ESSENTIAL SKILLS AND COMPETENCIES IN WORKING WITH TRAUMA

WASHINGTON STATE MENTAL HEALTH CO-OCCURRING DISORDERS CONFERENCE

Christine A. Courtois, PhD, ABPP
Psychologist, Independent Practice (retired)

Consultant & Trainer, Trauma Psychology
CACourtoisPhD@aol.com
Trauma and Symptomatic Survivors Have Been Stigmatized

We Like Heroes, We Don’t Like Victims

Victims Are Losers

The “Abuse Excuse”
The Problem

• In keeping with societal ignorance and denial, medical, mental health, social service, and criminal justice professionals have not known about or acknowledged the role of trauma in their client’s difficulties

They came by this “honestly:”

– “the history of traumatic stress studies is one of episodic dissociation” (Herman)
– little or no training in professional curricula, even today

May also be due to personal reactions of denial/dismissal/disbelief/contempt/hostility/judgment/parallel process
The Problem

- Trauma survivors have been further harmed by the very people who were charged with helping them
  - Misunderstanding, misdiagnosis and direct mistreatment
  - Abuse in the worse cases
  - Betrayal-trauma
  - Institutional betrayal

- Revictimization
  - Retraumatization
  - Hopelessness
  - Despair
  - Self-fulfilling prophecy
Challenges of Addressing Trauma

- External obstacles at a societal level
- Coping mechanisms developed by survivors can lead to severe symptoms

Adapted from *Risking Connection*, pp. 7-12
Challenges of Addressing Trauma

• Interpersonal styles developed by survivors can interfere with developing the helping alliance
  – Mistrust and shame

• The skepticism & fear many survivor clients have about the medical, mental health, social service, and criminal justice systems

• Personal and professional factors and response on the part of the therapist or other helper
Problem: Lack of Training or Adequate Training About Trauma and Its Impact in Most Professional Curricula
Problem: The Majority of Mental Health Clients/Consumer Have Some Sort of Trauma in Their Background
Therefore: Major Disparity and Disconnect Between Training and On the Job Reality
Who Pays? We All Do
Victim/Survivors
Families/Loved Ones
Communities
Society

Human Potential
Acute Suffering
Intergenerational & Historical Impact
Economic Impact
Untreated Effects of Trauma Are A Public Health Problem of MAJOR Proportions
Treatment Themes and Components

• The significance of relationship, support, and understanding/acceptance
  – Trauma-referenced
  – Trauma-informed
  – “It’s not you, it’s what happened to you.”
  – Betrayal-trauma and ambivalent attachment
  – Relational trauma and attachment style
  – “Relational treatment for relational injury.”
  – Respect, empathy, curiosity about the client
  – Reliability, consistency, transparency, management of response/CT/VT
Treatment Themes and Components

- Strength-based
- Problem-oriented
- **Safety first**
- Psych-education
- Emotion regulation training
- Identification of triggering events and experiences
- Countering dissociation and encouraging association
Treatment Themes and Components

• Exposure vs. avoidance
  – Titrated
  – Window of tolerance/therapeutic window
  – Processing within relationship
• Cognitive processing
• Identity issues
  – Attachment safety: Attunement, mirroring and supporting self-development
  – Challenging devaluation/shame
Treatment Themes and Components

- Family therapy
- Other caregivers
- School
- Cultural issues and supports
- Community supports
- Abstinence and recovery
  - Advocacy and support groups and resources
- The significance of peer support and groups
The Need for Trauma-Informed Care and What It Is
Traditional/Medical Models of Care

• Often stigmatize the traumatized for their symptoms and interaction styles

• Often misdiagnose and then mistreat (and medicate) the client’s condition, at times making it much worst

• At worst, directly abuse and retraumatize the client

• Assume the treater is the expert and should have authority: non collaborative and not strength-based; hierarchical and top-down

• Expect the treater to be invulnerable; view emotional response to the work as unprofessional & weak rather than a condition of the work
Traditional Models of Care

