**Building a Trauma-Informed Practice & Telehealth**

**A Comprehensive 6-Hour Continuing Education Course for Mental Health Professionals**

**Course Introduction and Overview**

**Welcome and Course Framework**

Welcome to "Building a Trauma-Informed Practice & Telehealth," a comprehensive 6-hour continuing education course designed to transform how you understand, approach, and deliver mental health services in our increasingly digital and trauma-aware world. This course represents a critical intersection of two fundamental shifts in mental health care: the widespread adoption of trauma-informed approaches and the rapid expansion of telehealth services.

As mental health professionals, we stand at a unique moment in history. The global pandemic accelerated telehealth adoption by decades in mere months, while simultaneously creating widespread collective trauma and highlighting pre-existing disparities in mental health access. This course equips you with the knowledge, skills, and practical tools to navigate this new landscape with confidence and competence.

**Course Learning Objectives**

By the completion of this 6-hour course, participants will be able to:

1. **Define and implement** the six core principles of trauma-informed care across various practice settings
2. **Identify and assess** trauma responses using evidence-based screening tools and clinical observation
3. **Develop and maintain** a trauma-informed telehealth practice that ensures safety and accessibility
4. **Apply culturally responsive** trauma-informed interventions that honor diverse healing traditions
5. **Navigate ethical and legal considerations** specific to trauma-informed telehealth services
6. **Create organizational policies** that support trauma-informed practices and prevent retraumatization

**The Convergence of Trauma-Informed Care and Telehealth**

The integration of trauma-informed principles with telehealth delivery represents more than a simple combination of two approaches—it's a fundamental reimagining of therapeutic engagement. Consider this scenario that illustrates the complexity:

*Sarah, a 34-year-old survivor of domestic violence, sits in her car for her therapy session. It's the only place she feels safe from her partner's surveillance. Her therapist, Dr. Martinez, notices Sarah's hypervigilance through the screen—the constant checking of mirrors, the startle response to passing cars. Traditional office-based trauma therapy would miss these environmental cues that reveal so much about Sarah's daily reality.*

This vignette highlights how telehealth can actually enhance trauma-informed practice when approached thoughtfully, providing windows into clients' lived experiences that office visits might never reveal.

**Module 1: Foundations of Trauma-Informed Care**

**Duration: 60 minutes**

**Understanding Trauma: Beyond DSM Definitions**

**Trauma Defined:** While the DSM-5-TR provides specific criteria for trauma and stress-related disorders, trauma-informed care adopts a broader, more inclusive understanding. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma through the "Three E's":

1. **Event(s):** An event, series of events, or set of circumstances
2. **Experience:** Experienced by an individual as physically or emotionally harmful or life-threatening
3. **Effects:** Having lasting adverse effects on functioning and mental, physical, social, emotional, or spiritual well-being

This definition intentionally moves beyond single-incident trauma to encompass complex developmental trauma, historical trauma, intergenerational trauma, and systemic oppression. Dr. Bessel van der Kolk's groundbreaking work "The Body Keeps the Score" emphasizes that trauma literally reshapes both body and brain, compromising sufferers' capacities for pleasure, engagement, self-control, and trust.

**The Neurobiology of Trauma**

Understanding trauma's neurobiological impact is essential for effective intervention. When we experience trauma, our brain's alarm system—primarily the amygdala—becomes hyperactive while the prefrontal cortex, responsible for executive functioning and emotional regulation, goes offline. This isn't a character flaw or weakness; it's evolutionary survival programming.

**The Triune Brain Model in Practice:**

Consider this clinical dialogue that demonstrates neurobiological understanding:

*Client: "I know logically that I'm safe now, but my body doesn't believe it. I feel so stupid."*

*Therapist: "What you're describing makes perfect neurobiological sense. Your amygdala—your brain's smoke detector—is still on high alert from past danger. It's trying to protect you. The thinking part of your brain knows you're safe, but trauma responses happen in a part of the brain that doesn't speak the language of logic. That's why we'll work with both your body and mind in healing."*

This response validates the client's experience while providing psychoeducation that reduces shame and self-blame.

**The Window of Tolerance**

Dr. Daniel Siegel's concept of the "Window of Tolerance" provides a practical framework for understanding trauma responses. Within this window, we can experience emotions without becoming overwhelmed. Trauma shrinks this window, causing people to oscillate between hyperarousal (anxiety, panic, racing thoughts) and hypoarousal (numbness, disconnection, depression).

**Clinical Application:** In telehealth sessions, teaching clients to recognize their window of tolerance becomes particularly crucial. Without physical presence, we must rely on verbal and visual cues:

* **Hyperarousal indicators on screen:** Rapid speech, visible tension, frequent position changes, shallow breathing visible in chest movement
* **Hypoarousal indicators on screen:** Flat affect, delayed responses, seeming "zoned out," minimal eye contact with camera

**The Six Core Principles of Trauma-Informed Care**

SAMHSA identifies six key principles that should guide trauma-informed approaches:

**1. Safety**

Physical and emotional safety forms the foundation. In practice, this means:

* Predictable session structures
* Transparent communication about treatment processes
* Respect for personal space and boundaries
* In telehealth: Ensuring private, secure platforms and discussing safety planning for home environments

**2. Trustworthiness and Transparency**

Building trust requires:

* Clear communication about policies and procedures
* Consistency in approach and availability
* Transparency about limitations and boundaries
* Following through on commitments

**3. Peer Support**

Recognizing that healing happens in relationship:

* Validating shared experiences
* Facilitating connection with others who've experienced trauma
* Supporting group interventions when appropriate
* Creating virtual support networks in telehealth settings

**4. Collaboration and Mutuality**

Power differentials can trigger trauma responses:

* Shared treatment planning
* Recognizing clients as experts on their own lives
* Eliminating "we/they" divisions
* Collaborative decision-making about telehealth versus in-person sessions

**5. Empowerment, Voice, and Choice**

Prioritizing client empowerment:

* Offering choices whenever possible
* Recognizing and building on strengths
* Supporting client self-advocacy
* Providing options for session format, timing, and modality

**6. Cultural, Historical, and Gender Issues**

Acknowledging identity and context:

* Understanding historical trauma's impact
* Recognizing systemic oppression as traumatic
* Incorporating cultural healing practices
* Addressing technology access disparities in telehealth

**Types of Trauma: A Comprehensive Framework**

**Acute Trauma**

Results from a single incident such as:

* Accidents
* Natural disasters
* Violent attacks
* Medical emergencies

*Clinical consideration:* Acute trauma may resolve with appropriate support, but can develop into PTSD if unprocessed.

**Chronic Trauma**

Results from repeated and prolonged exposure:

* Domestic violence
* War
* Long-term abuse
* Bullying

*Clinical consideration:* Chronic trauma often results in complex presentations requiring longer-term intervention.

**Complex Trauma**

Exposure to multiple traumatic events, often invasive and interpersonal:

* Childhood abuse and neglect
* Concentration camp experiences
* Human trafficking
* Organized abuse

*Clinical consideration:* Complex trauma affects development, attachment, and self-concept, requiring specialized approaches.

**Developmental Trauma**

Disruptions in early attachment and caregiving:

* Neglect
* Separation from caregivers
* Multiple placement changes
* Caregiver mental illness or substance abuse

*Clinical consideration:* Impacts fundamental organizing systems and requires developmentally-informed intervention.

**Historical and Intergenerational Trauma**

Trauma experienced by groups that affects subsequent generations:

* Slavery and its aftermath
* Genocide
* Colonization
* Forced migration

*Clinical consideration:* Requires understanding of collective healing and cultural restoration.

**Trauma Responses: Beyond Fight, Flight, and Freeze**

While the classic trauma responses of fight, flight, and freeze are well-known, contemporary understanding includes:

**Fawn Response**

Developed by Pete Walker, the fawn response involves:

* People-pleasing behaviors
* Difficulty setting boundaries
* Over-accommodation of others' needs
* Conflict avoidance at personal cost

*Clinical vignette:* *"Maria constantly apologizes during sessions, even for showing emotion. She asks repeatedly if she's 'doing therapy right' and becomes visibly anxious when expressing any disagreement. This fawn response developed as a survival strategy in an unpredictable childhood home."*

**Submit/Collapse**

A dorsal vagal response involving:

* Complete shutdown
* Dissociation
* Feeling "not real"
* Physical immobility

**Implementing Trauma-Informed Principles in Practice**

**Creating Safety in Every Interaction:**

Consider this intake dialogue demonstrating trauma-informed principles:

*Therapist: "Before we begin, I want you to know that you're in charge of how much or how little you share today. We can pause anytime you need, and you don't have to answer any question that doesn't feel right. Would it help to know what we'll cover in this session?"*

*Client: "Yes, that would help."*

*Therapist: "We'll spend about 45 minutes together. I'll ask about what brings you here, your goals for therapy, and some background information. But remember, 'I'm not ready to discuss that' is always a valid answer. How does that sound?"*

This approach provides predictability, choice, and control—essential elements for trauma survivors.

