

TRAUMA RECOVERY CENTER TRAUMA-INFORMED, EVIDENCE-BASED PSYCHOTHERAPY

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Photograph by Ezme Kozuszek

“Courage doesn’t always roar. Sometimes courage is the
quiet voice at the end of the day saying,
I will try again tomorrow

—Mary Anne Radmacher

*The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and
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TRC psychotherapy interventions fall within an established three-stage model of trauma treatment that addresses survivors' differing needs and environments (Herman, 1997) (see *Clinical Model Overview* in this chapter's Appendix 1). The TRC Clinician selects from evidence-based, trauma-informed and trauma-specific therapy models appropriate for this population—a diverse group of survivors, many of whom have experienced multiple incidents and types of violent crime. The treatment stages are:

STAGE ONE: Stabilization and establishment of safety

STAGE TWO: Addressing and processing the trauma memories or related beliefs, and/or grieving the losses inherent in trauma

STAGE THREE: Restoring or creating connection between survivors and their communities by increasing engagement in meaningful, positive activities and relationships

This overarching stage model serves as a useful tool to guide decisions about treatment selection. Within each stage of treatment, evidence-based practices (EBPs) are used. EBPs require clinicians to use techniques and approaches that are based on the best available research evidence (Sackett et al., 2000). This includes those that are empirically supported as well as those recommended in expert consensus treatment guidelines.

Although every client is different, many people benefit from 12-16 sessions of Stage One treatment. Clinicians generally start services by offering 16 sessions of treatment, or less if clients are reluctant to engage. There is a process by which services can be extended beyond 16 sessions if treatment will continue beyond Stage One and certain other criteria are met, or if extenuating circumstances require a slower pacing of Stage One interventions (see Supervision chapter for more detail).

However, in their Expert Consensus Treatment Guidelines For Complex PTSD in Adults, the International Society for Traumatic Stress Study (ISTSS) states that the “length of treatment for patients with Complex PTSD symptom profiles in the research literature has varied from 4 to 5 months and these timelines have been associated with substantial benefits.” ISTSS experts in this survey recommended the need for longer courses of treatment than have been applied in clinical trials.” They consider “6 months to be a reasonable amount of time for Stage One, and another 3 to 6 months for Stages Two and Three, producing a combined treatment duration of 9 to 12 months” (Cloitre et al., 2012). For clients with a history of early and repeated trauma, Clinicians and their supervisors can consider extending treatment in increments of 16 sessions.

Stage One Interventions for Safety and Stabilization

The goals of this initial stage include identifying and addressing any safety concerns, stabilizing biological rhythms, and reducing post-trauma distress.

Establish a Sense of Safety and Trust in the Clinician

The TRC Clinician begins therapy by helping the client establish feelings of safety and trust in the Clinician. After being victimized, a person's ability to trust others is typically significantly compromised. This contributes to under-engagement in usual services, or causes premature drop-out. Building a positive therapeutic alliance is key to any successful therapy and can be a particular challenge when working with acute survivors of violent crime (Norcross, 2011), and those with complex PTSD. Strategies to build the alliance include:

- ◁ Offering an overtly warm, welcoming stance in order to demonstrate caring about the client and their needs.
- ◁ Following through with planned session start/stop times and any treatment plans discussed. This increases trust in the Clinician's word.
- ◁ Providing clinical case management along with therapy to serve as a concrete demonstration of caring, respect, attunement with needs, and trustworthiness.
- ◁ Limiting talk of the most distressing details of the client's trauma. At the start of treatment, the client has not yet developed a healthy trust in the Clinician and the Clinician does not yet know if the client is stable enough to tolerate revisiting these details (see *Safety in the Therapy*, below).
- ◁ Using a collaborative approach to set treatment goals.
- ◁ Asking the client for their perspective about how early sessions are going. This can increase the client's trust that the Clinician is attuned to their unique needs and feelings about the process.
- ◁ Offering the client choices when possible (e.g., appointment times, therapy interventions) to increase feelings of control and balance power.
- ◁ Providing psychoeducation to normalize trauma responses (Appendix 2) and the need for mental health care.
- ◁ Communicating recognition of the client's culture, identity, history, and community, as well as differences between the client and Clinician.
- ◁ It can also be helpful to educate about the "culture of therapy" including weekly attendance. This is a culturally sensitive intervention in recognition of the fact that

many people experience stigma in regards to mental healthcare or may not understand the way therapy works.

Use a Culturally-Sensitive Trauma-Informed Approach

The TRC Clinician is attuned to the client’s identity and history as well as beliefs about psychotherapy that may impact treatment engagement. For some clients, there may be an unspoken assumption that one goes to appointments only when feeling very bad or sick. In this case, the Clinician should briefly provide education about the expectation of weekly appointments in order to have an effective “dose” of treatment, as well as highlighting the importance of making therapy a priority for their recovery. Stigma about having a mental health issue, about being a victim, about receiving mental health services, or about taking psychotropic medication are culturally-mediated beliefs that should be recognized and addressed early in treatment. Psychoeducation that normalizes traumatic stress reactions can be helpful, as can reframing a client’s ability to acknowledge vulnerabilities and accept help as a strength.

The TRC Clinician must be sensitive to a wide variety of human diversity issues in order to work meaningfully with clients in their trauma recovery. For example, gender, sexual orientation, and gender presentation can be intimately linked to trauma history and recovery. A disproportionate percentage of transgender individuals experience violence and discrimination. Among American Indians, the cumulative effects of historical injustices coexist with individual victimization. Likewise, among black Americans, intergenerational trauma stemming from slavery and ongoing/institutionalized racism can be intertwined with the effects of current community violence and crime victimization. The trauma histories of these and other clients may be very complex, and it is critical for providers to acknowledge that complexity in order to create a trusting therapeutic alliance.

Use Safety Interventions for the Therapy Itself

Survivors of violence often presume they will have to talk about the details of their trauma—a very anxiety-arousing prospect for most. They are usually struggling with the desire to avoid any trauma reminders, and can feel triggered (the experience of psychological and/or physiological distress) when coming to the “trauma center.” The Clinician addresses this early in the treatment by communicating that there is no *expectation* that clients must talk about the details of their trauma(s), and that there are many other ways therapy can help them recover (e.g., anxiety management skills, increasing safety, decreasing depression, improving sleep). Many clients wind up wanting to discuss their trauma, but this relieves them of the pressure to do so.

In order to help a client feel safe while talking about trauma-related topics, the TRC Clinician teaches the client how to communicate their level of emotional distress by use of a *subjective units of distress* (SUDS— see Appendix 3) rating or distress scale (Wolpe & Lazarus, 1973). The Clinician also monitors the client for any signs of emotional numbing or dissociation. If a client’s distress level rises to the point that they are flooded with painful memories, intense emotion or anxiety, or if they are dissociating (e.g., numbing or spacing out or “going away”), the SUDS rating gives them a way to communicate this to the Clinician. The Clinician will then help by teaching the client strategies for *grounding* (Najavits, 2002). Grounding is a key intervention that refocuses a client’s attention away from upsetting trauma-related thoughts to neutral and calming thoughts, often described as “changing the channel.” The Clinician and client assess SUDS levels before and after grounding to measure the effectiveness in reducing emotional distress or dissociation. The client can choose which of the three types of grounding they prefer to use and can increase the effectiveness by practicing outside the session as well.

