An Interprofessional Approach to Trauma-Informed Care

In the Mood and Anxiety Program at Health Sciences North

By

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Abstract

The advanced practicum explored an interdisciplinary approach to trauma-informed care while working on an interprofessional health team in the Mood and Anxiety Program (MAP) at Health Sciences North in Sudbury, Ontario. The MAP team offers group-based therapy that is guided by evidence-based practices which include Cognitive Behavioural Therapy (CBT), mindfulness-based approaches and Dialectical Behavioural Therapy (DBT). Individual treatment is also offered to individuals with a diagnosis of Post-Traumatic Stress Disorder. The literature review analyzed the following key themes: CBT trauma treatment, DBT trauma treatment, trauma and substance abuse, interprofessional collaboration and narrative therapy trauma models. Entry-level social workers have little knowledge about working with PTSD and trauma exposure is often the driving force of many presenting issues for individuals struggling with mental health issues. Social work students need to be educated and have practical experience about trauma-informed care to be effective practitioners in the field of social work.

Acknowledgements

Table of Contents

List of Appendices

List of Figures

I: Introduction

The focus of the advanced practicum was to explore the importance of an interdisciplinary approach to trauma-informed care while working on an interprofessional health team in the Mood and Anxiety Program (MAP) at Health Sciences North in Sudbury, Ontario. The advanced practicum included 450 hours of preparation supervised by Dr. Carol Kauppi and direct practice with individuals who access individual and group therapy with the MAP team. The impact of collaborative practice in health care settings has been recognized as an asset in maintaining quality care to clients by providing an expansive range of understanding to client needs and abilities from different disciplines (Gould, Lee, Berkowitz, & Bronstein, 2015). The connection between physical health and mental health is especially present in chronic health issues where poor mental health puts individuals at risk for chronic physical conditions; conversely, individuals experiencing severe physical conditions are at a higher risk of developing poor mental health (Canadian Mental Health Association, 2016). The importance of a treatment model that partners professionals who specialize in healthcare and mental health fields is an essential component of effectively working with individuals who present with complex issues. Specifically, an interprofessional approach to care is needed that meets the needs of clients struggling with issues related to post traumatic stress disorder (PTSD). PTSD refers to individuals who have "…experienced or witness a stressful event, re-experiencing symptoms of the event that include nightmares or flashbacks, efforts to avoid situations, places, and people that are reminders of the traumatic events and hyperarousal symptoms, such as irritability, concentration problems, and sleep disturbances" (Sareen, 2014, p. 460).

PTSD results in a multitude of challenges that affect the physical and mental health of individuals and requires treatment approaches that focus on the psychological and somatic

symptoms experienced by the individual. Treatment cannot occur in isolation and a holistic approach to care is best facilitated by an interprofessional team of specialists who can provide the best plan of care for the individual. The role of social workers in interprofessional collaborative health care contributes to the traditional medical model by providing a greater understanding of the individual (Ambrose-Miller & Ashcroft, 2016), improving the quality of interventions with vulnerable populations through a combination of primary care and behavioural health (Comer & Rao, 2016) and improving the identification of physical and social problems (Albrithen & Yalli, 2015).

PTSD impacts individuals on biological, psychological, and behavioural levels, which have a direct effect on physical health (Schnurr, 2015), reinforcing the importance of a therapeutic intervention that incorporates all components of an individual's wellbeing. The purpose of the advanced practicum was to explore an interprofessional model of care in the treatment of PTSD. Participation with an interprofessional team of health care providers included individual and group sessions guided by a structured series of Cognitive Behavioural Therapy (CBT) interventions to aid clients in managing symptoms related to PTSD, developing coping skills, acquire functional behaviours, and committing to healthy choices that will improve their quality of life. The central question guiding the practicum goals were, 'how can social workers working on an interprofessional health care team with the Mood and Anxiety Program at Health Sciences North develop skills to treat PTSD?'

II: Literature Review

A literature search on the topic of trauma treatment models used the following search terms: PTSD, interprofessional social work, interprofessional trauma and trauma models.

Literature was gathered from Sage Publications, Google Scholar, Social Work Abstracts, Routledge Publications and Oxford Journals. The information collected from the databases revealed several articles that highlighted the following key themes: Cognitive Behavioural Therapy trauma treatment, Dialectical Behavioural Therapy (DBT) trauma treatment, trauma and substance abuse, interprofessional collaboration and narrative therapy trauma models.

Cognitive Behavioural Therapy Trauma Treatment

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a psychotherapeutic model that responds to the unique needs of children and youth who struggle with symptoms of PTSD, depression, behavioural issues related to trauma exposure (National Child Traumatic Stress Network, 2008). TF-CBT is an evidence-based model that takes a psychoeducational approach to trauma treatment by providing children and their families with stress management skills and cognitive coping mechanisms through the connection of thoughts, feelings and behaviours, helping children and youth to identify and reframe unhelpful thoughts related to the trauma (National Child Traumatic Stress Network, 2008). TF-CBT has been identified as the best approach for treating trauma with children and adolescents, showing a significant reduction in emotional and behavioural issues compared to other approaches (Lawson & Quinn, 2013).

TF-CBT has been recognized as especially significant in the treatment of trauma with sexually abused children; superior to play therapy and supportive therapies (Cohen, Deblinger, & Mannarino, 2004). It is recommended that play therapists should participate in TF-CBT training to build on their knowledge of trauma treatment and integrating play when working with children who have experienced trauma (Green & Myrick, 2014). The significance of a trauma model that incorporates CBT focuses on the connection between thought processes and emotional responses

to target unhealthy behavioural patterns. In regards to trauma work with children, caregiver inclusion is important in addressing avoidance and the manifestation of inaccurate thoughts the caregiver might feel related to the child's role in the trauma (Yasinski et al., 2016). CBT models are useful treatment approaches for children and youth who are experiencing the effects of trauma without a formal diagnosis of PTSD. Typically, experience with complex trauma and the impact of childhood abuse on the individual is not seen as a priority without a formal diagnosis of PTSD and leads to an inadequate provision of services (Corrigan & Hull, 2015).

TF-CBT has been accepted as a model of best practice for treating symptoms of trauma exposure for children who have been sexually abused, witnessed domestic violence and been impacted by grief (Holtzhausen, Ross, & Perry, 2016). It has also been beneficial at decreasing symptoms of anxiety and depression and addressing feelings related to emotional distress and shame (Neubauer, Deblinger, & Sieger, 2007). An evidence-based model for treating children who have experienced trauma has proven beneficial but there are gaps in the literature related to how the treatment can be accessed in community settings. Lack of access to the treatment model was explored in the development of an adapted TF-CBT training model to be used in countries with limited resources and was tested in work with Zambian children who were affected with HIV (Cohen & Mannarino, 2016). The adaptation of the treatment model was effective at improving PTSD and depressive symptoms for the children who had undergone the treatment (Chen, Olin, Stirman, & Kaysen, 2017). The flexibility of adapting the TF-CBT model for the treatment of trauma in community settings shows that a lack of access to trained mental health professionals can be remedied by training local practitioners with a variety of professional backgrounds and experience in mental health and that this does not affect the improvement of PTSD symptoms amongst individuals accessing the treatment.

Cognitive behavioural therapy (CBT) was chosen as the most preferred form of therapy among adult participants who evaluated seven different treatment options for post-traumatic stress disorder (Becker, Darius, & Schaumberg, 2007). Treatment options included prolonged exposure, cognitive-behavioral therapy, pharmacological treatment, eye movement desensitization, psychodynamic therapy, thought-field therapy and 'my therapy buddy' which were rated by 160 individuals with different levels of trauma (Becker, Darius, & Schaumberg, 2007). The effectiveness of trauma treatment presents limitations since developing and implementing a model of treating PTSD involve a multitude of factors. An overemphasis on techniques to regulate emotional distress has the potential of ignoring an individual's intrinsic nature to heal their emotional wounds and denies them the opportunity for a natural resolution (Corrigan & Hull, 2015). However, the complexities of a single approach to trauma therapy can be limiting to the healing process. Exposure to larger interactions in group therapy or the opportunity to work with different therapists or support systems can also be beneficial to clients (Silverstone, Suen, Ashton, Hamza, & Martin, 2016). The research on CBT as a trauma treatment approach focuses on the availability of the treatment (Cavanagh, 2014), the access to treatment (Wamser-Nanney, Scheeringa, & Weems, 2014) and therapist factors that help determine the outcome of treatment (Becker, Darius, & Schaumberg, 2007).

TF-CBT has been recognized by the National Registry of Evidence-Based Practices and Programs and the National Child Traumatic Stress Network which has contributed to a large circulation of the treatment model but there is still a lack of research on the dissemination of the model in community mental health settings (Webb, Hayes, Grasso, Laurenceau, & Deblinger, 2014). CBT is a model that is deemed beneficial when practiced regularly with a strict commitment to program modalities. The effectiveness of the approach is challenged when

working with adolescents with early attrition or sporadic attendance, thus affecting the efficacy of the treatment (Shirk, DePrince, Crisostomo, & Labus, 2014). Additional challenges include widespread dissemination efforts to ensure that evidence-based practice trauma models are being accessed by children who have experienced trauma. A proper dissemination and implementation framework must include a source (e.g. TF-CBT), a destination (an individual or organization that will take on the model), a communication link (e.g. trainers or program developers) and a feedback mechanism (e.g. evaluation tool) that all operate within an environment of influence (Sigel, Benton, Lynch, & Kramer, 2013). This conceptual model of dissemination is particularly important in regards to TF-CBT because of its success at overcoming the barriers of dissemination by offering "…web-based learning, live training with ongoing consultation and learning collaborative" (Sigel et al., 2013, p. 324). Offering alternative training methods have reduced barriers related to cost, travel, and the ability to train multiple participants at once.

Prolonged exposure (PE) and eye movement desensitization and reprocessing (EMDR) therapy have been strongly supported in the research for treating people with PTSD (van den Berg et al., 2015). Practices such as imaginal exposure and in vivo exposure to trauma reminders that are feared or avoided by the individual have been empirically supported but are underutilized due to insufficient training and client decompensation (Jayawickreme et al., 2014). Jayawickreme et al. (2014) researched the effects of PE treatment on female assault survivors (n= 361) with chronic PTSD and found that CBT that included exposure therapy and EMDR are safe treatments as long as PTSD is the primary disorder and the individual is not psychotic, actively suicidal or dependent on substances. The direct confrontation of situations or objects associated with the trauma makes in vivo exposure a beneficial aspect of treatment because it allows individuals to desensitize their fear and anxiety around aspects of the trauma. Imaginal

exposure allows the individual to imagine situations or images that are associated with the trauma to build a tolerance to manage difficult memories. A pilot study of prolonged exposure therapy with female methadone patients in Israel who were victims of sexual assault included weekly individual sessions where individuals were introduced to assignments such as the creation of in-vivo hierarchies and creating an audiotape of the imaginal exposure during sessions (Schiff, Nacasch, Levit, Katz, & Foa, 2015). The women benefitted from prolonged exposure which was evident in a decrease in PTSD and depressive symptoms after this study and at the 12-month follow-up (Schiff et al., 2015).

The literature supports EMDR as a treatment approach for individuals with PTSD. This treatment is guided by Shapiro's Adaptive Information Processing Model (AIP) that focuses on the storage of memories that are linked to different thoughts, emotions and images that become infused with new information (Jeffries & Davis, 2013). When a traumatic event is experienced, the information may not be processed properly, thus isolating the memory. As described by Jeffries & Davis (2013), "Thus elements of experiences are stored as they were input, along with the distorted thoughts, sensations and emotions that are associated with them. If these memories remain unprocessed, they become the basis of symptoms of PTSD" (p. 3). This is significant to the treatment of PTSD because it describes the importance of properly processing and integrating trauma memories to reach a resolution which can be facilitated by EMDR. The desensitization of traumatic memories is assessed after holding a distressing image in their hand and engaging in saccadic eye movements while noticing negative thoughts and body sensations (Cusack et al., 2016). EMDR has proven to be an effective treatment recognized and recommended on an international scale for its ability to decrease PTSD symptoms as compared to individuals on the

waiting list, standard care and pill placebo groups (Boccia, Piccardi, Cordellieri, Guariglia, & Giannini, 2015).