**Module 1 Quiz**

**Question 1:** According to SAMHSA's definition, trauma is characterized by the "Three E's." Which of the following is NOT one of these E's? a) Event b) Exposure c) Experience d) Effects

**Answer: b) Exposure** *Explanation: SAMHSA's Three E's of trauma are Event, Experience, and Effects. "Exposure" is not part of this framework. The model emphasizes that trauma involves an event or series of events, how the individual experiences these events (as harmful or threatening), and the lasting adverse effects on functioning and well-being.*

**Question 2:** The "fawn" trauma response, identified by Pete Walker, primarily involves: a) Aggressive behavior toward perceived threats b) Running away from dangerous situations c) People-pleasing and over-accommodation behaviors d) Complete physical and emotional shutdown

**Answer: c) People-pleasing and over-accommodation behaviors** *Explanation: The fawn response is characterized by people-pleasing, difficulty setting boundaries, conflict avoidance, and over-accommodation of others' needs. This response often develops as a survival strategy in childhoods where appeasing caregivers was necessary for safety.*

**Question 3:** Which trauma-informed care principle specifically addresses the need to recognize and respond to the impact of systemic oppression and historical trauma? a) Safety b) Peer Support c) Cultural, Historical, and Gender Issues d) Trustworthiness and Transparency

**Answer: c) Cultural, Historical, and Gender Issues** *Explanation: This principle acknowledges that trauma often occurs within cultural and historical contexts, including systemic oppression, historical trauma, and discrimination. It emphasizes the need for culturally responsive services that recognize how identity, culture, and historical factors influence trauma and healing.*

**Module 2: Assessment and Screening for Trauma**

**Duration: 60 minutes**

**The Art and Science of Trauma Assessment**

Trauma assessment requires a delicate balance between thoroughness and safety. Unlike traditional diagnostic assessments that prioritize symptom identification, trauma-informed assessment prioritizes the therapeutic relationship and client safety. The goal isn't just to identify trauma but to do so in a way that doesn't retraumatize.

**Universal Trauma Screening: Assuming Trauma**

The paradigm shift from "What's wrong with you?" to "What happened to you?" fundamentally changes assessment approaches. Universal trauma screening operates from the assumption that trauma is prevalent rather than exceptional. Research indicates that:

* **70% of adults** in the U.S. have experienced at least one traumatic event
* **90% of clients** in public behavioral health services have experienced significant trauma
* **Childhood trauma** increases the risk of adult mental health issues by 2-4 times

**Evidence-Based Screening Tools**

**The Adverse Childhood Experiences (ACEs) Questionnaire**

The original ACEs study identified ten categories of childhood adversity. While revolutionary, the traditional ACEs has limitations—it doesn't capture experiences like racism, poverty, or community violence. The Expanded ACEs addresses these gaps.

**Clinical Application in Telehealth:**

*Therapist: "I'd like to share my screen to go through a questionnaire together. This isn't a test—there are no right or wrong answers. We can skip any questions, and we can stop anytime. Would you prefer to answer verbally, or would you like me to send you the form to complete privately first?"*

This approach offers choice and control, essential for trauma survivors.

**The BRFSS Adverse Childhood Experiences (ACE) Module**

A more comprehensive tool that includes:

* Physical abuse
* Sexual abuse
* Emotional abuse
* Physical neglect
* Emotional neglect
* Household mental illness
* Household substance abuse
* Household domestic violence
* Incarcerated household member
* Parental separation/divorce

**Scoring Considerations:** Higher ACE scores correlate with increased health risks, but the score itself doesn't determine individual outcomes. Resilience factors significantly influence trajectory.

**The Trauma Screening Questionnaire (TSQ)**

A brief 10-item screening tool for PTSD that can be administered in under 5 minutes. Items assess re-experiencing and arousal symptoms:

Sample items:

* Upsetting thoughts or memories about the event
* Bad dreams or nightmares
* Feeling jumpy or being startled easily
* Difficulty concentrating

**Telehealth Consideration:** The TSQ can be administered via secure form prior to sessions, allowing discussion time for processing results.

**The PC-PTSD-5 (Primary Care PTSD Screen)**

A 5-item screen designed for primary care settings, easily adapted for mental health intake:

1. Had nightmares or intrusive thoughts?
2. Avoided situations that remind you?
3. Been on guard or hypervigilant?
4. Felt numb or detached?
5. Felt guilt or blame?

**Scoring:** A positive response to 3 or more items suggests need for comprehensive assessment.

**Comprehensive Trauma Assessment Tools**

**The Clinician-Administered PTSD Scale (CAPS-5)**

The gold standard for PTSD diagnosis, the CAPS-5 provides:

* Diagnostic status
* Symptom severity
* Functional impairment assessment
* Dissociative subtype identification

**Telehealth Adaptation:** The structured interview format translates well to video platforms, though observations of body language may be limited.

**The Dissociative Experiences Scale (DES)**

Critical for identifying dissociative symptoms often present in complex trauma:

* Depersonalization
* Derealization
* Dissociative amnesia
* Identity confusion

**Clinical Dialogue Example:**

*Therapist: "Some people who've experienced trauma describe feeling disconnected from themselves or their surroundings. Have you ever felt like you were watching yourself from outside your body?"*

*Client: "Yes! I thought I was going crazy. It happens when I'm stressed."*

*Therapist: "That's actually a protective response your mind developed. It's called dissociation, and it's your brain's way of managing overwhelming experiences. How often would you say this happens?"*

**Cultural Considerations in Trauma Assessment**

**The Cultural Formulation Interview (CFI)**

The DSM-5's CFI provides a framework for culturally sensitive assessment:

1. **Cultural Definition of the Problem**
   * How does the client's culture understand their difficulties?
   * What terms or concepts does their community use?
2. **Cultural Perceptions of Cause**
   * What does the client believe caused their problems?
   * How do family/community members explain it?
3. **Cultural Factors Affecting Coping**
   * What sources of strength exist in their culture?
   * What cultural practices provide healing?
4. **Cultural Factors Affecting Help-Seeking**
   * What has prevented or facilitated getting help?
   * How does their culture view mental health treatment?

**Case Example:**

*"Maria, a 45-year-old Latina woman, describes 'ataque de nervios' rather than panic attacks. Her therapist recognizes this culturally-bound syndrome that encompasses anxiety, dissociation, and somatic symptoms. Instead of imposing Western diagnostic categories, the therapist explores: 'Tell me more about what ataque de nervios means in your family. How have other women in your family coped with this?'"*

**Assessing Complex and Developmental Trauma**

**The International Trauma Questionnaire (ITQ)**

Designed to assess both PTSD and Complex PTSD (CPTSD), measuring:

* Core PTSD symptoms (re-experiencing, avoidance, hypervigilance)
* Disturbances in self-organization (affect dysregulation, negative self-concept, interpersonal difficulties)

**The Developmental Trauma Disorder Semi-Structured Interview (DTD-SI)**

For assessing developmental trauma in children and adolescents:

* Exposure to interpersonal trauma
* Triggered dysregulation
* Attentional and behavioral dysregulation
* Self and relational dysregulation

**Trauma Assessment in Special Populations**

**Children and Adolescents**

Special considerations include:

* Developmental appropriateness of measures
* Caregiver involvement versus client privacy
* Non-verbal assessment methods (play, art)
* School-based trauma impacts

**Telehealth Technique:** *"Would you like to show me your room? Sometimes seeing where you spend time helps me understand you better. You can show me anything you'd like—your artwork, pets, or favorite things."*

**Older Adults**

Unique factors include:

* Cohort effects on trauma disclosure
* Medical comorbidities
* Cognitive considerations
* End-of-life trauma reactivation

**LGBTQIA+ Individuals**

Additional screening considerations:

* Minority stress and discrimination
* Family rejection trauma
* Violence related to identity
* Medical trauma from discriminatory care

**The Assessment Process: Phase-Oriented Approach**

**Phase 1: Stabilization and Safety Assessment**

Before deep trauma exploration:

* Current safety assessment
* Support system evaluation
* Coping resource inventory
* Psychoeducation about trauma responses

**Safety Planning in Telehealth:**

*Therapist: "Before we continue, I need to ensure you're in a safe, private space. Are you alone? Is your door locked? Do you have your coping tools nearby? Let's also confirm your current location in case we need emergency services."*

**Phase 2: Trauma Narration and Processing**

Only when stabilized:

* Gradual trauma exploration
* Titrated exposure
* Window of tolerance monitoring
* Integration of narrative

**Phase 3: Reconnection and Integration**

Focus on:

* Meaning-making
* Post-traumatic growth identification
* Future orientation
* Relapse prevention

**Documentation and Ethical Considerations**

**Trauma-Informed Documentation Principles:**

1. **Factual, non-judgmental language**
   * Instead of: "Client was dramatic and attention-seeking"
   * Write: "Client exhibited elevated emotional expression and frequently sought reassurance"
2. **Strength-based observations**
   * Include resilience factors
   * Note coping strategies
   * Document progress and growth
3. **Privacy considerations**
   * Minimum necessary information
   * Consider who may access records
   * Protect sensitive trauma details

**Red Flags and When to Pause Assessment**

Stop or slow assessment when observing:

* Severe dissociation
* Panic symptoms
* Suicidal ideation emergence
* Flooding or overwhelm
* Inability to return to baseline

**Clinical Response:** *"I'm noticing you seem overwhelmed. Let's pause here and focus on grounding. Can you tell me five things you see in your room right now?"*

**Module 2 Quiz**

**Question 1:** The paradigm shift in trauma-informed assessment is best represented by changing the question from "What's wrong with you?" to: a) "How can I diagnose you?" b) "What happened to you?" c) "What symptoms do you have?" d) "How severe is your trauma?"

