TRAUMA AWARENESS

ABOUT THIS LEARNING MATERIAL

This learning material is based on Chapter 2 of *Trauma-Informed Care in Behavioral Health Services:* Treatment Improvement Protocol (TIP) Series 57 by Substance Abuse and Mental Health Services Administration (SAMHSA) published in 2014.

In 2019, Justin Russotti, PhD, LCSW modified chapters 2, 3, and 4 from the original TIP 57 for Ce4Less learners to include current information on the topics detailed in the 2014 articles. These modifications include some text changes and updated citations.

What is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific, best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

About Justin Russotti, PhD, LCSW

Justin Russotti, PhD, LCSW, is a research associate in the Clinical Psychology department at the University of Rochester and a lecturer in the Counseling Department at the same institution. He obtained his master's degree in social work from the University of Southern California and his PhD in Counseling from the University of Rochester. He is completing a postdoctoral fellowship at the TRANSFORM National Center for Child Abuse & Neglect. His research focuses on the etiological roots and mechanistic underpinnings of stress-related disorders and the developmental sequela of trauma and adversity. He teachers several courses related to trauma-informed intervention and has published numerous articles on the topic. Dr. Russotti is also in private practice with an emphasis in treating trauma and stress-related disorders.

INTRODUCTION

Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. This course explores several main elements that influence why people respond differently to trauma. Using the social-ecological model some of the contextual and systemic dynamics that influence individual and community perceptions of trauma and its impact are explored.

This course is designed for social workers, psychologists, marriage and family therapists, and counselors. The main objective is to highlight the key characteristics of traumatic experiences. Trauma-informed behavioral health service providers understand that many influences shape the effects of trauma among individuals and communities – it is not just the event that determines the outcome, but also the event's context and the resultant interactions across systems.

<u>Learning Objectives</u>

After completing this course, the learner will be able to:
1. List the types of trauma.
2. Identify objective and subjective characteristics of trauma.
3. Explain individual and sociocultural features that serve as risk or protective factors.

TYPES OF TRAUMA

The following section reviews various forms and types of trauma. It does not cover every conceivable trauma that an individual, group, or community may encounter. Specific traumas are reviewed only once, even when they could fit in multiple categories of trauma. Additionally, the order of appearance does not denote a specific trauma's importance or prevalence, and there is no lack of relevance implied if a given trauma is not specifically addressed in this learning material. The intent is to give a broad perspective of the various categories and types of trauma to behavioral health workers who wish to be trauma informed.

Table 1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	**Intentional Acts**
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Refugee Trauma
Volcanic eruption	Crane collapse	Border Separation
Blizzard	Gas explosion	Warfare
Hurricane	Electrocution	Domestic violence
Cyclone	Machinery-related accident	Poisoned water supply
Typhoon	Oil spill	Human trafficking
Meteorite	Maritime accident	School violence
Flood	Accidental gun shooting	Bullying
Tsunami	Sports-related death	Torture
Epidemic		Home invasion
Famine		Bank robbery
Landslide or fallen boulder		Genocide
		Medical or food tampering

Natural or Human-Caused Traumas

The classification of a trauma as natural or caused by humans can have a significant impact on the ways people react to it and on the types of assistance mobilized in its aftermath (see Table 1 for trauma examples). Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (e.g., returning to school or work, being able to do laundry, having products to buy in a local store). The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions as well as the recovery process. Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. Examples include the threat of others stealing what remains of personal property, restrictions on travel or access to property or living quarters, disruption of privacy within shelters, media attention, and subsequent exposure to repetitive images reflecting the devastation. Therefore, it isn't just the natural disaster or event that can challenge an individual or community; often, the consequences of the event and behavioral responses from others within and outside the community play a role in pushing survivors away from effective coping or toward resilience and recovery. Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or unintentional, such as the technological accident of a bridge collapse (as occurred in Minneapolis, Minnesota, in 2007; U.S. Fire Administration, 2007).

The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of people is typically the target of the survivors' anger and blame. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the motives for performing the act, the calculated or random nature of the act, and the

psychological makeup of the perpetrator(s).

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Case Illustrations: Quecreek Mine Flood and Greensburg's Tornado

Quecreek Mine Flood

The year following the rescue of nine miners from the Quecreek mine in western Pennsylvania in 2002 was a difficult one for residents of Somerset County. The dazzle of publicity surrounding a handful of workers from a small town, tension between miners and rescuers, and animosity over money for movie and book deals, in addition to the trauma itself, resulted in a rescuer's suicide, a number of miners having trauma-related symptoms, and several rescuers needing to seek treatment for posttraumatic stress disorder (PTSD; Goodell, 2003).

Greensburg's Tornado

Greensburg, a small town in southern Kansas, was hit by a large tornado in 2007 that killed 11 residents and leveled 95 percent of the town while causing severe damage to the remaining 5 percent. Families and community members experienced significant grief and traumatic stress after the disaster. Yet today, Greensburg is rebuilding with a focus on being "green"—that is, environmentally responsible—from design to construction and all the way through demolition. This town has the highest number of Leadership in Energy and Environmental Design–certified buildings in the world. A reality television show about the town's reinvention ran for three seasons, demonstrating the town's residents and business owners working with local government and various corporations to make their home an even better place than it was before the tornado.

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Individual, Group, Community, and Mass Traumas

In recognizing the role of trauma and understanding responses to it, consider whether the trauma primarily affected an individual and perhaps his or her family (e.g., automobile accident, sexual or physical assault, severe illness); occurred within the context of a group (e.g., trauma experienced by first responders or those who have seen military combat) or community (e.g., gang-related shootings); transpired within a certain culture; or was a large-scale disaster (e.g., hurricane, terrorist attack). This context can have significant implications for whether (and how) people experience shame as a result of the trauma, the kinds of support and compassion they receive, whether their experiences are normalized or diminished by others, and even the kinds of services they are offered to help them recover and cope.

Individual Trauma

An individual trauma refers to an event that only occurs to one person. It can be a single event (e.g., mugging, rape, physical attack, work-related physical injury) or multiple or prolonged events (e.g., a life-threatening illness, multiple sexual assaults). Although the trauma directly affects just one individual, others who know the person and/or are aware of the trauma will likely experience emotional repercussions from the event(s) as well, such as recounting what they said to the person

before the event, reacting in disbelief, or thinking that it could just as easily have happened to them, too. Survivors of individual trauma may not receive the environmental support and concern that members of collectively traumatized groups and communities receive. They are less likely to reveal their traumas or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the trauma. Some survivors of individual traumas, especially those who have kept the trauma secret, may not receive needed comfort and acceptance from others; they are also are more likely to struggle with issues of causation (e.g., a young woman may feel unduly responsible for a sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized.

Advice to Counselors*: Working with Clients Who Have Experienced Individual Traumas

In working with clients who have histories of individual trauma, counselors should consider that:
- Empathy, or putting oneself in the shoes of another, is more potent than sympathy (expressing a feeling of sorrow for another person).
- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on reexperiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- It is helpful to examine how the trauma affects opportunities to receive substance abuse and/or mental health treatment as well as treatment for and recovery from the trauma itself (e.g., by limiting one's willingness to share in or participate in group counseling).
- Identifying and exploring strengths in the client's history can help the client apply those strengths to his or her ability to function in the present.
- Counselors should employ culturally informed techniques such as cultural humility.
- Some clients experience post-traumatic growth that should be incorporated into their treatment.

Physical injuries

Physical injuries are among the most prevalent individual traumas. Millions of emergency room (ER) visits each year relate directly to physical injuries. Most trauma patients are relatively young; about 70 percent of injury-related ER cases are people younger than 45 years old (Gindi, Black, & Cohen, 2016). Dedicated ER hospital units, known as "trauma centers," specialize in physical traumas such as gunshot wounds, stabbings, and other immediate physical injuries. The term "trauma" in relation to ERs does not refer to psychological trauma, which is the focus of this learning material, yet physical injuries can be associated with psychological trauma. Sudden, unexpected, adverse health-related events can lead to extensive psychological trauma for patients

and their families. Excessive alcohol use is the leading risk factor for physical injuries; it's also the most promising target for injury prevention. Studies consistently connect injuries and substance use (Eriksen, Shumba, Ekeberg, & Bogstrand, 2018); a significant percentage of patients admitted to trauma centers have injuries attributable to alcohol abuse and dependence (Mello et al., 2018). Multiple studies have found that approximately 30% of hospitalized trauma patients screened positive for substance misuse (Johnson et al., 2014; Maung, Becher, Schuster, & Davis, 2018). A strong, dose response relationship exists between identified problematic drinking and relative risk for emergency department injury (Cherpitel, Ye, Bond, Borges, & Monteiro, 2015). For further information, see the SAMHSA "Screening, Brief Intervention and Referral to Treatment (SBIRT)" toolkit (SAMHSA, 2019).