Cognitive processing therapy (CPT) was developed by Resick and Schnicke (1993) with the assumption that dysfunctional thinking contributes to and helps to maintain PTSD. CPT relies on components of CBT by focusing on dysfunctional posttraumatic cognitions to reduce symptoms of PTSD (Schumm, Dickstein, Walter, Owens, & Chard, 2015). The literature on CPT shows a reduction in symptoms of PTSD for active duty military personnel with combat-related PTSD (Resick & al., 2015). The National Center for PTSD (2016) advocates on behalf of CPT as one of the best treatments for PTSD and offers a mobile application for individuals to access the treatment with a therapist as a guide to work through the treatment. CPT models have been adapted to work with different demographics such as adolescents with PTSD from physical and sexual abuse by adjusting treatment modules and changing the therapy setting (Matulis, Resick, Rosner & Steil, 2014).

There has been skepticism in the literature and in the social work community regarding the efficacy of trauma-informed CBT for Indigenous people. While there has been support in the literature on the use of CBT for Indigenous people, there has also been criticism of the model, citing its inability to be helpful to Indigenous people (Bennett-Levy et al., 2014). However, there has been a successful adaption of CBT for a variety of non-Western cultures that include the Maori, Alaskan Native people, First Nations communities in Canada, Native Americans, Middle Eastern cultures, China, Bangladesh and Pakistan (Nelson et al., 2014). The adaptability of the model is also contingent on the role of the therapist and the relationship between client and practitioner. This is especially significant when practitioners and clients share cultural

similarities and can benefit from a mutual understanding from a cultural perspective. Creed (2014) elaborates on this point by recognizing culturally-informed core beliefs and their benefit in providing practitioners with increased understanding of personal perception and the relationship to the social environment. When working within a similar culture, practitioners have the potential benefit of having an appreciation for values and belief systems that might be misinterpreted outside of that culture.

The literature cites the importance of adaptations for CBT with Indigenous people but lacks a detailed explanation into how this can be facilitated. A research study conducted with the Maori people in New Zealand revealed the importance of incorporating spirituality, using language and examples that were culturally relevant and incorporating different methods to teach therapeutic materials (Bennett & Babbage, 2014). This highlights similarities in treatment approaches amongst Indigenous people across the world but variations are still required within specific communities. It is also important to note that a treatment approach that benefits groups of people may not be applicable at the individual level. The suitability of CBT with Canada's First Nations people recognizes the similarities between some concepts of CBT and First Nations perspectives. The relation of the mental, physical and emotional aspects of an individual's health is consistent with both perspectives (Nowrouzi, Manassis, Jones, Bobinski, & Mushquash, 2015).

The structured aspects of CBT contrast with First Nations teachings that encourage individuals to emphasize their personal narrative and encourage healing from a community perspective (Nowrouzi et al., 2015). Evidence-based treatments like CBT can be beneficial when working with Indigenous people who have experienced trauma but in Northern Algonquin and

other native communities, the emphasis is on healing as opposed to treatment (Gone, 2013). The Indigenous healing perspective differs from the medical model in that it highlights the importance of holistic healing. Gone (2013) summarizes this by stating, that Indigenous people see healing as "…coping toward a more robust state of wellness, as indicated by strong Aboriginal identification, cultural reclamation, spiritual wellbeing, and purposeful living in contrast to the secular origin of treatment" (p. 9). This is significant in an analysis of trauma treatment approaches for Indigenous communities because it points to the need for healing that goes beyond the individual pathology of the client and toward a collective understanding of treatment that cannot be effective without the incorporation of culture, family, community and individual resources.

Dialectical Behavioural Therapy Trauma Models

Individuals who have experienced trauma related to childhood abuse and neglect, detached bonds with caregivers and prolonged separation from caregivers have higher rates of self-harm than individuals with other mental health challenges (U.S. Department of Veterans Affairs, 2015). The engagement in self-harming behaviours for individuals with PTSD provides them with the opportunity to numb the symptoms of PTSD and release stress and tension associated with the illness. Dialectical Behavioural Therapy (DBT) has been adapted as a model for treating PTSD to help manage self-injurious behaviour since many PTSD treatment guidelines require clients to manage self-harming and suicidal behaviours prior to participating in treatment (Harned, Korslund, & Linehan, 2014). Thus, individuals exhibiting high risk behaviours related to self-harm and suicide are excluded from PTSD treatment studies, resulting in a lack of treatment that targets PTSD among individuals who self-harm or are suicidal

(Harned et al., 2014). The research strongly supports trauma-focused CBT and EMDR as first-line treatments for PTSD but exposure-focused treatments have been questioned by therapists for fear that symptoms will worsen or increase comorbid symptoms (Krüger et al., 2014).

The efficacy of a treatment program that incorporates DBT into PTSD treatment includes DBT and trauma-focused interventions. DBT-PTSD programs allow the inclusion of clients who are suicidal, engage in frequent self-harm, and have severe features of dissociation (Bohus et al., 2013). Incorporating prolonged exposure with DBT helps to reduce behaviour related to shame, guilt, dissociation, depression and anxiety (Carmel, Comtois, Harned, Holler, & McFarr, 2016). DBT-PTSD is designed to meet the different needs of individuals living with PTSD by matching psychopathology with skills to manage behaviours associated with the diagnosis. Kleindienst et al. (2016) studied the operationalization of dissociation during treatment using DBT-PTSD with individuals with PTSD after childhood sexual abuse and found that dissociation improved after DBT-PTSD treatment because participants were given specific DBT skills to control dissociative behaviours related to trauma-related emotions as they came up in the study. Non-suicidal self-harm and suicidal behaviours are recognized as a coping strategy for emotional dysregulation related to childhood trauma. A DBT intervention is beneficial in these cases because of the focus on improving emotional dysregulation and the opportunity to learn positive coping mechanisms for managing symptoms of trauma (Geddes & Lee, 2013).

Borderline personality disorder (BPD) is a debilitating disorder characterized by affect dysregulation, and difficulty with interpersonal relationships, impulse control, daily functioning and self-image (National Institute of Mental Health, 2016). As discussed by Lieb, Zanarini, Schmahl, Linehan, & Bohus, (2004), "…genetic factors and adverse events during childhood, such as physical and sexual abuse, contribute to the development of the disorder. Dialectical

behaviour therapy and psychodynamic partial hospital programmes are effective treatments for out-of-control patients…" (p. 453). The research demonstrates a connection between PTSD and BPD due to childhood trauma. As a result of the comorbidity of BDP and PTSD, treatment outcomes for the two disorders have found positive outcomes with the amalgamation of DBT and prolonged exposure (Granato, Wilks, Miga, Korslund, & Linehan, 2015). The research highlights the importance of creating a treatment model that is beneficial for individuals struggling with both disorders concurrently.

DBT developed by Marsha Linehan aims to change behaviours and emotions through a balance of acceptance and change by using principles of CBT, with an emphasis on learning and practicing new skills (O'connell & Dowling, 2014). DBT is important to understand from a trauma perspective because it teaches individuals to manage the symptoms of PTSD. Children who are emotionally vulnerable need an environment where their feelings are validated and emotional management is provided. Individuals with childhood histories that have included trauma, neglect, or stressful environments were not given that validation, causing them to lack proper methods of problem solving and properly manage the consequences of emotional experiences (Neacsiu, Ward-Ciesielski, & Linehan, 2012). Although DBT has been beneficial when used to treat BPD and PTSD, there is a lack of research regarding its application to trauma without comorbidity.

DBT was primarily developed to treat individuals who were suicidal or exhibited self-harming behaviours that were associated with BPD. However, the research shows adaptations of the model for binge eating disorder (Masson, von Ranson, Wallace, & Safer, 2013), attachment disorder (Andrew, Williams, & Waters, 2014), individuals with learning disabilities (McNair, Woodrow, & Hare, 2015), and BPD and attention deficit hyperactivity disorder (Prada et al.,

2015). Although there have been different adaptions of the DBT model, the research lacks an efficacy-based model on how DBT can apply to individuals with PTSD or those who have experienced trauma. It has been researched extensively in conjunction with BPD but lacks its own application as it relates solely to trauma. Aspects of DBT would be beneficial to individuals who have experienced trauma because of its focus on "…cognitive and behavioral interventions (e.g., behavioral assessment, contingency management, exposure, cognitive restructuring, and skills training), dialectics, and the radical acceptance practices of validation and mindfulness" (Linehan et al., 2015, p. 476).

DBT with Indigenous people was used in a pilot study with American Indian and Alaska Native youth in a traditional residential treatment center who derived positive outcomes when traditional cultural practices were blended with evidence-based practices like DBT (Beckstead, Lambert, DuBose, & Linehan, 2015). The research supports the incorporation of evidence-based practices with traditional, spiritual and cultural practices for Indigenous trauma treatment but there is little research in support of the efficacy of how this can be applied using DBT. When working with Indigenous youth, distress tolerance skills promoted through DBT would be beneficial when conducting trauma treatment because it equips youth with positive coping strategies as they are working through their trauma treatment which can invoke feelings of anxiety and depression.

Mainstream mental health models that are driven by the medical model do not appreciate the complexity of Indigenous understanding of mental health and self-determination (Vukic, Gregory, Martin-Misener, & Etowa, 2011). DBT can act as an alternative to the biomedical model with its focus on interpersonal interactions and the power of collective reliance when delivered in a group format, thus aligning with Indigenous teachings that value community and

seeking wisdom from others. Kinsey (2017) tested the compatibility of a culturally modified version of DBT, *Healthy and Whole* with a Native American community to assess the suitability of the treatment model and whether it was feasible for reducing high-risk behaviour connected to historical trauma. The findings indicated that a successful treatment model for managing maladaptive behaviours involved the revitalization and maintenance of cultural values which need to be coupled with the skills taught in the culturally adapted version of DBT (Kinsey, 2017). Cultural adaptation of DBT in the treatment of trauma symptoms among First Nations communities in Canada is missing from the research. However, there have been successful applications with Indigenous communities across the world, which have the potential to benefit First Nations people in Canada. A culturally adapted version of DBT within the transactional-ecological framework was used with a Navajo female by incorporating DBT skills training with Navajo healing methods and focusing on an improvement of protective factors in her environment (Kohrt, Lincoln, & Brambila, 2017). Despite the individual's condition, when there is exposure to intergenerational trauma, it is important to focus on community healing rather than individual healing for the treatment to be sustainable.

Trauma and Substance Abuse

There is a direct correlation between individuals who have experienced a trauma and substance abuse. This is especially prevalent with victims of childhood abuse who have an increased risk of developing psychiatric disorders, specifically mood and anxiety disorders as adults (Segal, Morral, & Stevens, 2014). Individuals with mental illness gravitate towards substances to reduce positive or negative psychiatric symptoms. As a result of their propensity to experience feelings of distress and depression, they are more likely to use substances and have a

higher chance of developing a substance abuse disorder (Bizzari et al., 2009). The Self-

Medication Hypothesis (SMH) was developed through observations of clients with substance

abuse disorders who experience extremes in their feelings and use substances to reduce painful

effects or control emotions that are too overwhelming (Mariani, Khantzian, & Levin, 2014). The

SMH provides a critical perspective to trauma because it views substance use as a comfort to

unbearable feelings rather as a form of pleasure-seeking or as a self-destructive behaviour. The

decision to use substances allows the level of distress to be temporarily mitigated by the use of

substances.

Individuals who use substances after their exposure to trauma are more likely to delay

behaviours such as seeking help, thus limiting their ability to regulate their emotions or process

the trauma in a healthy way (Sheerin et al., 2016). This is supported by a research study in the

United States that shows a gap between mental health diagnosis and seeking help (Sheerin et al.).

This reality has led to treatment models that are designed to work with individuals with

concurrent disorders. Concurrent disorders are defined as "…co-occurring addiction and mental

health problems. It covers a wide array of combinations of problems, such as anxiety disorder

and an alcohol problem, schizophrenia and cannabis dependence, borderline personality disorder

and heroin dependence and bipolar disorder and problem gambling" (Centre for Addiction and

Mental Health, 2012). Treatment models have been developed to treat the co-occurrence of

PTSD and substance abuse disorders such as *Seeking Safety* developed by Lisa Najavits (2002)

that recognizes that a dual diagnosis of PTSD and substance abuse is very common, especially

among women.