**Answer: b) "What happened to you?"** *Explanation: This fundamental shift recognizes that symptoms and behaviors often make sense in the context of what a person has experienced. It moves from a deficit-based medical model to an understanding that acknowledges the impact of life experiences on current functioning.*

**Question 2:** When using the PC-PTSD-5 screening tool, a positive screen is indicated by: a) Any positive response b) 2 or more positive responses c) 3 or more positive responses d) All 5 positive responses

**Answer: c) 3 or more positive responses** *Explanation: The PC-PTSD-5 uses a cutoff score of 3 or more positive responses to indicate probable PTSD and the need for more comprehensive assessment. This threshold balances sensitivity and specificity for identifying individuals who likely meet PTSD criteria.*

**Question 3:** Which assessment tool is specifically designed to differentiate between PTSD and Complex PTSD? a) The ACEs Questionnaire b) The Dissociative Experiences Scale (DES) c) The International Trauma Questionnaire (ITQ) d) The Trauma Screening Questionnaire (TSQ)

**Answer: c) The International Trauma Questionnaire (ITQ)** *Explanation: The ITQ was specifically developed to assess both PTSD and Complex PTSD as defined in the ICD-11. It measures core PTSD symptoms as well as disturbances in self-organization (affect dysregulation, negative self-concept, and interpersonal difficulties) that characterize Complex PTSD.*

**Module 3: Evidence-Based Trauma Interventions**

**Duration: 90 minutes**

**The Evolution of Trauma Treatment**

The field of trauma treatment has evolved dramatically from early psychoanalytic approaches to today's neurobiologically-informed, evidence-based interventions. This evolution reflects our growing understanding that trauma affects not just the mind but the entire body-brain system. As Dr. Judith Herman notes in "Trauma and Recovery," healing requires attention to safety, remembrance and mourning, and reconnection with life.

**First-Line Trauma Treatments**

**Cognitive Processing Therapy (CPT)**

CPT, developed by Patricia Resick, is a 12-session manualized treatment that focuses on modifying trauma-related cognitive distortions or "stuck points." The therapy helps clients understand how trauma has affected their thoughts and feelings.

**Core Components:**

1. **Psychoeducation** about PTSD and trauma responses
2. **Identifying stuck points** - problematic beliefs that keep clients stuck
3. **Challenging cognitions** using Socratic questioning
4. **Processing trauma** through written accounts
5. **Developing balanced** self-statements

**Telehealth Adaptation:**

*Session Dialogue Example:*

*Therapist: "I'm going to share my screen to show you the Challenging Questions Worksheet. Can you see it clearly?"*

*Client: "Yes, it's clear."*

*Therapist: "Let's work with the stuck point you identified: 'I should have fought back.' First question: Is this thought realistic or helpful?"*

*Client: "I mean... I know freezing is a trauma response, but I still feel like I failed."*

*Therapist: "That's the stuck point talking. Let's examine the evidence. What was actually happening to your nervous system when you froze?"*

**CPT Modifications for Complex Trauma:**

* Extended treatment duration (16-20 sessions)
* Additional focus on emotion regulation
* More time on safety and stabilization
* Integration of attachment-focused interventions

**Prolonged Exposure (PE)**

Developed by Edna Foa, PE involves gradually confronting trauma-related memories, feelings, and situations. The treatment typically spans 8-15 sessions of 90 minutes each.

**Key Elements:**

1. **Breathing retraining** for anxiety management
2. **Psychoeducation** about trauma and recovery
3. **Imaginal exposure** - revisiting trauma memories
4. **In vivo exposure** - confronting avoided situations
5. **Processing** - discussing thoughts and feelings

**Telehealth Considerations for PE:**

*Setting up imaginal exposure via telehealth:*

*Therapist: "Before we begin the imaginal exposure, let's ensure your environment is set up for success. Do you have tissues nearby? Water? Is your door locked for privacy? Have you arranged to have no interruptions for the next 90 minutes?"*

*Client: "Yes, I've prepared everything."*

*Therapist: "Good. Remember, I'll be monitoring you closely through the camera. If you need to stop at any point, raise your hand, and we'll pause immediately. We'll check your SUDS level every few minutes. Are you ready to begin?"*

**Contraindications for PE:**

* Active substance use disorders
* Imminent suicide risk
* Ongoing contact with perpetrator
* Severe dissociation
* Current life instability

**Eye Movement Desensitization and Reprocessing (EMDR)**

Francine Shapiro's EMDR integrates elements of various therapeutic approaches with bilateral stimulation (originally eye movements) to process traumatic memories.

**Eight Phases of EMDR:**

1. **History and Treatment Planning**
   * Comprehensive trauma history
   * Target memory identification
   * Resource assessment
2. **Preparation**
   * Establishing safety
   * Teaching self-soothing
   * Explaining EMDR process
3. **Assessment**
   * Identifying target image
   * Negative cognition identification
   * Positive cognition development
   * Emotion and body sensation identification
   * SUDS and VOC ratings
4. **Desensitization**
   * Bilateral stimulation while focusing on target
   * Processing until SUDS reaches 0-1
5. **Installation**
   * Strengthening positive cognition
   * Bilateral stimulation for integration
6. **Body Scan**
   * Checking for residual somatic distress
   * Additional processing if needed
7. **Closure**
   * Return to calm state
   * Self-care instructions
   * Preparation for between sessions
8. **Reevaluation**
   * Checking previous work
   * Identifying new targets
   * Assessing progress

**EMDR Telehealth Adaptations:**

*Bilateral Stimulation Options:*

* **Butterfly hug:** Client crosses arms and alternately taps shoulders
* **Online platforms:** Specialized EMDR platforms with visual/auditory bilateral stimulation
* **Self-administered tapping:** Alternating knee taps or heel presses

*Clinical Example:*

*Therapist: "Since we're working online, we'll use the butterfly hug for bilateral stimulation. Let me demonstrate. Cross your arms over your chest, and alternate tapping your shoulders. The rhythm should be like this [demonstrates]. Try it now."*

*Client: [Attempts butterfly hug]*

*Therapist: "Perfect. Remember to keep the taps at a steady rhythm, about one per second. If you need to stop, simply stop tapping and tell me."*

**Second-Wave Trauma Therapies**

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

Originally developed for children and adolescents by Cohen, Mannarino, and Deblinger, TF-CBT has been adapted for adults. It combines trauma-sensitive interventions with cognitive-behavioral principles.

**PRACTICE Components:**

* **P**sychoeducation and Parenting skills
* **R**elaxation and stress management
* **A**ffective expression and modulation
* **C**ognitive coping and processing
* **T**rauma narrative and processing
* **I**n vivo mastery of trauma reminders
* **C**onjoint child-parent sessions
* **E**nhancing safety and future development

**Adult Adaptation Example:**

*Therapist: "Let's work on your trauma narrative. You can choose how to tell your story—writing, drawing, or speaking. What feels most comfortable?"*

*Client: "I think I'd like to write it but read it to you."*

*Therapist: "That's perfect. Between now and next session, write as much or as little as feels manageable. Remember, you're in control of this process."*

**Narrative Exposure Therapy (NET)**

Developed for survivors of multiple traumas, particularly refugees and survivors of political violence, NET creates a coherent life narrative.

**The Lifeline Exercise:**

Using rope or string to represent the client's life:

* Flowers represent positive experiences
* Stones represent traumatic events
* The narrative integrates both into a coherent story

**Telehealth Adaptation:**

*Therapist: "Let's create your lifeline digitally. I'll share a virtual whiteboard. We'll use green circles for positive experiences and red squares for difficult ones. Can you start by placing your birth at the beginning of the line?"*

**Body-Based and Somatic Approaches**

**Somatic Experiencing (SE)**

Peter Levine's SE focuses on releasing trapped trauma from the body through attention to physical sensations.

**Core Principles:**

* Trauma is stored in the body
* Healing occurs through discharge of trapped energy
* Titration prevents overwhelming
* Pendulation between activation and calm
* Resources strengthen resilience

**Telehealth SE Session:**

*Therapist: "Notice where you feel that anxiety in your body right now."*

*Client: "My chest feels tight, like there's a band around it."*

*Therapist: "Good noticing. Now, scan your body for somewhere that feels calm or neutral."*

*Client: "My feet feel okay, grounded."*

*Therapist: "Let's pendulate between these sensations. Focus on your feet... notice that groundedness... now gently shift attention to your chest... and back to your feet. What happens?"*

*Client: "The chest tightness is softening a little."*

**Sensorimotor Psychotherapy**

Pat Ogden's approach integrates somatic interventions with attachment theory and cognitive processing.