• Emphasize control over collaboration

• Reflect a belief in a mind/body split

• Hold a disease perspective:
  – Focus on symptoms to be cured

• Have largely been ignorant of trauma

• Do not know or assume that trauma has anything to do with the client’s symptoms

Adapted from *Risking Connection*, pp. xiii-xiv
Medical services are the usual entry point into the system
  – Without assessment of trauma or knowledge of its possible impact and connection, diagnoses may be missed and unnecessary treatment or medication utilized

Financial and economic costs and burdens
  – Individual, family, community, society
Trauma-Informed Care

“Trauma-informed services are those that incorporate an understanding of the impact of violence and psychological trauma in the lives of consumers of mental health, healthcare, and social services.”

(Clark, Classen, Fourt, & Shetty, 2015)
Trauma-Informed Care

• Focuses on the strong possibility (or even the likelihood) of trauma in the mental health and medical client’s background and as highly pertinent to the client’s distress and symptoms

• Directly acknowledges and is sensitive to trauma-related issues
Trauma-Informed Care

• Major paradigm shift in view of clients and their symptoms/injuries

  – Views symptoms as coping attempts, skills, and adaptations to injury and not as disorders

  • A much less pathologizing way of viewing symptoms
  • A much more open and understanding perspective

Adapted from Risking Connection, pp. xiii-xiv
What happened to you versus what’s wrong with you?

(Bloom)

It’s not you, it’s what happened to you

(Courtois)
Trauma-Informed Care

- Makes the connection:
  - “Germ theory of trauma” (Bloom)
  - We have a major pathogen in our midst
- TIC offered as a “universal precaution”
  - Applies to all clients and services
  - Across all levels of the organization
  - Basis of good professional practice in general but
  - Especially important for those who have been traumatized
Guiding Principle of TIC

First, Do No More Harm
Core Principles of TIC

- **Awareness**: Everyone knows the role of trauma
- **Safety**: Ensuring physical and emotional safety
- **Trustworthiness**: Maximizing trustworthiness, making tasks clear, and maintaining clear and appropriate boundaries
- **Choice**: Respect and prioritize consumer choice and control
- **Collaboration**: Maximizing collaboration and sharing of power with consumers
- **Empowerment**: Prioritizing consumer empowerment and skill-building; motivation enhancement
Some Major Assumptions of TIC

- Many symptoms are misguided attempts to regulate emotions
  - What once worked may stop working and become a problem in its own right

- Symptoms and problems are often “secondary elaborations of the untreated original effects of the trauma”

- The relational impact of trauma often affects the helping relationship
Some Major Assumptions (Risking Connection)

- A shared trauma perspective fosters collaboration

- A treater offers:
  - Respect
  - Connection
  - Information
  - Hope

- Treaters need the same from one another

- Working with survivor clients affects the person of the helper
Some Major Assumptions (Risking Connection)

- Trauma shapes the survivor’s basic beliefs about identity, relationships, world view, & spirituality
- The effects of childhood abuse are important and can be addressed within mental health (and substance abuse) treatment and service systems with a trauma framework

pp. 12-15
Trauma-Informed Care

• Individual respect and regard as a starting point
  – May be difficult to accept

• Founded on acknowledgement and inquiry:
  – asking about signifies importance and ability to talk about

• Founded on safety: emotional, relational, physical, environmental
  ▶ Consistency, reliability, and trustworthiness of environment and treaters
  ▶ A safe organized environment w/ no physical threat
Trauma-Informed Care

• Starts with assessment
• Why it is important to ask about trauma
• How to ask and respond to disclosures
• Safety first
• Asking does not ensure accurate response
  – Does not mean the client is a liar or a malingerer
• Violence and risk-assessment with safety planning, as needed
• Assessment is best considered as ongoing
  – Resolution of one issue might open another
Trauma-Informed Care

