SAMHSA’S TRAUMA INFORMED CARE
Must Know Practices of Integrated Diagnosis and Treatment

American Mental Health Counselors Association
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AMHCA

• Continues to lobby for Medicare reimbursement
• Launched a series of CE credit webinars dealing with professional development & practice
• Is working to revise the AMHCA Standards of Practice and AMHCA Code of Ethics

AMHCA needs your support & participation

Your dues pay for legislative initiatives and professional development resources

What can you do for your profession to do your part?
CASE STUDY - ELIZA

Patient presented with anxiety related to appearance

    Also noted her high sensitivity to certain noises

Met criteria for Body Dysmorphic Disorder 300.7

Self-belief from childhood: “I am ugly”

Treatment: EMDR focused on beliefs that resolved traumatic experiences of childhood.

Results: Self-beliefs regarding her appearance improved and symptoms subsided
Six Months Later – Eliza returns for counseling

She notes: “I get really upset with the sounds of people eating, chewing gum.”

Still presenting with anxiety symptoms

Self-belief from childhood: “I’m a freak!”

What is your provisional diagnosis?

What else do you want to know?
CASE STUDY - ELIZA

I missed important clues

   My clinical focus was on the body dysmorphic disorder

Eliza had researched her condition and wondered if it was “Misophonia”

Misophonia, literally "hatred of sound" is a rarely diagnosed neuropsychiatric disorder in which negative emotions (anger, rage, flight, hatred, disgust) are triggered by sounds.

It appears that this is a developmental neurological disorder with no known physiological resolution.

   Is clinical mental health counseling warranted for this neurological disorder? Why?
THREE LEGS OF TOTAL HEALTH

Which of these services are most critical to individual or family health?

Addiction Recovery
Mental healthcare
Medical Care
THE PARADIGMS ARE CHANGING:

Paradigm:

A set of assumptions, concepts, values, and practices that constitutes a way of viewing reality for the community that shares them.
PARADIGM CHANGES:

Old Paradigm:

Healthcare is provided by physicians

New Paradigm:

Healthcare is provided by a variety of providers who are specialists in medicine, psychology, & substance abuse
PARADIGM CHANGES:

Old Paradigm:

The DSM-IV diagnoses mental disorders

New Paradigm:

The DSM-5 focuses on comprehensive health assessment: medical, psychological, & environmental concerns
PARADIGM CHANGES:

Old Paradigm: We work with “Clients”

- We are not attorneys or financial advisors who have clients

New Paradigm: We work with “Patients”

- The change is driven by the Affordable Care Act and insurers
- We are “Healthcare Providers” who offer mental health psychotherapy to individuals who are suffering from diagnosable disorders

I do not use either term in the presence of the individuals I work with
PARADIGM CHANGES:

Old Paradigm: Trauma treatment is reserved for specialists

“CMHCs don’t see many PTSD patients”

New Paradigm: CMHCs must skilled in resolving trauma and chronic distress

July, 2014, SAMHSA report for a Trauma Informed Approach
SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Substance Abuse and Mental Health Service Administration
July 2014
Trauma is a widespread, harmful and costly public health problem

Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders

Studies of people in the justice system reveal high rates of mental and substance use disorders and personal histories of trauma

Many patients in primary care similarly have significant trauma histories which impact their health and their responsiveness to health interventions
SAMHSA: MAJOR FINDINGS

With advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms which interact and contribute to mental and substance use disorders across the life-span.

They include:

- **Neurobiology**
- **Psychological processes, and**
- **Social attachment**

This informs CMHCs that all of these areas must be addressed.
SAMHSA: CONCEPT OF TRAUMA

“Individual trauma results from

an event, series of events, or set of circumstances

that is experienced by an individual as physically or emotionally harmful or life threatening and

that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”

Both the DSM-5 & SAMHSA emphasize the significance of trauma

However, there is less gravity given by the DSM-5 to a new classification: Other Specified Trauma and Stressor-Related Disorders
“Individual trauma (chronic distress) results from

an event, series of events, or set of circumstances

that is experienced by an individual as physically or emotionally harmful or life threatening and

that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”

The above definition includes the concept of Chronic Distress

Just because a patient does not meet symptom criteria for PTSD does not mean that they are not subject to trauma or chronic distress
SAMHSA: THE THREE “E’s”

- **Event(s)** DSM-5 requires all conditions classified as trauma or stressor-related disorders to include exposure to a traumatic or stressful event(s) as a diagnostic criterion.