**Three Levels of Processing:**

1. **Sensorimotor:** Body sensations and movement
2. **Emotional:** Feelings and affects
3. **Cognitive:** Thoughts and meaning-making

**Window of Tolerance Work:**

*Therapist: "Let's map your window of tolerance today. On a scale of 1-10, where 1 is completely shut down and 10 is panic, where are you?"*

*Client: "About a 7—pretty anxious."*

*Therapist: "What might bring you down to a 5 or 6?"*

*Client: "Maybe some deep breathing?"*

*Therapist: "Let's try that together. I'll guide you through a breathing exercise that we can use whenever you approach the edge of your window."*

**Integrative and Emerging Approaches**

**Internal Family Systems (IFS)**

Richard Schwartz's IFS views the mind as containing multiple sub-personalities or "parts," with trauma creating extreme roles:

**Key Concepts:**

* **Exiles:** Young, vulnerable parts holding pain
* **Managers:** Protective parts preventing pain
* **Firefighters:** Parts that distract from pain
* **Self:** Core consciousness with compassion and clarity

**IFS Dialogue Example:**

*Therapist: "It sounds like there's a part of you that's very angry about what happened."*

*Client: "Yes, furious. But another part feels guilty for being angry."*

*Therapist: "Can you ask the guilty part to step back just a bit so we can get to know the angry part better? What does this angry part want you to know?"*

*Client: "It wants me to know it's trying to protect me from being hurt again."*

*Therapist: "Thank that part for its protection. How do you feel toward it now?"*

**Cognitive Behavioral Therapy for Insomnia (CBT-I) for Trauma-Related Sleep Issues**

Sleep disturbance affects 70-90% of trauma survivors. CBT-I adapted for trauma includes:

**Components:**

* Sleep restriction therapy
* Stimulus control
* Cognitive restructuring about sleep
* Relaxation training
* Nightmare rescripting

**Imagery Rehearsal Therapy (IRT) for Nightmares:**

*Therapist: "Let's work on rescripting your recurring nightmare. First, write down the nightmare as you typically experience it."*

*Client: [Describes nightmare]*

*Therapist: "Now, let's change the ending to something that gives you power or resolution. You're the director—how would you like it to end?"*

*Client: "Maybe instead of being chased, I turn around and the threat disappears?"*

*Therapist: "Perfect. Practice visualizing this new ending for 10 minutes daily, especially before bed."*

**Cultural and Indigenous Healing Approaches**

**Integration of Traditional Healing**

Trauma-informed practice must honor diverse healing traditions:

**Examples of Cultural Interventions:**

* **Talking Circles:** Indigenous practice of communal healing
* **Sobadoras/Curanderos:** Latin American traditional healers
* **Meditation and Mindfulness:** Buddhist-informed practices
* **Movement and Dance:** Cultural expressions of healing

**Clinical Integration:**

*Therapist: "You mentioned your grandmother was a healer. What practices did she use that brought comfort?"*

*Client: "She would do limpias—spiritual cleansings with herbs and prayers."*

*Therapist: "How would you feel about incorporating some of those elements into our work? Perhaps creating your own cleansing ritual for after difficult sessions?"*

**Psychopharmacology in Trauma Treatment**

While therapy is first-line treatment, medications can support the therapeutic process:

**FDA-Approved Medications for PTSD:**

* **Sertraline (Zoloft):** 25-200mg daily
* **Paroxetine (Paxil):** 20-50mg daily

**Off-Label Medications Commonly Used:**

* **Prazosin:** For nightmares (1-15mg at bedtime)
* **Propranolol:** For reconsolidation disruption
* **Mood stabilizers:** For affect dysregulation
* **Atypical antipsychotics:** For severe symptoms

**Medication Discussion in Telehealth:**

*Therapist: "I'm noticing your sleep disturbance is significantly impacting your daily functioning. How do you feel about discussing medication options with your prescriber?"*

*Client: "I'm hesitant about medications."*

*Therapist: "That's completely understandable. Many trauma survivors have concerns about feeling 'numbed out' or losing control. Would it help to discuss specific concerns so you can make an informed decision?"*

**Module 3 Quiz**

**Question 1:** In EMDR therapy, bilateral stimulation is used during which phases? a) Only during the Desensitization phase b) During Desensitization and Installation phases c) Throughout all eight phases d) Only during the Assessment phase

**Answer: b) During Desensitization and Installation phases** *Explanation: Bilateral stimulation is primarily used during the Desensitization phase (Phase 4) to process traumatic memories and reduce distress, and during the Installation phase (Phase 5) to strengthen positive cognitions. While the other phases involve preparation, assessment, and integration, they don't typically involve bilateral stimulation.*

**Question 2:** Which trauma therapy approach specifically focuses on creating a coherent life narrative that integrates both positive and traumatic experiences? a) Prolonged Exposure (PE) b) Narrative Exposure Therapy (NET) c) Cognitive Processing Therapy (CPT) d) Somatic Experiencing (SE)

**Answer: b) Narrative Exposure Therapy (NET)** *Explanation: NET was specifically developed for survivors of multiple traumas and uses techniques like the "lifeline exercise" with flowers (positive experiences) and stones (traumatic events) to create an integrated life narrative. This approach is particularly effective for refugees and survivors of political violence.*

**Question 3:** In Internal Family Systems (IFS) therapy, which type of "part" is responsible for using extreme measures to distract from emotional pain? a) Exiles b) Managers c) Firefighters d) Self

**Answer: c) Firefighters** *Explanation: In IFS, Firefighters are parts that react when Exiles' pain breaks through, using extreme measures to distract from or numb emotional pain. These might include substance use, self-harm, binge eating, or other impulsive behaviors. Managers try to prevent pain proactively, while Exiles hold the pain itself.*

**Module 4: Telehealth Best Practices for Trauma Work**

**Duration: 90 minutes**

**The Digital Transformation of Trauma Therapy**

The rapid adoption of telehealth has fundamentally transformed mental health service delivery. What began as a necessity during the COVID-19 pandemic has evolved into a preferred modality for many clients and clinicians. For trauma survivors, telehealth offers unique advantages: accessing therapy from a safe space, reducing barriers related to transportation or mobility, and maintaining treatment during life transitions. However, it also presents distinct challenges that require specialized knowledge and skills.

**Technical Infrastructure for Trauma-Informed Telehealth**

**Platform Selection and Security**

Selecting appropriate technology is crucial for maintaining the safety and trust essential to trauma work:

**HIPAA-Compliant Platforms:**

* **Zoom for Healthcare:** End-to-end encryption, BAA available
* **Doxy.me:** Browser-based, no downloads required
* **SimplePractice Telehealth:** Integrated with practice management
* **VSee:** Medical-grade video quality
* **TherapyNotes Telehealth:** Built-in documentation features

**Essential Security Features:**

* End-to-end encryption
* Waiting room functionality
* Session recording capabilities (with consent)
* Screen sharing for therapeutic materials
* Breakout rooms for family sessions

**Setting Up Your Digital Office:**

*Clinical Consideration:* *"Dr. Thompson's telehealth setup includes a ring light for consistent lighting, a high-quality external microphone, and a virtual background showing her actual office. She maintains the same artwork and plants visible in both settings, providing continuity for clients who transition between in-person and virtual sessions."*

**Emergency Protocols and Safety Planning**

**Comprehensive Telehealth Intake Must Include:**

1. **Location Verification**
   * Current physical address
   * Nearest hospital/emergency room
   * Local crisis resources
2. **Emergency Contacts**
   * Primary support person
   * Local emergency services
   * Backup therapist/covering clinician
3. **Technology Backup Plans**
   * Alternative connection methods
   * Phone numbers for audio-only backup
   * Plan for technology failures

**Sample Emergency Protocol Dialogue:**

*Therapist: "Before we begin our work together, I need to establish our safety protocol. While I don't anticipate emergencies, trauma work can sometimes bring up intense feelings. Can you confirm your current address?"*

*Client: "I'm at 123 Main Street, Apartment 4B, Austin, Texas."*

*Therapist: "Thank you. If we were to lose connection during a difficult moment, I would call you immediately. If you're experiencing a crisis and I can't reach you, I would contact your emergency contact—that's your sister Sarah, correct?—and if necessary, local emergency services. Are you comfortable with this plan?"*

**Creating Safe Therapeutic Spaces in Telehealth**

**Environmental Assessment and Optimization**

The client's physical environment becomes an extension of the therapeutic space:

**Initial Environmental Scan:**

*Therapist: "I'd like to understand your space better. Could you show me your therapy area using your camera?"*

*Client pans camera around room*

*Therapist: "I notice you have a door behind you—can that be locked for privacy? And is that a comfort object on your couch? Feel free to have anything nearby that helps you feel safe."*

**Optimizing Client Spaces:**

* Private, quiet location
* Comfortable seating with back support
* Access to grounding objects
* Tissues and water within reach
* Adequate lighting (facing window ideal)
* Minimal distractions (notifications off)

**Establishing Telepresence**

"Telepresence"—the sense of genuine connection despite physical distance—is crucial for trauma work:

**Techniques for Enhancing Telepresence:**

1. **Eye Contact Simulation**
   * Look at camera, not screen
   * Place client window near camera
   * Use "speaker view" not "gallery view"
2. **Verbal Attunement**
   * Increase verbal reflections
   * Name observations explicitly
   * Use voice modulation intentionally
3. **Synchronized Actions**
   * Breathing exercises together
   * Bilateral movements in tandem
   * Shared mindfulness practices

**Clinical Example:**

*Therapist: "I notice your shoulders just tensed when you mentioned your father. Take a moment to notice that sensation. I'm going to mirror your breathing to stay connected with you through this."*

**Adapting Trauma Interventions for Telehealth**

**Grounding Techniques for Virtual Sessions**

**5-4-3-2-1 Technique Adapted:**

*Therapist: "Let's ground together. Tell me 5 things you can see in your room."*

*Client: "My bookshelf, the window, my cat, the painting, my coffee mug."*

*Therapist: "Good. Now 4 things you can physically touch from where you're sitting."*

*Client: "The couch fabric, my sweater, the pillow, the remote."*

*Therapist: "Excellent. 3 things you can hear?"*

*Client: "Your voice, the air conditioner, birds outside."*

*Therapist: "2 things you can smell?"*

*Client: "My coffee, the lavender candle."*

*Therapist: "And one thing you can taste?"*

*Client: "The mint from my tea earlier."*

*Therapist: "How do you feel now compared to before we started?"*

**Managing Dissociation Through Screens**

Detecting and responding to dissociation requires heightened awareness:

**Visual Cues of Dissociation on Screen:**

* Fixed gaze or "thousand-yard stare"
* Delayed responses to questions
* Sudden stillness or freezing
* Looking away from camera consistently
* Apparent disconnection from conversation

**Intervention Protocol:**

*Therapist notices client's gaze becoming unfocused*

*Therapist: "Sarah, I'm noticing you might be drifting away. Can you hear my voice?"*

*Client: [No response]*

*Therapist: "Sarah, I'm going to count from 5 to 1. With each number, try to come back to this room, to this moment. 5... notice my voice... 4... feel your feet on the floor... 3... take a deep breath with me... 2... look at something blue in your room... 1... you're here, you're safe."*

*Client: [Blinks, refocuses] "Sorry, I just... went somewhere else."*

*Therapist: "No apology needed. Your mind was protecting you. Let's talk about what just happened."*

**Exposure Therapy Modifications**

**Virtual Reality Integration:**

Emerging technologies enhance exposure therapy:

* VR headsets for immersive exposure
* 360-degree videos for gradual exposure
* Augmented reality for in-home practice

**In Vivo Exposure via Telehealth:**

*Therapist: "Today we're doing exposure to your trigger of crowded spaces. I want you to take your laptop to increasingly busy areas of your home, then eventually to your front porch. I'll be with you the entire time."*

*Client: "Okay, I'm starting in my quiet bedroom."*

*Therapist: "Rate your anxiety 1-10."*

*Client: "About a 3."*

*Therapist: "Now move to your living room where your family is."*

*Client moves*

*Client: "Anxiety is at a 5 now."*

*Therapist: "Perfect—stay with it. Use your breathing. I'm right here with you."*

**Cultural Competence in Telehealth Trauma Work**

**Addressing Digital Divides**

Not all clients have equal access to technology:

**Common Barriers:**

* Limited internet bandwidth
* Shared devices or spaces
* Technology literacy gaps
* Cultural attitudes toward technology
* Economic constraints

**Adaptive Solutions:**

*Therapist: "I understand you're using your phone in your car because it's your only private space. Let's problem-solve this together. Could we schedule sessions during your lunch break when you can park somewhere safe? We can also do audio-only if video uses too much data."*

**Culturally Responsive Telehealth Practices**

**Considerations for Diverse Populations:**

1. **Collectivist Cultures**
   * Family involvement expectations
   * Privacy concerns in multigenerational homes
   * Indirect communication styles on video
2. **Religious/Spiritual Integration**
   * Virtual space for prayer/meditation
   * Religious objects in view
   * Scheduling around religious obligations
3. **LGBTQIA+ Clients**
   * Chosen family involvement
   * Safety in non-affirming households
   * Gender-affirming virtual backgrounds

**Clinical Vignette:**

*"Ahmad, a Muslim client, requests to pause sessions for prayer time. His therapist responds: 'Of course. Would you like to keep the video on while you pray, or would you prefer I turn off my camera to give you privacy? We can resume when you're ready.' This respectful accommodation strengthens the therapeutic alliance."*

**Group Trauma Therapy via Telehealth**

**Virtual Trauma-Informed Groups**

**Structure Considerations:**

* Maximum 6-8 participants for trauma groups
* Co-facilitation highly recommended
* Clear group agreements about confidentiality
* Mute protocols and hand-raising features

**Safety in Virtual Groups:**

*Group Leader: "Before we begin sharing today, let's review our group agreements. What's shared here stays here. Please use the 'raise hand' feature if you need to speak. If you become overwhelmed, you can turn off your video for a moment of privacy, but please stay connected by audio if possible. Remember, you can private message me or my co-facilitator if you need individual support."*

**Managing Multiple Nervous Systems**

**Co-Regulation Strategies:**

* Synchronized breathing exercises
* Group grounding activities
* Shared somatic experiences
* Collective resource building

**Example Group Exercise:**

*Facilitator: "Everyone, let's do our group butterfly hug. Ready? Cross your arms over your chest. Now let's tap together—right, left, right, left. Notice how we're all connected in this rhythm even though we're in different places."*

**Documentation and Legal Considerations**

**Telehealth-Specific Documentation**

**Required Documentation Elements:**

* Platform used and technical quality
* Client location and privacy status
* Emergency protocols reviewed
* Any technical interruptions
* Interventions modified for virtual delivery

**Sample Progress Note:**

*"Client participated in 50-minute telehealth session via Zoom from private home office. Video and audio quality good throughout. Processed trauma narrative using modified PE protocol with butterfly hug for bilateral stimulation. Client demonstrated ability to use grounding techniques independently when approaching window of tolerance edge. Reviewed emergency protocol and confirmed current location. No safety concerns identified."*

**Informed Consent for Telehealth Trauma Work**

**Additional Consent Elements:**

* Technology failure protocols
* Recording policies
* Limits of confidentiality in digital spaces
* Emergency procedures
* Interstate practice limitations

**Therapist Self-Care in Telehealth**

**Preventing Zoom Fatigue**

**Strategies for Sustainable Practice:**

* Schedule breaks between sessions
* Use audio-only check-ins when appropriate
* Vary therapeutic activities
* Practice the 20-20-20 rule (every 20 minutes, look at something 20 feet away for 20 seconds)

**Boundaries in Digital Practice**

**Maintaining Professional Boundaries:**

* Set "office hours" for availability
* Use separate devices for work/personal
* Create transition rituals
* Maintain professional virtual backgrounds

**Self-Care Protocol:**

*"Dr. Martinez ends each telehealth day with a closing ritual: She turns off her computer, takes three deep breaths, and physically steps away from her home office space. This boundary helps her transition from therapist to person, crucial for preventing vicarious trauma."*

**Module 4 Quiz**

**Question 1:** When conducting trauma therapy via telehealth, which of the following is MOST critical to establish during the initial session? a) The client's insurance information b) The client's physical location and local emergency resources c) The client's preferred video platform d) The client's therapy goals

**Answer: b) The client's physical location and local emergency resources** *Explanation: While all elements are important, knowing the client's exact physical location and local emergency resources is critical for safety in trauma work. This information is essential if a crisis occurs during a session, allowing the therapist to dispatch appropriate emergency services if needed. This is especially important in trauma therapy where intense emotions and dissociation can occur.*

**Question 2:** A client appears to be dissociating during a telehealth session (blank stare, not responding to questions). What is the BEST initial intervention? a) End the session immediately and call emergency services b) Wait silently for the client to return to awareness c) Use grounding techniques with voice and counting to bring them back to present d) Send a text message to get their attention

**Answer: c) Use grounding techniques with voice and counting to bring them back to present** *Explanation: When dissociation occurs during telehealth, the best approach is to use grounding techniques such as counting, asking them to notice your voice, and guiding them to focus on their immediate environment. This helps reorient them to the present moment. Dissociation is a common trauma response and doesn't typically require emergency services unless accompanied by safety concerns.*

**Question 3:** Which adaptation is MOST appropriate when conducting EMDR therapy via telehealth? a) Skip the bilateral stimulation component entirely b) Use butterfly hugs or self-tapping for bilateral stimulation c) Only use EMDR with clients who have high-speed internet d) Require clients to purchase specialized equipment

**Answer: b) Use butterfly hugs or self-tapping for bilateral stimulation** *Explanation: The butterfly hug (crossing arms and alternately tapping shoulders) or self-administered tapping on knees are effective adaptations for bilateral stimulation in telehealth EMDR. These methods maintain the essential bilateral component while being easily self-administered by clients in their own space without requiring special equipment or technology.*

**Module 5: Cultural Considerations and Special Populations**

**Duration: 60 minutes**

**The Imperative of Cultural Humility in Trauma Work**

Cultural competence in trauma treatment extends beyond awareness of different cultural practices—it requires understanding how culture shapes the very experience and expression of trauma. Cultural humility, rather than cultural competence, better captures the ongoing, self-reflective process required for effective cross-cultural trauma work. This approach acknowledges that becoming "competent" in another's culture is impossible; instead, we must remain curious, humble, and willing to be educated by our clients.

