Trauma-Informed Care Guidelines
Developed in Collaboration with FBHPartners’ Providers, Mental Health Partners, Jefferson Center for Mental Health, and Arapahoe House

The following provides an overview of the application of Trauma-Informed Care Guidelines to interactions and treatment provided in behavioral health settings. It is not intended as a substitute for diagnostically based clinical practice guidelines, which should always be used according to the individual-specific clinical assessment and relevant best practices.

Key Definitions:

- **Trauma-informed Care** is an approach to engaging individuals with histories of trauma; it recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their development of coping skills.
- **Resilience** refers to a person’s ability to bounce back or rise above adversity or traumatic experiences.
- **Trauma** occurs when a person experiences an intense event that harms or threatens harm to the person’s physical or emotional well-being, or to someone close to the person such as another family member or a friend.
- **Acute trauma** refers to a single traumatic event that is limited in time, such as an auto accident, a gang shooting, a parent’s suicide, or a natural disaster.
- **Chronic trauma** refers to repeated assaults on the person’s mind or body, such as chronic sexual or physical abuse or exposure to ongoing domestic violence.
- **Complex trauma** is a term used by some trauma experts to describe both exposure to chronic trauma and the long-term impact of such exposure.
- **Re-traumatization** is the occurrence of traumatic stress reactions and symptoms after exposure to multiple events; re-traumatization can occur inadvertently when systems of care are not trauma-informed.
- **Secondary Trauma** is also known as “compassion fatigue” or “vicarious traumatization.” It can occur when behavioral health workers are repeatedly exposed to the trauma experiences of other individuals.
- **Adverse Childhood Experiences (ACE) Study** surveyed over 17,000 participants to identify how stressful or traumatic experiences in childhood affect adult health and social adjustment.
- **Trauma-specific therapies** are evidence-based practices that are specifically designed to address recovery from the trauma symptoms and behaviors.
- **Trauma-informed organizations** address the seven domains of trauma-informed care, which pertains to all facets of an organization, not only treatment services, but also the physical environment and the interaction with community partners.

The Importance of Trauma-Informed Care

- Trauma-informed care promotes:
  - Safe expression of feelings;
  - Relief from symptoms and post-traumatic behaviors;
  - Recovery of a sense of mastery and control in life;
  - Corrections of misunderstanding and self-blame;
  - Restoration of a sense of trust in oneself and the future; and
  - An enhanced sense of safety and security.
- Benefits to the individual:
o Better behavioral and emotional health;
o Fewer suicidal thoughts and suicide attempts;
o Better school attendance and grades, fewer school problems; and
o Reduced symptoms of PTSD and depression.

➢ It is important to remember that just because an individual experiences a traumatic event does not mean that they are a victim.

Prevalence of Trauma

➢ 90% of those served in public behavioral healthcare settings have experienced trauma. Traumatic stress increases a person’s risk for developing behavioral health disorders and is also associated with severity of symptoms.
➢ Trauma can affect individuals from every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region.
➢ Trauma can be a single event or an accumulation of repeated exposures to threatening events or situations.
➢ Recent research has indicated that trauma exposure is very common. According to the National Co-morbidity Study, 61% of men and 51% of women in the general population of the U.S. report at least one trauma in their lifetime.
➢ Wave 2 of the National Epidemiological Survey on Alcohol and Related Conditions reported that 71.6% of the sample reported witnessing trauma, 30.7% experienced a trauma that resulted in an injury, and 17.3% experienced psychological trauma.
➢ 63% of participants in the ACE study experienced at least one category of childhood trauma.

