Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services

An Update of the 2004 Report

DRAFT

Prepared by:
Ann Jennings, Ph.D.

Prepared for:
Abt Associates Inc.
Under contract with the Center for Mental Health Services (DMHS), Substance Abuse and Mental Health Services Administration (SAMHSA),
U.S. Department of Health and Human Services (HHS)

Table of Contents

Survivors

Acknowledgments

The Abt Associates, Inc, the National Association of State Mental Health Program Directors (NASMHPD) and the National Center for Trauma Informed Care gratefully acknowledge the many individuals and organizations that contributed to the development of this updated report.   In particular, we would like to thank Terry Cline, Ph.D. Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), and A. Kathryn Power, M.Ed. and Susan E. Salasin of the Center for Mental Health Services (CMHS) within SAMHSA for their time and effort and for continuing to demonstrate their commitment to this issue.

Among the many individuals who contributed resources and time to this updated publication we would like to especially thank those dedicated and talented people who created the trauma-informed and trauma-specific service models and treatment approaches contained in this manual. Their response to our request for revised or new descriptions of their models according to a format easily reviewed by readers within state mental health and substance abuse service systems was generous and timely.   They patiently and carefully summarized key aspects of their models, indicating the status of research and evaluative findings, identifying the specific settings and individuals   for whom each approach was designed and/or adapted, and providing contact information for readers to easily obtain more information and/or materials.   Their commitment and continuing work in the field of trauma, especially with regard to the creation and research of models which address the complex deeply rooted kinds of childhood abuse trauma experienced by so many recipients of public mental health and addition services, has been essential to moving the field forward towards achieving the vision of recovery and transformation portrayed in the Presidents New Freedom Commission on Mental Health Final Report. (Anything else to say or person or document to identify regarding a "vision of recovery and transformation??)

In this section we should acknowledge the contributions of Rebecca Tregerman of Abt for here invaluable assistance contributing to the research and preparation of this manual. Also to be acknowledged are members of the review team (NCTIC????)

Introduction

This 2007 technical report identifies revised criteria for building a trauma-informed mental health service system, summarizes the evolution of trauma-informed and trauma-specific services in state mental health systems, and describes the increasing numbers and range of trauma-based service models and approaches available for implementation by state service systems, provider agencies and communities across the country. This report includes updated author descriptions of trauma service models identified by states and organizations for the 2004 technical report; author descriptions of evidence based and promising practice models identified in SAMHSA's Model Programs and National Registry of Evidence-Based Programs and Practices; author descriptions of empirically supported treatments and promising practices identified by the National Child Traumatic Stress Network, and empirically supported treatment approaches and promising practices reported by state trauma-informed contacts. All models were designed explicitly to address trauma in the lives of children, their parents or caregivers, and adults.

Who Are the Models Designed For?

- All of the models described in this document are designed for persons receiving or at risk for receiving public mental health and/or substance abuse services who have been traumatized by interpersonal violence and abuse and other adverse experiences during their childhood and/or adolescence. Many of the models were designed specifically to address the kinds of complex traumatic stress issues and problems common in the lives of children and adults seen in public service sector settings today. These individuals often have severe and persistent mental health and/or substance abuse problems and are frequently the highest users of the system's most costly inpatient, crisis, and residential services. As adults, they may carry any psychiatric diagnosis, and frequently carry varied diagnoses over time such as borderline personality disorder, schizophrenia, depression and other affective disorders, anxiety disorder, eating disorder, psychosis, dissociative disorder, addictive, somatoform, and sexual impairment—all diagnoses which have been related to past trauma (Ford et al., 2004; Read et al., 2001 and 2003; Felitti et al., 1998; Mueser et al., 2002; Mueser and Rosenberg, 2003; Sareen, 2005;). As children and adolescents, a multiplicity of trauma-related behaviors and coping mechanisms may lead to misdiagnoses such as attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, substance related disorders, juvenile or pediatric bipolar, bipolar depression, borderline personality disorder, and major depression. (Glad and Teicher, 1996; Perrin et al, 2000, Hodas, 2006). In spite of the prevalence of trauma and its severe impacts on the mental health of adults and children, a primary or secondary trauma-based diagnosis of Post-traumatic Stress Disorder is seldom given. (NYS-OMH, 2001; Tucker, 2002)

Many of the individuals described above have developed extreme coping strategies, in childhood, adolescence and as adults, to manage the impacts of overwhelming traumatic stress, including suicidality, substance abuse and addictions, self-harming behaviors such as cutting and burning, hallucinations, emotional numbing and dissociation, hypervigilance, somatization, aggression and rage, re-enactments such as abusive relationships, and serious health risk behaviors (Saakvitne et al., 2000; Dube et al, 2001; Felitti et al, 2002; Felitti, 1998; Hammersley, 2004; Sareen, 2005; CDC, 2005)

Although the trauma adults experienced in their formative years as children may be core to their condition and central to their healing, it has seldom been asked about or viewed as an issue central to treatment in public mental health settings. (Cusack et al., 2007). For the most part these individuals have never received screening, assessment or treatment for trauma. (Cusack, Frueh, and Brady, 2004; Frueh et al., 2002; Mueser et al., 1998).
The situation is similar for children in the mental health service system. Although many have histories of severe interpersonal violence and multiple adverse childhood experiences, recognition of the trauma underlying their behaviors and diagnoses typically does not occur. (Hodas, 2006; Perrin et al, 2000)

What Kinds of Trauma are Experienced by Persons Who Develop Serious and Persistent Mental Illness and Addiction?

The kinds of trauma experienced by persons who are or who become recipients of public mental health services are usually not associated with "single blow" traumatic events (Terr, 1991) such as natural disasters, accidents, terrorist acts, or crimes occurring in adulthood such as rape and domestic violence (Giller, 1999). Rather, the traumatic experiences of adults, adolescents and children with the most serious mental health problems are interpersonal in nature, intentional, prolonged and repeated, occur in childhood and adolescence, and may extend over years of a person's life. They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse. They may also include the witnessing of violence, repeated abandonments, and sudden and traumatic losses. They frequently include several different kinds of traumatic or adverse experiences resulting in cumulative traumas that have neurological impacts and lead to health risk behaviors or symptoms adopted as attempts to ease the pain. These in turn can result in severe sometimes chronic dysfuntions over the lifespan including disease, disability, and serious social and mental health problems. (Felitti, 1998, Jennings, 2006)

As adolescents and adults, individuals abused in childhood often experience trauma and re-victimization through domestic violence, sexual assaults, gang and drug related violence, homelessness, and poverty (Saakvitne, 2000). They are traumatized further by coercive interventions and unsafe psychiatric environments (Jennings, 1994; Cusack et al., 2003; Frueh et al., 2000; Frueh et al., 2005; Grubaugh et al., in press; Robins et al., 2005) and at times sexual and physical abuse in inpatient or institutional settings, jails,

and prisons. They frequently develop serious and disabling health problems (Felitti et al., 1998). As parents, individuals with serious mental health problems may participate in or witness the intergenerational effects of violence and abuse, and adolescent and teenage girls and women in particular are vulnerable to revictimization, ongoing exploitation and abuse (Browne, 1992; Frueh et al., 2000; Rosenberg et al., 2001; Russell, 1986).

What Percentages of Mental Health Clients Have Histories of Trauma?

Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of clients served by public mental health and substance abuse service systems.

- 51 – 98% of public mental health clients with severe mental illness, including schizophrenia and bipolar disorder, have been exposed to childhood physical and/or sexual abuse. Most have multiple experiences of trauma. (Goodman et al, 1999, Mueser et al, 1998; Cusack et al, 2003)

- 75% of women and men in substance abuse treatment report abuse and trauma histories (SAMHSA/CSAT, 2000)

- 97% of homeless women with mental illness experienced severe physical and/or sexual abuse, 87% experienced this abuse both as children and as adults (Goodman, Dutton et al., 1997)

- Nearly 8 out of 10 female offenders with a mental illness reports having been physically or sexually abused (Smith, 1998)

- 93% of psychiatrically hospitalized adolescents had histories of physical and/or sexual and emotional trauma. 32% met criteria for PTSD. (Lipschitz et al, 1999)

- In Massachusetts, 82% of all children and adolescents in continuing care inpatient and intensive residential treatment have trauma histories. (NETI, 2003).

- Teenagers with alcohol and drug problems are 6 to 12 times more likely to have a history of being physically abused and 18 to 21 times more likely to have been sexually abused than those without alcohol and drug problems (Clark et al., 1997)

- Among juvenile girls identified by the courts as delinquent, more than 75% have been sexually abused. (Calhoun et al, 1993)

- 3 years of data from New York State Office of Mental Health showed that only 1 in 200 adult inpatients and only 1 in 10 child/adolescent inpatients carried either a primary or secondary diagnosis of PTSD.   (NYS-OMH, 2001; Tucker, 2002)

Evolution of Trauma-Informed and Trauma-Specific Services in State Mental Health Systems

As awareness of the prevalence and impacts of trauma increases, the individuals for whom the trauma-informed and trauma-specific services described in this report were designed are increasingly viewed not as a subgroup or an anomalous population of clients, but as encompassing nearly *all* children, adolescents and adults served by public mental health and substance abuse service systems. This increasing awareness is reflected in the rising number of states taking significant steps toward integrating knowledge about trauma into existing services and developing and/or implementing new "trauma-specific" services.

In 2001, about 12 states formed an informal network (State Public Systems Coalition On Trauma (SPSCOT) to share ideas and support the development of trauma-informed systems of care. State mental health policymakers including Commissioners and senior staff, trauma experts, advocates, and mental health consumers with histories of sexual and physical abuse trauma (Consumer/Survivor/Recovering persons [C/S/Rs]) formed a listserve as a vehicle for on-going communication. A list of criteria for building trauma-informed mental health service systems was compiled, and a report entitled *Trauma Services Implementation Toolkit for State Mental Health Agencies* was prepared, listing trauma-related activities initiated and resources created by 15 state public service systems. This report, published as an appendix to *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System* (Jennings, 2004), was 28 pages in length.

In 2004, an update of the *Trauma Services Implementation Toolkit for State Mental Health Agencies* had grown from 21 to over 130 pages, reflecting a dramatic increase both in the number of states reporting trauma-related activities (from 15 to 31) and the multiplicity of strategies and programs they had adopted, initiated, or in some way support. In 2007, SAMHSA will publish another update on state systems' activities in developing trauma-informed mental health service systems. Preliminary research for that document shows a continued increase in trauma-related activities, especially in the area of children's services.

Trauma-related activities reported by states fall within 3 areas: 1) administrative policies or guidelines regarding the service system; 2) administrative policies and guidelines regarding services; and 3) trauma services. They meet one or more of the following twelve *Criteria for Building a Trauma-Informed Mental Health Service System* (Revised from Blanch, 2003). Many of the criteria are related to recommendations made in the President's New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America*. (See Appendix for criteria descriptions).

1. A designated trauma function and focus in the state mental health department

2. State trauma policy or position paper

3. Workforce Recruitment, Hiring and Retention

4. Workforce orientation, training, support, competencies and job standards related to trauma

5. Consumer/Trauma Survivor/Recovering person (C/S/R) involvement and trauma-informed rights

6. Financing criteria and mechanisms to support development of trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services

7. Clinical practice guidelines for working with children and adults with trauma histories

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment,to develop a trauma-informed system, and to avoid retraumatization

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

10. Univeral trauma screening and assessment

11. Trauma-informed services and service systems

12. Trauma-specific services, including evidence-based and promising practice treatment models

Factors Contributing to the Growth of Awareness and Activity in State Mental Health Service Systems

A number of factors are shaping and influencing increased awareness of trauma as a key public health and policy issue. It has become evident to a critical mass of mental health leaders in decision making positions that:

- a majority of persons served in public mental health and substance abuse systems have experienced repeated trauma since childhood;
- they have been severely impacted by this trauma;

- ignoring and neglecting to address trauma has huge implications for use of services and costs incurred;
- evidence exists for effectiveness of trauma-based integrated treatment approaches and promising practice models designed for, and providing renewed hope of recovery to, clients with complex, severe, and persistent mental health or addiction problems; and
- many of these trauma-informed and trauma-specific models are applicable and replicable within public service sector settings.

The following factors provide both impetus and support for changes leading to a large-scale transformation of traditional mental health service systems and their core services to trauma-informed mental health service systems and trauma-informed and trauma-specific services.

- **Leadership of the Substance Abuse and Mental Health Services Administration (SAMHSA)**. SAMHSA has designated trauma a cross-cutting issue in its formal matrix of SAMHSA Priorities: Programs & Principles and has consistently supported local, state, and national level initiatives addressing trauma in the lives of both adults and children with mental health and substance abuse problems. In the 1990s, SAMHSA's Center for Mental Health Services (CMHS) developed a specific agenda on women's issues and gender-specific treatment, and in 1994 held a landmark conference, Dare To Vision. The conference brought together over 350 consumers, practitioners, and policy makers and created a national momentum on trauma and violence. This momentum led to the creation of a series of national "technical expert groups" on trauma and stimulated the development and testing of innovative approaches. In the 2000s, SAMHSA's Center for Substance Abuse Treatment (CSAT) published the first Treatment Improvement Protocol (TIP) on Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues. Several major studies and initiatives focused on trauma have also been initiated by SAMHSA/CMHS including the Women, Co-Occurring Disorders and Violence Study and the National Child Traumatic Stress Network.

- **The Women, Co-Occurring Disorders and Violence Study (WCDVS).** This landmark five-year multi-site study, launched by SAMHSA in 1998, was the first federal effort to address the significant lack of appropriate services for women with co-occurring substance abuse and mental health disorders who experienced trauma, and their children. During the first two years of the program, 14 organizations located in ten states developed and documented integrated service models and agreed upon site-specific and cross-site research protocols. A separate study focusing on the children in these families was also developed. In the second phase of the study, nine study sites developed and tested manualized trauma-specific service intervention models integrating trauma, mental health, and substance abuse issues. Preliminary cross-site findings indicated significantly positive outcomes for the women and their children who received these integrated services. Further, the study indicated that interventions are cost effective. This

study has impacted on service delivery, both within the states where study sites were located and nationally. It has contributed a group of evidence-based and promising practice models which are applicable to public sector service settings and relevant and appropriate to clients served by public mental health service systems. The models are increasingly being adopted by state systems and adaptations of some models have made them appropriate for men and a variety of ethnic groups (www.nationaltraumaconsortium.org).

- **Leadership of the National Association of State Mental Health Program Directors (NASMHPD).** NASMHPD, and it's National Technical Assistance Center for State Mental Health Planning (NTAC), has utilized its established reputation and considerable networking capacity with federal and other national agencies, state mental health authorities (SMHAs), researchers, service providers, and mental health service consumers across the country to promote the development, dissemination, and implementation of new scientific knowledge and to bring emerging best practices in the field of trauma to state mental health systems. In 1998, the NASMHPD membership of state mental health Commissioners unanimously passed a *Position Statement on Services and Supports to Trauma Survivors* (NASMHPD, 1998). In 2005, reflecting increased scientific validation for the centrality of trauma in the lives of mental health clients, the NASMHPD membership unanimously passed a revised position statement: *NASMHPD Position Statement on Services and Supports to Trauma Survivors.*

    In 1998, NASMHPD held the first national trauma experts meeting, created an annotated bibliography on trauma and mental health, and declared NASMHPD to have a strategic role in keeping trauma at the forefront of a national mental health agenda. Plenary panels and other major presentations on trauma have been held at biannual NASMHPD Commissioners meetings. From 2002 to 2004, additional expert meetings were hosted by NASMHPD. A major initiative undertaken by NASMHPD/NTAC to reduce seclusion and restraint practices and the retraumatization of such practices, and a comprehensie curriculum: *Creating Violence Free and Coercion Free Mental Health Treatment Settings*, was developed and implemented in numerous state systems. A technical assistance project was produced to bring emerging best practice models to NASMHPD Division directors, the NASMHPD Research Institute, Inc., and SMHAs across the country.

    NASMHPD/NTAC has produced and implemented nationally a second curriculum "Creating Trauma Informed Systems of Care", and several trauma-related documents including, *Developing Trauma-Informed Behavioral Health Systems* (Blanch, 2003), *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System* (Jennings, 2004), *Trauma Informed Mental Health Service Systems: Blueprint for Action* (Jennings, 2004), *Models for Developing Trauma-Informed behavioral Health Systems and Trauma-Specific Services for Children* (Jennings, 2004), *Responding to Childhood Trauma: The Promise and Practice of Trauma-*

Informed Care (Hodas, 2006), and *Organizational Stress as a Barrier to Trauma – Sensitive change and System Transformation* (Bloom, 2006)

- **The National Trauma Consortium (NTC).** Dedicated to improving the lives of trauma survivors and their families, the NTC was founded in 2003 by a group of individuals who had played key roles in the SAMHSA WCDVS study. NTC has three primary goals: to strengthen the interaction of research and practice; to increase the impact of our growing knowledge about trauma through activities in the public arena, including advocacy, public policy, and public education and awareness; and to enhance the capacity of individuals and organizations to plan, implement, and oversee effective service approaches by offering high quality training and technical assistance, including leadership development. In the winter of 2004, NTC collaborated with SAMHSA/CMHS to organize the second landmark national conference on trauma: "Dare To Act: Trauma Survivors, Practitioners, Researchers and Policymakers Creating a Blueprint for Change." The event provided a forum for practitioners, researchers, survivors of physical and sexual abuse with histories of mental health and substance abuse problems, and decision makers to encourage and support the applicability of the trauma paradigm (centrality of trauma) in mental health, substance abuse, and family and children's service systems. NTC continues to function as a clearinghouse of information about trauma and emerging best practices in trauma treatment and services, offering training and consultation services to mental health and substance abuse providers, hospitals, the criminal justice system, child-serving agencies, women's organizations, community agencies, advocates, and others. (www.nationaltraumaconsortium.org).

- **National Child Traumatic Stress Network (NCTSN).** Established by Congress in 2000, the national Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN is a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

    The network comprises 70 member centers-45 current grantees and 25 previous grantees – and is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services through a congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative. (www.nctsnet.org)

- **The Adverse Childhood Experiences (ACE) Study.** The Adverse Childhood Experiences (ACE) Study, a decade long collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego, is the largest epidemiological study ever conducted on the links between childhood maltreatment and trauma, and later-life health, mental health and social well-being. According to data collected from over 17,000 Kaiser patients in this ongoing retrospective and prospective study, adverse childhood experiences, though well concealed, are unexpectedly common, and are major risk factors for the leading causes of death and disability in this country, including heart disease, cancer, stroke, diabetes, skeletal fractures, chronic lung disease, and liver disease.

  7 categories of adverse and potentially traumatizing categories of childhood experiences were explored with study participants: psychological abuse, physical abuse, sexual abuse, household member with substance abuse, household member with serious mental health problems, mother treated violently, and criminal behavior in household.

  A strong graded relationship was consistently shown to occur between the number of categories of adverse childhood experiences and adult reports of health risk behaviors including smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, hallucinations, suicide attempts, sexual promiscuity, and sexually transmitted diseases – all identified as leading causes of death and disability. These health risk behaviors, traditionally viewed as public health or mental health problems, are viewed by the ACE Study as coping mechanisms to ease the neurological impacts and psychological pain resulting from multiple childhood adverse and traumatic experiences.

  The ACE Study has had a major impact on health and mental health care professionals both nationally and internationally, revealing the importance of routinely screening all patients or clients for adverse childhood experiences; and underscoring the fact that a childhood trauma history may be very relevant to both serious physical illness and mental health problems and that appropriate approaches to treatment must include dealing with childhood trauma. Additional data suggest that evaluating patients for ACEs is also cost-effective.

  To date, over 30 scientific articles have been published and over 100 conference and workshop presentations have been made about ACE study findings and their implications for public health and health and mental health care professionals. (www.acestudy.org; www.cdc.gov/nccdphp/ace/)

- **The Institute of Medicine *Crossing the Quality Chasm* Report.** In 2001, the Institute of Medicine published the report of the Committee on the Quality of Health Care in America, *Crossing the Quality Chasm, A Report on the Quality of Health Care in America*. The report identifies critical problems within the American health care system and begins to lay out a strategic direction for the redesign of systems for the 21st century. A 2002 summit was held on the "translation" of the *Quality Chasm* report for the Mental Health and Addictive Disorders fields. Ongoing work of the Quality Chasm Initiative includes collaborating with the Institute of Medicine; meeting with policy and payer

stakeholder groups such as SAMHSA, NASMHPD, and CMS to explore collaborative initiatives; development of best practice model programs; and field testing results (Institute of Medicine, 2001).

- **President's New Freedom Commission on Mental Health Report (2003).** Like the *Quality Chasm* report, this report calls for a complete transformation in the delivery of mental health care and articulates goals and recommendations that can serve as measurable outcomes for service systems. The Commission report explicitly draws attention to the seriousness of childhood traumatic stress and the need to better address the mental health needs of children. It also stresses the importance of implementing evidence-based practices and emerging best practices such as those developed and under development in the field of trauma. In addition, the report identifies the research and treatment of trauma as an important focus of mental health reform (President's New Freedom Commission on Mental Health, 2003).

- **9/11 and Disaster Planning.** Following an immediate response to 9/11 by providing resources to the state of New York, SAMHSA convened a pre-summit, where nine of the most directly affected jurisdictions shared their experiences and set an agenda for a national summit 3 weeks later. At that national summit, almost 700 individuals representing 42 states, 5 territories, the District of Columbia, 2 Tribal Governments, and over 100 other key stakeholder organizations participated. As a result, states have made progress toward finalizing their own disaster/emergency plans that include both mental health and substance abuse, and SAMHSA, the National Institute of Mental Health (NIMH), and the National Institute on Drug Abuse (NIDA) issued grants to move new knowledge about the effects of trauma to service programs nationwide. Though not directly addressing complex stress disorders such as those found in clients of public mental health services, this and other disaster planning and response initiatives have helped to raise the level of public and professional knowledge regarding the impacts of trauma and appropriate responses.

- **Center on Women, Violence and Trauma (CWVT).** Created and funded by the Center for Mental Health Services (CMHS)/SAMHSA in 2005, CWVT initially focused on work surrounding the Women and Co-occurring Disorders and Violence Study, the related Dare to Vision and Dare to Act conferences, and provided consultation and resources for state initiatives to develop trauma-informed service systems. Largely due to tireless work done by trauma champions and advocates across the country, interest in trauma exploded at the national and state levels, leading to a need for the Center to focus clearly on national policy issues, increase support for states in developing trauma-informed systems, and strengthen commitment to the leadership of people with lived experience of trauma. In 2006 CWVT was relocated to the Washington D.C. area and renamed the National Center for Trauma-Informed Care to reflect a national focus.

- **National Center for Trauma-Informed Care (NCTIC).** Funded by the Center for Mental Health Services (CMHS)/SAMHSA, and in partnership with the National Technical Assistance Center at the National Association of State Mental Health Program Directors (www.nasmhpd.org) , and with Witness Justice (www.witnessjustice.org) , NCTIC provides free and low-cost trauma training and technical assistance to policymakers and administrators, caregivers, institutional workforces, consumers and survivors in the mental health, substance abuse, criminal justice, victim assistance, education, primary care, and other publicly-funded systems. NCTIC also offers an expert speakers bureau, resources, and education and outreach activities around the issue of trauma for these same target audiences. These and other activities stimulate and support change in publicly-funded programs and systems across the country in order to address the trauma experienced by survivors and consumers. http://www.mentalhealth.samhsa.gov/nctic

- **Development of Evidence-Based Practices and Emerging Best Practices with Applicability for Public Mental Health and Substance Abuse Systems.** As a result of all or some of the above factors, there has been a significant increase in the number of trauma-informed and trauma-specific services and models, which are applicable, replicable, and appropriate for use in public sector service settings. Some of the models have been researched and they demonstrated positive client outcomes. The following section of this report contains descriptions of over 80 service models and examples reported to be implemented within state mental health and substance abuse service systems or in use with public sector clients.

Trauma-Informed and Trauma-Specific Models

Definitions of "Trauma-Informed" and "Trauma-Specific"

To address the treatment and support needs of survivors of trauma within the public system requires a systemic approach characterized both by "trauma-specific" diagnostic and treatment services and a "trauma-informed" environment capable of sustaining these services and supporting the positive outcomes to clients who receive these services.

Change to a trauma-informed organizational or service system environment will be experienced by all involved as a profound cultural shift in which consumers and their conditions and behaviors are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently. The new system will be characterized by safety from physical harm and re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and history, cultures, and society; There will be open and genuine collaboration between provider and recipients of services at all phases of the service delivery; an emphasis on skill building and acquisition rather than symptom management; an understanding of symptoms as attempts to cope; a view of trauma as a defining and organizing experience that forms the core of an individual's identity rather than a single discrete event; and by a focus on what has happened to the person rather than what is wrong with the person (Saakvitne, 2000; Harris & Fallot, 2001). Without such a shift in the culture of an organization or service system, even the most "evidence-based" treatment approaches may be compromised.

"Trauma-informed" services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors. A "trauma-informed" system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of adults, children and adolescents and families or caregivers seeking mental health and addictions services (Harris & Fallot, 2001). A "trauma informed" system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in "traumatology" (Harris & Fallot, 2001).

"Trauma-specific" services are designed to treat the actual sequelae of sexual or physical abuse trauma. Examples of trauma-specific services include grounding techniques which help trauma survivors manage dissociative symptoms, desensitization

therapies which help to render painful images more tolerable, and behavioral therapies which teach skills for the modulation of powerful emotions (Harris & Fallot, 2001). Treatment programs designed specifically for survivors of childhood trauma are consistent on several points: the need for respect, information, connection, and hope for clients; the importance of recognizing the adaptive function of "symptoms;" and the need to work in a collaborative empowering way with survivors of abuse (Saakvitne, 2000).

All trauma-specific service models, including those that have been researched and are considered emerging best practice models, should be delivered within the context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections. The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992).

The trauma-informed and trauma-specific models described in this manual are manualized or packaged in a way as to make them accessible to review and implementation by State Mental Health Authorities and agencies serving adults, children and families/caregivers in public mental health and substance abuse service systems. They are listed alphabetically and organized in the following categories.

- **Trauma-Informed Models for Service Systems and Organizations: Adults**
- **Individual Trauma-Informed Service Models for Adults**
- **Trauma-Specific Service Models for Adults**
- **Manualized Adaptations to Trauma-Specific Service Models for Adults**
- **Trauma-Informed Models for Service Systems and Organizations: Children**
- **Trauma-Specific Models for Parenting**
- **Trauma-Specific Service Models for Children and Parents, Family, Caregivers Family/Parents/Caregivers**
- **Trauma-Specific Service Models for Children**
- **Trauma-Specific Peer Support and Self Help Models**

Information on research studies and findings regarding specific service interventions are indicated for each service example or model.

Based on the reports of their creators and experiences reported by state service systems and organizations, many of the trauma-informed and trauma-specific emerging best practice models and services described in this report are applicable and replicable within public mental health and substance abuse service system settings, and in community settings where children and adults who are or who are at risk of being in need of public system resources, may receive services.

Models for Developing Trauma-Informed Service Systems and Organizations: Adults

Creating Trauma Informed Systems of Care: Facilitating Recovery in Mental Health Service Settings

Description: This curriculum training toolkit is for use in state mental health agencies and other public sector service provider agencies. It is designed to improve staffs' knowledge and understanding about the prevalence, experience, and impact of trauma on individuals served in public settings, including state institutions. The contents of each module are organized for use by agency in-house trainers, educators, and managers to assist in disseminating this information to staff members.   While the curriculum contains a pre and post-test to assist in determining knowledge transfer, the most important outcomes will be measured in behavioral change. The experiential component embedded in most modules will seek to ensure that participants successfully transfer learning to their work settings. Agencies will be encouraged to identify outcome measures that can be tracked toward the goal of implementing a system of care that is trauma-informed and recovery-based.

The curriculum is designed for senior managers, middle managers, and direct care staff members in public service settings. Agencies/service providers include: behavioral health, criminal justice, homeless services, developmental disabilities, public health, and peer support. Curriculum modules can be tailored to the needs of the specific audience.

The full day curriculum contains seven modules. These modules are:
- Module 1: Setting the Stage
- Module 2: Trauma: An Introduction
- Module 3: Understanding the Biopsychosocial Impact of Trauma
- Module 4: Trauma Informed Care
- Module 5: Leadership
- Module 6: Trauma Tools I
- Module 7: Trauma Tools II
- Module 8: Experiences of Trauma/Current Assumptions about Seclusion and Restraint
- Module 9: Identifying and Managing Risk Factors
- Appendices include Exercises, Pre and Post Test, and Trauma Template Plan

Each Module Contains:
1. Power Point Slides – with "Instructor Notes" to serve as a training guide, improving understanding of the exercises, usefulness of the slide content, and consistency of the presentations in training.
2. Objectives
3. References
4. Briefly Annotated Bibliography of well chosen resources for further readings

5. Handouts – with Transfer of Learning Exercises for note taking and commitment to change

First person examples are used throughout the curriculum modules to convey the experiences of consumers with histories of trauma who have been recipients of services in state operated facilities and agencies.

A two-hour training is designed for direct care staff who work in hospital settings and need information on trauma informed care, but may have little time to attend all day trainings. The training provides the workers with an understanding of the effects of trauma on the lives of those they serve. This training may be delivered at orientation, staff development trainings, and in continuing education classes.

Status of Research: No research to date

Contact Information:
National Technical Assistance Center/National Center for Trauma Informed Care
703-739-9333 or 301- 634-1785
NCTIC@abtassoc.com
http:// mentalhealth.samhsa.gov/nctic/

Developing Trauma-Informed Organizations: A Tool Kit

Description of Model: Developed by members of the Massachusetts State Leadership Council of the WCDVS Women Embracing Life and Living (WELL) Project of the Institute for Health and Recovery, this Toolkit is geared toward directors of organizations and policymakers. It is designed to help organizations develop plans to improve the quality of care offered to women with co-occurring substance abuse and mental health difficulties and histories of experiencing violence. To date, it has been used as the basis for planning changes within substance abuse treatment provider agencies, mental health provider agencies, domestic violence agencies and correctional programs. It includes: principles for trauma-informed treatment of women with co-occurring mental health and substance abuse disorders; self-assessment for provider organizations; organizational assessment (for non-service providing organizations); and instructions for using the assessments to move toward providing trauma-informed, integrated care.

Status of Research: No research to date.

Contact Information: To obtain the Tool Kit, materials, and training information, contact:
Laurie Markoff
617-661-3991
lauriemarkoff@healthrecovery.org
www.healthrecovery.org

National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Settings

Description: This is a trauma-informed approach to preventing violence and educing seclusion and restraint (S/R) practices in mental health settings, practices often experienced as retraumatizing by service users. In developing this model, the National Association of State Mental Health Program Directors worked with national experts in the field and completed an extensive literature review on seclusion and restraint, culture change, leadership, trauma-informed care, recovery-oriented systems of care, the public health prevention approach, and the principles of continuous quality improvement (CQI). Using this information, substantiated in other literature reviews completed by objective and unrelated colleagues, NASMHPD developed the first comprehensive curriculum to successfully reduce the use of seclusion and restraint in mental health facilities.

The 17-module, two or two and one-half day NASMHPD training curriculum is designed to assist child, youth, adult, and forensic mental health facilities to reduce the use of seclusion and restraint. It is founded on the theoretical principles inherent in the public health prevention approach, leadership theory, trauma-informed care, the neuro/bio/psychological effects of trauma on human beings, consumer and staff experiences and self reports of S/R, and CQI. This training is designed for executive and middle management staff and leads to the creation of an individualized facility prevention plan to reduce S/R use. The plan needs to be designed around the <u>Six Core Strategies for the Reduction of Seclusion and Restraint©.</u> These include: leadership toward organizational change; use of data, workforce development; use of S/R reduction tools; consumer roles in inpatient settings; and debriefing activities. This curriculum is manualized in English only and is also available on compact discs that video-taped a training in 2005.

Status of Research: One evaluation study has been done on the first eight states that sent in data pre- and post-training and it demonstrated significant reductions in hours of restraint, consumers restrained, restraint events, seclusion hours, clients secluded, and seclusion events. S/R hours were reduced by as much as 79%, the proportion of consumers in S/R was reduced by as much as 62%, and the incidents of S/R events in a month were reduced by as much as 68%. An ongoing three year, 36+ site program evaluation is ongoing through 2007.

Contact Information: To obtain information about the Draft Training Curriculum for the Reduction of Seclusion and Restraint or how to participate in current or future trainings and evaluations, contact:
Kevin Huckshorn, R.N., M.S.N., C.A.P.; Director, Office of Technical Assistance, NASMHPD
703-739-9333 extension 140
kevin.huckshorn@nasmhpd.org
www.nasmhpd.org/ntac

Risking Connection®: A Training Curriculum for Working with Survivors of Childhood Abuse

Description: Risking Connection® is a theoretically sophisticated, accessible treatment and response framework guided by a manual. Its helps providers develop optimally helpful responses to trauma survivors through a comprehensive contextual foundation for trauma informed services. As a "relational" model, it emphasizes the therapeutic value of relationships for those hurt in relationships. The knowledge and skills acquired support overlaying of additional trauma-specific interventions and treatment modalities.

Implementing the Risking Connection® model results in increased effectiveness in the healing relationship between the skilled helper and the survivor, reducing the time, trauma, and cost of recovery. The focus of the program on the impact of the work on the helping professional, and from teaching providers to understand and use their own reactions productively, supports decreased levels of stress and burnout for providers.

Risking Connection® for Working with Survivors of Childhood Abuse is used in many states as workforce development for all levels of staff and providers of care to persons who have survived trauma. This includes non-degreed direct care workers as well as workers with advanced degrees, and front line staff. Please note that Risking Connection® is a core model which has contextual adaptations for different audiences (see "Additional Contextual Adaptations.")

Modules in the version for use for those providing clinical services—and time frames— may be used flexibly and selectively. Modules include
  • Understanding Trauma is the First Step;
  • Using Connections to Develop Treatment Goals with Survivor Clients;
  • Keeping a Trauma Framework When Responding to Crises and Life-Threatening Behaviors;
  • Working with Dissociation and Staying Grounded: Self-Awareness as a Tool for Clients and Helpers;
  • Vicarious Traumatization and Integration: Putting It All Together.

This five module, 20 hour curriculum from Sidran Institute is guided by a manual and offers assessment, self-reflection, group discussion, and clinical practice exercises, making it interactive and experiential. The manual also contains client and provider worksheets. Modules used and time frame are flexible.

Risking Connection® has been used successfully in diverse settings and fields including corrections, substance abuse, child residential and developmental disabilities. Because it emphasizes collaboration and a broad overview of the effects of trauma, the model has been very effectively used to develop multidisciplinary responses to trauma treatment and support. Disciplines involved in common trainings include mental health, substance

abuse, domestic violence, child abuse, social services and other fields from which trauma survivors seek help. All learn a common framework and language which enables them to work together more productively and address trauma more holistically.

Risking Connection® was developed by the Sidran Institute. Karen W. Saakvitne, Ph.D. and Laurie Anne Pearlman and their colleagues at the Trauma Research, Education, and Training Institute, Inc. (TREATI) wrote the text with input from an editorial board consisting of other helping professionals and trauma survivors with extensive experience in state mental health systems, clinical treatments of traumatic stress conditions, curriculum design, and the law.

Additional contexted adaptations. In collaboration with the International Conference of War Veteran Ministers, Risking Connection® has been adapted for use by leaders of faith communities who wish to acknowledge the presence of and better relate to trauma survivors in their congregations (see entry for Risking Connection® in Faith Communities). Other contextual adaptations in progress focus on domestic violence settings, military families, and providers of primary health care.

