

VII. Trauma-Informed Care

Lisa M. Najavits, Ph.D.

This chapter addresses the importance of trauma and trauma-informed care to help the MISSION-VET treatment team, including the Clinical Supervisor, identify and assist Veterans who have symptoms of trauma. This chapter has been included because of the high rate of trauma experienced by Veterans, particularly those in the current cohort of returning Veterans. MISSION-VET is not a PTSD intervention or one designed to treat co-occurring PTSD and addiction. However, this chapter does address the need to screen and refer Veterans who may have symptoms of serious trauma. For Veterans whose PTSD is severe or chronic, referral to a specialized program to stabilize and treat symptoms is advised. Suggestions for interacting with Veterans who have experienced trauma are also provided.

A. What is Trauma-Informed Care?

In the past decade, the term “Trauma-Informed Care” (TIC) has become a central component of treatment services for all vulnerable populations, including Veterans and the homeless. TIC is based on the idea that trauma is common and thus has important impact on how treatment is best delivered (Fallot & Harris, 2001). The more providers are aware of trauma and its impact, the better they can attend to it in treatment to promote recovery.

“Trauma” refers to the experience, threat, or witnessing of physical harm (American Psychiatric Association, 1994). It includes various types of experiences such as military combat, military sexual trauma, terrorist attacks, serious car accidents, natural disasters, major medical illnesses and injuries, childhood physical or sexual abuse, assault, and violence. Most Americans (about 61% of males and 51% of females) experience one or more traumas during their lifetime (Kessler et al., 1995). Globally, too, trauma is common (Kessler, 2000). Various stressors related to military service in particular may cause trauma (Seal, et al., 2007).

Trauma is an important treatment consideration for MISSION-VET Case Managers (CMs) and Peer Support Specialists (PSSs) because it can have varied and major impacts on functioning, the development of mental disorders, and life problems of all kinds (Najavits, et al., 1997; Ballenger, et al., 2000; Felitti et al., 1998). Trauma is associated with numerous symptoms, including depression, suicidality and self-harm, anxiety, social skills problems, dissociation, somatization, and psychotic symptoms (Mueser, et al., 2002). Trauma victims are

also at “much higher risk for co-occurring mental health and substance abuse disorders (COD), violence victimization and perpetration, self-injury, and a host of other coping mechanisms which themselves have devastating human, social, and economic costs. Trauma has been linked to social, emotional and cognitive impairments, disease, disability, serious social problems, and premature death” (Witness Justice, ND).

The MISSION-VET treatment team can also benefit from considering some important contextual factors that may impact how a person responds to trauma. These include gender differences in response to trauma, how culture may play a role (Hudnall-Stamm, 2001), delayed response (i.e., some people may react months or years after the traumatic event), single versus repeated trauma (how many times it occurred), age at time of trauma (child versus adult), the biological impact of trauma (mind-body connections), and how others reacted (family, community, colleagues, and society at large) (Najavits & Cottler, in press). Thus, it is important to remember that even traumas that appear similar in nature (for example, a car accident) may have a different impact depending on the individual and the context.

B. Trauma-related Disorders

Several psychiatric disorders can directly arise from trauma (American Psychiatric Association, 1994). These are important to assess and to treat when present. However, most people exposed to trauma, including Veterans, do not develop psychiatric disorders from trauma. Those more likely to develop trauma-related psychiatric disorders are those who experience repeated trauma (e.g., multiple military deployments), those who suffered greater physical injuries, and those who were more vulnerable before the trauma (e.g., younger persons with a pre-existing history of mental illness themselves or history of mental illness in their family) (Kessler et al., 2005; Najavits & Cottler, in press; Seal et al. 2007, 2009). Disorders related to trauma include the following:

Acute stress disorder occurs during or up to four weeks after trauma. It is characterized by various symptoms including a sense of numbing or detachment; reduced awareness of surroundings (being in a “daze”); difficulty recalling important aspects of the trauma; feeling unreal; feelings of anxiety, avoiding reminders of the trauma; re-experiencing the trauma, such as through flashbacks or nightmares; and significant decline in functioning.

