Trauma Informed Care

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What Is Trauma?

- According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2)

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What Percentages of Mental Health Clients Have Histories of Trauma?

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

- 50-98% of public mental health clients with severe mental illness, including schizophrenia and bipolar disorder, have been exposed to childhood physical and/or sexual abuse. Most have multiple experiences of trauma (Goodman et al., 1999, Mueser et al., 1998; Cusack et al., 2003).
- 75% of women and men in substance abuse treatment report abuse and trauma histories (SAMHSA/CSAT, 2000).
- 97% of homeless women with mental illness experienced severe physical and/or sexual abuse, and 87% experienced this abuse both as children and as adults (Goodman, Dutton et al., 1997).

Models for Developing Trauma-Informed Behavioral HealthSystems and Trauma-Specific Services (Center for Mental Health Services, 2008).

What Percentages of Mental Health Clients Have Histories of Trauma?

- Nearly 8 out of 10 female offenders diagnosed with a mental illness report histories of physical or sexual abuse (Smith, 1998).
- 93% of psychiatrically hospitalized adolescents had histories of physical and/or sexual and emotional trauma; 32% met criteria for PTSD (Lipschitz et al., 1999).
- In Massachusetts, 82% of all children and adolescents in continuing care inpatient and intensive residential treatment have trauma histories (NETI, 2003).
- Teenagers with alcohol and drug problems are 6 to 12 times more likely to have a history of being physically abused and 18 to 21 times more likely to have been sexually abused compared with teenagers without alcohol and drug problems (Clark et al., 1997).

Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services (Center for Mental Health Services, 2008).

What Percentages of Mental Health Clients Have Histories of Trauma?

- Among juvenile girls identified by the courts as delinquent, more than 75% have been sexually abused (Calhoun et al., 1993).
- 3 years of data from New York State Office of Mental Health showed that only 1 in 200 adult inpatients and only 1 in 10 child/adolescent inpatients carried either a primary or secondary diagnosis of PTSD (NYS-OMH, 2001; Tucker,

Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services (Center for Mental Health Services, 2008).

ACES

- **The Adverse Childhood Experiences Study** (Centers for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from United States; it analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.

Adverse Childhood Experiences (ACEs)
Growing up in a household with:

- Verbal Abuse
- Recurrent physical, sexual or emotional abuse
- Emotional or physical neglect
- Domestic violence between parents
- An alcoholic
- Substance abuser
- An incarcerated household member
- Someone who is chronically depressed, suicidal, institutionalized or mentally ill
- Live with One or no biological parents

(2006, http://www.acestudy.org/)

Findings of the Study

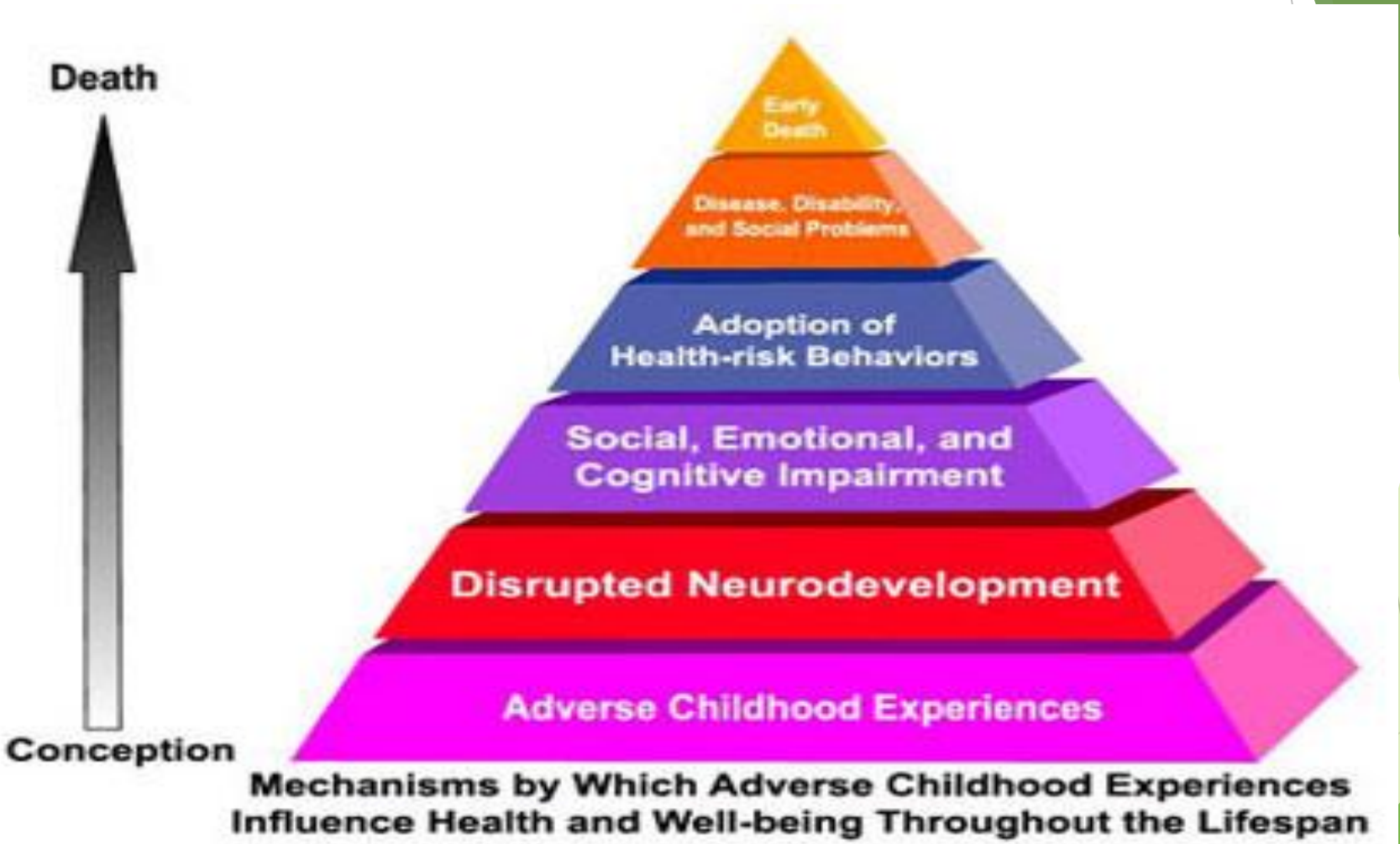
- Over 17,000 people participated in the study
- Almost 2/3 experienced at least one ACE
- Over ¼ reported one ACE
- Over 25% reported 2 or more
- Over 12% reported 4 or more. One out of 8
- Higher ACES scores =
  - Higher scores = increased risk for health problems
  - Strong relationship to health-related behaviors during childhood & adolescence including smoking, early sexual activity, illicit drug use, teen pregnancies, and suicide attempts.