The Clinician may choose to use 10-15 minutes at the end of each session to check distress levels, do grounding, and plan for self-care and skills use that evening and the rest of the week to aid clients with anticipating and managing difficult feelings in a healthy way.

Address Threats to Safety in the Client’s and Behaviors Environment

Acute trauma and crime victimization carry increased risk for a variety of safety concerns, including risk for revictimization by perpetrators or others around them, as well as risk due to severe psychiatric symptoms. The term *continuous traumatic stress* has been used for clients in ongoing traumatic and aversive environments such as domestic violence, community violence, homelessness, stalking, gang involvement, and human trafficking (Eagle & Kaminer, 2013). These clients have ongoing acute stress symptoms as well as chronic PTSD, because they are in *current danger*. In these cases the TRC Clinician focuses on helping the client reduce current threats to their safety and well-being by providing case management assistance (e.g., moving to a safe location, obtaining a restraining order, making a police report) and safety planning (Appendix 5, LEAP).

There may also be a risk of homicidal ideation (HI) towards a perpetrator after an assault or after the murder of family members. A client may have recurring thoughts of retribution, including harming or murdering the perpetrator. The client may say something like, "Since they’re not going to prosecute the shooter, I think about killing him. I can't seem to stop thinking about it. I've never been a violent person. I know these

are awful thoughts, but they keep coming back to me. Especially at night, I get all wound up and I can't sleep.” The TRC Clinician conducts a full HI risk assessment when indicated (Appendix 6) and considers whether higher intensity services or mandated reporting (Tarasoff) are warranted. If able to be managed on an outpatient basis, the Clinician assists the client by normalizing the thoughts (“It's natural to have these kinds of thoughts after a traumatic loss like the one you had”) and discussing strategies for dealing with them. These include helping clients to distinguish thoughts and urges from actions, and realizing that they do not have to act on the urges; considering negative consequences of acting on urges such as further harming family members or going to prison; helping the client express the positive intention or goal underlying the thoughts such as protection and the desire to be safe; and exploring alternative actions to attain such goals.

Suicidal ideation (SI) is quite common after trauma as well, with clients who have experienced repeated or severe traumas and substance use at significantly higher risk. Early and ongoing assessment and monitoring of SI and correlated safety planning are indicated as priorities in the treatment for such clients. The TRC Clinician may use the *Brief Risk Assessment Protocol* (BRAP, Appendix 7) to fully assess SI and the *Collaborative Assessment and Management of Suicidality* tools to help join with the suicidal client in uncovering their most distressing concerns, and give them hope in collaboratively developing a plan to address them (Jobes, 2012).

IMMEDIATE SAFETY CHECKLIST. If at any point in the therapy the Clinician becomes aware of any of the immediate safety issues specified in this checklist (Appendix 8), then risk management and safety become the focus of treatment. All of these are considered threats to environmental and bodily integrity and require the Clinician to address these safety issues immediately. Regularly review the client’s situation and determine if any of the following risks are present:

- ◁ In danger of harming self or others (SI, HI, self-injury, recklessness)
- ◁ In danger of being harmed by perpetrator(s)
- ◁ Acute community violence, domestic violence, unsafe living environment
- ◁ Untreated serious medical condition(s)
- ◁ Severe substance abuse/dependence
- ◁ Eating disorder with regular purging or severe restriction with Body Mass Index below 17
- ◁ Severe dissociation during which client loses awareness/memory for events
- ◁ Psychosis with command hallucinations; paranoid delusions

The Clinician and the team assess the degree of structure needed to ensure safety (e.g., day treatment for cutting or other self-harming behaviors, medical detoxification facility for alcohol withdrawal, psychiatric hospitalization for containment of suicidality), and also help to arrange safe housing/shelter. They also obtain restraining orders, arrange urgent medical care, or more intensive mental health care as needed. Safety planning for any ongoing or future danger to client or others is a part of the therapeutic process.

Address Risk Due to Problems with Regulation of Emotions and Impulses

Clients who have longer-term histories of childhood and repeated interpersonal trauma will likely also manifest emotional dysregulation symptoms of Complex PTSD (CPTSD) or Borderline Personality Disorder (BPD). Emotional dysregulation is the inability to flexibly respond to and manage emotional reactions in a safe or healthy way, and it can result in increased risk of re-victimization and self-harm. The Clinician provides case management interventions to address dangerous environments and people as described above, and focuses therapeutic interventions on client emotions, reactions, and behaviors which place them at risk.

Capacity to Handle Emotions. The TRC Clinician does an early assessment of the client's most troubling feelings and their capacities for coping with them (Saakvitne, Gamble, Pearlman, & Lev, 2000). When faced with strong feelings, does the client:

- ◁ Rarely or never express them?
- ◁ Become unsafe with self or others/lose control?
- ◁ Dissociate (space out, lose connection with self)?
- ◁ Lose touch with external reality—become delusional, hallucinate?
- ◁ Isolate, become depressed, lethargic?
- ◁ Use alcohol or other substances?
- ◁ Engage in other excessive or addictive behaviors?

A critical element in the treatment of acute crime survivors and chronically traumatized clients is to help them find words for emotional states. Naming feelings gives a sense of control and mastery over what has had to be avoided or seemed unknowable. Increasing a client's insight by connecting events to feelings also increases their sense of control. The client can learn to see the TRC Clinician as a support— providing strength, understanding, and companionship in times of pain. The Clinician's tools for this work may include face/feeling charts and emotion words handouts.

The TRC Clinician selects from several evidence-based approaches to address risk behaviors related to impulsivity and emotion dysregulation depending on the specific types of behavior and the client's stage of readiness for addressing the behaviors.

DIALECTICAL BEHAVIOR THERAPY (DBT). For clients whose trauma adaptations have interfered with emotion regulation and interpersonal relating, methods drawn from DBT can be very helpful (Linehan, 1993). DBT provides specific instruction in skills for emotional modulation, self-soothing, and assertiveness, including psychoeducation and tools for managing overwhelming emotions. For example, clients can be told “Intense emotions may come and go in waves, and like the seemingly overpowering ocean wave, will recede and pass.” The Clinician can ask the client to recall times they felt overwhelming emotional distress in the past, and how it passed with time. Clients with longstanding trauma histories in addition to acute crime victimization often benefit from focusing on these skills for the duration of their 16 treatment sessions.

SKILLS TRAINING IN AFFECTIVE AND INTERPERSONAL REGULATION (STAIR). This is a manualized brief skills approach that the Clinician can use to provide emotion regulation skills to clients and to address problematic relationship patterns (Cloitre, Cohen, & Koenen, 2011). It was originally created as a two-phase, 16 session, individual therapy protocol: Phase 1: Emotional and interpersonal regulation skill building; and Phase 2: Narrative Therapy. It was developed for adults who are dysregulated because of complex childhood trauma histories and is now being implemented with single-trauma populations as well. STAIR was also recently adapted as a 12-session group treatment. Utilizing STAIR in this fashion can help restore clients' sense of safety and stabilization before shifting into more trauma-focused treatment. STAIR is an alternative to DBT that is less time intensive and can be a good fit for briefer treatment.