Status of Research: Unpublished one-year post training survey of Risking Connection® users in New York and Massachusetts completed in August 2002 reported high levels of satisfaction with the increase in ability to help trauma survivors in a variety of treatment settings. Over 90% of respondents gave Risking Connection® training credit for "improving my effectiveness as a treatment provider", "empowered me to help clients address symptoms and work toward more effective methods of coping", and "boosting my enthusiasm and levels of hope regarding working with trauma survivors."

Evaluation for Risking Connection® use in a trauma-informed HIV prevention project in partnership with the University of Maryland School of Psychiatry, Center for School Mental Health Services, Maryland State Department of Education, and Maryland State AIDS Administration has been completed. Evaluation was highly positive for Risking Connection's role in contextualizing the childhood trauma antecedents to drug use, unsafe sex, and other risk-taking behavior which may lead to HIV.

Evaluation has been designed and funded in partnership with St. Vincent's Center, a Catholic Charities residential treatment facility for children and adolescents who are suffering from the trauma of child abuse and neglect. Training of residential staff is in progress.

Research has been designed, submitted, and is pending National Institutes of Health (NIH) funding in partnership with Georgetown Center for Trauma and the Community, Georgetown University Medical School, for use of Risking Connection® in an urban primary care setting.

Evaluation has been designed and proposal submitted to SAMHSA by the Klingberg Family Centers, in New Britain, CT for a NCTSN level 3 site using Sidran Institute's Risking Connection® model in three Connecticut child treatment facilities.

Evaluation of multidisciplinary approach: Sidran Institute was selected as one of five sites nationally to develop a 3-year pilot project, Collaborative Response to Crime Victims in Urban Areas, funded by a grant from Department of Justice, Office of Victims of Crime, and the Maryland Crime Victim's Resource Center.

The objective was to build collaboration between faith based providers and traditional victim services providers (which, taking a public health approach, Sidran expanded to include mental health, substance abuse, and social services agencies). This project used Risking Connection®: A Training Curriculum for Working with Survivors of Childhood Abuse with multi-disciplinary groups of secular service providers and Risking Connection® in Faith Communities with clergy, parish nurses and congregational leaders as the core training and operational philosophy.

As the basis for one of five sites federally funded to address integrated support for crime victims in high crime areas, the project using both contexted versions of Risking Connection® was thoroughly evaluated by an independent evaluator from the University of South Carolina. Evaluator's reported: "In-depth evaluations for the Risking Connection® trainings were overwhelmingly positive for multiple sessions."

"Sidran's Risking Connection® trainings were used to help faith-based and secular providers gain understanding of the effects of crime on victims, the role that spirituality can play in their healing, and how providers can make more successful cross-referrals to address victims' needs holistically. An important component of the training is the philosophy that all persons working in the community are providers, and that faith leaders provide a spiritual service that complements the more traditional human services of secular providers. The trainings helped providers from diverse backgrounds establish a common language, shared vision, and mutual trust to further future work together.

> Quote: "It was evident in the trainings that people started with separate languages and then began to rely on their overlapping languages. People made an effort to be inclusive in listening and speaking. They were engaging each other in their differences (Community organizer).

This series of [Risking Connection®] trainings included those specifically for faith-based providers, for secular providers, combined faith-secular trainings, and even trainings co-sponsored by the Baltimore Departments of Health and Social Services for selected social-service staff."

Contact Information: To learn more, or to schedule a training event, contact:
Esther Giller at Sidran Institute
410-825-8888, ext. 207
esther.giller@sidran.org
www.sidran.org

Risking Connection® in Faith Communities: A Training Curriculum for Faith Leaders Supporting Trauma Survivors

Description: Studies show that people who are regularly involved in faith communities generally approach their clergy person first when terrible things happen in their lives. In collaboration with the International Conference of War Veteran Ministers and a multifaith board of clergy, pastoral counselors and survivor/congregants, Sidran Institute developed a contextual version of the Risking Connection® model for use in faith-based settings across the Abrahamic traditions (the Jewish, Islamic, and Christian communities). While the core elements are the same, emphasis is placed on issues related to the spiritual effects of trauma and concerns about world view, identity, and making meaning—without engaging doctrine or dogma in mixed training groups.

This curriculum is offered primarily as a 20 hour, three day program focusing on five modules, however other formats are possible. Understanding trauma, growth promoting relationships, and identifying and managing vicarious traumatization are the foundational modules, with additional modules focusing on the spiritual connection and trauma, and healing communities.

Faith leaders and mental health providers are taught how to collaborate with each other to provide a congruent healing experience for the congregant/client. Specifics about when and how to refer are included, without addressing the specifics of the canonical law of any tradition.

Status of Research: Sidran Institute was selected as one of five sites nationally to develop a 3-year pilot project, Collaborative Response to Crime Victims in Urban Areas, funded by a grant from Department of Justice, Office of Victims of Crime, and the Maryland Crime Victim's Resource Center.

The objective was to build collaboration between faith based providers and traditional victim services providers (which, taking a public health approach, Sidran expanded to include mental health, substance abuse, and social services agencies). This project used Risking Connection®: A Training Curriculum for Working with Survivors of Childhood Abuse with multi-disciplinary groups of secular service providers and Risking Connection® in Faith Communities with clergy, parish nurses and congregational leaders as the core training and operational philosophy.

As the basis for one of five sites federally funded to address integrated support for crime victims in high crime areas, the project using Risking Connection® was thoroughly evaluated by an independent evaluator from the University of South Carolina. Evaluator's reported: "In-depth evaluations for the Risking Connection® trainings were overwhelmingly positive for multiple sessions."

"Sidran's Risking Connection® trainings were used to help faith-based and secular providers gain understanding of the effects of crime on victims, the role that spirituality

can play in their healing, and how providers can make more successful cross-referrals to address victims' needs holistically. An important component of the training is the philosophy that all persons working in the community are providers, and that faith leaders provide a spiritual service that complements the more traditional human services of secular providers. The trainings helped providers from diverse backgrounds establish a common language, shared vision, and mutual trust to further future work together.

> "It was evident in the trainings that people started with separate languages and then began to rely on their overlapping languages. People made an effort to be inclusive in listening and speaking. They were engaging each other in their differences." (Community organizer).

This series of trainings included those specifically for faith-based providers, for secular providers, combined faith-secular trainings, and even trainings co-sponsored by the Baltimore Departments of Health and Social Services for selected social-service staff."

Contact Information: To learn more, or to schedule a training event, contact:
Esther Giller at Sidran Institute
410-825-8888, ext. 207
esther.giller@sidran.org
www.sidran.org

The Sanctuary Model ®

Description: The Sanctuary Model ®, developed by Sandra Bloom, M.D. and her colleagues is a trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community in which staff are empowered as key decision-makers to influence their own lives and the welfare of their constituents. Although the model is based on trauma theory we have found its tenets have application in working with children, adults, and families across a wide diagnostic spectrum.

The Sanctuary Model enables organizations to: work more effectively and therapeutically with fragile and traumatized clients; improve outcomes; reduce restraints; build cross-functional teams, improve staff morale; increase employee retention; reduce violence, increase staff accountability, and create a truly collaborative and healing environment. The Sanctuary Model is not an intervention but a <u>full system approach</u> focused on helping injured clients recover from the damaging effects of interpersonal trauma. Because it is a full system approach, effective implementation of the Sanctuary Model requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process.

The aims of the Sanctuary Model are to guide an organization in the development of a culture with seven dominant characteristics all of which serve goals related to trauma resolution:

- Culture of Nonviolence – helping to build safety skills and a commitment to higher goals
- Culture of Emotional Intelligence – helping to teach affect management skills
- Culture of Inquiry & Social Learning – helping to build cognitive skills
- Culture of Shared Governance – helping to create civic skills of self-control, self-discipline, and administration of healthy authority
- Culture of Open Communication – helping to overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries
- Culture of Social Responsibility – helping to rebuild social connection skills, establish healthy attachment relationships
- Culture of Growth and Change – helping to restore hope, meaning, purpose

In the Sanctuary Model, the impact of creating a trauma-informed culture should be observable and measurable. The outcomes we should expect to see include:

- Less violence including physical, verbal, emotional forms of violence
- Systemic understanding of complex biopsychosocial and developmental impact of trauma and abuse with implications for response
- Less victim-blaming; less punitive and judgmental responses
- Clearer more consistent boundaries, higher expectations, linked rights and responsibilities
- Earlier identification of and confrontation with perpetrator behavior
- Better ability to articulate goals, create strategies for change, justify need for holistic approach
- Understanding of reenactment behavior and resistance to change
- More democratic environment at all levels

The Sanctuary Model® was originally developed by Dr. Sandra Bloom and her colleagues in the mid-1980's in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children, a program that did not close until 2001 (see Bloom, S. L. 1997, Creating Sanctuary: Toward the Evolution of Sane Societies. In the 1990s the Sanctuary Model was extended to the longer-term treatment of adults in a state hospital setting and in a private psychiatric hospital in Canada (see below). In the late 1990's it was adapted for use in three residential settings for children, all in New York State, with an NIMH research project based in one of the centers (MH62896). It was also employed in an acute care setting at Salem Hospital in Salem, Oregon with a dramatic reduction in seclusion and restraint (see below).

Beginning in September of 2005 and in partnership with Andrus Children's Center in Yonkers, NY, Dr. Sandra Bloom has been directing the development of the Sanctuary Leadership Development Institute, an intensive three-year program aimed at trauma-informed organizational change. After an application process that includes full leadership participation and a thorough on-site evaluation, an organization develops a Core Team that represents participation from every level of the organization.

The responsibility of the Core Team is to actively represent and communicate with their constituency and to become trainers for the entire organization. This process begins when a small group of organizational leaders attend a five-day intensive training program with other organizations struggling with similar issues. In this intensive team process, this group engages in prolonged dialogue that serves to surface the major strengths, vulnerabilities, and conflicts within the organization. By looking at shared assumptions, goals, and existing practice, staff members from various levels of the organization are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never been overtly surfaced before. During the training, these leaders develop some skills in the use of the Sanctuary Toolkit and begin developing their own individualized implementation plan based on the Sanctuary Implementation Guide and the Sanctuary Staff Training Manual.

The initial training institute is followed by three years of on-going consultation and technical assistance provided remotely and on-site by the Sanctuary Leadership Development Institute Faculty. Participation in the Sanctuary Leadership Development Institute qualifies an organization to join the Sanctuary Network and participate in an on-going certification program. Sanctuary is a registered trademark and the right to use the Sanctuary name is contingent on engagement in this training program and an agreement to participate in an on-going, peer-review certification process.

As of May of 2007, twenty programs from around the country are a part of the Sanctuary Network and include residential programs for children; juvenile justice facilities; acute care adult inpatient; community-based programs for children and families; substance abuse programs for women, children, and adolescents and acute care psychiatric programs for children. Two states have provided funding for participating programs through the Oklahoma Office of Mental Health and the New York State Office of Children and Family Services.

Materials: The Sanctuary Implementation Guide and Sanctuary Staff Training Manuals and materials are available only through participation in the Sanctuary Leadership Development Institute. The group curriculum written by Bloom, Foderaro, and Ryan titled, S.E.L.F: A Trauma-Informed Psychoeducational Group Curriculum is available for purchase at www.sanctuaryweb.com. Many other articles about the Sanctuary Model are available at this site as well.

Since the Sanctuary Model is an organizational approach, there really are no limits in terms of ages, genders, or specific client groups. Programs from Ecuador and Mexico are participating in the Sanctuary Network so we have some minimal non-English-speaking adaptability.

Status of Research:

Homewood Hospital, Guelph, Canada.
The Program for Traumatic Stress Recovery (PTSR) is a 28-bed, 6-week inpatient treatment program for adult survivors of childhood abuse with posttraumatic stress

disorder that merges the concepts of the Sanctuary Model with that of the therapeutic community. In a study designed to examine this comprehensive inpatient treatment program, 132 formerly abused individuals completed clinician-administered and self-administered measures of PTSD symptomatology at admission and discharge. All participants experienced a range of physical, sexual, and/or emotional abuse as children prior to the age of 17. Approximately 1/3 of these individuals also completed measures at 3-months post-discharge and 1-year post-discharge. Data were collected using a clinician-administered PTSD measure and self-administered PTSD measure at admission and discharge. On admission, all participants met criteria for a diagnosis of PTSD.

Analyses revealed that the program was effective in reducing symptoms from admission to discharge. Additionally, treatment gains were maintained at 1-year post-discharge. The findings of this investigation suggest that the current intensive inpatient group treatment program appears to reduce PTSD symptoms effectively for a sample of adult survivors of abuse (Wright et al., 2003).

Salem Hospital, Salem, Oregon.
This hospital is a 400-bed community general hospital serving a catchment area of approximately 350,000 people. The adult inpatient psychiatry unit is in a freestanding building on the edge of the hospital campus. The program has been open for 13 years. Capacity is 22 patients (16 general adults and 6 geriatric adults), and the unit is usually full. Salem Hospital is one of several regional acute care units that replaced the state hospital system in Oregon nearly a decade ago. The unit accepts all patients in need of psychiatric care, with approximately 70% being involuntary. The average length of stay is nine days. More than 95% of patients are discharged into the community, though a small number are transferred for longer-term state hospitalization or to step-down units.

In consultation with Dr. Sandra Bloom, founder of the Sanctuary Model®, Salem Hospital Psychiatry initiated a new environment of adult inpatient hospitalization using the basic tenets of Sanctuary in early 2001 with the goal of reducing coercion. Seclusion and restraint rates were used as measures of progress. Use of mechanical restraint had been virtually eliminated by October of 2002. Use of locked seclusion decreased from 150 episodes in 1999 to one episode for 11 months. Time in locked seclusion decreased from an average of 10 hours per episode in 1999 to 10 minutes during the last episode. There was no increase in the use of psychotropic medications; in fact, there was an overall decrease in the use of emergent and "forced" medication injections.

There was no change in patient selection. Emergency departments, police, jails, and crisis centers all referred patients regularly. Many patients had co-occurring substance abuse disorders along with symptoms of a major mental illness. Throughout this period, patient satisfaction scores improved. There were significantly decreased staff and patient injuries, decreased time off due to work-related injuries, increased staff retention, and very little staff turnover once the model was fully implemented. There was an overall slight decrease in staff numbers due to more efficient use of time. Physician recruitment and retention was extremely successful due to the model.

West Chester Campus, Jewish Board of Family and Children's Services, Hawthorne, NY
Evaluation Methods: Dr. Jeanne Rivard was the primary investigator of the NIMH grant that funded this study. The project took place in a suburban community outside New

York City where the Sanctuary Model is being implemented in three residential treatment programs on one large campus. The model was piloted in four residential units that self-selected to participate in the initial phase of the project. The staff training protocol and manual was developed and piloted between February and August 2001, then four additional residential treatment units were randomly assigned to implement the Sanctuary Model the following fall. Eight other units that provided the standard residential treatment program served as the control group. Changes in the therapeutic communities and in youth were assessed every three to six months through April 2003. Results of the Sanctuary Model units were compared to results of units with standard residential services. Although the Sanctuary Model was in a very early stage of implementation, the evaluation was guided by hypotheses that projected what specific outcomes were expected to occur in the therapeutic communities and in youths.

Therapeutic Community Outcomes: The short form of the Community Oriented Programs Environment Scale (COPES; Moos, 1996) was used to assess the extent to which units were operating as therapeutic communities along selected dimensions. Trends in the frequency of critical incidents were then measured by analyzing data from the agency's management information system. We found no significant differences between the Sanctuary Model units and the standard residential treatment units during the first two waves of measurement. By the final wave of measurement, however, we found significant differences between the groups via independent t-tests, with the Sanctuary Model units improving on the following constructs of the COPES: support ($p < .05$), spontaneity ($p < .01$), autonomy ($p < .05$), personal problem orientation ($p < .05$), safety ($p < .05$), and in the total score ($p = .001$). We are still analyzing data measuring trends over time in the frequency of critical incidents that occurred in the residential treatment units.

Youth Outcomes: The following instruments were used to assess youth outcomes that were hypothesized to be responsive to the Sanctuary Model: Child Behavior Checklist (Achenbach, 1991), the Trauma Symptom Checklist for Children (Briere, 1996), the Rosenberg Self Esteem Scale (Rosenberg, 1979), the Nowicki-Strickland Locus of Control Scale (Nowicki & Strickland, 1973), the peer form of the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987), the Youth Coping Index (McCubbin, Thompson, & McCubbin, 1996) and the Social Problem Solving Questionnaire (Sewell, Paikoff, & McKay, 1996). Although baseline data were collected for 165 youth, substantial attrition occurred due to youth being discharged through usual program operations. By study end, 87 youth yielded three waves of data (i.e., baseline, three months, and six months). No significant differences were found comparing baseline and three-month measures. On repeated analyses ($N = 87$) comparing baseline and six-month outcomes, however, we found a few differences by time and group, favoring youth in the Sanctuary Model units. These were on the incendiary communication/ tension management construct of the Youth Coping Index ($p < .05$), locus of control ($p = .15$), and the verbal aggression construct of the Social Problem Solving Questionnaire ($p = .15$).

Results were modest and consistent with a newly implemented intervention, especially considering that rates of implementation varied across units. The few positive youth findings offer promise that full implementation may yield greater youth benefits. The finding that the treatment environments of the Sanctuary units were functioning at

significantly higher levels than the standard residential units by the final wave of data collection suggests that implementation was becoming stronger with time. In studying children's service systems, Glisson & Hemmelgarn (1998) found that organizational climates with greater job satisfaction, fairness, cooperation, personalization, and lower levels of conflict were associated with both service quality and positive outcomes in children's psychosocial functioning. These findings validate the current project's intensive program development efforts aimed at strengthening the treatment environment for the benefit of staff and youths. More analyses of the data will follow. Some of the most important lessons learned from this project focus on the need to support implementation efforts with more intensive onsite technical assistance, promote ongoing evaluation to assess change in the treatment environments and youth over time, and incorporate the use of brief behavior checklists that can be used as part of the regular program operations, and that may be more sensitive to change than measures of three-month self-reports of youth.

SLDI Evaluation Research

To participate in the Sanctuary Leadership Development Institute, every organization must be willing to perform repeated evaluations over the three-year period and beyond. The data being collected is part of a three-year study developed to assess the impact of the Sanctuary Model on the organizational cultures of participating agencies/facilities. The data component of the Sanctuary process is comprised of four assessment tools, three of which were developed by the Division of Policy, Planning and Research at Andrus Children's Center. They are an environmental assessment, an implementation survey, and a demographic assessment. The fourth assessment, the Community Oriented Programs Environment Scale, is used to assess the organization's ability to function as a therapeutic community.

The study takes place in three phases over three years. Assessments are conducted either once or twice a year, with analysis reports provided to participating agencies once the assessments are completed. Organizations are asked to collect data related to their environments, incidents and the types of clients they serve because the researchers believe that the Sanctuary Model has a significant impact on organizational culture which creates a better environment for staff and clients and promotes positive client treatment outcomes. Measuring the changes in environment and measuring incidents is one of the first steps in moving toward an evidence base for the model. This study is currently using these measures to determine the success that organizations have in implementing the model as well as the impact that using the model has on the environment.

What has emerged from experience with various therapeutic and social service settings is a plan, process, and method for creating trauma-sensitive, democratic, nonviolent cultures that are far better equipped to engage in the innovative treatment planning and implementation that is necessary to adequately respond to the extremely complex and deeply embedded injuries that children, adults, and families have sustained.

Contact Information: To obtain further information on the manual, the institute, and training and consultation services, contact:

Sandra L. Bloom, M.D; CommunityWorks
215-248-5357,
S13132020@msn.com
www.sanctuaryweb.com .

For information on the Sanctuary Leadership Development Institute, contact:
Sarah Yanosy, LCSW; Andrus Children's Center
 914-965-3700 ext. 1117
syanosy@jdam.org
 www.andruschildren.org

Using Trauma Theory to Design Service Systems

Description: Used by state service systems and provider organizations, this small (103 pp.) book edited by Maxine Harris, Ph.D., and Roger Fallot, Ph.D. (2001) presents a step-by-step model for state mental health, substance abuse, and other public human service systems, provider agencies, and individual services and programs to become "trauma-informed." The model provides guidelines for evaluating and modifying all system and service components in light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services, most of whom have been traumatically impacted by unaddressed histories of sexual and physical abuse.

Using Trauma Theory to Design Service Systems identifies essential elements necessary for a system to integrate a basic understanding about trauma into its core service programs so that the vulnerabilities of consumers with histories of sexual and/or physical abuse are accommodated, retraumatization is avoided, and participation in treatment is facilitated. It identifies fundamental characteristics of a trauma-informed system, guidelines for transforming an existing system of services, and necessary supports for bringing about system change. The book also examines and makes recommendations for modifying core service components (assessment and screening, inpatient treatment, residential services, addictions programming and case management) and addresses changing roles of consumers and providers in a trauma-informed system.

The authors and their colleagues have developed materials to accompany the book: 1) a "Trauma-Informed Services Self-assessment and Planning Protocol;" 2) a "Trauma-informed Self-assessment Checklist;" and 3) a "Trauma-informed Services Implementation Form." The *protocol* provides a structured model for programs to review and set priorities for change in three services-level domains (informal and formal service procedures; formal service policies; and trauma screening, assessment, and service planning) and in three administrative-level domains (administrative support for trauma-informed change; trauma training and education; and human resources practices). The *checklist* is used by programs as part of their initial review and then as a tool for monitoring their progress toward more trauma-informed service settings. The implementation form guides the specific changes each program establishes as its priorities. Throughout the review and planning process, the guiding principles of a

trauma-informed service system—safety, trustworthiness, choice, collaboration, and empowerment—are highlighted.

Status of Research: Several states have participated in this approach to trauma-informed systems change, with most efforts to date focusing on smaller regions or pilot projects within a larger state system. Two formal qualitative evaluations have been conducted. One pilot project, in a mental health agency, evaluated responses from administrators, clinicians, and consumers to the services modifications. Qualitative responses from all three groups were positive. Administrators emphasized the value of: their increased collaboration with both clinicians and consumers; recovery skills-oriented services; an emphasis on physical and emotional safety; and enhanced trauma assessment. Clinicians noted the increased openness of their work with consumers; the value of focusing services on recovery skills, and the emphasis on vicarious traumatization and clinician self-care. Consumers reported having a more significant "voice" in services, especially via a Consumer Advisory Team established for the agency. In addition, they described an enhanced sense of safety and collaboration with agency staff. Quantitative evaluation of this program focused on new consumers who entered services after the trauma-informed systems change was in process. Clinician ratings at baseline and three or six months indicated increases in overall functioning and recovery skills along with decreases in mental health symptoms, physical health concerns, consumer risk behaviors, and use of hospitalizations and crisis services. Consumer satisfaction ratings were very high, with 84% of the consumers giving their "overall experience" with the agency the scale's highest rating.

The second evaluation described the implementation process in one region of a state system and the responses from administrators, service providers, and consumers. This evaluation also reported largely positive responses from all stakeholder groups. Increased awareness of trauma, enhanced consumer choice, and greater safety and hospitality in the physical environment were especially noteworthy findings.

Contact Information: To obtain the book, contact
Kate Boucek, M.S.W
202-608-4784
kboucek@ccdc1.org
Or order it through: at www.ccdc1.org.

To obtain the assessment and planning protocol and training or consulting information, visit www.ccdc1.org or call
Rebecca Wolfson Berley, M.S.W., Director of Trauma Training
202-608-4735
rwolfson@ccdc1.org

Women and Addiction: A Gender-Responsive Approach

Description: Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, *Women and Addiction: A Gender-Responsive Approach* (2007) is a manual and DVD that provides an overview of the essentials for creating trauma-informed, woman-centered services. It includes a theoretical foundation and guiding principles, the current research on gender differences, a discussion of what counselors need to know and do in order to be effective, and a description of important program elements. The complete package is part of Hazelden's Clinical Innovators Series and includes a self-test for continuing education units (CEU's).

This comprehensive, integrated approach is based on theory, research, and years of clinical experience. It integrates theories of addiction, women's psychological development, and trauma. It offers program directors, counselors, clinicians, and other helping professionals a basic understanding of current knowledge, treatment philosophies, and principles that can serve as a framework for creating services for women and increasing women's opportunities for sobriety and ongoing recovery. The principles are applicable in a variety of settings and are suitable for individual and group therapy.

In the past, substance abuse treatment was developed as a single-focused intervention. Counselors would focus only on the addiction and assumed that other issues would either resolve themselves through recovery or would be dealt with by another helping professional at a later time. However, the interrelationship between substance abuse, trauma, and mental health in women's lives requires a multi-focused approach. One of the most important developments in health care over the past several decades is the recognition that a history of serious traumatic experiences plays an often unrecognized role in a woman's physical and mental health problems. In this manual, "woman centered" and "gender- responsive" refer to the creation of an environment – through site selection, staff selection, program development, program content and materials – that reflects an understanding of the realities of women's and girls' lives and that addresses and responds to their challenges and strengths.
Included in the manual are the following topics:

- current research on the differences between women and men
- relational-cultural theory
- trauma theory
- elements of woman-centered treatment
- using trauma theory in women's treatment
- importance of the therapeutic environment

Status of Research: No research to date

Contact Information: To obtain the *Women and Addiction: A Gender-Responsive Approach* materials (manual, DVD, CEU test), and for additional information on training, consultation, and research:
Stephanie S. Covington, Ph.D., L.C.S.W.
858-454-8528
sscird@aol.com
www.stephaniecovington.com
www.centerforgenderandjustice.org

Individual Trauma-Informed Service Models for Adults

Domestic Violence Group Intervention

Description: This ten-session manualized group intervention helps women who have experienced domestic violence to break the cycle of abuse. Intervention is written as a leader's manual, with a rationale, goals, questions to prompt discussion, and experiential exercises for each topic. Topics include: the relational context of domestic violence; the cycle of violence; power and control; multi-generational violence; the impact of domestic violence on children; anger; assertiveness; communication skills; and stopping the cycle.

Status of Research: No research to date.

Contact Information: To obtain a leader's manual (Domestic Violence: A 10 Session Group Treatment Intervention) and more information contact:
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

Economic Success in Recovery

Description: An educational group curriculum for women in recovery developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission and Institute on Urban Health Research at Northeastern University. Exito Con Mi Dinero y Mi Recuperacion: Un curriculo educativo y grupal para mujeres en recuperacion. (Spanish). The curriculum (Spanish and English) is for women with histories of trauma, mental illness, and substance abuse. This group model focuses on the options in planning for the future and financial success. Within a trauma-informed context, the women explore their strengths, skills, job and educational opportunities, decision-making, and understanding of their past and present experiences with money.

Status of Research: The Economic Success in Recovery was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a non-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the 'package' of services and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment 'package.' Three documents are in press for publication indicating that women in the intervention stay in treatment longer and at followup have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2006a). Effects of Trauma Intervention on HIV Sexual Risk Behaviors Among Women with Co-occurring Disorders in Substance Abuse Treatment. *Journal of Community Psychology,* in press.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., Gatz, M. (2006b). Does Integrated Trauma-Informed Substance Abuse Treatment Increase Treatment Retention? *Journal of Community Psychology*, in press.

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma-informed substance abuse treatment on addiction severity, mental health and PTSD symptomatology compared to services as usual. *Journal of Urban Health,* posted on-line March 14, 2007; *hardcopy in press*

Contact Information: To obtain curriculum and additional information, contact:
Dr. Hortensia Amaro
h.amaro@neu.edu
or
Rita Nieves, R.N., M.P.H.
Rita_Nieves@bphc.org

Trauma Informed Addictions Group Intervention

Description: This is a 20-session (75 minutes per), psycho-educational group intervention designed to address substance abuse issues within a trauma-informed perspective with survivors in the active treatment phase of recovery from substance addiction. Intervention used with all male, all female, or co-ed group membership. The group is aimed at helping survivors understand the connections between family history and addiction, substance use, and violence; the role of behavioral and emotional triggers in patterns of substance use; the emotional, interpersonal, and behavioral consequences of abuse; and re-victimization patterns. The final several topics are focused on empowerment, rebuilding relationships, achieving balance, and envisioning a dream for the future. The leader's manual, *Trauma-Informed Addictions Treatment: A 20-Session Psycho-Educational Group Intervention Designed to Address Substance Abuse Issues*

Within a Trauma-Informed Perspective, is written with a rationale, goals, questions and exercises to facilitate discussion and exploration for each session topic.

Status of Research: No research to date.

Contact Information: To obtain the leader's manual, materials, and more information contact:
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

Trauma Issues Associated with HIV Infection: A Group Intervention

Description: This is an 11-session group intervention designed for women trauma survivors who have also been diagnosed with HIV infection. Intervention is written as a leader's manual, with a rationale, goals, questions to prompt discussion, and experiential exercises for each topic. The group helps HIV positive individuals view the infection itself as an additional trauma. Issues to be discussed include disclosure and stigma; hopelessness and fear; dealing with the system; creating collaborative relationships; sexuality and future relationships; and acceptance and spirituality. Members have a chance to explore how their trauma histories might be affecting their management of the HIV infection and to design healthy approaches for dealing with the illness.

Status of Research: No research to date.

Contact Information: To obtain the manual, Trauma Issues Associated with HIV Infection: An 11-Session Group Treatment Intervention, and more information contact:
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

Trauma-Specific Service Models for Adults:

Addictions and Trauma Recovery Integration Model (ATRIUM)

Description: Developed by Dusty Miller, Ed.D., and Laurie Guidry, Psy.D., ATRIUM is a manualized, sequentially organized, 12-week curriculum designed for people who are survivors of sexual and physical abuse, those with substance abuse and other addictive behaviors, those who are actively engaged in harmful relationships, who self-injure, have serious psychiatric diagnoses, and for those who enact violence and abuse against others.

ATRIUM is designed to work as a peer-led (as well as professionally led) group model and can be used for individuals working with therapists or counselors, or in group or peer support settings. ATRIUM is implemented within substance abuse and mental health treatment settings as well as in peer group environments. The model has primarily been used with single-sex groups.

Informed by Miller's personal knowledge of the mental health system and addiction recovery, and based on the premise that trauma impacts survivors on the physical, mental, and spiritual levels, ATRIUM is designed to intervene at all three levels. Integrating cognitive-behavioral and relational treatment, ATRIUM blends psycho-educational, process, and expressive activities. The curriculum provides information on the body's response to addiction and traumatic stress as well as the impact of trauma and addiction on the mind and spirit. Information is also included on anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. New ways are also presented for thinking about self-care, self-soothing (relaxation response, mindfulness training), and self-expression.

The ATRIUM manual, Addictions and Trauma Recovery: Healing the Body, Mind and Spirit, may be used in conjunction with 12-step or other addiction treatment programs, as a supplement to trauma-focused psychotherapy, or as an independent model for healing. Each treatment component includes explanations and interventions to be used collaboratively by professionals and consumers in groups or individual treatment. Handouts allow consumers to work on coping skills between sessions.

Status of Research: ATRIUM was selected as one site of the 9-site SAMHSA Women, Violence and Co-occurring Disorders study. Results of that cross-site study show positive effects for trauma treatment and indicate that participation in integrated counseling that addresses treatment issues related to trauma, mental health, and substance seems to be the key ingredient in achieving better outcomes.

Contact Information: To obtain the manual, and for information on training and technical assistance (in English and Spanish), contact:
Dusty Miller
413-584-8404
413 203 1432 (h&w)
(413) 313 6317 (c)
dustymi@aol.com
www.dustymiller.org

The Associative Skills Model: Taking Charge of Change; The Trouble with Feelings; and Boundaries, Precious Boundaries

Description: This three-module model, which can be taught on a flexible time and content-specific basis, teaches a basic trauma informed cognitive framework with accompanying skills. The premise is that the developmental disruptions of childhood

trauma often prevent the development of a coherent frame of reference for three major areas impacted by trauma: the ability to cope with change in constructive ways; to identify, respond to and modulate affect, and the ability to identify, explore, set and change basic boundaries. Each module can be presented in a four-hour or one day format. An overview of all three, without skill development, is available as a one day program.

Audiences for this model range from direct services workers to highly degreed professionals as well as survivors of trauma. Greatest effect is achieved when providers as well as survivors both employ the elements of the model.

Delivery is a combination of lecture, experiential activity, and as appropriate role play. Adult learning principles and practices are integral in the delivery of this model, which is guided by module-specific manuals. Contexted versions for specific settings are available as customizations. Adaptations have been presented in the corporate environment, in faith communities, to persons with life changing diseases and in the community of persons with disabilities, and a video/DVD lecture only version has been available.

Taking Charge of Change addresses the issue of coping with and making change as fundamental to recovery from traumatic experiences. It teaches a set of constructs that, like algorithms, create a common framework for developing self-regulation that leads to increased self-determination and more effective coping skills. This module is a prerequisite to the modules on affect and boundaries.

Objectives for this module are:
- Identifying the feelings of change
- Differentiating between reactions and responses to the feelings of change
- Recognizing why people often focus on failure over success when faced with change
- Using the awareness of the benefits of failure and success to redirect the self
- Converting self-discipline, often abusive, to "discipling" the self in the service of change

The Trouble with Feelings builds on the change module in response to the role of feelings in change. Often survivors of childhood trauma have exceptionally limited vocabularies for affect, and without a construct for how feelings develop, names for different feelings, and even placement of feelings along a continuum, management and modulation of affect is even more difficult.

This module in the Associative Skills series supports increased effectiveness of the therapeutic work required around affect regulation through addressing these objectives:
- How children develop their knowledge and experience of affect (at a general level)
- Describing situations in which affect becomes problematic and why
- Defining the concept of a continuum and its role in affects

- Recognizing the three basic feelings of pleasure, fear, and anger
- Identifying and placing gradations of these three feelings on a continuum
- Determining healthy expressions of each
- Practicing modulation skills

Boundaries, Precious Boundaries is the final module in the Associative Skills Series, and like the module on feelings, seeks to remediate knowledge and experience often simply missing for those who experience childhood trauma. By focusing on how boundaries are developed, types of boundaries people have, how those boundaries are identified and expressed, how to change boundaries (and what to expect when this occurs), trauma survivors and skilled helpers have a common knowledge set from which to operate.

This series was developed by professional educator and trauma survivor Elizabeth Power, M.Ed., whose work in self-determination and recovery includes materials for persons with dissociative disorders, adapting to disabilities, and coping with change. Her work along the spectrum of association and dissociation has been used in multiple contexts from the corporate to the clinical since the 1990s.

Status of research:: None conducted. Program reviews, and user comments, are highly positive.

Contact Information: To learn more or schedule this training event, contact
Esther Giller , Sidran Institute
410-825-8888 extension 207
esther.giller@sidran.org.

Beyond Trauma: A Healing Journey for Women

Description: Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, Beyond Trauma: A Healing Journey for Women (Covington, 2003) is a manualized curriculum for women's treatment based on theory, research, and clinical practice. While the materials are trauma-specific, the connection between trauma and substance abuse is recognized and integrated throughout the curriculum. The program is designed for use in outpatient, residential, and criminal justice settings. Beyond Trauma has a psycho-educational component that teaches women what trauma is, its process, and its impact on both the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). The major emphasis is on coping skills with specific exercises for developing emotional wellness. The curriculum includes a facilitator manual, participant workbook, and three instructional videos or DVD's (two for facilitators, one for clients).