Acute stress disorder (ASD) prevalence among patients at medical trauma centers is very high, making trauma related disorders some of the most common complications seen in physically injured patients.

Clients who have sustained serious injuries in car crashes, fires, stabbings, shootings, falls, and other events have an increased likelihood of developing trauma related mental disorders. Research suggests that PTSD is evident in upwards of 50 percent of patients 1 year after discharge from trauma surgical units, with rates differing based on injury type

(see Molina, Berry, Nielsen, & Winfield, 2018 for review)

Group Trauma

The term "group trauma" refers to traumatic experiences that affect a particular group of people. This learning material intentionally distinguishes group trauma from mass trauma to highlight the unique experiences and characteristics of trauma-related reactions among small groups. These groups often share a common identity and history, as well as similar activities and concerns. They include vocational groups who specialize in managing traumas or who routinely place themselves in harm's way—for example, first responders, a group including police and emergency medical personnel.

Some examples of group trauma include crews and their families who lose members from a commercial fishing accident, a gang whose members experience multiple deaths and injuries, teams of firefighters who lose members in a roof collapse, responders who attempt to save flood victims, and military service members in a specific theater of operation. Survivors of group trauma can have different experiences and responses than survivors of individual or mass traumas. Survivors of group trauma, such as military service members and first responders, are likely to experience repeated trauma. They tend to keep the trauma experiences within the group, feeling that others outside the group will not understand; group outsiders are generally viewed as intruders. Members may encourage others in the group to shut down emotionally and repress their traumatic experiences—and there are some occupational roles that necessitate the repression of reactions to complete a mission or to be attentive to the needs at hand. Group members may not want to seek help and may discourage others from doing so out of fear that it may shame the entire group. In this environment, members may see it as a violation of group confidentiality when a member seeks assistance outside the group, such as by going to a counselor.

Group members who have had traumatic experiences in the past may not actively support traumatized colleagues for fear that acknowledging the trauma will increase the risk of repressed trauma-related emotions surfacing. However, groups with adequate resources for helping group members can develop a stronger and more supportive environment for handling subsequent traumas. These main group features influence the course of short- and long-term adjustments, including the development of traumatic stress symptoms associated with mental and substance use disorders. Certain occupational groups are at greater risk of experiencing trauma—particularly multiple traumas. This learning material briefly reviews two main groups as examples in the following sections: first responders and military service members. For more detailed information on the impact of trauma and deployment, refer to the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned f).

<u>First responders</u>

First responders are usually emergency medical technicians, disaster management personnel, police officers, rescue workers, medical and behavioral health professionals, journalists, and volunteers from various backgrounds. They also include lifeguards, military personnel, and clergy. Stressors associated with the kinds of traumatic events and/or disasters first responders are likely to experience include exposure to toxic agents, feeling responsible for the lives of others, witnessing catastrophic devastation, potential exposure to gruesome images, observing human and animal suffering and/or death, working beyond physical exhaustion, and the external and internal pressure of working against the clock.

<u>Military service members</u>

Military personnel are likely to experience numerous stressors associated with trauma. Service members who have repeatedly deployed to a war zone are at a greater risk for traumatic stress reactions (also known as combat stress reaction or traumatic stress injury), other military personnel who provide support services are also at risk for traumatic stress and secondary trauma. So too, service members who anticipate deployment or redeployment may exhibit psychological symptoms associated with traumatic stress. Some stressors that military service members may encounter include working while physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, fear of being struck by an improvised explosive device, and so forth.

Trauma Affecting Communities and Cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.

> *"The excitement of the season had just begun, and then, we heard the news, oil in the water, lots of oil killing lots of water. It is too shocking to understand. Never in the millennium of our tradition have we thought it possible for the water to die, but it is true."*
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> —Chief Walter Meganack, Port Graham, 1989
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> Of all the groups negatively affected by the Exxon Valdez oil spill, in many ways Alaska Natives were the most devastated. The oil spill destroyed more than economic resources; it shook the core cultural foundation of Native life. Alaska Native subsistence culture is based on an intimate relationship with the environment. Not only does the environment have sacred qualities for Alaska Natives; their survival also depends on the well-being of the ecosystem and the maintenance of cultural norms of subsistence. The spill directly threatened the well-being of the environment, disrupted subsistence behavior, and severely disturbed the sociocultural milieu of Alaska Natives.
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> *Source: Gill & Picou, 1997, pp. 167–168.*

Historical trauma

Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma. In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families. More recent literature has extended the concept of historical or generational trauma to the traumatic experiences of Native Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities (Cromer, Gray, Vasquez, & Freyd, 2018).

A growing body of literature has examined the association of mental and substance use disorders with historical trauma among Native people and literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Steinka-Fry, Tanner-Smith, Dakof, & Henderson, 2017). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes.

Mass trauma

Mass traumas or disasters affect large numbers of people either directly or indirectly. It is beyond

the scope of this learning material to cover any specific disaster in detail; note, however, that mass traumas include large-scale natural and human-caused disasters (including intentional acts and accidents alike). Mass traumas may involve significant loss of property and lives as well as the widespread disruption of normal routines and services. Responding to such traumas often requires immediate and extensive resources that typically exceed the capacity of the affected communities, States, or countries in which they occur. Recent examples of such large-scale catastrophes include:

- In January 2010, a massive earthquake hit Haiti, killing hundreds of thousands of people and leaving over a million homeless.
- A nuclear reactor meltdown in the Ukraine in 1986 resulted in a technological and environmental disaster that affected tens of millions of people.
- The tsunami in the Indian Ocean in 2005 left hundreds of thousands dead in nine countries.

One factor that influences an individual's response to trauma is his or her ability to process one trauma before another trauma occurs. In mass traumas, the initial event causes considerable destruction, the consequences of which may spawn additional traumas and other stressful events that lead to more difficulties and greater need for adjustments among survivors, first responders, and disaster relief agencies. Often, a chain reaction occurs. Take, for example, Hurricane Katrina and its impact on the people of Louisiana and other coastal States. After the initial flooding, people struggled to obtain basic needs, including food, drinking water, safe shelter, clothing, medicines, personal hygiene items, and so forth, all as concern mounted about the safety of children and other relatives, friends, and neighbors. In this and similar cases, the destruction from the initial flooding led to mass displacement of families and communities; many people had to relocate far from New Orleans and other badly affected areas, while also needing to gain financial assistance, reinitiate work to generate income, and obtain stable housing. People could not assimilate one stressor before another appeared.

Nevertheless, mass traumas can create an immediate sense of commonality—many people are "in the same boat," thus removing much of the isolation that can occur with other types of trauma. People can acknowledge their difficulties and receive support, even from strangers. It is easier to ask for help because blame is often externalized; large-scale disasters are often referred to as "acts of God" or, in cases of terrorism and other intentional events, as acts of "evil." Even so, survivors of mass trauma often encounter an initial rally of support followed by quickly diminishing services and dwindling care. When the disaster fades from the headlines, public attention and concern are likely to decrease, leaving survivors struggling to reestablish or reinvent their lives without much outside acknowledgment.

The experience of mass trauma can lead to the development of psychological symptoms and substance use at either a subclinical or a diagnostic level. Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of preexisting mental and co-occurring disorders, and individuals who are in early recovery from substance use disorders are at greater risk for such reactions as well. Nonetheless, people are amazingly resilient, and most will not develop long-term mental or substance use disorders after an event; in fact, most trauma-related symptoms will resolve and the onset of PTSD can be prevented with preventive efforts (Qi, Gevonden, & Shaley, 2016).

Interpersonal Traumas

Interpersonal traumas are events that occur (and typically continue to reoccur) between people who often know each other, such as spouses or parents and their children. Examples include physical and sexual abuse, sexual assault, domestic violence, and elder abuse.