Integrate Substance Abuse Treatment with Trauma-Focused Therapy

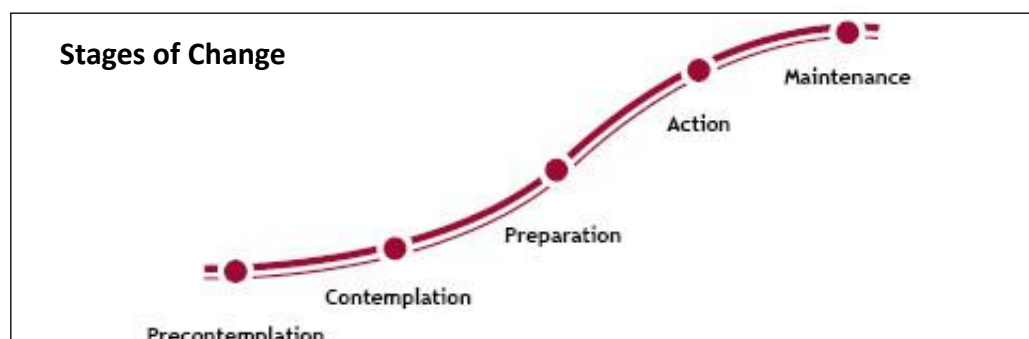
Trauma survivors often have substance use problems, and one of the Clinician's important roles is to help clients address them. Referrals to substance abuse agencies, such as detox and residential treatment, can augment the Clinician's interventions but not replace them. Integrated treatment is needed because PTSD symptoms can trigger substance use and the use of substances increases the risk that clients will be exposed to further traumatic experiences, creating a vicious cycle. However, abstinence from substances can increase PTSD symptoms. This puts the client in a double bind. When trauma survivors have substance use problems, the Clinician is faced with the challenge of finding a non-shaming way to address this in therapy.

TRC incorporates a harm reduction approach to substance use, as it is unrealistic to require total abstinence from clients who are caught in this bind (Marlatt, Larimer, & Witkiewitz, 2011). It is helpful to begin the conversation about substance use at the start of therapy when educating clients about common reactions to trauma, which includes substance use. Normalizing the desire to use alcohol and/or drugs after a terrible experience helps reduce shame, gently cautions about the use of substances to self-medicate symptoms, and brings up the idea of the need to re-think use of substances in order to avoid additional problems.

There are a number of ways to address substance abuse during the trauma recovery process. Effective management requires individualized, sequential assessment and planning. Treatment is dynamically adapted over time based on an individual's changing course and treatment readiness.

SEEKING SAFETY. This is a Cognitive Behavioral Therapy (CBT)-based manualized treatment for co-occurring substance abuse and PTSD, specifically developed for those in the early stages of readiness to acknowledge or address the problem. It has been widely used and its efficacy established in several randomized clinical trials (Najavits, 2002). The psychoeducation piece alone has great value in decreasing shame, and an emphasis on increasing safe coping skills empowers clients to make safer choices without requiring abstinence to participate. Seeking Safety has a positive psychology slant that addresses the demoralization inherent in both disorders and evokes humanistic themes with the goal of restoring a client's belief in the potential for a better future. For example, the title of each session is framed as a value or ideal such as honesty or authenticity. Seeking Safety can be used in individual therapy as well as in group settings.

MOTIVATIONAL INTERVIEWING (MI). This is a key intervention in TRC treatment to facilitate client movement toward commitment to change risk behaviors, especially when they are not motivated or hardly motivated to change (Miller & Rollnick, 2012). MI is generally applied in combination with the transtheoretical model of change (Prochaska & DiClemente, 1982). From this perspective, an unmotivated client is seen as being in the precontemplative stage of change as represented in the figure:



In working with substance abuse as well as other risk behaviors (e.g., ongoing involvement with a violent partner, sex work), the TRC Clinician responds with strategies that meet the client at their stage of readiness for change. The spirit of MI is based on three elements, including: collaboration between client and Clinician, drawing out the client's ideas about change, and emphasizing the autonomy of the client.

For substance-abusing clients who are already in the stages of preparation or action, the Clinician provides chemical dependency counseling (e.g. the American Society of Addiction Medicine's chemical dependency treatment model, Perkinson, 2011) and/or provides case management for residential rehabilitation or detoxification facility arrangements, depending on client needs.

Stabilize Emotional and Symptomatic Distress by Regulating Biological Rhythms

In early treatment, the Clinician provides information about the importance of self care in coping with trauma. Trauma can destabilize people emotionally, physically, interpersonally, and cognitively (i.e., thinking). It can throw people off balance in many ways. Clients can also become numb or disconnected from themselves after trauma. They do not notice how their lack of self care impacts their physical and emotional well-being. After trauma, people need not just good self care, but radical self care because it helps rebuild their foundation for emotion regulation. The Clinician collaborates with the client to consider the different areas of self care and assess which ones they are already on top of, and which could use some work).

Address Insomnia. Sleep is a priority because insomnia is prominent after trauma and exacerbates PTSD symptoms if left untreated. Insomnia can lead to problems with attention and concentration, increase irritability, and interfere with activities that require sustained effort. The TRC Clinician introduces Sleep Hygiene, offers an evaluation with the psychiatrist for sleep medications early on if indicated, and provides CBT for insomnia (DeViva & Capehart, 2015).

The Clinician assesses and helps create a self care plan if needed for other domains including:

- < Getting care for any illness
- < Taking medications as prescribed
- < Eating three balanced meals and two snacks daily
- < Staying hydrated

- < Limiting caffeine and substances
- < Structuring daily routines
- < Delegating tasks
- < Getting some physical activity
- < Self-soothing

Prioritize Anxiety and Other Severe Symptoms

Heightened anxiety and physiological distress at reminders of trauma are hallmark PTSD symptoms. Survivors become sensitized to react to even milder problems and can feel overwhelmed by daily living tasks, such as shopping at the grocery store or caring for children. Symptoms often rise to the level of anxiety attacks or panic attacks, and the TRC Clinician prioritizes these symptoms in treatment. The Clinician provides psychoeducation to normalize the anxiety attacks as the “fight or flight” response after trauma and explains that these symptoms are normal survival responses and are not actually dangerous, although they are unpleasant to experience. For example, the Clinician can explain, “After trauma certain things may trigger strong, upsetting, ‘false alarm’ reactions in the body, as though the trauma or danger is occurring in the present. But the danger is over now and is in the past.” If panic attacks continue to occur, the Clinician considers a psychiatric medication referral early on in treatment, and provides CBT for panic attacks (Craske & Barlow, 2006). The Clinician incorporates other acute distress management interventions including grounding, calming breath, progressive muscle relaxation, and mild physical activity such as walking and yoga. The Clinician also monitors depressive symptoms and introduces additional CBT interventions for depression as needed.

Caution about Debriefing

Prior to 2002, psychological debriefing, also termed critical incident stress debriefing (CISD) was the customary and most widely used early intervention after trauma (Litz, Gray, Bryant, & Adler, 2002). Group or individual, single-session intervention components included education about trauma, recounting of the recent traumatic event, and encouragement of emotional expression about trauma-related experiences. The idea was that if those who had been exposed to a traumatic event were debriefed, it would reduce the likelihood of PTSD. However, debriefing is no longer recommended, as evidence indicates that it is not effective and may possibly cause harm (Forneris et al., 2013).

Stage Two Interventions for Processing Trauma and Loss: Remembrance and Mourning

A large percentage of survivors will complete their TRC therapy without moving beyond Stage One interventions. This is still a successful treatment because safety and stabilization are increased. However, when a client has attained basic safety and stabilization and can approach the trauma and loss, or their beliefs about them, there are additional benefits to including Stage Two interventions.