The facilitator's manual has two parts. The first part gives group leaders background information about trauma. Having a basic understanding of the depth and complexity of the issues helps the facilitator work more effectively with the group. The second part of

the manual includes session outlines that are like lesson plans. There are 11 sessions total in the 3 modules: a) Violence, Abuse, & Trauma; b) Impact of Trauma; and c) Healing from Trauma.

The women in the group will go through a process of understanding what has happened to them by learning what abuse is and how wide spread it is in women's lives; exploring how abuse and trauma have impacted them; focusing on safety and learning coping mechanisms, including exercises to help them feel grounded and safe; and learning strategies for symptom reduction.

Beyond Trauma promotes a strength-based approach that seeks to empower women and increase their sense of self. The exercises are designed to give them a corrective experience of connecting with others in a safe environment. In using this model, the facilitator helps the women in the group to see the strengths they have and to increase the skills they need. The curriculum also focuses on emotional development. Dealing with the expression and containment of feelings (fear, loss, grief, anger, shame) is a critical part of trauma work. The program uses cognitive-behavioral techniques (CBT), expressive arts, and is based on the principles of relational therapy. Beyond Trauma can also be used with Helping Women Recover: A Program for Treating Addiction (see description) to extend and deepen the trauma work introduced in *Helping Women Recover.*

Status of Research: Beyond Trauma is in the process of being evaluated at several sites. There is also a completed study funded by the California Endowment. The site for this study was a residential substance-abuse program for women and children. Pre- and post-tests were used with 50 women to evaluate the following domains: relapse, mental health symptoms related to trauma (anxiety, depression, PTSD), and family functioning (parenting skills and reunification). Results show a decrease in depression, as well as a decrease in other trauma-related symptoms.

Trauma-informed Services for Women in Treatment   (completed) (5/1/04- 10/30/06)
Funded by the California Endowment. Contact for data:
Sandy Keaton at SANDAG
ske@sandag.org
and
Cynthia Burke at SANDAG
cbu@sandag.org

Gender-Responsive Treatment for Women in Prison   (ongoing)
Two year experimental pilot study funded by NIH IR21DA 18699-01A1 (August 20, 2005-June 30, 2007). A random assignment of women in a prison TC to treatment as usual or enhanced gender-responsive treatment. Treatment being enhanced by *Beyond Trauma* as well as *Helping Women Recover* and other materials developed by Dr. Covington.
Contact person: Nena Messina, Ph.D. at UCLA at nmessina@ucla.edu

Enhancing Substance Abuse Treatment and HIV Prevention for Women Offenders (ongoing) Funded by NIDA 1R01DA22149-01. (September 1, 2006 – August 31, 2009). This 3-year study is examining Mental Health Systems, Inc. (MHS) Readiness and Capacity for Practice Improvement as it incorporates women-focused treatment into four MHS program sites currently serving female drug court participants. An experimental component will determine the effectiveness of a women-focused (WF) treatment program based on HWR, BT and other Covington materials compared to standard mixed-gender (MG) outpatient treatment to promote positive behaviors among 150 women offenders (e.g., HIV risk reduction and substance abuse, and increased psychological functioning). Contact person: Nena Messina, Ph.D. at UCLA at nmessina@ucla.edu

Contact Information: To obtain the Beyond Trauma program curriculum (facilitator's manual, participant's workbook, instructional videos or DVD's) and for additional information on training, consultation, and research, contact
Stephanie S. Covington, Ph.D., L.C.S.W.,
858-454-8528
sscird@aol.com
www.stephaniecovington.com
www.centerforgenderandjustice.org .

Cognitive-Behavioral Treatment for PTSD Among People with Severe Mental Illness

Description: Developed by B. Christopher Frueh, Ph.D. and colleagues, this is a manualized, multi-component cognitive-behavioral treatment model appropriate for chronic and severe PTSD among people with serious mental illness who are treated in public-sector mental health clinics. All components are designed for administration in a group format with the exception of Exposure Therapy, which takes place in 8 individual therapy sessions. Group work takes place in 14 (90-minute) sessions. This treatment model should serve as an intervention guide to be administered with flexibility. The exact sequencing, implementation, and dose of components may vary across settings and among clients, but clinicians and investigators may use this model as a starting point for developing, delivering, and evaluating treatment with this population.

The model includes a comprehensive treatment designed specifically to target various aspects of the clinical syndrome associated with PTSD in persons with SMI, particularly emotional and physiological reactivity to traumatic cues, intrusive symptoms and avoidance behavior, impaired interpersonal skills and emotion modulation (e.g., anger control), and reduced range of enjoyable social activities. It incorporates the PTSD psychosocial treatment approach with the most empirical support (exposure therapy) with a social skills and anxiety management training component that has been shown to work for other clinical populations.

The model consists of three phases: education/motivation/anxiety management skills; exposure; and coping/social skills. The major components of the model are: Education;

Anxiety Management Skills Training; Social Skills Training; Social Environment Awareness; Social Skills Enhancement; Anger Management; Trauma Issues Management; Exposure Therapy; "Homework" Assignments; Long-term Follow-up Care.

For further information refer to <u>Cognitive-Behavioral Treatment for PTSD among People with Severe Mental Illness: A Proposed Treatment Model</u> (Frueh et al., 2004).

Status of Research: The project was funded by an three-year NIMH treatment development grant. Data show that staff at community mental health centers are reluctant to engage in trauma-focused therapy themselves, but agree that people with SMI have high rates of trauma, need PTSD treatments, and that cognitive-behavioral interventions are likely to be efficacious if delivered with sensitivity and skill (Frueh et al., 2006). Data analyses on an open trial using this treatment model for adults with schizophrenia and comorbid PTSD are currently underway. Preliminary analyses suggest the treatment program is acceptable to consumers with SMI and offers strong promise of therapeutic benefit, with no evidence of adverse effects.

Contact Information: For information about the model and obtaining a draft manual and materials, contact:
B. Christopher Frueh, Ph.D
frueh@hawaii.edu

Eye Movement Desensitization and Reprocessing (EMDR)

Description: EMDR is a scientifically validated integrative psychotherapy for the treatment of PTSD and other trauma-related conditions. Developed by Francine Shapiro in 1989 (www.emdr.com), it is a phase-oriented approach using a protocol with a standardized set of procedural steps, grounded in a theoretical foundation known as the Adaptive Information Processing model (AIP). The model assumes that unprocessed experiences are the basis of much psychopathology and there is a natural ability of the brain, under appropriate conditions, to resolve disturbing emotional material that fuels current symptoms. Standardized procedures which include bilateral stimulation (eye movements, taps or tones) facilitate entry into an accelerated learning state in which traumatic experiences can be processed effectively.

EMDR can also be used as a means of accessing and accentuating positive affective states. The ultimate goal of EMDR treatment is to achieve the most profound and comprehensive treatment effects in the shortest period of time, while maintaining client stability within a balanced family and social system. EMDR is grounded in psychological, neurobiological and clinical research and practice. EMDR training is readily available but only provided to mental health professionals who are licensed, certified or registered for independent practice, or others who have received specific approval in order to work in underserved communities (see <u>www.emdria.org</u> for requirements).

The eight phases and specific protocols used to address the client's presenting complaints are described in detail in the book Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures (Shapiro 2001) and training is available in many US locations throughout the year. The model includes a careful clinical history to identify client strengths and vulnerabilities and to identify the experiences to begin to process. The client is educated about the symptom picture and given tools for stabilization and preparation for the work. Processing the trauma includes a focus on the attendant negative beliefs, emotion and physical sensations and closely monitors the client's subjective level of discomfort throughout the procedures. In contrast to exposure therapies, the client is allowed to move at his/her own pace through the associative chain to work though the traumatic experiences. The closing parts of the session focus on returning the client to equilibrium, and verifying plans in the event of distress in between sessions. The EMDR protocols include the targeting of past events that contribute to the pathology, triggers that elicit disturbance (including triggers to substance use), and positive templates for self-image and behavior.

With respect to substance abuse, there is a specific EMDR protocol targeting urges and a comprehensive EMDR protocol that also includes procedures for increased stabilization and processing the underlying trauma that plays a key role in drug use. Some case reports have indicated that processing the underlying trauma with EMDR also results in increased stabilization. An innovative pilot study in the Thurston County Drug Court Program in Olympia, Washington utilized Seeking Safety as a structured preparation phase for safety and stabilization prior to individual treatment with EMDR. Outcomes showed significant improvement on all four post-treatment assessments for those who completed the ITTP, including reduction and/or elimination of trauma symptoms, decreased dissociation, decreased depression and increased self-esteem. One of the most important findings for future investigation was that participants who completed the entire ITTP graduated 75% of the time, while those that declined to volunteer for individual EMDR treatment (which was voluntary), though completing *Seeking Safety*, had significantly lower Drug Court Program completion and graduation rates (25%). Program completion and graduation is the variable most consistently associated with low post-program recidivism (Drug Courts: The Second Decade; 2006). The ITTP is intended to be a replicable, structured, phased trauma treatment intervention for trauma and substance abuse.

Status of Research: EMDR is listed as an empirically validated and effective treatment in numerous practice guidelines *including* those of the American Psychiatric Association (2004), and the Department of Veterans Affairs/Department of Defense (2003). There are at least 18 randomized clinical trials that have been conducted on EMDR with a wide range of trauma populations and comparison conditions. EMDR has been demonstrated to be superior to a wide range of therapies, and equivalently effective to trauma focused CBT, without the need for sustained arousal, detailed description of the event, prolonged focus on the trauma, or the 40-100 hours of homework needed in CBT treatments. EMDR has also been found superior to antidepressants. For a full list of studies and outcomes see www.emdrhap.org.

Contact Information: For EMDR clinical training and supervision offered internationally, contact EMDR Institute at:
www.emdr.com
For the EMDR Chemical Dependency Treatment Manual, and for low cost trainings provided for U.S. mental health agencies and individuals clinicians working in agencies, contact the EMDR Humanitarian Assistance Programs at:
(www.emdrhap.org).

Growing Beyond Survival: A Self Help Toolkit for Managing Traumatic Stress

Description: This approach teaches skills that empower survivors to take control of and de-escalate their most distressing trauma-related symptoms. The model was originally designed for therapist-run symptom management therapy groups.

This workbook version, developed by Sidran Institute, can also be used effectively by survivors for managing trauma symptoms between therapy sessions and for individual survivor self-help. It teaches trauma survivors to recognize, contextualize, and understand distressing dissociative and posttraumatic reactions. It also creates a structure in which to learn and practice skills for self-regulation of the troublesome thoughts, feelings, and impulses related to traumatic experiences.

Developed in part and extensively field tested at Trauma Disorders Programs at Sheppard Pratt Hospital in Baltimore, Growing Beyond Survival offers tools enabling survivors to find relief from trauma-related symptoms (including poor concentration, sleep disturbances, panic attacks, nightmares, flashbacks, and other physical responses). It also examines the relationship between trauma and self-harming behaviors, difficulties with sexuality, and substance abuse.

Status of Research: No research to date.

Contact Information: To obtain this resource and for additional information, contact:
Sidran Institute
410-825-8888
orders@sidran.org
www.sidran.org/gbs

Helping Women Recover (HWR): A Program for Treating Addiction

Description: Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, Helping Women Recover: A Program for Treating Addiction (with a special edition for criminal justice settings entitled Helping Women Recover: A Program for Treating Substance Abuse) is an integrated, manualized curriculum for treating women with histories of

addiction and trauma. It is designed for use in a variety of settings including outpatient and residential substance abuse treatment programs, domestic violence shelters, and mental health clinics, as well as jails, prisons, and community corrections. Helping Women Recover is grounded in research, theory, and clinical practice. The foundation of the treatment model is the integration of three theories: a theory of addiction, a theory of women's psychological development, and a theory of trauma. The therapeutic strategies include psycho-educational, cognitive-behavioral, expressive arts, and relational approaches.

The facilitator's manual for the 17-session program is a step-by-step guide containing the theory, structure, and content needed for running groups. *A Woman's Journey*, the participant's workbook, allows women to process and record the therapeutic experience. The program model is organized into four modules: self, relationships, sexuality, and spirituality. These are the four areas that recovering women have identified as triggers for relapse and as necessary for growth and healing. The materials are designed to be user-friendly and self-instructive. This allows the HWR program to be implemented by a staff with a wide range of training and experience.

Each session is organized in the following way.

- The objectives, general topics to be covered, and materials needed are listed at the beginning of each session.
- There is a check-in with the women in the group at the beginning of each session.
- Each session contains a teaching component—a segment in which the key topic(s) for the session are presented to enhance the women's understanding of the topic(s).
- Each session contains an interactive component in which the women discuss the issues, ask questions for clarification, and process the new information.
- Each session contains an experiential component in which the women do exercises to try out new skills, based on the information just presented, in a safe, supportive environment.
- Closure includes questions for the women to think about until the next session.

The groups are designed to be 90 minutes in length and to include 6 to 10 women with one facilitator. It is recommended that the curriculum be implemented sequentially in closed groups, but this is not a requirement. It can also be adapted for work with individuals.

Status of Research: HWR is currently being evaluated at several sites. One completed evaluation funded by the California Endowment was conducted at a residential substance-abuse program for women and children. Pre- and post-tests were used with 50 women to evaluate the following domains: relapse, mental health symptoms related to trauma (anxiety, depression, PTSD), and family functioning (parenting skills and reunification). This study evaluated both Helping Women Recover and Beyond Trauma. The results include a decrease in depression and other trauma-related symptoms, as well as less relapse. One prison-based pilot uses an experimental design with 50 women

randomly assigned to HWR or to a standard prison therapeutic community (TC) program. The study is testing the impact of HWR on program performance, aftercare participation, and recidivism for women offenders, compared to the impact of a standard TC. It also qualitatively assesses treatment staff and client perceptions of the elements of the program. It is anticipated that this pilot will be expanded to a 5-year randomized study of 400 women using specific post-treatment outcome measures including recidivism, substance abuse and relapse, and social adjustment (e.g., employment, parenting behaviors, psychological improvement, relationship issues), compared to the impact of standard treatment. The curriculum is also part of a large drug court study (see below).

In addition, there is approximately 10 years of anecdotal clinical data and self-report showing increased treatment retention, stronger therapeutic alliance, and lower rates of relapse, as well as high client and staff satisfaction. HWR (criminal justice version) has been selected by the Correctional Services of Canada as the basis of their female offender programming. They are also doing quantitative and qualitative research.

Trauma-informed Services for Women in Treatment   (completed) (5/1/04- 10/30/06)
Funded by the California Endowment. Contact for data:
Sandy Keaton at SANDAG at ske@sandag.org and Cynthia Burke at SANDAG at cbu@sandag.org

Gender-Responsive Treatment for Women in Prison (ongoing)
Two year experimental pilot study funded by NIH IR21DA 18699-01A1
(August 20, 2005-June 30, 2007). A random assignment of women in a prison TC to treatment as usual or enhanced gender-responsive treatment. Treatment is being enhanced by using Helping Women Recover as well as Beyond Trauma and other materials developed by Dr. Covington.
Contact person: Nena Messina, Ph.D. at UCLA at nmessina@ucla.edu

Enhancing Substance Abuse Treatment and HIV Prevention for Women Offenders (ongoing) Funded by NIDA 1R01DA22149-01. (September 1, 2006 – August 31, 2009). This 3-year study is examining Mental Health Systems, Inc. (MHS) Readiness and Capacity for Practice Improvement as it incorporates women-focused treatment into four MHS program sites currently serving female drug court participants. An experimental component will determine the effectiveness of a women-focused (WF) treatment program based on HWR, BT and other Covington materials compared to standard mixed-gender (MG) outpatient treatment to promote positive behaviors among 150 women offenders (e.g., HIV risk reduction and substance abuse, and increased psychological functioning). Contact person: Nena Messina, Ph.D. at UCLA at nmessina@ucla.edu

HWR has also been adapted for adolescent girls in a program entitled Voices: A Program of Self-Discovery and Empowerment for Girls. (see description)

To extend and deepen the trauma work introduced in HWR, Beyond Trauma: A Healing Journey for Women (see description) can be used with HWR.

Contact Information: To obtain the HWR facilitator's manual and a <u>Woman's Journal</u> and for additional information on training, consultation, and research, contact:
Stephanie S. Covington, Ph.D., L.C.S.W.
858-454-8528
sscird@aol.com
www.stephaniecovington.com
www.centerforgenderandjustice.org.

Individual Cognitive-Behavioral Treatment for PTSD in People with Severe Mental Illness

Description: Developed by Kim Mueser, Ph.D. and Stanley Rosenberg, Ph.D. at the Dartmouth Psychiatric Research Center and the Dartmouth Trauma Intervention Research Center. This treatment program is a manualized 12-16 week individual intervention for men or women with persistent mental illness and PTSD. The program incorporates the following components: orientation to the program, developing a crisis plan, breathing retraining, psychoeducation about PTSD and related effects of trauma, cognitive restructuring, and termination. The program does not utilize exposure therapy approaches for PTSD. The preponderance of the program is focused on teaching cognitive restructuring as a skill for managing negative feelings, and for identifying and correcting trauma-related beliefs that contribute to and maintain PTSD symptoms.

Status of Research: One pilot study of the CBT for PTSD program has been completed which demonstrated the feasibility of the intervention, high rates of retention in treatment, and significant reductions in PTSD symptoms, depression, and other psychiatric symptoms from pre- to post-treatment, with gains maintained at a 3-month follow-up (Hamblen et al., 2004; Mueser et al., 2004; Rosenberg et al., 2004). In addition, one randomized controlled trial of the program has been completed, in which the CBT for PTSD program was compared with treatment as usual in 108 individuals with severe mental illness (primary diagnoses of major depression, bipolar disorder, schizoaffective disorder, or schizophrenia) and PTSD living in rural northern New England (Mueser et al., under review). Results showed high rates of retention in the CBT for PTSD program, and significantly greater improvements for clients who received CBT compared to TAU in PTSD symptoms, depression, other psychiatric symptoms, knowledge about PTSD, trauma-related beliefs about the world, and working alliance with the case manager (who was different than the therapist who provided the treatment). A replication study is currently underway in an urban setting.

The manual for this intervention is currently being turned into a book by Mueser and Rosenberg for American Psychological Association Press.

Hamblen, J., Jankowski, M. K., Rosenberg, S. D., & Mueser, K. T. (2004). Cognitive-behavioral treatment for PTSD in people with severe mental illness: Three case studies. *American Journal of Psychiatric Rehabilitation, 7*, 147-170.

Mueser, K. T., Rosenberg, S. D., Jankowski, M. K., Hamblen, J., & Descamps, M. (2004). A cognitive-

behavioral treatment program for posttraumatic stress disorder in severe mental illness. *American Journal of Psychiatric Rehabilitation, 7*, 107-146.

Mueser, K. T., Rosenberg, S. R., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, W., Hamblen, J. L., Rosenberg, H., McHugo, G. J., & Wolfe, R. (under review). A randomized controlled trial of cognitive-behavioral treatment of posttraumatic stress disorder in severe mental illness.

Rosenberg, S. D., Mueser, K. T., Jankowski, M. K., Salyers, M. P., & Acker, K. (2004). Cognitive-behavioral treatment of posttraumatic stress disorder in severe mental illness: Results of a pilot study. *American Journal of Psychiatric Rehabilitation, 7*, 171-186.

Contact Information: Information about the program can be obtained from either:
Kim Mueser
kim.t.Mueser@dartmouth.edu
or
Stanley Rosenberg
Stanley.d.Rosenberg@dartmouth.edu

Managing Traumatic Stress Through Art: Drawing from the Center

Description: Under the auspices of Sidran Institute, three art therapists, Barry M. Cohen, Mary-Michola Barnes, and Anita B. Rankin, have collaborated to produce this workbook style manual and model. Designed for trauma survivors to use in individual therapy, in groups, or independently, Managing Traumatic Stress Through Art introduces inventive ways to understand, manage, and transform the aftereffects of trauma. It consists of 26 carefully structured step-by-step art projects, augmented by tear out images, and writing experiences.

The model's first section, Developing Basic Tools for Managing Traumatic Stress, is devoted to art projects for establishing safety and containing strong feelings and impulses. The second section, Acknowledging and Regulating Your Emotions, helps the trauma survivor to make sense of overwhelming emotional experiences. The final section, Being and Functioning in the World, focuses on self and relational development, leading into the future.

Managing Traumatic Stress Through Art will inspire survivors to explore the aftermath of traumatic stress as it affects self-image, relationships with others, and functioning in the world. The projects encourage creative growth and help to establish a sense of personal safety, while exploring and honoring feelings of anger, fear, shame, and sadness. The art experiences are broad enough to be of value to survivors of a wide variety of traumatic experiences, ranging from childhood abuse to accidents to disabling mental illness.

Status of Research: No research to date.

Contact Information: To obtain this resource and for additional information, contact
Sidran Institute
410-825-8888

www.sidran.org/store
orders@sidran.org.

The PTSD Psychoeducation Program for People with Severe Mental Illness

Description: Developed by Stanley Rosenberg, Ph.D. Kim Mueser, Ph.D., and their colleagues at the Dartmouth Psychiatric Research Center and the Dartmouth Trauma Intervention Research Center. This program for clients with severe mental illness and PTSD can be implemented on an individual- or group-basis. The goal of the program is to provide basic information about PTSD and its treatment, but is not intended as a direct treatment for PTSD symptoms. The program is conducted in 3 sessions and includes a video about trauma and PTSD, which is used to provide basic information and to stimulate discussion between the client(s) and clinician.

Status of Research: Two non-controlled pilot studies of the CBT for PTSD program have been completed. The first study included 70 inpatients with severe mental illness and PTSD at New Hampshire Hospital. Results showed that participants reported high levels of satisfaction with the program and improvements from before the program to after the program in knowledge about PTSD (Pratt et al., 2005). A second study evaluated the program delivered in two group cohorts to 13 female outpatients in Indianapolis with severe mental illness and PTSD (M. Salyers, unpublished data). Similar improvements in knowledge about PTSD from before to after treatment were reported, as well as qualitative feedback indicating participants' satisfaction with the group.

Pratt, S. I., Rosenberg, S. D., Mueser, K. T., Brancato, J., Salyers, M. P., Jankowski, M. K., & Descamps, M. (2005). Evaluation of a PTSD psychoeducational program for psychiatric inpatients. Journal of Mental Health, 14, 121-127.

Contact Information: Information about this program can be obtained from
Stanley Rosenberg
Stanley.d.Rosenberg@dartmouth.edu

Prolonged Exposure (PE) Therapy

Description: Prolonged Exposure (PE) therapy is a cognitive-behavioral treatment program for individuals suffering from posttraumatic stress disorder (PTSD). This treatment was developed by Edna B. Foa, Ph.D., Professor of Psychology at the University of Pennsylvania and the founder and director of the Center for the Treatment and Study of Anxiety. In 1982, Dr. Foa and her colleagues began developing the Prolonged Exposure program for treating women who had chronic PTSD following sexual and non-sexual assault. The program consists of a course of individual therapy designed to help clients process traumatic events and thus reduce trauma-induced psychological disturbances. Twenty-five years of research has shown that PE significantly reduces the symptoms of PTSD, depression, anger, and general anxiety. The

standard treatment program consists of 9 to 12, 90-minute sessions. PE includes three main components:

- Psychoeducation about common reactions to trauma and the cause of chronic post-trauma difficulties

- Imaginal exposure: repeatedly revisiting the traumatic memory in imagination and recounting the experiences

- In-vivo exposure: gradually approaching situations, places, people, and objects that are feared and avoided despite being safe because of their association with the trauma memory

PE is designed for adults aged 18 and older who have experienced either single or multiple/continuous traumas and currently suffer from significant PTSD symptoms. PE substantially reduces PTSD and related symptoms in female victims of rape, aggravated assault, and childhood sexual abuse, and in men and women whose PTSD symptoms are related to combat, traffic and industrial accidents, and violent crime. Most extensively used with adults, PE has also been successfully used with children, primarily with those whose symptoms were related to sexual abuse or assault. PE is also useful with children whose PTSD is related to accidents, disasters, and terrorist attacks. A developmentally sensitive version of PE, called Prolonged Exposure for Adolescents (PE-A), has obtained promising results in pilot studies and is currently being investigated in two randomized controlled trials. PE-A is described in the next section.

PE can be used in a variety of clinical settings, including community mental health outpatient clinics, veterans' centers, rape counseling centers, private practice offices, and inpatient units. Treatment is individual and is conducted by therapists trained to use the *PE Therapist Guide* (Foa, Hembree, & Rothbaum, 2007), which specifies the agenda and treatment procedures for each session. Standard treatment consists of 9 to12 once- or twice-weekly sessions**,** each lasting 90 minutes:

- **Sessions 1 and 2**: information gathering, presentation of treatment rationale, construction of a list of avoided situations for in-vivo exposure (i.e., gradually approaching trauma reminders such as situations and objects that, despite being safe, are feared and avoided), and initiation of in-vivo homework. Clients are taught to reduce anxiety by slow, paced breathing.

- **Sessions 3 to 8 or 11**: homework review, imaginal exposure (i.e., 35-45 minutes of repeated recounting of traumatic memories), processing of imaginal exposure experience, reviewing in-vivo exposure, and homework assignment.

- **Final session**: imaginal exposure, review of progress and skills learned, and discussion of client's plans for maintaining gains.

The treatment course can be shortened or lengthened depending on the needs of the client and the rate of progress, but usually range from 7 to 15 sessions.

Training: PE is a form of CBT and is implemented by trained therapists (e.g., social workers, counselors, psychologists, psychiatrists). Thus training in PE is essential to its successful implementation. Several levels of training are available, ranging from a half-day workshop to familiarize the therapist with PE to a 4-day in-depth workshop. In a 2-day basic workshop, the three PE procedures are demonstrated on videotapes and therapists practice the procedures using role-playing. In addition to this basic training, the comprehensive 4-day workshop includes in-depth examination and discussion of typical and atypical treatment responses and how to recognize and manage challenges presented by complex clients. Therapists are shown techniques for promoting effective emotional engagement during imaginal and in-vivo exposures as well as how to overcome difficulties with homework assignments.

Status of Research: Over the last 25 years, Dr. Foa and her colleagues have continued to study the efficacy of the program and have used the findings of these studies to enhance and refine the PE program. In the last 10 years, the efficacy of the PE program has been further established through case series and studies conducted in other academic centers in the USA, Australia, England, Canada, Japan, Holland, and Israel. Numerous clinicians around the world currently practice PE

To date, eight large randomized controlled trials investigating the comparative efficacy of PE have been published and more are underway. Clients in these studies were predominantly African American and white. On average, over 70% of clients no longer have the diagnosis of PTSD after a 9- to 12-session course of PE therapy (i.e., they have a highly significant reduction in trauma-related symptoms, including distressing thoughts, feelings, and flashbacks; avoidance of thoughts and other reminders of the traumatic event; and hyperarousal symptoms). Improved daily functioning, including substantial reduction in depression, general anxiety, and anger have been observed in clients treated with PE. Treatment gains are maintained for at least 1 year after treatment ends. PE has also been beneficial for those suffering from co-occurring PTSD and alcohol or substance abuse when combined with substance abuse treatment. The PE therapist guide is in English and has been translated into Hebrew. Spanish and Japanese translations are underway.

In 2001, PE received an Exemplary Substance Abuse Program Award from SAMHSA, U.S. Department of Health and Human Services, and was designated a Model Program PE also received an Exemplary Service and Support to Victims and Witnesses of Crime Award from the Philadelphia Coalition for Victim Advocacy

Foa, EB, Hembree, EA, Rothbaum, BO. (2007). Prolonged Exposure for PTSD: Emotional Processing of Traumatic Experiences. New York: Oxford University Press

Rothbaum, BO, Foa, EB, Hembree, EA. (2007). Reclaiming Your Life From A Traumatic Experience Workbook. New York: Oxford University Press

Contact Information: For program, training, and research information, contact Dr. Edna Foa or Dr. Elizabeth Hembree: Center for the Treatment and Study of Anxiety
Phone: 215-746-3327
Web site: ctsa@mail.med.upenn.edu

Seeking Safety

Description: Developed by Lisa M. Najavits, Ph.D., at Harvard Medical/McLean Hospital, *Seeking Safety* is a manualized model that offers coping skills to help clients attain greater safety in their lives. It is present focused and designed to be inspiring and hopeful. It is highly flexible and can be used for group or individual format; women or men; all levels of care (e.g., outpatient, inpatient, residential); and all types of trauma and substances. There are 25 treatment topics, each representing a safe coping skill relevant to both PTSD and SUD. All topics are independent, and thus can be done in any order, with as few or many sessions as there is time for (it is not required to do all 25 topics). The model has been successfully implemented with a variety of populations including incarcerated, homeless, adolescents, veterans, substance abuse, mental health, and diverse ethnicity. Seeking Safety is used broadly with traumatized clients who need improved coping skills; they do not have to meet criteria for PTSD and substance abuse as the skills can be generalized. It can be implemented by a very wide range of counselors, including those without a degree in mental health (e.g., substance abuse counselors, case managers).

The treatment manual, <u>Seeking Safety: A Treatment Manual for PTSD and Substance Abuse,</u> (Najavits, 2002) includes client handouts and clinician guidelines. It offers 25 topics to address cognitive, behavioral, interpersonal, and case management domains: Introduction/Case Management; Safety; PTSD; Taking Back Your Power; When Substances Control You; Honesty; Asking for Help; Setting Boundaries in Relationships; Getting Others to Support Your Recovery; Healthy Relationships; Community Resources; Compassion; Creating Meaning; Discovery; Integrating the Split Self; Recovery Thinking; Taking Good Care of Yourself; Commitment; Respecting Your Time; Coping with Triggers; Self-Nurturing; Red and Green Flags; Detaching from Emotional Pain (Grounding); Life Choices; and Termination.
Implementation of the model is enhanced by various materials including a website with extensive downloadable materials (www.seekingsafety.org), the published manual in English and Spanish; five hours of video-based training; and numerous national trainings. Information on all of these is available from www.seekingsafety.org.

Status of Research: Seeking Safety is the most empirically studied treatment thus far for trauma/PTSD and substance abuse, and was designed from the start as an integrated treatment for both domains. Published studies are two multisite controlled trials (Desai & Rosenheck, 2006; Morrissey, Jackson, Ellis, Amaro, Brown, & Najavits, 2005); two RCTs (Hien, Cohen, Miele, Litt, & Capstick, 2004; ; Najavits, Gallop, & Weiss, 2006); a controlled nonrandomized trial (Gatz et al., in press); and six uncontrolled pilots (Cook, Walser, Kane, Ruzek, & Woody, 2006; Holdcraft & Comtois, 2002; Mcnelis-Domingos & May, 2004; Najavits, Schmitz, Gotthardt, & Weiss, 2005; Najavits, Weiss, Shaw, & Muenz, 1998; Weller, 2005; Zlotnick, Najavits, & Rohsenow, 2003). Other completed studies are available at www.seekingsafety.org, but are not yet published (including a dissemination study by Rugs, Hills, & Peters, 2004). The published studies were

conducted with various populations including outpatient women in group modality (Najavits et al., 1998); women in prison in group modality (Zlotnick *et al.*, 2003); women in a community mental health setting in group format (Holdcraft & Comtois, 2002); low-income urban women in individual format (Hien *et al.*, 2004); adolescent girls in individual format (Najavits et al., 2006); men and women veterans in group format (Cook et al., 2006); homeless women veterans in group and/or individual format (Desai & Rosenheck, 2006), women with co-occurring disorders in group format (Morrissey et al., 2005), outpatient men in individual format (Najavits, Schmitz, Gotthardt, & Weiss, 2005), and women veterans in group format (Weller, 2005). One study, Brown et al. (in press) is not reviewed here as it evaluated implementation rather than outcome. Two outcome studies are omitted from the summary below as they included Seeking Safety as one model among several, but did not report differences between them (Holdcraft & Comtois, 2002; Morrissey et al., 2005). Seeking Safety was selected by four sites of the 9-site SAMHSA Women, Violence and Co-occurring Disorders study.

All outcome studies evidenced positive results. Eight of the nine studies that reported on substance use found improvements in that (Hien et al., 2004; Najavits et al., 2006; Najavits et al., 2005; Najavits et al., 1998; Weller, 2005; Zlotnick et al., 2003). The ninth, Cook et al. (2006) did not have quantitative results for substance use, but reported that clients maintained abstinence, verified by urinalysis. All nine studies assessed PTSD and/or or trauma-related symptoms and found improvements in one or both of those areas. Improvements were also found in other domains, such as social adjustment, suicidal thoughts, problem-solving, sense of meaning, and quality of life. Treatment satisfaction and attendance were reported to be high in all studies.

In the four controlled trials, Seeking Safety outperformed treatment-as-usual (Desai & Rosenheck, 2006; Hien et al., 2004; Najavits et al., 2006; Gatz et al., in press). All allowed clients in Seeking Safety to obtain unlimited treatment-as-usual (TAU), and thus essentially evaluated the impact of (a) Seeking Safety plus TAU versus (b) TAU alone. This is a challenging test as clients had so much treatment other than Seeking Safety. Results for the controlled trials are as follows. In Hien et al. (2004), with a study sample of 107 women, both Seeking Safety and relapse prevention (an additional arm of the study that represents a gold-standard treatment for SUD) had reductions in PTSD, substance abuse, and psychiatric symptoms, while the TAU nonrandomized control worsened. In the Najavits et al. (2006) study of 33 adolescent girls, Seeking Safety outperformed TAU for on numerous variables including substance use and trauma symptoms. In the Desai & Rosenheck (2006) multisite study of 450 homeless women veterans, Seeking Safety outperformed a nonrandomized TAU comparison condition on several variables including PTSD and psychiatric symptoms. That study is notable for having used case managers without prior therapy training to conduct Seeking Safety. In the Gatz et al. (in press) study of 313 women in community treatment, Seeking Safety outperformed the control in PTSD, coping skills, and treatment retention. They were also the only study to evaluate possible mechanisms of action, and found that increased coping skills partially mediated outcomes. Finally, one of the pilot studies (Najavits et al., 2005) combined Seeking Safety with an adapted version of PE (Foa & Rothbaum, 1998) with dosage based on choice. Clients chose an average of 21 Seeking Safety sessions and nine PE sessions.

Seeking Safety is the only co-occurring PTSD model that is established as effective at this point using criteria for empirically supported treatments (e.g., Chambless & Hollon, 1998). It has shown consistent positive outcomes on various measures, superiority to treatment-as-usual, comparability to a gold standard treatment (relapse prevention), positive results in populations considered challenging (e.g., the homeless, prisoners, adolescents, and veterans), and high acceptability. All of the published articles on the model can be freely downloaded from www.seekingsafety.org (section "articles").

Najavits, L. M., Ryngala, D., Back, S. E., Bolton, E., Mueser, K. T., & Brady, K. T. (in press). Treatment for ptsd and comorbid disorders: A review of the literature. In E. B. Foa, T. M. Keane, M. J. Friedman & J. Cohen (Eds.), Effective treatments for ptsd: Practice guidelines from the international society for traumatic stress studies (2nd ed.). New York: Guilford.

Contact Information: To obtain a manual, obtain research articles on the model, and for information on training and consultation
Lisa M. Najavits, Ph.D.
617-731-1501 (phone)
617-701-1295 (fax
info@seekingsafety.org
www.seekingsafety.org

Spirituality and Recovery Curriculum

Description: This is a 7-session group manual and curriculum that helps women in recovery from addiction and trauma explore their spiritual roots, assess the impact of religion and spirituality in their lives and make choices about how to grow and develop their chosen spiritual traditions to support recovery and healing from trauma. The curriculum was developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission, the Institute on Urban Health Research, Northeastern University.