• Strength and resiliency-based
  – assumes strength and resources
  – builds on what is available
  – assesses motivation
  – gives attention to client goals and resources
  – “resources” the client
  – collaborative and empowering
  – addresses therapy-interfering behavior

• Informed consent and refusal
Trauma-Informed Care

• Psych-education: normalize, validate, educate throughout
  – 1. Psychotherapy process and how to engage; “rules of the road”
  – 2. Trauma and its effects
    • psychological, biological, neurobiological & social effects and development of symptoms
  – 3. The process of change
    • Change is not linear—it is “messy” and recursive
    • Asserts that crises are best managed through development of “feeling and self-management skills”
Trauma-Informed Care

• Create hope
  – Healing is possible
  – Healing is a process
  – Setbacks, crises, lapses or relapses are opportunities for problem-solving and new learning, not failure
Trauma Informed Care

• The significance of the relationship
  – The treater as essential to the healing process
  – The treater will be personally impacted by the trauma work
    • May have own trauma history
    • Even without own history
• Many treaters are traumatized by the system itself (organization, managed care, caseload demands, lack of support, moral injury) and are burned out
  – Trauma-informed model provides them with a new “operating system” and values along with additional training and support
CONSENSUS TREATMENT PRINCIPLES

1. Safety is an essential condition for successful treatment and may take time to develop.

2. Relational attachment and safety in the therapeutic relationship are essential.

3. Treatment must enhance the ability to manage extreme arousal states and tolerate feelings. Somatosensory and affective identification and skill-building in self-regulation are needed.

4. Treatment is strength-based and should enhance the sense of personal control, empowerment, and self-efficacy.
5. Treatment must enhance the client’s ability to approach and master rather than avoid experiences that trigger symptoms.

6. Treatment must assist in maintaining an adequate level of functioning consistent with past and current lifestyle.

7. Therapists must be aware of clients’ trauma/transference reactions and effectively manage their own countertrauma/countertransference and VT and personal health status.
8. Treatment, like complex trauma, is complex and multimodal and integrative.

9. Treatment focuses on desensitization of traumatic memories and associated emotions to enhance personal authority over memory and meaning-making rather than memory retrieval. Resolution results in the lessening of trauma-based symptoms and posttraumatic adversity and decline.
APA Competencies for Trauma Treatment (2014)

• Competencies are defined as knowledge, skill, and attitudes.

• The competencies are expectations for a psychologist at entry level to practice.

• The competencies articulate minimal expectations; all trauma psychologists who seek to practice at the entry level should be able to demonstrate acquisition of these core competencies.

• The competencies assume that general competencies for professional psychology have been attained.

• There are a number of models for trauma-informed and trauma-focused mental health practice; the proposed competencies are not specific to any one model, but rather outline necessary competencies for all trauma-related psychology practice regardless of models.
APA Competencies for Trauma Treatment

• A total of **five broad competencies**, each with a subset of knowledge, attitudes, and skills necessary for achieving proficiency in a given area

• Note: There are now many sub-specialty areas in trauma psychology and treatment
APA Competencies for Trauma Treatment

• Eight cross-cutting competencies represent areas of knowledge, attitude, or skill that are foundational to all other competencies, including issues such as individual and cultural diversity, incorporation of life-span factors, and therapist self-awareness and self-care.
Cross-Cutting Trauma-Focused Competencies

1. Demonstrate understanding about trauma reactions and tailor trauma interventions and assessments in ways that honor and account for individual, cultural, community, and organizational diversity. This includes demonstrating the ability to identify the professionals’ and clients’ models of intersecting cultural identities (e.g., gender, age, sexual orientation, disability status, race/ethnicity, SES, military status, occupational identity, rural/urban, immigration status, religion, national origin, indigenous heritage, and gender identification) as related to trauma and articulate the professionals’ own biases, assumptions, and problematic reactions emerging from trauma work and cultural differences.

2. Demonstrate understanding and ability to tailor assessment and interventions to account for developmental lifespan factors at time(s) and duration of trauma as well as time of contact.