**Historical and Intergenerational Trauma**

**Understanding Historical Trauma**

Historical trauma refers to cumulative emotional and psychological wounds transmitted across generations. Dr. Maria Yellow Horse Brave Heart's seminal work with Native American populations identified how the trauma of colonization, forced assimilation, and genocide continues to impact descendants who didn't directly experience these events.

**Manifestations of Historical Trauma:**

* Disrupted attachment patterns
* Loss of cultural identity
* Internalized oppression
* Substance use as coping
* Increased vulnerability to additional trauma

**Clinical Example:**

*Client: "I don't understand why I feel so anxious all the time. My life has been relatively safe."*

*Therapist: "Sometimes we carry the experiences of our ancestors in our bodies. You mentioned your grandparents were Holocaust survivors. Even though you didn't experience the camps yourself, research shows that trauma can be transmitted through epigenetic changes, family dynamics, and cultural narratives. Your anxiety might be your body's inherited vigilance—a protective mechanism passed down through generations."*

**Intergenerational Trauma Transmission Mechanisms**

**Biological Transmission:**

* Epigenetic modifications
* Altered stress response systems
* Changes in brain structure and function

**Psychological Transmission:**

* Attachment disruptions
* Emotional dysregulation modeling
* Trauma-related cognitive schemas

**Social/Cultural Transmission:**

* Family narratives and silence
* Cultural loss and disruption
* Systemic oppression continuation

**Race-Based Traumatic Stress**

**Understanding Racial Trauma**

Dr. Robert T. Carter's work on race-based traumatic stress injury recognizes that experiences of racism can produce trauma symptoms similar to PTSD. This framework validates the psychological impact of racial discrimination, microaggressions, and systemic oppression.

**Types of Race-Based Traumatic Experiences:**

1. **Direct Traumatic Experiences**
   * Hate crimes
   * Police brutality
   * Discriminatory treatment
2. **Vicarious Traumatic Experiences**
   * Witnessing violence against one's group
   * Media exposure to racial violence
   * Community member experiences
3. **Microaggressions**
   * Daily indignities and slights
   * Environmental invalidations
   * Systemic barriers

**Clinical Dialogue:**

*Therapist: "You mentioned feeling on edge after watching the news. Can you tell me more about that?"*

*Client: "Every time I see another Black person killed by police, it feels like it could be me, my brother, my son. I can't stop watching, but I also can't sleep."*

*Therapist: "What you're experiencing is racial trauma—a very real psychological injury from witnessing violence against your community. Your hypervigilance makes sense; it's your mind trying to protect you from a threat that's both real and ongoing. Let's talk about how to tend to this wound while also finding moments of safety and restoration."*

**LGBTQIA+ Trauma Considerations**

**Minority Stress Theory**

Meyer's Minority Stress Theory identifies unique stressors faced by LGBTQIA+ individuals:

1. **Distal Stressors**
   * Discrimination and rejection
   * Violence and victimization
   * Non-affirmation
2. **Proximal Stressors**
   * Anticipation of rejection
   * Concealment/hiding
   * Internalized homophobia/transphobia

**Gender-Affirming Trauma Care:**

*Therapist: "I want to make sure I'm creating a safe space for you. What name and pronouns would you like me to use? And how can I best support you if we need to discuss experiences from before your transition?"*

*Client: "Thank you for asking. I use they/them pronouns. When talking about my childhood, it's okay to reference that time, but please don't use my deadname."*

*Therapist: "Of course. I'll make a note so all our documentation respects your identity. If I ever make a mistake, please correct me—your comfort and safety are my priority."*

**Immigrant and Refugee Trauma**

**Pre-Migration, Transit, and Post-Migration Trauma**

The refugee experience often involves sequential traumatization:

**Pre-Migration:**

* War and conflict
* Persecution
* Loss of home and community

**Transit:**

* Dangerous journey conditions
* Exploitation and violence
* Uncertainty and waiting

**Post-Migration:**

* Acculturation stress
* Language barriers
* Employment challenges
* Discrimination
* Separation from family

**Clinical Approach:**

*"Amira, a Syrian refugee, presents with nightmares and hypervigilance. Her therapist uses a culturally adapted narrative exposure therapy, incorporating Arabic concepts of resilience ('sumud') and community ('jama'a'). Sessions begin with a traditional greeting in Arabic, honoring her cultural identity while addressing her trauma in English, her developing second language."*

**Trauma in Older Adults**

**Unique Considerations**

Older adults face specific trauma-related challenges:

**Late-Onset PTSD:**

* Retirement removing protective routine
* Medical procedures triggering memories
* Loss of partners who were co-regulators
* Cognitive changes affecting coping

**Clinical Adaptations:**

*Therapist: "Mr. Johnson, you mentioned that your WWII memories have been coming back since your wife passed. Grief can sometimes unlock old traumas we thought were resolved. Your wife might have been helping you regulate these memories without either of you realizing it."*

*Client: "I thought I was going senile, having these flashbacks after 70 years."*

*Therapist: "Not at all. This is actually quite common. Major life changes like loss can reactivate old trauma. The good news is that the treatments we have now didn't exist when you came home from war. We can help these memories finally find rest."*

**Disability and Trauma**

**Medical Trauma and Chronic Illness**

People with disabilities experience higher rates of trauma:

* Medical procedures and hospitalization
* Loss of autonomy and control
* Abuse and exploitation
* Systemic ableism
* Lack of accessible services

**Accessible Trauma Treatment:**

*Therapist: "I want to ensure our sessions are fully accessible. You mentioned you have chronic fatigue. Would it help to have shorter sessions more frequently? We can also plan for rest breaks."*

*Client: "That would be amazing. Most therapists don't understand that my fatigue isn't just being tired—it's my body shutting down."*

*Therapist: "Let's create a signal for when you need a break. We can pause, and you can lie down if needed. Your body's needs take priority over any predetermined session structure."*

**Religious and Spiritual Considerations**

**Integrating Spiritual Resources**

For many trauma survivors, spiritual beliefs provide crucial meaning-making and coping resources:

**Spiritual Assessment Questions:**

* What role does spirituality play in your life?
* How has trauma affected your spiritual beliefs?
* Are there spiritual practices that bring comfort?
* Would you like to incorporate prayer or meditation?

**Clinical Integration:**

*Client: "I feel like God has abandoned me. How could He let this happen?"*

*Therapist: "Crisis of faith is common after trauma. Many survivors struggle with questions about divine presence in suffering. Would it be helpful to explore how your faith tradition understands suffering? Or would you prefer to process these feelings from a psychological perspective?"*

*Client: "Maybe both? I still want to believe, but I'm angry."*

*Therapist: "That's completely valid. We can hold space for both your anger at God and your desire for faith. Some clients find it helpful to write letters to God expressing their anger, or to explore scriptures about suffering with their spiritual leader while we process the emotional impact here."*

**Working with Military and Veteran Populations**

**Military Cultural Competence**

Understanding military culture is essential for treating combat trauma:

**Key Cultural Values:**

* Mission first
* Never leave anyone behind
* Strength and self-reliance
* Chain of command
* Dark humor as coping

**Clinical Considerations:**

*Veteran Client: "You wouldn't understand. You haven't been there."*

*Therapist: "You're absolutely right—I haven't been in combat. I can't fully understand that experience. But I'd like to understand your specific experience as much as you're willing to share. You're the expert on what you've been through; I'm just here to help you process it in a way that brings relief."*

**Moral Injury**

Beyond PTSD, many veterans experience moral injury—the psychological damage from witnessing or participating in events that violate deeply held moral beliefs:

**Components of Moral Injury:**

* Perpetrating harm
* Failing to prevent harm
* Witnessing harm by trusted others
* Betrayal by leadership

**Treatment Approach:**

*Therapist: "PTSD treatment focuses on fear and safety, but what you're describing sounds like moral injury—a wound to your conscience. The guilt you feel about that civilian casualty isn't a symptom to eliminate; it's evidence of your intact humanity. Our work is to help you find a way to live with this burden, perhaps even find meaning or restoration through it."*

**Trauma-Informed Care for Children and Adolescents**

**Developmental Considerations**

Trauma impacts children differently depending on their developmental stage:

**Early Childhood (0-5):**

* Attachment disruptions
* Developmental delays
* Regression
* Separation anxiety

**Middle Childhood (6-11):**

* Academic difficulties
* Behavioral problems
* Somatic complaints
* Trauma reenactment in play

**Adolescence (12-18):**

* Risk-taking behaviors
* Identity confusion
* Relationship difficulties
* Substance experimentation