Status of Research: The Spirituality and Recovery Curriculum was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a no-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma-integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the 'package' of services and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment 'package.' Three documents are in press for publication indicating that women in the intervention stay in treatment longer and at followup have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2006a). Effects of Trauma Intervention on HIV Sexual Risk Behaviors Among Women with Co-occurring Disorders in Substance Abuse Treatment. *Journal of Community Psychology,* in press.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., Gatz, M. (2006b). Does Integrated Trauma-Informed Substance Abuse Treatment Increase Treatment Retention? *Journal of Community Psychology*, in press.

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma-informed substance abuse treatment on addiction severity, mental health and PTSD symptomatology compared to services as usual. *Journal of Urban Health,* posted on-line March 14, 2007; hardcopy in press

Contact Information: For more information or copies of these materials, please contact
Dr. Hortensia Amaro
h.amaro@neu.edu
or
Rita Nieves, R.N., M.P.H.,
Rita_Neives@bphc.org

Spirituality in Trauma Recovery Group

Description: This manualized group intervention was developed as part of the D.C. Trauma Collaboration Study at Community Connections, one of the Women, Co-Occurring Disorders, and Violence Study sites. Its 11 sessions address spiritual and religious resources for empowerment and recovery from the impact of physical and sexual abuse. Group topics include: What It Means To Be Spiritual; Spiritual Gifts; Spiritual Coping Strategies; Anger; Fear and Powerlessness; Shame and Guilt; Loneliness; Despair; Forgiveness and Letting Go; Hope and Vision; and Continuing the Journey of Healing.

Status of Research: This group's effectiveness is currently being studied, in a randomized wait-list control design, as part of a doctoral dissertation at Washington University in St. Louis. Though informal reports from participants have been positive, no formal results are yet available.

Contact Information: To obtain a manual and for training and consultation information, visit www.ccdc1.org or contact
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

**Symptom-Specific Group Therapy (SSGT) for
Complex Post Traumatic Stress Disorder (CPTSD).**.

Description: Symptom-Specific Group Therapy (SSGT) for individuals with Complex Post Traumatic Stress Disorder (CPTSD) is a manualized, group-based program, developed by Anne-Marie Shelley PhD, Kristina Muenzenmaier MD and colleagues, to address the symptoms of CPTSD often observed in individuals with serious mental illness (SMI) (Muenzenmaier et al, 2005). The clinical goal of the program is to educate people about symptoms of CPTSD and to teach coping skills to deal with these distressing symptoms, using psycho-education, skills training (both cognitive and behavioral) and social support. There are separate groups for males and for females and both have been manualized (Shelley, 2006). SSGT for CPTSD is a component of BPC's Trauma Program, directed by Kristina Muenzenmaier MD.

The SSGT for CPTSD program and manual consists of 12 modules presented over 12 weekly sessions. Each module is aimed specifically at one of the symptoms of CPTSD, such as nightmares, flashbacks, dissociation, avoidance, addiction, numbing, hyperarousal, impulsivity, aggression, self-injury and poor self-esteem. Each module also teaches a coping skill or 'tool' for the management of the targeted CPTSD symptom. The analogy of a toolbox is used, with each group providing a new skill, or 'tool' to add to the toolbox. These tools include behavioral coping skills (for example grounding, behavior scripts, positive distractions), cognitive strategies (re-scripting nightmares, self-soothing, positive coping statements, safe places imagery), social support (communication skills and assertiveness training) and medication management.

Each of the 12 modules is subdivided into the following sections:
1. Introduction to topic (and brief revision of previous session)
2. Stickers to illustrate the module's Topic and corresponding Tool
3. Relating and sharing personal experiences.
4. Psychoeducation, with written handouts for patients
5. Skills training (or 'tool') for symptom management
6. Practice exercises and/or homework

Our experience with SMI patients has shown that CBT needs some modifications before it can be applied optimally in this population. These modifications include:

1. Simplifying language and concepts to be concise and concrete.
2. Using visual input such as illustrations, graphics and color to capture attention, provide aesthetically pleasing material, entertain with humor, relax participants, and optimize learning in people who have problems with auditory processing, executive functions and reading.
3. Making the material relevant at all levels, including symptom specificity, personalized tools, and examples from everyday concerns.
4. Using 'gentle persuasion' as opposed to confrontational approaches when doing cognitive disputations.
5. Using a lot of repetition and revision.
6. Rewarding and reinforcing any and all improvement and progress.

The SSGT for CPTSD Project (Muenzenmaier et al, 2007) is part of a larger program, conceived and developed at Bronx Psychiatric Center (BPC) over the past 10 years: The SSGT for SMI (Serious Mental Illness) Project (Battaglia et al, 2007). SSGT for SMI is a group-based treatment program, created for the management of those syndromes, or symptom clusters, that are routinely observed in Serious Mental Illnesses (SMIs). SSGT consists of eight treatment groups, each of which has been manualized. These are:

1. Positive Symptoms (such as delusions, hallucinations and paranoia)
2. Negative Symptoms (for isolation, amotivation, lack of involvement)
3. Activation (for affective dysregulation, anger and aggression)
4. Dysphoric Mood (for depression, anxiety, panic and irritability)
5. Autistic Preoccupation (for attentional problems, exaggerated internal focus, turning inward).
6. Trauma Symptoms for Women (as described above) and
7. Trauma Symptoms for Men
8. Substance Abuse

We are currently also developing the SSGT Peer Empowerment Project. This project gives patients who have graduated from one or more SSGT groups the opportunity of receiving training to become assistant group leaders and co-leaders. Another new direction we are exploring is combining SSGT for CPTSD with art or music therapy, for individuals who prefer more non-verbal modalities.

Status of Research: A pilot study (Shelley et al, 2001) examining the efficacy of the first 5 groups, which correspond to the 5 factors of schizophrenia as identified by the Positive and Negative Syndrome Scale (PANSS) (Kay, Opler & Fiszbein, 1992), found that participants showed a 22% decrease in symptom severity over 6 months. Preliminary pilot data for the male and female CPTSD groups, showed that participants who received SSGT in the Trauma Symptoms for Men or the Trauma Symptoms for Women Groups, in addition to standard medication and routine care, showed a decrease in symptom severity as indexed by the Post-Traumatic Symptom Checklist (PCL), Abbreviated Dissociative Experiences Scale (DES-A), Abbreviated Psychoticism Scale (PS-A) and an increase in the Knowledge, Use and Helpfulness of Positive Coping Skills (KUH-PCS).

THE SSGT for SMI Project (2007) (Vol. I-VIII) Battaglia et al. Library of Congress, Washington D.C.

THE SSGT for CPTSD Project (2007) Muenzenmaier et al. Library of Congress, Washington D.C.

Muenzenmaier, Castille, Shelley, Jamison, Battaglia & Opler (2005) Comorbid posttraumatic stress disorder and schizophrenia. Psychiatric Annals, 35 (1), 51-56.

Shelley A.M. (2004) Symptom-Specific Group Treatment (SSGT) Program for Serious Mental Illness Manual (Volume I-VI). Library of Congress, Washington D.C.

Shelley, Battaglia, Lucey, Ellis & Opler (2001) Symptom-Specific Group Therapy for Inpatients with Schizophrenia. The Einstein Quarterly Journal of Biology and Medicine, 18, 21-28.

Shelley, Muenzenmaier, Spei, Margolis, Battaglia & Opler (submitted)

Symptom-Specific Group Therapy for Inpatients with Complex Post Traumatic Stress Disorder: A Preliminary Report

The Manuals 'Complex PTSD (Trauma) Group for Women' (Shelley 2006) and 'Complex PTSD (Trauma) Group for Men' (Shelley 2006) are both available from Lulu.com.

Contact Information: For further information please contact:
A.M. Shelley PhD , shelleybpc@aol.com, brpgams@omh.state.ny.us
J. Battaglia, brcdjbb@omh.state.ny.us
K. Muenzenmaier, brmdkmm@omh.state.ny.us

The Trauma Recovery Group: Group Cognitive-Behavioral Treatment for PTSD in People with Severe Mental Illness

Description: Developed by Kim Mueser, Ph.D. at the Dartmouth Psychiatric Research Center and the Dartmouth Trauma Intervention Research Center, and Patricia Carty, M.S., C.C.B.T. and colleagues at the Mental Health Center of Greater Manchester, Manchester, NH, based on the individual CBT for PTSD model developed by Mueser and Rosenberg (described above). This program is a 21-week standardized group intervention for women and men with severe mental illness and PTSD. Group size ranges between 6 and 8 clients. The components of the program include: orientation, breathing retraining, psychoeducation about PTSD and related effects of trauma, cognitive restructuring, teaching coping skills for managing persistent PTSD symptoms, and developing a personal recovery plan. Women and men are included in groups, which are co-facilitated by male and female co-leaders. The program has been in place for seven years at the Mental Health Center of Greater Manchester.

Status of Research: One non-controlled pilot study of the CBT for PTSD program has been completed, which included 80 clients who participated in the first 11 groups. This study showed high rates of retention in treatment, and significant reductions in PTSD symptoms, depression, and post-traumatic cognitions from pre- to post-treatment, with gains maintained at a 3-month follow-up (Mueser et al., 2007).

The manual for this program is currently being developed. Thus far, groups have been based on a detailed outline, supplemented by the manual for the individual CBT for PTSD program developed by Mueser and Rosenberg (above).

Mueser, K. T., Bolton, E. E., Carty, P. C., Bradley, M. J., Ahlgren, K. F., DiStaso, D. R., Gilbride, A., & Liddel, C. (2007). The trauma recovery group: A cognitive-behavioral program for PTSD in persons with severe mental illness. Community Mental Health Journal. Published ahead of print: DOI: 10.1007/s10597-006-9075-2.

Contact Information: Further information can be obtained from:
Kim T. Mueser
kim.t.Mueser@dartmouth.edu

Trauma Affect Regulation: Guide for Education and Treatment (TARGET

Description: TARGET was developed by Julian Ford, Ph.D., as an educational and therapeutic approach for the prevention and treatment of complex Posttraumatic Stres Disorder (PTSD). TARGET provides a practical skill set that can be used by trauma survivors and family members to de-escalate and regulate extreme emotion states, to manage intrusive trauma memories in daily life, and to restore the capacity for information processing and autobiographical memory. TARGET teaches a sequence of seven (7) skills described as the FREEDOM steps. The focus in TARGET is on shifting the way a person processes information and emotions so that s/he is able to live life and make sense of memories without being trapped in an alarm state.

TARGET explains post-traumatic symptoms as the product of an ingrained, but reversible, biological change in the brain's alarm and information processing systems and the body's stress response systems. Using graphics and simple language, TARGET describes the stress response system as an "alarm" in the brain that is triggered by trauma or extreme stress. When the brain becomes stuck in "alarm" mode a person cannot access the brain's capacities for clear thinking, and therefore reacts to all types of current stressors as survival threats. This causes serious difficulties in their relationships and daily life activities that can be addressed by using the FREEDOM skill set.

Essential Components

TARGET is designed to address the primary personal issues that are related to trauma, usch as PTSD symptoms, rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation. The seven (7) core skills in TARGET are taught through repeated coaching and guided practice and are described by the acronym, FREEDOM.

Applications:

TARGET originally was designed for and has been field tested in public-sector and private nonprofit community mental health and addiction treatment settings with adults and adolescents. Although the information provided is complex, the language used in participant materials and in leader guides is down-to-earth rather than technical or academic terminology. The pacing of materials within and across sessions is designed to sustain participant interest without taxing clients' sometimes impaired information processing abilities. TARGET has been adapted for several other trauma-affected populations:
- Survivors, rescue workers, and families affected by September 11, 2001
- Advocacy for women who have experienced domestic violence and their children
- Incarcerated men and women in prison or when newly re-entering the community
- Girls and boys in the juvenile justice system in secure and community programs

-Girls and boys in mental health and addictions treatment programs and schools
-Women with young children who are at risk for criminal justice involvement

TARGET can be offered in individual or group counseling or psychoeducation sessions conducted by clinicians, case managers, rehabilitation specialists, or teachers for 10 to 12 sessions. TARGET has been adapted for interventions that are not specifically focused on trauma recovery, such as anger management, anxiety/stress management, pain management, interpersonal skills, screening and orientation for new clients or residents, and general support groups.

Status of Research: A three-year randomized clinical trial study funded by the Department of Justice of TARGET delivered as a 12-session individual therapy for PTSD with 135 low-income urban mothers will be completed in Fall 2007; all participants have completed the study treatments and follow-up assessments are being conducted. Initial findings comparaing TARGET to a present-centered problem solving therapy and to treatment as usual will be presented at the American Psychological Associations' Annual Convention August 18, 2007.

A three-year randomized clinical trial study funded by the Office of Juvenile Justice and Delinquency Programs of TARGET delivered as a 12-session individual therapy for PTSD with 90 girls involved in delinquency will be completed in Fall 2008; half of the anticipated participants presently are enrolled and completing study treatments or follow-up assessments.

A two-year field trial funded by the Office of Juvenile Justice and Delinquency Programs of TARGET delivered as a group and milieu intervention in every Juvenile Detention Center in Connecticut will be completed in Fall 2008. Juvenile Justice data and admission/discharge questionnaire data are being collected in this quasi-experimental study of the impact of the sequential introduction of TARGET into mixed-gender and gender-specific (girls only) detention centers.

Contact Information: For information, training, and materials, contact
Judith Ford
860 679-2360
fordj@psychiatry.uchc.edu
www.ptsdfreedom.org

Trauma, Addictions, Mental health And Recovery (TAMAR) Trauma Treatment Group Model

Description: Developed as part of the first phase of the SAMHSA Women, Co-Occurring Disorders and Violence Study, TAMAR Trauma Treatment Group Model is a structured, manualized 15-week, 15-module trauma-specific group intervention combining psycho-educational approaches with expressive therapies. It is designed for women and men with histories of trauma. Groups are run inside detention centers, in

state psychiatric hospitals, and in the community. Group sessions meet twice weekly for 90 minutes, an interval that fits smoothly into the daily schedules of county detention centers. Men and women taking part in groups while detained in the detention center complete it on-site or continue in a community group if released before completion.

The Trauma Addictions Mental health and Recovery Treatment Manual provides basic education on trauma, its developmental effects on symptoms and current functioning, symptom appraisal and management, the impact of early chaotic relationships on health care needs, the development of coping skills, preventive education concerning pregnancy and sexually transmitted diseases, sexuality, and help in dealing with role loss and parenting issues. The modules integrate education about childhood physical and sexual abuse and its impact on adult development and functioning with cognitive-behavioral and expressive therapy principles and activities. In 2001, the Mental Hygiene Administration partnered with the Maryland AIDS Administration to fund two sites. Modules on HIV and AIDS (including condom use, communication, and negotiation skills) were added to the manual. The TAMAR manual incorporates work by Maxine Harris, Marsha Linehan, Elizabeth Vermilyea, Barry Cohen, and Andrea Karfgin. Expressive Art Therapy exercises are often used.

Status of Research: The TAMAR Program is currently being evaluated by the Maryland AIDS Administration. Participants are given pre-tests when starting the group and post-tests after they have completed the program. The AIDS Administration is conducting the evaluation to demonstrate potential benefits of the program. One such benefit is that TAMAR builds participants' self-efficacy, and improves self-esteem and coping skills. Another potential benefit is the reduction of the incidence of contracting HIV and STD's for this high-risk population.

Initial research by the University of Maryland during the Women and Violence study found that prior to the TAMAR program, 72% of the women had a history of at least one prior incarceration. After the program was initiated, recidivism back to detention centers was 3%.

Contact Information: To obtain the manual and for information on training and technical assistance,
Marian Bland, LCSW-C
410-724-3242
blandm@dhmh.state.md.us.

Trauma Recovery and Empowerment Model (TREM)

Description: Developed by Maxine Harris, Ph.D., and the Community Connections Trauma Work Group, TREM is a manualized, sequentially organized, 24–33 session group approach to healing from the effects of trauma. It is designed for women with major mental health, PTSD, and/or substance abuse problems. The TREM model for

women was developed and refined over a period of five years by 27 clinicians and more than 500 participants.

TREM combines elements of recovery skills training, psychoeducation, and other cognitive-behavioral techniques, and emphasizes peer support, which has proven to be a highly effective approach with survivors. TREM is co-facilitated by female clinicians. TREM focuses initially on the survivor's personal and relational experience, with emphasis on empowerment and skill building. At this stage, members learn strategies for self-comfort and accurate self-monitoring as well as ways to establish safe physical and emotional boundaries. TREM then provides a supportive (gender-separated) group peer environment in which each survivor can explore current life problems as they relate to past or present experiences of physical, sexual, and emotional abuse. Some group members may disclose personal stories of trauma, though each woman has her own path to healing, and disclosure is not required. The model helps women overcome fear, grief, and shame while reintegrating trauma experiences into a personal life narrative and reframing the connection between their experiences of abuse and other current difficulties including substance use, mental health symptoms, and interpersonal problems. Several sessions focus on skills building, emphasizing self-awareness, self-soothing, communication style, decision-making, problem solving, regulating overwhelming feelings and emotional modulation, and establishing safer, more reciprocal, relationships. Throughout, TREM addresses substance abuse problems and relapse prevention. In conjunction with their participation in a TREM group, participants may use the self-help workbook *Healing the Trauma of Abuse* by Mary Ellen Copeland (see below).

The TREM model for women and its adaptations for men and for girls have been implemented in multiple states in a wide range of settings including residential and non-residential substance abuse and mental health programs, correctional institutions, health clinics, and welfare-to-work programs, among others. Although fidelity to the manualized model is likely to produce the most positive results, it has been provided with benefit to public mental health and substance abuse clients in a variety of ways including selected sessions and in combination with other models and programs.

Participants largely have been recipients of publicly funded mental health, substance abuse and other human services, and have been diverse in terms of overall life skills and functioning. They include the most disenfranchised clients who often are homeless and make heavy use of inpatient, crisis, and other high cost services. TREM was developed in Washington, D.C., with a predominately African American population, and has been used with Caucasian and Latina women (see below for Spanish Cultural and Linguistic Adaptation) who have trauma and other mental health and/or substance abuse problems, and who may have had contact with the criminal justice system.

Status of Research: TREM was adopted by three sites of the nine-site SAMHSA-funded Women, Co-Occurring Disorders and Violence (WCDVS) project. TREM groups explicitly address trauma, mental health, and substance abuse concerns, using an integrated approach that seems to be a key ingredient in achieving better outcomes for project participants. TREM-specific studies to date have focused on the group's retention

of participants, consumer satisfaction, fidelity of implementation, and effectiveness. TREM groups have shown a very high rate of retention, even among women with multiple vulnerabilities and few supports. At the D.C. site of the WCDVS, over 70% of the women enrolled completed over 70% of the group sessions. Pilot studies have indicated a high level of participant satisfaction with the group, with over 90% finding it helpful on a number of trauma-related dimensions, including recovery skill development. Results from studies using a formal TREM Fidelity Scale have demonstrated that trained leaders can implement the TREM group with high fidelity to the manual's content and leadership process. Preliminary studies of TREM have found improvement in overall functioning; mental health symptoms (including anxiety and depression); and trauma recovery skills (e.g., self-soothing, emotional modulation, and self-protection). In addition, these evaluations found decreased high-risk behaviors and reduced use of intensive services such as emergency room visits and hospitalizations. Results of the quasi-experimental WCDVS study conducted in D.C. and Baltimore showed advantages for TREM over services as usual in both PTSD symptoms and drug and alcohol abuse (Fallot, McHugo, & Harris, 2005). At the Denver site (Toussaint, VanDeMark, Bornemann, & Graeber, in press), results indicated that TREM participants, in comparison to those receiving usual services, had better outcomes on both mental health symptoms in general and trauma-related symptoms in particular (e.g., sense of personal safety, feelings of dissociation, coping with trauma). An NIMH-funded randomized controlled trial of TREM is currently in progress, jointly conducted by the New Hampshire-Dartmouth Psychiatric Research Center and Community Connections.
The TREM model has been adapted for men (M-TREM) and has been translated into Spanish and culturally adapted for Latina women (see descriptions below). It has also been adapted for adolescent girls and young women ages 12-18 (Love and Life: G-TREM) (see Trauma-Specific Service Models for Children).

TREM Manual: <u>Trauma Recovery and Empowerment: A Clinician's Guide to Working with Women in Groups</u>, by Maxine Harris, Ph.D. and the Community Connections Trauma Work Group, is a step-by-step leader's guide covering 33 group sessions. Each topic includes a rationale and goals for the session, specific discussion questions, a sampling of typical responses, and experiential exercises.

TREM Instructional Video: <u>Trauma Recovery and Empowerment: A Clinician's Guide to Working with Women in Groups,</u> by Maxine Harris, Ph.D. and the Community Connections Trauma Work Group, is an 8.5-hour instructional video designed for clinicians to learn the rationale and philosophy behind the TREM intervention, with focus on the content and format of each of the 33 sessions. The video provides general information about sexual and physical abuse and can be used as part of a curriculum on trauma.

Fallot, R.D., McHugo, G.J., & Harris, M. (2005). DC Trauma Collaboration Study: Background and Preliminary Report. Unpublished manuscript, Community Connections.

Toussaint, D., VanDeMark, N., Bornemann, A., & Graeber, C. (in press). Modifications to the Trauma Recovery and Empowerment Model (TREM) for substance-abusing women with histories of violence: Outcomes and lessons learned at a Colorado substance abuse treatment center. Journal of Community Psychology.

Healing the Trauma of Abuse: A Women's Workbook, by Mary Ellen Copeland, M.A., M.S. and Maxine Harris, Ph.D. Used by women participants in conjunction with their work in the TREM group, this workbook can also be used by a woman on her own, or with a therapist or supportive friend. The manual assists women recovering from the effects of physical, sexual, and emotional abuse. It is divided into four parts: Empowerment, Trauma Recovery, Creating Life Changes, and Closing Rituals. Each part has a number of topics to work on, helps women develop individual goals for the recovery work, and addresses self-care while doing recovery work.

Contact Information: To obtain the manual or the instructional video contact;
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org
For information on training and consultation, contact
Rebecca Wolfson Berley, M.S.W.
Director of Trauma Training
202-608-4735
rwolfson@ccdc1.org
To obtain the Copeland workbook and more information, visit:
www.mentalhealthrecovery.com

Trauma Recovery and Empowerment Profile (TREP) and Menu of Strategies for Improving a Woman's Trauma Recovery and Empowerment Profile

Description: Developed by Maxine Harris, Ph.D., and Roger D. Fallot, Ph.D., this skills rating scale and menu of skill building strategies may be used in conjunction with the TREM group program or individually as clinical tools for clinicians and survivors to evaluate skill levels and work toward development of skills. TREP is a rating instrument with eleven dimensions. Each dimension describes a skill that is central to coping effectively with the impact of emotional, physical, and/or sexual abuse. Completed by a clinician who knows the consumer/survivor well, or by the survivor him/herself, the TREP is designed to provide an assessment of the consumer/survivor's recovery skills at a particular point in time. The manual, Menu of Strategies for Improving a Woman's Trauma Recovery and Empowerment Profile, contains interventions designed to develop skills in the eleven domains of trauma recovery. The interventions are used in conjunction with a case manager, counselor, therapist or peer advocate, and are in some circumstances used in a self-help format. Exercises are categorized into beginning and intermediate level exercises. Exercises may also be useful for individuals who are not trauma survivors but who desire skill development to deal with addictions or mental health problems.

Status of Research: No research to date.

Contact Information: To obtain copies of TREP and the Menu of Strategies, contact:

Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org
For additional information, contact
Rebecca Wolfson Berley, M.S.W.
Director of Trauma Training
202-608-4735
rwolfson@ccdc1.org

Trauma Safety Drop-In Group: A Clinical Model of Group Treatment for Survivors of Trauma

Description: Designed by Pat Gilchrist of Ulster County Mental Health and Peri Rainbow of Women's Studies at New Paltz State University of New York, this model provides trauma survivors with basic safety skills. A low-intensity group model that requires no commitment from participants, the group is open to all survivors regardless of diagnosis, level of functioning, and place in the healing process. Goals of the group include increasing the survivor's ability to function and feel safe in a more intensive level of group treatment, to learn about the healing process and the after-affects of trauma, and to assess readiness for further treatment. The drop-in nature of the group is an essential and unique feature. Survivors who are beginning trauma-specific treatment are often not prepared to fulfill the commitment of consistent attendance required by traditional group therapy. The group is structured so that survivors can join at any point and complete the cycle at their own pace.

Status of Research: No research to date

Contact Information: Manuals are available from the New York State Office of Mental Health Trauma Unit at nominal cost from
NYS OMH Printing and Design Services.
Fax number: 518-473-2684.

TRIAD Women's Group Model

Description: Developed by and implemented at one of the SAMHSA Women Co-Occurring Disorders and Violence Study sites, this manualized, 16-session (2-hours a week for 16 weeks) cognitive behavioral group model is based on the perspective that complex disorders arise from trauma and that particular fundamental issues must be addressed for long-term recovery to occur (Herman, 1992). It is designed for and takes an integrated approach to women who experience challenges around the three issues of trauma, mental health, and substance abuse.

TRIAD is structured into four phases: Mindfulness, Interpersonal Effectiveness Skills, Emotional Regulation, and Distress Tolerance, with four weekly sessions in each phase.

This design allows for a "modified open" format in which women can join the group at the beginning of each of the four phases. Each session includes specific goals and objectives to facilitate short-term treatment planning. A leaders manual, Triad Women's Project Group Treatment Manual, was developed by the Clinical Interventions Committee of the Triad Women's Project. TRIAD's primary treatment goals are to reduce psychiatric and trauma-related symptoms associated with histories of violence/abuse and substance use for those with substance abuse disorders. Additional model goals are to increase abstinence for those with substance dependence and to support women in maintaining their personal safety. This cognitive behavioral model is based, in part, on Linehan's Cognitive-Behavioral Treatment model, Evans and Sullivan's work on substance abuse and trauma and Harris' work on trauma and serious mental illness.

TRIAD groups are implemented in outpatient or residential community mental health centers and substance abuse treatment facilities and a modified version of TRIAD is currently being offered in jails.

Status of Research: Triad was developed and implemented by one site of the 9-site SAMHSA WCVDS. Results of this cross-site study show positive effects for trauma treatment and indicate that participation in integrated counseling that addresses treatment issues related to trauma, mental health, and substance seems to be the key ingredient in achieving better outcomes.

Contact Information: To obtain the manual and for information on training and consultation, contact
Colleen Clark, Ph.D.
813-974-9022
cclark@fmhi.usf.edu

Manualized Adaptations to Trauma-Specific Service Models for Adults

An Introduction to Trauma Issues for Women on Inpatient or Short-Stay Units

Description: Created by Maxine Harris, Ph.D., Bronwen Millet, Ph.D., Lori Beyer, M.S.W., Jerri Anglin, M.S.W., and Rebecca Wolfson, M.S.W., this manualized, four-session (45-50 minute) group treatment intervention is drawn from the TREM model. It is made for women with histories of sexual and physical abuse who have been diagnosed as having a mental illness or a substance abuse disorder and are receiving treatment on a psychiatric, detoxification, or battered women's short-stay residential unit. The curriculum has a suggested order but is capable of being attended by a woman in any order as each session is designed to stand alone. The woman may attend one, two, three, or all sessions depending on her readiness and circumstances. A brief written version of

the sessions is available for residents so they have a chance to benefit from sessions missed.

The curriculum is designed to introduce women to important connections between a history of physical, sexual, and /or emotional abuse and current difficulties and symptoms. It helps women assess their need for longer-term recovery work and identify community resources for doing trauma recovery work in an outpatient setting.

Status of Research: No research to date.

Contact Information: To obtain a manual and for additional information visit www.ccdc1.org or contact
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

Men's Trauma Recovery and Empowerment Model (M-TREM): A Clinician's Guide to Working with Male Trauma Survivors in Groups

Description: Developed by Community Connections with Roger D. Fallot, Ph.D., Maxine Harris, Ph.D., H. Urs Affolter, M.S.W., Jerri Anglin, M.S.W., Ellen Arledge, M.S.W., Richard Bebout, Ph.D., John Dende, M.A., David Freeman, Psy.D., Walter Green, M. Div., and Matthew Lee, M.S.W., this group is an adaptation of the original TREM for women tailored to the specific concerns of male trauma survivors. The men's 24-session group (75 minutes per session) is structured in three sections. Part I addresses the emotional readiness of male trauma survivors for trauma-focused discussions. Group members develop a shared emotional and relational vocabulary via sessions that center on both key emotions (anger, fear, hope, shame) and relationship characteristics (friendship, intimacy, trust, loss). Part I helps men to place their personal experiences in a larger context by exploring the cultural understanding of "what it means to be a man." In Part II, attention focuses more directly on trauma and its connections to emotional, addictive, and relationship difficulties. Part III adopts an explicitly skill-building emphasis with, among others, sessions on communication, problem-solving, and self-soothing. This program can be used with African American, Caucasian, and Latino men who have trauma, other mental health and/or substance abuse problems, and who may have had contact with the criminal justice system.

Status of Research: Pilot studies of M-TREM have shown promising results, based on the feedback of group leaders and participants. In an initial group of six participants, for example, changes from pre-group to six-month post-group follow-up were consistently positive, reflecting enhanced overall functioning and decreased mental health (including posttraumatic stress) symptoms. M-TREM is currently being examined in an NIMH-funded study designed, first, to revise and refine the treatment manual and, second, to

conduct a small, randomized controlled trial of the group's effectiveness in reducing PTSD and other symptoms.

Contact Information: To obtain the manual, visit www.ccdc1.org or contact
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org
For information on training, call
Rebecca Wolfson Berley, M.S.W., Director of Trauma Training
202-608-4735
rwolfson@ccdc1.org

Spanish Cultural and Linguistic Adaptation and Expansion of Trauma Recovery and Empowerment Model

Description: Developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission and the Institute on Urban Health Research at Northeastern University, TREM is translated into Spanish and culturally adapted to make it more appropriate and accessible to Latina women. The title of this cultural adaptation and Spanish language translation is:

Saber Es Poder: Modelo de Trauma y Recuperación para Mujeres Latinas, Harris, M., Wallis, F., Amaro, H., translated by Cortes, D., August 2006

Multiple issues addressed by the TREM manualized group treatment are translated and contextualized within the Latino culture and the African American culture, and compared to the viewpoints of mainstream American culture and other cultures. The model has also been expanded to include strategies for reduction of HIV sexual risk behaviors.

Status of Research: The Spanish Cultural and Linguistic Adaptation and Expansion of Trauma Recovery and Empowerment Model was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a no-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma-integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the 'package' of services and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment 'package.' Three documents are in press for publication indicating that women in the intervention stay in treatment longer and at followup have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2006a). Effects of Trauma Intervention on HIV Sexual Risk Behaviors Among Women with Co-occurring Disorders in Substance Abuse Treatment. *Journal of Community Psychology,* in press.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., Gatz, M. (2006b). Does Integrated Trauma-Informed Substance Abuse Treatment Increase Treatment Retention? *Journal of Community Psychology*, in press.

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma-informed substance abuse treatment on addiction severity, mental health and PTSD symptomatology compared to services as usual. *Journal of Urban Health,* posted on-line March 14, 2007; hardcopy in press

Contact Information: To obtain a manual and for more information, contact
Dr. Hortensia Amaro
h.amaro@neu.edu
or
Rita Nieves, R.N., M.P.H.
Rita_Nieves@bphc.org

Models for Developing Trauma-Informed Service Systems and Organizations: Children

Child Adult Relationship Enhancement (CARE)

Description: Child Adult Relationship Enhancement (CARE) is a trauma-informed, field-initiated modification of specific Parent-Child Interaction Therapy (PCIT) skills for general usage by adults who work with traumatized children. This promising intervention approach is based on PCIT, but it is a separate intervention that began developing collaboratively in 2004 by the Trauma Treatment Training Center (TTTC) and Cincinnati Children's Hospital Medical Center with therapists and service providers in a variety of settings whom the TTTC had trained in PCIT. In response to feedback from the children and families they served, these therapists modified the standard PCIT model to serve special circumstances and culturally diverse clients. Using the TTTC's structured conference call and listserv platforms, these community providers then shared their successful adaptations of core PCIT components so that they could be incorporated into the developing CARE model. Thus, CARE reflects a collaborative co-creation between the TTTC and a range of agencies (i.e., battered women shelters, foster care agencies, residential care facilities, medical care settings, homeless shelters). As a result, CARE can be generalized to a wide variety of settings and implemented at different levels of intensity.

CARE utilizes the 3 P skills (Praise, Paraphrase and Point-out-Behavior) based on PCIT's PRIDE skills: Praise, Reflect, Imitate, Describe and Enthusiasm, to connect with children, a set of techniques for giving children effective positive commands to increase

compliance, and selective ignoring techniques to redirect problematic behaviors. CARE also contains a trauma education component to contextualize the use of these skills with the kinds of behaviors and problems exhibited by many traumatized children. The basics of the CARE skills can be taught in about 3-6 hours in groups or individually. A CARE Curriculum Guide for Trainers is available to clinicians who have completed PCIT training.

CARE training is applicable for adults who interact with children from preschool through adolescence in a large range of settings. These settings include but are not limited to: 1) foster parents; 2) foster care caseworkers and child protection workers; 3) battered women shelter staff; 4) homeless shelter staff; 5) child victim advocates; 6) residential treatment center staff; 7) day care providers and Head Start teachers; 8) medical care providers; 9) partial hospitalization staff; 10) social service case aides; 11) home visitation providers; 12) international adoptions staff; 13) medical students; and 14) receptionists/other administrative staff who come in contact with children. The TTTC has had direct or indirect experience working with service providers in all of these populations/settings and has used this accumulated experience to shape the CARE Curriculum Guide.

Status of Research: CARE is supported by pragmatic evidence of its effectiveness with concepts derived from the evidence-based PCIT, but further evaluation is warranted.

*Contact Information***:**
Trauma Treatment Training Center, Cincinnati, OH
www.OhioCanDo4Kids.org
CARE trainers: Erica Pearl, PsyD, Barbara Boat, PhD, & Erna Olafson, PhD, PsyD

For questions about how to obtain CARE training:
Lacey Thieken, Mayerson Center for Safe & Healthy Children
Phone: 513.636.0042
Fax: 513.636.0204
Email: Lacey.Thieken@cchmc.org

Child Development Community Policing Program (CD-CP)

Description: The CD-CP Program is a collaborative partnership between police, mental health, domestic violence advocacy, child protection, and juvenile justice professionals. The program's mission is to decrease the negative psychological consequences of violence exposure on children and families. The CD-CP Program was developed in New Haven, Connecticut in 1991 by the Yale Child Study Center and the New Haven Department of Police Service. The program model includes the following components:

* Cross training for police, mental health clinicians and others in principles of child development and psychological response to trauma and principles and practice of community policing;

* Acute response service, which places trained clinicians and officers on-call 24/7 to provide immediate direct assessment and intervention for children and families exposed to or involved in violence or other potentially traumatic incidents;

* Weekly interdisciplinary program conference to develop, review and track case-specific intervention plans for children and families referred to the acute response service;

* Domestic Violence-Home Visit Intervention (DV-HVI) provides outreach home visits and follow-up advocacy by teams of patrol officers and domestic violence advocates to children and families affected by intimate partner violence;

* Trauma Clinic that provides services for acute response and treatment for children and families. This serves as a secondary prevention model for post-traumatic stress and long term treatment for the effects of traumatic stress.   The Child and Family Traumatic Stress Intervention (CFTSI) has been developed and implemented with children and families within days or weeks of traumatic events to decrease post traumatic impact.