Post-traumatic stress disorder can only be diagnosed four weeks or more after the trauma, thus indicating a persistence of trauma-related symptoms that do not diminish with time. Symptoms include many of the same symptoms as acute stress disorder, as well as others. In general, the symptoms fall into three main categories: re-experiencing the trauma (such as through nightmares and intense physical and emotional “triggering” when reminded of the trauma); avoidance of reminders of the trauma; and intense arousal (e.g., difficulty sleeping, anger outbursts, and startle reactions).

The two brief screening tools provided in Appendix K, can be used by the MISSION-VET team to assist in making treatment decisions: the PTSD four-item screen (originally developed for primary care settings, but used more broadly as well) and the PTSD Checklist (which maps onto the full list of DSM-IV criteria for PTSD).

Dissociative disorders may occur in a small percentage of the population after exposure to extreme and chronic trauma, such as in repeated childhood or prisoner-of-war trauma experiences. Dissociative disorders are marked by changes to consciousness, memory, identity, or perception. For example, the Veteran may have major memory gaps or feel unreal. In severe cases, dissociative identity disorder may be present, which is characterized by the presence of “alters” (different personalities) within the self, with switching between them that may occur without awareness or control of the Veteran. If this is noticed among Veterans in MISSION-VET, the CM/PSS team should work closely with the Clinical Supervisor and consider a referral to a specialized PTSD program as part of the treatment plan. In those instances, the MISSION-VET treatment team can assist by helping the Veteran accept a referral and engage in those services, and by continuing to support their ongoing attendance as part of the broader and more comprehensive treatment plan. The MISSION-VET treatment team should work closely with the PTSD team whenever possible. Additionally, every VA currently has a PTSD specialist who can assist with additional treatment considerations and ongoing supports in the community.

C. Elements of Trauma-informed Care

All MISSION-VET team members need education on the importance of incorporating trauma-informed care (Fallot & Harris, 2001) into MISSION-VET into service delivery. According to the National Center for Trauma-Informed Care, “When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services” (<http://mentalhealth.samhsa.gov/nctic>).

Specifics of trauma-informed care include the following (Elliott *et al.*, 2005; Fallot & Harris, 2001; Morrissey *et al.*, 2005; Weine *et al.*, 2002):

- Training all MISSION-VET staff in basics of trauma education (rates, impact of trauma, how to interact with traumatized Veterans, etc.);
- Taking steps to avoid retriggering trauma (e.g., restraints, isolation, or coercion);
- Creating advance directives on how to manage intense emotions (i.e., concrete plans of what to do if the Veteran becomes agitated, such as who s/he will talk to and what strategies help to calm the person);
- Eliciting input from survivors of trauma on how to design services that are trauma-sensitive;
- Focusing on dynamics that empower the traumatized Veteran, such as offering choices, expressing compassion, and listening;
- Learning how to help Veterans understand how some behavioral patterns may have developed from trauma; and
- Modifying policies to respect trauma sensitivity (e.g., a Veteran may need lights on at night while in residential treatment).

Note that all of the above are within the scope of the MISSION-VET team, but may require training or guidance from their local VA PTSD specialist and/or PTSD treatment team. In addition, resources for incorporating such trauma-informed care approaches are also available from some of the references and web resources listed in Appendix K.

Trauma-informed Treatment versus Trauma-specific Services

It is important to distinguish trauma-informed from trauma-specific treatment (Fallot & Harris, 2001):

- **Trauma-informed services:** basic trauma education, where all staff are trained to become *trauma-aware* (knowledgeable about trauma symptoms and the impact of trauma on Veterans’ lives, able to implement basic skills such as grounding and trauma screening, and aware of how and when to refer Veterans out for specialized help). An example of a model that is used in VA for trauma education is Seeking Safety (Najavits, 2002).
- **Trauma-specific services:** trauma therapy models in which a smaller number of staff become *trauma-competent* (able to effectively treat trauma-related disorders using evidence-based models). Examples of trauma-therapy models that are used in VA include Prolonged Exposure (PE) (Foa, 2007) and Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1999).