Intimate Partner Violence

Intimate partner violence (IPV), often referred to as domestic violence, is a pattern of actual or threatened physical, sexual, and/or emotional abuse. It differs from simple assault in that multiple episodes often occur and the perpetrator is an intimate partner of the victim. Trauma associated with IPV is normally ongoing. Incidents of this form of violence are rarely isolated, and the client may still be in contact with and encountering abuse from the perpetrator while engaged in treatment.

Intimate partners include current and former spouses, boyfriends, and girlfriends. The majority of all nonfatal acts of violence and intimate partner homicides are committed against women; IPV accounts for over 20 percent of nonfatal violence against women but only 3.6 percent of that committed against men (Catalano, 2012). Children are the hidden casualties of IPV. They often witness the assaults or threats directly, within earshot, or by being exposed to the aftermath of the violence (e.g., seeing bruises and destruction of property, hearing the pleas for it to stop or the promises that it will never happen again). Substance abuse, particularly involving alcohol, is frequently associated with IPV. It is the presence of alcohol-related problems in either partner, rather than the level of alcohol consumption itself, that is the important factor.

Drinking may or may not be the cause of the violence; that said, couples with alcohol-related disorders could have more tension and disagreement within the relationship in general, which leads to aggression and violence. The consumption of alcohol during a dispute is likely to decrease inhibitions and increase impulsivity, thus creating an opportunity for an argument to escalate into

a physical altercation. More information on domestic violence and its effects on partners and families, as well as its connection with substance use and trauma-related disorders, is available in TIP 25, *Substance Abuse Treatment and Domestic Violence* (SAMSHA, 2015a), and from the National Online Resource Center on Violence Against Women (http://www.vawnet.org/).

Developmental Traumas

Developmental traumas include specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and physical and mental health. Often, these traumas are related to adverse childhood experiences (ACEs), but they can also result from tragedies that occur outside an expected developmental or life stage (e.g., a child dying before a parent, being diagnosed with a life-threatening illness as a young adult) or from events at any point in the life cycle that create significant loss and have life-altering consequences (e.g., the death of a significant other in the later years that leads to displacement of the surviving partner).

Child Neglect

Child neglect occurs when a parent or caregiver does not give a child the care he or she needs according to his or her age, even though that adult can afford to give that care or is offered help to give that care. Neglect can mean not providing adequate nutrition, clothing, and/or shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or is not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments (e.g., exposure to domestic violence). It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can mean abandoning a child or expelling him or her from home. Lack of psychological care, including emotional support, attention, or love, is also considered neglect—and it is the most common form of abuse reported to child welfare authorities.

Source: dePanfilis, 2006.

Adverse Childhood Experiences

Some people experience trauma at a young age through sexual, physical, or emotional abuse and neglect. The Adverse Childhood Experiences Study (Felitti et al., 1998) examined the effects of several categories of ACEs on adult health, including physical and emotional abuse; sexual abuse; a substance-dependent parent; an incarcerated, mentally ill, or suicidal household member; spousal abuse between parents; and divorce or separation that meant one parent was absent during childhood. The National Comorbidity Studies examined the prevalence of trauma and defined childhood adversities as parental death, parental divorce/separation, life-threatening illness, or extreme economic hardship in addition to the childhood experiences included in the Adverse Childhood Experiences Study (Green et al., 2010).

ACEs can negatively affect a person's well-being into adulthood. Whether or not these experiences occur simultaneously, are time-limited, or recur, they set the stage for increased vulnerability to physical, mental, and substance use disorders and enhance the risk for repeated trauma exposure across the life span. Childhood abuse is highly associated with major depression, suicidal thoughts, PTSD, and dissociative symptoms. So too, ACEs are associated with a greater risk of adult alcohol use. ACEs are not often unique events and studies suggest that ACEs occur as multiple, rather than single experiences for most individuals (Shin, McDonald, & Conley, 2018). In fact, one study examined different profiles of ACE exposure and found that individuals with high/multiple ACE exposure were more likely to experience substance abuse problems than individuals with lower ACE exposure (Shin et al., 2018).

A detailed examination of the issues involved in providing substance abuse treatment to survivors of child abuse and neglect is the subject of TIP 36, *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues* (SAMSHA, 2015b).

Political Terror and War

Political terror and war are likely to have lasting consequences for survivors. In essence, anything that threatens the existence, beliefs, well-being, or livelihood of a community is likely to be experienced as traumatic by community members. Whether counselors are working with an immigrant or refugee enclave in the United States or in another country, they should be aware of local events, local history, and the possibility that clients have endured trauma. (For international information about the clinical, historical, and theoretical aspects of trauma and terrorism, see Danieli, Brom, & Sills, 2005.) Terrorism is a unique subtype of human-caused disasters. The overall goal of terrorist attacks is to maximize the uncertainty, anxiety, and fear of a large community, so the responses are often epidemic and affect large numbers of people who have had direct or indirect exposure to an event (Bajo et al., 2018; Garfin, Poulin, Blum, & Silver, 2018). Bajo et al (2018) suggest that while both direct and indirect exposure to a traumatic event can have an impact, the type of exposure can result in unique effects for each group. Terrorism has a variety of results not common to other disasters, such as reminders of the unpredictability of terrorist acts; increases in security measures for the general population; intensified suspicion about a particular population, ethnicity, or culture; and heightened awareness and/or arousal.

Refugees

According to the United Nations Refugee Agency (2018), there an estimated 68.5 million people forcibly displaced in the world. More specifically, 40 million people are internally displaced people, 3.1 million are asylum-seekers, 52% of the refugee population is made up of children under the age of 18, and 173,800 are unaccompanied or separated children (United Nations Refugee

Agency, 2018). Many of these people have survived horrendous ordeals with profound and lasting effects for individuals and whole populations. In addition to witnessing deaths by execution, starvation, or beatings, many survivors have experienced horrific torture.

Refugees are people who flee their homes because they have experienced or have a reasonable fear of experiencing persecution. They differ from immigrants who willingly leave their homes or homeland to seek better opportunities. Although immigrants may experience trauma before migrating to or after reaching their new destination, refugees will often have greater exposure to trauma before migration. Refugees typically come from war-torn countries and may have been persecuted or tortured. Consequently, greater exposure to trauma, such as torture, before migrating often leads to more adjustment-related difficulties and psychological symptoms after relocation (Schock, Böttche, Rosner, Wenk-Ansohn, & Knaevelsrud, 2016).

Refugees typically face substantial difficulties in assimilating into new countries and cultures. Moreover, the environment can create a new set of challenges that may include additional exposure to trauma and social isolation (von Werthern et al., 2018). For example, many governments resort to detaining asylum seekers in detention centers, which have been demonstrated to contribute to high levels of PTSD, depression, and anxiety in detainees (von Werthern, et al., 2018). These as well as additional factors influence adjustment, the development of mental illness (including PTSD), and the occurrence of substance use disorders. Additional factors that influence outcomes after relocation include receptivity of the local community, along with opportunities for social support and culturally responsive services.

Among children and adolescents in the United States, refugees exhibit higher rates of PTSD and anxiety symptoms than U.S.-origin youth, however, refugees have comparably lower rates of substance abuse (Betancourt et al., 2017). Substance use patterns vary based on cultural factors as well as assimilation, yet research suggests that trauma increases the risk for substance use among refugees after war-related experiences (Horyniak, Melo, Farrell, Ojeda, & Strathdee, 2016). Therefore, providers should expect to see trauma-related disorders among refugees who are seeking treatment for a substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

Torture and Captivity

Torture traumatizes by taking away an individual's personhood. To survive, victims have to give up their sense of self and will. They become the person the torturer designs or a nonperson, simply existing. Inevitably, the shame of the victim is enormous, because the focus of torture is to humiliate and degrade. As a result, victims often seek to hide their trauma and significant parts of their selfhood long after torture has ended and freedom has been obtained. According to Judith Herman, "the methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others."

Source: Herman, 1997, p. 77.