Consider Whether Stage Two Interventions are Indicated

Although there is no one clear indicator of readiness, considerations about whether or not to move to Stage Two interventions include:

- ◁ That the client is no longer in unsafe situations such as domestic violence, sex work, or severe substance use
- ◁ Has some ability to self-care and self-soothe
- ◁ Does not have active suicidal ideation, disabling anxiety or high-risk self-harm
- ◁ Does not currently meet full criteria for anorexia, bulimia or a primary psychotic disorder
- ◁ Does not have continuing exposure to traumatic stress such as chronic community violence or stalking
- ◁ Does not have severe ongoing major psychosocial stressors such as serious medical illness (e.g. cancer), or persistent severe pain

An assumption underlying most trauma processing therapies is that the trauma is in the past and is no longer occurring. After assessing these considerations, the Clinician can consider Stage Two processing to target intrusive re-experiencing symptoms, or when subsequent avoidance keeps a client functionally impaired.

Potential Risks and Benefits of Trauma Processing

Trauma processing does not necessarily require revisiting the actual details of the trauma itself. It may include exploration and integration of actual traumatic memories, and/or it may focus on discussion of changes in beliefs due to the trauma, and/or it may include a grieving process in which losses incurred as a result of the trauma are identified and experienced.

The TRC Clinician can discuss these alternatives with the client, as well as reasons to undertake trauma processing. These types of interventions can help:

- ◁ “Cognitively metabolize” the trauma memories through repeated verbal mediation (talking). This changes the way memories are experienced, from being highly emotionally charged to more calmly recalled memories. This stops alarm reactions to memories and triggers because they lose their power to reactivate the fight-or-flight response.
- ◁ Decrease nightmares, intrusive memories, flashbacks, distress at reminders— with less need to avoid reminders. Clients are able to move out of the cycle of avoidance and intrusive memories that is emblematic of PTSD.
- ◁ Uncover and shift assumptions and beliefs that generate emotional distress, for example, “The world is a dangerous place,” “It’s my fault that someone did this to me,” or other common thinking distortions that develop after trauma.
- ◁ Increase empowerment/mastery of experience. Clients can feel more in control of their experience by deciding to address it in therapy. This changes their self-view from incompetent and weak to competent and strong.
- ◁ Decrease anxiety and increase self-confidence. This can help clients who are participating in a criminal trial and can also be an important step toward achieving a sense of post-traumatic growth.

How does the TRC Clinician make the decision about Stage Two processing for a given client?

Consider Briere’s concept of the “therapeutic window” which refers to a psychological midpoint between inadequate and overwhelming activation of trauma-related emotion during therapy (Briere & Scott, 2014). When a Clinician undershoots this window, they consistently avoid discussion of trauma memories, and instead focus primarily on supporting and validating a client who could actually tolerate greater processing. Many Clinicians make the mistake of colluding with the client’s avoidance of the trauma material.

On the other end, a Clinician may inadvertently allow too much trauma memory exposure relative to the client’s existing affect regulation and ability to cope with emotional distress. Additionally, some clients insist on plunging headlong into details of trauma, with the idea of “ripping off the band aid” and a fantasy of a violent cathartic cure which will get rid of the trauma. In either case a client may dissociate, be flooded with trauma memories, or feel anxious or panicky. When the client becomes too upset to deal

constructively with the material, the Clinician needs to back off, slow down, do grounding, and establish a more appropriate pace. Judith Herman's metaphor (1997) that compares recovery to a marathon where clients need to prepare, pace themselves, and train in order to build stamina is useful here. When a Clinician helps the client titrate exposure to the trauma material, emotional activation does not exceed the client's coping capacities, which allows the client to process trauma memories without needing to shut down or becoming re-traumatized.

Overview of Trauma Processing Approaches

What are the empirically supported approaches for processing trauma? In reviewing this research it is important to keep in mind that the majority of data is for those approaches that are more easily studied experimentally. Additionally, the population characteristics in most of these studies are often very different from those of diverse, urban communities with high rates of polyvictimization. Given these caveats, meta analyses and reviews of randomized clinical trials (RCTs) indicate that prolonged exposure therapy (PE), cognitive therapy, including Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR) are very helpful in reducing PTSD symptoms. Repeated therapeutic exposure to the trauma memory and/or to situations avoided since the trauma, as well as cognitive restructuring and EMDR, were found to lead to markedly greater reductions in PTSD than no treatment, waitlist, and supportive counseling which is often the "treatment as usual." There were no substantial differences among types of CBT, whether exposure, cognitive, a blend of the two, or EMDR (Pole, Fields, & D'Andrea, 2016). When the exposure and cognitive processing components of CPT were dismantled and tested separately and together, the combination was not superior to the individual components.

For Complex PTSD (CPTSD), moderate to large effect sizes were noted for PTSD and emotional and interpersonal regulation outcomes for skills-based DBT and STAIR treatments. CPTSD treatments that included both skills and trauma memory processing were superior to skills-only treatments.

The TRC Clinician simultaneously considers the evidence from the clinical trials and aspects of their clients' lives to make decisions about which *type* of trauma processing will be best for a given client. Considerations include:

- ◁ Whether there is history of long-term, childhood, or repeated victimization
- ◁ Comorbidity of other psychological disorders

- ◁ Cultural considerations (e.g., overt discussion of sexual trauma by unmarried Islamic women; touching on vulnerable feelings of victimization for Latino males)
- ◁ Whether the client has memory of the trauma itself
- ◁ Coping and affect regulation capacities
- ◁ Client preference and choice

Given all of the above considerations, TRC clinicians often find the greatest overall benefit with the least risk in selecting Stage Two approaches that are oriented toward cognitive changes and skill building, and/or that emphasize a supportive, titrated processing of trauma memories. These include Cognitive Processing Therapy (CPT) (Resick & Schnicke, 1993), Stress Inoculation Training (SIT) (Meichenbaum, 1985), Narrative Storytelling (NST) which is the second stage of the STAIR skills approach for Complex PTSD (Cloitre et al., 2011), and Briere’s Self-Trauma model (2014).

COGNITIVE PROCESSING THERAPY. This is a comprehensive approach that uses a written impact statement to identify and challenge mistaken beliefs that are causing distressing emotions for clients after victimization (Resick & Schnicke, 1993). Trauma survivors with PTSD tend to exhibit specific cognitive distortions and CPT addresses these. They neglect or forget key facts, for example, that during the trauma they were in a fight-or-flight state and did not have the same capacities available to them that they do now in looking back at it. They are unaware of these errors but have intense emotional pain as a result of them. They avoid thinking about or talking about trauma because their distress is compounded by these errors. Avoidance prevents access to corrective information. The TRC Clinician decides whether to include the additional component of writing about the trauma details. This is followed by a sequential presentation of five domains of beliefs affected by trauma: safety, trust, power, esteem, and intimacy, for further focused processing of beliefs in those domains.

NARRATIVE STORY TELLING is framed as “revisiting” the traumatic memories to put the trauma in perspective as an experience that is part of an evolving life story (Cloitre et al., 2011). It includes calm breathing, the use of SUDS ratings to monitor distress, and emotion regulation skills applied to the processing itself. In collaboration with the client, the Clinician constructs a memory hierarchy of a small number of traumatic memories without much detail and assigns a SUDS rating to each, with a focus on those that are most disturbing and disruptive in the client’s current life. The Clinician reminds the client that they have many more coping resources now than they did in the past, and helps the client to revisit memories of the past while incorporating the strengths and resources of the present. The Clinician also reminds the client that they will not be going through it

alone. Together the client and Clinician discuss beliefs about self and others that are identified while revisiting the memories explicitly seeking to uncover, process, and transform narratives of fear, shame, and loss into more positive and self-affirming beliefs.