Treatment models that focus on the comorbidity of substance use and PTSD are often

missing from the research due to the exclusion of PTSD patients from substance abuse treatment

since managing the symptoms of PTSD are not typically included in the treatments (Foa et al.,
2013). The high comorbidity of alcohol dependence and PTSD requires special attention due to
the increased rates of dysfunctionality and distress amongst individuals who use alcohol to
manage the symptoms of their trauma. Treatment for PTSD often excludes individuals with
alcohol dependence because of potential risk that the treatment will increase alcohol
consumption due to increasing levels of distress (Foa et al., 2013). Trauma models would also
benefit from distinguishing trauma types as an attempt to understand which trauma histories are
associated with alcohol and substance use (Ullman, Relyea, Peter-Hagene, & Vasquez, 2013). In
their research on female sexual assault victims, Ullman et al., (2013) found that distinguishing
trauma types between interpersonal/non-interpersonal and historical trauma/new exposure to
trauma influence how an individual uses substances as a coping mechanism. The research on
trauma and substance use would benefit from understanding the role of specific trauma histories
and substance abuse to develop specific treatments for individuals with concurrent disorders.

     In a comprehensive review on treatment outcomes for PTSD and substance abuse
disorders (SUD), Najavits & Hien (2013) concluded that most treatments were present-focused
approaches targeting stability, psychoeducation and coping skills and excluded an emphasis on
past-focused models that explore the trauma narrative and exposure-based therapy. The research
found positive outcomes for most PTSD-SUD models and concluded that client symptoms
decreased because of manualized models of treatment that helped to target specific problems.
This is supported by the research that shows evidence of TF-CBT models delivered in
conjunction with SUD intervention is more effective at reducing symptoms of PTSD and
substance use than regular treatment or minimal interventions for PTSD (Roberts, Roberts,
Jones, & Bisson, 2015).

Efficacy-based models to treat PTSD and substance abuse disorders have been explored in the research but the evidence is strongly supported by the Seeking Safety (SS) model. SS has been recognized as one of the most well-known treatments for a dual diagnosis of trauma and substance abuse. The literature on SS found positive outcomes in both controlled and randomized trials and surpassed comparison groups with high treatment satisfaction in all studies (Lange-Altman, Bergandi, Borders, & Frazier, 2017). The efficacy of the treatment model was positive with males and females in both individual and group formats in a variety of treatment settings which have included inpatient, outpatient, correctional facilities, residential treatment and community mental health programs (Lange-Altamn et al., 2017). Adaptations of SS have been developed since the model was published in 2002 and have proven its efficiency in a variety of treatment settings. Investigating the co-occurrence of substance abuse and trauma amongst a male prisoner population in Australia found that participants were receptive to the program and that positive outcomes were derived because participants attended most sessions (Barrett et al., 2015). This demonstrates the applicability of the model in a variety of settings due to its success with a population with high rates of trauma exposure and significant levels of PTSD.

Recent literature on SS efficacy explores an integrated approach to PTSD and SUD treatment by pairing the SS program with other evidence-based models of treatment. A study on voluntary EMDR therapy paired with mandatory participation in SS among males and female prisoners found that individualized trauma treatment approaches had the potential to increase the chance of recovery from addiction, reduce recidivism in the criminal justice system, improve relationships and stop the cycle of multigenerational trauma and abuse (Brown, Gilman, Goodman, Adler-Tapia, & Freng, 2015). Although an individualized trauma treatment model is

ideal, it is evident in the research that the feasibility of delivering such a model, especially to challenging populations such as prisoners, is not realistic. The evidence continues to be critical of the high attrition of treatment models for PTSD and comorbid SUD (Roberts, Roberts, Jones, & Bisson, 2015), a reduction in PTSD symptoms more that SUD symptoms (Back et al., 2014). There is a lack of research on the efficacy of the model outside of the United States and how the model can be adapted in conservative environments where drugs are prohibited (Kok, de Haan, van der Meer, Najavits, & DeJong, 2013).

Since its development in 2002, SS has gone through a variety of adaptations to accommodate different demographics. Recent studies have explored the feasibility of the SS model with Indigenous populations in Canada and Australia. The amalgamation of traditional Indigenous healing approaches with an evidence-based model has the potential of benefitting a population that has been severely impacted by generations of trauma on a national, community-based and familial level. Intergenerational trauma can be defined as "A collective complex trauma inflicted on a group of people who share a specific group identity or affiliation. It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events" (Evans-Campbell, 2008 p. 320). Research related to the decolonization of social work practices and the importance of embracing an Indigenous perspective in social work has been highly recommended in the literature from both countries (Nakata, Nakata, Keech, & Bolt, 2012; Stirling, 2015; Cunneen & Rowe, 2014).

The pairing of Indigenous and mainstream approaches requires an analysis of power dynamics within the field of social work. The concept of Whiteness has been brought to the

forefront on the discussion around cultural safety because it requires reflexive practice by the

practitioner when working with any individual who is culturally different. Personal reflection is

essential in repairing the relationship between the practitioner and Indigenous people due to the

historical trauma that has affected their communities. A qualitative study exploring the low rates

of Aboriginal and Torres Strait Islander social workers participating in the *Australian*

Association of Social Workers (AASW) discussed the need for higher representation of

Aboriginal social workers in social service settings (Bennett, 2015). This is especially important

within a trauma treatment model to ensure that participants are exploring trauma in a safe

environment. The combination of Indigenous and Western approaches has been coined as Two-

Eyed Seeing which is described by Marshall from Eskasoni First Nation as: "to see from one eye

with the strengths of Indigenous ways of knowing, and to see from the other eye with the

strengths of Western ways of knowing, and to use both of these eyes together" (Marsh, Cote-

Meek, Toulouse, Najavits, Young, 2016, p. 3).

Indigenous researchers, Elders and traditional healers agree that the treatment of

intergenerational trauma and SUD in Indigenous people should involve cultural models of

intervention (Marsh, Cote-Meek, Young, Najavits, & Toulouse, 2016). The importance of

Indigenous interventions in mainstream social service settings is an essential step in creating a

safe space that encourages Indigenous people to access trauma services. Strengthening the

involvement of Indigenous community leaders within the organization to provide traditional

teachings, workshops and as guest speakers helps to facilitate a culturally inclusive space which

reduces tokenism within organizations (Bennett, 2015). The use of cultural practices as a key

component to clinical interventions has been explored as an essential component of inclusive

practice. A community-based participatory research project with thirteen Blackfoot women who

19

have experienced domestic violence used storytelling and shawl making—Blackfoot cultural

practices—to emphasize the importance of traditional knowledge and challenge individualized

approaches to case management and trauma treatment (Jackson, Coleman, & Sweet Grass,

2015). The research tells us that social work interventions must include Indigenous social

workers to facilitate and deliver practice and programs that include culture as a key component

that helps Indigenous people feel safe and understood.

The Western worldview in social work has proven to be an ineffective way of meeting

the needs and understanding the experiences of Indigenous people through the domination of

individualized discourses that are connected to the involvement of social work in colonial

practices (Cunneen & Rowe, 2014). Western social work approaches such as individual

counselling and play therapy are not discounted as useful to address the needs of Indigenous

people, but they do require the acknowledgement and involvement of culture. Western

approaches are not rejected but there needs to be an alliance between Indigenous people and

Western approaches to care (Cunneen & Rowe, 2014). A study conducted on the use of play

therapy with Indigenous children confirmed the usefulness of the treatment approach when

working with children but the importance of including traditional practices into the therapy such

as "…the incorporation of traditional arts, the use of relevant materials and symbols, the value of

interconnection through participation and collaboration with family or community members, and

the role of spirituality" (Brady, 2015, p. 105). This is of relevance to blending Indigenous and

Western treatment models for intergenerational trauma and SUD because there is an

underutilization of mental health and substance use services amongst Indigenous people in

Canada. With the complex symptoms that are associated with intergenerational trauma and SUD,

it is crucial to assess the wellness of the Indigenous community that encompasses a holistic and

inclusive balance between the physical, emotional, social and spiritual elements of life (Marsh,

Coholic, Cote-Meek, & Najavits, 2015).

A trauma treatment model is needed that is unique to the specific needs of Indigenous

populations, understands intergenerational trauma, socioeconomic disadvantages and parental

influences as contributors to PTSD and the acquisition of SUD (Bombay, Matheson, & Anisman,

2009). The importance of adjusting SS to be inclusive of Indigenous people is a result of current

health challenges of Indigenous people and the lack of traditional and culturally-sensitive models

of treatment for intergenerational trauma and SUD (Marsh, Cote-Meek, Toulouse, Najavits, &

Young, 2016). An adaptation of SS could verbally convey the cognitive, interpersonal,

behavioural and case management skills of the participants in the program (Marsh, Coholic,

Cote-Meek, & Najavits, 2015). The effectiveness of SS for reducing the comorbidity of PTSD

and SUD symptoms present mixed findings in the research. The ethnic and cultural background

of participants is a factor in program effectiveness because without individual culture being

identified, the interpretation of program material may not resonate or apply to everyone (Lenz,

Henesy, & Callender, 2016). It can also be noted that individuals who have experienced long-

term trauma exposure require additional trauma treatment beyond the program since it does not

facilitate an in-depth processing of the trauma (Lenz et al., 2016). Despite limitations, SS is one

of the few efficacy-based models of treatment for PTSD and SUD and has been adapted in a

variety of settings over the course of its development.

Interprofessional Collaboration

The World Health Organization published a report on a framework for collaborative

practice and found that in community health settings, collaborative practice can increase client

satisfaction, reduce the length of treatment, decrease the incidence of suicide, increase treatment for psychiatric disorders, decrease stigmatism related to treatment and reduce outpatient visits (Baker, 2010). The increase in treatment for psychiatric disorders is relevant in an analysis of trauma treatment for individuals with PTSD. Although a variety of treatment options are available for individuals with PTSD, the availability of evidence-based treatment is lacking in institutional settings and within private practice, with geographic region having a large bearing on accessibility (Quindara & Brown, 2016). Interprofessional collaboration is "a partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues" (Orchard, Bursey, Peterson, & Verrilli, 2016, p. 75). This is significant to the treatment of trauma because a multidisciplinary team of professionals can provide different sets of knowledge and perspectives to the client.

The Canadian Collaborative Mental Health Initiative (2006) outlined four key elements that were paramount to collaborative mental health care which included accessibility, richness of collaboration, collaborative structures and consumer centeredness. The goal of a collaborative team in the treatment of trauma would incorporate these four components to facilitate the sharing of information where multiple services can be accessed at one location. This is important to individuals with PTSD who would benefit from multiple health care and mental health providers working together towards the treatment of the individual. Within the Department of Veterans Affairs, interprofessional care is provided to veterans by core teams that consist of pharmacists, social workers, psychologists, and other mental health professionals to address challenges related to mental illness (Kearney, Post, Pomerantz, & Zeiss, 2014).

The role of interprofessional collaboration in trauma treatment and support is demonstrated in a variety of health care settings where patients benefit from the support of

psychiatric and psychological comorbidities related to life-threatening diseases. Research on the assessment of the levels of patient distress with breast cancer treatment found that physicians relied on external support to manage psychological symptoms of their patients. This points to the importance of collaboration between "…physicians, surgeons, nurses, physiotherapists, nutritionists and social workers to work closely together with psychologists to take care of patients effectively" (Arnaboldi, Oliveri, & Pravettoni, 2015, p. 321). Being diagnosed with a life-threatening illness has the potential to be traumatic for the individual, even years after overcoming the diagnosis. The ability to survive a life-threatening illness such as cancer is often not defined by one traumatic event since many aspects of a cancer diagnosis and treatment can be traumatic which makes PTSD difficult to treat (Dukes, Thompson, & Heathcote, 2013).