Present- versus Past-Focused Trauma Treatments

Another key distinction in the trauma treatment field is between present- focused and past-focused trauma treatments (Najavits, 2006).

In *past-focused* models, the client focuses on intense details of the trauma story as a way to face the feelings that arise from it. Typical interventions include having the client tell the trauma narrative in detail, having the client focus on body sensations they associate with the trauma, and having them seek out real-life reminders of the trauma (e.g., look at the clothes worn at the time of the trauma). Examples of past-focused models used in VA include EMDR, Prolonged Exposure Therapy, and Cognitive Processing Therapy.

In *present-focused* models, the client learns coping skills and education to improve functioning. Typical interventions include grounding (using sensory experience to reconnect with the present environment), relaxation, learning to ask for help, cognitive restructuring, and coping with triggers of trauma. Examples of present-focused models include Seeking Safety, Trauma Recovery and Empowerment Model, and Stress Inoculation Training.

Research indicates, overall, that both present- and past-focused models are effective, and in virtually all head-to-head research studies, they perform with no significant difference between them in outcomes (Najavits, 2007). This means there is a lot of choice in what models clinicians can conduct. Choices should be made based on the setting, the client, and the clinicians' own training and skills.

D. Trauma Services in MISSION-VET

When delivering MISSION-VET services to Veterans, the goal is to be sensitive to trauma and how it may manifest in Veterans. CMs and PSSs delivering MISSION-VET services should be trauma-informed. All Veterans enrolled in a MISSION-VET program should be screened for PTSD and, if positive, should be formally assessed by a qualified assessor. Additionally, MISSION-VET CMs and PSSs should use an empathic stance (as described in the next sections) with Veterans on their caseloads.

Some MISSION-VET CMs (under the direction of their Clinical Supervisor) may also choose to engage in present-focused trauma-specific treatments (or parts of such models) in conjunction with their MISSION-VET work. Such models have been found to be very safe for clinicians to use, even with a very broad range of co-morbid clients, even if they do

not have a formal background in mental health (Morrissey et al., 2005). For example, MISSION-VET CMs and PSSs may choose to do grounding with Veterans, in which they provide brief psychoeducation about trauma and its impact (See Appendix K for more information on grounding). However, it is important to emphasize that CMs and PSSs delivering MISSION-VET services are advised not to conduct intensive past-focused trauma-specific services unless they have formal training and supervision in those models (e.g., EMDR, Prolonged Exposure, Cognitive Processing Therapy). These treatments can result in negative outcomes or harm to Veterans if conducted poorly. "First do no harm" remains the central principle of all treatment.

Keys in Interacting with a Veteran who has Trauma-Related Symptoms

- Anticipate proceeding slowly with a Veteran who has trauma-related symptoms. Consider the effect of a trauma history on the Veteran's current emotional state, such as an increased level of fear or irritability.
- Develop a plan for increased safety where warranted.
- Establish both perceived and real trust.
- Respond more to the Veteran's behavior than his or her words.
- Limit questioning about details of trauma.
- Recognize that trauma injures a Veteran's capacity for attachment. The establishment of a trusting relationship will be a goal of treatment, not a starting point.
- Recognize the importance of one's own trauma history and countertransference.
- Help the Veteran learn to de-escalate intense emotions.
- Help the Veteran to link trauma and substance abuse.
- Provide psychoeducation about trauma and substance abuse.
- Teach coping skills to control trauma symptoms.
- Recognize that Veterans may have a more difficult time in trauma/substance abuse treatment and that treatment for trauma may be long term, especially for those who have a history of serious trauma.
- Refer to trauma experts for trauma exploratory work.