6 F = 9 F 9 D TRAUMA MODEL provides a helpful clinical framework for reprocessing work. It offers guidance to help Clinicians manipulate the intensity of trauma processing so that it remains within a therapeutic window that does not retraumatize (Briere and Scott, 2014). This model gives the Clinician tools to regulate the intensity during sessions in several ways. Intensity can be increased by asking for specific trauma details, emotional reactions, or sensory details (e.g. auditory, visual, etc. memories of the event) or what happened to their body. To decrease the intensity when distress or dissociation increase too much, Briere suggests asking content questions not specifically related to trauma (e.g., “How old were you at that time?”); using a soothing voice tone to calm; suggesting the client stop talking about the trauma and ground them in the present; rephrasing what the client has just said; getting the client to open their eyes and describe the current setting; using relaxation and breathing techniques in session; and asking the client to talk about neutral events in the present not related to the trauma.

CULTURALLY ADAPTED TRAUMA-SPECIFIC THERAPY. Culturally adapted treatment refers to the modification of psychotherapy to better match the preferences of culturally diverse clientele (Pole, Fields & D’Andrea, 2016). Understanding a client’s culture is enhanced by adopting a stance of cultural humility (Tervalon & Murray-Garcia, 1998). The TRC Clinician makes every effort to culturally adapt the therapy by incorporating cultural values and traditional healing practices; respectfully considering race, ethnicity, and language preference; and increasing accessibility by providing services nearer to clients’ communities. Culture-specific treatment and treatment provided in clients’ native language have been shown to be much more effective. An important predictor of positive outcome is respecting, accepting, and incorporating the client’s illness explanation into the treatment plan, which highlights the importance of attending to culture-bound syndromes and conceptualization of post-trauma experiences. Culturally Adapted CBT has been developed for PTSD (CA-CBT) (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012). This approach addresses challenges in applying evidence-based trauma treatments to some immigrant populations by including culturally relevant references such as Christian symbols when working with Catholic Latinos and Buddhist imagery when working with Southeast Asians. It addresses limitations in English language skills, education, and familiarity with mental health concepts; and makes adaptations for culture-specific idioms of distress and difficulty tolerating exposure therapy techniques.

GRIEVING THE LOSSES INHERENT IN TRAUMA. General processing of grief for losses incurred due to the trauma, including recognition of the traumatized self, is considered a

more routine aspect of this stage for a majority of clients. Trauma usually involves loss of some sort. The losses are different for each person but may include:

- ◁ Loss of a sense of safety and security in the world
- ◁ Loss of a healthy sense of invulnerability and entitlement
- ◁ Loss of easy connectedness with others
- ◁ Actual loss of other people through death or sudden ending
- ◁ Loss of physical integrity from injury or related health issues
- ◁ Loss of easy comfort in one's own skin
- ◁ Loss of self-esteem, identity
- ◁ Loss of future plans, meaning or purpose in life

The TRC Clinician is attuned to the client's expressions of loss and grief and helps name them, and also provides psychoeducation about the grieving process: "Grief or mourning is a natural emotional reaction to a significant loss. The words sorrow and heartache are often used to describe feelings of grief. Grieving is the process of emotional and life adjustment after a loss" (see Appendix 8 for client handout).

BENEFITS OF GRIEVING. Although there is no doubt that grieving is painful, it has its benefits:

- ◁ Giving voice to underlying feelings about loss can be very relieving, and can free up life energy as well as positive feelings that have been numbed
- ◁ Acknowledging the loss or what one has endured can be a way to move into compassion for the traumatized self and away from self-blame, shame, or anger
- ◁ Acknowledging loss provides direction in finding ways to fill now unmet needs such as purpose or relationships
- ◁ Grief is a way to show how much you care for yourself

GUIDELINES FOR GRIEVING.

It is OK to cry; to be sad; to mourn. We are built for it. Tears serve a purpose.
Why should we not honor our grief as we do our joy and happiness?

Over time the trauma and loss can be mastered by putting the feelings and experiences into words shared with a caring other.

There is no "normal and expected" period of time for grieving.

A wide range of feelings and symptoms are common during grieving. While one may feel shock, numbness, sadness, anger, guilt, anxiety, or fear, there may also be moments of relief, peace, or happiness.

Although grieving is not simply sadness, "the blues," or depression, some may become depressed or anxious during the grieving process.

Sometimes when we grieve, the anger fades.

Find a safe place or someone safe to be able to express the sadness.

Each person is unique in the way they grieve—it is not one size fits all.

Balance the grief with taking a break, finding humor, or being active.

Have faith that there is an end to it.

Traumatic Loss: Homicide

When the trauma is the violent death of a family member or loved one, grief can take on additional layers of complexity and severity. Stage One interventions focus on provision of support during criminal judicial proceedings, burial and memorial services, and handling financial matters, as well as the prioritization of self care, as survivors may be destabilized, numb, or in shock for quite some time. In addition, the TRC Clinician also considers incorporating Stage Two interventions that have been specifically developed for traumatic loss and complicated grief such as “restorative retelling” which involves commemorating the living memory of the deceased as well as discussing the most distressing thoughts and memories associated with the death (Rynearson, Favell, & Saindon, 2002). The Clinician includes positive as well as negative memories of the deceased, cognitive restructuring to address thinking errors, goal setting, and pleasant event planning as well. Such treatments have been found to be efficacious in reducing psychological symptoms (Simon, 2013). Ongoing support is especially important for this client group because of the loss of relationship and length of recovery time, and a special support group for this client subgroup is discussed below in Stage Three treatment.

Stage Three Interventions: Restoring Connection and Ending Treatment

The third stage of therapy focuses on building or restoring connection between survivors, their recovering selves, and their communities through increasing engagement in

meaningful activities and relationships. The goal is to create new and positive directions for the future. At this point the client is fairly stable and has established environmental and behavioral safety. Treatment has addressed distressing beliefs that developed as a result of the trauma, and/or traumatic memories have been integrated and resolved, and/or related losses incurred have been recognized and grieved. At this stage, the survivor benefits by connecting with self and others in a way that moves beyond the conceptualization of a “victim” to become an active participant in life, and to gain or regain meaning and purpose. After coming to terms with the trauma in these ways, the survivor can reconnect to stronger aspects of the self, and becomes ready to engage more actively in the world. Many survivors naturally begin to move in this direction.

Interventions to assist this process include encouraging the client to connect with safe and positive others, and to explore what is meaningful to the self. Clients may need assertiveness skills, CBT for agoraphobia (if phobic about going out, consider desensitization through imaginal or in-vivo exposure) or activities scheduling interventions to help get them started with social reconnection.

Address Avoidance and Fears in Activating and Reconnecting

Recovery is not always a perfectly linear process, and avoidance and fears may still be present or may re-emerge and interfere with the process of restoring connection. The Clinician monitors avoidance, helps clients face underlying fears, and when triggers reappear, helps the client work through them so they can continue on the path toward a better life. The Clinician implements Stress Inoculation Training (SIT) interventions or other CBT imaginal coping and in-vivo exposure practices, as well as activities scheduling, in order to increase the client’s ability to engage in activities that may be anxiety-provoking but will improve their lives (Meichenbaum, 1985).