- **Experience** How the individual labels, assigns meaning to, and is disrupted physically and psychologically determines if the event is traumatic or chronically distressing – this includes feeling powerless, humiliated, or shamed.

- **Effect** Adverse effects may be occur immediately or may have delayed onset and may be associated with inability to cope with normal stresses, inattention, inability to regulate thinking, feelings, behaviors, etc.
SAMHSA: TRAUMA INFORMED CARE

- **Realize** All professionals in a facility or organization have a basic realization regarding trauma and how it can affect individuals as well as families, groups, communities, etc.

- **Recognize** Professionals are able to recognize the signs of trauma or chronic distress through awareness, specific trauma screening, assessment, and supervision.

- **Reponds** Professional and organizations respond by integrating trauma training, treatment planning, mission focus, and consistently addressing trauma related issues in an on-going basis.

- **Resist Re-traumatization** Systematically work to eliminate practices or mindsets that interfere or disrupt recovery and trauma resolution.
SAMHSA: TRAUMA INFORMED CARE

- Realize
- Recognize
- Reponds
- Resist Re-traumatization

What can you expect? She just like every other borderline.

How would you respond?
Professionals use and are trained in interventions based on best available empirical evidence.

Successful trauma screening and assessments are essential.

Trauma-specific interventions are effective and available for individuals and families seeking services.

When trauma-specific services are not available, there is a trusted referral system in place.
USING THE NEW PARADIGMS

- These are exciting times in medicine, psychotherapy, & healthcare
- CMHCs must understand the new paradigms
- Your future success relies on both:
  1. Comprehensive health assessments and
  2. Effective treatment outcomes
OUTCOME BASED RESULTS

- Our patients do not have an understanding of what they are buying for their mental health dollar
- What assurance do they have that our clinical mental health counseling is effective? Are you keeping individual outcome statistics?
AN INTEGRATED APPROACH

- An integrated healthcare framework combined with a focus of patient care outcomes can make sense of all of these healthcare pieces.
PARADIGMS OF PRACTICE

As concepts of healthcare are rapidly changing, CMHCs have the opportunity to construct new paradigms of mental health delivery that will include:

1. Advanced Behavioral Health Assessment for Trauma & Chronic Distress
2. Effective, Ethical Treatment

The distinguishing factor will be 

*Effective clinical outcomes*
PARADIGMS OF PRACTICE

As concepts of healthcare are rapidly changing, CMHCs have the opportunity to construct new paradigms of mental health delivery that will include:

1. Advanced Behavioral Health Assessment for Trauma & Chronic Distress
2. Effective, Ethical Treatment

CMHCs must be able to resolve trauma and chronic distress as well as the underlying shame core beliefs.
The effective CMHC will:

1. Understand how to comprehensively assess the health of the patient

2. Positively address the trauma & chronic distress of psychological disorders:
   - What the patient believes about self – core beliefs
   - The etiology of shame core beliefs
   - The means available for the patient to transform shame core beliefs

This fundamentally changes the nature of clinical practice
1. Comprehensive health assessment of the patient

*Most therapists center their diagnostic energy on mental disorders*

*This is unethical and incompetent patient care as attested by the DSM-5*

2. The underlying issue of disorders: trauma & chronic distress shame core beliefs

*Ask yourself; what is the percentage of patients who come to you who have a strong sense of self as defined by Brene Brown, PhD?*

“I firmly believe I am worthy to love and to be loved. I am enough!”