*Reprinted from SAMHSA's *Treatment Improvement Protocol: Trauma and Substance Abuse (in press)*. Consensus panel chairs: Lisa M. Najavits, PhD and Linda B. Cottler, PhD, MPH

Style of Interaction

According to VA's National Center for PTSD (<http://www.ptsd.va.gov>), style interaction is a key element of Trauma-Informed Care. Those interacting with the Veteran should interact with Veterans in ways that promote the best response possible. The following advice is provided:

"Another consideration within the therapeutic relationship between client and clinician is placing less emphasis on confrontation and more tolerance of the problem. Many individuals who treat substance use disorders can use a harsh confrontational style. They can draw the line in a very specific way and say to their client things like "You need to get yourself together," or "You need to stop doing this." And can really push on the client in a way that is very confrontational. The thing to consider when working with somebody who has trauma is that their trauma may have occurred under conditions of harsh confrontation and so the very intervention may be triggering the individual, thus causing problems within the therapeutic relationship and perhaps even affecting treatment. On the other side of that is misguided sympathy. There are providers who feel that their clients have had too many traumas and really over-sympathize with what's happening for them, and they don't hold them responsible for doing homework or engaging in the responsible actions that are necessary for them to recover. So you want to think of this as harsh confrontation on one end of a continuum and misguided sympathy on the other end of the continuum and see if you can put yourself right in the middle using a soft confrontational style and holding the client responsible for the different things that they need to do to promote recovery."

The Importance of Culture and Gender

It is also important to be sensitive to how culture and gender may play a role in how trauma is perceived, addressed and treated. For example, culture and gender may affect whether a MISSION-VET client is able to identify trauma symptoms as "legitimate" (e.g., in some cultures psychological problems are considered more taboo to discuss than in others); may affect how symptoms are expressed (e.g., as emotional versus more physical in nature); may affect co-morbidity (e.g., the likelihood of using certain substances as ways of coping with trauma symptoms); and may affect treatment response (e.g., whether the counselor is aware of cultural and gender subgroup issues). Thus, MISSION-VET CMs and PSSs are encouraged to seek training in cultural, diversity, and gender-based issues so as to provide the most compassionate care possible to "their" Veterans.

Trauma and the Clinician

It is also important to recognize that members of the MISSION-VET treatment team themselves may have experienced trauma.

Given that the majority of people in the U.S. population experience one or more traumas in their lifetime, a large percentage of clinicians may have their own trauma history. Sometimes working with traumatized Veterans may activate the MISSION-VET CM's or PSS's own trauma reactions, or it may result in strong feelings toward the Veteran. These may be especially powerful if the MISSION-VET CM or PSS still has trauma symptoms that are not "worked through" or treated sufficiently (Pearlman & Saakvitne, 1995). Thus, self-care is a necessary principle. This includes attending to one's reactions while working with traumatized Veterans, getting help if needed, and maintaining boundaries between one's own experience and the Veteran's.

When to Refer a Client out for Trauma-Related Treatment

MISSION-VET team members should know when to refer a Veteran on their caseload out for specialized PTSD or trauma-related assessment or treatment. Key examples of such scenarios are as follows.

- The Veteran has emotional or behavioral problems that are consistent with PTSD (e.g., intense anger, hypervigilance, nightmares).
- The Veteran screens positive for PTSD, and there is a need for formal diagnostic assessment.
- The Veteran requests additional PTSD treatment.
- The Veteran keeps relapsing on substances and has a major trauma history.
- Members of the MISSION-VET treatment team notice the Veteran dissociating during sessions (e.g., spacing out, blank stare) and feel the need for additional therapeutic help.
- The MISSION-VET treatment team suspects PTSD may be present, but are not sure and would like a consult to offer expert advice.

In all of these cases, we suggest that the MISSION-VET CM work closely with the Clinical Supervisor to make an appropriate referral. It is also important to note that in the MISSION-VET treatment model, the referral does not end treatment. It is the MISSION-VET treatment team's job to facilitate the referral and offer assistance to the treatment team during the assessment process, at other times when the treatment team deems it appropriate and helpful, during discharge planning, and in execution of the new discharge treatment plan.