As the number of ACEs increases so does the risk for the following:

- Myocardial infarction
- Asthma
- Mental distress
- Depression
- Smoking
- Disability

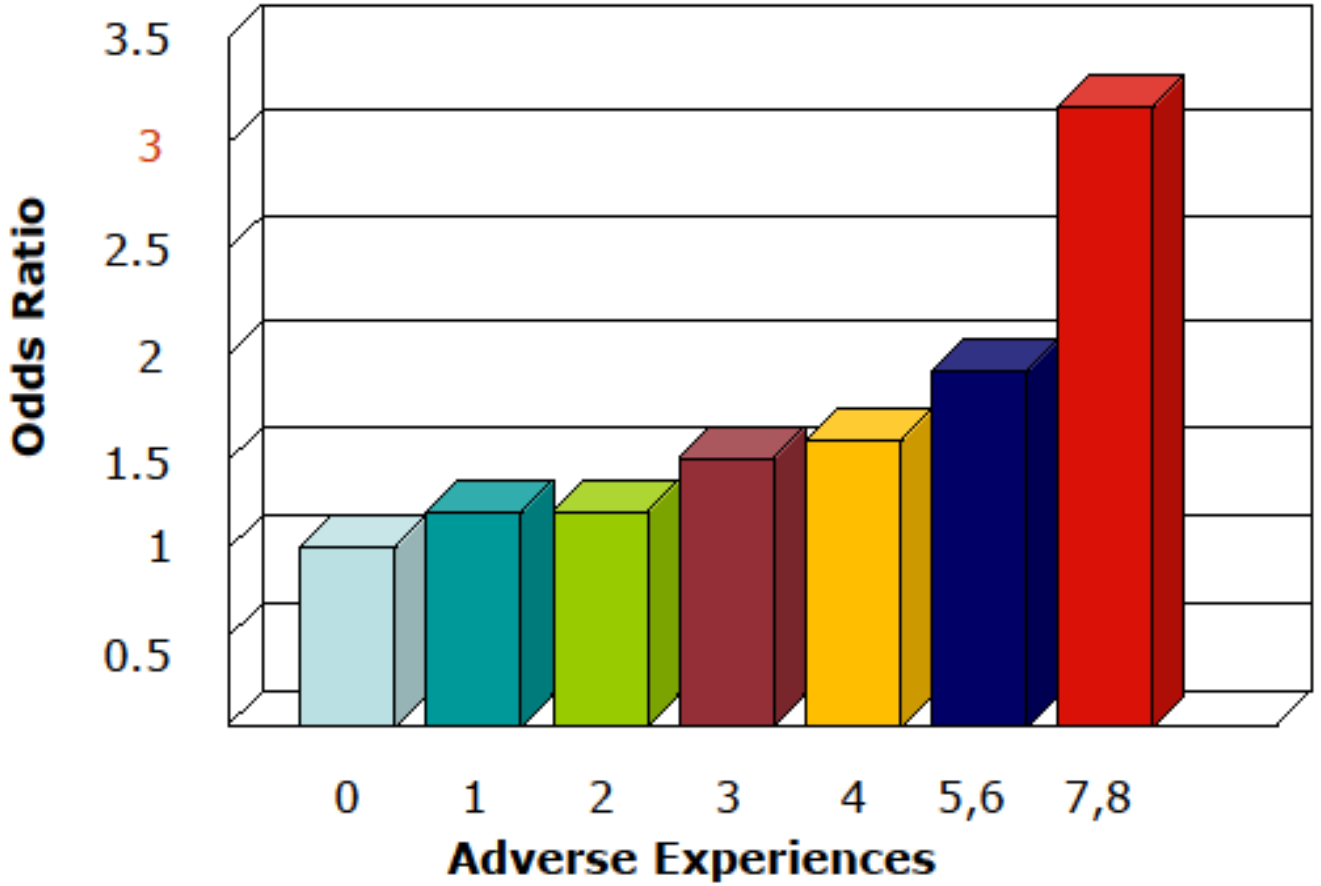
- Reported income
- Unemployment
- Lowered educational attainment
- Coronary heart disease
- Stroke
- Diabetes