*These individuals don’t see us because they don’t need psychotherapy*
THE COMMON THREADS

1. Comprehensive health assessment

2. Resolving traumatic or chronically distressful shame core beliefs

Premise: The above two paradigms form the basis of clinical mental health practice because they focus on the causalities as well as addressing symptoms

“For every thousand individuals hacking at the leaves of . . . disease . . . there is one striking at the root”

(paraphrasing Henry David Thoreau)
AMHCA STANDARDS for the Practice of Clinical Mental Health Counseling

**Recommended Clinical Practice Training**

- The Biological Basis of Behavior
- Specialized Clinical Assessment
- Co-occurring Disorders
- Trauma

What would be crucial for my work in addiction recovery?
AMHCA STANDARDS
for the Practice of
Clinical Mental Health Counseling

Recommended Clinical Practice Training

- The Biological Basis of Behavior
- Specialized Clinical Assessment
- Co-occurring Disorders
- Trauma

What would be crucial for my work in addiction recovery?

This is a map for the integration of Clinical Mental Health Counselors into Healthcare Reform & Accountable Care Organizations

Are you prepared?
AMHCA Diplomate & Clinical Mental Health Specialist

- Child and Adolescent Specialist
- Couples & Family Specialist
- Developmental Disability Specialist
- Geriatric Specialist
- Substance Abuse & Co-occurring Disorders Specialist
- Trauma Specialist
AMHCA Diplomate & Clinical Mental Health Specialist

- Child and Adolescent Specialist
- Couples & Family Specialist
- Developmental Disability Specialist
- Geriatric Specialist
- Substance Abuse & Co-occurring Disorders Specialist
- Trauma Specialist

The future of integrated healthcare will need each of these specializations to:

1. Understand how to comprehensively assess the health of the patient
2. Successfully address the underlying issues of psychological disorders
Case example: Jason & Jill have come to you for couple’s counseling:
- Jason – started drinking heavily four years ago
- Consistent level of hostility in marriage
- Jill - presented with anxiety & depression symptoms

What would be crucial to form an accurate case conceptualization of this couple?

- Biological Basis of Behavior?
- Co-occurring Disorders?
- Trauma?
- Specialized Clinical Assessment?

What would you diagnose? How would you treat?
Case example: Jason & Jill have come to you for couple’s counseling:

- Jason – started drinking heavily four years ago
- Consistent level of hostility in marriage
- Jill - presented with anxiety & depression symptoms

What would be crucial to form an accurate case conceptualization of this couple?

- Biological Basis of Behavior? Jill’s depression?
- Co-occurring Disorders? Jill & Jason
- Trauma? Jason’s addiction, Jill’s anxiety
- Specialized Clinical Assessment? Teasing out the total picture

Is typical couples counseling (e.g. communications) going to be enough?
Case example: Jason & Jill:

- **Jason** – *started drinking heavily four years ago at age 25*
  Three months earlier he was terminated from his job
  His father had told him as an adolescent: “You will never amount to much.”

- **Consistent level of hostility in marriage for the last 8 years**
  They both said that they married too fast and did not know each other
  They believed that they had married the wrong person
  They were quite verbally critical of each other

- **Jill** - *presented with anxiety & depression symptoms*
  Jill noted that she had a number of health problems
  She recounted how her father had abandoned their family when she was 7

*How much evidence is there of trauma or chronic distress?*
WHAT IS THE INTERRELATED ETIOLOGY OF TRAUMA, ANXIETY, DEPRESSION, & ADDICTION?

Premise:

Trauma and chronic distress underlie most psychological cases

Presenting Symptoms or Complaints

Presenting symptoms are identifiable & diagnosable

Underling Trauma or Distress

Underlying trauma or chronic distress is often not identified therefore untreated

What are the chances for an effective outcome if underlying conditions ignored?
<table>
<thead>
<tr>
<th>Trauma &amp; Chronic Distress Features</th>
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<tbody>
<tr>
<td>- Impairment of affect regulation</td>
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<td>- Self-destructive behaviors:</td>
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<td>- Self-injury</td>
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<tr>
<td>- Eating disorders</td>
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<td>- Substance abuse</td>
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<td>- Hyper arousal</td>
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<td>- Dissociative symptoms</td>
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<tr>
<td>- Somatic symptoms</td>
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<tr>
<td>- Feelings of ineffectiveness</td>
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<tr>
<td>- Shame, despair, hopelessness</td>
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<tr>
<td>- Feeling permanently damaged</td>
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<tr>
<td>- Loss of sustained beliefs (God)</td>
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<td>- Hostility</td>
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<td>- Withdrawal</td>
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<td>- Consistently feeling threatened</td>
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<td>- Change of personality</td>
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<tr>
<td>- Impulsivity</td>
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<tr>
<td>- ADD</td>
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<tr>
<td>- Other?</td>
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EVIDENCE OF TRAUMA & CHRONIC DISTRESS