There are numerous situations where the Veteran's presentation may suggest the need for a stronger PTSD treatment focus than can be provided as part of MISSION-VET services. However, many CMs conducting MISSION-

VET can deliver elements of Trauma-Informed Care and exercise some trauma-specific coping skills, even while seeking out additional PTSD expertise.

Case Example

Jason is a returning Veteran from OIF, who is currently in residential care at VA due to homelessness and multiple psychiatric problems. He struggles with alcohol dependence that arose about six months after returning home from Iraq. He was exposed to multiple traumas during his deployment, including seeing a fellow soldier, Bill, die in a blast from a roadside bomb. Jason was nearby and was almost killed himself. He said he felt dead inside ever since losing Bill, who was a good friend.

Jason had nightmares many nights and became afraid to go to sleep. He became more isolated and withdrawn and volunteered for the most dangerous assignments, not caring if he lived or died. On returning home, his wife and children seemed afraid of him, as he would burst into angry episodes over small things, such as someone not putting things away correctly. He had been an easy-going, quiet person before Iraq, and they felt they barely recognized him now. His wife told him to get treatment or she would leave him. He refused and then moved out.

Without a job, Jason ended up on the streets, where he became a low-level worker for a drug dealer in an attempt to try to earn some money. An outreach worker from the VA talked him into trying to get into VA care. He felt hopeless that anything would make a difference but agreed to an intake, where they diagnosed him with post-traumatic stress disorder, substance dependence (alcohol), dysthymia, and intermittent explosive disorder. He entered a residential program where he was required to attend treatment as a condition of receiving temporary housing.

Initially, Jason was withdrawn, distrustful, and somewhat paranoid, but as he settled in, he began to speak a bit in groups and was able to connect with a counselor whom he trusted. The counselor helped him to understand the impact of trauma on his life and helped him see how his misuse of alcohol and prescription medications had been a way to try to cope with trauma-related symptoms. He now says,

“My counselor got it, even when I didn’t, that trauma had played a huge role in how I ended up homeless and at my bottom. I kept blaming myself, but my counselor helped me see that the traumas I had been through had festered inside me and affected everything I did, yet I never dealt with it or even acknowledged how important they were. My counselor was kind, and moved slowly, pacing to what I was able to do at any time and never pushing or judging me.”

Jason ultimately entered individual PTSD treatment with a VA therapist trained in this area, continued to work on his alcohol dependence, and gradually learned new coping skills and engaged in family therapy. Ultimately, about three years from the date when he left home, he was able to reunite with his family and move back in with them.

Case questions

Consider the following questions about Jason’s story above.

1. How did trauma play a role in Jason’s problems?
2. What helped him to recover?
3. What elements of Trauma-Informed Care do you notice in his treatment?
4. Are there other things his counselor could have done to create a trauma-sensitive treatment experience?
5. When you work with clients, how much do you practice Trauma-Informed Care? What could you do differently to increase this aspect?

Case discussion

Jason is typical of some returning Veterans in his exposure to trauma during deployment to Iraq and in his development of alcohol dependence after coming home. His family problems, homelessness, and multiple psychiatric problems are also representative of some of the more severe clients. His hopelessness, sleep problems, difficulty taking care of himself, and downward spiral are all typical trauma-related problems that have even greater impact in the context of substance dependence and other psychiatric disorders. Yet Jason is a success story in several ways:

- A VA outreach worker was able to engage him into treatment, even amid Jason’s significant distrust and isolation.
- Jason’s counselor used a trauma-informed approach focusing on building trust, pacing, and education about trauma and related problems.
- Jason was referred to a VA PTSD specialist for treatment of the PTSD, and, eventually, when ready, to family treatment to help re-unite with his family.

In sum, a trauma-sensitive approach helped Jason engage in recovery and through specialized treatment for PTSD, he was able to make significant progress in addressing alcohol dependence and family problems.