Consequences Of Unresolved Trauma



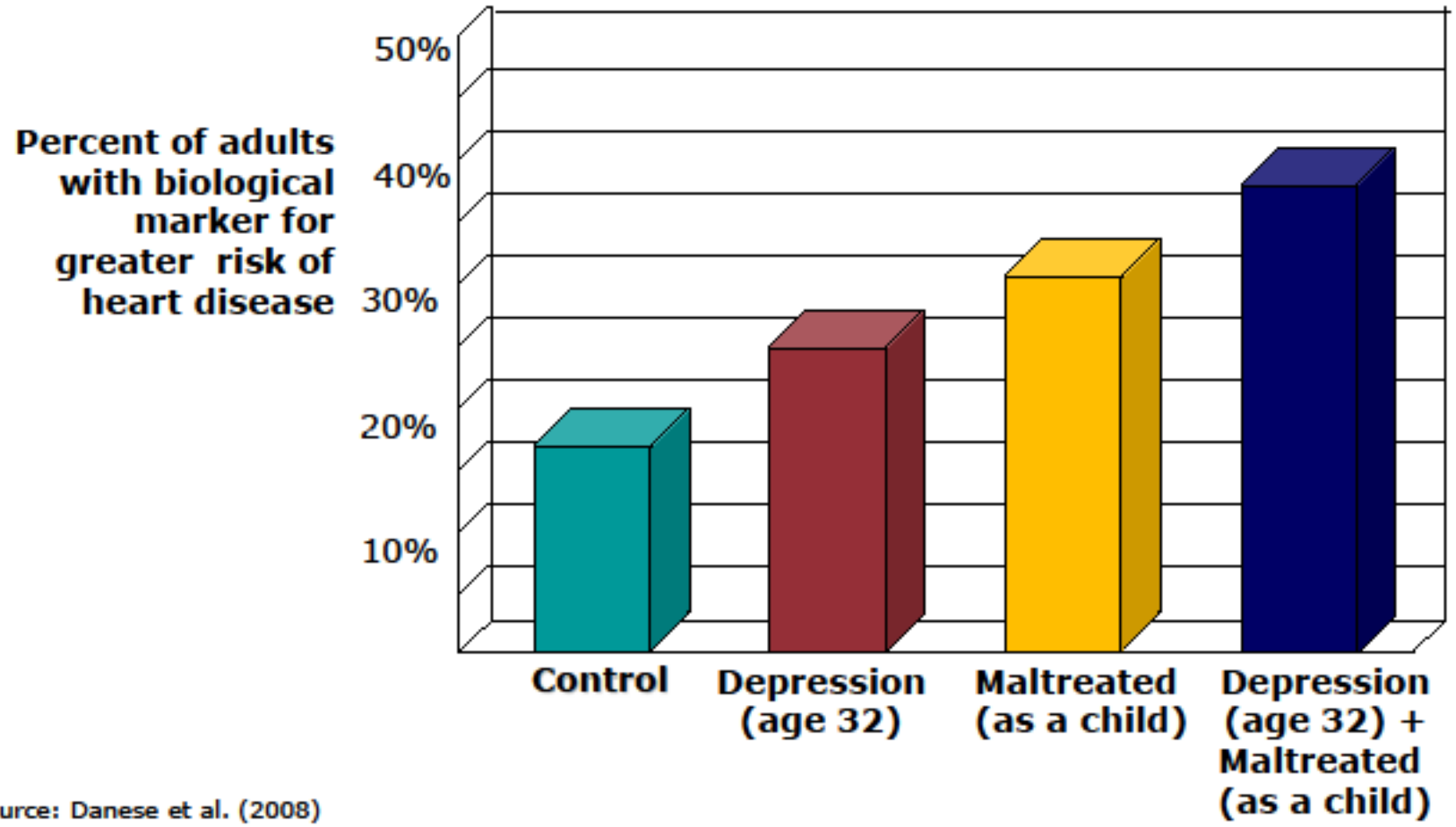
(2004, http://www.acestudy.org/)

Risk Factors for Adult Heart Disease are Embedded in Adverse Childhood Experiences



Source: Dong, et al. (2004)

Biological "Memories" Link Maltreatment in Childhood to Greater Risk of Adult Heart Disease



Source: Danese et al. (2008)

What is Stress?

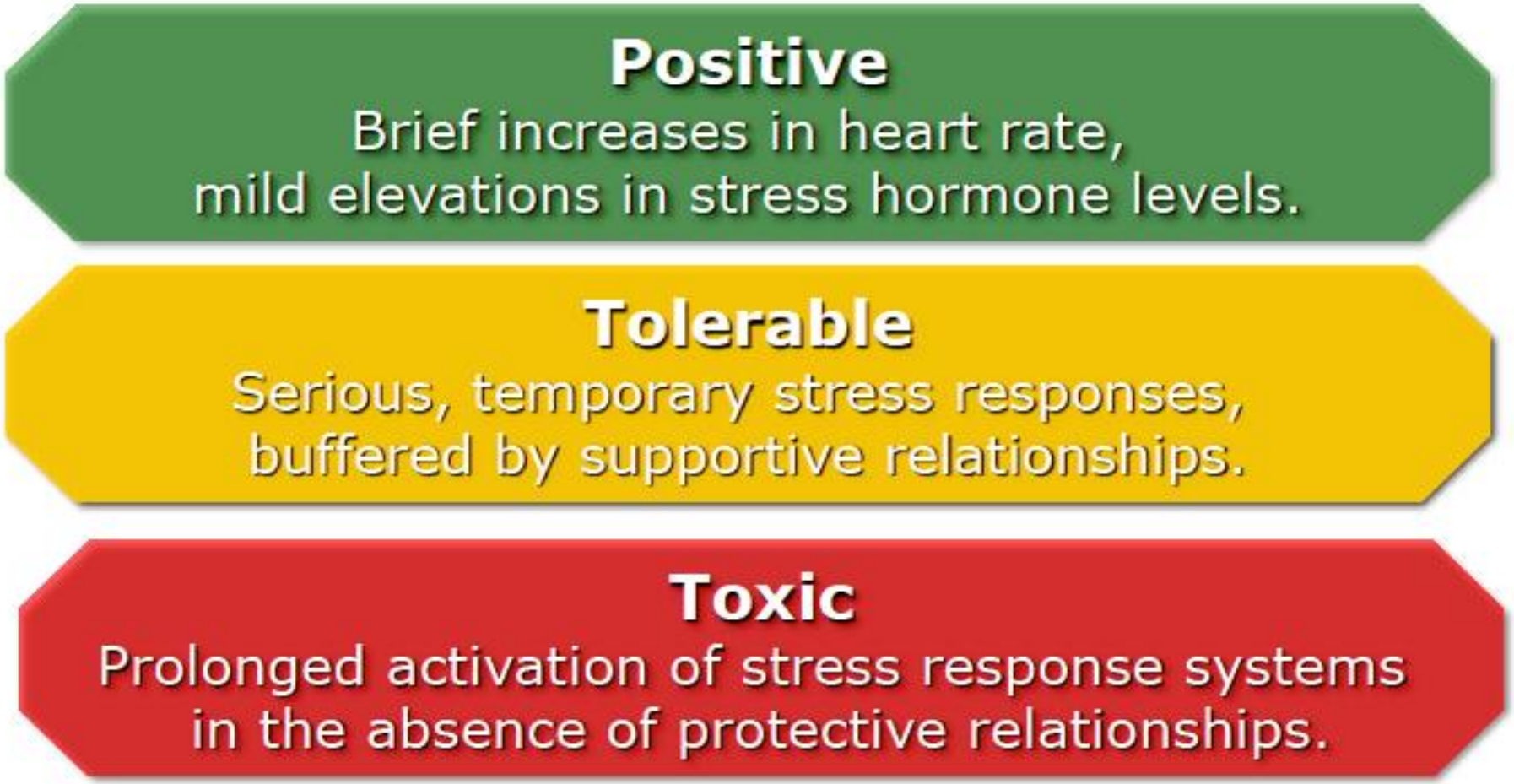
- Stress is defined as a process that exists over time. When is continues, it can often lead to a debilitating outcomes as it accumulates.
- Stress affects all aspects of ones functioning