**Telehealth Adaptation for Youth:**

*Therapist: "Hi Jamie! I see you have your stuffed animals with you today. Would they like to join our session?"*

*Child (age 7): "This is Mr. Bear. He has bad dreams like me."*

*Therapist: "Thank you for introducing me to Mr. Bear. Maybe he can help us understand your bad dreams better. Can you show me how Mr. Bear feels when he has bad dreams?"*

**Module 5 Quiz**

**Question 1:** According to Meyer's Minority Stress Theory, which of the following is considered a "proximal stressor" for LGBTQIA+ individuals? a) Experiencing workplace discrimination b) Internalized homophobia c) Being victim of a hate crime d) Lack of legal protections

**Answer: b) Internalized homophobia** *Explanation: Proximal stressors are internal processes that occur within the individual as a result of minority status, including internalized homophobia/transphobia, anticipation of rejection, and concealment of identity. Distal stressors, in contrast, are external events like discrimination, violence, and lack of legal protections.*

**Question 2:** When working with refugees who have experienced sequential traumatization, which phase of the refugee experience is often overlooked but crucial to address? a) Pre-migration trauma only b) Post-migration stressors c) Transit trauma d) Cultural beliefs about trauma

**Answer: c) Transit trauma** *Explanation: While pre-migration and post-migration experiences are commonly addressed, transit trauma—the often dangerous journey between leaving home and arriving at destination—is frequently overlooked. This period often involves exploitation, violence, dangerous conditions, and prolonged uncertainty that can be deeply traumatizing.*

**Question 3:** What distinguishes moral injury from PTSD in military populations? a) Moral injury only affects officers b) Moral injury involves violation of deeply held moral beliefs and values c) Moral injury is less severe than PTSD d) Moral injury doesn't require treatment

**Answer: b) Moral injury involves violation of deeply held moral beliefs and values** *Explanation: Moral injury results from perpetrating, witnessing, or failing to prevent acts that violate one's moral or ethical beliefs, leading to guilt, shame, and spiritual crisis. Unlike PTSD, which centers on fear and threat, moral injury involves a wound to conscience and requires different therapeutic approaches focusing on forgiveness, meaning-making, and moral repair.*

**Module 6: Building and Sustaining a Trauma-Informed Practice**

**Duration: 30 minutes**

**Creating a Trauma-Informed Practice Environment**

Building a sustainable trauma-informed practice requires intentional attention to both clinical excellence and business sustainability. This final module synthesizes our learning into practical implementation strategies for creating and maintaining a practice that serves both clients and practitioners effectively.

**Physical and Virtual Space Considerations**

**Designing Healing Environments**

Whether physical or virtual, therapeutic spaces should embody trauma-informed principles:

**Physical Office Design:**

* Clear sight lines to exits
* Comfortable, non-clinical furnishing
* Natural light when possible
* Sound protection for privacy
* Calming colors and textures
* Cultural representations and art
* Temperature control options
* Sensory regulation tools available

**Virtual Space Optimization:**

* Professional but warm backgrounds
* Consistent setup across sessions
* Good lighting (avoiding shadows)
* Clear audio without echo
* Minimal visual distractions
* Option for background blur if needed

**Practice Policies Through a Trauma-Informed Lens**

**Intake and Onboarding**

**Trauma-Informed Intake Process:**

*"Welcome to Healing Pathways Therapy. We recognize that seeking help takes courage. Our intake process is designed to gather necessary information while respecting your pace and comfort level. You can complete forms in sections, skip questions that feel too difficult, and we'll discuss anything unclear in our first session. Remember, you're in control of what and when you share."*

**Policy Examples:**

* 48-hour cancellation policy with flexibility for trauma symptoms
* Sliding scale options to address financial barriers
* Multiple contact methods (text, email, phone)
* Clear communication about session structure
* Transparent fee structure and billing practices

**Documentation and Record-Keeping**

**Trauma-Informed Documentation Principles:**

1. **Collaborative Documentation**
   * Share notes with clients when appropriate
   * Use client's language and terms
   * Focus on strengths and resilience
2. **Privacy Protection**
   * Minimum necessary information
   * Consider who might access records
   * Separate psychotherapy notes

**Example Progress Note:** *"Client demonstrated remarkable resilience in discussing childhood experiences. Utilized newly learned grounding skills independently when approaching edge of window of tolerance. Identified three personal strengths that helped survival. Collaboratively developed coping plan for upcoming family visit. Client's determination and insight continue to facilitate healing progress."*

**Preventing Vicarious Trauma and Burnout**

**Understanding Vicarious Trauma**

Repeated exposure to client trauma can impact therapists:

**Signs of Vicarious Trauma:**

* Intrusive thoughts about client's traumas
* Increased anxiety or hypervigilance
* Emotional numbing or detachment
* Cynicism about the world
* Physical symptoms (headaches, fatigue)
* Disrupted personal relationships

**Sustainable Practice Strategies**

**The PRACTICE Model for Therapist Wellness:**

* **P**ersonal therapy and supervision
* **R**egular breaks and vacations
* **A**ctive self-care routines
* **C**onnection with colleagues
* **T**raining and continued education
* **I**ntegration of joy and meaning
* **C**ase diversity and balance
* **E**xercise and somatic practices

**Implementation Example:**

*"Dr. Chen structures her practice with intentional variety: she sees no more than three trauma clients per day, alternates intensive trauma work with supportive therapy sessions, takes a 15-minute reset break between clients, and ends each day with a transition ritual of journaling three moments of client resilience she witnessed."*

**Building a Referral Network**

**Essential Referral Partners**

A comprehensive trauma-informed practice requires collaborative relationships:

**Core Referral Network:**

* Psychiatrists comfortable with trauma medication
* EMDR or somatic therapy specialists
* Group therapy facilitators
* Substance abuse counselors
* Domestic violence advocates
* Cultural healers/spiritual leaders
* Nutritionists understanding trauma-eating connections
* Body workers trained in trauma

**Referral Conversation Template:**

*"I believe you might benefit from additional support alongside our work. I know an excellent [psychiatrist/EMDR therapist/group facilitator] who specializes in trauma. This wouldn't replace our work but would complement it. How do you feel about exploring this option?"*

**Organizational Trauma-Informed Care**

**Creating Trauma-Informed Organizations**

For those in agency settings, implementing organizational change:

**Leadership Commitment:**

* Clear trauma-informed mission
* Resource allocation for training
* Policy review through trauma lens
* Staff wellness prioritization

**Staff Development:**

* Universal trauma training
* Regular consultation groups
* Vicarious trauma support
* Cultural humility workshops
* Self-care planning

**Client Voice Integration:**

* Survivor advisory boards
* Regular feedback mechanisms
* Collaborative program development
* Peer support programs

**Measuring Outcomes and Continuous Improvement**

**Outcome Measurement Tools**

**Recommended Assessments:**

* PCL-5 for PTSD symptoms
* DES-II for dissociation
* ACE scores for childhood trauma
* Resilience scales
* Quality of life measures
* Client satisfaction surveys

**Using Data for Improvement:**

*"Monthly review of outcome measures revealed clients showing less improvement in sleep disturbances. This led to implementing CBT-I techniques and adding sleep hygiene psychoeducation to standard trauma treatment, resulting in 40% improvement in sleep scores over the next quarter."*

**Ethical Considerations in Trauma-Informed Telehealth**

**Navigating Complex Ethical Terrain**

**Common Ethical Dilemmas:**

1. **Boundary Flexibility vs. Structure**
   * When to extend sessions for crisis
   * After-hours availability
   * Self-disclosure decisions
2. **Competence and Scope**
   * Recognizing limits of expertise
   * When to refer specialized trauma
   * Managing complex comorbidities
3. **Technology and Privacy**
   * Recording sessions for training
   * Social media boundaries
   * Digital communication limits

**Ethical Decision-Making Framework:**

*Situation: Client in crisis at session end*

1. Assess immediate safety
2. Consider client's best interest
3. Review ethical guidelines
4. Consult if time permits
5. Document decision rationale
6. Follow up appropriately

**The Future of Trauma-Informed Telehealth**

**Emerging Trends and Technologies**

**On the Horizon:**

* AI-assisted assessment tools
* Virtual reality exposure therapy
* Biometric monitoring integration
* Asynchronous therapy options
* Digital therapeutics/apps
* Global mental health initiatives

**Preparing for Change:**

*"The integration of technology in trauma treatment will continue evolving. Maintain curiosity about innovations while grounding decisions in trauma-informed principles. Not every new tool will serve trauma survivors well, but dismissing innovation entirely may limit access to healing."*

**Module 6 Quiz**

**Question 1:** Which of the following is NOT a sign of vicarious trauma in therapists? a) Increased interest in professional development b) Intrusive thoughts about clients' traumas c) Emotional numbing or detachment d) Cynicism about the world

**Answer: a) Increased interest in professional development** *Explanation: Increased interest in professional development is actually a positive coping strategy and sign of professional growth, not a symptom of vicarious trauma. Vicarious trauma symptoms include intrusive thoughts about client traumas, emotional numbing, cynicism, hypervigilance, and physical symptoms like fatigue or headaches.*