STRESS INOCULATION TRAINING (SIT.) Is another treatment that has been shown to be efficacious (Pole et al., 2016) in treating PTSD. It differentiates aspects of trauma and trauma reactions that are changeable and those that cannot change, so that coping efforts can be adjusted accordingly (Meichenbaum, 1985). Acceptance-based coping is appropriate for aspects of situations that cannot be altered, while more active interventions are appropriate for more changeable stressors. It includes a menu of emotion regulation, relaxation, cognitive appraisal, problem-solving, communication and socialization skills. There is an emphasis on practice of coping skills using simulation methods to increase the realism of coping practice (e.g., visualization exercises, imaginal practice (i.e., practicing in imagination first); modeling and vicarious learning; role playing of feared or stressful situations). Simple repetitious behavioral practice of coping routines is encouraged until they become over-learned and easy to carry out. Clinicians

especially use this approach when the client has been avoiding places or activities that they would like to be comfortable visiting or doing due to the trauma.

Simple repetitious behavioral practice of coping routines is encouraged until they become over-learned and easy to carry out. Clinicians especially use this approach when the client has been avoiding places or activities that they would like to be comfortable visiting or doing due to the trauma.

Facilitating Posttraumatic Growth

In discovering what is meaningful, clients may take on a “survivor mission” and may find benefit in taking social action. The TRC Clinician facilitates this process by detecting and attending to the subtle beginnings of these experiences in earlier recovery, and highlights or even celebrates when the client feels celebratory about them. The TRC speakers bureau CHATT (Communities Healing and Transforming Trauma) was created to support this process (see chapter on TRC Speakers Bureau). Other clients may take on roles such as youth mentor or peer counselor. As survivors venture forth, establish an agenda for their lives, return to work or obtain vocational training, and discover aspirations, they accumulate restitutive, gratifying emotional experiences that contribute to reparation of past injuries to the self. This posttraumatic growth enables clients to (re)connect with their empowered selves, (re)establish social connections, and (re)gain a sense of interpersonal efficacy.

TRC Group Therapy

TRC utilizes group therapy as a tool to facilitate reconnection as well as to impart skills. Many survivors benefit greatly by coming out of isolation and by finding meaningful new roles for themselves there. Outside support groups or religious communities may also be of benefit. TRC Clinicians provide specific shorter-term, structured therapy groups which include psychoeducation and skills. Seeking Safety groups and Surviving to Thriving: Allies in Recovery from DFSA (STAR-D) (Fields, Stein, Smith, Richer, & Shumway, 2011) groups for sexual assault have been found to be beneficial and popular among clients. Ongoing meetings of Family Members of Homicide Victims support groups have also been well received due to the tremendous impact of this type of loss, the length of recovery, and the importance of building new connections with others.

Ending the Therapy: Progress Review, Relapse Prevention, and Loss Revisited

At the end of the therapy, a collaborative review of progress toward goals, accomplishments in the work, and areas for the client to continue to work on can be very important. Relapse prevention that addresses past risk behaviors and trauma-related symptoms is a key Stage Three intervention. Together with the client, the Clinician identifies when and where the symptoms or behaviors may be triggered in the future (e.g., anniversary dates of traumas, settings where substances were used). Then, they make a plan to permit difficult feelings to happen at that future time, while simultaneously planning for safe coping that addresses the reactions in a healthy way. In this manner, the work of the therapy continues on after the treatment ends. The ending of the therapy relationship may engender current feelings of loss, and may re-trigger past losses as well. The Clinician addresses the impact of this ending, and also facilitates an opportunity for a healthy ending that allows direct expression of sadness, anger, gratitude, love, relief, or other responses, in addition to a mutual celebration of accomplishments and recovery.

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Additional Resources

<http://www.leapsf.org/html/index.shtml>

http://www.mirecc.va.gov/VISN16/docs/Sleep_Therapy_Group_Patient_Manual.pdf

http://www.mirecc.va.gov/visn16/docs/Sleep_Therapy_Group_Therapist_Manual.pdf

<https://cpt.musc.edu/introduction>

http://www.ptsd.va.gov/PTSD/ptsd_search.asp?SECT=2&QT=STAIR&RPP=20

Appendix 1 to Trauma-Informed Psychotherapy: TRC Clinical Model Overview

Please see following page.

TRC Clinical Model Overview

The following table shows how the TRC clinical model follows a 3-stage model of trauma treatment (Herman, 1992), with goals and guiding principles for each stage and typical treatment modalities/interventions used. The table is meant to be an overview of the clinical model rather the outline of a specific process, keeping in mind that recovery from trauma generally follows these stages, but is not always a linear progression. Also, because the TRC model is short-term, it is possible for some clients to remain in the Safety and Stabilization phase while having met their goals for the treatment episode. The Common Interventions column is not exhaustive, as some TRC Clinicians have expertise in additional treatment modalities (i.e. Narrative Therapy, Image Rehearsal Therapy, etc.). However, the interventions listed are commonly used by TRC Clinicians.

Treatment Stage	Goals	Guiding Principles	Common Interventions
Safety and Stabilization	<p>Symptom reduction and management</p> <p>Self-regulation of emotions and impulses</p>	<p>Harm Reduction re:</p> <ul style="list-style-type: none"> < Substance abuse < Self-harming behaviors < Abusive or violent relationships < Anything that puts the client at risk of further victimization <p>Strengths Perspective</p> <ul style="list-style-type: none"> < Identification and growth of existing internal and external resources < Expanding options for positive coping <p>Provision of a Restorative, Healing Experience</p> <ul style="list-style-type: none"> < Build and strengthen the therapeutic and institutional alliances < Use these alliances to foster an experience of safety, caring, acceptance, trust, and healing 	<p>Outreach and assertive engagement</p> <p>Clinical case management and linkage to resources</p> <p>Psychoeducation</p> <p>Motivational Interviewing</p> <p>Cognitive Behavioral Therapy</p> <p>Skills Training in Affect and Interpersonal Regulation (STAIR)</p> <p>Crisis Intervention & safety planning</p> <p>Relaxation training</p> <p>Grounding skills</p> <p>Mindfulness training</p> <p>Seeking Safety</p> <p>Dialectical Behavior Therapy</p>

Treatment Stage	Goals	Guiding Principles	Common Interventions
Remembrance and Mourning	<p>Reduction/resolution of any continuing intrusive symptoms</p> <p>Find meaning in the trauma experience</p>	<p>Integration of Traumatic Memories</p> <ul style="list-style-type: none"> ◁ Sufficient safety and stabilization will allow a client to tolerate and benefit from revisiting the trauma and its impact ◁ Support client in grieving any losses (of a loved one, an aspect of their physical/mental functioning, an identity or role, a belief about the world, etc.) ◁ Support client in reviewing the trauma experience 	<p>Continuation of Stage One Interventions as needed</p> <p>Cognitive Processing Therapy</p> <p>Prolonged Exposure Therapy</p>
Reconnection	<p>Reduce focus on trauma and relegate it to being only one aspect of a full life experience</p>	<p>Reconnection to or Development of a Healthy Self Identity</p> <p>Reconnection to or Development of Relationships with Safe Others, in areas of:</p> <ul style="list-style-type: none"> ◁ Romantic relationships ◁ Family ◁ Work ◁ Education ◁ Etc. <p>Reconnection to or Development of Connection to Meaningful Activities</p>	<p>Continuation of Stage One Interventions as needed</p> <p>Supportive Psychotherapy</p>

Appendix 2 to Trauma-Informed Psychotherapy: Psychoeducation

For a psychoeducation handout on normal responses to trauma, please see following page.