Vietnamese Refugees

"Wars always have consequences, both immediate and remote, and the consequences are often tragic. One tragic circumstance often caused by war is the forceful, disorganized, and uncontrollable mass movement of both civilians and soldiers trying to escape the horrors of the wars or of an oppressive regime.…

"Vietnamese communists, by taking power in the North in 1954 and then in the South in 1975, caused two major upheavals in the Land of the Small Dragon, as Vietnam was once called. The first Vietnam War led to the 1954 exodus during which 1 million people fled from the North to the South. The second Vietnam War resulted in the dispersion, from 1975-1992, of approximately 2 million Vietnamese all over the world. These significant, unplanned, and uncoordinated mass movements around the world not only dislocated millions of people, but also caused thousands upon thousands of deaths at sea.…

"The second and third wave of refugees from 1976 onward went through a more difficult time. They had to buy their way out and to hide from soldiers and the police who hunted them down. After catching them, the police either asked for brides or threw the escapees into jails. Those who evaded police still had to face engine failures, sea storms, pirates…They then had to survive overcrowded boats for days or weeks, during which food and water could not be replenished and living conditions were terrible… Many people died from exhaustion, dehydration, and hunger. Others suffered at the hands of terrifying pirates… After the sea ordeal came the overcrowded camps where living conditions were most often substandard and where security was painfully lacking.…

"In the United States, within less than 3 decades, the Vietnamese population grew from a minority of perhaps 1,000 persons to the second largest refugee group behind Cubans."

Source: Vo, 2006, pp. 1–4.

System-Oriented Traumas: Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it, and sometimes clients themselves are

not consciously aware that a clinical situation has actually triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

Staff and agency issues that can cause retraumatization include:
- Being unaware that the client's traumatic history significantly affects his or her life.
- Failing to screen for trauma history prior to treatment planning.
- Challenging or discounting reports of abuse or other traumatic events.
- Using isolation or physical restraints.
- Using experiential exercises that humiliate the individual.
- Endorsing a confrontational approach in counseling.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling behavior/feelings as pathological.
- Failing to provide adequate security and safety within the program.
- Limiting participation of the client in treatment decisions and planning processes.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate setting.
- Having clients undress in the presence of others.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Imposing agency policies or rules without exceptions or an opportunity for clients to question them.
- Enforcing new restrictions within the program without staff–client communication.
- Limiting access to services for ethnically diverse populations.
- Accepting agency dysfunction, including lack of consistent, competent leadership.

CHARACTERISTICS OF TRAUMA

The following section highlights several selected characteristics of traumatic experiences that influence the effects of traumatic stress. Objective characteristics are those elements of a traumatic event that are tangible or factual; subjective characteristics include internal processes, such as perceptions of traumatic experiences and meanings assigned to them.

Objective Characteristics

Was it a Single, Repeated, or Sustained Trauma?

Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A *single trauma* is limited to a single point in time. A rape, an automobile accident, the sudden death of a loved one—all are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others— especially those with histories of previous trauma or mental or substance use disorders, or those for whom the trauma experience

is particularly horrific or overwhelming – a single trauma can result in traumatic stress symptoms and trauma-and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas.

After the terrorist attacks on September 11, 2001—a significant single trauma—many Manhattan residents experienced intrusive memories and sleep disruption whether they were at the site of the attacks or watched television coverage of it (Lowell et al., 2018).

A series of traumas happening to the same person over time is known as *repeated trauma*. This can include repeated sexual or physical assaults, exposure to frequent injuries of others, or seemingly unrelated traumas. Military personnel, journalists covering stories of mass tragedies or prolonged conflicts, and first responders who handle hundreds of cases each year typify repeated trauma survivors. Repetitive exposure to traumas can have a cumulative effect over one's lifetime. A person who was assaulted during adolescence, diagnosed with a life-threatening illness in his or her thirties, and involved in a serious car accident later in life has experienced repeated trauma. Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders. Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events. So too, early exposure to ACEs is associated with traumatic stress reactions and subsequent exposure to trauma in adult years. People who have encountered multiple and longer doses of trauma are at the greatest risk for developing traumatic stress. For example, military reservists and other military service members who have had multiple long tours of duty are at greater risk for traumatic stress reactions (see the planned TIP, *Reintegration- Related Behavioral Health Issues in Veterans and Military Families;* SAMHSA, planned f). In addition, people are more likely to encounter greater impairment and distress from trauma if that trauma occurs with significant intensity and continues sporadically or unceasingly for extended periods.

Was There Enough Time to Process the Experience?

A particularly severe pattern of ongoing trauma, sometimes referred to as "cascading trauma," occurs when multiple traumas happen in a pattern that does not allow an individual to heal from one traumatic event before another occurs. Take, for example, California residents – they repeatedly face consecutive and/or simultaneous natural disasters including fires, landslides, floods, droughts, and earthquakes. In other cases, there is ample time to process an event, but processing is limited because people don't have supportive relationships or environments that model preventive practices. This can lead to greater vulnerability to traumas that occur later in life.

How Many Losses has the Trauma Caused?

Trauma itself can create significant distress, but often, the losses associated with a trauma have more far-reaching effects. For instance, a child may be forced to assume adult responsibilities, such as serving as a confidant for a parent who is sexually abusing him or her, and lose the opportunity of a childhood free from adult worries. In another scenario, a couple may initially feel grateful to have escaped a house fire, but they may nevertheless face significant community and financial losses months afterward. In evaluating the impact of trauma, it is helpful to access and discuss the losses associated with the initial trauma. The number of losses greatly influences an individual's ability to bounce back from the tragedy.

In the case illustration on the next page, Rasheed's losses cause him to disconnect from his wife, who loves and supports him. Successful confrontation of losses can be difficult if the losses compound each other, as with Rasheed's loss of his friend, his disability, his employment struggles, and the threats to his marriage and liberty. People can cite a specific event as precipitating their trauma, or, in other cases, the specific trauma can symbolize a series of disabling events in which the person felt his or her life was threatened or in which he or she felt emotionally overwhelmed, psychologically disorganized, or significantly disconnected from his or her surroundings. It will be important for Rasheed to understand how his losses played a part in his abuse of prescription medications to cope with symptoms associated with traumatic stress and loss,

(e.g., guilt, depression, fear). If not addressed, his trauma could increase his risk for relapse.

Case Illustration: Rasheed - Rasheed was referred to an employee assistance program by his employer. He considered quitting his job, but his wife insisted he talk to a counselor. He is a 41-year-old auto mechanic who, 4 years ago, caused a head-on collision while attempting to pass another vehicle. A close friend, riding in   the passenger's seat, was killed, and two young people in the other vehicle were seriously injured and permanently disabled. Rasheed survived with a significant back injury and has only been able to work sporadically. He was convicted of negligent homicide and placed on probation because of his physical disability. He is on probation for another 4 years, and if he is convicted of another felony during that time, he will have to serve prison time for his prior offense.

While still in the hospital, Rasheed complained of feeling unreal, numb, and disinterested in the care he received. He did not remember the crash but remembers waking up in the hospital 2 days later. He had difficulty sleeping in the hospital and was aware of feelings of impending doom, although he was unaware of the legal charges he would later face. He was diagnosed with ASD.

He was discharged from the hospital with a variety of medications, including pain pills and a sleep aid. He rapidly became dependent on these medications, feeling he could not face the day without the pain medication and being unable to sleep without sleep medicine in larger doses than had been prescribed. Within 3 months of the accident, he was "doctor shopping" for pain pills and even had a friend obtain a prescription for the sleeping medication from that friend's doctor. In the 4 intervening years, Rasheed's drug use escalated, and his blunted emotions and detachment from friends became more profound. He became adept at obtaining pain pills from a variety of sources, most of them illegal. He fears that if he seeks treatment for the drug problem, he will have to admit to felony offenses and will probably be imprisoned. He also does not believe he can manage his life without the pain pills.

In the past 2 years, he has had recurring dreams of driving a car on the wrong side of the road and into the headlights of an oncoming vehicle. In the dream, he cannot control the car and wakes up just before the vehicles crash. At unusual times—for instance, when he is just awakening in the morning, taking a shower, or walking alone—he will feel profound guilt over the death of his friend in the accident. He becomes very anxious when driving in traffic or when he feels he is driving faster than he should. His marriage of 18 years has been marked by increasing emotional distance, and his wife has talked about separating if he does not do something about his problem. He has been unable to work consistently because of back pain and depression. He was laid off from one job because he could not concentrate and was making too many mistakes.