The following is a sample of available materials regarding the program:

- Marans, S., Adnopoz, J., Berkman, M., Esserman, D., MacDonald, D., Nagler, S., et al. (1995). The police-mental health partnership: A community-based response to urban violence. New Haven: Yale University Press.
- Marans, S., Berkman, M. (2005). Police-mental health collaboration on behalf of children exposed to violence: TheChild-Development Community Policing program model. In, Handbook of Community-Based Clinical Practice, Lightburn, A. & Sessions, P. (Eds.). Oxford University Press (USA).
- CD-CP Program Manual
- CD-CP Acute Response Protocol
- Domestic Violence Home Visit Intervention (DV-HVI) Manual
- One on One: Connecting Cops and Kids: DVD and Training Manual
- Child and Family Traumatic Stress Intervention Manual
- Guidelines for Parents and Professionals on Trauma and Catastrophic Events

The CD-CP Program was developed to assist children ages 0-18 and their families who have been affected by violence or other potentially traumatic events, such as serious accidents, sudden deaths, and acute medical injuries and emergencies (e.g., house fires).   The program was developed in New Haven, CT, a small urban community with a high rate of poverty and a diverse population that is comprised of, African American, Latino, Caucasian and mixed ethnicity communities. The program has been implemented in over a dozen other communities in the U.S. with

varied demographics. The program has also been adapted nationally to assist first responders, mental health practitioners, communities, and governmental entities, and to educate the public, in the wake of violent events, terrorist incidents (e.g., 9/11 terrorist attacks), and natural disasters (e.g., hurricane Katrina).

Status of Research:

*   An intensive CD-CP program evaluation in New Haven, CT and Charlotte, NC that examines changes in law enforcement practice and child and family functioning is underway.

*   A 12 month longitudinal study comparing 50 women who received DV-HVI home visits with 50 others who received standard police services only found that, at baseline, intervention subjects felt safer and more positively toward the police than comparison subjects. At 6 month and 12 month follow-up interviews, intervention subjects were more likely to call the police for new domestic violence incidents than control subjects, but the new calls to the police were more likely to be for less serious, non-violent incidents. Intervention subjects were also more likely to be engaged in court based advocacy/legal services for themselves and mental health services for their children.

*   A randomized evaluation of the Child and Family Traumatic Stress Intervention (CFTSI) is currently in progress in the city of New Haven. Two hundred and fifty children who have experienced a traumatic event (e.g. motor vehicle accidents, sexual abuse, domestic, community violence, etc) will be recruited within 4 weeks of the incident and randomly assigned to the CFTSI or a treatment as usual comparison group. Parents and children will be interviewed at baseline, post-intervention and 3 months later to determine the effectiveness of the CFTSI in reducing child symptoms and increasing parent-child communication and feelings of social support. To date 42 families have completed baseline interviews and been randomized and 15 families have completed 3 month follow-up.

Contact Information: For further information on Program Research contact:
Dr. Carla Stover, Ph.D
carla.stover@yale.edu.
For more information about the program contact National Center for Children Exposed to Violence:
Steven R. Marans, Ph.D.**,** Director, and Professor of Child Psychiatry and Psychiatry
Phone: (203) 785-3377
Email: steven.marans@yale.edu
or
Colleen Vadala, Coordinator and Chief Administrator
Phone: (203) 785-2975
Email: colleen.vadala@yale.edu
or Visit our Website:
www.nccev.org

Preventing Child Abuse Within Youth Serving Organizations: Getting Started on Policies and Procedures

Description: In the first section, you will find six key components of child sexual abuse prevention for organizations. These components were identified by the Centers for Disease Control and Prevention (CDC) in conjunction with experts. The experts included advocates, child sexual abuse researchers, professionals who provide prevention resources for organizations, and representatives of youth-serving organizations that have child sexual abuse prevention programs.

1.   Screening and selecting employees and volunteers
2.   Guidelines on interactions between individuals
3.   Monitoring behavior
4.   Ensuring safe environments
5.   Responding to inappropriate behavior, breaches in policy, and allegations and suspicions of child sexual abuse
6.   Training about child sexual abuse prevention.

Each component is described in detail, including the prevention goals, critical strategies, and additional strategies that could be considered depending on the context and resources of individual organizations.

The sections that follow offer suggestions for addressing challenges to developing and implementing a strategy to prevent child sexual abuse and provide tools to help organizations move forward. A list of publications and organizations that can provide helpful information is provided in Appendix B.

Population (s) the model is designed for and used with (e.g.
ages, genders, cultures, specific client groups, settings, language adaptations, etc.) This is important as we plan to create an easy-to-refer-to summary chart highlighting the populations and age groups served by each model;

This report is designed for representatives of youth-serving organizations who are interested in adopting strategies to prevent child sexual abuse. Whether these strategies are developed within the context of an overall risk management plan or are addressed separately, organizations need to examine how they can protect youth from sexual abuse.

Status of research : No research to date

Contact information: for readers to obtain materials and acquire additional information, in the following order:

For information or questions about content -- Renee Wright, CDC
770-488-1146
rwright@cdc.gov
www.cdc.gov/injury

For copies of the report:
Wendy Heaps, CDC
770-488-1345
wheaps@cdc.gov
www.cdc.gov/injury

Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)

Description: The Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART) Model developed by a team of clinicians at the Kennedy Krieger Institute Family Center is a structured, phase-based, abuse-focused, treatment approach to address the emotional and behavioral needs of young children with a history of sexual abuse exhibiting problematic sexual behavior (PSB). A major premise of the model is that the PSB stems from emotional responses to the prior child sexual abuse causing the child to form cognitive distortions about themselves, others, and the world around them. A unique feature of the model is the formation of parallel narratives of the child's experiences as a victim and as one who victimizes others. Children are supported to examine their roles and perceptions associated with each of these experiences. Clinicians guide children and their families through this process and provide the context for comparison leading to the integration of these experiences into a single narrative.

The SMART Model consists of three clinically essential phases: Safety and Stabilization, Triggers/Integration, and Re-Socialization. Each phase of treatment incorporates established practices proven to be effective in trauma treatment, such as CBT and psycho-education that reinforce safety/stability concerns, affect and behavioral regulation, as well as strategies for developing new coping patterns that no longer involve harm to self or others through trauma-informed interventions. A primary concern at all times is the provision of safety, both physical and emotional.

The SMART model utilizes individual, family, and group therapy simultaneously. Used independently, these therapeutic approaches are frequently insufficient to eliminate PSB; however, the synergy created by concurrent use of these approaches yields an integrated comprehensive treatment model that promotes recovery and the acquisition of appropriate adaptive skills. To date, the average length of stay for model completion is 12 months. Length of stay may vary based on the individualized needs of the family and the child's ability to master concepts and build skills.

Status of Research: An analysis of the data collected during the piloting of the model (N=62) supports the effectiveness of the SMART model in reducing and/or eliminating PSB exhibited by young children with a history of sexual abuse. Children treated with the SMART model made behavioral and emotional improvements in functioning across multiple areas up to one year following treatment. Mean total functional impairment from the beginning to the end of treatment was reduced in half. Future research using a comparison group and randomized design is planned.

Contact Information: For more information on the model and on training and consultation services, contact lead developer,
Betsy Offermann, LCSW-C
443-923-5907
Offermann@kennedykrieger.org,.

Stewards of Children: Adults Protecting Children from Abuse

Description: Darkness to Light's Stewards of Children Prevention Program is a revolutionary sexual abuse prevention training program that educates adults to how to prevent, recognize, and react responsibly to child sexual abuse. The program addresses the trauma of child sexual abuse in a sensitive and empowering way, increasing the understanding of its impact on health, mental health and well being. Procedures to reduce the risk of re-victimization are also presented.

The program is empowering and motivates adults to take courageous action in the protection of children. The 2.5 hour training program is based on Darkness to Light's "7 Steps to Protecting Our Children" as the core curriculum and interweaves the stories of adults with lived experiences of child sexual abuse with the advice of experts in the areas of prevention, intervention and law enforcement to emphasize and teach the 7 steps. The presentation of the survivor stories and outcomes are based on hope, self-determination and empowerment. Hearing the lived experiences of childhood sexual abuse trauma survivors often enablers other survivors to come forward and consider treatment for the first time, although the focus is to teach adults the skills to protect children. The training is presented using a 1.25 hour training dvd/video and interactive workbook in a format that teaches specific tools and encourages discussion and participation in the development of a personal prevention plan. The curriculum also includes interactive discussions that can be customized for various audiences, organizations and settings.

The Stewards of Children program is designed for any adult who has responsibility for a child's safety, targeting parents, staff and volunteers of organizations, clubs, corporations and agencies that serve children and youth. The focus of the curriculum is primary prevention, accomplished by teaching adults how to prevent child sexual abuse from occurring the first time. For example, adults learn about the prevalence and consequences of sexual abuse and are encouraged to monitor situations where one-on-one contact between adults and children might occur, to screen adults who work with children, and to initiate conversation about healthy sexuality, appropriate physical contact and child sexual abuse prevention. The curriculum also addresses secondary prevention by teaching adults to identify when abuse has occurred, how to respond appropriately, as well as, the prevention of re-victimization. Prevention education occurs within the context of asking participants to think about the children for whom they are responsible and how they may be vulnerable to child sexual abuse, thus providing both the motivation and the empowerment to act.

The philosophy of the Stewards of Children curriculum is to change attitudes about child sexual abuse through the principles of choice, consciousness, personal power, and relentless compassion and to motivate individuals to act courageously and assertively toward child sexual abuse prevention. The Stewards of Children curriculum is being used in numerous youth serving agencies, organizations and settings including child advocacy centers, family advocacy programs on military bases, prevention programs, faith-based, sports and recreational clubs and organizations, youth camps, educational settings (primary, secondary and higher education), foster care, treatment foster care, residential settings, early childhood education, child welfare, juvenile justice, as well as numerous other agency, non profit and intervention programs.

The Stewards of Children program utilizing the 7 Steps to Protecting our Children, incorporates seven simple, proactive steps adults can take to protect children from sexual abuse. Steps 1-3 (Know the Facts and Understand the Risks; Minimize Opportunity; Talk about It) are oriented toward primary prevention. They address the prevalence of child sexual abuse and encourage adults to pay attention to risk in various settings, ensuring that when children are alone with an older youth or adult the situation is observable and interruptible. Adults are also reminded to talk about child sexual abuse prevention with children and other adults. Steps 4-6 (Stay Alert; Make a Plan; Act on Suspicions) provide ways for adults to act if abuse is suspected, awareness of the signs of child sexual abuse and incorporating contact information for local and national resources that includes Darkness to Light's national helpline support. Step 7 circles back to primary prevention, urging adults to "Get Involved" by supporting agencies that deal with child sexual abuse, contacting legislators, and encouraging youth organizations to enact safe practices.

Steward of Children is made available through two formats, instructor led and online. In the instructor led format, a Darkness to Light trained facilitator is taught to lead group discussion that reinforces the learning objectives and addresses thoughts and feelings stimulated by the DVD and workbook. Facilitators have ongoing contact with Darkness to Light that includes updates in their training and support for initiatives in their communities including funding strategies and evaluation tools. They also have opportunities to learn about the development of child protection policies and practices for organizations. This resource enhances primary prevention in that facilitators not only train individuals in child sexual abuse prevention, but also equip organizations to create a culture where prevention efforts are supported.

The web-based version of Stewards of Children is available through the Darkness to Light website, www.darknesstolight.org. A web-based version of the interactive workbook is downloaded and participants are able to work at their own individual pace.

Additional assets are the structure and standardization of the Stewards of Children program. The curriculum incorporates basic principles of adult learning that includes delivery in visual, auditory and written modes to support different learning styles. The facilitated discussion of the instructor led format affords active participation in learning with the idea that personal engagement will lead to action. The workbook is written at an 8th grade reading level, making it broadly accessible to adults of all educational levels.

The standardized training for facilitators ensures that facts about child sexual abuse are delivered accurately and prevention strategies are enacted in a climate that supports their effectiveness.

Status of Research: Darkness to Light has demonstrated its investment in an evidence-based approach to child sexual abuse prevention for all of its programs and products, distinguishing it as an organization determined to make a lasting impact. In addition to the Stewards of Children program, media and "7 Steps to Protecting Our Children" booklets, advanced training programs in policy and procedure development, community prevention implementation, funding and evaluation, a mini course for parents and parent brochures are also available.

Given the mixed results on the effectiveness of child-focused programs (Wurtele, in press), Darkness to Light's emphasis on adult education fills a critical gap. Darkness to Light's programs represent a novel approach to child sexual abuse prevention and have the potential to impact primary and secondary prevention. Their broad distribution increases the probability that adults worldwide will have the opportunity to learn how to protect children from sexual abuse.

Two important features of Darkness to Light's programs are the comprehensive approach and research foundation. The media, the 7 Steps printed booklets and web-based version, and the Stewards of Children curriculum in face-to-face training and web-based formats, together ensure that Darkness to Light's powerful resources are widely available and adaptable to different circumstances. These prevention tools are founded on best practices as reflected in the literature on child sexual abuse prevention (CDC, 2004), and all have been evaluated for their effectiveness in several studies.

In an evaluation of the Stewards of Children program, nine organizations and nearly 500 individuals participated in a comparison of pre- and post-training evaluating the effectiveness of the Stewards of Children curriculum and the efficiency of the training format. Results showed a 38% improvement in both child sexual abuse knowledge and attitudes, changes that were maintained over two months. Participants also reported significant increases in preventive behaviors after training. Participants were more likely to:
  • Discuss issues of sexual abuse with a child or another adult
  • Pay attention to potential signs of sexual abuse
  • Drop in unexpectedly to ensure that a child is safe in the care of another adult

The core curriculum, "7 Steps" of the Stewards of Children program has also undergone evaluation. In 2004, researchers with the College of Charleston completed a web-based study and found a significant increase in knowledge of child sexual abuse prevention after exposure to the "7 Steps" information. This finding suggests that the "7 Steps" effectively reached individuals with varying degrees of knowledge regarding child sexual abuse, and then brought all groups to the same performance level.

The efficacy of the "7 Steps" web-based versus print version was also evaluated in 2005.

The study used two separate Solomon 4 Group Research Designs to test the effectiveness of the web-based and the print version of the prevention materials. In addition to comparing the efficacy of each version against a control group, the research design afforded comparison of the web-based and print versions of the prevention information. The results established that regardless of presentation format, exposure to 7 Steps has a significant impact on knowledge and attitudes about sexual abuse and its prevention. This finding has particular interest for the web-based Stewards of Children program.

Contact Information: To obtain additional information:
Pat Patrick, LISW
843-954-5444
ppatrick@d2l.org
www.darknesstolight.org

Trauma Informed Organizational Self Assessment

Description : Developed by the National Center on Family Homelessness (NCFH), the Trauma-Informed Organizational Self-Assessment was designed to provide programs with specific ways to understand how to be trauma-informed. The Self-Assessment contains concrete items that describe specific practices necessary for creating a trauma-informed shelter system. The Self-Assessment is divided into five categories including: supporting staff development, creating a welcoming and safe environment, assessing and planning services, involving consumers, and establishing policies. The Trauma-Informed Organizational Self-Assessment also can be used by providers to assess the extent to which their systems are trauma-informed. When completed by program staff and administrators at all levels of an organization, an agency can determine the degree to which they are "trauma-informed". Based on their findings, they can then design a strategic plan for increasing their capacity to provide trauma-informed services using the Self-Assessment as a guide.

Accompanying the Trauma-Informed Organizational Self-Assessment is a Companion Guide that provides information about the relationship between trauma and homelessness; the nature of trauma-informed care; the content, development and implementation of the items in the Self-Assessment; and a detailed description of the five domains and examples of how to provide trauma-informed care within each domain. The Companion Guide is designed to be used in conjunction with the Self-Assessment. Together, the Companion Guide and Trauma-Informed Organizational Self-Assessment constitute the Trauma-Informed Organizational Toolkit.

The Trauma-Informed Organizational Self-Assessment was developed by the National Center on Family Homelessness with the help of experts in the fields of homelessness and trauma, consumers, and Boston area homeless service providers. Based on early feedback from providers and researchers, the growing focus on evidence-based practices, and the need for more concrete ways to measure program change, NCFH concluded that the Trauma-Informed Organizational Self-Assessment would be more effective if it was

converted from a checklist into an instrument with psychometric properties that allowed the tool to be scored and the results to be easily interpreted. During the second year in the development and refinement of the Self-Assessment, NCFH transformed the Self-Assessment into a formal measure by 1)adding a scoring component; 2) revising the items and format; 3) piloting the Self-Assessment in nine Massachusetts area shelters; 4) evaluating the process and using the piloting experience to clarify the items and shorten the Self-Assessment; and 5) creating a Companion Guide that corresponds to the newly refined Self-Assessment and more fully describes the implementation process.

Pending approval for piloting the Self-Assessment and Companion Guide nationally in 2008, we plan to further revise it.

The Trauma-Informed Organizational Self-Assessment can be used by staff and administrators in residential programs serving homeless families, including emergency shelters, domestic violence shelters, and transitional and supportive housing programs.

Status of Research:
The initial development of the Trauma-Informed Organizational Self-Assessment involved the creation of Self-Assessment items by experts in the fields of homelessness and trauma, along with refinement of the tool based on feedback gathered from focus groups with shelter providers.

In year two of its development, the following steps were taken to create a more rigorous tool by which organizations can assess the extent to which they provide trauma-informed care and measure program change. We modified the tool as follows:

1. Modifying the Tool
   • Developing a scoring system for the self-assessment that people could use when thinking about the extent to which they incorporate each item into daily practice. This involved creating a range of possible responses for each item, rather than using a yes or no checklist format.
   • Modifying the wording and order of individual Self-Assessment items based on pre-testing of the scaled instrument. Administrators, case managers and direct care staff provided feedback about the items and their usefulness, the format of the Self-Assessment, and the new scoring system.
   • Revising the Self-Assessment based on feedback from the pre-testing.

2. Determining the Reliability and Validity of the Self-Assessment Tool
   • Identifying minimally trauma-informed, moderately trauma-informed and highly trauma-informed shelters to pilot the Self-Assessment. Area programs were labeled as low, medium or high using guidelines developed by NCFH based on the principles of trauma-informed care. This step was added so that NCFH could assess whether the Self-Assessment is a valid and reliable instrument that measures the extent to which a shelter is trauma-informed.
   • Piloting the Self-Assessment tool. 87 staff members in nine Massachusetts area shelters used the tool to examine their systems and evaluate the extent to which

they incorporated trauma-informed practices into their programs. Shelter staff members completed the Self-Assessment twice in order for NCFH to analyze the reliability of the measure.

- Analyzing responses to the Self-Assessment. Responses collected during the piloting process were analyzed and items were identified that consistently discriminated between high, medium and low programs. This analysis helped us shorten the tool and determine which items were most representative of highly trauma-informed practices.

3. Evaluating the Change Process
- Pre-testing and post-testing at pilot sites. After completing the Self-Assessment tool, five area shelters agreed to form multi-disciplinary trauma workgroups to work to mobilize systemic changes. NCFH facilitated this process, and assessed training needs. After 4 months of consultation with NCFH, using the Self-Assessment as a guide for creating change, sites completed the Self-Assessment and differences between pre and post-test responses were analyzed.
- Process evaluation of the effectiveness of the Self-Assessment in facilitating programmatic change. Evaluation of the change process included incorporating provider feedback in refining the Self-Assessment, examining the implementation process and its barriers, and defining the necessary steps to expand its use in shelter systems across the country. This evaluation process also helped us develop the Companion Guide and describe the implementation process.

Contact information:
Kathleen Guarino, LMHC/ The National Center on Family Homelessness
617-964-3834 x24
Kathleen.guarino@familyhomelessness.org
www.familyhomelessness.org

Trauma Systems Therapy (TST)

Description: Trauma Systems Therapy (TST) was developed to help agencies and organizations effectively work with traumatized children and their families. This treatment model aims to assist agencies and organizations develop specific and integrated treatment plans for these children and families through the integration of 4 service elements considered critical for providing effective care. These service elements are 1) skill-based psychotherapy, 2) home and community based preventative care, 3) psychopharmacology, and 4) advocacy. TST specifies how these services should be integrated and operationalizes the activities that should occur within each respective service element. TST also includes recommendations on organizational process related to supporting and integrating these 4 service elements. This model is meant to be adapted by organizations based on the services they are already providing and receiving reimbursement for via third party payment. The TST organizational process facilitates an organizations ability to leverage existing programs and resources and forming partnerships with other organizations that may already be providing 'missing' service

elements. The aim of this process is an organizations ability to support a well trained and functioning TST team that includes the aforementioned 4 service elements of TST. This team may include members from different organizations based on how services are organized and reimbursed in a given county or state. This team is trained to develop and implement integrated treatment plans for traumatized children and families with fidelity to the TST model.

TST includes a formalized and specific assessment and treatment planning process. All children with traumatic stress are believed to have problems that relate to 2 main factors 1) the inability to regulate emotional and behavioral states when confronted with a stressor (that usually consciously or unconsciously reminds the child of the traumatic event or events), 2) the inability of the child's social environment and system of care to sufficiently help him or her regulate these emotional states. The assessment, treatment planning, and treatment implementation process has a high degree of focus on these two main factors. TST also assumes that, to be effective, trauma-oriented services must be family-focused, strength-based, and well-integrated with systems of care. Services must also be specific, integrated with, operationalized and delivered close to the source of the problem (e.g. home, school, neighborhood, etc.).

TST includes plans and procedures for engaging all service providers, specific treatment planning forms that can cross systems of care, and legal consultation when needed to help a family access needed services related to recovery from traumatic stress. Specific intervention modalities that are contained within the TST are home-based care, legal advocacy, emotional regulation skills training, cognitive processing skills, and psychopharmacology. TST is specific about engaging families in treatment and specifies ways of building the treatment alliance and troubleshooting practical barriers to treatment engagement.

As described, TST is a central organizing structure that brings together different service systems that are involved in a child's care. In order to provide TST, a service system must be able to provide 4 types of services/skills: individual skills-based psychotherapy, home or community-based care, advocacy, and psychopharmacology. The configuration of a team providing these services differs by community, and is typically built out of existing resources.

TST was developed to service trauma-exposed children ages 6-19. It is particularly useful for children who are contending with complex problems associated with poverty and/or ongoing exposure to stressors. It has been used in urban and rural areas, and adapted for use with young children (ages 3-6)*, substance-using traumatized adolescents, refugee children, medically-traumatized children. It has been implemented in schools, mental health outpatient clinics, through social service departments, in residential care facilities, in medical hospitals (for medically-traumatized youth), and in foster care settings

TST is fully manualized and was published in book form in 2006 (Saxe, Ellis, & Kaplow, 2006).

Status of Research: TST has been fully developed, manualized and can be delivered with fidelity. The results of an open trial of 110 families comprising a cohort of children from inner city Boston and another from rural New York state have been published (Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005). These families were enrolled in TST and assessed 3 months later. These children were largely multiply traumatized and managing significant environmental stressors such as poverty, risk of homelessness, and parental mental illness and substance abuse. While almost 60% of families needed more intensive home and community-based care at the beginning of treatment, only 39% of families needed this level of treatment after 3 months. A recent, not yet published follow up study shows that at 15-months after enrollment in treatment these gains persist and even improve. Unpublished data from a pilot randomized controlled study of TST vs. treatment as usual in an inner city sample of traumatized children show that three months following enrollment in treatment 90% of families receiving TST were still in treatment whereas only 10% of the treatment as usual families were still in treatment. This finding suggests that TST is very effective at engagement, and highlights the importance of 1) family engagement and 2) integration of care within the existing services system.

*currently being adapted for this age group

Saxe, G., Ellis, B. H., & Kaplow, J. (2006). *Collaborative Care of Traumatized Children and Teens: The Trauma Systems Therapy Approach*. New York, NY: Guilford Press.
Saxe, G. N., Ellis, B. H., Fogler, J., Hansen, S., & Sorkin, B. (2005). Comprehensive care for traumatized children: An open trial examines Trauma Systems Therapy. *Psychiatric Annals, 35*(5), 443-447.

Contact information:
Glenn Saxe, Children's Hospital Boston/Harvard Medical School
617 919 4676
Glenn.saxe@childrens.harvard.edu
Website TBD

Trauma-Specific Models for Parenting

Impact of Early Trauma on Parenting Roles

Description: A 14-session group intervention for women whose traumatic experiences of early sexual and /or physical abuse have created symptoms and responses that make parenting tasks difficult. The intervention is designed to address the connections between trauma sequelae and parenting, and help a woman deal with her feelings and responses so that she can be maximally available to parent her children.

Status of Research: No research to date.

Contact Information: To obtain the manual *Non-Traditional Parenting Interventions,* which contains this group intervention, contact
Kate Boucek, M.S.W.,
202-608-4784 or
kboucek@ccdc1.org
For information on training or consultation, call
Rebecca Wolfson Berley, M.S.W., Director of Trauma Training
202-608-4735 or
rwolfson@ccdc1.org
Or visit website at: www.ccdc1.org

Parenting at a Distance

Description: A 10-session group intervention to address issues of parenting for women who are involved in some form of partial parenting, but who do not have full-time residential custody of their children.

Status of Research: No research to date.

Contact Information: To obtain the manual Non-Traditional Parenting Interventions, which contains this group intervention,
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org
For information on training or consultation, contact
Rebecca Wolfson Berley, M.S.W.
Director of Trauma Training
202-608-4735
rwolfson@ccdc1.org

Pathways to Family Reunification and Recovery (Caminos Para la Reunificacion y la Recuperacion): An educational group curriculum for women in recovery

Description: Available in Spanish and English, this multi-session group intervention was developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission and the Institute on Urban Health Research, Northeastern University. The manual focuses on the different possible scenarios that women in recovery may encounter in the process of reuniting with their children. It has some focus on understanding the Department of Social Services regulations and policies but also explores other family dynamics when the children are in custody of the women's sister, grandmother, aunt or any other family members. Curriculum explores the different stages of reunification and the possible reactions and emotions children and mothers might experience when going through this period of transition coming from a foster home or

any other environment. Contains tools for parents to develop nurturing relationships with children.

Status of Research: The Pathways to Family Reunification and Recovery was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a no-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma-integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the 'package' of services and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment 'package.' Three documents are in press for publication indicating that women in the intervention stay in treatment longer and at followup have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2006a). Effects of Trauma Intervention on HIV Sexual Risk Behaviors Among Women with Co-occurring Disorders in Substance Abuse Treatment. *Journal of Community Psychology,* in press.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., Gatz, M. (2006b). Does Integrated Trauma-Informed Substance Abuse Treatment Increase Treatment Retention? *Journal of Community Psychology*, in press.

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma-informed substance abuse treatment on addiction severity, mental health and PTSD symptomatology compared to services as usual. *Journal of Urban Health,* posted on-line March 14, 2007; hardcopy in press

Contact Information: To obtain the curriculum and for further information, contact
Dr. Hortensia Amaro
h.amaro@neu.edu
or
 Rita Nieves, R.N., M.P.H.,
Rita_Nieves@bphc.org

Strengthening Multi-Ethnic Families and Communities: A Violence Prevention Parent Training Program

Description: This program was developed by Marilyn Steele, Ph,D. (Child Clinical Psychologist) in collaboration with Marilyn Marigna (community focus); Jerry Tello (cultural focus), and Ronald Johnson (youth focus), and is a prevention-intervention parent training program for parents with children between 3 and 18 years that addresses violence against the self (drugs/alcohol, depression/suicide), violence in the family (child abuse, domestic violence), and violence against the community (juvenile delinquency, crime, gangs). The curriculum is structured into an Orientation and 12 weekly 3-hour sessions, provides for two community speaker sessions, and integrates anger management

and developmental information in five component areas: Cultural/Spiritual Focus; Rites of Passage; Positive Discipline; Enhancing Relationships, and Community Involvement. This strength-based program emphasizes the importance of spiritual / cultural / family values, and utilizes a "facilitative-discussion" format to enhance parent competence, parent/child interactions, child competence, parent relationships and community involvement. All facilitators must attend a Five-Day Training Workshop.

The program has been used successfully in the US, England, Australia and Ireland with high-risk and hard-to-reach groups, including teen parents, foster parents, court-ordered parents (child abuse, substance abuse, domestic violence), parents of troubled youth, parents of teens, grandparents, fathers, parents of children with developmental challenges, gay parents, single parents, parents in prison, parents with refugee status, and parents who do not read/write or speak English. It has also been used in the wider community in schools (all levels), churches, and with parents whose children are 0-5 years. Parent materials have been translated into Arabic, Bengali, Bosnian-Serbo Croatian, Chinese, Farsi, African-Based French, Hmong, Korean, Laotian, Russian, Samoan, Somali, Spanish, Turkish, Urdu, and Vietnamese. By the end of 2007, the number of translations will increase with the additions of Gujerati, Polish, Punjai, Simplified Chinese, Dinka, and Hazaragi.

Status of Research: The program contains a built-in 32-item Parent Pre/Post Evaluation Process. The results of over 3,000 parent pre/post questionnaires were analyzed and documented in The Monograph: Parenting Styles and Program Impact, Consulting and Clinical Services, 2002.   The program significantly enhanced parent competence in managing child behavior, expression and management of emotions, and access/ utilization of community resources, as well as their perception of their children's self-esteem, self-discipline, and problem-solving skills. Parents reported that the program also enhanced family bonding, community bonding, and pride in cultural heritage. Although analyses revealed interaction effects for individual groups, the program significantly impacted parent attitudes and behaviors, regardless of sex, marital status, ethnic background, level of education, risk factors or child age group.

The Strengthening Families and Communities Program was selected by 30% (2000) and 50% (2001) of the communities receiving funding under SAMHSA's Strengthening Families Initiative.   In a report dated January 2004: Content Analysis of Family Strengthening Final Reports (Cohort I), F. Belgrave, D. Brome, Gears, Inc., consultation by Center for Substance Abuse Prevention & McFarland and Associates, SAMHSA concluded that the Strengthening Multi-Ethnic Families and Communities Program, as compared to other parent training programs, was particularly suited to meeting community high-risk issues, the program was implemented with good fidelity, and grantees made fewer cultural and structural modifications, reporting that the curriculum was already well suited to meeting the needs of their families.

The curriculum's ability to significantly impact six protective factors for 71 women in a home for recovering single mothers is documented in an article published in The Source, Volume 12, No.2; National Abandoned Infants Assistance Resource Center. A research

article entitled "Empowering High-Risk Families of Children with Disabilities," <u>Research on Social Work Practice, Vol. 15, No.6, November 2005, 501-515; M. Farber, Lt. Joseph P. Kennedy Institute, Washington DC,</u> concluded that the curriculum was able to meet the needs of high-risk African American families rearing children with development delays, and that all outcomes evidenced statistically significant and practically meaningful positive trends. A recent evaluation (July 2007) of 82 parent classes in the United Kingdom (2004-2005) concluded that the Program had a positive impact on the participants and the children, and to some extent the wider family/community. Three-fourths (75%) of the participants were of minority ethnic origin, reporting a total of 89 different ethnicities, and almost half (46%) had a first language other than English. Evaluations are currently being conducted for the projects in Australia and Ireland.

Program Materials are only available to individuals/organizations that have trained facilitators to implement the program.

Contact Information: For more information contact
Dr. Marilyn Steele, Ph.D.
Parenting Across Cultures
323-936-0343
<u>dr_mls@earthlink.net</u>,
<u>www.parentingacrosscultures.com</u>

Trauma-Specific Service Models for Children and Family/Parents/Caregivers

Abuse-Focused Cognitive-Behavioral Treatment (AF-CBT)

Description: AF-CBT was developed by David J. Kolko, Ph.D., and updated, in collaboration with Amy D. Herschell, Ph.D., and Barbara L. Baumann, Ph.D., to help children, parents, and families involved in child physical abuse and exposed to related circumstances such as harsh physical discipline/punishment, hostile and emotionally abusive interactions, and chronic family conflict or coercion. With its integration of interventions for caregivers and children/adolescents, AF-CBT seeks to reduce caregiver/family risk factors for physically abusive or coercive behavior and ameliorate the consequences of these experiences for children, at both the individual and family-context levels. Children who have been exposed to physical abuse/coercion are at risk for developing significant psychiatric, behavioral, and adjustment difficulties, many of which may persist through adolescence and young adulthood, and they are at risk for re-abuse. Appropriate candidates for AF-CBT include caregivers who rely upon the use of physical force or hostility with their children, children and adolescents who exhibit externalizing behavior problems, including aggressive behavior, and limited social

competence, and families who present with heightened conflict and coercion, and volatile relationships.

AF-CBT incorporates several behavioral and cognitive-behavioral methods that have been described and examined for use with physically abusive or at-risk families by several investigators over the past few decades. The approach draws from several conceptual models, including behavioral and learning theory, cognitive therapy, family-systems therapy, and developmental victimology. AF-CBT emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, promote positive family relations, and reduce violent behavior. Its primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring/problem-solving, and communication. Common treatment goals include reducing a caregiver's level of anger and use of force, promoting non-aggressive (alternative) discipline strategies, minimizing family risks for re-abuse, enhancing a child's coping skills, and encouraging non-aggressive family problem-solving and communication. With its integration of both individual and joint sessions, AF-CBT is suitable for application by trained practitioners in individual, parent-child or family, and group sessions across diverse outpatient, residential, and home settings. The techniques, relevant handouts, training examples, and outcome measures are integrated in a structured approach designed to enhance accessibility to practitioners and supervisors.

Status of Research: Over the past three decades, many of the procedures incorporated in AF-CBT have been found effective by other investigators in improving child, parent, and/or family functioning, and reducing abuse risk or re-abuse among diverse populations of parents, children, and families. In a clinical trial that examined both clinical and child welfare outcomes through 1-year follow-up, the two main interventions that have now been integrated in AF-CBT (i.e., individual child and parent CBT, family therapy) were evaluated separately and compared to a condition representing usual care (i.e., cases receiving routine services in other community agencies). Weekly ratings of parents' use of physical discipline/force and their level of anger problems during treatment decreased for the two AF-CBT interventions, but the decline was significantly faster for individual CBT than for family therapy (Kolko, 1996a). Compared to routine community services, the individual CBT and family therapy interventions were also associated with significantly greater improvements in child (e.g., less child-to-parent aggression, fewer child externalizing behaviors), caregiver (e.g., decreased child abuse potential, improvement in individual treatment targets reflecting abusive behavior, less psychological distress), and family outcomes (e.g., less conflict and more cohesion), which were generally maintained at follow-up (Kolko, 1996b). Official records revealed abuse recidivism rates of 5% and 6% for the individual CBT and family therapy conditions, respectively, and 30% for those receiving routine services. Both CBT and family therapy had high rates of treatment fidelity, session attendance, and consumer satisfaction.

Much of the material on AF-CBT is found in the book "Assessing and Treating Child Physical Abuse in Children and their Families: A Cognitive-Behavioral Approach" (Kolko, D. J., & Swenson, C. C.), which is available from Sage Publications at www.Sagepub.com or www.amazon.com. Practitioner materials include a treatment

session guide, accompanying workbook, and orientation and stakeholder brochures. The materials are being used on a local, national, and international basis with clients from diverse ethnic, racial, and socioeconomic backgrounds. AF-CBT is currently being examined in a randomized treatment effectiveness trial across several types of community agencies, services, and programs that will evaluate outcomes related to practitioner implementation and child welfare/family health status (www.partnershipsforfamilies.org).