Effects of Trauma:

➢ Short-term effects of trauma exposure may include physical and emotional reactions. Physical symptoms include: increased heart rate, trembling, dizziness, vomiting, fainting or seizures. Emotional reactions may include: feelings of terror, intense fear, helplessness, memory impairment, and disorganized or agitated behavior.
➢ Acute symptoms may periodically reoccur when an individual is exposed to re-traumatizing situations or emotional triggers. Post-traumatic symptoms may include re-experiencing the trauma through nightmares or flashbacks, avoidance of situations or stimuli associated with the trauma, increased physiological arousal, or decreased responsiveness to one’s environment (numbing, social isolation, anhedonia). For more information on diagnosis and treatment, see PTSD guidelines.
➢ Several long-term effects of trauma were identified in the ACE Study. These included a greater likelihood of experiencing the following:

<table>
<thead>
<tr>
<th>Alcoholism or alcohol abuse</th>
<th>Chronic obstructive pulmonary disease</th>
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<tr>
<td>Depression and anxiety disorders</td>
<td>Fetal death</td>
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<tr>
<td>Poor health-related quality of life</td>
<td>Illicit drug use</td>
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<tr>
<td>Ischemic heart disease</td>
<td>Liver disease</td>
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<tr>
<td>Risk for intimate partner violence</td>
<td>Multiple sexual partners</td>
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<tr>
<td>Sexually transmitted diseases</td>
<td>Smoking</td>
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<tr>
<td>Obesity</td>
<td>Suicide attempts</td>
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<td>Unintended pregnancies</td>
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Secondary Trauma:
- Secondary Trauma can have a significant impact on staff who work with clients with trauma histories. Repetitive exposure to traumatic material is now one possible diagnostic criteria for PTSD in the DSM 5, illustrating the significant impact that secondary trauma can have. The four main concepts of secondary trauma are compassion fatigue, vicarious trauma, secondary traumatic stress and burnout, and each can have varying effects on staff, personally and professionally (see Tips for Behavioral Healthcare Staff for additional resources).
- The Comprehensive Self-Care Plan Worksheet (see Appendix B) can help identify coping strategies related to physical, psychological, emotional, and spiritual well-being.

Diagnostic Considerations:
- Trauma related disorders include disorders in which traumatic or stressful events are listed explicitly as a diagnostic criterion, according to the DSM-5. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders (see PTSD clinical practice guidelines for more information.)
- Symptoms manifest differently in different people. Symptoms are generally well recognized when presentation is anxious or fearful. However, other individuals may display angry and aggressive, or dissociative symptoms.
- Complex traumatic events and experiences can be defined as stressors that are:
  - Repetitive, prolonged, or cumulative
  - Most often interpersonal, involving direct harm, exploitation, and maltreatment including neglect/abandonment/antipathy by primary caregivers or other ostensibly responsible adults
  - Often occur at developmentally vulnerable times, especially in early childhood or adolescence, but can also occur later in life and in conditions associated with disability, disempowerment, dependency, age, infirmity, and so on.
  - The experience of multiple traumas, particularly occurring in childhood, may impact resiliency and sensitize the client to other potential traumatic experiences and his/her ability to cope with them.
- Trauma is subjective according to the Trauma-Informed Care model. What one person finds traumatic, someone else may not (e.g. being bullied as a child). Trauma-Informed Care should be considered regardless of whether an individual meets diagnostic criteria for a trauma-related disorder.

Ten Principles of Trauma-Informed Care
- Principle 1. Trauma-Informed Services Recognize the Impact of Violence and Victimization on Development and Coping Strategies. Trauma survivors are validated when organizations recognize their experience, which increases the survivor’s sense of safety and hope. Trauma has a broad impact on identity, relationships, expectations of self and others, ability to regulate emotions, and overall world view. Many behaviors that are now the focus of treatment were developed originally as ways of coping with and adapting to traumatic events.

- Principle 2. Trauma-Informed Services Identify Recovery From Trauma as a Primary Goal. Services directly address recovery from past trauma or coordinate with an agency that does provide those services. Because the issues interact so significantly, it is essential that treatment for trauma and co-occurring disorders be integrated rather than sequential or parallel.

- Principle 3. Trauma-Informed Services Employ an Empowerment and Recovery Model. Ideally, treatment facilitates the client’s ability to take charge of his or her own life and to have conscious choice and control over his or her actions. The empowerment model facilitates recovery from the overwhelming fear and helplessness that is often the legacy of victimization.
The following premises underlie the empowerment model:
- Both the provider and the client are valued for their knowledge and perspective.
- The goals of the work are mutual and collaborative.
- Providers should consider the effects of gender and racial bias in our culture.
- The program facilitates a forum where members can interact in a mutually supportive way.
- The therapeutic relationship builds on existing strengths to increase a sense of inner strength.
- The therapeutic relationship is mutually beneficial to both client and therapist.
- Expanding a client’s resources and support, so they become less reliant on professional services.
- Becoming more engaged and moving beyond their healing to become an advocate for others.