The importance of interprofessional collaborative in the treatment of trauma shows that interventions benefit from an interprofessional team to improve patient care and outcome for the family (Curtis et al., 2016). This is of relevance in trauma treatment where the ability to communicate a PTSD diagnosis and options for treatment is best conducted by an interprofessional team who specialize in different areas. It is also crucial that family members are communicated with effectively, especially with children and youth who have been exposed to trauma. Early recovery from trauma exposure for youth is largely missing from the literature and it is crucial that health care practitioners are trained to normalize the trauma by taking on a 'watchful waiting approach' or to engage in active treatment (Meiser-Stedman et al., 2017). The specialization of healthcare professionals and their experience with trauma would be beneficial when there are long waitlists for community referrals or barriers to accessing treatment at crucial points in the diagnosis phase.

The success of interprofessional collaboration points to the importance of interprofessional education prior to working together and establishing clear models of service, communication strategies, regular team consultations, professional development and the opportunity for clinical supervision (Bennett, Hauck, Radford, & Bindahneem, 2016). It is important to understand that the success of interprofessional collaboration does not simply occur by creating a team of different professionals and that there is a framework to ensure sustainability of the team. Social work has expanded to a holistic model of care which incorporates social, physical, psychological and emotional components when assessing an individual's needs (Glaser & Suter, 2016). This points to the importance of interprofessional collaboration to properly assess all components of an individual's mental health.

The role of social workers within an interprofessional team has yielded positive outcomes in the literature. Collaboration between physicians and social workers provided a better understanding of patient strengths and abilities and widened the range of pharmacological and non-pharmacological treatments for geriatric patients (Gould, Lee, Berkowitz, & Bronstein, 2015). Social workers working collaboratively with teachers for children at-risk showed that the professionals did not maintain a sense of inequality in power relations or guard their activity limits but instead were able to work towards the best interests of the child no matter what the value of their profession (Hesjedal, Hetland, & Iversen, 2015). Despite gains in social workers being included in interprofessional collaboration, there is a gap in the research regarding how interprofessional teams can work together towards the diagnosis and treatment of PTSD. The literature explores the role of social workers in a variety of interprofessional teams including social workers and pediatric health professionals (Delany, Richards, Stewart, & Kosta, 2017), social workers and lawyers (Boys, Quiring, Harris, & Hagan, 2015) and child protection workers

and elementary school teachers (Schaefer & Larkin, 2015) but lacks an analysis of how this functions in regards to trauma.

Despite the advocacy in the literature on behalf of a model of interprofessional collaboration that involves health care practitioners and social workers, there is also a significant amount of data on the challenges of the model. Similar to engaging in interprofessional education before participating in a team, it is essential to explore the pitfalls of the model to ensure its sustainability and success. In their research on social work educators, practitioners and students, Miller & Ashcroft (2016) identified six barriers to interprofessional collaboration which include "culture, self-identity, role clarification, decision-making, communication, and power dynamics" (p. 101). Power dynamics have the potential of being an issue with interprofessional teams where historical power roles take the preference when it comes to decision-making. Decision-making can also be challenging if professionals do not understand or respect the roles of their colleagues. This is reinforced in the reliance on the knowledge of psychology and psychiatry to inform the field of social work and these disciplines tend to rely on scientific principles as opposed to social and cultural influences on an individual's mental health (Williams, 2016). In regards to the role of interprofessional teams in the diagnosis and treatment of trauma, interpersonal trauma has been identified as a major factor maintaining symptoms of PTSD and as a result, treatment requires a professional team who can fully understand the factors that have influenced that diagnosis that go beyond individual pathology. The impact of interpersonal trauma includes experiencing an unsafe or insecure environment due to human threat and has a direct bearing on assessment and intervention for survivors (Phelps et al., 2014).

The research is extensive on interprofessional collaboration within healthcare settings but lacks a direct focus on the field of mental health. The medical model remains the dominant

perspective in the field of mental health which often results in challenges when making decisions with clients since "…the social and psychological models of mental health, and a combination of both of these models in the form of a psycho-social perspective compete for authority and recognition alongside the traditional medical approach" (Maddock, 2015, p. 247). Interprofessional collaboration within the medical field still lacks a clear definition of roles and collaboration among professionals which are barriers to providing patient-centered care to individuals (Oishi & Murtagh, 2014). The shift to community-based mental health care system in Ireland has recommended the conceptualization of mental illness through the biopsychosocial model which incorporates the different dimensions of mental health (Maddock, 2015).

Effective communication strategies within an interprofessional team also focuses on different patterns of thinking among professionals which would encourage critical reflection on widely held practices and beliefs (Raine et al., 2015). This highlights one of the benefits of an interprofessional collaboration because it gives professionals the opportunity to think outside their professional experience and knowledge sets and consider alternative points of view. This is evidenced in the *Wraparound Model* in children's mental health where social workers work with community partners to establish a treatment plan for the child and their family and ensure their needs are met as opposed to relying on outside referrals and long wait times (Kutash et al., 2014).

Narrative Therapy Trauma Models

Narrative therapy is beneficial when clients reach a stuck point in therapy where they have a difficult time expressing their thoughts, emotions and behaviours and are given an opportunity to find another solution by externalizing difficult experiences and revising the

internalized maladaptive narrative (Ricks, Kitchens, Goodrich, & Hancock, 2014). Most evidence-based treatment for individuals with PTSD focuses on veterans and the military population and lacks an analysis of evidence-based practices for community mental health. STAIR Narrative Therapy was developed to treat women with PTSD, comorbidity and impaired functioning to help women improve daily functioning and focus on reviewing and re-narrating trauma memories (Cloitre et al., 2014). Understanding the applicability of a narrative treatment approach in a community setting provides perspective on delivering an evidence-based treatment that is client-centered by being open to adaptations of the model depending on the severity of mental illness. STAIR Narrative Therapy is a cognitive-based therapy that provides individuals with skills attainment prior to engaging in trauma treatment, especially those with childhood or several forms of trauma and at-risk of unhealthy coping mechanisms due to prolonged exposure to difficult social environments and poor role models (Cloitre, Jackson, & Schmidt, 2016).

Narrative therapy is beneficial for individuals who have experienced trauma because it gives them the opportunity to adjust the trauma narrative in a way that will empower them to lead healthier lives. Despite its effectiveness, narrative therapy lacks a manualized conception which makes its implementation challenging when working with individuals with complex needs. As a result, there have been various adaptions of the narrative therapy model for PTSD including narrative exposure therapy. Narrative exposure therapy (NET) is proven to be an effective treatment for survivors of mass violence and torture because it has shown better outcomes than individual counselling, psychoeducation, group interpersonal therapy, waitlist groups and individuals who received no treatment (McPherson, 2012). NET has proven to be beneficial in its ability to "…contextualize the particular associative elements of the fear network, the sensory, affective and cognitive memories of trauma to understand and process the

memory of a traumatic event in the course of the particular life of a client" (Robjant & Fazel, 2010, p.1). This gives the client the opportunity to create a chronological narrative of their life story with a primary focus on the traumatic experience. This can be an effective strategy in trauma treatment because it gives clients the opportunity to reprocess the trauma and create new meanings, especially those who have experienced multiple and complex trauma.

NET was developed as a response to meeting the needs of individuals from different countries who may have experienced multiple traumas or complex trauma such as exposure to war (Mørkved et al., 2014). This model is of interest in Canada where there is a recent increase in immigrants from the Middle East and other regions who have experienced several traumas. The implications for practice are significant when working with refugees who require a trauma-based treatment to focus on their unique needs. A meta-analysis on the effectiveness of using NET to treat trauma with refugee populations found that it was more accessible because it requires less training than alternative therapies and gives the client the self-determination to empower themselves through the telling of their own story (Gwozdziewycz & Mehl-Madrona, 2013). This has the potential for working within the social work field in Canada where we have a diverse population of clients who may require treatment.

Although exposure therapy has been recognized in the literature as an effective form of treatment for PTSD, there are many clients that prematurely leave treatment, experience residual symptoms after treatment or do not respond to the therapy at all (Halvorsen, Stenmark, Neuner & Nordahl, 2014). A study with refugees and asylum seekers on the effectiveness of NET found that 50% of participants still met the diagnostic criteria for PTSD at the 6-month follow-up, indicating that it is important to personalize treatments to meet individual needs (Stenmark, Catani, Neuner, Elbert & Holen, 2013). Taking a client-centered approach is essential in trauma-

informed care to ensure client continuity and success in treatment. NET allows a flexible

implementation style where the client and therapist choose applicable interventions within the

core modules of emotional management, interpersonal and social skills and narrative therapy

based on individual needs (Cloitre et al., 2014).

Developing a treatment plan that focuses on the specific needs of the individual must also

recognize personal and interpersonal losses that may impede the recovery process (Schnyder et

al., 2015). This may include the loss of individual protective factors and environmental factors

such as loss of an income or a relationship. Treatment should also be cognizant of the impact of

continual trauma exposure and how that will affect the intervention. Treatment strategies should

focus on strengthening protective factors such as community connections, social supports and

personal self-efficacy (Schnyder et al., 2015). The flexibility of the treatment is also a key

feature when working with different cultures with a successful application of the treatment in

both industrialized and non-industrialized regions (Morkved et al., 2014). This is an important

aspect of a treatment module that is beneficial to individuals who have gone through multiple

traumas to ensure that the services are being accessed, regardless of the region or training of the

therapists.

Time perspective therapy is the most recent form of treatment for PTSD that focuses on

an individual's perception of psychological time and how experiences are divided into separate

time zones, known as time perspectives (Sword, Sword, Brunskill & Zimbardo, 2014). The

unique aspect of time perspective therapy allows a focus on the human tendency to remember the

past, live in the present or think about the future. Time perspective therapy is unique to trauma-

focused treatment because it targets an individual's life story and the past and future aspects of

their personal narrative which influences the self-schema and shapes experiences by influencing

behaviour (Matthews & Stolarski, 2015). Individual interpretations of past traumatic experiences have the potential of making the trauma narrative a part of the person, thus shaping experiences and behaviour in-line with that re-storied version of themselves. Time perspective narrative therapy lacks evidence-based support in the research community and requires further research to prove the efficacy of the model. However, it has proven to be beneficial when working with individuals with depression (Oyanadel & Buela-Casal, 2014) or ADHD (Weissenberger et al., 2016) and could contribute to trauma treatment as an alternative approach to other modalities.

The components of narrative therapy can be applied to individuals who have experienced trauma at different stages of their lives. When working with children, it is beneficial to incorporate aspects of the underlying theory to aid them in reconstructing an incoherent or chaotic personal narrative after exposure to family violence or neglect. As described by May (2005), "When faced with a frightening situation, the inability to contemplate a solution seems to retard developmental accomplishments and interfere with successful processing of subsequent traumatic experiences" (p. 222). Narrative therapy gives the child the tools to make sense of their life to properly process trauma in a way that is not debilitating. Negative scripts are beneficial in the management of difficult emotions or managing anxiety related to the trauma (Singer, Singer & Berry, 2013). Narrative therapy is helpful in challenging "all or nothing thinking" and makes room for a flexible narrative in which clients are empowered to think of multiple possibilities rather than getting stuck in a state of emotional reasoning. The incorporation of CBT and narrative therapy with Cognitive Behavioural Narrative Therapy is beneficial for children with oppositional defiance disorder and treatment of trauma through stories to address behavioural problems associated with trauma exposure (Zolghadrnia, Mahmoudian, & Heydari, 2016).

According to Gone (2013), when treating PTSD amongst Indigenous people, the preferred course of treatment is the participation of traditional cultural practices that involves a spiritual transformation that is followed by changes in collective identity, purpose and meaning-making. PTSD treatment for Indigenous people rejects the efficacy of CBT, anti-depressants and flooding as treatment methods for historical and intergenerational trauma (Gone, 2013). This relates to narrative therapy because of its ability to empower individuals and be in control of the narrative on their life. It is connected to the re-creation of meaning-making as a successful form of treatment for PTSD with Indigenous people. This is also exemplified in the Truth and Reconciliation Commission (TRC) Final Report (Truth and Reconciliation Commission of Canada, 2015) where survivors of residential school were given a platform to share their stories as a form of healing the trauma that has been passed through generations of First Nations people in Canada.