Contact Information: General information about AF-CBT is available from the National Child Traumatic Stress Network (www.nctsn.org).
Information about training in AF-CBT and additional resources for implementing the model are available from:
David Kolko
kolkodj@upmc.edu

Attachment, Self-Regulation, and Competency (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth

Description: ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth, and which are relevant to future resiliency. ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers working with these children and their caregivers, while recognizing that a one-size-model does not fit all. ARC is designed for youth from early childhood to adolescence and their caregivers or caregiving systems.

ARC is a flexible framework, rather than a protocolized intervention. Within the three core domains (attachment, self-regulation, and competency), ten building blocks of trauma-informed treatment and service are identified. ARC is a menu-based approach. For each principle, the ARC manual provides key concepts and guiding theoretical structure, educational information for providers and caregivers, specific tools for clinicians, and developmental considerations.

The ARC framework is built around the following ten building blocks:

Attachment	Self-Regulation	Competency
Caregiver Affect Management	Affect Identification	Developmental Tasks
Attunement	Affect Modulation	Executive Functions
Consistent Response	Affect Expression	Self Development
Routines and Rituals		

The goal of creating the ARC framework was to identify key principles that translate across service system settings. For instance, when applying the attachment principles within outpatient therapy, a clinician may be working with a biological, foster, or adoptive caregiver. Within a milieu setting, systemic staff may take on the role of caregiver.

Although application will vary, the principles remain the same. ARC principles have successfully been applied in a range of settings, including outpatient clinics, residential treatment centers, schools, and day programs.

ARC is designed as an adaptable treatment framework. The goal of designing an adaptable framework was to allow for differences in implementation and application across settings and across populations. To date, ARC has been used with a range of populations (including pre-/post-adoptive, internationally adopted, urban high-risk, Native Alaskan, juvenile justice-involved, child-welfare involved, and war refugee youth), in a range of settings (including outpatient, community mental health, residential treatment, secure facility, domestic violence shelter, and hospital settings), and age groups (ap. age 5 through late adolescent, and their caregiving systems).

Status of Research: ARC is in the pilot stages of evaluation. Formal evaluation (pre-/post-assessment/program evaluation) is being done at all sites currently using ARC. Experimental research has not yet been done, but comparison data is being collected at one site (treatment-as-usual comparison group); this data has not yet been analyzed.

Preliminary data from a pilot study with adoptive children treated in an outpatient setting indicates that ARC leads to reduction in child posttraumatic stress symptoms, anxiety, and depression, as well as increased adaptive and social skills. Caregivers report reduced distress and view their children's behaviors as less dysfunctional.

Kinniburgh & Blaustein (2005)

Contact Information: To obtain materials and acquire additional information: contact:
Kristine M. Kinniburgh, LICSW
Margaret E. Blaustein, Ph.D.
The Trauma Center at Justice Resource Institute
617-232-1303
kkinniburgh@jri.org
mblaustein@jri.org
Main Trauma Center Page: www.traumacenter.org
ARC Information Page: http://www.traumacenter.org/research/ascot.php

Child-Parent Psychotherapy (CPP)

Description: CPP is an evidenced-based treatment for children aged 0-6 who have experienced a trauma. The model incorporates a focus on trauma experienced by the parent, the child, or both. It examines how the trauma and the parents' relational history affect the parent-child relationship and the child's developmental trajectory. A central guiding goal is to support and strengthen the parent-child relationship as a vehicle for establishing and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the parent-child relationship (e.g. culture and socioeconomic and immigration related stressors). Targets of the intervention include

parents' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, parent and child are guided to create a joint narrative of the traumatic event, identify and address traumatic triggers that generate dysregulated behaviors and reinforce mutual traumatic expectations, and place the traumatic experience in perspective. The treatment is detailed in the published manual by Alicia F. Lieberman, Ph.D. and Patricia Van Horn, J.D., Ph.D. titled <u>Don't hit my mommy: A manual for Child-parent Psychotherapy with young witnesses of family violence</u>. Information regarding conducting CPP with children who have experienced the traumatic loss of a loved one is provided in <u>Losing a parent to death in the early years: Guidelines for the treatment of traumatic bereavement in infancy and early childhood.</u>

As noted above, CPP was designed for children aged 0-6 and their caregivers. The model was originally developed as a home visiting model but can and has been implemented in clinic and school settings as well as in a variety of other settings, such as playgrounds and hospitals. The basic theoretical principals and core goals of CPP are thought to apply across diverse groups. The model has been used with a wide range of ethnic minority groups including Spanish and English speaking Latinos (Mexican, Central, and South Americans), African Americans, and Asians (predominantly Chinese). Additional information about the use of CPP with culturally diverse families can be found at http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/CPP_Culture%20_7-13-07.pdf.

Status of Research: Five randomized controlled trials (RCT's) detailed in 7 published studies support the efficacy of CPP with infants, toddlers, and preschoolers. Three of these trials were conducted with trauma-exposed children. These studies support the use of CPP with young children with documented histories of maltreatment and exposure to domestic violence. They also suggest that CPP is efficacious for parents and children who have experienced multiple, chronic traumas. In these studies, CPP was found to be efficacious in terms of reducing child and caregiver general symptoms and PTSD symptoms, strengthening the child-parent attachment relationship, and improving children's representations of themselves, their parents, and their relationships. One study involving a 6-month longitudinal follow-up shows that improvements in child and caregiver symptoms continue after the end of treatment.

Of note, of the five CPP RCT's, four were conducted with predominantly ethnic minorities. CPP is often conducted with Spanish speaking immigrants. One RCT involving 100 Spanish speaking Latina immigrant mothers whose children were anxiously attached found positive treatment effects even in this multiply stressed population.

Contact Information: For information on CPP and training and consultation in this model, contact
Chandra Ghosh Ippen, Ph.D , Child Trauma Research Project
415-206-5312
chandra.ghosh@ucsf.edu.

Combined Parent-Child Cognitive Behavioral Therapy: Empowering Families At-Risk for Physical Abuse to Develop Healthy Outlooks and Positive Environments

Description: Combined Parent-Child Cognitive-Behavioral Treatment (CBT), which was developed by Treatment Services Director Melissa K. Runyon, PhD, in collaboration with Esther Deblinger, PhD, at the Institute, is an evidence-based treatment model that aims to empower parents to effectively parent their children in a non-coercive manner, improve parent-child relationships, assist children in healing from their abusive experiences, and enhance the safety of family members. This model helps to reduce the risk of the recurrence of child physical abuse in children and families at-risk for child physical abuse. The model incorporates elements from TF-CBT model for sexually abused children, which was co-developed by the Institute's Clinical Director Esther Deblinger, PhD, and other CBT models targeting families in which physical abuse and domestic violence occurs.

The program offers both group and individual therapy to children, ages three to 18, and their caregivers. The group therapy program is time-limited and consists of 16-two hour sessions which involve meeting with both parents and children separately and together. The individual therapy program consists of 90 minute sessions which involve meeting separately with both the parent and child, as well as family meetings. The length of therapy may exceed 16 sessions if necessary.

The treatment consists of three components:
(1) Child Intervention
(2) Parent Intervention
(3) Parent-Child Intervention

Parent and child interventions are conducted concurrently for the first hour of each session, while the end of the session involves integrated joint parent-child therapy. Over the course of group sessions, more time is devoted to the joint parent-child sessions during which families receive individual attention from a consistent coach.
Some of the topics covered in the structured therapy sessions include:
• Providing parents with information concerning emotional and behavioral effects on children of severe corporal punishment and child physical abuse
• Providing education about realistic expectations for children's behavior based on developmental level
• Empowering parents to be effective by working collaboratively with them to develop adaptive coping skills, non-violent conflict resolution skills and a variety of child behavior management skills
• Teaching children a variety of positive coping skills (i.e., identification and expression of feelings, cognitive coping, assertiveness and anger management)
• Enhancing safety and communication in the family by developing a safety plan and discussing and processing past abusive interactions

Status of Research: For information, contact Melissa K. Runyon, Ph.D.

Contact Information:
Melissa K. Runyon, Ph.D., Associate Professor of Psychiatry
runyonmk@umdnj.edu

International Family Adult and Child Enhancement Services (IFACES): A Comprehensive Service Model for Refugee Children

Description: International Family, Adult and Child Enhancement Services (FACES), a community-based mental health program of the Heartland Alliance for Human Needs & Human Rights, provides comprehensive services to children, adolescents, and their families from a variety of countries. The organization, formerly known as Travelers and Immigrants Aid, has been providing a range of services for immigrants since 1888. Comprehensive refugee resettlement services were begun in 1976, initially designed for Southeast Asian refugees fleeing Vietnam following the fall of Saigon. Because of concerns among resettlement workers about mental health issues among this population, a program was established in 1978 for bilingual and bicultural paraprofessionals to serve as a bridge to existing mental health services for refugees that needed them. However, even with such supports, few refugees gained access and were engaged in mental health services at mainstream agencies. As a result, the program was expanded to include professional mental health staff, as the population of traumatized refugees increased with an influx of Bosnians in the mid 1990's. Clinicians now worked with bilingual/bicultural paraprofessionals to provide linguistically competent and culturally sensitive mental health services. However while children and adolescents were seen by mental health staff in the context of providing family services, they were not the focus of the treatment team.

The larger organization continued to grow, and in 1995 the name was changed from Travelers and Immigrant Aid to Heartland Alliance for Human Needs & Human Rights. This change signaled a transition to embracing a human rights perspective on service delivery (Batia, Beehler, & Birman, in press), emphasizing empowerment and respect for those receiving services, and referring to them as "program participants" rather than "clients". The agency also transitioned to serving a broader range of high risk and high need populations, such as people who were homeless and had severe mental illness. This led to cross-fertilization between newly formed community based programs, such as the Assertive Community Treatment (ACT) teams, and the evolving refugee mental health services.

In 1999 FACES was established with a focus on children and adolescents. The program provides culturally informed multidisciplinary services in both the office and community settings when indicated. The outreach-oriented services model has evolved as a result of staff efforts to create a program that can be culturally sensitive and creative around overcoming obstacles to providing services for refugees from a variety of different cultural and linguistic backgrounds. Like ACT and mental health work with people who are homeless, the FACES team provides case management services, tending to basic survival needs and adjustment challenges, often prior to beginning more traditional mental health services. Case management activities build trust between the program

participant and staff and allow for assessment and engagement into mental health services at the same time.

The staff at FACES uses a team approach. The team is multidisciplinary, and includes a psychologist, master's level clinicians, an art therapist, a dance therapist, an occupational therapist, and a child psychiatrist, and practicum students from local mental health training programs who provide services under supervision of staff. In addition, ethnic mental health workers are recruited from refugee groups that are being served by the program. While each program participant is assigned to a primary staff member, multiple team members provide different services as intensively as deemed necessary by the team, in accordance with the service plan designed by the team. This approach allows team members to share responsibility for meeting the sometimes overwhelming needs of program participants, thereby supporting one another and reducing staff stress. A team approach also ensures that a range of resources are available to the participants, and that the cultural context and norms are understood broadly across disciplines.

The team is not only multidisciplinary, but also multi ethnic. Ethnic mental health workers have themselves come to the U.S. as refugees, and are a critical link to the refugee communities, able to conduct outreach, and work in partnership with clinical staff as both interpreters and cultural brokers. The ethnic mental health workers during the time of the study were Congolese, Kosovar, Togolese, Algerian, Bosnian, and Ethiopian, and spoke the following languages: Albanian, Amharic, Arabic, Berber, Bosnian, French, Kurdish, Lingala, Oromo, Swahili, and Tigrinya.   In addition to English, clinical staff also spoke Spanish, Russian, and Ukrainian. As a result, in all, FACES staff spoke 15 different languages among them during the time of the study. Although not every ethnicity and language is covered by the team, a concern with culture is at the forefront of the work. If a child being served speaks a language not represented within the team, a trained health care interpreter provided by the agency's Cross Cultural Interpreting Service serves in a similar capacity as the FACES ethnic mental health worker.

FACES services are provided to program participants at locations that are most comfortable and convenient for them, including at home, in the community, or at school. This helps to reduce the stigma associated with seeking services at a mental health clinic, and allows staff to observe and intervene in children's natural settings. Consultation with other providers, such as teachers, and advocacy with other service systems is also seen as an important component of the mental health service.

In summary, the service provided by FACES are designed to address the kinds of barriers to services faced by refugee children and families, and to be responsive to the resettlement stress the families experience while addressing the mental health concerns of the children and youth. Ethnic mental health workers conduct extensive outreach in the refugee communities, and services are provided at locations most comfortable for the program participants. While clinical staff provide therapeutic interventions to address specific mental health concerns, both clinical staff as well as the ethnic mental health workers also provide tangible assistance to families when needed to help them in resettlement (e.g. housing, transportation, school placement).

Status of Research: For information contact Dr. Liautaud (below)

Contact Information:
Joan M. Liautaud, Psy.D., Director of Clinical Operations
jliautaud@heartlandalliance.org
773/751-4054
www.heartlandalliance.org

Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma

Description: This is a parenting curriculum offered in groups for women and children in recovery from substance abuse, mental illness, and trauma. The curriculum provides a first step in repairing the fractured parent-child relationship by helping families work toward a place where they can grow and heal together. Developed and piloted by the Institute for Health and Recovery as part of the Women Embracing Life and Living (WELL) Project—one of nine SAMHSA Women, Co-Occurring Disorders and Violence Study sites—the curriculum builds upon IHR's Nurturing Program for Families in Substance Abuse Treatment and Recovery, which was recognized by the Center for Substance Abuse Prevention as a model program for best practices in strengthening families. The WELL Project adapted this curriculum to encompass the needs of families affected by substance abuse, mental illness, and trauma.

The model is based on the relational development principles of authenticity, mutuality and empathy, and emphasizes the critical role self-nurturing plays in the lives of women who are parenting and in recovery. It consists of three modules.

- Module 1. One-on-one mentoring and intensive skills building. Two sessions on setting goals, and building connections.
- Module 2. Nurturing families affected by substance abuse, mental illness and trauma group. Twelve 90-minute sessions designed to increase parents' understanding of the effects of substance abuse, mental illness and trauma on their lives and the lives of their families.
- Module 3. Four sessions on parent-child skill-building activities, when parents and children engage in structured skill-building activities designed to repair and strengthen the bond between them.

The curriculum is intended to enhance coping strategies through concept presentations, practice sessions, role-plays, and activities, and it includes a skills-building component to apply techniques and strategies. Each session covers a different topic including hope; building trust; self-esteem; setting boundaries; family communication; feelings; managing stress; guiding behavior; schedules and routines; safety and protecting children; helping families grieve; and having fun.

Groups of no more than 12 participants are implemented in a variety of settings including inpatient, outpatient, and community-based service agencies. Women may join at any time throughout the series.

Since the development of this curriculum, a second edition of our original Nurturing Program for Families in Substance Abuse Treatment and Recovery has been published, incorporating trauma and other information learned through the development and use of the Nurturing Families curriculum.

Status of Research: A demonstration project measured the impact of implementing the original Nurturing Program in two urban residential treatment programs in Massachusetts for pregnant and parenting chemically-dependent women. Women in both programs made dramatic improvements in self-esteem and experienced significant gains in parenting knowledge and attitudes. Participants were also overwhelmingly positive about the impact of the parenting training on their lives. A number of other studies have been done around the country that have shown positive outcomes from using the Nurturing Program, including in California, Rhode Island, Florida, and Massachusetts. In addition, the original Nurturing Program is listed on the California Evidence-Based Clearinghouse for Child Welfare, an on-line connection that provides up-to-date information on evidence-based child welfare practices.

Contact Information: To obtain the manual <u>Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma,</u> to obtain copies of published articles about the original curriculum, or for information on training and consultation, contact
Terri Bogage
617-661-3991
terribogage@healthrecovery.org
www.healthrecovery.org

Parent-Child Interaction Therapy (PCIT)

Description: Parent Child Interaction Therapy (PCIT) is an evidence-based intervention developed by Sheila Eyberg, PhD, for oppositional and disruptive children aged 2-7 and their parents. It has been modified as a promising practice for the treatment of children aged 2-12 with trauma and/or maltreatment histories and their parents. PCIT addresses the common behavior challenges and/or relationship difficulties often seen in children who have had complex trauma histories. PCIT stabilizes family relationships and sets the stage, when necessary, for subsequent trauma-focused treatment.

PCIT offers effective parenting skills transmitted by the therapist, using live coaching, while parents or caregivers interact with children during two sequential treatment components of several weeks each: a relationship enhancement component followed by a positive discipline component. PCIT is a criteria-based therapy, so that parents progress to the next treatment stage when they demonstrate mastery of key skills during weekly 5-minute coded interactions. PCIT is typically completed in 12-20 sessions.

The goals of PCIT treatment are:
- An improvement of the parent-child or caregiver-child relationship;
- An increase in children's prosocial behaviors and a decrease in child behavior problems;
- An increase in positive parenting skills and a decrease in negative disciplinary behaviors by parents;
- A decrease in parental stress.

Dr. Eyberg's evidence-based, session by session PCIT manual, coding manual and workbooks are available at PCIT.org, the University of Florida's PCIT website. Current protocols and checklists for the modifications suitable to treat older children (7-12) or traumatized children and their caregivers are made available during trainings conducted by the Trauma Treatment Training Center at Cincinnati Children's Hospital or the Indian Country Child Trauma Center at the University of Oklahoma. Additional PowerPoint and research materials are available at PCIT.org; www.OhioCanDo4Kids.org, OKPCIT.org, and www.pcit.tv.

Modifications
PCIT's relationship enhancement component (Child-Directed Interaction or CDI) remains unchanged from its evidence-based original, but there have been necessary modifications to the discipline component (Parent-Directed Interaction or PDI) for older children with a primary referral of family violence. The original PCIT for disruptive children aged 2-7 includes physical prompts for children who noncomply during PDI (e.g., physically moving the child to a timeout area.). When Chaffin et. al (2004) adapted PCIT for physically abusive parents with children aged 7-12, they replaced the required or prompted compliance for preschool children with graduated consequences for noncompliance in school-aged children. Centers who train foster parents or parents have also replaced the hands-on timeout room backup used in the original PCIT with loss of privileges as timeout backup when developmentally appropriate. This modification brings the intervention into compliance with SAMHSA's guidelines limiting the use of isolation and restraint with children. There is evidence from research on similar parenting programs that loss of privileges as a backup for timeout is effective (Barkley, 1997; Forgatch, Bullock, & Patterson, 2004).

Cincinnati's Trauma Treatment Training Center teaches loss of privilege rather than timeout room isolation as backup for a child's timeout chair noncompliance. Preliminary outcome data on this modification as used by community providers trained by the Cincinnati team demonstrates its effectiveness as a promising practice, with results showing significant improvement on several measures regarding problem behavior, trauma symptoms, dissociative characteristics, and stress levels of caregivers.

PCIT is grounded theoretically in developmental, social learning, family systems, and attachment theory. PCIT's strongest evidence base is for oppositional defiant children aged 2-7 and their parents, but there is a growing body of evidence for its application to older children when physical abuse is the presenting concern (up to age 12) and families

with trauma and maltreatment histories. It is effective with single parents, cognitively limited parents, court-ordered parents, two-parent families, and foster parents. Cultural adaptations have been effective with Latino/Hispanic families, African American Families, and Native American families. PCIT has been disseminated internationally (e.g., Hong Kong, Norway, The Netherlands) and has been translated into different languages (e.g., Spanish and Mandarin).

PCIT has been adapted for:
> Head Start classrooms;
> Group treatment;
> Home rather than office based sessions;
> Domestic violence shelters;
> Residential treatment centers.

Status of Research: PCIT is supported by more than 20 years of research and practice (Herschell, Calzada, Eyberg, & McNeil, 2002), and there are over 100 published research articles and book chapters, and doctoral dissertations including several randomized controlled studies showing its effectiveness. Hood & Eyberg (2003) examined the long-term maintenance of changes following PCIT for young children with Oppositional Defiant Disorder (ODD) and associated behavior disorders. Results indicated that the significant changes that mothers reported in their children's behavior at the end of treatment were maintained at long-term follow-up three to six years after treatment.

PCIT has been shown to significantly improve outcomes for high-risk families (Ware, Fortson, & McNeil, 2003; Timmer, Urquiza, Zebell & McGrath, 2005; Urquiza & McNeil, 2006). In a randomized controlled study by Chaffin, et al. (2004), 19 percent of parents assigned to PCIT had a re-report for physical abuse at a median of 850 days after treatment termination compared with 49 percent of parents assigned to the standard community parenting group.

Adaptations for PCIT have been and continue to be studied for various populations in several PCIT laboratories and training sites. McCabe et al. (2005) have developed the GANA program for Mexican American families in PCIT, and Choate, Pincus, Eyberg, & Barlow (2005) have adapted PCIT for children with Separation Anxiety Disorder. In a recent CDC-funded project, PCIT has been effective in children with Fetal Alcohol Spectrum Disorders and other prenatal substance exposure (Gurwitch, Mulvihil, Chaffin, et al., in preparation)

1. Barkley, R.A. (1987). Defiant children: A clinician's manual for parent training. New York: Guilford Press.
2. Chaffin, M., Silovsky, J.F., Funderburk, B., Valle, L.A., Brestan, E.V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B.L. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, 72(3), 500-510.
3. Choate, M. L., Pincus, D. B., Eyberg, S. M., & Barlow, D. H. (2005). Parent-Child Interaction Therapy for treatment of separation anxiety disorder in young children: A pilot study. *Cognitive and Behavioral Practice, 12*, 126-135.

4. Forgatch, M. S., Bullock, B. M., & Patterson, G. R. (2004). From theory to practice: Increasing effective parenting through role-play. The Oregon Model of Parent Management Training (PMTO). In H. Steiner, K. Chang, J. Lock & J. Wilson (Eds.), *Handbook of mental health interventions in children and adolescents: An integrated developmental approach* (pp. 782-812). Hoboken, NJ: Jossey-Bass.
5. Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent-Child Interaction Therapy*. Delete until 2nd edition available?
6. Herschell, A. D., Calzada, E. J., Eyberg, S. M., & McNeil, C. B. (2002). Clinical issues in Parent-Child Interaction Therapy. *Cognitive and Behavioral Practice*, 9, 16-17.
7. Hood, K. K., & Eyberg, S. M. (2003). Outcomes of Parent-Child Interaction Therapy: Mothers' reports of maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology, 32(3)*, 419-429.
8. McCabe, K.M., Yeh, M., Garland, A.F., Lau, A.S., & Chavez, G. (2005). The GANA Program: A Tailoring Approach to Adapting Parent Child Interaction Therapy for Mexican Americans. *Education & Treatment of Children, 28(2)*, 111-129.
9. Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parent-child interaction therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect, 29*, 825-842.
10. Ware, L. M., Fortson, B. L., & McNeil, C. B. (2003). Parent-child interaction therapy: A promising intervention for abusive families. *The Behavior Analyst Today, 3(4)*, 375-382.

Contact Information:
For information on PCIT training: Dr. Sheila Eyberg of the University of Florida (PCIT.org) and the University of California Davis CAARE Center (www.pcit.tv). University of Oklahoma Health Sciences Center (http://devbehavpeds.ouhsc.edu/pcit.asp) Trauma Treatment Training Center-Cincinnati Children's Hospital (www.OhioCanDo4Kids.org).
For information on PCIT research labs: Go to http://pcit.org
For information on PCIT dissemination studies: contact University of Oklahoma Health Sciences Center and University of Washington – Seattle Harborview.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for Children and Parents; Cognitive Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG); Combined TF-CBT and Sertraline for Children

Description: TF-CBT and its adaptations were developed by Judith A. Cohen, M.D., Anthony P. Mannarino, Ph.D, and Esther Deblinger, Ph.D. to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disaster, terrorist attacks, or war trauma. TF-CBT was developed by integrating cognitive and behavioral interventions with developmental, psychobiological, humanistic and psychodynamic principles in order to restore and enhance children's interpersonal trust, empowerment and resilience. Whenever possible this model also includes parents or other caretakers in treatment in order to focus on strengthening familial support and relationships. TF-CBT can be provided to children 3 to 18 years old and their parents by trained mental health professionals in individual, family, or group sessions in outpatient, residential, home or foster home or school settings. TF-CBT targets symptoms of posttraumatic stress disorder (PTSD) such as intrusive thoughts of the traumatic event; avoidance of reminders of the trauma; emotional numbing; excessive physical arousal/activity; irritability; trouble sleeping or concentrating, as well as

depressive, anxiety and behavioral symptoms which often co-occur with PTSD. The intervention also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. **The childhood traumatic grief (CTG)** adaptation of the model, **CBT –CTG**, was developed by adding grief-focused components to TF-CBT. CBT-CTG has been used with diverse populations including uniformed service families, survivors of domestic homicides, disaster survivors and victims of war. The **TF-CBT + Sertraline model** was designed and evaluated because many traumatized children receive selective serotonin reuptake inhibitors (SSRI) and/or other medications in usual care despite few studies to evaluate whether this approach is helpful.

Status of Research: **TF-CBT** is recognized as a Model Program by SAMHSA. Compared to traumatized children receiving other forms of active therapy such as child-centered therapy, children receiving TF-CBT experience significantly greater improvement in: PTSD symptoms, depression, negative attributions (such as self-blame) about the traumatic event, defiant and oppositional behaviors, social competency, and anxiety. The **CBT-CTG** model has been tested in two open studies and one small randomized trial; children with CTG symptoms experienced significant improvement in CTG and PTSD symptoms while parents experienced significant improvement in their own PTSD symptoms and functioning. In contrast, in a pilot randomized trial the **TF-CBT + Sertraline** model did not appear to be more effective than TF-CBT + placebo in reducing children's PTSD or other symptoms.

The TF-CBT and CBT-CTG treatment models are described in the book "Treating Trauma and Traumatic Grief in Children and Adolescents" which is available from www.guilford.com or www.amazon.com. The manual has been translated into Dutch and German. TF-CBT and CBT-CTG are being implemented internationally, particularly in Zambia where assessment instruments and the manual are being adapted to be culturally appropriate. Other international implementation projects are occurring in Germany, Holland, Israel, Norway and Pakistan. Many resources for implementing TF-CBT are available in Spanish and can be obtained at www.musc.edu/tfcbt. Free online training in the TF-CBT model is available to licensed mental health professionals at www.musc.edu/tfcbt; 10 free CE credits are provided to course completers. Limited opportunities to participate in TF-CBT Learning Collaboratives are available through the National Child Traumatic Stress Network (www.nctsn.org).

Contact Information:
For information on training in the TF-CBT model and implementation resources see www.musc.edu/tfcbt or at www.pittsburghchildtrauma.org.
For information about participating in a TF-CBT Learning Collaborative, contact
Jan Markiewicz
jmarkiewicz@psych.duhs.duke.edu
For more information visit:
www.modelprograms.samhsa.gov or contact:
Judith Cohen
jcohen1@wpahs.org

Trauma Systems Therapy

Description: Trauma Systems Therapy (TST) was developed to help agencies and organizations effectively work with traumatized children and their families. One of the aims of this treatment model is to facilitate the development of trauma informed service systems. Details of TST within the services system is provided in section *Trauma-Informed Models for Service Systems and Organizations: Children* of this manual.

TST contains 4 operationalized and integrated service elements considered critical for providing effective traumatic stress care. These service elements are 1) skill-based psychotherapy, 2) home and community based preventative care, 3) psychopharmacology, and 4) advocacy.

TST conceptualizes child and adolescent traumatic stress as the interface of two conceptual axes: 1) the degree of emotional and behavioral dysregulation when a child is triggered by overt and subtle reminders of a trauma and 2) the capacity of the child's social-ecological environment to protect the child from these reminders, or help the child to regulate emotions in the face of such reminders.

The treatment is phase-based, and recommends different treatment modules depending on the degree of emotional dysregulation and the stability of the social environment. Treatment proceeds in stages depending on the child's degree of emotional/behavioral regulation and environmental stability (see Table 1). Children experiencing greater dysregulation of emotions and more unstable environments are assessed to be in a more acute stage, and receive correspondingly more intensive interventions. Recommended treatment modules for the most acute problems include modules that focus specifically on aspects of the social environment that are believed to be impacting the child's symptomatology. Children move from one module to the next based on improvements in the stability of the social environment and/or emotional regulation. As children transition to a more stable environment, and demonstrate better emotional regulation skills, the focus of the intervention plan shifts and may include more office or clinic-based work to help the child develop coping skills or cognitively process the trauma.

TST was developed to service trauma-exposed children ages 6-19. It is particularly useful for children who are contending with complex problems associated with poverty and/or ongoing exposure to stressors.   It has been used in urban and rural areas, and adapted for use with young children (ages 3-6)*, substance-using traumatized adolescents, refugee children, medically-traumatized children. It has been implemented in schools, mental health outpatient clinics, through social service departments, in residential care facilities, in medical hospitals (for medically-traumatized youth), and in foster care settings

Status of research: TST has been fully developed, manualized and can be delivered with fidelity. results of an open trial of 110 families comprising a cohort of children from

inner city Boston and another from rural New York state have been published (Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005). These families were enrolled in TST and assessed 3 months later. These children were largely multiply traumatized and managing significant environmental stressors such as poverty, risk of homelessness, and parental mental illness and substance abuse. While almost 60% of families needed more intensive home and community-based care at the beginning of treatment, only 39% of families needed this level of treatment after 3 months. A recent, not yet published follow up study shows that at 15-months after enrollment in treatment these gains persist and even improve. Unpublished data from a pilot randomized controlled study of TST vs. treatment as usual in an inner city sample of traumatized children show that three months following enrollment in treatment 90% of families receiving TST were still in treatment whereas only 10% of the treatment as usual families were still in treatment. This finding suggests that TST is very effective at engagement, and highlights the importance of 1) family engagement and 2) integration of care within the existing services system.

*currently being adapted for this age group

Contact information:
Glenn Saxe, Children's Hospital Boston/Harvard Medical School
617 919 4676
Glenn.saxe@childrens.harvard.edu
Website TBD

Trauma-Specific Service Models for Children

Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP)

Description: The Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP) is a treatment model developed by the Chadwick Center for Children & Families at Rady Children's Hospital in San Diego. The TAP model incorporates assessment, triage, and essential components of trauma treatment into clinical pathways designed to treat children from 2-18 years of age who have experienced one or more traumatic events or situations. This model is meant to be adaptable and flexible in order to meet the cultural and language needs of the child and his or her family. The goals of TAP include: (1) providing treatment center staff with the knowledge and skills to incorporate standardized assessments into the intake and ongoing treatment process; (2) providing a treatment model that is directed by the uniqueness of the child and his or her family; (3) providing guidelines for clinicians to make decisions regarding trauma treatment strategies based upon the child's unique presentation. TAP is divided into two parts. Part I of the model describes the assessment process how to develop a Unique Client Picture, how to triage, and when to make referrals. Part II focuses on trauma treatment and includes an explanation of evidence-supported

interventions found in the literature that are organized into a "Trauma Wheel" and used to create a "Treatment Pathway."

As stated previously, the TAP model has three components. The first component is Assessment, which includes clinical interview, behavioral observations, and standardized assessment measures that help clinicians organize and understand the client's symptom presentation, history, cultural and family influences. This process leads to the creation of the Unique Client Picture, and guides the clinician as they hypothesize about the bases for the client's problems and identify treatment needs. Triage is the second component of TAP and is the process in which children are referred to the most appropriate and available evidenced-based treatment (i.e. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Abuse-Focused Cognitive Behavioral Therapy (AF-CBT), or Parent Child Interaction Therapy (PCIT)) and/or other additional services (i.e. medication evaluation, Kids in Court programs, mentor programs, etc.) based on the needs of the child and his/her family. Decision trees are available to help the clinician to make appropriate triage decisions based on assessment and the Unique Client Picture. The third component is Treatment. This component of the model is defined through the Trauma Wheel and the Treatment Pathway. These identify and structure the use of essential elements of trauma treatment for children based upon the most current research evidence. Treatment through the TAP model is used when a child does not fit specific criteria for existing evidence-based treatment models or needs additional treatment after receiving treatment through a referred treatment model. Treatment through the TAP model is also used when the most appropriate evidenced-based treatment is not available (i.e. no training or appropriate setting).

The Trauma Wheel includes Relationship Building, Child Development, Cultural Influences, Psychoeducation and Skill Building, Maladaptive Cognitions, Affect Regulation, and Trauma Integration. The first three features of the wheel, relationship building, child development, and cultural influences, are considered ongoing influences and considerations. These aspects of the wheel influence how a clinician will proceed with therapy and will influence decisions about types of interventions used during the course of treatment. The other features of the Trauma Wheel are considered essential components of trauma treatment for children and are also included in the Treatment Pathway. The Treatment Pathway helps the clinician decide where to begin in treatment based on the Unique Client Picture. During the course of treatment, the clinician spends time on each component of the Trauma Wheel, but the length of time and order of intervention depends on the Unique Client Picture. Decisions concerning order of interventions and any changes in treatment are influenced by ongoing assessment, including follow-up standardized assessments, behavioral observations, and clinical interview. Treatment tasks are provided with the intent that specific interventions used to address the treatment tasks are selected based on the needs of the individual client and his/her Unique Client Picture.

Status of Research: Although the TAP model is still in the early stages of research, we have been testing the TAP model within the Chadwick Center and with some of our partner National Child Traumatic Stress Network (NCTSN) sites. Initial efforts focused on the

utility of assessment measures in the treatment process. Results of this pilot test are reported in an unpublished article by Hazen and colleagues (2006). Thirty-five Chadwick Center clinicians participated in a survey regarding the utility of assessment measures in the treatment process. On average, clinicians felt that assessment measures were only moderately useful for identifying client problems, developing treatment goals, and initial treatment plans, as well as monitoring progress in treatment. Most clinicians indicated a need for further training on administration and clinical use of assessments. Based on the results of this study, the TAP Model was created to fulfill this need by providing pathways for making assessment decisions and instruction on integrating assessments into treatment planning, triage, and tracking treatment progress. Guidelines for integrating assessment information to form the Unique Client Picture were also included in the model, along with decision and triage trees intended to help clinicians make referral, triage, and treatment decisions for their clients.

The Chadwick Center is currently in the process of testing the TAP model at four independent sites across the country. Clinicians trained thus far (*N* = 47) report they are able to confidently make sense of information obtained through assessment, interview, and observation, and create clinical hypotheses and the Unique Client Picture using the revised TAP Model. They feel confident in their ability to provide assessment results to clients and monitor change throughout the course of treatment. In addition to the reported studies, several studies are either currently underway or are in the stages of development. These studies involve an independent study on the implementation of the TAP model at the four NCTSN sites trained, a case study and a treatment outcome study examining triage and treatment decisions made by therapists using the TAP model and symptom changes as a result of treatment through the TAP model at the Chadwick Center.

Hazen, A., Taylor, N., Landsverk, J., Ryan, B.E., Garland, A., Wilson, C. (2006). *Clinician Perspectives on the Use of Standardized Assessments in Mental Health Services for Maltreated Children.* Unpublished Manuscript.

Taylor, N., Gilbert, A., Mann, G., & Ryan, B.E. (2005). *Assessment-based treatment for traumatized children: A trauma assessment pathway*. San Diego, CA: Chadwick Center for Children & Families.

Contact Information:
Alicia Gilbert, PhD, TAP Training Coordinator
(858) 966-8682
agilbert@rchsd.org   or
Lisa Conradi, PsyD, NCTSN/SAMHSA Project Manager
(858) 576-1700 ext. 6008
lconradi@rchsd.org
For further information see:
www.chadwickcenter.org

Cognitive Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG)

Please refer to Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for Children and Parents in Section on "Trauma-Specific Service Models for Children and Family/Parents/Caregivers", on page ___ of this manual.