The counselor in the employee assistance program elicited information on Rasheed's drug use, although she suspected Rasheed was minimizing its extent and effects. Knowledgeable about psychological trauma, the counselor helped Rasheed feel safe enough to talk about the accident and how it had affected his life. She was struck by how little Rasheed connected his present difficulties to the accident and its aftermath. The counselor later commented that Rasheed talked about the accident as if it had happened to someone else. Rasheed agreed to continue in treatment.

Was the Trauma Expected or Unexpected?

When talking about a trauma, people sometimes say they didn't see it coming. Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common components of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). People with substance use disorders, mental illness, and/or cognitive disabilities may be especially vulnerable in that they may attend less or have competing concerns that diminish attention to what is going on around them, even in high-risk environments. However, most individuals attempt to gain some control over the tragedy by replaying the moments leading up to the event and processing how they could have anticipated it. Some people perseverate on these thoughts for months or years after the event.

Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. Learning about what is likely to happen can reduce traumatization. For instance, training military personnel in advance of going to combat overseas prepares them to handle traumas and can reduce the impact of trauma.

Were the Trauma's Effects on the Person's Life Isolated or Pervasive?

When a trauma is isolated from the larger context of life, a person's response to it is more likely to be contained and limited. For instance, military personnel in combat situations can be significantly traumatized by what they experience. On return to civilian life or noncombat service, some are able to isolate the traumatic experience so that it does not invade ordinary, day-to-day living. This does not mean that the combat experience was not disturbing or that it will not resurface if the individual encounters an experience that triggers memories of the trauma; it just means that the person can more easily leave the trauma in the past and attend to the present.

Conversely, people who remain in the vicinity of the trauma may encounter greater challenges in recovery. The traumatic event intertwines with various aspects of the person's daily activities and interactions, thus increasing the possibility of being triggered by surrounding cues and experiencing subsequent psychological distress. However, another way to view this potential dilemma for the client is to reframe it as an opportunity—the repetitive exposure to trauma-related cues may provide vital guidance as to when and which treatment and coping techniques to use in the delivery of trauma-informed and trauma-specific behavioral health services.

Who was Responsible for the Trauma and was the Act Intentional?

If the severity of a trauma is judged solely by whether the act was intentional or not, events that reflect an intention to harm would be a primary indicator in predicting subsequent difficulties among individuals exposed to this form of trauma. For most survivors, there is an initial disbelief that someone would conceivably intend to harm others, followed by considerable emotional and, at times, behavioral investment in somehow making things right again or in making sense of a

senseless, malicious act. For instance, in the wake of the World Trade Center attacks in New York City, people responded via renewed patriotism, impromptu candlelight vigils, attacks on people of Arab and Muslim descent, and unprecedented donations and willingness to wait in long lines to donate blood to the Red Cross. Each example is a response that in some way attempts to right the perceived wrong or attach new meaning to the event and subsequent consequences.

When terrible things happen, it is human nature to assign blame. Trauma survivors can become heavily invested in assigning blame or finding out who was at fault, regardless of the type of trauma. Often, this occurs as an attempt to make sense of, give meaning to, and reestablish a sense of predictability, control, and safety after an irrational or random act. It is far easier to accept that someone, including oneself, is at fault or could have done something different than it is to accept the fact that one was simply in the wrong place at the wrong time. For some trauma survivors, needing to find out why a trauma occurred or who is at fault can become a significant block to growth when the individual would be better served by asking, "What do I need to do to heal?" Behavioral health professionals can help clients translate what they have learned about responsibility in recovery to other aspects of their lives. For instance, someone in treatment for co-occurring disorders who has internalized that becoming depressed or addicted was not his or her fault, but that recovery *is* a personal responsibility, can then apply the same principle to the experience of childhood abuse and thereby overcome negative judgments of self (e.g., thinking oneself to be a bad person who deserves abuse). The individual can then begin to reassign responsibility by attaching the blame to the perpetrator(s) while at the same time assuming responsibility for recovery.

Was the Trauma Experienced Directly or Indirectly?
Trauma that happens to someone directly seems to be more damaging than witnessing trauma that befalls others. For example, it is usually more traumatic to be robbed at gunpoint than to witness someone else being robbed or hearing someone tell a story about being robbed. Yet, sometimes, experiencing another's pain can be equally traumatic. For instance, parents often internalize the pain and suffering of their children when the children are undergoing traumatic circumstances (e.g., treatments for childhood cancer).

There are two ways to experience the trauma of others. An individual may witness the event, such as seeing someone killed or seriously injured in a car accident, or may learn of an event that happened to someone, such as a violent personal assault, suicide, serious accident, injury, or sudden or unexpected death. For many people, the impact of the trauma will depend on a host of variables, including their proximity to the event as eyewitnesses, the witnesses' response in the situation, their relationship to the victims, the degree of helplessness surrounding the experience,

their exposure to subsequent consequences, and so on.

The effects of traumas such as genocide and internment in concentration camps can be felt across generations—stories, coping behaviors, and stress reactions can be passed across generational lines far removed from the actual events or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

Case Illustration: Frank

Frank entered substance abuse treatment with diagnoses of co-occurring PTSD and substance use disorder. While on a whitewater kayak trip with his wife, her kayak became pinned on a rock, and Frank could only watch helplessly as she drowned. His drinking had increased markedly after the accident. He acknowledged a vicious cycle of sleep disturbance with intrusive nightmares followed by vivid memories and feelings of terror and helplessness after he awoke. He drank heavily at night to quiet the nightmares and memories, but heavy alcohol consumption perpetuated his trouble sleeping. He withdrew from contact with many of his old "couple friends" and his wife's family, with whom he had been close. At treatment entry, he described his life as "going to work and coming home." The trauma occurred 3 years before he sought treatment, but Frank continued to feel numb and disconnected from the world. His only emotion was anger, which he tried to keep in check. Integrated treatment for PTSD and substance abuse helped him sleep and taught him coping skills to use when the memories arose; it fostered his engagement and retention in long-term care for both disorders.

What Happened Since the Trauma?

In reviewing traumatic events, it is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, community events, behavioral health services, local stores, and recreational areas. There is typically an initial rally of services and support following a trauma, particularly if it is on a mass scale. However, the reality of the trauma's effects and their disruptiveness may have a more lasting impact. The deterioration of normalcy, including the disruption of day-to-day activities and the damage of structures that house these routines, will likely erode the common threads that provide a sense of safety in individual lives and communities. Hence, the degree of disruption in resuming normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders. For example, adults displaced from their homes because of Hurricanes Katrina or Rita had significantly higher rates of past-month cigarette use, illicit drug use, and binge drinking than those who were not displaced (Office of Applied Studies, 2008) and these rates have been sustained (Shuler et al., 2016).

> It is important to remember that what happened is not nearly as important as what the trauma means to the individual.

Subjective Characteristics

Psychological Meaning of Trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event— that is, their beliefs and assumptions— contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or his or her family? How does the individual attach meaning to his or her survival? Does he or she believe that it is a sign of a greater purpose not yet revealed? People who attempt to share their interpretation and meaning of the event can feel misunderstood and sometimes alienated (Steger, Owens, & Park, 2015). People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but his or her interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

Disruption of Core Assumptions and Beliefs

Trauma often engenders a crisis of faith (Frankl, 1992) that leads clients to question basic assumptions about life. Were the individual's core or life-organizing assumptions (e.g., about safety, perception of others, fairness, purpose of life, future dreams) challenged or disrupted during or after the traumatic event? (See the seminal work, Shattered Assumptions, by Janoff-Bulman, 1992.) For example, some trauma survivors see themselves as irreparably wounded or beyond the possibility of healing. The following case illustration (Sonja) explores not only the importance of meaning, but also the role that trauma plays in altering an individual's core assumptions—the very assumptions that provide meaning and a means to organize our lives and our interactions with the world and others.

Cultural Meaning of Trauma

Counselors should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, an Alaska Native individual or

community, depending upon their Tribal ancestry, may believe that the traumatic experience serves as a form of retribution. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture that has a strong belief in a positive afterlife. It is important for counselors to recognize that their perceptions of a specific trauma could be very different from their clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system. For more information on culture and how to achieve cultural competence in providing behavioral health services, see SAMHSA's planned TIP, Improving Cultural Competence (SAMHSA, planned c).

> **Resilience: Connection and Continuity**
>
> Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of survivors of Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents directly affected by the purge experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. Whether the grandparents survived was less important than the connection the grandchildren felt to their pasts.