• Mood disorders linked to ‘victimized thinking’
• Blaming without taking responsibility for self
• Any addiction or dependence pattern of behavior
• High need to protect self
• High expectation of others and need to control them
• Borderline symptoms
• Couples problems that don’t make sense
• Treatment that does not resolve symptoms
TRAUMA & CHRONIC DISTRESS BEHAVIORS

- IED
- OCD
- OCPD
- Paranoia
- Sexual Compulsions
- Workaholic Behaviors
- Fitness Junkies
- Psychotic disorders
- Somatic conditions
- Other?

All addiction-like behaviors are coping mechanisms that numb psychic pain by producing the release of epinephrine and other hormones.
BORDERLINE PERSONALITY

What is the percentage of individuals with diagnosed Borderline Personality Disorder who do not have related, unresolved psychic trauma or chronic distress?
SUBSTANCE DEPENDENCE

What is the percentage of individuals with diagnosed substance dependence disorders who do not have related, unresolved psychic trauma or chronic distress?
CONSIDERATIONS

- Not all conditions are a result of trauma or chronic distress.
- Psychic trauma does not excuse wrongful behavior but it does help us understand it.
- In all cases, trauma & chronic distress should be ruled out or considered as a underlying cause to presenting symptoms.
TRAUMA & CHRONIC DISTRESS SEVERITY

Birth to age 20
- Single episode acute trauma – death of a older sibling child
- Chronic distress – consistent parental criticism
- Complex, distress & acute trauma – divorce of parents + alcoholic parent
- Persistent severe trauma – recurrent sexual abuse, extensive neglect

Age 21 or older
- Single episode acute trauma – life threatening injury to self or family member
- Chronic distress – emotional abuse by narcissistic spouse
- Complex, distress & acute trauma – rape + emotional distress of justice system
- Persistent severe trauma – history of domestic violence, battering

Generally speaking, the younger the age, the more severe the occurrences, and the more multifaceted the distress— the more difficult trauma is to resolve.

When do you refer?
MEASURING TRAUMA & CHRONIC DISTRESS

• Trauma and, or chronic distress is experienced by almost everyone
• It is personal & highly subjective (e.g. some are resilient, others not)
• Measure: Subjective Units of Disturbance (SUDs)
  “Tell me about a disturbing event that you experienced.”
  “On a scale from 0 to 10, how disturbing was this?”
  “From your earliest memories until now, what other events have been disturbing to you – 0 to 10?”
• Watch for signs of emotion or bodily reactions
THE CORE BELIEFS OF SHAME IN TRAUMA & CHRONIC DISTRESS
Every person possesses a number of Core Beliefs

We all require fundamental Positive Core Beliefs to live productive, caring, and valued lives (e.g. “I am honest,” “I am smart,” “I learn new things,” “I am helpful,” etc.)

Those who present with psychological disorders have prevailing negative, Shame Core Beliefs (e.g. “I am a liar,” “I am stupid,” “I can’t learn,” “I am helpless,” “I am selfish,” “I am worthless,” etc.)
EXERCISE

Those suffering from unresolved trauma or chronic distress develop *Shame Core Beliefs*

Teen-ager who was sexually abused in childhood

*I am dirty, disgusting, undeserving, contemptible, etc.*

Veteran whose close friend died in combat

*I am cowardly, don’t deserve to live, disloyal, etc.*

Woman who was emotionally devastated by divorce

*I am unattractive, a failure, broken, etc.*

An adult who was extensively criticized as a child

*I am stupid, a mess, disappointing, etc.*
Brene Brown, PhD, noted that people fall into one of two groups: Those individuals who deeply believe:

“I am unworthy to be loved”

- “I am not enough and never will be.”
- “I am ashamed of myself.”
- “I cannot stand who I am so I numb myself with food, addictions, ‘right’ thinking, meds, anger, exercise, depression, etc.”