  Collins & Collins (2005)

- When a child encounters a perceived threat to their safety, their brains trigger a complex set of chemical and neurological events known as the “stress response”.

  Massachusetts Advocates for Children (2005)

Three Levels of Stress Response



Reactions to Stress and Trauma

- Fight
- Freeze
- Flee

- Under normal circumstances these responses to stress are constructive and help keep a child or adolescent safe.

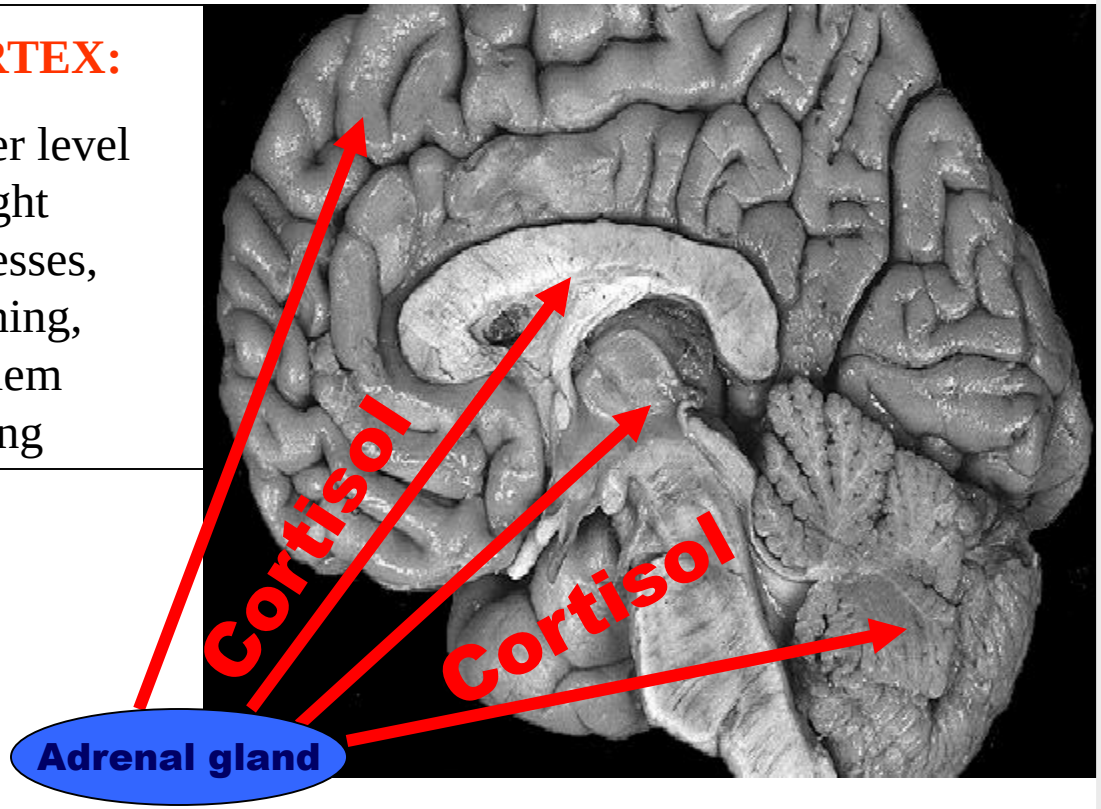
- However, when a child is traumatized, and is overwhelmed with stress and fear, these responses can become a regular mode of functioning.

- Consequently, a youth may react to their world even when the dangers are NOT present because they cannot turn off the survival strategies in their brains.

Explicit and Implicit Memory

CORTEX:

higher level thought processes, planning, problem solving



HIPPOCAMPUS:

Explicit memory - governs recollection of facts, events or associations

AMYGDALA:

Implicit memory – No conscious awareness (procedural memory – e.g., riding a bike and emotional memory- e.g., fear)

Chronic stress = overstimulation of the **Amygdala,** resulting in the release of cortisol, possible shrinkage or atrophy of the **Hippocampus** and **Cortex**, affecting memory and cognition, and leading to anxiety or depression.