INDIVIDUAL AND SOCIOCULTURAL FEATURES

A wide variety of social, demographic, environmental, and psychological factors influence a person's experience of trauma, the severity of traumatic stress reactions following the event, and his or her resilience in dealing with the short- and long-term environmental, physical, sociocultural, and emotional consequences. This section addresses a few known factors that influence the risk of trauma along with the development of subclinical and diagnostic traumatic stress symptoms, such as mood and anxiety symptoms and disorders. It is not meant to be an exhaustive exploration of these factors, but rather, a brief presentation to make counselors and other behavioral health professionals aware that various factors influence risk for and protection against traumatic stress and subsequent reactions.

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history as they influence the person's experience and interpretation of, as well as his or her reactions to, trauma. However, many factors influence individual responses to trauma; it is not just individual characteristics. Failing to recognize that multiple factors aside from individual attributes and history influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

Case Illustration: Sonja

Sonja began to talk about how her life was different after being physically assaulted and robbed in a parking lot at a local strip mall a year ago. She recounts that even though there were people in the parking lot, no one came to her aid until the assailant ran off with her purse. She sustained a cheek- bone fracture and developed visual difficulties due to the inflammation from the fracture. She recently sought treatment for depressive symptoms and reported that she had lost interest in activities that typically gave her joy. She reported isolating herself from others and said that her perception of others had changed dramatically since the attack.

Sonja had received a diagnosis of major depression with psychotic features 10 years earlier and received group therapy at a local community mental health center for 3 years until her depression went into remission. She recently became afraid that her depression was becoming more pronounced, and she wanted to prevent another severe depressive episode as well as the use of psychotropic medications, which she felt made her lethargic. Thus, she sought out behavioral health counseling.

As the sessions progressed, and after a psychological evaluation, it was clear that Sonja had some depressive symptoms, but they were subclinical. She denied suicidal thoughts or intent, and her thought process was organized with no evidence of hallucinations or delusions. She described her isolation as a reluctance to shop at area stores. On one hand, Sonja was self-compassionate about her reasons for avoidance, but on the other hand, she was concerned that the traumatic event had altered how she saw life and others. "I don't see people as very caring or kind, like I used to prior to the event. I don't trust them, and I feel people are too self-absorbed. I don't feel safe, and this bothers me. I worry that I'm becoming paranoid again. I guess I know better, but I just want to have the freedom to do what I want and go where I want."

Two months after Sonja initiated counseling, she came to the office exclaiming that things can indeed change. "You won't believe it. I had to go to the grocery store, so I forced myself to go the shopping center that had a grocery store attached to a strip mall. I was walking by a coffee shop, quickly browsing the items in the front window, when a man comes out of the shop talking at me. He says, 'You look like you need a cup of coffee.' What he said didn't register immediately. I looked at him blankly, and he said it again. 'You look like you need a cup of coffee. I'm the owner of the shop, and I noticed you looking in the window, and we have plenty of brewed coffee left before we close the shop. Come on in, it's on the house.' So, I did! From that moment on, I began to see people differently. He set it right for me—I feel as if I have myself back again, as if the assault was a sign that I shouldn't trust people, and now I see that there is some goodness in the world. As small as this kindness was, it gave me the hope that I had lost."

For Sonja, the assault changed her assumptions about safety and her view of others. She also attached meaning to the event. She believed that the event was a sign that she shouldn't trust people and that people are uncaring. Yet these beliefs bothered her and contradicted how she saw herself in the world, and she was afraid that her depressive symptoms were returning.

For an inexperienced professional, her presentation may have ignited suspicions that she was beginning to present with psychotic features. However, it is common for trauma survivors to experience changes in core assumptions immediately after the event and to attach meaning to the trauma. Often, a key ingredient in the recovery process is first identifying the meaning of the event and the beliefs that changed following the traumatic experience. So, when you hear a client say "I will never see life the same," this expression should trigger further exploration into how life is different, what meaning has been assigned to the trauma, and how the individual has changed his or her perception of self, others, and the future.

Case Illustration: Sonja (continued)

Sometimes, reworking the altered beliefs and assumptions occurs with no formal intervention, as with Sonja. In her situation, a random stranger provided a moment that challenged an assumption generated from the trauma. For others, counseling may be helpful in identifying how beliefs and thoughts about self, others, and the world have changed since the event and how to rework them to move beyond the trauma. It is important to understand that the meaning that an individual attaches to the event(s) can either undermine the healing process (e.g., believing that you should not have survived, feeling shame about the trauma, continuing to engage in high-risk activities) or pave the road to recovery (e.g., volunteering to protect victim rights after being sexually assaulted). The following questions can help behavioral health staff members introduce topics surrounding assumptions, beliefs, interpretations, and meanings related to trauma:

• In what ways has your life been different since the trauma?
• How do you understand your survival? (This is an important question for clients who have been exposed to ACEs or cumulative trauma and those who survived a tragedy when others did not.)
• Do you believe that there are reasons that this event happened to you? What are they?
• What meaning does this experience have for you?
• Do you feel that you are the same person as before the trauma? In what ways are you the same? In what ways do you feel different?
• How did this experience change you as a person? Would you like to return to the person you once were? What would you need to do, or what would need to happen, for this to occur?
• Did the traumatic experience change you in a way that you don't like? In what ways?
• How do you view others and your future differently since the trauma?
• What would you like to believe now about the experience?

History of Prior Psychological Trauma

People with histories of prior psychological trauma appear to be the most susceptible to severe traumatic responses (Schock et al., 2016), particularly if they have avoided addressing past traumas. Because minimization, dissociation, and avoidance are common defenses for many trauma survivors, prior traumas are not always consciously available, and when they are, memories can be distorted to avoid painful affects. Some survivors who have repressed their experiences deny a history of trauma or are unable to explain their strong reactions to present situations. Remember that the effects of trauma are cumulative; therefore, a later trauma that outwardly appears less severe may have more impact upon an individual than a trauma that occurred years earlier. Conversely, individuals who have experienced earlier traumas may have developed effective coping strategies or report positive outcomes as they have learned to adjust to the consequences of the trauma(s). This outcome is often referred to as posttraumatic growth or psychological growth.

Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to attend to histories, adjust treatment to avoid retraumatization, and steer clear of labeling clients' behavior as pathological.

History of Resilience

Resilience – the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder, Torres, Southwick, & Charney, 2019), flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions (Bonanno & Mancini, 2011; Southwick & Charney, 2018; Southwick, Pietrzak, Tsai, Krystal, & Charney, 2015).

History of Mental Disorders

The correlations among traumatic stress, substance use disorders, and co-occurring mental disorders are well known. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association, 2013a), traumatic stress reactions are linked to higher

rates of mood, substance-related, anxiety, trauma, stress-related, and other mental disorders, each of which can precede, follow, or emerge concurrently with trauma itself. A co-occurring mental disorder is a significant determinant of whether an individual can successfully address and resolve trauma as it emerges from the past or occurs in the present. Studies have shown that pre-existing mental disorders (such as substance use) may intensify psychological vulnerability to the effects of trauma (i.e., increased PTSD symptom severity; Berenz & Coffey, 2012; Roberts et al., 2015). For additional information on comorbidity of trauma and other mental disorders, see TIP 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders (*SAMHSA, 2013).

Sociodemographic Factors

Demographic variables are not good predictors of who will experience trauma and subsequent traumatic stress reactions. Gender, age, race and ethnicity, sexual orientation, marital status, occupation, income, and education can all have some influence, but not enough to determine who should or should not receive screening for trauma and traumatic stress symptoms. The following sections cover a few selected variables.

Gender

In the United States, men are at greater risk than women for being exposed to stressful events. Despite the higher prevalence among men, lifetime PTSD occurs at about twice the rate among women as it does in men. Less is known about gender differences with subclinical traumatic stress reactions. There are also other gender differences, such as the types of trauma experienced by men and women.

Women are more likely to experience physical and sexual assault, whereas men are most likely to experience combat and crime victimization and to witness killings and serious injuries (Kucharska, 2017). Women in military service are subject to the same risks as men and are also at a greater risk for military sexual trauma. Men's traumas often occur in public; women's are more likely to take place in private settings. Perpetrators of traumas against men are often strangers, but women are more likely to know the perpetrator.