Unresolved trauma & chronic distress alters our sense of wellness as well as our sense of self.
### Shame Core Belief Examples

<table>
<thead>
<tr>
<th>Belief</th>
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<tbody>
<tr>
<td>I don't deserve love</td>
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<td>I cannot trust others</td>
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<tr>
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<td>I am imperfect, flawed, I must please</td>
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The second of Brene Brown’s two identified groups:

Those individuals who deeply believe:

“I am worthy to be loved”

As noted before, CMHCs do not see these individuals?

What can we learn from this?
DEFINING SHAME CORE BELIEFS

Distinguishing between guilt and shame

GUILT: An underlying feeling

  e.g. “I did something wrong or bad”

  Guilt motivates us to change

SHAME: A continuing emotion

  e.g. “There is something wrong with me – I am bad”

Shame beliefs lead us to accept the untruth that we cannot change

  CMHCs must be skilled in resolving Shame Core Beliefs
CONSEQUENCES OF SHAME

Shame Core Beliefs create emotional dysregulation & volatility
To cope clients turn to work, activities, religion, politics, narcissism, drugs, alcohol, or other dependence behaviors

- Shame Core Beliefs have deep roots that often lie in the subconscious
- Shame Core Beliefs trump everything else mentally & emotionally
- We must go beyond cognitive-behavioral therapy
- CMHCs cannot create Positive Core Beliefs
- However, CMHCs can create the conditions so that patients can transform Shame Core Beliefs into Positive Core Beliefs
CMHCs need evidenced-based approaches to treat the underlying basis of disorders:

- **SHAME CORE BELIEFS** are related to attachment, abandonment, chronic distress, & trauma

- Shame Core Beliefs can be transformed into constructive, **POSITIVE CORE BELIEFS**

- Outcome research shows that addressing underlying shame is fundamental to resolving many DSM disorders
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<th>Positive Core Beliefs</th>
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<tr>
<td>I deserve bad things</td>
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<td>I am healthy, whole</td>
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POSITIVE CORE BELIEF OUTCOMES

- Alleviation of root source of mental disorders
- Improved relationships
- Increased life appreciation & enjoyment
- Heightened sense of purpose
- Better physical well-being
- Lasting recovery outcomes
- Enhanced emotional resilience

*Central to health is mental health wholeness*
Understanding the neurobiology of trauma & chronic distress helps CMHCs provide advanced diagnosis of co-morbid disorders.

Clinicians without skills misinterpret symptoms & create partial diagnoses.

CMHCs must meet the highest professional as well as ethical standards:

- **Biological Basis of Behavior** – in tandem with medical specialists
- **Specialized Clinical Assessment** – comprehensive & accurate
- **Thorough diagnoses** – including *Trauma* & *Co-occurring Disorders*
- **Effective treatment** – evidenced based practice & evidenced based outcomes

Is it possible to practice ethically or effectively without these skills?
THE BEST CMHCS

Educated, certified, & licensed CMHCs are qualified to become outstanding healthcare providers

- They work to integrate comprehensive healthcare services for their patients
- They provide the highest level of assessment & diagnosis for those who are entrusted to they care
- They offer effective treatment outcomes

The Paradigm of Advanced Behavioral Health

*Understanding these paradigm shifts in healthcare while constantly seeking advanced practice outcomes is evidence that you are among the best*
HOW IS ELIZA?

For the first time in forty-three years she understands her condition

- She feels heard and understood
- She has explored new ways of dealing with sound management
  - Bedroom sound generator
  - Behind-the-ear sound generator
  - Quiet times
  - Other coping mechanisms
- She recognized that there is nothing ‘wrong’ with her “I’m a freak” – “I’m okay!”
- She is working to strengthen her positive self-beliefs to create better resiliency
- She has enlisted the support of her husband, children, trusted friends, etc.

*Eliza believes that she is better managing her life and her relationships!*

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