Normal Reactions to Trauma

EVERYONE is affected when they experience traumatic stress :

- *Traumatic events are so frightening or overwhelming that they would upset anyone & your mind and body are in shock*
- *After a trauma, almost everyone has some symptoms of post-traumatic stress.*
- *Different people may be affected in different ways.*

Traumatic stress reactions are NORMAL & not signs of danger or weakness :

- *People sometimes think it means they are going crazy, are mentally ill, are having a heart problem, or are weak.*
- *These are normal reactions to such an abnormal situation and although it may FEEL like that, it does not mean you are going crazy, are mentally ill, are having a heart problem, or weak.*

Traumatic stress reactions may affect the way you work and relate to others temporarily:

- *It may be harder to concentrate, remember, or get motivated*
- *You may be less patient or withdraw from family, friends, or coworkers*
- *You may have decreased sexual or loving feelings*
- *DO NOT add to the problem by beating yourself up & it is hard enough that you were traumatized & be gentle with yourself and know that these will pass with time.*

Traumatic stress reactions DO get better:

- *People may worry these feelings will never go away or will keep getting worse. Symptoms can pass with time and are also highly treatable.*

Learning about the different reactions people can have:

- < One group of symptoms are the hyper-arousal symptoms where the mind and body are keyed-up, tense & nervous.
- < Another group includes the re-experiencing of the traumatic event such as trauma memories popping into your head, or nightmares. There may be a lot of flashbacks of the trauma.
- < A third group includes avoiding trauma reminders and/or feeling numb. In fact, this strong tendency after trauma to avoid anything that reminds them of the trauma, is a major reason people avoid coming to treatment.
- < It is also normal for trauma to contribute to depression symptoms temporarily that often relate to feelings of shame, tendencies for self-blame, and beliefs about being responsible for what happened.
- < Sometimes with early trauma and interpersonal violence, people can have symptoms of complex trauma that may include a rollercoaster of painful emotions, very low self-esteem, and difficulty trusting others.
- < A common problem for people after trauma (and sometimes before) is to use alcohol or drugs to self-medicate bad feelings or anxiety. This is also one way people avoid trauma reminders. We do not judge anyone for this but rather have compassion for the pain involved.
- < While it is common to use alcohol or drugs after trauma, treatment will help develop other more adaptive skills to feel better. Substance use can create additional problems or make symptoms worse in the long run.

The main things to remember about all of these reactions is that they are normal reactions, are not dangerous, do not signify mental illness, are not shameful, & will improve with treatment.

Appendix 3 to Trauma-Informed Psychotherapy: Subjective Units of Distress (SUDS)

For a subjective units of distress handout, please see following page.

Subjective Units of Distress Scale (SUDS)

100 = Highest level of anxiety, distress, or agitation. Overwhelmed or out of control.

90 = Extremely anxious or distressed; feeling that you are losing control.

80 = Very anxious or distressed. Bodily signs (increased heart rate, shaking, sweating, gastrointestinal distress) are present.

70 = Quite strong anxiety or distress. Bodily signs may be present.

60 = Somewhat strong anxiety or distress.

50 = Moderate anxiety or distress. Unpleasant feelings are still manageable with some effort.

40 = Mild-to-moderate anxiety or distress. Tolerable but unpleasant.

30 = Mild anxiety or distress that does not interfere with functioning.

20 = Minimal anxiety or distress.

10 = Feeling basically good; able to think and concentrate well.

0 = No anxiety or distress. Total relaxation.

Appendix 4 to Trauma-Informed Psychotherapy: Time Out for Calming Breath

For a Calming Breath relaxation handout, please see following page.

Time Out for Calming Breath

- ◁ One tool you can use that will bring distress down is calming breath.
- ◁ When we breathe out, it activates the relaxation part of our nervous system.
- ◁ There are many different types of relaxation breathing – the one we're using here is just to focus on the out-breath rather than trying to breathe deeper or slower or from the belly.

Guidelines:

- ◁ Follow the natural flow of the breath.
- ◁ The next time you breathe out, start to notice in your arms, legs, and lower body, there is a slight shift into a heavier feeling of relaxation there.
- ◁ Each time you breathe out, notice this feeling.
- ◁ You may want to experiment with slightly extending the outbreath to increase this effect.
- ◁ Be careful – you might end up having a relaxation attack...our brains and bodies are wired to feel relaxing pleasurable feelings naturally and without using substances.

Appendix 5 to Trauma-Informed Psychotherapy: LEAP Safety Planning Guide

For LEAP Safety Planning Guide, please see following page.

My Safety Plan

You deserve to be safe and happy.

Do not take this with you unless it is safe to do so.

My Relationship and My Safety

Being in a relationship that is hurtful can cause a lot of different feelings. It is normal to have some or all of these feelings. Check all that you feel:

- | | |
|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Ashamed | <input type="checkbox"/> Confused |
| <input type="checkbox"/> Hopeful | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Afraid | <input type="checkbox"/> Love |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Hopeless | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Trapped | <input type="checkbox"/> Alone |

What do I think about my relationship?

- I'm not sure how I feel about this relationship.
- I think this relationship will get better.
- I want to end this relationship.

Many people love their partners and also feel that their relationships put them in danger. Does my relationship have any of these signs of danger?

- My partner has injured me badly enough that I needed medical treatment.
- My partner follows me everywhere I go.
- My partner has threatened to hurt my children.
- My partner uses alcohol or drugs.
- My partner has forced me to have sex when I didn't want to.
- My partner has threatened to kill me.
- My partner has threatened to kill himself/herself.
- My partner has a gun or can get a gun easily.

Other things my partner does that concern me:

Safety during a fight:

Move away from

- Weapons (guns and knives)
- Small and dangerous places (car, kitchen, bathroom)

Move toward a safer place such as

- Room with exit
- Room with phone
- Public place

If I need to call the police

I will give them my address and tell them if there is a weapon.

The closest place I can go if I need help or need to leave:

Police/fire station: _____

Hospital/clinic: _____

Friend's/neighbor's/family member's house:

(name/address/phone number)

Other: _____

Steps to staying safe:

Keep a little money with me.

Keep my cell phone charged and with me.

Teach my children to go to a safe place:














(friend's, neighbor's, relative's home)

Teach my children to call the police when there is danger and to give their full name, address, and phone number.

Keep an emergency bag ready in a safe place.

Developed by LEAP. May be used unaltered without permission as long as you credit LEAP (Look to End Abuse Permanently), c/o Maxine Hall Health Center, 1301 Pierce St., San Francisco, CA 94115 www.leapsf.org.

Things to put in my emergency bag:

- | | |
|--|--|
| <input type="checkbox"/> Medications/
prescriptions  | <input type="checkbox"/> Money  |
| <input type="checkbox"/> Phone card/
change  | <input type="checkbox"/> Cell phone
and charger  |
| <input type="checkbox"/> Extra keys  | <input type="checkbox"/> Photo ID/
driver's
license  |
| <input type="checkbox"/> Bank card/
credit card  | <input type="checkbox"/> Restraining
order |
| <input type="checkbox"/> Custody order | <input type="checkbox"/> Passports/green
cards/immigration
papers |
| <input type="checkbox"/> Work permits | <input type="checkbox"/> Electronic Benefit
Transfer
(EBT) card  |
| <input type="checkbox"/> Photos of
abuser  | <input type="checkbox"/> Clothes  |
| <input type="checkbox"/> Address
book  | <input type="checkbox"/> Toiletries
and
diapers  |
| <input type="checkbox"/> Special toys  | <input type="checkbox"/> Other: _____
_____ |

If you have any proof of abuse, bring it with you.