Age

In general, the older one becomes, the higher the risk of trauma—but the increase is not dramatic. Age is not particularly important in predicting exposure to trauma, yet at no age is one immune to the risk. However, trauma that occurs in the earlier and midlife years appears to have greater impact on people for different reasons. For younger individuals, the trauma can affect developmental processes, attachment, emotional regulation, life assumptions, cognitive interpretations of later experiences, and so forth (for additional resources, visit the National Child Traumatic Stress

Network; http://www.nctsn.org/). For adults in midlife, trauma may have a greater impact due to the enhanced stress or burden of care that often characterizes this stage of life—caring for their children and their parents at the same time. Older adults are as likely as younger adults to recover quickly from trauma, yet they may have greater vulnerabilities, including their ability to survive without injury and their ability to address the current trauma without psychological interference from earlier stressful or traumatic events. Older people are naturally more likely to have had a history of trauma because they have lived longer, thus creating greater vulnerability to the effects of cumulative trauma.

Race, Ethnicity, and Culture

The potential for trauma exists in all major racial and ethnic groups in American society, yet few studies analyze the relationship of race and ethnicity to trauma exposure and/or traumatic stress reactions. Some studies show that certain racial and ethnic groups are at greater risk for specific traumas. For example, African Americans experienced higher rates of overall violence, aggravated assault, and robbery than Whites but were as likely to be victims of rape or sexual assault (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011). Literature reflects that diverse ethnic, racial, and cultural groups are more likely to experience adverse effects from various traumas and to meet criteria for posttraumatic stress (Alegría et al., 2013; López et al., 2018).

Sexual Orientation and Gender Identity

Lesbian, gay, bisexual, and transgender individuals are likely to experience various forms of trauma associated with their sexual orientation, including harsh consequences from families and faith traditions, higher risk of assault from casual sexual partners, hate crimes, lack of legal protection, and laws of exclusion (Brown, 2008). Gay and bisexual men as well as transgender people are more likely to experience victimization than lesbians and bisexual women. Moreover, sexual minorities experience greater negative effects following trauma and report more recovery challenges (Sigurvinsdottir & Ullman, 2016). Heterosexual orientation is also a risk for women, as women in relationships with men are at a greater risk of being physically and sexually abused.

People Who are Homeless

Homelessness is typically defined as the lack of an adequate or regular dwelling, or having a nighttime dwelling that is a publicly or privately supervised institution or a place not intended for use as a dwelling (e.g., a bus station). The U.S. Department of Housing and Urban Development (HUD) estimates that between an estimated 553,000 individuals were homeless on any given night in 2018 (HUD, 2018). Two thirds were unaccompanied persons; the other third were people in families. Veterans and African Americans are considerably overrepresented among the homeless population and many of these individuals experience chronic patterns of homelessness (HUD,

2018).

Rates of trauma symptoms are high among people who are homeless and some studies suggest the majority of individuals experiencing homelessness have a trauma history (Woodhall-Melnik, Dunn, Svenson, Patterson, & Matheson, 2018), and the diagnosis of PTSD is among the most prevalent non-substance use mental health disorders (Whitbeck, Armenta, & Welch-Lazoritz, 2015). People who are homeless report high levels of trauma (especially physical and sexual abuse in childhood or as adults) preceding their homeless status; assault, rape, and other traumas frequently happen while they are homeless. Research suggests that many women are homeless because they are fleeing domestic violence (National Coalition for the Homeless, 2002). Other studies suggest that women who are homeless are more likely to have histories of childhood physical and sexual abuse and to have experienced sexual assault as adults. A history of physical and/or sexual abuse is even more common among women who are homeless and have a serious mental illness.

Youth who are homeless, especially those who live without a parent, are likely to have experienced physical and/or sexual abuse. Homeless youth are three times more likely to have experienced trauma and four times more likely to be rape survivors (Davies & Allen, 2017). Additionally, data reflect elevated rates of substance abuse for youth who are homeless and have histories of abuse. More than half of people who are homeless have a lifetime prevalence of mental illness and substance use disorders. Those who are homeless have higher rates of substance abuse; and, substance use disorders, including alcohol and drug abuse/dependence, increase with longer lengths of homelessness (McVicar, Moschion, & van Ours, 2015).

For more information on providing trauma- informed behavioral health services to clients who are homeless, and for further discussion of the incidence of trauma in this population, see TIP 55-R, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2015c).

REFERENCES

Alegría, M., Fortuna, L. R., Lin, J. Y., Norris, L. F., Gao, S., Takeuchi, D. T., ... & Valentine, A. (2013). Prevalence, risk, and correlates of posttraumatic stress disorder across ethnic and racial minority groups in the US. *Medical care*, *51*(12), 1114.

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders*. (5th ed.). Arlington, VA: American Psychiatric Association.

Bajo, M., Blanco, A., Stavraki, M., Gandarillas, B., Cancela, A., Requero, B., & Díaz, D. (2018). Post-traumatic cognitions and quality of life in terrorism victims: the role of well-being in indirect versus direct exposure. *Health and quality of life outcomes*, *16*(1), 96.

Baker, K. G. & Gippenreiter, J. B. (1998). Stalin's purge and its impact on Russian families: A pilot study. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 403–434). New York: Plenum Press.

Berenz, E. C., & Coffey, S. F. (2012). Treatment of co-occurring posttraumatic stress disorder and substance use disorders. *Current Psychiatry Reports, 14*(5), 469-477.

Betancourt, T. S., Newnham, E. A., Birman, D., Lee, R., Ellis, B. H., & Layne, C. M. (2017). Comparing trauma exposure, mental health needs, and service utilization across clinical samples of refugee, immigrant, and US-origin children. *Journal of traumatic stress*, *30*(3), 209-218.

Brown, L. S. (2008). Feminist therapy. In J. L. Lebow (Ed.), *Twenty-first century psychotherapies: Contemporary approaches to theory and practice* (pp. 277–306). Hoboken, NJ: John Wiley & Sons, Inc.

Catalano, S. (2012). *Intimate partner violence in the U.S.* Washington, DC: Bureau of Justice Statistics.

Cherpitel, C. J., Ye, Y., Bond, J., Borges, G., & Monteiro, M. (2015). Relative risk of injury from acute alcohol consumption: modeling the dose–response relationship in emergency department data from 18 countries. *Addiction*, *110*(2), 279-288.

Cromer, L. D., Gray, M. E., Vasquez, L., & Freyd, J. J. (2018). The relationship of acculturation to historical loss awareness, institutional betrayal, and the intergenerational transmission of

trauma in the American Indian experience. *Journal of Cross-Cultural Psychology*, *49*(1), 99-114.

Danieli, Y., Brom, D., & Sills, J. (2005). Sharing knowledge and shared care. *Journal of Aggression, Maltreatment & Trauma, 10*, 775-790.

Davies, B. R., & Allen, N. B. (2017). Trauma and homelessness in youth: Psychopathology and intervention. *Clinical Psychology Review*, *54*, 17-28.

dePanfilis, D. (2006). *Child neglect: A guide for prevention, assessment, and intervention.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Children's Bureau, Office on Child Abuse and Neglect.

Eriksen, T. R., Shumba, L., Ekeberg, Ø., & Bogstrand, S. T. (2018). The association between hospital admission and substance use among trauma patients. *Journal of Substance Use*, *23*(1), 79-85.

Feder, A., Torres, S. F., Southwick, S. M., & Charney, D. S. (2019). The Biology of Human Resilience: Opportunities for Enhancing Resilience across the Lifespan. *Biological Psychiatry*.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14,* 245–258.

Frankl, V. E. (1992). *Man's search for meaning: An introduction to logotherapy.* (4th ed.). Boston: Beacon Press.

Gindi RM, Black LI, Cohen RA. Reasons for emergency room use among U.S. adults aged 18–64: National Health Interview Survey, 2013 and 2014. National health statistics reports; no 90. Hyattsville, MD: National Center for Health Statistics. 2016.

Goodell, J. (2003). *Who's a hero now?* Retrieved on November 21, 2013 from: http://www.nytimes.com/2003/07/27/magazine/who-s-a-hero-now.html

Green, J. G., McLaughlin, K. A., Berglund, P. A., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., et al. (2010). Childhood adversities and adult psychiatric disorders in the National

Comorbidity Survey Replication I: Associations with first onset of DSM-IV disorders. *Archives of General Psychiatry, 67,* 113–123.