The mandate of the TRC was to reveal the truth about the historical legacy of the residential schools by giving survivors a platform to speak about their individual and collective trauma and guide a process of healing through the sharing of testimonies (Truth and Reconciliation Commission of Canada, 2015). This is connected to the basic tenets of narrative therapy that advocate on behalf of creating a definition of yourself based on memories of a past life, present life and interpersonal relationships (Ricks, Kitchens, Goodrich, & Hancock, 2014). It also focuses on "the ideology that problems in people's lives are derived from social, cultural, and political contexts. The origins from which stories manifest are the result of influences from a person's family of origin, peers, other interpersonal relationships, and sociocultural directives" (Ricks et al., p. 100). The opportunity to speak on behalf of a collective trauma and begin the process of healing demonstrates the power of narrative therapy as a treatment for PTSD on a

national scale. In an analysis of successful treatment approaches for Indigenous people who have experienced trauma, narrative therapy has been cited as an acceptable form of treatment because it aligns with Indigenous culture that values storytelling and healing through stories told by the Elders (Mehl-Madrona, 2016).

III: Approach to Advanced Practicum

A. Setting: Mood and Anxiety Program at Health Sciences North

The advanced practicum took place with the Mood and Anxiety Program (MAP) with Health Sciences North in Sudbury, Ontario. The Mood and Anxiety Program offers mental health support to individuals 16 years of age or older who are experiencing bipolar disorder, depression, generalized anxiety disorder, obsessive compulsive disorder, BPD, social anxiety and PTSD. The MAP team offers group-based therapy that is guided by evidence-based practices to psychotherapy which include CBT, mindfulness-based approaches and DBT. Individual treatment is also offered to individuals with a diagnosis of PTSD. Therapists are trained in cognitive processing therapy, prolonged exposure therapy, EMDR and conduct individual trauma treatment for individuals who have previously completed group therapy.

The MAP team consists of an interprofessional group of therapists who are trained in a variety of health care roles to meet the needs of the individuals they serve. The team consists of two consulting psychiatrists, eleven social workers, a psychometrist, an occupational therapist and a clinical nurse specialist. The interprofessional team works collaboratively in group sessions and provides consultation for individual sessions. Individuals are referred to the MAP team by family physicians, psychiatrists, crisis intervention and residential treatment facilities. The prioritization of effective communication and team building is demonstrated in daily team

'huddles' where the staff have the opportunity to share clinical issues and ask for support from the team. Hall, Weaver, Gravelle, and Thibault (2007) discuss how the interchange of individual learning leads to the development of a common conceptual framework that is based in common values and understanding which leads to successful interprofessional collaboration.

The advanced practicum was guided using CBT to inform group material, individual sessions and trauma treatment. Although mindfulness-based approaches and components of DBT were used in therapy, CBT was the primary therapy used throughout the program. Support for CBT as the best evidence-based treatment for social anxiety (Leichsenring et al., 2014), PTSD (Ehlers, 2014), generalized anxiety disorders (Brenes, Danhauer, Lyles, Hogan, & Miller, 2015), BPD (Linehan et al., 2015) and depression (Yoshimura, 2013) makes it the preferred form of treatment for the MAP team. The following diagram (figure 1) illustrates the type of groups offered by the MAP team.
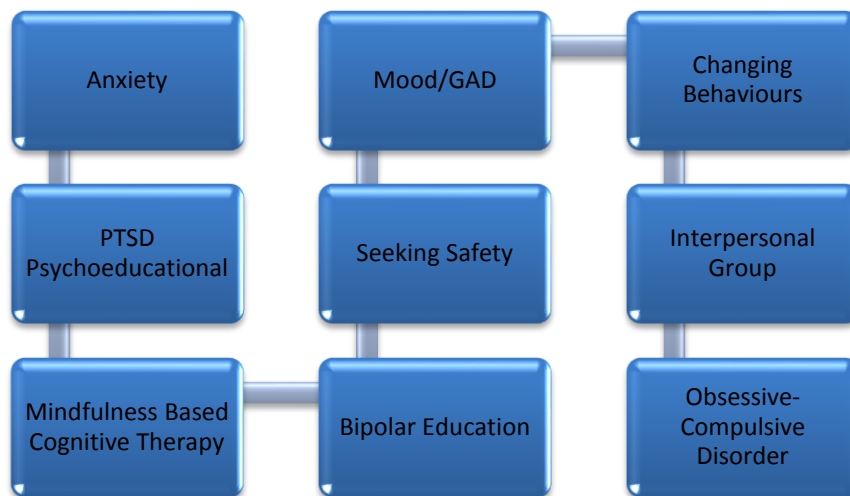
The Anxiety Group is a 20-week group that assists individuals in learning therapeutic skills using CBT to help them reduce and prevent social anxiety and panic symptoms through graded exposure therapy. This group is recommended for individuals who struggle with symptoms of

panic and social anxiety. Participants learn the role of relaxation and mindfulness in the treatment of anxiety, develop breathing strategies designed to decrease panic and anxiety symptoms, and apply mindfulness skills to be present for difficult experiences rather than avoid them. The Mood/GAD Group is 18-week group that assists individuals in learning therapeutic skills using CBT to reduce and prevent depression and generalized anxiety symptoms. This group is recommended for individuals who struggle with symptoms of depression and excessive worry.

The Changing Behaviours Group is a12-week psycho-educational mindfulness skills based group to assist individuals in developing and improving coping skills. Clients learn how to regulate emotions, change dysfunctional behaviours and to improve their overall quality of life. The Changing Behaviours group provides an opportunity for multi-impulsive clients to receive a skills-based training program while having the support of an individual therapist whom they must work with at least once every two weeks. The PTSD Psychoeducational Group is a 6-week group that provides education to individuals with a diagnosis of PTSD and learns strategies on how to manage symptoms of PTSD. Individuals gain an understanding of PTSD, breathing and grounding strategies, developing coping skills and options for treatment. Once individuals complete the group, they are eligible for individual trauma treatment.

The Seeking Safety Group is a 12-week group to address the needs of individuals suffering with both post-traumatic stress disorder (PTSD) and substance abuse. Individuals whose lives have been affected by trauma can also benefit and a diagnosis of PTSD is not mandatory. It is targeted to address the first stage in recovery from PTSD which is the achievement of safety. Individuals learn strategies for safety, detaching from emotional pain, learning self-compassion and creating a personal safety plan. The Interpersonal Group is a 16-week group that promotes

the maintenance and expansion of therapeutic gains across areas of a person's life. Participants in this group must have completed the Mood/GAD Group or Anxiety Group and recognize their difficulties adjusting to personal life issues such as loss and grief, role transitions, interpersonal role conflict, and interpersonal struggles, such as low self-confidence and issues with assertiveness.

The Mindfulness-Based Cognitive Therapy Group is a 12-week group based on systematic and intensive training in mindfulness meditation and mindful stretching. This group focuses on shifting the relationship to thoughts, bodily sensations and feelings that contribute to depressive relapse. The group is recommended for individuals who have completed a CBT group and wish to address relapse prevention. The Bipolar Education Group is a 10-week group for individuals, 16-years of age and older, who have been diagnosed with Bipolar Disorder. This is not a treatment or a support group. The Obsessive Compulsive Disorder (OCD) Group is a 12-week group. The OCD Group is recommended for individuals who have a diagnosis of Obsessive Compulsive Disorder and who will learn ways to manage their diagnosis in a supportive environment.

B.   Approaches to Practicum

As a student social worker, it was essential to take a reflective approach when working in community mental health. Reflective practice in social work can be defined as "the engagement of the practitioner in analysis of experiences leading to new insights into him/herself and/or his/her practice" (Coffey, 2016, p. 12). This was essential to enhance my learning with the MAP team by being open to new experiences and using them as an opportunity to improve as a practitioner. I practiced reflexivity by keeping a journal and writing daily entries after group therapy or individual sessions. The journal was an opportunity to reflect on the roles of the

individual facilitators, the material that was taught during the session, the experiences of the participants and my role as a student. I had the opportunity to practice critical reflection by asking questions to team members throughout the day and during debriefing sessions.

The approach to the advanced practicum draws from the ecological theory which analyzes the systems in an individual's life and how they contribute to their overall wellbeing. For treatment to be successful, it was important to incorporate social, familial and cultural factors into the assessment and intervention process (Greene, 2011). An ecological perspective was important when providing treatment for individuals who has experienced trauma because their environment played a role in their current challenges and their recovery. An ecological perspective is also important during the assessment phase to understand the effect of the individual's environment and interpersonal relationships on their current wellbeing. Although the ecological perspective was beneficial in having a greater understanding of the client's role in their life, it often contradicted the CBT paradigm that focuses inward on individual thought processes and challenging individual behaviour.

C: Role within the Agency

As a registered social worker, I was treated as a professional on the team and was given my own office and opportunity to practice independently. Prior to group sessions, I met with the group facilitators and be involved in the planning process. My feedback was valued and I had the opportunity to delegate roles for myself. I had the opportunity to observe weekly group sessions with the Anxiety Group, the Mood/GAD group and the PTSD Psychoeducational Group. During group sessions, I observed the facilitators and reflected on individual teaching styles and how they delivered program material. I was also given the role of facilitator in which I had the

responsibility of conducting different activities throughout the sessions. Group sessions began with a mindfulness activity and I drew upon grounding exercises and breathing strategies to teach during that part of the group. As I familiarized myself with group material, I also had the opportunity to facilitate the psychoeducational components of the group and deliver group material.

In terms of individual sessions, I had the opportunity to observe and facilitate sessions with individuals who had a diagnosis of PTSD. These individuals were attending the Seeking Safety group and were entitled to 4-6 individual sessions with a therapist on the team. During individual sessions, I observed the social worker as they reviewed group material with the individual and applied it to their own lives. I also had the opportunity to facilitate aspects as the session such as beginning with a breathing exercise to ground the individual before discussing distressing topics. I worked independently with one individual and used CBT to reinforce material that was taught in group sessions and applying it to her life. On the team, I also had the responsibility of conducting intake assessments with individuals who had attended the mandatory orientation session and were open to treatment with the MAP team. My role was to meet individually with clients and conduct an intake assessment by discussing current life stressors and how they can be supported by the MAP team. Intakes included reviewing the limitations of confidentiality, assessing risk of suicide, exploring the presenting problem, discussing protective factors and register them for a group within the program. My role also included documenting case notes and updating medical information.

D: Professional Practice and Trauma Training

As a new social worker with five years in the field, I have had the opportunity to work with a diverse range of people both within Canada and internationally. My work in two fly-in First Nations communities was the beginning of my work with children and youth who struggled with symptoms of mental illness. Throughout my practice, I have been challenged by an individual's exposure to trauma and how to provide support for them. Many community health agencies I have worked for both locally and abroad do not have the resources to properly treat symptoms of trauma and PTSD. As a counsellor, I felt limited in my ability to aid individuals who were suffering from symptoms of PTSD that often presented as depression and/or anxiety. My decision to complete my advanced practicum with the Mood and Anxiety Program was chosen in hope of gaining skills on how to work with individuals who have experienced trauma and to begin learning about models of trauma treatment.

Learning successful treatment tools was essential in growing as a social worker. I had the opportunity to participate in online trauma training to contribute to my professional development. I have received my certification in Cognitive Processing Therapy (CPT) through The U.S. Department of Veterans Affairs (2015) and Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) through the Medical University of Southern Carolina (2005). CPT training was beneficial in learning to apply many of the CBT tools I had been using over the course of the practicum. The CPT training was useful in understanding an individual's pre-existing core beliefs and how they are either changed or reinforced after a traumatic event, depending on whether the beliefs about themselves are positive or negative. This was relevant to my facilitation of individual and group sessions because it gave me an opportunity to challenge clients on unhelpful automatic thoughts that spoke to their unhelpful core beliefs. I have always

struggled with challenging clients and the teaching on Socratic questioning was beneficial because it provided me with the tools necessary to uncover maladaptive thoughts without shaming the client or making them feel judged.

The TF-CBT training was useful but did not directly apply to the advanced practicum because most the individuals that participate in the program are adults. However, the TF-CBT model that is developed for trauma work with children and youth taught many components that were transferrable to working with adults who have experienced trauma. The role of psychoeducation, stress management skills, cognitive processing and creating a trauma narrative (National Child Traumatic Stress Network, 2008) were all concepts that could also be used when working with adults. Independent personal development also included reading Seeking Safety (Najavits, 2002) and the DBT Skills Training Manual (Linehan, 2014).