(Adapted from: Brunson, Lorang, & Baram, 2002)

Historical trauma

- refers to cumulative emotional and psychological wounding, extending over an individual lifespan and across generations, caused by traumatic experiences. (http://en.wikipedia.org/)

- https://www.youtube.com/watch?v=Gs0iwY6YjSk

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Attachment

Mirroring: Affect Synchrony

Mirror systems : areas in the premotor cortex and Broca's area that are activated during observation, imagination, empathy and execution of motor movements. The mirror system also extends to insula, amygdala, basal ganglia and cerbellum.

Effects: recognizing emotional states of self and others, empathy, theory of mind

Attachment

Attunement:

- The mother must be attuned not so much to the child's overt behavior as to the reflections of the rhythms of his or her internal state, enabling the dyad to create "mutual regulatory systems of arousal." To regulate the infant's arousal, she must be able to regulate her own arousal state. (Alan Schore June, 2006)
- Effects: recognizing emotional states of self and others, empathy, theory of mind, sense of efficacy, feeling of reward in relational encounters

Contingent Communication

- Transaction that involves :
  - Perception of the child's signals
  - Making sense of the signals in terms of what they mean for the child
  - A timely and effective response
- Effects: recognizing emotional states and physical state of self, theory of mind, sense of efficacy, basic trust that ones needs will be met, capacity to self soothe

Attachment

Repair

- When there is the inevitable rupture in the ideal attuned, contingent communication, repair is an acknowledgement of the disconnection and the attempt to reconnect.

- Effects: recognizing emotional states and physical state of self, theory of mind, sense of efficacy, basic trust that ones needs will be met, capacity to self soothe, capacity to tolerate negative physical and affect states

Attachment

Emotional Communication

- Sharing and amplification of positive emotions
- Sharing and soothing of negative emotions

Attachment

Reflective dialogue

- Focusing verbally based discussions on the contents of the mind itself
- Parents elaborate on the deeper layer of subjective human experience by focusing on the mental processes (thoughts, feelings, perceptions, beliefs etc.)

Attachment

Coherent narratives

- Help us to make sense of our own narrative as well as other people

Why Trauma Informed Care

- The characteristics of the trauma and the subsequent traumatic stress reactions can dramatically influence how individuals respond to the environment, relationships, interventions, and treatment services, and those same characteristics can also shape the assumptions that clients/consumers make about their world (e.g., their view of others, sense of safety), their future (e.g., hopefulness, fear of a foreshortened future), and themselves (e.g., feeling resilient, feeling incompetent in regulating emotions).

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Trauma Informed Systems

- "Trauma-informed systems and services are those that have thoroughly incorporated an understanding of trauma, including its consequences and the conditions that enhance healing, in all aspects of service delivery. Any human service program, regardless of its primary task, can become trauma-informed by making specific administrative and service-level modifications in practices, activities, and settings in order to be responsive to the needs and strengths of people with lived experience of trauma" (Harris & Fallot, 2008).

What Is Trauma Informed Care?

- There are many definitions of TIC and various models for incorporating it across organizations, but a “trauma-informed approach incorporates three key elements: (1) *realizing* the prevalence of trauma; (2) *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) *responding* by putting this knowledge into practice” (SAMHSA, 2012, p. 4).

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Trauma Informed Care

- It is important to generate trauma awareness in agencies through education across services and among all staff members who have any direct or indirect contact with clients (including receptionists or intake and admission personnel who engage clients for the first time within the agency). Agencies can maintain a trauma-aware environment through ongoing staff training, continued supervisory and administrative support, collaborative (i.e., involving consumer participation)trauma-responsive program design and implementation, and organizational policies and practices that reflect accommodation and flexibility in attending to the needs of clients affected by trauma.

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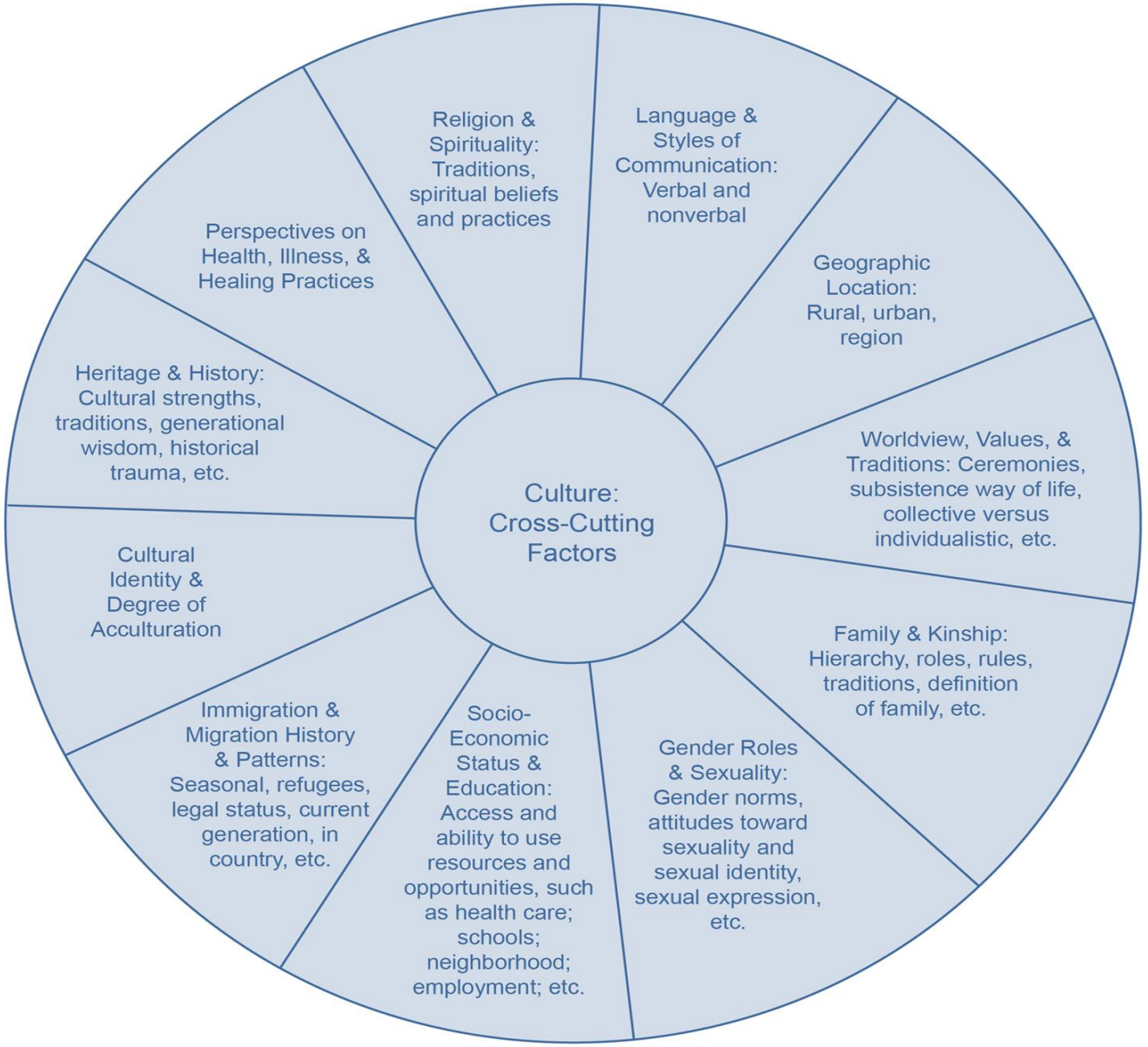