3. Demonstrate the ability to understand, assess, and tailor interventions and assessments that address the complexities of trauma-related exposure, including any resultant long- and short-term effects (e.g., comorbidities, housing-related issues, etc.), and person–environment interactions (e.g., running away from home and being assaulted).

4. Demonstrate the ability to appropriately appreciate, assess, and incorporate trauma survivors’ strengths, resilience, and potential for growth in all domains. Facilitate shared decision making whenever appropriate.
Cross-Cutting Trauma-Focused Competencies

5. Demonstrate understanding about how trauma impacts a survivor’s and organization’s sense of safety and trust. Apply the professional demeanor, attitude, and behavior necessary to enhance the survivor’s and organization’s sense of physical and psychological safety. This includes respecting the autonomy of those exposed to trauma but also protecting survivors as appropriate.

6. Demonstrate the ability to recognize the practitioners’: (1) capacity for self-reflection and tolerance for intense affect and content, (2) ethical responsibility for self-care, and (3) self-awareness of how one’s own history, values, and vulnerabilities impact trauma treatment deliveries.

7. Demonstrate ability to critically evaluate and apply up-to-date existing science on research-supported therapies and assessment strategies for trauma-related disorders/difficulties.

8. Demonstrate the ability to understand and appreciate the value and purpose of the various professional and paraprofessional responders in trauma work and work collaboratively and cross systems to enhance positive outcomes.
Knowledge Competency

1. Demonstrate the ability to recognize the epidemiology of traumatic exposure and outcomes, specifically:
   a. Prevalence, incidence, risk and resilience factors, and trajectories.
   b. Subpopulations and settings.

2. Demonstrate basic knowledge of findings, mechanisms, models, and interactions among social, psychological, neurobiological factors (e.g., relational, cognitive and affective, economic, genetic/epigenetic findings, health and health behaviors).

3. Demonstrate understanding of the social, historical, and cultural context in which trauma is experienced and researched.

4. Demonstrate the ability to critically review published literature on trauma and PTSD by employing general knowledge as well as trauma-specific knowledge.

5. Demonstrate the ability to effectively and accurately communicate and educate scientific knowledge about trauma to a broad range of audiences, including those communities and organizations that are impacted by trauma.
Assessment Competency

1. Demonstrate a willingness to ask about trauma exposure and reactions with all clients, in both trauma- and non-trauma-focused presentations.

2. Demonstrate the ability to conduct comprehensive assessment of trauma exposure and trauma impact based on the most current available evidence base.

3. Demonstrate awareness of, and capacity to appropriately adjust procedures, processes, and interpretations related to, the unique impacts of trauma (e.g., dissociation, avoidance, triggers) as they affect assessment processes and responses.

4. Demonstrate the ability to understand the course and trajectory of trauma responses and tailor assessment accordingly.

5. Demonstrate the ability to assess strengths, resilience and growth both preexisting and post-trauma.
Assessment Competency

6. Demonstrate the awareness of test interpretation issues frequently encountered in trauma-exposed populations (e.g., appropriate use of validity scales, response styles, motivation).

7. Demonstrate the ability to assess the extent to which culture, beliefs, and practices influence the expression and coping with trauma exposure, including barriers to assessing treatment.

8. Demonstrate knowledge about the practical consequences of trauma-related assessment and diagnosis in different contexts (e.g., social services, military, forensic).

9. Demonstrate the ability to tailor the trauma assessment, battery, and interview questions to match characteristics (e.g., culture, age, socioeconomic, family or systems) of client, setting, and trauma experience.

10. Demonstrate knowledge appropriate to scope of practice regarding major trauma-relevant and generic questionnaires/interviews; this can include the psychometrics, strengths, limitations, and appropriateness for specific groups of trauma survivors.
Trauma-Focused *Psychological Interventions*

1. Demonstrate knowledge about the current existing science on research-supported interventions (psychosocial, pharmacological, and somatic) for trauma-related disorders/difficulties.