Complex Trauma Cognitive Behavioral Therapy

Description: Complex Trauma Cognitive Behavioral Therapy (CT-CBT) was developed by David J. Kolko, Ph.D., Judith A. Cohen, M.D., Anthony P. Mannarino, Ph.D, Esther Deblinger, Ph.D., and Elissa J. Brown, Ph.D. to address the severe, varied trauma-related psychopathology among children and adolescents served in inpatient psychiatric facilities. Psychopathological syndromes experienced by the inpatient youth include: oppositional defiant disorder, conduct disorder, substance-related disorders, posttraumatic stress disorder and other anxiety disorders, bipolar depression, and major depressive disorder. Thus, CT-CBT is a combination of two empirically-supported trauma-specific interventions designed to reduce: (1) behavior problems and social-cognitive deficits (Abuse-Focused Cognitive Behavioral Therapy) and (2) internalizing symptoms and trauma-specific fears (Trauma-Focused Cognitive Behavioral Therapy).

Abuse-Focused Cognitive Behavioral Therapy (AF-CBT) was developed by David J. Kolko, Ph.D. to help physically-abused youth and their caregivers. AF-CBT specifically aims to reduce children's aggression and oppositional behavior and families' use of interpersonal violence. AF-CBT incorporates conceptual principles and therapeutic procedures from several areas (e.g., learning, behavioral therapy, family-systems theory, cognitive therapy, developmental victimology). Treatment emphasizes instruction in specific intrapersonal (e.g., cognitive, affective) and interpersonal (e.g., behavioral) skills designed to promote the expression of prosocial behavior and discourage the use of coercive/aggressive behavior at both the individual and family levels. CT-CBT includes the following AF-CBT components: affection regulation skills, psychoeducation about interpersonal violence and cognitive behavioral therapy, relaxation training, social problem solving, and anger management.

TF-CBT was developed by Judith A. Cohen, M.D., Anthony P. Mannarino, Ph.D, and Esther Deblinger, Ph.D. to help youth and their caregivers overcome the negative effects of child sexual abuse. TF-CBT targets symptoms of posttraumatic stress disorder, anxiety, depression, and self-injurious behavior, such as substance abuse. CT-CBT emphasizes the following TF-CBT components: cognitive restructuring and developing a trauma narrative. Cognitive restructuring helps children systematically identify and challenge negative or distorted thoughts that may be precursors of emotional problems. The trauma narrative is designed to habituate children to cues of the trauma (e.g., smells, sights, sounds) without the feared consequences, such that emotional distress and avoidance decrease. The trauma narrative also helps children contextualize the trauma. During the narrative sessions, children and their therapist will identify previously

unreported emotions and cognitions associated with the trauma. These will be addressed systematically using the aforementioned coping skills, especially cognitive restructuring.

After completion of AF- and TF-CBT components, youth complete a "tool box reminder." The tool box reminder is a creative representation of the skills they have learned in therapy. It not only allows the youth to teach the skills to others (resulting in having a better understanding of them), but provides relapse prevention against future trauma-related mental health problems.

Although both AF-CBT and TF-CBT were designed as child-caregiver programs, the inpatient youth have little contact with their caregivers. As a result, CT-CBT was designed for the children and adolescents, with the ability to include caregivers should they choose to participate.

CT-CBT was developed for children and adolescents, age 10-to-17-years old, of diverse racial, ethnic, and socioeconomic backgrounds, and complex trauma histories. The intervention is conducted at inpatient psychiatric facilities in individual sessions, the length of which vary from 20 to 45 minutes, depending on the abilities of the patient.

Status of Research: CT-CBT is currently being evaluated by Dr. Brown in a randomized clinical trial comparing CT-CBT to treatment-as-usual with 10-17-year-old youth in an inpatient psychiatric facility in New York City.

Contact information: to obtain materials and acquire additional information, contact:
Elissa J. Brown, Ph.D., Associate Professor of Psychology, St. John's University
718-990-2355
browne@stjohns.edu
http://stjohns.edu/academics/centers/psychology/partners/partners.stj

Component Therapy for Trauma and Grief (CTTG)

Description: Developed by Christopher Layne, Ph.D., William Saltzman, Ph.D., and Robert Pynoos, M.D., M.P.H., Component Therapy for Trauma and Grief (CTTG) is a manualized treatment for trauma-exposed or traumatically bereaved older children and adolescents that may be implemented in school, communty mental health, or other service settings. The program has been implemented with a wide range of trauma-exposed and traumatically bereaved older child and adolescent populations, in both the United States and international settings. These populations include youth impacted by community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events. Individual session length is an average of 50 minutes. (Sessions can be shortened in length to accommodate school class periods. Alternatively, individual sessions can be expanded up to 90 minutes in length, as needed and if time allows.) Depending on the number and types of treatment modules that are implemented, the total number of sessions ranges from 10 to 24. The

program is applicable to either individual or group-based treatment modalities and guidelines are provided for adapting the program in a culturally and ecologically sensitive manner. CTTG is specifically designed to identify and effectively treat youths whose distress and dysfunction fall within the severely distressed, as well as moderately distressed, ranges. It is thus intended to address the needs of the most severely exposed, as well as moderately exposed, youths.

CTTG is a multi-component (modularized) treatment manual and accompanying workbook with detailed instructions for conducting individual or group sessions. The intervention is assessment-driven, with specific treatment modules being selected for implementation based on clients' problems, needs, and strengths. The intervention contains a variety of components. These include (a) initial assessment, case conceptualization, and treatment planning; (b) psychoeducation, (c) emotional regulation skills, (d) addressing youths' and families' traumatic stress experiences and reactions, (e) promoting adaptive coping (e.g., social support, problem-solving, contending with trauma and loss reminders), (f) addressing maladaptive beliefs relating to trauma and loss, (g) promoting adaptive developmental progression, (h) addressing grief and loss, (i) maintaining adaptive routines, (j) relapse prevention, and (k) ongoing monitoring, surveillance, and evaluation of treatment response. Family/parent sessions are offered at key points in treatment. Assessment tools are available to measure all major targeted therapeutic outcomes.

The program has been implemented and evaluated with a broad variety of school age to high school groups (ages 10 – 18), including war-exposed Bosnian adolescents (comprised of ethnic Muslim, Croatian, and Serbian youths); multi-racial, multi-ethnic middle and high school students exposed to community violence and school shootings in Pasadena, Long Beach, and Santee, Southern California; and among adolescents exposed to the September 11th 2001 terrorist attacks in New York City. Preliminary versions of the intervention were implemented with children exposed to community violence in an impoverished urban community in Ingelewood, California; with socioeconomically disadvantaged youths exposed to gang-related violence in San Fernando, California; and with youths exposed to a massive earthquake in Armenia. It has been translated into Bosnian and has been implemented in school, clinic and community outpatient settings.

Status of research
Context: This is the first multi-site randomized controlled treatment outcome study of the effectiveness of a trauma/grief-focused group treatment for war-exposed adolescents, as delivered in-country within a public school system.

Objective: To evaluate the effectiveness of a trauma/grief-focused group therapy program developed for adolescents exposed to severe trauma and traumatic bereavement in reducing symptoms of posttraumatic stress disorder (PTSD), depression, and maladaptive grief.

Design: A randomized controlled trial conducted during the 2000-2001 school year that compared trauma/grief-focused group treatment to a control condition consisting of a psychoeducation- and skill-based school milieu intervention.

Setting and Participants: Students attending 10 Bosnian secondary schools who had histories of extensive trauma exposure, traumatic loss, and severe adversity, who reported persisting severe symptoms of PTSD, depression, or traumatic grief, and significant impairment in school performance or interpersonal relationships.

Intervention: Students were randomly assigned to either a 17-session manualized trauma/grief-focused group treatment (Trauma and Grief Component Therapy) (n = 71) conducted by trained school psychologists and pedagogues, or a control group (n = 73) who received a school milieu intervention conducted by the same school psychologists and pedagogues.

Main Outcome Measures: Students were assessed at pre-treatment (beginning of school year), post-treatment (end of school year), and at 4-month follow-up on self-report measures of PTSD symptoms (UCLA Reaction Index; range 0-68), depression symptoms (Depression Self-Rating Scale; range 0-72), traumatic grief (UCLA Grief Scale, Traumatic Grief Subscale; range 0-24), and existential grief (UCLA Grief Scale, Existential Grief Subscale; range 0-24).

Results: Reliable reductions in PTSD symptoms (58% at post-treatment; 81% at selected follow-up) found in the treatment group compare favorably to rates reported in randomized controlled efficacy trials. Rates of reliable reductions in depression (23% at post-treatment, 61% at follow-up) and traumatic grief (40% at post-treatment) found in the treatment group are comparable or superior to rates found in community treatment settings. Substantial, but lower, rates of change in the control group were found for PTSD symptoms (33% at post-treatment; 21% at follow-up) and depression symptoms (13% at post-treatment; 52% at follow-up). Odds ratios of the likelihood of reliable symptom reduction were higher in the treatment group compared to the control group (up to 15.19 for PTSD at follow-up) for all outcomes. The treatment group had minimal to modest percentages of reliably worsened cases (0% to 9%), whereas the control group had modest to substantial percentages (3% to 17%), at post-treatment and follow-up.

Conclusion: A multi-tiered, school- and community-based mental health intervention provides an effective, efficient, and manageable method for promoting adolescent post-war recovery in resource-poor regions. This includes the broad dissemination of psychoeducational knowledge and skills in schools (Tier 1); specialized school-based mental health interventions for youths with severe persisting posttraumatic stress and traumatic grief reactions (Tier 2); and the referral of youths at acute risk to intensive mental health treatment in community clinics (Tier 3).

Contact Information: To obtain a manual and for information on training and consultation, contact
Christopher Layne, Ph.D. , UCLA - National Center for Child Traumatic Stress

(310) 235-2633, extension 223.
cmlayne@mednet.ucla.edu
,

Culturally Modified Trauma-Focused Treatment (CM-TFT)

Description: CM-TFT was developed for use with Latino children and is based on Trauma-Focused Cognitive Behavior Therapy (Cohen, Mannarino, & Deblinger, 2006) for use with Latino trauma victims. The treatment development has been based on the research literature and over 10 years of clinical work with this population. CM-TFT is a tailored approach to providing treatment that attempts to increase engagement by increasing the cultural relevance of the intervention. Potential cultural factors are assessed and addressed, including spirituality, familismo, gender roles, beliefs about sex, views of mental health and mental health treatment, racism/discrimination, exploitation, and barriers to accessing treatment (e.g., transportation, poverty). In collaboration with several National Child Traumatic Stress Networks across the country, the intervention has been further developed to address the needs of Hispanic children from various countries of origin, regions of the United States, and levels of acculturation. CM-TFT was developed by Michael de Arellano, Ph.D. and Carla Danielson, Ph.D. The CM-TFT manual is presently under revision, and a powerpoint is also available.

The population the model is designed for and used with ranges in age from 4 to 18, and includes Latino/Hispanic males and females, with a broad range of acculturation levels from recently immigrated to multi-generation in the U.S. The majority of children are of Mexican descent, in addition to children from other Latin American countries.

Status of Research: Several focus groups were conducted with Latino parents, therapists working with Latino families, and other mental health professionals with expertise in Latino populations to further develop the intervention and treatment manual. Currently, individual case studies have been conducted, and a multi-site pilot feasibility trial is currently underway with diverse group of Latino families, in terms of nationality, socioeconomic status, level of acculturation, and geographic location in the United States.

Contact information: for readers to obtain materials and acquire additional information: Michael de Arellano, Ph.D., National Crime Victims Research & Treatment Center
(843) 792-2945
dearelma@musc.edu
www.musc.edu/ncvc

Group Intervention for Children of Mothers with Co-occurring Mental Health and Substance Abuse Disorders and Histories of Interpersonal Violence

Description: This is a structured, children's skills-building group intervention that was developed as part of the SAMHSA Women, Co-Occurring Disorders and Violence Children's Subset Study. The group intervention has been modified from Einat Peled and

Diane Davis' *Groupwork with Children of Battered Women: A Practitioner's Manual* to account for the presence of children in families without domestic violence, to address substance use and abuse and to meet developmental needs of two age groups (ages 5-7 and 8-10). The WCDVS modified Group Intervention for Children incorporated a variety of activities across sessions, including check-in, discussion, drawing, movement, skill practice, storytelling, videoclips, and free play. Core content includes teaching children to verbalize feelings, modeling expression of emotions in appropriate ways, educating the children about substance abuse and domestic violence, helping to identify good and bad touch, teaching assertiveness skills, learning relaxation exercises, and helping children develop a safety plan for themselves. The program consists of an hour-long orientation, nine core group sessions, and two booster sessions. Groups are conducted by a facilitator and co-facilitator, who can be a consumer/survivor/recovering (C/S/R) woman.

Status of Research: A preliminary summary of outcome effects as measured by the SAMHSA Women, Co-Occurring Disorders and Violence Study indicate that children who participated in this intervention sustained positive improvement when compared to children receiving treatment-as-usual, regardless of their mothers' outcome, with younger children showing a greater degree of positive change than older children.

Contact Information: To obtain the curriculum, *Groupwork with Children of Battered Women: A Practitioner's Manual* by Einat Peled and Diane Davis as adapted by The Coordinating Center and the Children's Subcommittee for the Women, Co-Occurring Disorders and Violence Study, and for information on training and consultation, visit www.nationaltraumaconsortium.

Integrative Treatment of Complex Trauma (ITCT) for Children and Adolescents

Description: ITCT is a comprehensive, assessment driven, components-based model integrating theoretical and clinical approaches for the treatment of complex trauma in children and adolescents. The ITCT model was developed through the collaborative efforts of Cheryl Lanktree, Ph.D. at Miller Children's Abuse and Intervention Center (MCAVIC) and John Briere, Ph.D. at the Psychological Trauma Program at University of Southern California, Keck School of Medicine. This is a relationally based model incorporating tenets of complex trauma theory (Cook, Spinazzola, Ford, Lanktree, et al., 2005; Herman, 1992), and aspects of attachment theory (Bowlby, 1988), cognitive behavioral theories, and the Self Trauma Model (Briere, 2002). ITCT is designed to address the multiple domains of functioning impacted by exposure to severe, multiple, and/or prolonged traumatic experiences of an interpersonal nature. Results of regular, standardized assessment of functioning assist clinicians in identifying significant problem areas and provide information about improvement or exacerbation in problem areas (e.g., attachment insecurity, affect dysregulation, hyperarousal) specific to individual clients. Consideration of titrated exposure and the "therapeutic window" (Briere, 1996, 2002) guides the pace of treatment and use of ITCT treatment components (e.g., relationship processing, emotion identification, relaxation training). Treatment is provided through multiple modalities, including individual, collateral, and family sessions, in addition to

group therapy for sexual abuse victims, those suffering from traumatic grief, students exposed to community violence, and caregivers requiring therapy or parenting education.

ITCT was originally developed for use in school and clinic settings with culturally diverse clients, ages 3 to 21, and their families. Specific cultural groups for which ITCT has been used include ethnic minorities (African American, Latino American, Asian American, and Pacific Islander Americans), low socioeconomic status, gender-specific child and adolescent groups, and immigrants from Mexico, Central America, Pacific Islands, and Southeast Asia. ITCT has also been adapted for use in urban schools in economically impoverished areas, including alternative (e.g., storefront) school settings. Traumatic experiences addressed by ITCT include child abuse and neglect, exposure to domestic violence, community violence, traumatic losses, parental substance abuse, and severe medical trauma. This model has been used with English- and Spanish- speaking clients. ITCT groups have been designed for adolescent girls' who have experienced sexual abuse, children and adolescents experiencing traumatic loss and grief, and for non-offending female caregivers.

Status of Research: Preliminary outcome studies demonstrate significant and clinically meaningful improvement in trauma-related symptoms, such as posttraumatic symptoms, depression, anxiety, dissociation, and sexual concerns. Additional studies examining outcomes for clinic based and school-based clients are currently underway. A two-site study (Lanktree, Gilbert, Briere, Taylor, Chen, Maida, & Saltzman, in press) examined the trauma specific measures used with ITCT, specifically the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) and the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005), and indicated evidence of convergent and discriminant validity for these measures.

Separate manuals outlining ITCT treatment protocols for children (8 – 12), adolescents (13 – 21), and group treatment of sexually abused adolescent girls will be available in 2008.

Contact Information: To obtain information and materials on ITCT and training/consultation in this model, contact
MCAVIC-USC Child and Adolescent Trauma Program
Cheryl Lanktree, Ph.D.
Executive director
clanktree@memorial.org
Or
John Briere, Ph.D.
Co-director
562 933-0590, ,
Or visit our web pages at http://www.memorialcare.com/miller/services/abuse.cfm, www.johnbriere.com., http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices.

Life Skills/Life Story

Description: Life Skills/Life Story was specifically developed to meet the needs of adolescent girls who have experienced childhood abuse and other traumas such as domestic violence and community violence. The program is comprised of two modules. The first module focuses on developing positive goals, the skills to meet this goals and sense of self-efficacy. Skills development focuses on those that are typically compromised from exposure to chronic trauma and interpersonal violence. These include developing emotional awareness and modulation, appropriate assertiveness skills, and flexibility and range in ways of relating to others, depending on the relationship and the context. Topics include sexual activity, group pressure and gangs/cliques, independence from and disappointment in parents and other caretakers, the importance of social support and how to request it. The skills component has been successfully implemented in a group format in residential and school settings but can be implemented in one-on-one setting with a therapist. This component of the treatment has been implemented in periods as short as three months and as long as one year. The second module is a titrated discussion and analysis of the traumatic events that have occurred. This has been implemented through written narrative, poetry, and collage. The treatment has been developed by the Institute for Trauma and Resilience directed by Marylene Cloitre at the Child Study Center in New York City. It has been successfully implemented in a residential school setting, in inner city public schools and in clinic settings. The program has served primarily minority girls, with ages 12 through 22.

Status of Research: Research has been completed indicating that the treatment as compared to those not participating in the program (either waitlist or treatment as usual) significantly reduces symptoms of post traumatic stress and depression and enhances interpersonal skills, sense of social connection and teacher reported improvement in school functioning.

Contact Information: For additional information contact:
Marylene Cloitre
NYU Child Study Center
marylene.clotre@nyumc.org

Love and Life: Trauma Recovery and Empowerment for Adolescent Girls and Young Women Ages 12-18 (G-TREM): A Clinician's Guide for Working with Adolescent Girls in Groups

Description: This guide was originally prepared in collaboration with staff from Community Connections, Inc. and Sasha Bruce Youthwork, Inc. in Washington, D.C. as two separate group leader's manuals for work with 12 to 14 year olds and 15 to 18 year olds. The guide was then revised, updated, and combined into one group leader's manual in summer 2004 by clinicians from Community Connections and the District of Columbia's Department of Mental Health School Mental Health Program, and revised a

third time in summer 2005. The guide was also re-titled as <u>Love and Life Group</u>, which appeals more to girls, especially those who may not want to attend what is publicly known as a "trauma group." This manualized model consists of 16 (75-90 minute) sessions addressing issues and approaches that make sense to adolescent girls. For groups of 8 to 10 girls who have experienced or witnessed physical, sexual, and emotional abuse and community violence with 2-3 leader/facilitators. Topics are adapted, learning approaches are modified, and overall tone respects the age appropriate struggles of adolescents. Each session begins with an icebreaker, continues with a series of discussion questions designed to accomplish the goals of the session, and concludes with an experiential exercise and a "Dear Alicia" problem-solving activity. The format combines discussion and limited (optional) disclosure with experiential exercises and non-verbal modalities of expression. Also, the model is sensitive to the issue that many older adolescent girls in particular believe that they have put experiences of abuse behind them, and are focused on building relationships, seeking relationships, and becoming parents. The model engages girls and allows them to work through issues related to abuse without requiring disclosure of abuse experiences.

Participants who complete the Love and Life: G-TREM program are given the book, <u>The Twenty-Four Carat Buddha and Other Fables</u> Written by Maxine Harris, this book is a collection of original fairy tales set in imaginary space and time but with   relevance   for modern life. The stories explore themes of coming of age and learning to trust in one's own judgment and intuition; dealing with experiences of   profound   loss;   coming   to terms with the demons of past abuses and trauma; and confronting the choices which must be made while trying to figure out how to live a meaningful life. An appendix includes observations about each story by the author on how the story might be useful to someone trying to grow or heal from hurt or disappointment, and a set of questions for each of the stories to facilitate self-exploration and to suggest potential directions.

Status of Research: In the spring of 2004 through the spring of 2005, the SAMHSA-funded Youth Violence Prevention Program, Project Hope in Washington, D.C., offered a total of 16 Love and Life: G-TREM groups in 11 different public schools, co-led by clinicians from Community Connections and DC's Department of Mental Health's School Based Mental Health Program. Evaluation of this project found positive responses to the groups among both participants and leaders. In qualitative interviews, over 90% of participants reported overall satisfaction with the group, and over 90% said they would recommend it to friends. They also reported specific beneficial effects of group participation: increases in such skill areas as improvement in handling anger and in self-confidence and self-esteem, as well as increased knowledge about sex and their bodies. Girls rated strongest potential group benefits in the key outcome domains of perceived general safety, self-esteem and the ability to assert oneself. Similarly, feedback from group leaders indicated that girls' skills in these areas had increased, identifying areas of relationships with others, girls' ability to deal with stressful events, and self-esteem as the domains most positively affected by the group. All of the 14 group leaders said they would recommend the group to colleagues and other agencies.

Contact Information: To obtain the manual, the book, and additional information,

Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org
or
For a report of G-TREM pilot data, please contact
Rebecca Wolfson Berley, M.S.W., Director of Trauma Training
202-608-4735
rwolfson@ccdc1.org

Prolonged Exposure Therapy for Adolescents with Post Traumatic Stress (PE-A)

Description: This program is based on Prolonged Exposure Therapy (PE), a method of treatment developed by Edna Foa and colleagues at the University of Pennsylvania. Prolonged Exposure targets the symptoms of Posttraumatic Stress Disorder as well as associated symptoms of depression that may develop as a result of trauma. PE-A reduces symptoms by helping clients emotionally process their traumatic experiences. This is accomplished by systematically confronting safe but anxiety producing situations, places or thoughts that have developed in the wake of the trauma. Prolonged and repeated confrontation of anxiety helps trauma survivors overcome their excessive fear and anxiety by providing corrective information related to the survivors beliefs about self, others and the world, and by helping the survivor to habituate to the discomfort associated with memories of the trauma and activities that evoke the memory of the trauma.

The adult PE program has been modified for use with adolescents by increasing family involvement, increasing attention to the social and developmental challenges faced by adolescents, and building in developmentally appropriate exercises that can be selected by the therapist, in response to the needs of the individual patient. Treatment is provided in weekly 60 to 90 minute sessions over approximately 14 weeks. Treatment is composed of four distinct phases:

- Pretreatment Preparation, which includes a motivational building exercise to improve attendance and treatment adherence, and a case management exercise to address potential barriers to therapy.

- Psychoeducation, which provides education about common reactions to trauma, breathing retraining (i.e., teaching the client how to breath in a calming way), and education about the rationale for the treatment.

- Exposure and Processing, which includes both in-vivo exposure to situations that produce anxiety by evoking memories or thoughts of the trauma, and imaginal exposure to the story of the trauma itself.

- Relapse Prevention, which includes a review of the treatment and anticipation of future challenges

The treatment is designed for male and female adolescents aged 13-17 but has been implemented with younger children. The pilot data were collected in a Philadelphia urban rape crisis center specializing in the treatment of adults and children who have been sexually assaulted, and in a hospital based clinic in Israel where patients experienced a variety of traumatic events including sexual assault and abuse, motor vehicle accidents, and terror attacks. Clients were predominantly African American and White in the American sample, and White in the Israeli sample. The manual is in English and has been translated into Hebrew.

Status of Research: Though two randomized, controlled treatment outcome studies of PE-A are currently underway, neither has been completed. Pilot data collected in the U.S. and Israel are quite promising. In an open trial of PE-A, PTSD symptoms among 45 adolescent clients were significantly reduced from pre- to post-treatment and 71% percent of the patients achieved remission by the end of treatment. The within subject effect size of 2.13 found for these 45 patients who received PE is similar to published results of adult assault survivors following treatment with prolonged exposure.

Contact Information: To obtain materials or to acquire additional information about PE-A, contact
Dr. Edna Foa or Dr. Elizabeth Hembree at Center for the Treatment and Study of Anxiety
Phone: 215-746-3327
Web site: ctsa@mail.med.upenn.edu

Real Life Heroes

Description: Real Life Heroes*,* created by Richard Kagan, Ph.D., utilizes an activity-based workbook to help children with traumatic stress to build the skills and interpersonal resources needed to re-integrate painful memories and to foster healing after abuse, neglect, family violence, severe illness, losses, deaths, or abandonment. The workbook utilizes creative arts and life story work to engage children and caring adults in trauma and attachment-centered therapy and to rebuild (or build) positive, enduring relationships between hurt (and often hurting) children and adults committed to guiding children into adulthood. The curriculum integrates nonverbal and verbal modalities and helps children and caring adults move step-by-step from trauma narratives to life stories highlighting mastery, helping others, and nurturing relationships**.** The Practitioner Manual provides detailed guidelines for therapists and can be used as a chapter by chapter reference including: Objectives, Overview Step-by-step (key points and sequence), Pitfalls (problems that can undermine therapy), Troubleshooting (challenges and solutions), and Checkpoints (essential elements).

Real Life Heroes was especially designed for children in child and family service programs who frequently lack safe, nurturing homes and secure relationships with caring and committed adults but can also be used to help children . The model assists therapists

and family members to recover and enhance family and cultural strengths and to promote skill building, attachments, and trauma processing. The model can be used by programs and agencies as a prescriptive methodology to address primary goals including preventing placements, reuniting families, or finding alternate permanent homes for children who cannot return to biological parents.

Real Life Heroes helps children:

- recognize heroes within their families, communities and ethnic heritage and to develop a sense of hope that they can move past traumas

- develop skills to identify and express feelings and manage emotions utilizing drawings, rhythm, melodies, and movement

- use pictures, photos, and stories in a structured workbook format to tell the unique story of a child's life strengthening positive memories of caring

- develop children's capacity and confidence to cope with past, present, and future stressors and enables troubled children to transform from victims into 'heroes' within their families and communities

Interventions:

- engage caring adults to validate children by building on the caring of family members, strengthening each child's cultural and family heritage, fostering an understanding of trauma, and reduction of shaming/blaming include specific steps to make it safe for children to work on healing including guidelines for involving aring adults and helping caring adults become mentors, protectors, and heroes for children

- engage children to work chapter by chapter on building competence and a stronger identity

- utilize activities to build critical skills to manage intense affective reactions including affect recognition and regulation, acceptance and understanding of trauma reactions, self monitoring, working with peers and adults to overcome adversity, and helping others as a means of building self esteem

- utilize creative arts (drawing, color, rhythm, music, movement) to foster attunement between children and caring adults, strengthen positive memories of caring, increase capacity for problem resolution, share 'tough times,' and develop coping strategies strong enough to counter reminders, 'triggers,' to trauma reactions

- utilize components of cognitive behavioral therapy (CBT) including psycho-education on trauma, affect regulation, social skill training, changing dysfunctional beliefs, progressive desensitization, and telling the story by providing a structured curriculum and child-friendly workbook

- can be easily integrated with trauma-focused therapies and home-based family preservation, therapeutic foster family, residential treatment, and juvenile justice programs

The manual and workbook were designed to prevent or treat traumatic stress with children and adolescents who function developmentally between ages 6-12 and who have experienced losses, neglect, abuse, violence, illness, or disasters including:

- children identified as abused, neglected, or PINS/JD

- children with Complex PTSD, 'Developmental Trauma Disorder'

- children at risk of placement

- children placed into foster families, residential treatment centers, psychiatric hospitals, crisis residences, or runaway/homeless youth programs

- families working in pre-and post-adoption counseling

- older adolescents, preschool children, and children who have learning disabilities utilizing adaptations outlined in the manual

The manual was designed to help therapists strengthen caring adults, or when necessary, to search for caring adults and engage them to rebuild attachments and provide long term guidance, nurture, and safe homes.

Real Life Heroes meets the minimum requirements of the National Registry of Evidence-based Programs and Practices (Substance Abuse and Mental Health Services Administration) and is listed as an Evidence-supported and Promising Practice by the National Child Traumatic Stress Network (www.nctsnet.org).

Status of Research: Therapists have consistently reported positive results during eight years of case studies with children with Complex PTSD involved in home-based or clinic-based family counseling and with children who have been living in foster families and residential treatment centers due to dangerous behaviors and often repeated experiences of physical or sexual abuse, and neglect. A pilot research study (Kagan, Douglas, Hornik & Kratz, In Press) was conducted to evaluate the effectiveness of this model with 41 children and adolescents at Parsons Child and Family Center, a community practice site of the National Child Traumatic Stress Network. Data from the Parsons study were utilized to assess changes from enrollment and at four, eight, and 12 months of treatment. Therapists reported that the model helped them to engage children who had experienced neglect, abandonment, physical and sexual abuse, domestic violence, multiple losses, and separations including histories of placements away from families of origin and that the curriculum helped therapists persevere with application of cognitive behavioral therapy components over time as noted on chapter checklists and in informal feedback sessions.

At four months, children (N = 36) demonstrated reductions ($p<.05$) in:
- trauma symptoms on child self-reports evaluated with the Trauma Symptom Checklist for Children, TSCC (Briere, 1996).
- problem behaviors reported by primary caretakers on the Conners Behavior Rating Scale--Parent-Long Version (Conners, 1997).

At the end of the 12 month study period (N = 25), results included:

- reduced trauma symptoms reported by the adult caregiver on the PROPS (Greenwald, 1999a, 1999b) in relation to the number of *Real Life Heroes* chapters completed (p<.001).
- Increased security/attachment over time reported by the child (p<.05) on the Security Scale (Kerns, Klepac & Cole, 1996).

The pilot study did not include a control group and does not establish the efficacy of this model. However, results supported the model's effectiveness to reduce symptoms of traumatic stress and increase children's security with primary caregivers. For additional information, please see Kagan, R., Douglas, A., Hornik, J., & Kratz, S. (In Press). Real Life Heroes Pilot Study: Evaluation of a Treatment Model for Children with Traumatic Stress. Journal of Child and Adolescent Trauma.

Contact Information: For additional information including training and consultation, contact:
 Richard Kagan, Ph.D, Director of Psychological Services at Parsons Child and Family Center
518-426-2600
kaganr@parsonscenter.org

To obtain the workbook, practitioner manual, and accompanying text, Rebuilding Attachments with Traumatized Children, contact :
Haworth Press
1 800 Haworth
www.haworthpress.com

Sanctuary Model for Children in Residential Settings

Description: The Sanctuary Model® for Children in Residential Treatment is an intervention designed to address the special treatment needs of youth with emotional and behavioral disturbances and histories of maltreatment or exposure to domestic and community violence. The Sanctuary Model® integrates trauma theories, an enhanced therapeutic community philosophy, and recommended child treatment strategies that address post-traumatic symptoms, developmental disruptions, and unhealthy accommodations to traumatic experiences. A fundamental premise of the intervention is that the treatment environment is a core modality for modeling healthy relationships among interdependent community members. What has emerged from experience with residential treatment settings is a plan, process, and method for creating trauma-sensitive, democratic, nonviolent cultures that are far better equipped to engage in the innovative treatment planning and implementation that is necessary to adequately respond to the extremely complex and deeply embedded injuries that these children have sustained.

As of 2007, The Sanctuary Model® is being adapted for use in over twenty acute care, residential, out-patient, juvenile justice and substance abuse settings for children in various parts of the United States and Mexico.

Status of Research: Two evaluation projects are now underway. Eighteen of the current organizations in the Sanctuary Leadership Development Institute are participating in a three-year evaluation to determine whether or not the training and consultation brings about significant changes in key determinants of safe environments, including reductions in restraints, staff injuries, staff turnover. A parallel project is being conducted on seven of the agencies – five residential treatment settings and two juvenile justice programs – that have been funded through New York State Office of Family and Children's Services. This evaluation is being independently conducted by Stonybrook University.

An earlier research project was conducted on the implementation of the Sanctuary Model, funded by NIMH grant MH62896. The study showed support for the implementation of the model. An evaluation of The Sanctuary Model® was conducted as a partnership between researchers of Columbia University School of Social Work, the Center for Trauma Program Innovation of the Jewish Board of Family and Children's Services in New York City, and the model developer, Sandra Bloom. Dr. Jeanne Rivard was the primary investigator. The research component was funded through an exploratory/developmental research grant by the National Institutes of Mental Health as part of an initiative to promote research on interventions for youth violence. The project took place in a suburban community outside New York City where the Sanctuary Model® is being implemented in three residential treatment programs on one large campus. Results of the Sanctuary Model® units were compared to results of units with standard residential services. Although the Sanctuary Model® was in a very early stage of implementation, the evaluation was guided by hypotheses that projected which specific outcomes were expected to occur in the therapeutic communities and in youths. The evaluation emphasized an assessment of the processes of model implementation.

There was greater implementation among those units exposed to the model longer, those serving girls, and those with leaders who had greater enthusiasm and commitment to the model. The short form of the Community Oriented Programs Environment Scale (COPES) (Moos, 1996) [Moos, R.H. (1996). Community oriented program scale: Sampler set manual, test booklets, and scoring key (3rd Ed). Redwood City, CA: Mindgarden; Moos, R.H. (1997). Evaluating treatment environments: The quality of psychiatric and substance abuse programs. New Brunswick, NJ: Transaction Publishers.] was used to assess the extent to which units were operating as therapeutic communities along selected dimensions. There were no significant differences between the Sanctuary Model units and the standard residential treatment units during the first two waves of measurement. By the final wave of measurement, however, we found significant differences between the groups via independent t-tests, with the Sanctuary Model® units improving on the following constructs of the COPES: support ($p < .05$), spontaneity ($p < .01$), autonomy ($p < .05$), personal problem orientation ($p < .05$), safety ($p < .05$), and in the total score ($p = .001$). There were also a few differences by time and group, favoring youth in the Sanctuary Model® units. These were on the incendiary communication/

tension management construct of the Youth Coping Index ($p < .05$), locus of control ($p = 15$), and the verbal aggression construct of the Social Problem Solving Questionnaire ($p = .15$). Results were modest and consistent with a newly implemented intervention, especially considering that rates of implementation varied across units. The positive youth findings offer promise that full implementation may yield greater youth benefits. The finding that the treatment environments of the Sanctuary units were functioning at significantly higher levels than the standard residential units by the final wave of data collection suggests that implementation was becoming stronger with time.