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Culture and Trauma

- • Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma.
- • Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- • Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- • Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.

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Culture and Trauma

- • Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- • Traumatic stress symptoms vary according to the type of trauma within the culture.
- • Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- • In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

The Fallot and Harris (2006) **five guiding principles of *Trauma-Informed Care***

- Safety
- Trustworthiness
- Choice
- Collaborration
- Empowerment

These apply to patients and the entire organization including the employees.

Safety

- ensure the physical and emotional safety of patients and employees. Shift to a whole person focus of *"what happened to you?"* instead of *"what is wrong with you?"*

Safety

- ***Provide culturally appropriate symbols of safety in the physical environment***. These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.

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Safety

- ***Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process***. Strive to maintain a soothing, quiet demeanor. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been traumatized may be more reactive even to benign or well-intended questions.

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Safety

- ***Be aware of one's own emotional responses to hearing clients' trauma histories.*** Hearing about clients' traumas may be very painful and can elicit strong emotions. The client may interpret your reaction to his or her revelations as disinterest, disgust for the client's behavior, or some other inaccurate interpretation. It is important for you to monitor your interactions and to check in with the client as necessary.

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Safety

- ***Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic stress symptoms and related disorders***. There is no need to probe deeply into the details of a client's traumatic experiences at this stage in the treatment process.

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Safety, Empowerment, Collaboration

Provide Psychoeducation

- Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders as well as the related consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, to highlight potential short-term and long-term consequences of trauma and various paths to recovery, and to underscore the message that recovery is possible

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Safety: *safety from trauma symptoms*

- Awareness
- Universal screening
- Referral if amenable
- Evidence Based Trauma Specific Treatments

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Safety : *safety in the environment*

- Trauma reactions can be triggered by sudden loud sounds (e.g., television at high volume, raised voices), tension between people, certain smells, or casual touches that are perceived as invasions of physical boundaries.

- The vulnerability of exposing one's history in the treatment setting can manifest in the client as feeling physically vulnerable and unsafe in the treatment environment.
- Sudden or inadequately explained treatment transitions, such as moving from one level of treatment to another or changing counselors, can also evoke feelings of danger, abandonment, or instability.
- Early in treatment, trauma survivors generally value routine and predictability.

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Safety: *preventing a recurrence of trauma*

- People with histories of trauma and substance abuse are more likely to engage in high-risk behaviors and to experience subsequent traumas. Early treatment should focus on helping clients stop using unsafe coping mechanisms. Eg –substances, cutting, unsafe sex, overeating etc.

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Safety: Prevent re-traumatization

Some staff and agency issues that can result in re-traumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.
- Discounting a client's report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling certain negative feelings as pathological.

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Safety: Prevent re-traumatization

- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a non-private and/or disrespectful manner.
- Having clients undress in the presence of others.
- Being insensitive to a client's physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including a lack of consistent, competent leadership.

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Trustworthiness

provide clear and sufficiently detailed information about what patients and employees can expect and need to know:

- What will be done?
- By whom?
- When?
- Under what circumstances?
- At what cost?
- With what goal?

Trustworthiness: **Familiarize the Client With Services**

- These services may be new to them. Thus, introducing clients to program services, activities, and interventions in a manner that *expects* them to be unfamiliar with these processes is essential, regardless of their clinical and treatment history. Beyond addressing the unfamiliarity of services, educating clients about each process—from first contact all the way through recovery services—gives them a chance to participate actively and make informed decisions across the continuum of care.

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Trustworthiness

- Provide realistic and accurate information about what can and can't be done.
- What are reasonable expectations regarding time frames, outcomes, experiences?
- Maintain appropriate professional boundaries
- Return calls and requests for information consistently and in a timely manner.

Case illustration: Mike

- From the first time you provide outpatient counseling to Mike, you explain that he can call an agency number that will put him in direct contact with someone who can provide further assistance or support if he has emotional difficulty after the session or after agency hours. However, when he attempts to call one night, no one is available despite what you've described. Instead, Mike is directed by an operator to either use his local emergency room if he perceives his situation to be a crisis or to wait for someone on call to contact him. The inconsistency between what you told him in the session and what actually happens when he calls makes Mike feel unsafe and vulnerable.