E: Reflection and Learning about Trauma Treatment

The need to develop my understanding of trauma treatment came from an inability to fully help individuals who were experiencing symptoms of anxiety and depression because of their exposure to trauma in their lives. In my experience working with children and youth, their ability to communicate traumatic experiences was varied. Using a critical reflection approach, I could identify the fact that the topic of trauma was both important and fear-inducing; I did not have the tools to help individuals manage PTSD or symptoms of trauma exposure. Previous experiences with trauma work led me to the understanding that it should be approached with openness and honesty and the individual should be given the environment to share about their experience. I understand now that venturing into a trauma narrative must be done methodically and purposefully. Encouraging the individual to share the trauma, although well intentioned can

be extremely harmful if it is not being supported by an evidence-based model. In my attempts to give individuals an outlet to discuss their trauma, I was causing them more harm by not providing them with an adequate model of support.

Practitioners who are working with individuals who have PTSD must be very purposeful in conducting a treatment that respects the self-determination of the individual and giving them evidence-based tools to reduce their symptoms of PTSD. The importance of an efficacy-based model of trauma treatment is recognized in the research, especially for the use of CBT therapies such as CPT and PE for their ability to reduce symptoms of PTSD (Jeffereys et al., 2014). The framework of trauma therapies is methodical and purposeful in their strategy to manage difficult subjects and re-formulate them in a way that is more manageable for the client. This is effective at keeping the therapist and the client on track. In a CPT intervention, therapists are trained to recognize client avoidance and remind them that avoidance is a mechanism to help maintain PTSD. Similarly, therapists must recognize their own behaviour around avoidance and how it might prevent the client from disclosing distressing events by discouraging them to share as a way to protect them from having to discuss difficult things (CPT Web, 2005).

I recognize that my previous experience working with children and youth resulted in using mixed methods to help them with coping strategies or behavioural modification. This is consistent with the literature that recognizes despite the availability of evidence-based practices in social work, they are not frequently used in child and youth mental health (Glisson, Williams, Hemmelgarn, Proctor, & Green, 2016). As a practitioner, this information was important as it highlights the significance of being critically reflective and following a trauma model to mitigate against both client and therapist avoidance. Although well intentioned, it has the potential of being damaging to the client if the therapist becomes overwhelmed or protective of distressing

information. The reality is that trauma treatment is complex and multi-layered and must be handled with a proper model to promote improved wellness for the client.

F: Reflections on Vicarious Trauma and Self-Care

Choosing trauma treatment as a professional focus for the advanced practicum was a decision based on professional practice and a lack of knowledge in the area. However, I was not naïve to the challenges that accompany trauma-focused work and the impact it would have on myself as a practitioner. Whether it would challenge me during the advanced practicum or in my future work in the field, vicarious trauma could affect my thoughts and emotions through the transfer of traumatic stress by listening to distressing clinical material (Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). I understand the importance of viewing myself as a holistic practitioner required to be physically, emotionally, spiritually and mentally balanced if I am going to work with individuals with PTSD. Although we cannot be expected to be well-adjusted all of the time, developing strategies of self-care to ensure personal wellbeing are essential when working in the field of trauma.

During my advanced practicum, professional support within the team was essential in ensuring that I was not isolated in my work. Daily huddles were an opportunity to quickly address challenging clinical issues and receive feedback from the team. It was also beneficial to hear concerns from the other therapists and have the team work together to create solutions. Weekly supervision was another mechanism to build professional resilience by having the opportunity to discuss difficult topics in a safe and supportive environment. Having the option of consultation is important as is the personal willfulness to use that resource in order to be a good practitioner. Self-efficacy is understood as a professional's confidence in their ability to treat

trauma victims, how they perceive the success of the intervention and rating their feelings of helplessness during the treatment (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015). Professional self-efficacy acted as a protective factor when working with individuals with PTSD due to the organizational support and personal coping strategies to manage self-care.

In my previous experience as a social worker in different agencies, it was common to have high caseloads and feel a professional obligation to provide service to clients, often at my own expense. The best advice I had ever received was from a professor at the School of Social Work at Lakehead University who spoke about the importance of self-care and how it is our duty as professionals to prioritize our personal wellbeing as a responsibility to the clients. She mentioned that if we are given vacation time, coffee breaks, lunch breaks and statutory holidays, to take them. This lesson has been at the forefront of my practice as a social worker and has been beneficial during my advanced practicum when learning about trauma-informed care. I have adopted mindfulness-based practices to help maintain self-care and keep me grounded between sessions. Learning diaphragmatic breathing, practicing workplace stretches and taking the opportunity to go for walks during breaks have been beneficial in distancing myself from traumatic information discussed in sessions. I have recognized the importance of practicing self-care both at work and at home; it must be constantly maintained.

G: Treatment Models used at MAP

Cognitive Behavioural Therapy (CBT)

The MAP team operates from a CBT framework in the design of the group therapy and individual sessions within the program. As a result of its strong empirical base, CBT is the preferred form of treatment for psychotherapies for the treatment of disorders and personal

challenges (Dobson, & Dobson, 2016). The majority of the groups within the MAP team are based on CBT principles with the focus on maladaptive thought processes and managing distressing emotions. Concepts of CBT are taught on the first session to affirm clients for attending group and to introduce them to the pattern of thoughts, emotions and how it impacts their behaviour. Refer to Figure 2 for a teaching on an exploration of thoughts, feelings and behaviours using CBT (Health Sciences North, 2015). CBT is effective in getting individuals to recognize unhelpful thought patterns, regardless of their diagnosis or presenting issues. It is the primary choice for the therapeutic framework at MAP because it is applicable to individuals struggling with anxiety, depression, bipolar disorder, OCD, BPD and challenges related to emotional regulation and impulsivity. Despite the diagnosis, individuals are given the tools to recognize and challenge automatic thoughts and recognize unhelpful thinking styles that result in maladaptive behaviours.

Figure 2: CBT Group Framework- Exploration of Thoughts, Feelings and Behaviours

(Health Sciences North, 2015)
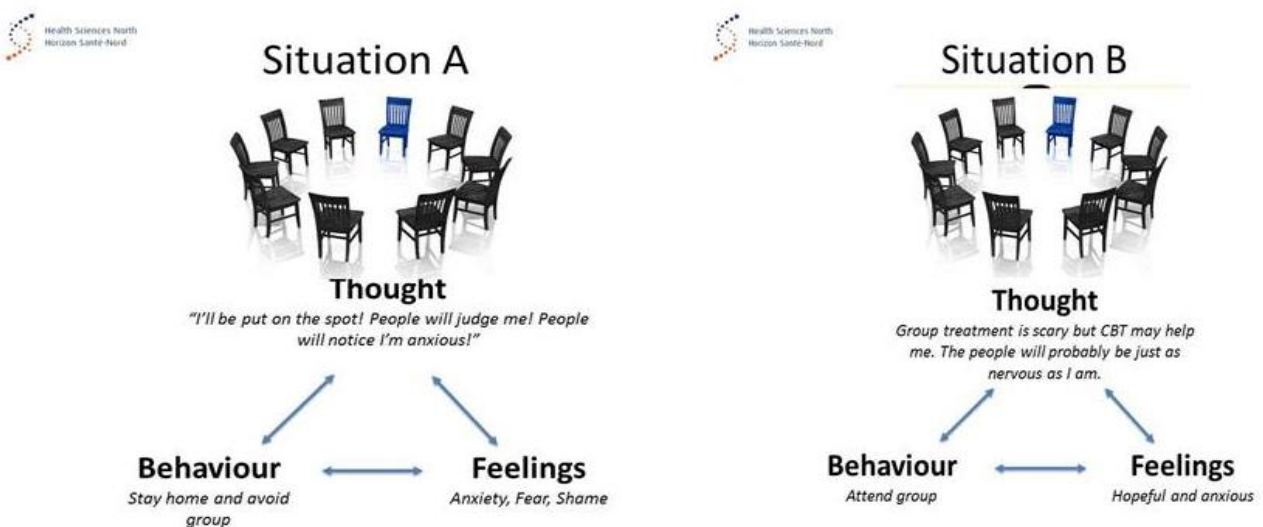
Dialectical Behavioural Therapy (DBT)

DBT is used in the Changing Behaviours group and the Mood/GAD group to teach individuals self-soothing techniques and the importance of distress tolerance. CBT is beneficial in learning to control emotional reactions to situations within the individual's control but DBT is useful when there are situations beyond an individual's control. Learning the concept of radical acceptance is recognizing the present situation without judgment and understanding that it is the result of a chain of events that began in the past and beyond your control (McKay, Wood, & Brantley, 2010). When individuals have reached a point of radical acceptance, they learn coping statements, distraction techniques and self-soothing skills to occupy their thoughts and manage their behaviours both at home and in public. DBT skills are often used at the end of therapy to help clients design their own relaxation plan when they are in situations they cannot avoid. Of particular importance are the radical acceptance coping statements that help individuals reach a point of acceptance that gives them permission to avoid fighting the inevitable and use reminders to activate the need for distraction techniques. See Figure 3 for coping statements (McKay, Wood, & Brantley, 2010, pp. 12-13).

Figure 3: DBT Coping Statements

- "This is the way it has to be."
- "All the events have led up to now."
- "I can't change what's already happened."
- "It's no use fighting the past."
- "Fighting the past only blinds me to my present."
- "The present is the only moment I have control over."
- "It's a waste of time to fight what's already occurred."
- "The present moment is perfect, even if I don't like what's happening."
- "This moment is exactly as it should be, given what's happened before it."
- "This moment is the result of over a million other decisions."

Mindfulness-Based Practice

Mindfulness-based practice was incorporated into every group session to give individuals the opportunity to practice being in the present moment with a non-judgemental awareness of their thoughts, emotions, body sensations and perceptions connected to the past or future (Garland, 2013). Mindfulness-based practice included grounding techniques and breathing strategies to help individuals focus on their breath and slow down their cognitions. Mindfulness included exercises on diaphragmatic breathing, counting breaths and practicing mindful meditation. Grounding techniques often included an object to help ground individuals to the present moment. Mindfulness was also incorporated into individual sessions where clients were taught a grounding exercise to slow down their breathing and their thoughts before going into distressing topics. This was beneficial with clients who were anxious coming in for individual sessions and it was also an opportunity for them to use those skills outside of therapy.

When working with individuals with OCD, mindfulness is beneficial at reducing symptoms of the disorder when individuals mindfully allow the 'peak moment' to pass and reduce their anxiety in the moment, decreasing the need to engage in certain behaviors (Westwood Anxiety Institute, 2007). Mindfulness is particularly useful for anxiety groups where individuals benefit from purposely paying attention to the present moment which leads to an increased awareness of personal thoughts. The connection between anxiety and mindfulness is important as discussed by Gause and Coholic (2010) when they state, "…this kind of paying attention to the present moment develops an ability to maintain focus, including attending to negative affect, physical sensations, or distressing thoughts, and a reduction of the tendency to attempt to control cognition and affect via thought suppression and avoidant coping" (p. 5). Mindfulness is an important strategy for individuals struggling with mental illness, specifically

PTSD because it gives them tools that they can use both in therapy and in their own lives. It equips them with control over their recovery process by creating their own plan of what works and what does not and empowers them to learn strategies on how to control their own distress in the moment. Realistically, therapeutic interventions are one part of recovery and clients need to be given tools on how to manage their own distress when groups and sessions are over.

IV: Application of Trauma Treatment Models

A: Individual Intake Sessions

The opportunity to conduct intake assessments upon a client's referral in the program was to assess the presenting problem and find a program that would be helpful in meeting their individual needs. Initially, I conducted the intakes with a checklist, making sure to cover all pertinent information which included presenting problem, substance use, coping strategies, suicidality, trauma exposure and protective factors. In my experience, asking individuals directly about trauma was often met with confusion or they were overwhelmed by the question. Younger clients often did not understand the questions and asked what I meant by 'trauma.' Although it is an important question to ask, I found that there was a way to approach it that would respect the individual and their experience.

