if they are addressed effectively in relation to the goals stage 2 trauma processing work is designed to achieve [1].

Clinicians working with clients with trauma histories should determine if they have the ability and resources necessary to cope with abreaction on a regular basis. Forging into stage 2 trauma work generally results in abreactions (and the intense affect that accompany them) on a more regular basis. If this sounds daunting, engaging in some extended self-care or using personal therapy or support resources to work through unresolved personal issues may be necessary before attempting effective stage 2 work with clients.

COLLABORATION AND REFERRAL OPTIONS

As the saying goes, it takes a village to help clients affected by trauma. Often, this comes in the form of needed social support, but in many cases, it also involves collaboration among several providers to ensure clients meet their treatment goals. Best practices for collaboration in treating trauma-related disorders include:

- Know your limits. If a client is triggering you or treatment has moved outside your scope of practice, refer to another clinician.
- The Internet can be a valuable resource. Many websites focusing on specific therapies publish national databases of clinicians specializing in trauma.
- Network in your local community. Get to know clinicians in the area who offer treatment for trauma survivors.

In making psychiatric referral, become familiar with the local physicians (or nurse practitioners) with experience treating clients with a history of trauma and/or addiction. Clients who struggle with addiction and trauma issues may not benefit from referral to a psychiatrist who relies heavily on benzodiazepine prescribing (or use of other controlled substances). However, pharmacotherapy can be a vital aspect of treatment, and the provider should feel comfortable prescribing appropriate medications to addicts who may benefit from them. Evidence suggests that certain psychotropic medications are effective in addressing the symptoms of PTSD and trauma-related disorders, which is particularly helpful during stage 1 stabilization [16]. However, these medications should be used in combination with psychotherapy or other psychosocial interventions for the goals of stage 2 trauma processing to truly be achieved [58].

CONCLUSION

Clearly, PTSD and other trauma-related disorders that do not meet formal DSM-5 criteria are an issue in American society. Instances of trauma affecting people are plentiful—war, natural disasters, bullying, school violence, sexual violence, job loss. However, developmental or innocuous trauma (e.g., going through a divorce, being teased) is even more widespread. Everyone endures some type of trauma in their lives, but some may be in better positions to integrate traumatic experiences into their total human experience than others. In order to ensure that clients receive the best possible care, all mental health professionals should have a better understanding of trauma, its effects, and strategies for addressing it.

In 2014, the Substance Abuse and Mental Health Services Administration published an extensive document on the principles of trauma-informed care based on the latest available research and practice knowledge of an expert task force. This document defines a trauma-informed approach to the delivery of behavioral health services as including an understanding of trauma and an awareness of the impact it can have across settings, services, and populations [7]. It involves viewing trauma through an ecologic and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. The following are examples of practicing trauma-informed care: Specific examples of trauma-informed practice include [7]:

- Promoting trauma awareness and understanding
- Recognizing that trauma-related symptoms and behaviors originate from adapting to traumatic experiences
- Viewing trauma in the context of individuals' environments
- Minimizing the risk of retraumatization or replicating prior trauma dynamics

- Creating a safe environment
- Identifying recovery from trauma as a primary goal
- Supporting control, choice, and autonomy
- Creating collaborative relationships and participation opportunities
- Familiarizing the client with trauma-informed services
- Incorporating universal routine screenings for trauma
- Viewing trauma through a sociocultural lens
- Using a strengths-based perspective to promote resilience
- Fostering trauma-resistant skills
- Demonstrating organizational and administrative commitment to trauma-informed care
- Developing strategies to address secondary trauma and promote self-care
- Providing hope

RESOURCES

WEBSITES

Center for Healthy Minds at the University of Wisconsin-Madison
https://centerhealthyminds.org

National Child Traumatic Stress Network
https://www.nctsn.org

The Greater Good Science Center at University of California, Berkeley
https://greatergood.berkeley.edu

HealthJourneys
https://www.healthjourneys.com

HeartMath Institute
https://www.heartmath.org

Integrative Trauma Treatment
https://www.trauma101.com

LifeForce Yoga
https://yogafordepression.com

National Center for PTSD
https://www.ptsd.va.gov

SAMHSA's Evidence-Based Practices Resource Center
https://www.samhsa.gov/nrepp

Trauma Made Simple
https://www.traumamadesimple.com

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GLOSSARY OF TERMS

Abreaction: The therapeutic process of bringing forgotten or inhibited material (e.g., experiences, memories) from the unconscious into consciousness, with concurrent emotional release and discharge of tension and anxiety [2].

Adaptive information processing model: Developed by Francine Shapiro to explain how trauma affects human learning and experience, suggesting that reprocessing therapies can be used to move the effects of trauma through to a more adaptive resolution. Though developed to explain EMDR, it also has applicability to trauma study in general.

Adverse life experiences: A phrase developed to replace earlier classification of large-T and small-t trauma. These are life events that may be classified or conceptualized as traumatic, whether or not they qualify for Criterion A trauma in the DSM-5.

Assessment: An ongoing process of gathering data to inform the course of treatment based on clients' goals.

Complex PTSD: Conditions of prolonged trauma or trauma that occurs at developmentally vulnerable times for an individual, causing effects much more significant than were thought possible with standard PTSD.

Dissociation: Generally refers to the rigid separation of parts of experience, including somatic experience, consciousness, affects, perception, identity, and memory [6].

Grounding strategies: Any coping skill or affect regulation exercise that helps keep clients (particularly those prone to dissociation) in the present.

Post-traumatic stress disorder (PTSD): A DSM-classified disorder characterized by actual or perceived threat of injury or death with response of hopelessness or horror (Criterion A), re-experiencing of the trauma (Criterion B), avoidance of stimuli associated with the trauma (Criterion C), negative cognitions and mood (Criterion D), heightened arousal symptoms (Criterion E), duration of symptoms longer than one month, and functional impairment due to disturbances.

Processing: Making sense of an experience or learning. Processing can include achieving the resolution needed to move on from a traumatic experience or series of experiences.

Recovery capital: The quality and quantity of internal and external resources that one can bring to bear on the initiation and maintenance of recovery [28; 29].

Reprocessing: Consciously accessing an affected memory or experience and striving to bring about a more adaptive experience or resolution.

Trauma: An event in which a person witnesses or experiences a threat to his or her own life or physical safety or that of others and experiences fear, terror, or helplessness. The event may also cause dissociation, confusion, and a loss of a sense of safety. Traumatic events challenge an individual's view of the world as a just, safe, and predictable place [2].

Trauma-informed: An approach to the delivery of behavioral health services that includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations [7].

Triune brain model: Suggests that the human brain actually operates as three separate brains, each with its own unique role. Each brain operates with its own respective senses of time, space, and memory [10].

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