Building my independence:

I can start **saving money** and store it in a safe place (like my own bank account).

I can **get help** from a counselor, an advocate, a health care provider, or legal services.

I can try to **keep in touch** with a friend or family member who I trust.

Important phone numbers:

Police 9-1-1

Local Domestic Violence Hotlines:

La Casa de Las Madres 1-877-503-1850

WOMAN, Inc. 415-864-4722

Local Sexual Assault Hotline 415-647-7273

For restraining order help call 415-255-0185

SF Suicide Prevention Hotline 415-781-0500

LGBT support (CUAV) 415-333-HELP

Bay Area Legal Aid 1-800-551-5554

National DV Hotline 1-800-799-SAFE

National Sexual Assault Hotline 1-800-858-HOPE

National Teen Abuse Hotline 1-866-331-9474

National Suicide Prevention Hotline 1-800-SUICIDE

Help after sexual assault:

If my partner or anyone else has forced me to have sex when I did not want to, I can:

Go to **SFGH Emergency Department/Rape Treatment Center, 1001 Potrero Avenue**

Call the **Trauma Recovery Center** between 8:00- 5:00 Monday through Friday: **(415) 437-3000**

Call **SF Women Against Rape's 24 hour hotline: (415) 647-7273**

Developed by LEAP. May be used unaltered without permission as long as you credit LEAP (Look to End Abuse Permanently), c/o Maxine Hall Health Center, 1301 Pierce St., San Francisco, CA 94115 www.leapsf.org. LEAP thanks San Francisco Kaiser Permanente and La Casa de las Madres for their contributions to this safety plan.

Appendix 6 to Trauma-Informed Psychotherapy: Brief Risk Assessment Protocol Part Two: Homicidal Ideation

For the *Brief Risk Assessment Protocol (BRAP) Part Two*, please see following page.

Brief Risk Assessment Protocol (B-RAP)
Part Two: Homicidal Ideation

Section A- Recent Homicidal Ideation

Any Recent Homicidal Ideation

A1. Sometimes people feel very angry when they've had such difficult experiences. Have you found yourself thinking about hurting or wanting to kill someone in the last 6 months? NO YES

If YES, continue. If NO, go to section B on page 2. →

Recency and Frequency of HI

A2. When did you last have these thoughts? _____
A3. How often do you think about it? _____

Active Homicidal Ideation

A4. Have you been thinking of acting on these thoughts by doing something to hurt someone? NO (passive) YES (active)

If YES, continue. If NO, go to section B on page 2. →

Homicide Plan/Identified Target

A5. Can you tell me what you have thought about doing and to whom? _____

(if NO ANSWER, gently inquire:)
Have you thought about physically attacking them or using a gun?.....pause.... Or something else? NO YES

If YES, continue. If NO, go to A8 on page 2. →

Means Available/Access to Target

- A6. Clinician assess whether client has access to means mentioned in A5 above (e.g. Do you have a knife at home?) NO YES
- A7. Clinician assess whether client has access to target person(s) in A5 above (e.g. Do you know how to find (person's name)?) NO YES
- A8. Do you have access to a firearm? NO YES

Intent

- A9. Do you think you will follow through with the plan to harm/kill (someone)? If so, when? _____

Section B- Past History of Homicidality:

- B1. In the past have you thought about hurting or killing someone? NO YES
- B2. In the past have you ever hurt or killed someone, or threatened to hurt or kill someone? NO YES

If YES to B2, continue. If NO, go to question C



- a. When was that?
- b. What exactly happened?

Dates: _____
 Lethality: _____

Section C – Future Orientation and Alliance Building

- C1. What is it that made you decide to share these thoughts with me (us)? _____

- C2. What has kept you from taking action on these thoughts so far? _____

**Appendix 7 to Trauma-Informed Psychotherapy:
Brief Risk Assessment Protocol Part One: Suicide Assessment**

For the *Brief Risk Assessment Protocol (BRAP) Part One*, please see following page.

Brief Risk Assessment Protocol (B-RAP)
Part One: Suicide Assessment

Section A- Recent Suicidality

Any Recent Suicidal Ideation

A1. When faced with a lot of difficulties, people sometimes have thoughts of wanting to die or wishing they weren't alive. Have you felt this way in the last 6 months? NO YES

If YES, continue. If NO, go to section B on page 2.



Recency and Frequency of SI

A2. When did you last have these thoughts? _____
A3. How often do you think about it? _____

Active Suicidal Ideation

A4. Have you been thinking of acting on these thoughts by doing something to end your life? NO (passive) YES (active)

If YES, continue. If NO, go to section B on page 2.



Suicide Plan

A5. Can you tell me what you have thought about doing to end your life? _____

(if NO ANSWER, gently inquire:)
Have you thought about taking an overdose of pills or using a gun?.....pause.... Or something else? _____

NO YES

Continue to next page.



Appendix 8 to Trauma-Informed Psychotherapy: Grieving the Losses

For a handout on the benefits for grieving, please see following page.

Grieving the Losses Inherent in Trauma

Trauma usually involves loss of some sort. The losses are different for each person but may include:

- < **loss of a sense of safety and security in the world**
- < loss of a healthy sense of invulnerability and entitlement
- < loss of easy connectedness with others
- < actual loss of other people through death or sudden ending
- < loss of physical integrity from injury or related health issues
- < loss of easy comfort in your own skin
- < loss of your self-esteem, your identity
- < loss of your future plans, meaning or purpose in life
- <

Grief is a natural emotional reaction to a significant loss. The words sorrow and heartache are often used to describe feelings of grief.

Grieving is the process of emotional and life adjustment you go through after a loss. There is no "normal and expected" period of time for grieving. A wide range of feelings and symptoms are common during grieving. While you may be feeling shock, numbness, sadness, anger, guilt, anxiety, or fear, you may also find moments of relief, peace, or happiness. And although grieving is not simply sadness, "the blues," or depression, you may become depressed or anxious during the grieving process. There **is** an end to it.

Benefits of Grieving Although there is no doubt that grieving is painful, it has its benefits:

- < giving voice to underlying feelings about loss can be very relieving, and can free up life energy as well as positive feelings that have been numbed
- < acknowledging the loss or what one has endured, can be a way to move into compassion for the traumatized self, and away from self-blame, shame, or anger
- < acknowledging loss provides direction in finding ways to fill now unmet needs such as purpose or relationships
- < grief is a way to show how much you care for yourself

Guidelines for Grieving

1. It is OK to cry; to be sad; to mourn. We are built for it. Tears serve a purpose. Why should we not honor our grief as we do our joy, happiness, etc.
2. Over time the trauma and loss can be mastered by putting the feelings and experiences into words shared with a caring other.
3. Sometimes when we grieve, the anger fades.
4. Find a safe place or someone safe to be able to express the sadness.
5. Each person is unique in the way they grieve – it is not one size fits all.
6. Balance the grief with taking a break, finding humor, being active.