Throughout the advanced practicum, I had the opportunity to consult the team and discover different ways of asking the question about trauma in a way that would not overwhelm the client or derail the conversation. Indirectly approaching the topic of trauma was beneficial when asking questions such as, 'have you experienced a very difficult situation before?', 'when you look back on your past, do you feel very angry about something or someone?' These were opportunities to approach the topic of trauma without asking the question directly. Many individuals are forthcoming about their traumatic experiences but many do not bring it up unless

it is addressed. It is important to discuss trauma in an intake assessment to understand whether it has a current impact on the client's mental health. Asking about trauma could also be explored by enquiring about the symptoms of PTSD such as re-experiencing a painful event, nightmares, avoiding situations that remind the individual of a certain event, hyperarousal, difficulty sleeping, trouble concentrating or being easily startled (U.S. Department of Veterans Affairs, 2015). By asking the client about their experience with specific symptoms of PTSD, it helps differentiate between the fear of judgment that comes from social anxiety and the fear of re-experiencing the trauma or seeing the attacker which is an anxiety symptom of PTSD.

In my experience conducting intake assessments with approximately twenty individuals over the course of my placement, it was evident that the majority of them had experienced at least one form of trauma in their lives. Many of them were referred to the program to see a psychiatrist with the hopes of receiving a PTSD diagnosis. In previous occupations, I felt that it was important to discuss the details of the trauma and give the client the opportunity to share their experience in a safe environment. I understand now the risks associated with discussing the trauma in full detail in an intake session. Having knowledge of the trauma is beneficial in understanding the client's experience, their healthy and unhealthy methods of coping and how it may have contributed to the presenting problem. It aids the practitioner in understanding the avenues of support for the individual. Within the MAP team, if an individual made a connection between their experience with trauma and current challenges, they were often a good candidate for the Seeking Safety group or PTSD Psychoeducational group. We were also connected to Voices for Women, a community organization that provides support services for women who have experienced sexual violence and would make referrals for female clients who disclosed sexual abuse. It was not beneficial to have the client discuss the details of their traumatic

experience(s) because the intake assessment has the goal of collecting information for program

placement and is not a therapy session. Encouraging the client to recount details of the trauma is

opening a door without follow-up support and can be damaging to the individual. Discussing

details of the trauma also has the potential of triggering the individual or cause them to re-

experience the event without a proper intervention plan.

B: Individual Trauma Treatment

Individual sessions started with a grounding exercise to orient the client to the present

space. Many of the PTSD clients also struggled with anxiety and mindfulness-based practice was

beneficial in bringing their attention to the present moment and to hold that experience with

openness and curiosity rather than judgement (Zoogman, Goldberg, Hoyt, & Miller, 2015).

Beginning an individual session with mindfulness decreases unhelpful ruminating thoughts

which improve the ability to regulate emotions and make clear choices about reacting to different

situations. Clients were appreciative of grounding strategies and used them outside of the session

when in distress. Diaphragmatic breathing and a grounding technique called 5-4-3-2-1 (Health

Sciences North, 2016) were beneficial to clients.

Figure 4: 5-4-3-2-1 Grounding Technique

Grounding to the Present

5   4   3   2   1

5 things you see

5 things you hear

5 things you feel (touch)
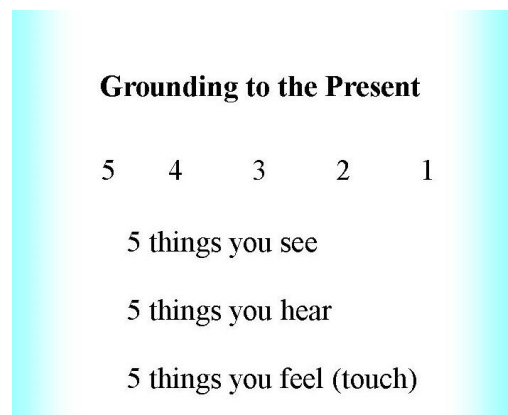
Mindfulness exercises were followed by a basic check-in where the client discussed challenges in the last week and they were explored using an extended thought record (see Appendix A) to identify the precipitating event that caused an emotional reaction based on automatic thoughts. The extended thought record is a CBT tool that is useful at teaching clients to challenge automatic thoughts and develop actions to decrease the intensity of their emotions. The extended thought records were beneficial at having clients identify anxiety around flashbacks and learning how to manage the intense emotions related to the flashback. The flashback protocol (Figure 5) was used as a grounding strategy for flashbacks or triggers to ground the client back to the present moment and manage daily symptoms of PTSD.

Figure 5: Flashback Protocol

Right now I'm feeling _____   (name emotion)

And I'm sensing in my body _____   (describe body
sensations)

Because I'm remembering _____   (name trauma NO
details)

Here _____   (name present location)

And I can see _____   (describe what you see
here now)

And so I know _____   is not happening now.

(Rothschild, 2000)

A useful grounding strategy for clients with PTSD who were triggered by nightmares related to the trauma involved dream re-scripting. This is an opportunity for individuals to

confront distressing dreams by re-writing the dream and regaining control of them. Nightmares can be vivid as if they are occurring in that moment which can be very distressing for an individual who is struggling with PSTD. Dream re-scripting helps the individual gain control of the dream by identifying the worst part of the dream, identifying any physical details related to the five senses, describing emotions and body-felt sensations both in the dream and when the individual wakes up. The restructuring component focuses on how the client would prefer to feel in that moment and how changing the sequence of events or the conclusion of the dream would impact their emotions (Kunze, Lancee, Morina, Kindt, & Arntz, 2016). This strategy was particularly beneficial with a client who had been managing her symptoms of PTSD but struggled with nightmares that created flashbacks of the trauma. Dream restructuring allowed her to fill in the blanks of her dream with something positive or funny, as opposed to feeling fear for missing details. She was also able to add less distressing details to the dream such as changing the colour of the room she was in, changing the colours of the clothes people were wearing and changing the dialogue from something negative or fear-inducing to something positive and hopeful.

A part of the individual trauma treatment sessions was to identify safety behaviours and how they are reinforcing avoidance and maintaining symptoms of anxiety related to the trauma. CBT interventions involved the identification of safety behaviours which are cognitive and behavioural strategies that help the individual decrease anxiety and reduce the likeliness of the feared event from occurring (Iverach & Rapee, 2014). This is crucial to creating a base for trauma work where it is common for clients to practice an avoidance of memories of the trauma because it decreases their level of distress or anxiety. However, distress is reduced only temporarily and strengthens avoidance behaviours that strengthen the PTSD (McLean & Foa,

2011). During individual sessions, safety behaviours such as carrying hand sanitizer to avoid fear

of sickness, requiring medication to go out in public and avoiding eye contact were identified

and included as part of the treatment. They are important to identify because they undermine the

individual's progress with other exposures related to the trauma. As a practitioner, it is important

to identify whether the person is engaging in the behaviour as a result of hypervigilance which is

a symptom of PTSD where the individual overestimates the potential for danger. The

identification of safety behaviours can be listening for cues from the individual on how they are

coping on a daily basis or to ask questions such as, 'Is there anything you're doing while you're

doing your exposures that helps to make you feel safer?' This gives the client the opportunity to

identify safety behaviours without judgement or fear of saying the wrong thing.

I had the opportunity to observe CPT treatment with an individual who had a diagnosis of

PTSD and had experienced multiple traumas over the course of her life. The sessions began with

identifying avoidance and discussing the importance of tackling avoidance. This was also a

chance to introduce the client to CPT treatment and do a psychoeducation piece on the symptoms

of PTSD. The life work for the first session was to compose an impact statement which is a one

page personal narrative where the client writes about why s/he believes the trauma occurred and

how it has affected her or his thoughts and perceptions about the self and others (Boyd, Rodgers,

Aupperle, & Jak, 2016). The impact statement also included any areas about trust issues, safety

and self-esteem that were impacted by the event. In the following session, the client read the

impact statement which was followed by a discussion on the meaning of the trauma. This is an

opportunity for the practitioner to identify stuck points which are strong negative beliefs that

cause the client to feel unpleasant emotions or engage in unhealthy behaviour (Resick, Monson,

& Chard, 2014). For example, a strategy was to recognize the difference between power and

control by having positive power rather than negative power when s/he felt that something was taken away from her or him. It was an opportunity for the client to see that people have both good and bad sides and to increase their level of positive power by disconnecting themselves from the other person's behaviour by taking themselves out of the equation.

The A-B-C Worksheet (See Appendix B) was given to the client to begin to identify the relationship between their thoughts, feelings and behaviours. The worksheet was assigned as lifework to be completed once a day, including one that is specific to the identified trauma. When working with individuals with multiple traumas, it is important to focus on one trauma at a time to isolate the specific thoughts and feelings associated with that experience and not confuse them with distressing feelings related to other traumatic experiences. The ABC worksheet was beneficial at decreasing the intensity of emotions related to triggers of the traumatic experience. The client was able to manage difficult emotions with greater ease the more that she applied the ABC worksheet to her weekly challenges. The client also used this tool to the application of positive experiences and noticed an increase in positive emotions when she challenged her automatic thoughts about different situations. At this stage, it was important to focus on the thoughts and not the emotions. When the client became overly distressed recalling difficult automatic thoughts, she used an object the therapist had in her office to hold in order to ground her to the present moment. She benefitted from having something concrete to hold onto while she was emotionally activated and was able to put it away after the moment had passed.

Recurring automatic thoughts for example, "I'm not good enough" have the illusion that they are true when they are not challenged. This is an example of an unhelpful thinking style known as emotional reasoning when individuals make conclusions based on their emotional response to a situation (Verduijn, Vincken, Meesters, & Engelhard, 2015). Identifying stuck

points in the impact statement also uncovered feelings of anger at themselves or others regarding what they 'should' have done or what 'should' have happened. This is an example of manufactured emotions which are feelings that have come up as a result of thoughts related to the trauma or as an interpretation of the event. Natural emotions are feelings that come right after an event and would be experienced by the majority of people (Konig, 2015). At this point it was important to remind the client that every trauma has a closing point where it is no longer traumatic anymore. Being able to process difficult feelings related to the trauma helps in reducing their intensity so that they become easier to manage. During trauma treatment, it was important to be aware of assimilation which is the interpretation of an event so that it fits into a schema. For example, a common thought amongst veterans is 'if everybody does their job properly, nobody will die' (Konig, 2015). Giving up these beliefs can cause fear for the client and result in self-blame. When being confronted with assimilation, it was important to help the client differentiate between responsibility and blame.

C: Group Trauma Treatment

The PTSD Psychoeducational group met for 6 sessions to discuss challenges related to PTSD and how to learn positive coping strategies to manage triggers. On the first session, it was important to establish ground rules, especially for a group specific to individuals with PTSD. During the discussion on group safety guidelines, it was crucial to highlight that details of the trauma are not shared during group sessions to avoid triggering other participants and also because the group is not trauma treatment and there are not enough facilitators to disclose trauma details. It was also stated that participants can participate at their own level and take time if needed. This was important in the PTSD group because there were moments or specific sessions when participants had a difficult time sharing. Creating these terms was beneficial to the

participants because they knew that they were accepted even if they had a difficult time speaking

that day. This was particularly true for the individuals were still experiencing their trauma daily.

The group was based on Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and

focused on how the traumatic event changes thought processes which create strong emotional

reactions and result in the individual re-experiencing the trauma as if it is happening in real time

(see Figure 6). This diagram also illustrates the reality that avoidance of trauma reminders does

not prevent the individual from re-experiencing the trauma or from affecting their cognitive

processes (Ehlers & Clark, 2000).