The research project was published in four articles: Rivard, J.C., McCorkle, D., Duncan, M.E., Pasquale, L.E., Bloom, S. L., Abramovitz, R. (2004). Implementing a Trauma Recovery Framework for Youths in Residential Treatment. Child and Adolescent Social Work Journal, 21(5): 529-550; Rivard, J. C. (2004). Initial findings of an evaluation of a trauma recovery framework in residential treatment. Residential Group Quarterly 5(1): 3-5; Rivard,J.C., Bloom, S. L., Abramovitz, R., Pasquale, L.E., Duncan, M., McCorkle, D., Gelman, A. (2003). *Assessing the Implementation and Effects of a Trauma-focused Intervention for Youths in Residential Treatment* Psychiatric Quarterly 74(2): 137-154; Rivard, J.C., Bloom, S. L., McCorkle, D. and Abramovitz, R. (2005) Preliminary results of a study examining the implementation and effects of trauma recovery framework for youths in residential treatment. Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations 26(1): 83-96

Contact Information: An extensive collection of articles and information is available at www.sanctuaryweb.com. For additional information on the model and on training and consultation services via the Sanctuary Leadership Development Institute, contact:
Sarah Yanosy , Andrus Children's Center
914-965-3700 x1117
syanosy@jdam.org,
www.andruschildren.org

Seeking Safety

Description: The Seeking Safety model, developed by Lisa M Najavits, Ph.D., at Harvard Medical/McLean Hospital, is a manualized, 25-topic, flexible integrated treatment that offers coping skills to help clients attain greater safety in their lives. It is present focused and designed to be inspiring and hopeful. Originally designed to address PTSD and substance abuse, it since has been implemented with diverse traumatized clients who may not necessarily meet criteria for these disorders. Used widely with adults, it has been implemented with adolescents (both boys and girls), and a published randomized controlled trial is available on adolescent girls. The manual, Seeking Safety: A Treatment Manual for PTSD and Substance Abuse, includes both client handouts and clinician guidelines. A description of this model and manual is included in this document. All topics are independent, and thus can be done in any order, with as few or many sessions as there is time for (it is not required to do all 25 topics). It can be conducted in group or individual format with a wide variety of counselors and programs.

Status of Research: Seeking Safety (Najavits, 2002) is the only model for trauma/PTSD and substance abuse that thus far has been empirically studied in adolescents (Najavits et al., 2006). In a randomized controlled trial with 33 adolescent girls comparing Seeking Safety plus treatment-as-usual versus treatment-as-usual alone, positive outcome results were found in a variety of domains including substance use and associated problems, trauma-related symptoms, cognitions related to PTSD and SUD, psychiatric functioning, and several additional areas of pathology not targeted in the treatment (e.g., anorexia, somatization, generalized anxiety). Some gains were sustained at follow-up. The study used the existing treatment manual for Seeking Safety without substantial modification, indicating that—at least based on initial evidence—the model may be relevant and acceptable to adolescents.

Contact Information: To obtain the manual, the article on adolescents, and other materials related to Seeking Safety contact:
Lisa M. Najavits, Ph.D.
617-731-1501 (phone)
info@seekingsafety.org
www.seekingsafety.org

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

Description: SPARCS is a group intervention that was specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning. These areas include difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life as well as worldviews that make it difficult for them to see a future for themselves. Overall goals of the program are to help teens cope more effectively in the moment, enhance self-efficacy, connect with others and establish supportive relationships, cultivate awareness, and create meaning. Group members learn and practice each of the core SPARCS skills throughout the intervention and frequently report use of these skills outside of group. Core components of this intervention include Mindfulness practice, Relationship building/communication skills, Distress Tolerance, and Problem-solving and Meaning Making. Treatment also includes psychoeducation regarding stress, trauma, and triggers.

This intervention is strength-based and is appropriate for traumatized adolescents with or without current/lifetime PTSD. It is based on the assumption that the adolescents' symptoms (behavioral, interpersonal, and affective) represent their best efforts at coping with extreme stress. The treatment facilitates therapists' ability to help group members identify and build upon their strengths. SPARCS is a present-focused intervention, and is not an exposure based model. Although there is no direct exposure component or construction of a trauma narrative, traumas are discussed in the context of how they relate to adolescents' current behavior and to their understanding of their problems and

difficulties in the here and now. Group members routinely discuss and process their personal experiences throughout the group.

Groups are one hour in length and have been provided in a variety of settings including outpatient clinics, schools, group homes, boarding schools, residential treatment centers and facilities, and foster care programs. Sessions can be divided into two segments and conducted twice a week to accommodate class periods in a school setting. It is recommended that SPARCS be implemented in settings where adolescents can remain in treatment long enough to complete the intervention. SPARCS is predominantly cognitive-behavioral and draws upon Dialectical Behavior Therapy (Miller, Rathus, & Linehan, 2006), Trauma Adaptive Recovery Group Education and Therapy (TARGET) (Ford & Russo, 2006), and the UCLA Trauma/Grief Program (Layne, Saltzman, Pynoos, et. al., 2000).

To date SPARCS has been conducted with ethnically diverse groups, including African American, Latino, Native American, LGBTQ, and refugee/immigrant populations, as well as adolescents in gangs and in rural settings. SPARCS has also been implemented with adolescents in foster care and in shelters with runaway/homeless youth. Some SPARCS handouts are available in Spanish and have been used with Spanish speaking youth and their caregivers.

Status of Research: Pilot data indicate significant improvement in overall functioning over the course of treatment (as measured by the Youth Outcome Questionnaire SR-2.0) for adolescents receiving SPARCS, with changes noted on subscales measuring, conduct problems, inattention/hyperactivity, and interpersonal relationships. Encouraging results were also found in a pilot program conducted by the Illinois Department of Children and Family Services and The Mental Health Services and Policy Program at Northwestern University, with improvements noted on several of the subscales of the YOQ, including somatic complaints and anxious/depressive symptomatology. The pilot also compared SPARCS to treatment as usual using the Child and Adolescent Needs and Strengths (CANS) instrument. Results indicated that SPARCS was associated with significant improvements in Risk Behaviors as compared to the treatment as usual group.

Contact Information: To obtain a manual and for information on training and consultation, contact:
Mandy Habib, Psy.D. Division of Trauma Psychiatry
516-562-3276
mhabib@nshs.edu.

Trauma Affect Regulation: Guide for Education and Treatment (TARGET)
This model is adapted for use with adolescents. Please see description, research status and contact information in Section *"Trauma-Specific Service Models for Adults", page*

TRIAD Girls Group Treatment model

Description: Manualized 18-session (2-hour sessions) group treatment for adolescent girls with histories of substance abuse, emotional problems, and violence/trauma/abuse, based on the Triad Women's Group and extensively revised for at-risk adolescent females experiencing difficulties in their academic and social functioning. The manual is intended to assist girls in discontinuing or avoiding substance use and abuse as well as other risky behaviors, to empower them to a state of improved mental health, to support their survival and healing from violence and trauma, to identify strengths that helped them survive, and to decrease chances they will become involved with or re-enter the juvenile justice system.

Status of Research: Formative research on this model was designed to capture the participants' ideas, feelings and opinions about the model and incorporate changes based on their feedback. Outcome research is in process.

Contact Information: To obtain the manual, worksheets, and for further information, contact
Colleen Clark
813-974-9022
cclark@fmhi.usf.edu

Voices: A Program of Self-Discovery and Empowerment for Girls

Description: Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, Voices: A Program of Self-Discovery and Empowerment addresses the unique needs of adolescent girls and young women between the ages of 12 and 18. The program model uses a trauma-informed, strength-based approach that helps girls to identify and apply their power and voices as individuals and as a group. The focus is on issues that are important in the lives of adolescent girls, from modules about self and connecting with others to exploring healthy living and the journey ahead. Given the pervasive impact of abuse and substance use in many girls' lives, these themes are woven throughout the sessions. *Voices* encourages girls to seek and discover their "true selves" by giving them a safe space, encouragement, structure, and support to embrace their important journey of self-discovery. In addition, skill-building in the areas of communication, refusal skills, anger management, stress management, and decision making is integrated across program topics. It can be used in many settings (e.g., outpatient and residential substance abuse treatment, schools, juvenile justice, and private practice).

Voices: A Program of Self-Discovery and Empowerment for Girls is based on the realities of girls' lives and the principles of gender-responsivity. It is also grounded in theory, research, and clinical practice. Voices is an adaptation of Helping Women Recover for girls The following theories create the framework of thought for the development of the Voices model: psychological development, attachment, resilience,

addiction, and trauma. This is the theoretical base on which the *Voices* program was developed. The various treatment strategies used in the program apply the theories to create the therapeutic process. The therapeutic approaches include psycho-educational, cognitive-behavioral, expressive arts, and relational theory. The psycho-educational approach helps young women begin to link some of their current difficulties and experiences to larger social influences.

The first part of the facilitator's manual gives the facilitator background information about girls and about the formation of the Voices program. It includes information on the reality of girls' lives: socialization and identity, culture and class, sexuality, violence and aggression. It also addresses expressions of risk: depression, substance abuse, relationship violence, eating disorders, teen mothers, and girls in juvenile justice settings. The second part includes the four modules (self, connecting with others, healthy living, and the journey ahead), with a total of 18 90-minute sessions. There are over 90 exercises included in the facilitator's guide. The sessions may be arranged in a variety of ways, however, the curriculum is laid out in the suggested sequence.

Each group member is provided a Voices journal. This journal serves as a girl's personalized tool for exploring and recording her experiences, thoughts, and feelings as she progresses through the program in a safe space.

This program is designed for facilitation in a group setting but can be adapted for one-on-one use. The suggested number of participants per group is between 6 and 10. Ideally, the groups would be "closed," that is, the same girls would begin and end the program together. The curriculum can be adapted for larger groups and open groups, if either is essential to the program setting.

Status of Research: There are several grant applications pending for outcome studies in a variety of settings (schools, adolescent treatment, and juvenile justice). A pilot study was conducted in CT and NYC using the gender-responsive girls' curriculum, Voices: A Program of Self-Discovery and Empowerment. This study (funded by CSAT) focused on fidelity and gathered initial data for a larger NIDA grant proposal. The original NIDA proposal was submitted in 2006 and was resubmitted 3/07. This is a multi-site project with court-ordered girls in a randomized study that compares outcomes from Voices to current practices. Outcome measures will assess for reduction in risk factors associated with substance use, change in self-esteem and self image, increased knowledge regarding AOD issues and issues related to trauma, and involvement in the juvenile justice system (completion of probation, recidivism). The plan is to also have a follow-up to assess longer term outcomes. Both standardized tools for measurement and other developed instruments will be used.

Contact Information: For additional information on research, contact
Nancy Jainchill, Ph.D. at NDRI
nancy.jainchill@ndri.org

To obtain the <u>Voices</u> curriculum materials and for additional information on training, consultation, and research, contact
Stephanie S. Covington, Ph.D., L.C.S.W.,
858-454-8528
sscird@aol.com
www.stephaniecovington.com
www.centerforgenderandjustice.org.

Trauma-Specific Peer Support and Self Help Models

The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experienced Trauma

Description: Developed by Sidran Institute in partnership with the consumer advocates of the TAMAR Project, the Maryland Women, Co-occurring Disorders and Violence Study Site, this is a manualized approach to creating, facilitating, and maintaining a peer support program for people who have experienced traumatic events. It provides the framework, methods, and techniques to facilitate the development of successful peer support and examine some of the obstacles likely to be encountered. The program stands on its own, but uses many of the concepts and the RICH® relationships guidelines drawn from Risking Connection®, making it an ideal companion piece. The manual was written by Jennifer Wilkerson, M.S. who was on staff at Sidran at the time.

Status of Research: No research to date.

This resource can be downloaded for free from the Sidran website (www.sidran.org), but Sidran would like to know where it is being used, and by whom.

Contact Information: For additional information or to discuss use, contact:
Esther Giller , Sidran Institute
410-825-8888 x 207, or
To purchase printed bound copies of the manual, e-mail
orders@sidran.org.

Healing the Trauma of Abuse: A Women's Workbook

Description: Created by Mary Ellen Copeland, M.A., M.S., and Maxine Harris, Ph.D., this workbook can be used by a woman on her own, or with a therapist or supportive friend. The manual assists women recovering from the effects of physical, sexual, and emotional abuse. It is divided into four parts: Empowerment, Trauma Recovery, Creating Life Changes, and Closing Rituals. Each part has a number of topics to work on, helps women develop individual goals for the recovery work, and addresses self-care while doing recovery work.

Status of Research: No research to date.

Contact Information: To obtain the workbook and for more information, visit www.mentalhealthrecovery.com

Journey of Self-Discovery: A Study Guide for Trauma Survivors

Description: A manualized program updated in June 2007, created by New Partnerships for Women, a collaborative consumer/provider/advocate project in Wisconsin. The manual focuses on understanding the scope of trauma in women's lives, the effects of trauma, symptom self management, meeting basic needs, and self-advocacy. This four part psycho-educational training program, jointly taught by consumers and providers, is available for women who have experienced mental health and/or substance abuse problems and who have histories of trauma.

Status of Research: No research to date.

Contact Information: To obtain the curriculum and for additional information, contact
Dianne Greenley
608 267-0214
dianneg@drwi.org:

Well Recovery Groups

Description: WELL recovery is a manualized approach intended for consumers who wish to establish peer-run mutual help groups specifically for women in recovery from substance abuse, mental illness, and trauma. The groups are run on the principle that a person's addiction, mental illness, and trauma need to be discussed together, for each plays off the other. With support form the Institute for Health and Recovery, the intervention and manual were created by Suzanne Garverich and Naomi Pinson, themselves recovering from the triple trouble of mental illness, addictions, and trauma.

Status of Research: No research to date.

Contact Information: To obtain the manual WELL Recovery: Model for Peer Led Self/Mutual Help Groups for Women with Substance Abuse and Mental Health Problems and Histories of Trauma and for further information,contact:
Laurie Markoff
617-661-3991
lauriemarkoff@healthrecovery.org, or
Christine LaClair
christinelaclair@healthrecovery.org
www.healthrecovery.org

A Woman's Addiction Workbook

Description: This self-help book offers a step-by-step program to help women work on recovery from alcohol and drugs. It also addresses key issues that women face in relation to addiction, such as body image, trauma and violence, relationships, stress, and thrill-seeking. It explores how women differ from men in their addiction and recovery, and conveys a supportive tone for the journey to healing. A chapter on co-occurring emotional problems allows readers to evaluate whether they may have any of the key DSM-IV disorders common among women with addiction, such as depression, posttraumatic stress, eating disorders, and phobias. With a focus on building strength, women take steps to come to terms with their personal addiction stories. Healing exercises are offered in four areas— feelings, beliefs, action, and relationships—to help build self-respect. Exercises include <u>Listen to That Small Quiet Voice</u>, <u>Extreme Self-Care</u>, <u>Self-Soothing</u>, <u>Become Friends with Women</u>, <u>Rethink</u>, <u>Take Charge</u>, <u>Share Responsibility</u>, and <u>Mourn.</u> Throughout, recovery resources are provided. This model can also be conducted by clinicians (see the published outcome study described below for details).

Status of Research: A published outcome study (Najavits, Rosier, Nolan, Freeman, 2007) has been completed on this model in a public treatment program in Connecticut. Eight opiate-dependent women in methadone treatment attended a group therapy version of the model, led by professional counselors in 12 sessions of 1.5 hours each. The women completed pre- and post-outcome evaluation on several measures. Significant improvements were found in the Addiction Severity Index drug composite, the Clinical Global Improvement Scale, the Basis-32 impulsivity subscale, and knowledge test of the material. Urinalysis data confirmed clients' self-report. Client satisfaction and attendance were high.

Contact Information: To obtain the workbook, the published outcome study, and additional information, contact
Lisa M. Najavits, Ph.D.
617-731-1501 (phone)
617-701-1295 (fax).
info@seekingsafety.org, or go to:
www.seekingsafety.org

Women's Leadership Training Institute: "For and By Women in Recovery from Addiction, Mental Illness, and Trauma," Instituto de Entrenamiento para Mujeres Lideres en Recuperacion: Un curriculo educativo y grupal para mujeres en recuperacion

Description: This 3-session, 16-hour training, run by women in recovery, promotes leadership skills development among women in recovery so they may use their own experiences and voices to advocate for services. The curriculum was developed by the

Boston Consortium of Services for Families in Recovery, Boston Public Health Commission, the Institute on Urban Health Research, Northeastern University and Dorrington, Saunders and Associates.

Status of Research: The Women's Leadership Training Institute was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a no-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma-integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the 'package' of services, and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment 'package.' Three documents are in press for publication indicating that women in the intervention stay in treatment longer and at followup have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2006a). Effects of Trauma Intervention on HIV Sexual Risk Behaviors Among Women with Co-occurring Disorders in Substance Abuse Treatment. *Journal of Community Psychology,* in press.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., Gatz, M. (2006b). Does Integrated Trauma-Informed Substance Abuse Treatment Increase Treatment Retention? *Journal of Community Psychology*, in press.

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma-informed substance abuse treatment on addiction severity, mental health and PTSD symptomatology compared to services as usual. *Journal of Urban Health,* posted on-line March 14, 2007; hardcopy in press

Contact Information: To obtain a manual, contact:
 Dr. Hortensia Amaro
h.amaro@neu.edu
or
Rita Nieves, R.N., M.P.H.,
Rita_Neives@bphc.org

Your Surviving Spirit: A Spiritual Workbook for Coping With Trauma

Description: Written by Dusty Miller, Ed.D., this workbook contains a series of exercises and vignettes designed to help trauma survivors transform their pain and despair into the practice of healthy well-being. The author guides readers through skill-building exercises, journal-writing activities, and the creation of their own stories and affirmations. They learn to identify the ways in which trauma has impacted their lives in mind, body, and spirit, and specific ways they can help on each level of experience.

Status of Research: No research to date.

Contact Information: To obtain the manual, and for information on training and technical assistance (in English and Spanish) and to obtain copies of the manual, contact Dusty Miller
413-584-8404
413 203 1432 (h&w)
(413) 313 6317 (c)
dustymi@aol.com
www.dustymiller.org

Appendix: Criteria for Building a Trauma-Informed Mental Health Service System

The following elements should be in place in any public mental health system committed to meeting the needs of clients who have histories of trauma. Trauma is defined here as interpersonal violence, over the life span, including sexual abuse, physical abuse, severe neglect, loss, abandonment, threat, and/or the witnessing of violence. Although not as prevalent in the lives of most clients, trauma may also be caused by overwhelming experiences such as natural disasters, terrorism, and combat.

Administrative Policies/Guidelines Regarding The System

1. **Trauma function and focus in state mental health department.** A single, high-level, clearly identified point of responsibility should exist within the state administrative structure charged with and supported in implementing trauma-informed service systems and use of evidence-based and emerging best practices in trauma throughout state supported services. This could be a senior staff, a unit or office within the department, and/or ongoing, high-visibility leadership on the part of the lead system administrator. This person or group should develop a written plan with trauma related goals, objectives and timelines, approved and activated by administration, and should meet regularly with system administrator.

2. **State trauma policy or position paper.** A written statewide policy or position statement should be adopted and endorsed by administrative leadership, and disseminated to all parts of the service system, stakeholder groups, and other collaborating systems. This document should include a definition of interpersonal violence and trauma, make a clear statement about the relationship between trauma, mental health and recovery, and publicly declare trauma to be a priority health and mental health issue. Ideally, the position statement should commit the state to meeting the essential elements of a trauma-informed service system, and a trauma-specific clinical system. The *NASMHPD Position Statement on Services and Supports to Trauma Survivors* (www.nasmhpd.org) serves as a model of such a position paper.

3. **Workforce Recruitment, Hiring, and Retention.** The system should prioritize recruitment, hiring, and retention of staff with educational backgrounds, training in and/or lived experience of trauma. These staff or "trauma-champions" provide needed expertise and an infrastructure to promote trauma-informed policies, training and staff development, and trauma-based treatment and support practices throughout the service system. They advocate for consideration of trauma in all aspects of the system. There should be outreach to sources of prospective trauma-educated/informed employees (e.g. universities, professional organizations, peer-led and peer support programs, consumer advocacy groups; other training sites).

Professional organizations and universities should be approached to set standards and to offer curriculums preparing students to work with trauma survivors. Incentives, bonuses, and promotions for staff and supervisors should take into account their role in trauma-related activities. Support should be provided for direct care staff to address impacts on staff of trauma work. There should be a written policy and regularly monitored plan for building and supporting workforce trauma-competency in all aspects of the service system.

Policies and procedures should ensure safety from sexual offenders in all recruitment, screening and hiring practices of both employees and volunteers, and guidelines should be established to prevent and respond to reported incidents of such abuse.

4. **Workforce orientation, training, support, job competencies and standards related to trauma.** All human resource development activities should reflect understanding of and sensitivity to issues of violence, trauma and coercion; incorporate relevant skill sets and job standards; and address prevalence and impact of traumatic events.

All employees, including administration, should receive orientation and basic education about the prevalence and traumatic impacts of sexual and physical abuse and other overwhelming adverse experiences in the lives of service recipients. In order to ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. All employees must also be educated about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status on individuals' experiences of trauma.

Direct service staff and clinical staff should be educated in a trauma-informed understanding of unusual or difficult behaviors, in the maintenance of personal and professional boundaries, in trauma dynamics and avoidance of iatrogenic retraumatization, in the relationships between trauma, mental health symptoms and other problems and life difficulties, and in vicarious traumatization and self-care. They should learn application of trauma-informed issues and approaches in their specific content areas, and trauma-specific techniques such as grounding and teaching trauma recovery skills to clients.

Staff whose clinical work includes assessment and treatment should be required and supported to implement evidence-based and promising practices for the treatment of trauma, and to attend ongoing advanced trauma trainings.

Whenever possible, trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination.
(Goals 3.1, 3.2, 4.2, 4.3, 4.4, 5.3, 5.4: President's New Freedom Commission on Mental Health Final Report)

5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.** The voice and participation of consumers who have lived

experiences of trauma should be actively involved in all aspects of systems planning, oversight, and evaluation. Trauma-informed individualized plans of care should be developed in collaboration with every adult and child and child's family or caregivers receiving mental health system services. Consumers with trauma histories should be significantly involved in staff orientation, training and curriculum development and play a lead role in the creation of State Mental Health Plans, the improvement of access and accountability for mental health services, and in orienting the mental health system toward trauma and recovery. Special attention should also be paid to the rights of people with trauma histories (e.g. right to trauma treatment, freedom from re-traumatization, and rights to maximum choice, collaboration and empowerment) and to the ways in which these rights may be systematically violated. *(Goals 2.1, 2.2, 2.3, 2.4, 2.5: President's New Freedom Commission on Mental Health Final Report)*

Administrative Policies/Guidelines Regarding Services

6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.** Funding strategies for trauma-specific services should be clearly identified, and should eliminate disparities in mental health services by improving access to evidence-based and promising practices in trauma treatment. Existing exclusions and barriers to reimbursement should be eliminated. Although new funds are not necessarily critical to developing a trauma-informed system, the development of sufficient trauma-specific services to meet the treatment needs of the high percentage of clients with histories of unaddressed sexual and/or physical abuse and trauma may require creative fiscal reimbursement strategies. Attention to reimbursement and funding issues is key to a successful change strategy. *(Goal 3: President's New Freedom Commission on Mental Health Final Report)*

7. **Clinical practice guidelines for working with children and adults with trauma histories.** Findings from studies, including SAMHSA's Women, Co-Occurring Disorders, and Violence study and more recently studies involving traumatized children, increasingly provide evidence that trauma treatment is effective. Numerous clinical approaches have been manualized and guidelines have been developed. Clinical approaches to trauma treatment should clearly identify trauma as the issue being treated, promote recovery, allow for survivors to tell their stories, include trauma-sensitive training and supervision, address secondary trauma and self-care for the caregiver, respect cultural diversity, and be experienced as empowering by consumer/survivors.

8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.** Policies and regulations that guide system–wide practices are central to ensuring that trauma-informed and trauma-specific services are adopted consistently. Trauma-informed policies and procedures are crucial to reducing or

eliminating potentially harmful practices such as seclusion and restraint, involuntary medication, etc. They therefore must be carefully reviewed, revised, monitored and enforced to take into account the needs of trauma survivors. Licensing, regulations, certification, and contracting mechanisms should all reflect a consistent focus on trauma. Policies and regulations addressing confidentiality, involuntary hospitalization and coercive practices, consumer preferences and choice, privacy, human resources, rights and grievances for employees are also key. They should be modified periodically to conform to developments in knowledge of evidence-based and emerging best practice and to promote provision of and access to trauma-informed and trauma-specific services. *(Goal 3: President's New Freedom Commission on Mental Health Final Report)*

9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.** Data on trauma prevalence, trauma impacts, effectiveness of trauma services and consumer satisfaction can provide rationale for support/funding of such services and the training necessary for their implementation. Such data should be regularly collected and used as part of ongoing quality improvement and planning processes. Evaluation and research activities should be carried out through internal staffing or through liaison with external evaluators and researchers, to determine the effectiveness of systems change to a trauma-informed system, and to identify outcomes of trauma-related services. These finding are incorporated into ongoing services modifications and planning. *(Goals 5.1, 5.4: President's New Freedom Commission on Mental Health Final Report)*

Trauma Services

10. **Universal trauma screening and assessment.** All adults and children who enter the system of care, regardless of which "door" they enter, should be screened for abuse and trauma at or close to admission. At a minimum, questions should include histories of physical and sexual abuse, domestic violence, and witnessed violence. Individuals with a positive response to the screen should have a trauma assessment as an integral part of the clinical picture, to be revisited periodically and used as a part of all treatment, rehabilitation, and discharge planning. Clients with trauma histories should be informed about and referred to quality, trauma-informed and trauma specific services and supports.

11. **Trauma-informed services and service systems.** A "trauma-informed" service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addictions services. A "trauma-informed" organizational environment is capable of supporting and sustaining "trauma-specific" services as they develop. A

trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and trainings with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics, including that caused by childhood or adult sexual and/or physical abuse shown to be prevalent in the histories of mental health consumers, should be held by <u>all</u> staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. *(Trauma-informed service systems increase capacity to address Goals 2, 3, 4 and 5 in the President's New Freedom Commission on Mental Health Final Report)*

12. **Trauma-specific services, including evidence-based and promising practice treatment models.** Services designed specifically to treat the actual sequelae of sexual or physical abuse and other psychological trauma should be available in adequate numbers to serve the population and should be accessible to all consumers, including adults, and children and their families. As part of national research initiatives including the SAMHSA *Women, Co-Occurring Disorders, and Violence* study and SAMHSA's National Child Traumatic Stress Network, numerous evidence-based and promising practice trauma treatment models applicable in public sector service systems, have been manualized and proven to effective in reducing symptoms**.** Many of these best practice models have been identified in the SAMHSA publication "Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services". Selected models should be implemented by state mental health systems to treat trauma. Health technology and telehealth should be used to make these programs accessible for individuals in remote areas or in underserved populations. Although program models may vary widely, all should be recovery-oriented, emphasize consumer voice and consumer choice, and be fully trauma-informed. In addition, because of the numbers of trauma survivors with co-occurring disorders, and given significant positive findings from studies such as the WCDVS, trauma treatment programs should provide integrated trauma, mental health and substance abuse services and counseling designed to address all three issues simultaneously. . *(Goals 2.1; 3; 4.3; 5.2; 6.1 President's New Freedom Commission on Mental Health Final Report)*

References

Blanch, A. (2003). *Developing trauma-informed behavioral health systems.* Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

Bloom, S. (1997). *Creating sanctuary: Toward the evolution of sane societies.* New York, NY: Routledge.

Browne, A. (1992). Violence against women: Relevance for medical practitioners. Council on Scientific Affairs, American Medical Association Report. *JAMA, 257* (23).

Calhoun, O., Jurgens, E., Chen, F. (1993). The neophyte female delinquent: A review of the literature. *Adolescence, 28,*461-471.

Centers for Disease Control and Prevention, Department of Health and Human Services (2005). Adverse Childhood Experiences Study, www.cdc.gov.NCCDPHP/ACE/findings.htm

Clark, H., McClanahan, T., & Sees, K. (1997). Cultural aspects of adolescent addiction and treatment. *Valparaiso University Law Review, 31*(2).

Covington, S. S. (2003). *Beyond trauma: A healing journey for women.* Hazelden.

Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma history screening in a Community Mental Health Center. *Psychiatric Services, 55*, 157-162.

Cusack, K., Frueh, B., Hiers, T., Suffoletta-Maierle, S., Bennett, S. (2003). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health, 30*, 453-460.

Cusack, K. J., Wells, C. B., Grubaugh, A. L., Hiers, T. G., Frueh, B. C. (2007). An update on the South Carolina Trauma Initiative. *Psychiatric Services, 58*, 708-710.

Dube, S.R., Anda, R.F., Felitti, V.J., Chapman, D.P. et al. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *JAMA*. Chicago: Vol.286, Issue 24, pg 3089-3097

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Felitti, V.J. (2002). The relationship of adverse childhood experiences to adult health: Turning gold into lead. English translations of: Felitti V.J. (2002) Belastungen in der Kindheit und Gesundheit im Erwachsenenalter: die Verwandlung von Gold in Blei. *Z psychsom Med Psychother*, 48(4): 350-369

Foa, E., Keane, T., & Friedman, M. (2000). *Effective treatment for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Press.

Ford, J., Courtois, C., Steele, K., van der Hart, O., & Nijenhuis, E. (2004). *Treatment of the complex sequelae of psychological trauma*. Manuscript submitted for publication.

Frueh, B. C., Buckley, T. C., Cusack, K. J., Kimble, M. O., Grubaugh, A. L., Turner, S. M., Keane, T. M. (2004). Cognitive-behavioral treatment for PTSD among people with severe mental illness: A proposed treatment model. *Journal of Psychiatric Practice, 10*(1), 26-38.

Frueh, B., Cousins, V., Hiers, T., Cavanaugh, S., Cusack, K. I., & Santos, A. (2002). The need for trauma assessment and related clinical services in a state public mental health system. *Community Mental Health Journal, 38,* 351-356.

Frueh, B. C., Cusack, K. J., Hiers, T. G., Monogan, S., Cousins, V. C., & Cavenaugh, S. D. (2001). Improving public mental health services for trauma victims in South Carolina. *Psychiatric Services, 52*, 812-814.

Frueh, B. C., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Wells, C. (2006). Clinician perspectives on cognitive-behavioral treatment for PTSD among public-sector consumers with severe mental illness. *Psychiatric Services, 57*, 1027-1031.

Frueh, B., Dalton, M., Johnson, M., Hiers, T., Gold, P., Magruder, K., Santos, A. (2000). Trauma within the psychiatric setting: Conceptual framework, research directions, and policy implications. *Administration and Policy in Mental Health, 28,* 147-154.

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., Yim, E., Robins, C. S., Monnier, J., & Hiers, T. G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services, 56*, 1123-1133.

Giller, E. (1999). *What is psychological trauma?* Sidran Institute.

Glad, C. and Teicher, M. (1996). Relationship between early abuse, PTSD, and activity levels in prepubertal children. *Journal of the American Academy of Child and Adolescent Psychiatry,* 35 (10), 1384-1393.

Goodman, L., Dutton, M., & Harris, M. (1997). The relationship between violence dimensions and symptom severity among homeless, mentally ill women. *Journal of Traumatic Stress, 10*(1), 51-70.

Goodman, L., Rosenberg, S., Mueser, K., & Drake, R. (1997). Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin, 23*, 685-696.

Grubaugh, A. L., Frueh, B. C., Zinzow, H. M., Cusack, K. J., & Wells, C. (in press). Patients' perceptions of care and safety within psychiatric settings. *Psychological Services*.

Hammersley, P., Burston, D., Read, J. (2004). Learning to listen: Childhood trauma and adult psychosis. *Mental Health Practice*; 7(6) p. 18-21

Harris, M., & Fallot, R. (2001). Using trauma theory to design service systems. *New Directions for Mental Health Services, 89.* Jossey Bass.

Heuberger. (2001). Massachusetts Department of Mental Health.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror.* New York: Basic Books.

Hodas, G. (2006). Responding to childhood trauma: The promise and practice of trauma-informed care. www.nasmhpd.org

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academy Press.

Jennings, A. (1994). On being invisible in the mental health system. *Journal of Mental Health Administration* 21 (4): 374-387.

Jennings, A. (in press). *Trauma informed mental health service systems: Blueprint for action.* Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

Jennings, A. (2004). *The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the behavioral health system.* Alexandria, VA: Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

Jennings, A. (2006). *A Child's Path to Mental Illness and Suicide: A Powerpoint Presentation.* www.theannainstitute.org

Lipschitz DS, Winegar RK, Hartnick E, Foote B, Southwick SM (1999), Posttraumatic stress disorder in hospitalized adolescents: Psychiatric comorbidity and clinical correlates. *J Am Acad Child Adolesc Psychiatry*, 38:385-392

Morrison, A.P., Frame, L., Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology,* 42, 331-353

Mueser, K., Goodman, L., Trumbetta, S., Rosenberg, S., Osher, F., Vidaver, R., Anciello, P., & Foy, D. (1998). Trauma and Posttraumatic Stress Disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 66,* 493-499.

Mueser, K., Rosenberg, S., Goodman, L., & Trumbetta, S. (2002). Trauma, PTSD, and the course of schizophrenia: An interactive model. *Schizophrenia Research, 53,* 123-143.

Mueser, K.T. and Rosenberg, S.D. (2003). Treating the trauma of first episode psychosis: A PTSD perspective. *Journal of Mental Health* 12, 2, 103-108. *43, 269-278*

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse.* The Guilford Press.

National Association of State Mental Health Program Directors (NASMHPD). (1999). *Position statement on services and supports to trauma survivors.* Retrieved from the Internet at http://www.nasmhpd.org/general_files/position_statement/posstmb.htm on September 16, 2004.

National Executive Training Institute (NETI) (2003). Training cucurriculum for the reduction of seclusion and restraint. Alexandria, VA: national Technical Assistance Center for State Mental Health Planning.

NYS-OMH Division of Facility Management, figures for April 1, 1999 - 2001

Perrin, S., Smith, P., Yule, W. (2000). Practitioner Review: The assessment and treatment of Post-traumatic Stress Disorder in children and adolescents. *J.Clin.Psychol.Psychiat.,* 41, 277-289

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: DHHS

Read, J., Perry, B., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry, 64*(4), 319-345.

Read, J., Ager, K., Argyle, N., Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorders. *Psychology and Psychotherapy: Theory, Research and Practice*. 76, 1-22.

Robins, C. S, Sauvageot, J. A., Cusack, K. J., Suffoletta-Maierle, S., & Frueh, B. C. (2005). Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. *Psychiatric Services, 56*, 1134-1138.

Rosenberg, S., Mueser, K., Friedman, M., Gorman, P., Drake, R., Vidaver, R., Torrey, W., & Jankowski, M. (2001). Developing effective treatments for posttraumatic disorders among people with severe mental illness. *Psychiatric Services, 52,* 1453-1461.

Russell, D. (1986). *The secret trauma: Incest in the lives of girls and women.* New York, NY: Basic Books Inc.

Saakvitne, K., Gamble, S., Pearlman, S., & Tabor Lev, B. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse*. Sidran Institute.

Sareen, J., Cox, B.J., Goodwin, R.D., Asmundson, G. J.G. (2005) Co-Occurrence of Posttraumatic Stress Disorder with Positive Psychotic symptoms in a Nationally Representative Sample. *Journal of Traumatic Stress,* Vol 18, No. 4, pp. 1-10

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York, NY: Guilford Press.

Smith, B. (1998). *An end to silence: Women prisoners' handbook on identifying and addressing sexual misconduct.* National Women's Law Center.

Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). (2000). Substance abuse treatment for persons with child abuse and neglect issues. *Treatment improvement protocol (TIP) series.* Number 36. DHHS Publication No. (SMA) 00-3357. Washington DC: U.S. Printing Office.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148,* 10-20.

Tucker, W.M. (2002). How to include the trauma history in the diagnosis and treatment of psychiatric inpatients. *Psychiatric Quarterly,* Vol 73 Issue 2, p135-145.

Wright, D., Woo, W. L., Muller, R. T., Fernandes, C. B., & Kraftcheck, E. R. (2003). An investigation of trauma-centered inpatient treatment for adult survivors of abuse. *Child Abuse & Neglect, 27*, 393-405.

--