2. Demonstrate the ability to employ critical thinking and work collaboratively to tailor and personalize any psychosocial and pharmacological treatment and its pacing with survivors. This approach involves being responsive to particular trauma survivors’ trauma type and comorbidities, as well as culture, personality, values, strengths, resources, and preferences, within the context of the recovery environment.

3. Demonstrate the ability to apply trauma-focused phased treatment, and match treatments to evolving needs. This approach involves continually assessing the interaction of the client and the changing environment to assess for indicators of improvement or worsening.

4. Demonstrate understanding of the components and mechanisms of change, both common and unique, underlying various therapies for trauma-related disorders.

5. Demonstrate the ability to attend to trauma-related material nonjudgmentally and non-punitively with empathy, respect, and dignity and a belief in recovery and resilience (in contrast to pity, condescension, and resignation).
6. Demonstrate the ability to implement non-avoidant strategies in engagement, retention, and delivery of trauma-focused treatment (i.e., avoid avoidance).

7. Demonstrate the ability to maintain a focus to identify opportunities to reduce the deleterious effects of trauma and promote recovery and growth before, during, and following trauma exposure (i.e., prevention and mitigation).

8. Demonstrate understanding about how a comprehensive pharmacological treatment plan can be part of a biopsychosocial approach to trauma response.

9. Demonstrate an understanding about the pharmacology of each medication as it relates to therapeutic and adverse effects and how drug actions might be modified by genetics, gender, age, and health behaviors (e.g., diet, smoking, alcohol use).

10. Demonstrate the ability to collaborate with trauma clients’ families, social networks, and care systems to promote non-avoidance and positive trauma-related responses.

11. Demonstrate the ability to cultivate and maintain a therapeutic relationship with trauma-impacted individuals that fosters a sense of safety, trust, and openness to addressing trauma-focused material.
Trauma-Informed *Professionalism*

1. Demonstrate the ability to sensitively interface with legal and other external systems in ways that safeguard trauma survivors and enhance outcomes (e.g., create and share records that do not create iatrogenic harm when introduced into the system).

2. Demonstrate the ability to engage with relevant leaders around trauma issues and promoting systemic, social, and policy change.

3. Demonstrate an understanding of how public policy issues affect trauma work within organizations and with individuals.

4. Demonstrate enhanced attention to ethical issues that are relevant to trauma survivors and appropriate boundaries in trauma work (e.g., boundary maintenance, role overlap, informed consent, confidentiality).

5. Demonstrate skills to hear and work with clients’ trauma material and associated distress that minimizes the risk of iatrogenic harm.
1. Demonstrate knowledge of the disorganizing effects of trauma at all levels. Given that trauma results in changes at the individual and systems levels, psychologists must demonstrate the ability to respond to these deleterious effects appropriately.

2. Demonstrate knowledge about and skills of offering consultation on trauma-informed systems of care and models of care.

3. Demonstrate the ability to engage in interdisciplinary collaboration regarding traumatized individuals and communities.

4. Demonstrate understanding that institutions and systems can contribute to primary and secondary trauma and offer strategies to reduce these barriers as appropriate.

5. Demonstrate an understanding of the importance of using relational healing for relational injury (e.g., trustworthiness) and the capacity to use the relationship effectively.

6. Demonstrate knowledge about the role of organizations in building resilience, prevention, and preparedness (universal precautions).

7. Demonstrate the ability to consistently recognize how the cultural, historic, and intergenerational transmission influences perception of helpers.
Working Toward Mastery

- Get Familiar
- Get Experienced
- Achieve Mastery

Projects Worked On vs. Time Spent
References


References


• Poole, N. & Greaves, L. (Eds.) (2012). Becoming trauma informed. Canada: Centre for Addiction and Mental Health.


It’s Not You, It’s What Happened to You
http://www.amazon.com/dp/B00OF2ADL0