Figure 6: Trauma and Avoidance Cycle (Ehlers & Clark, 2000).
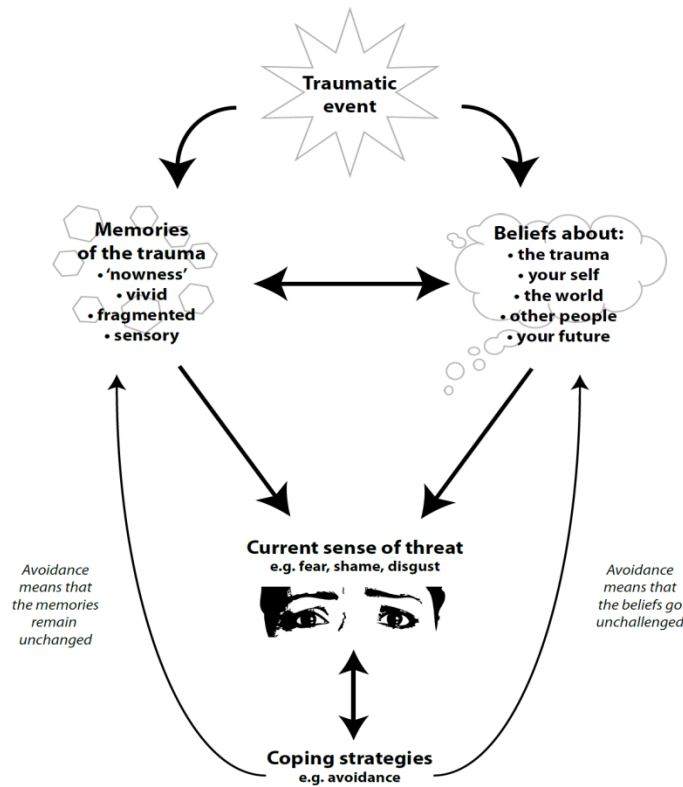
Avoidance means that thoughts and memories remain unchallenged and continue to cycle

through until they are acknowledged. Participants shared that it is much easier to push everything

54

down and keep going than face it directly. TF-CBT helps individuals begin to deconstruct those memories and thoughts by challenging the long-term benefits of avoidance.

A worksheet was given to the participants to have them personally identify how they have re-experienced trauma memories, felt an increased sense of threat and/or vigilance, avoided reminders of the trauma, changed beliefs about themselves or others and how their daily functioning has been impacted (Mood and Anxiety Program, 2017). I had the opportunity to facilitate a psychoeducation piece on the whiteboard about avoidance with the group. Participants shared coping mechanisms they used to manage the trauma such as drinking wine, talking to a friend, doing things for others and pushing the memories away. Then participants shared the short-term and long-term impacts of the coping mechanisms and whether it contributes to the perpetuation of PTSD symptoms. They were able to identify short term benefits of certain coping mechanisms (e.g. drinking wine) because it reduces anxiety and gives them a sense of relief in the moment but it affects them long term (e.g. dependence on alcohol, depresses the nervous system). Active coping is used in TF-CBT to empower individuals to cope with their stress reactions by accepting the impact of the trauma and actively taking steps to reduce the intensity of the impact (U.S. Department of Veteran's Affairs, 2016). During the group check-in, a participant shared that he has accepted that the trauma will always be a part of him but that he can decide how much he is going to let it affect his daily living.

Once participants had completed the group, they were offered a one-on-one exit interview to discuss their experience with the group and to assess their readiness for trauma treatment. Individuals filled out a form to establish stability criteria for PTSD treatment (Mood and Anxiety Program, 2017) and answered the followed questions:

- Have you been free from suicide attempts and in-patient psychiatry admissions in the last 6 months?

- Are self-harming and risky behaviours under control? Is solid safety and relapse prevention plans in place?

- Are you in objectively safe surroundings (e.g. not currently a victim of domestic abuse)?

- Are you in the midst of a major life crisis that increases distress (e.g. divorce)?

- Are you willing to tolerate a worsening of anxiety?

- Are you willing to intentionally focus on trauma for the purpose of treatment?

The stability criteria was a mandatory tool used to evaluate whether a person was ready for PTSD treatment. If they answered no to any of the questions, it was explored with a therapist during the exit interview to establish readiness. This was important to understand that although an individual has a diagnosis of PTSD and attended the PTSD Psychoeducational group, they may not be ready for individual trauma treatment. The exit interviews showed a range of readiness amongst participants based on the questions that were answered on the stability criteria tool. Many of the individuals had received some form of trauma treatment prior to engaging with the MAP team.

Unfortunately, the accessibility of trauma treatment was challenging due to cost or availability of treatment in out-patient settings. This is consistent with the research on availability of PTSD treatment as a major barrier in recovery with the availability of mental health treatment being the subject of criticism (Galea et al., 2012). It was evidenced by this group that the majority of people only receive help later in life, if at all. This could be attributed to a variety of factors such as client readiness, availability of treatment and accessibility. Mott, Stanley, Street, Grady, and Teng (2014) also identify barriers such as physical distance, stigma

around mental health and an insufficient understanding of treatment options and how they can be helpful. Individuals in the group had the opportunity to participate in an intensive trauma treatment in inpatient residential care but lacked a follow-up treatment in the community that they could afford. It can also be noted that the majority of the individuals who accessed the PTSD Psychoeducational group were not working due to symptoms of PTSD and/or anxiety which also creates a barrier for treatment options.

When assessing client readiness for PTSD treatment, it was evident that most of the participants struggled with anxiety. There was also the presence of suicidal thoughts as many individuals were trying to get through 'one day at a time.' Assessing their stability criteria was challenging because engaging in treatment had the potential to increase anxiety and suicidality but it also had the potential to significantly decrease it as memories and thoughts related to the trauma were managed. Self-determination is a concept that refers to an individual's autonomy and respect for the right for them to make their own decisions. This was important in discussing options for treatment because it gave the individual the autonomy to make the decision for themselves based on the information that was presented to them. During the exit interviews, there were times when it appeared that certain individuals were not ready for treatment due to high anxiety or recent life changing circumstances (e.g. the end of a relationship). Despite suggestions that it might be beneficial to engage in treatment at a better time, they insisted that they were ready for treatment. In these cases, it was beneficial to explore protective factors and assess whether the client had the capacity to participate in treatment and external support to withstand 18-20 sessions of trauma treatment. As a social worker, it was important to make recommendations but honour the self-determination of the client by empowering them to make

their own choices. In this way, the practitioner is not seen as the expert and gives the client the power to make decisions about their own mental health.

Introducing clients to exposures was a large part of the CBT treatment models with MAP. Exposures are gradual activities that make people feel anxious that need to be sustained for at least thirty minutes to communicate to the brain and body that the person is not in danger (Mood and Anxiety Program, 2016). Exposures are designed in a hierarchy according to the intensity of the anxiety when participating in that particular activity. The idea is that over time, the mind and the body will adjust to the situation through repeated and prolonged exposure to the event; for example, talking to people. A participant created a hierarchy about his fear of attending group sessions and stated that he rated his anxiety at 100/100. The exposure hierarchy gave him an opportunity to create steps that would ease his anxiety into attending group. For example, walking down the street, sitting at the bus station, walking through the mall or saying hello to a stranger were repeated steps that he could take to decrease the intensity of his anxiety regarding group. This is relevant to trauma treatment because prolonged exposure therapy is used in a similar fashion through imaginal exposure which is when the therapist and client revisit the memory and recount details of the traumatic memory and processing the thoughts and feelings related to this memory (Foa et al., 2013). The idea is that the traumatic memory becomes less distressing over time the more the client exposes herself or his self to it in a safe setting. This was also exemplified with the use of the trauma narrative used in CPT where the client is given multiple opportunities to read and hear the story of their trauma to reduce the rate of distress.

D: Interprofessional Collaboration

During my advanced practicum, I had the opportunity to work with a multidisciplinary

team of professionals who had expertise in different areas of mental health. It was through this

experience that I had the opportunity to consult with individuals who had different perspectives

on areas that affect an individual's mental health. It was common for clients to come into the

program with health anxiety which can be defined as the fear of having a serious disease or

medical issue that is persistent despite appropriate medical reassurance (McManus, Muse,

Surawy, Hackmann, & Williams, 2015). I had little experience in this area and it was beneficial

to work with a clinical nurse specialist who could provide a medical understanding of the client's

somatic symptoms and work with them on creating exposures that would involve a decrease in

consulting doctors, taking medication or checking online databases about different illnesses.

Working with the clinical nurse specialist was also beneficial when clients would ask specific

questions about medications they were on and how it affected the way they were feeling or their

experiences with different side effects. The clinical nurse specialist was able to provide the client

with knowledge about the medication and meet with them individually if they had other

concerns. This was beneficial for the client who may not have the resources to go out into the

community and get answers from different professionals. There were advantages to being in one

location and providing holistic care to the clients. The resident psychometrist was available for

consultations regarding diagnoses with his vast knowledge of the DSM-IV. The visiting

psychiatrists met with PTSD clients often to provide them with a diagnosis or to help them create

an intervention plan regarding their mental health concerns. It was beneficial to participate in

team meetings with all of the professionals present and understand client challenges from

different perspectives. It also provided me with a different knowledge set that I had not

considered since the majority of my knowledge has come from social work education and social service agencies where I only worked with social workers.

As a social work student, it was also beneficial for me to appreciate the contributions of different professionals that I had not been exposed to before. I was ignorant about the roles of different health care professionals and it was very important to be working together as a part of one team to fully understand how each professional can contribute to the field of mental health. The clinical nurse specialist had been working in mental health for 14 years and had the same level of understanding that the social workers did about meeting client needs. She also provided group sessions with different perspectives and knowledge that was beyond my scope of practice in social work. Observing facilitation of the anxiety group by a social worker and an occupational therapist provided me with a different perspective on the delivery of mental health services and how we all operate from a variety of knowledge bases. I understand that the literature discusses challenges related to interprofessional collaboration but in my experience, if all of the team members are working towards the same goal and practice effective communication, it can be a very pleasant experience.

V: Implications for Social Work Practice

The purpose of the advanced practicum with the Mood and Anxiety Program at Heath Sciences North was to gain a better understanding of the trauma treatment through interprofessional collaboration. As a social worker fairly new to the field, I had a need to have an in-depth understanding of how to provide support to individuals with PTSD and the options available to people with this diagnosis. In my experience, entry-level social workers have little knowledge about working with PTSD and trauma exposure is often the driving force of many

presenting issues for individuals struggling with mental health issues. Although there has been

attention given to traumatic stress in the literature, there is a lack of emphasis on training in

trauma theory and trauma treatment for social workers (Strand, Abramovitz, Layne, Robinson, &

Way, 2014). It is important for MSW students to be trained in trauma-informed practice because

of the growing need of people requiring trauma treatment in the community.

As described by Strand, Abramovitz, Layne, Robinson & Way (2014), "Because social

workers frequently interact with trauma-exposed clients, it is important to educate students

within the profession to become confident and competent in exploring, assessing, and treating

trauma-exposed clients and the debilitating emotional and behavioral conditions created by

traumatization" (p. 120). The practicum was also a valuable experience to learn the importance

of interprofessional collaborative trauma-informed care and how beneficial it is to clients to have

access to a variety of services and professions under one roof. This is particularly important in

the field of social work where a lot of the clients are already accessing different services and may

have physical or mental health challenges in making appointments and getting the support they

need. Despite the focus of treatment, the priority is in creating an environment and a treatment

approach that values a client-centered approach to mental health care.

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Appendix A: Extended Thought Record (Mood and Anxiety Program, 2015)

SITUATION (trigger) (What was happening?)	EMOTIONS (Write the emotions)	INTENSITY (Rate the intensity of the emotions) (1-10)	BODILY FELT SENSATION (Where in your body did you feel the emotions?)

AUTOMATIC THOUGHTS (What went through your mind?)	THINKING STYLES (see thinking style types)	Is this thought: • **True** • **Partly true but distorted** • **Not true at all**
		Unhelpful Thinking Styles: **#1 – All or nothing** **#2 – Mental filter** **#3 – Jumping to conclusions** **#4 – Emotional reasoning** **#5 – Labelling** **#6 – Over-generalizing** **#7 – Disqualifying the positive** **#8 – Catastrophizing** **#9 – Shoulds & musts** **#10 – Personalization**

CHALLENGE (reappraisal) What is the evidence? What is an alternative explanation? So what…now?	ACTION TO TAKE How can you test this out to improve the situation now or next time?	OUTCOME (List and re-rate the emotions) (1-10)

Appendix B: A-B-C Worksheet

Date: _____   Name: _____

ACTIVATING EVENT A "Something happens."	BELIEF/STUCK POINT B "I tell myself something."	CONSEQUENCE C "I feel something."

Are my thoughts above in "B" realistic?

_____

What can you tell yourself on such occasions in the future?

_____
_____
_____

(Resick, Monson, & Chard, 2014, p.25).