Herman, J. L. (1997). *Trauma and recovery.* (Rev. ed.). New York: Basic Books.

Horyniak, D., Melo, J. S., Farrell, R. M., Ojeda, V. D., & Strathdee, S. A. (2016). Epidemiology of substance use among forced migrants: a global systematic review. *PLoS one*, *11*(7), e0159134.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Johnson, K. N., Raetz, A., Harte, M., McMahon, L. E., Grandsoult, V., Garcia-Filion, P., & Notrica, D. M. (2014). Pediatric trauma patient alcohol screening: a 3 year review of screening at a Level I pediatric trauma center using the CRAFFT tool. *Journal of Pediatric Surgery*, *49*(2), 330-332.

Kucharska, J. (2017). Sex differences in the appraisal of traumatic events and psychopathology. *Psychological trauma: theory, research, practice, and policy*, *9*(5), 575.

López, C. M., Andrews III, A. R., Chisolm, A. M., de Arellano, M. A., Saunders, B., & Kilpatrick, D. (2018). Racial/ethnic differences in trauma exposure and mental health disorders in adolescents. *Cultural Diversity and Ethnic Minority Psychology*, *23*(3), 382.

Lowell, A., Suarez-Jimenez, B., Helpman, L., Zhu, X., Durosky, A., Hilburn, A., ... & Neria, Y. (2018). 9/11-related PTSD among highly exposed populations: a systematic review 15 years after the attack. *Psychological Medicine*, *48*(4), 537-553.

Maung, A. A., Becher, R. D., Schuster, K. M., & Davis, K. A. (2018). When should screening of pediatric trauma patients for adult behaviors start?. *Trauma Surgery & Acute Care Open*, *3*(1), e000181.

McVicar, D., Moschion, J., & van Ours, J. C. (2015). From substance use to homelessness or vice versa?. *Social Science & Medicine*, *136*, 89-98.

Mello, M. J., Bromberg, J. R., Wills, H., Gaines, B. A., Lapidus, G., Ranney, M. L., ... & Baird, J. (2018). Alcohol and Other Drug Use in a Sample of Admitted Adolescent Trauma Patients. *Journal of substance abuse and alcoholism*, *6*(2).

Molina, C. S. P., Berry, S., Nielsen, A., & Winfield, R. (2018). PTSD in civilian populations after hospitalization following traumatic injury: A comprehensive review. *The American Journal of Surgery*, *216*(4), 745-753.

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

National Coalition for the Homeless. (2002). *Why are people homeless?* Washington, DC: National Coalition for the Homeless.

Qi, W., Gevonden, M., & Shalev, A. (2016). Prevention of post-traumatic stress disorder after trauma: Current evidence and future directions. *Current Psychiatry Reports*, *18*(2), 20.

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine*, *41*(1), 71-83.

Roberts, N. P., Roberts, P. A., Jones, N., & Bisson, J. I. (2015). Psychological interventions for post-traumatic stress disorder and comorbid substance use disorder: a systematic review and meta-analysis. *Clinical Psychology Review*, *38*, 25-38.

Schock, K., Böttche, M., Rosner, R., Wenk-Ansohn, M., & Knaevelsrud, C. (2016). Impact of new traumatic or stressful life events on pre-existing PTSD in traumatized refugees: Results of a longitudinal study. *European Journal of Psychotraumatology*, *7*(1), 32106.

Shin, S. H., McDonald, S. E., & Conley, D. (2018). Patterns of adverse childhood experiences and substance use among young adults: A latent class analysis. *Addictive Behaviors*, *78*, 187-192.

Shuler, M. N., Wallington, S. F., Qualls-Hampton, R. Y., Podesta, A. E., & Suzuki, S. (2016). Trend analysis of substance abuse treatment admissions in New Orleans from 2000–2012: A population-based comparison pre-and post-Hurricane Katrina. *Substance Use & Misuse*, *51*(12),

1542-1554.

Sigurvinsdottir, R., & Ullman, S. E. (2016). Sexual orientation, race, and trauma as predictors of sexual assault recovery. *Journal of Family Violence*, *31*(7), 913-921.

Southwick, S. M., & Charney, D. S. (2018). *Resilience: The science of mastering life's greatest challenges*. Cambridge University Press.

Southwick, S. M., Pietrzak, R. H., Tsai, J., Krystal, J. H., & Charney, D. (2015). Resilience: an update. *PTSD research quarterly*, *25*(4), 1-10.

Steger, M. F., Owens, G. P., & Park, C. L. (2015). Violations of war: Testing the meaning-making model among Vietnam veterans. *Journal of Clinical Psychology*, *71*(1), 105-116.

Steinka-Fry, K. T., Tanner-Smith, E. E., Dakof, G. A., & Henderson, C. (2017). Culturally sensitive substance use treatment for racial/ethnic minority youth: A meta-analytic review. *Journal of Substance Abuse Treatment*, *75*, 22-37.

Substance Abuse and Mental Health Services Administration (SAMSHA). (2019). *Screening, brief intervention, and referral to treatment (SBIRT) toolkit*. Retrieved from: https://www.integration.samhsa.gov/clinical-practice/sbirt

Substance Abuse and Mental Health Services Administration (SAMSHA). (2013). *Substance abuse treatment for persons with co-occurring disorders.* Treatment Improvement Protocol (TIP) Series, No. 42. HHS Publication No. (SMA) 13-3992. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration (SAMSHA). (2015a). *Substance abuse treatment and domestic violence.* Treatment Improvement Protocol (TIP) Series, No. 25. HHS Publication No. (SMA) 133992. Rockville, MD: SAMHSA. Substance Abuse and Mental Health Services Administration (SAMSHA). (2015b).

Substance Abuse and Mental Health Services Administration (SAMSHA). (2015c). *Behavioral health service for people who are homeless.* Treatment Improvement Protocol (TIP) Series, No. 55. HHS Publication No. (SMA) 134734. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration (SAMSHA). (2015d). *Addressing*

suicidal thoughts and behaviors in substance abuse treatment.
Treatment Improvement Protocol (TIP) Series, No. 50. HHS Publication No. (SMA) 15-4381. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration. (planned a). *Behavioral health services: Building health, wellness, and quality of life for sustained recovery.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (planned b). *Behavioral health services for American Indians and Alaska Natives.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (planned c). *Improving cultural competence.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (planned d). *Managing anxiety symptoms in behavioral health services.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (planned e). *Relapse prevention and recovery promotion in behavioral health services.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (planned f). *Reintegration-related behavioral health issues in veterans and military families.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (planned g). *Using technology-based therapeutic tools in behavioral health services.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration & Office of Applied Studies. (2008). *Impact of hurricanes Katrina and Rita on substance use and mental health.* (Rep. No. January 31). Rockville, MD: Substance Abuse and Mental Health Services Administration & Office of Applied Studies.

U.S. Department of Housing and Urban Development & Office of Community Planning and Development. (2018). *The annual homeless assessment report to Congress.*

U.S. Fire Administration. (2007). *I-35W bridge collapse and response: Technical report series USFA- TR-166 August.* Emmittsburg, MD: U.S. Fire Administration.

United Nations Refugee Agency (2018). *Global trends. Forced displacement in 2017*. Retrieved from: https://www.unhcr.org/globaltrends2017/

Vo, N. M. (2006). *The Vietnamese boat people, 1954 and 1975-1992*. Jefferson, NC: McFarland & Co.

von Werthern, M., Robjant, K., Chui, Z., Schon, R., Ottisova, L., Mason, C., & Katona, C. (2018). The impact of immigration detention on mental health: a systematic review. *BMC Psychiatry 18,* 382

Whitbeck, L. B., Armenta, B. E., & Welch-Lazoritz, M. L. (2015). Borderline personality disorder and Axis I psychiatric and substance use disorders among women experiencing homelessness in three US cities. *Social psychiatry and psychiatric epidemiology*, *50*(8), 1285-1291.

Woodhall-Melnik, J., Dunn, J. R., Svenson, S., Patterson, C., & Matheson, F. I. (2018). Men's experiences of early life trauma and pathways into long-term homelessness. *Child abuse & neglect*, *80*, 216-225.