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Trustworthiness

- Clarity
- Consistency
- Transparency

Trauma survivors may have difficulty trusting

- Some traumatic experiences result from trusting others (e.g., interpersonal trauma).
- Trust may have been violated during or after the traumatic experience, as in cases when help was late to arrive on the scene of a natural disaster.
- This lack of trust can leave individuals alienated, socially isolated, and terrified of developing relationships. Some feel that the trauma makes them different from others who haven't had similar experiences.
- Sometimes, a client's trust issues arise from a lack of trust in self—for instance, a lack of trust in one's perceptions, judgment, or memories

The Outsider by Donna Williams

Support Empowerment and Choice

- **Choice-** prioritize patient and employee experiences of choice and control. Give patients options including evidence-based options so that they can make an informed decision; respond respectfully to their questions as they clarify needed information to make an informed decision

- **Empowerment-** recognize patient and employee strengths and skills; acknowledge patient experiences and their inner wisdom regarding their health and employee ideas regarding service provision.

Support Empowerment, Collaboration and Choice

Placing appropriate control for treatment choices in the hands of clients improves their chances of success.

Support Empowerment, Collaboration and Choice

Give clients the chance to collaborate in the development of their initial treatment plan, in the evaluation of treatment progress, and in treatment plan updates. Incorporate client input into treatment case consultations and subsequent feedback

Support Empowerment, Collaboration and Choice

- Encourage clients to assume an active role in how the delivery of treatment services occurs. An essential avenue is regularly scheduled and structured client feedback on program and clinical services (e.g., feedback surveys). Some of the most effective initiatives to reinforce client empowerment are the development of peer support services and the involvement of former clients in parts of the organizational structure, such as the advisory board or other board roles

POWER

Support Empowerment, Collaboration and Choice

- Establish a sense of self-efficacy in clients; their belief in their own ability to carry out a specific task successfully—is key. You can help clients come to believe in the possibility of change and in the hope of alternative approaches to achieving change. Supporting clients in accepting increasing responsibility for choosing and carrying out personal change can facilitate their return to empowerment (Miller & Rollnick, 2002).

Case illustration: Mina

- Mina initially sought counseling after her husband was admitted to an intensive outpatient drug and alcohol program. She was self-referred for low-grade depression, resentment toward her spouse, and codependency. When asked to define “codependency” and how the term applied to her, she responded that she always felt guilty and responsible for everyone in her family and for events that occurred even when she had little or no control over them. After the intake and screening process, she expressed interest in attending group sessions that focused primarily on family issues and substance abuse, wherein her presenting concerns could be explored. In addition to describing dynamics and issues relating to substance abuse and its impact on her marriage, she referred to her low mood as frozen grief

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Case illustration: Mina

- . During treatment, she reluctantly began to talk about an event that she described as life changing: the loss of her father. The story began to unfold in group; her father, who had been 62 years old, was driving her to visit a cousin. During the ride, he had a heart attack and drove off the road. As the car came to stop in a field, she remembered calling 911 and beginning cardiopulmonary resuscitation while waiting for the ambulance. She rode with the paramedics to the hospital, watching them work to save her father's life; however, he was pronounced dead soon after arrival. She always felt that she never really said goodbye to her father. In group, she was asked what she would need to do or say to feel as if she had revisited that opportunity. She responded in quite a unique way, saying, "I can't really answer this question; the lighting isn't right for me to talk about my dad."

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Case illustration: Mina

- The counselor encouraged her to adjust the lighting so that it felt “right” to her. Being invited to do so turned out to be pivotal in her ability to address her loss and to say goodbye to her father on her terms. She spent nearly 10 minutes moving the dimmer switch for the lighting as others in the group patiently waited for her to return to her chair. She then began to talk about what happened during the evening of her father’s death, their relationship, the events leading up to that evening, what she had wanted to say to him at the hospital, and the things that she had been wanting to share with him since his death. Weeks later, as the group was coming to a close, each member spoke about the most important experiences, tools, and insights that he or she had taken from participating.

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Case illustration: Mina

- She felt that the personal experience of losing her father and needing to be with him in the emergency room was marred by the obtrusiveness of staff, procedures, machines, and especially, the harsh lighting. She reflected that she now saw the lighting as a representation of this tragic event and the lack of privacy she had experienced when trying to say goodbye to her father. Mina stated that this moment in group had been the greatest gift: "…to be able to say my goodbyes the way I wanted… I was given an opportunity to have some control over a tragic event where I couldn't control the outcome no matter how hard I tried"

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Case illustration: Mina

- Mina disclosed that the group helped her establish boundaries and coping strategies within her marriage, but said that the event that made the most difference for her had been having the ability to adjust the lighting in the room. She explained that this had allowed her to control something over which she had been powerless during her father's death. To her, the lighting had seemed to stand out more than other details at the scene of the accident, during the ambulance ride, and at the hospital.

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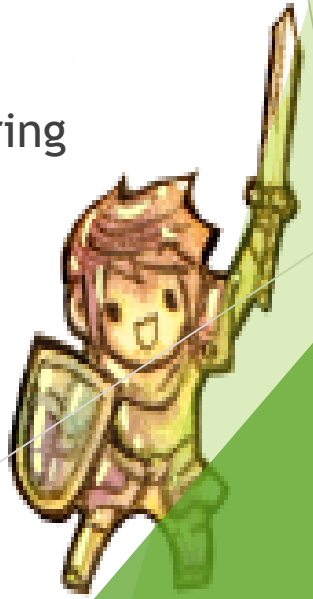
Use a Strengths-Focused Perspective: Promote Resilience

- The history that you provided suggests that you've accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?



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Use a Strengths-Focused Perspective: Promote Resilience

- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?
- Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? It doesn't matter how briefly or when they showed up in your life, or whether or not they are currently in your life or alive.
- How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)
- What does recovery look like for you?