- **Principle 4. Trauma-Informed Services Strive to Maximize Choices and Control Over Recovery.** Despite the great variability in need and vulnerability experienced by survivors, the ultimate goal is to work collaboratively to increase access to conscious choice and a sense of control over important life decisions. It is only through this personal experience of choice and control that a client reclaims the right to direct his or her own life and pursue personal goals and dreams. If a clinician feels a client is making a poor choice, the clinician needs to try to understand the client’s choice. Through the process of clarification, the clinician and the client reach a more mutually collaborative goal.

- **Principle 5. Trauma-Informed Services Are Based in a Relational Collaboration.** Interpersonal trauma needs to be healed in a context in which the interpersonal relationships are the opposite of traumatizing—one that offers respect, information, connection and hope. Safe relationships are consistent, predictable, non-violent, non-shaming and non-blaming. Interpersonal violence involves a perpetrator and a victim with a clear power differential. This hierarchy can be re-enacted in even the most well-intentioned treatment alliance. To reduce the pressure for the client to conform, the client’s right to direct the treatment must be made explicit.

- **Principle 6. Trauma-Informed Services Create an Atmosphere that is Respectful of Survivors’ Need for Safety, Respect, and Acceptance.** Providers should modify staff approaches, programs, procedures, and, in some cases the physical setting, to create a treatment experience that is perceived as safe and welcoming. A welcoming environment includes space for comfort and privacy, absence of exposure to violent or sexual material, and sufficient staffing to monitor the behavior of others that may be perceived as intrusive or harassing. Clear boundaries, clear information, and being consistent, predictable and having well-defined roles are help to provide a safe environment.

- **Principle 7. Trauma-Informed Services Emphasize Strengths, Highlighting Adaptations Over Symptoms and Resilience Over Pathology.** It is important for providers to focus on a person’s strengths rather than the problems. The medical model highlights pathology and inadvertently gives the impression that *something is wrong with a person* rather than that *something wrong was done to that person*. Validating resilience is important even when previously developed methods of coping are now causing problems. For example, dissociation may have been protective in the past, but now is disruptive to daily functioning.

- **Principle 8: Trauma-Informed Services Minimize the Possibilities of Re-traumatization.** Providers are encouraged to recognize and understand the potential for re-traumatization during treatment. Watch for signs that the client may be having this experience, for example a noticeable increase in anxiety, and check in frequently with the client regarding their experience of the therapeutic relationship and how the therapist may be inadvertently contributing to this experience.

- **Principle 9. Trauma-Informed Services Strive to be Culturally Competent and to Understand Each Person in the Context of His or Her Life Experiences and Cultural Background.** Cultural competence does not require that each provider have detailed knowledge of every culture, but rather that
he or she recognizes the importance of cultural context. It is often helpful to ask questions, be open to being educated, and try to understand the client’s experience and responses through the lens of his or her cultural context.

- **Principle 10. Trauma-Informed Agencies Solicit Consumer Input and Involve Consumers in Designing and Evaluating Services.** Clients should be involved in designing treatment services and be part of an ongoing evaluation of those services. They can be on an advisory board that reviews program design, serve as peer specialists, or participate in focus groups and/or in regular feedback forums about how to respond to program evaluations and improve services.

**Key Areas of Trauma Screening and Assessment**

- See Appendix A

**Evidence-Based Trauma-Specific Therapies**

Additional information about the following, and other, Evidence-Based Trauma-Specific Therapies can be found on SAMHSA’s National Registry of Evidence-based Programs and Practices ([http://www.nrepp.samhsa.gov/Index.aspx](http://www.nrepp.samhsa.gov/Index.aspx)) and from SAMHSA’s National Center for Trauma-Informed Care ([http://www.samhsa.gov/nctic/trauma-interventions](http://www.samhsa.gov/nctic/trauma-interventions)). It should be noted that these treatment models may require additional training, supervision, or certification. Many of these treatment approaches are available at one or both of FBHHP’s partner mental health centers. Check with a supervisor, if you have any questions about whether the treatment is available at your center.