Collaboration

- **Collaboration-** maximize collaboration and the sharing of power with patients and employees; it is the patient's body so the final decision is theirs; work together with them in partnership; remember that other medical providers may be involved and multiple differences of opinions often occur that the patient must process; the provider seeks collaboration with involved other providers. Create a treatment plan together with the patient, follow it, and update it as desired by the patient through collaborative discussion. Listen to office and support staff ideas and concerns as they often have great suggestions to improve the practice and service for the patient.

Essential Components of Self-Care

- 1. **Awareness** of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional, and spiritual needs. Such attention requires quiet time and space that supports self-reflection.

Essential Components of Self-Care

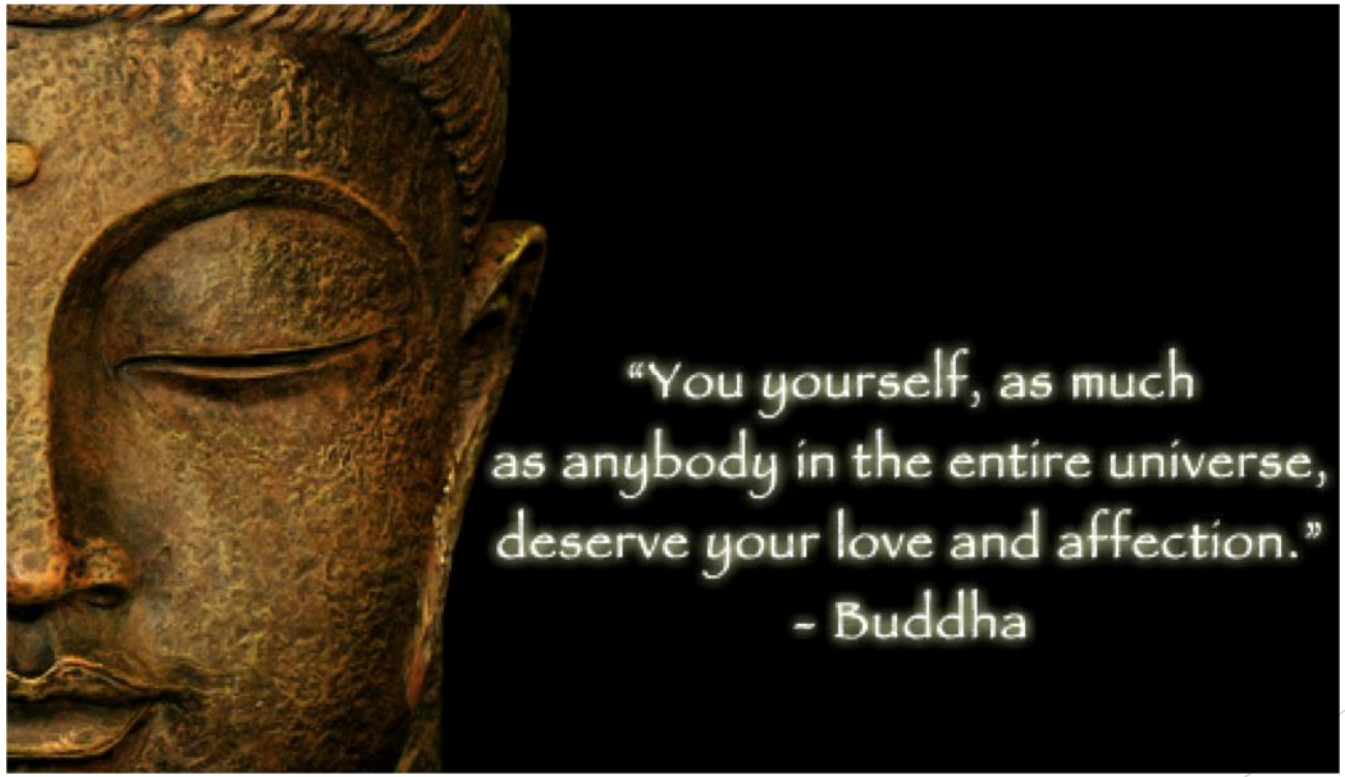
- 2. **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.

Essential Components of Self-Care

- 3. **Connection** to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it

The Ethics of Self-Care

- Caregiver self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative



Self-Care

- Create a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care.

"Teach this triple truth to all:
A generous heart,
kind speech,
and a life of service
and compassion
are the things which
renew humanity."

~Buddha

Self-Care

- Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives.

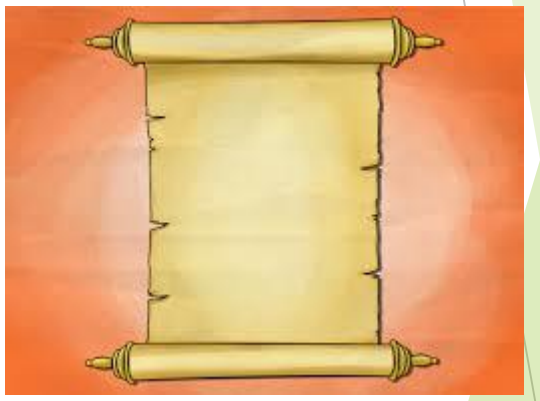
Ethical Principles of Self-Care in Practice

- The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995, bombing of the Alfred P. Murrah Federal Building.
- These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve

Source: Green Cross Academy of Traumatology, 2010

The Ethics of Self-Care: Standards of self-care guidelines:

- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care



Source: Green Cross Academy of Traumatology, 2010

The Ethics of Self-Care :Standards of humane practice of self-care

- • Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- • Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
- • Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
- • Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.

Source: Green Cross Academy of Traumatology, 2010

The Ethics of Self-Care: Commitment to self-care

- Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- • Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- • Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care. *Source: Green Cross Academy of Traumatology, 2010.*

Source: Green Cross Academy of Traumatology, 2010

Case Illustration: Carla

- Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain. Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work.

Case Illustration: Carla

- She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next . She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

Case Illustration: Carla

- The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach

Case Illustration: Carla

She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.