- Behavioral Exposure Therapy
- Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- Attachment, Self-Regulation, and Competency (ARC)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Child and Family Traumatic Stress Intervention (CFTSI)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Trauma Affect Regulation
- Addiction and Trauma Recovery Integrated Model (ATRIUM)
- Seeking Safety
- Trauma Recovery and Empowerment Model (TREM)
- Cognitive Processing Therapy (CPT)

**Resources**

- Adverse Childhood Experiences Study ([www.acestudy.org](http://www.acestudy.org))
- National Center for Children Exposed to Violence ([www.nccev.org](http://www.nccev.org))
- National Center for Post-Traumatic Stress Disorder ([www.ptsd.va.gov](http://www.ptsd.va.gov))
- National Center for Trauma-Informed Care ([www.samhsa.gov/nctic](http://www.samhsa.gov/nctic))
- National Child Traumatic Stress Network ([www.nctsn.net](http://www.nctsn.net))
- National Trauma Consortium ([www.nationaltraumaconsortium.org](http://www.nationaltraumaconsortium.org))
- National Registry of Evidence-Based Programs and Practices ([www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov))
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) ([www.musc.edu/cvc](http://www.musc.edu/cvc))
**Additional References**

- The Trauma Toolkit: A resource for service organizations and providers to deliver services that are trauma-informed (second edition). (2013). Klinic

*The Clinical Guidelines are meant to assist providers in making the best decisions about appropriate treatment in specific clinical circumstances. You are not required to follow them nor are you expected to be proficient in all of the therapeutic models described below. However, following the guidelines is one way to help ensure that your care is consistent with the most current research and best practices and that it is medically necessary.*
Appendix A
Key Areas of Trauma Screening and Assessment

**Trauma**

*Key question:* Did the client experience a trauma?

*Examples of measures:* Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

*Note:* A good trauma measure identifies experienced events (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

**Acute Stress Disorder (ASD) and PTSD**

*Key question:* Does the client meet criteria for ASD or PTSD?

*Examples of measures:* Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

*Note:* A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

**Other Trauma-Related Symptoms**

*Key question:* Does the client have other symptoms related to trauma? (i.e. depressive symptoms, self-harm, dissociation, sexuality problems, relationship issues or distrust)

*Examples of measures:* Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 1996b); Modified PTSD Symptom Scale (Falsetti et al., 1993).

*Note:* These measures gauge levels of symptoms, helpful for clinical purposes and outcome assessment. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn’t meet criteria for any specific diagnoses.

**Other Trauma-Related Diagnoses**

*Key question:* Does the client have other disorders related to trauma?

*Examples of measures:* Mental Health Screening Form III (Carroll & McGinley, 2001); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSMIV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

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

Appendix B

Comprehensive Self-Care Plan for Behavioral Healthcare Staff

Instructions:
Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

Physical
What are non-chemical things that help my body relax? What supports my body to be healthy?

Psychological/Mental
What helps my mind relax?
What helps me see a bigger perspective?
What helps me break down big tasks into smaller steps?
What helps me counteract negative self-talk?
What helps me challenge negative beliefs?
What helps me build my theoretical understanding of trauma and addictions?
What helps me enhance my counseling/helping skills in working with traumatized clients?
What helps me become more self-reflective?

Emotional/Relational
What helps me feel grounded and able to tolerate strong feelings?
What helps me express my feelings in a healthy way?
Who helps me cope in positive ways and how do they help?
What helps me feel connected to others?
Who are at least three people I feel safe talking with about my reactions/feelings about clients?
How can I connect with those people on a regular basis?

Spiritual
What helps me find meaning in life? What helps me feel hopeful? What sustains me during difficult times? What connects me to something greater?

Worksheet:

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<thead>
<tr>
<th>Name:</th>
<th>Personal</th>
<th>Professional/Workplace</th>
</tr>
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<tbody>
<tr>
<td>Date:</td>
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</table>

### Physical

### Psychological/Mental

### Emotional/Relational

### Spiritual

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