**Question 2:** In trauma-informed documentation, which approach is MOST appropriate? a) Document every detail of trauma to ensure thoroughness b) Use clinical jargon to maintain professionalism c) Focus on client strengths and resilience while documenting necessary clinical information d) Avoid documenting trauma details entirely

**Answer: c) Focus on client strengths and resilience while documenting necessary clinical information** *Explanation: Trauma-informed documentation balances clinical necessity with client dignity by highlighting strengths and resilience while including essential clinical information. This approach avoids unnecessarily detailed trauma descriptions that could be retraumatizing if records are accessed while ensuring adequate clinical documentation.*

**Question 3:** When building a trauma-informed practice, what is the recommended maximum number of trauma clients to see per day to prevent burnout? a) No limit if proper self-care is maintained b) Only one trauma client per day c) Three to four trauma clients maximum d) See only trauma clients to maintain expertise

**Answer: c) Three to four trauma clients maximum** *Explanation: Most experts recommend limiting intensive trauma work to 3-4 clients per day to prevent vicarious trauma and maintain therapeutic effectiveness. This allows for emotional sustainability while alternating with less intensive supportive therapy sessions, maintaining case diversity, and ensuring adequate time for processing and self-care between sessions.*

**Final Comprehensive Examination**

**10-Question Comprehensive Assessment**

**Question 1:** A client participating in telehealth trauma therapy lives in a state different from where the therapist is licensed. According to best practices, the therapist should: a) Continue therapy as normal since it's telehealth b) Verify licensing requirements and interstate compact agreements before proceeding c) Only provide crisis intervention services d) Require the client to travel to the therapist's state

**Answer: b) Verify licensing requirements and interstate compact agreements before proceeding** *Explanation: Therapists must be licensed in the state where the client is physically located during the session. Some states have interstate compacts (like PSYPACT) that allow practice across state lines, but this must be verified before providing services. This is both a legal and ethical requirement.*

**Question 2:** According to SAMHSA's trauma-informed care principles, "peer support" is important because: a) It reduces the therapist's workload b) Peers can provide therapy without licenses c) Healing happens in relationship and mutual self-help is vital d) It's more cost-effective than individual therapy

**Answer: c) Healing happens in relationship and mutual self-help is vital** *Explanation: The peer support principle recognizes that healing happens in relationship and that mutual self-help is a key vehicle for healing. It's about establishing safety and hope through relationship and shared experience, not about replacing professional services or reducing costs.*

**Question 3:** When using Cognitive Processing Therapy (CPT) for trauma, "stuck points" refer to: a) Moments when therapy reaches an impasse b) Problematic beliefs that interfere with recovery from traumatic events c) Points in the trauma narrative that are too difficult to discuss d) Technical difficulties during telehealth sessions

**Answer: b) Problematic beliefs that interfere with recovery from traumatic events** *Explanation: In CPT, stuck points are problematic beliefs or thoughts that develop after trauma and interfere with recovery. These might include thoughts like "I should have prevented it" or "I can't trust anyone." CPT focuses on identifying and modifying these stuck points through Socratic questioning and cognitive restructuring.*

**Question 4:** A trauma survivor exhibits the "fawn" response during therapy, constantly apologizing and asking if they're "doing therapy right." This response pattern MOST likely developed as: a) A manipulation tactic b) A survival strategy in an unpredictable or dangerous environment c) A sign of borderline personality disorder d) Normal politeness

**Answer: b) A survival strategy in an unpredictable or dangerous environment** *Explanation: The fawn response is a trauma response identified by Pete Walker, characterized by people-pleasing, over-accommodation, and difficulty setting boundaries. It typically develops as a survival strategy in childhoods where appeasing unpredictable or dangerous caregivers was necessary for safety.*

**Question 5:** When conducting EMDR therapy via telehealth, bilateral stimulation can be effectively achieved through: a) Requiring clients to purchase light bars b) Only using audio tones c) Self-administered butterfly hugs or tapping d) Eliminating this component entirely

**Answer: c) Self-administered butterfly hugs or tapping** *Explanation: The butterfly hug (crossing arms and tapping alternate shoulders) or self-tapping on knees are effective, accessible methods for bilateral stimulation in telehealth EMDR. These maintain the essential bilateral component without requiring special equipment.*

**Question 6:** In treating Complex PTSD, which additional symptoms beyond core PTSD must be addressed? a) Only dissociation b) Disturbances in self-organization including affect dysregulation, negative self-concept, and interpersonal difficulties c) Exclusively somatic symptoms d) Only depression and anxiety

**Answer: b) Disturbances in self-organization including affect dysregulation, negative self-concept, and interpersonal difficulties** *Explanation: Complex PTSD, as defined in the ICD-11, includes core PTSD symptoms plus disturbances in self-organization (DSO). These DSO symptoms include affect dysregulation, negative self-concept, and interpersonal difficulties, all requiring specific therapeutic attention.*

**Question 7:** The "Window of Tolerance" concept is MOST useful for: a) Determining session length b) Understanding and managing hyper- and hypoarousal states c) Scheduling appointment times d) Setting therapy fees

**Answer: b) Understanding and managing hyper- and hypoarousal states** *Explanation: The Window of Tolerance, developed by Dan Siegel, describes the optimal zone of arousal where a person can effectively process experiences. Understanding this helps therapists and clients recognize when someone is in hyperarousal (anxiety, panic) or hypoarousal (numbness, dissociation) and develop strategies to return to the window.*

**Question 8:** When working with refugees who have experienced trauma, which factor is MOST critical to address for successful treatment? a) Ensuring they speak perfect English b) Current post-migration stressors and safety c) Only focusing on pre-migration trauma d) Avoiding any discussion of their homeland

**Answer: b) Current post-migration stressors and safety** *Explanation: While pre-migration trauma is important, current post-migration stressors (safety, housing, employment, legal status, discrimination) must be addressed first. Maslow's hierarchy applies—basic safety and stability needs must be met before deeper trauma processing can be effective.*

**Question 9:** Historical trauma differs from individual trauma in that it: a) Is less severe than individual trauma b) Only affects people who directly experienced the traumatic events c) Is transmitted across generations and affects entire communities d) Doesn't require treatment

**Answer: c) Is transmitted across generations and affects entire communities** *Explanation: Historical trauma is cumulative emotional and psychological wounds transmitted across generations. It affects descendants who didn't directly experience the original traumatic events (like slavery, genocide, colonization) through epigenetic changes, disrupted attachment patterns, and cultural transmission of trauma.*

**Question 10:** In telehealth trauma therapy, if a client begins dissociating during session (blank stare, unresponsive), the therapist should FIRST: a) Call 911 immediately b) End the session and document the incident c) Use grounding techniques with voice, counting, and orientation cues d) Wait silently until the client returns to awareness

**Answer: c) Use grounding techniques with voice, counting, and orientation cues** *Explanation: Dissociation is a common trauma response that can be safely managed with grounding techniques. Using voice, counting (5-4-3-2-1), and orientation cues helps bring the client back to present awareness. This is a therapeutic intervention, not a medical emergency unless accompanied by other safety concerns.*

**Course Conclusion**

**Integration and Moving Forward**

Congratulations on completing "Building a Trauma-Informed Practice & Telehealth." Through these six comprehensive modules, you've developed a sophisticated understanding of trauma-informed care principles, evidence-based interventions, telehealth adaptations, cultural considerations, and practice sustainability.

**Key Takeaways for Implementation**

As you return to your practice, remember:

1. **Trauma-informed care is a lens, not just a technique** - It should influence every aspect of your practice, from intake procedures to office design to documentation.
2. **Safety is the foundation** - Both physical and psychological safety must be established before deep trauma work can begin.
3. **Technology enhances but doesn't replace connection** - Telehealth offers unique opportunities for trauma treatment when implemented thoughtfully.
4. **Cultural humility is ongoing** - Continue learning about how culture, identity, and systemic factors influence trauma and healing.
5. **Your wellness matters** - Sustainable trauma practice requires intentional self-care and professional support.

**Your Action Plan**

Before implementing changes:

1. Assess your current practice through a trauma-informed lens
2. Identify one immediate change you can make this week
3. Develop a three-month plan for larger implementations
4. Schedule regular consultation or supervision
5. Plan your continuing education path

**Continuing Education Resources**

* National Center for Trauma-Informed Care (SAMHSA)
* International Society for Traumatic Stress Studies (ISTSS)
* EMDR International Association (EMDRIA)
* International Association of Trauma Professionals (IATP)
* Somatic Experiencing International (SEI)

**Final Reflection**

The work of trauma healing is sacred work. Each day, you hold space for humanity's deepest wounds and greatest resilience. This course has equipped you with advanced knowledge and skills, but remember that the most powerful tool you possess is your compassionate presence.

As Dr. Peter Levine reminds us, "Trauma is a fact of life. It does not, however, have to be a life sentence." Through your trauma-informed practice, you offer pathways from surviving to thriving, from fragmentation to wholeness, from isolation to connection.

Thank you for your commitment to trauma-informed care. Your dedication to learning and growing in this field makes a profound difference in the lives of trauma survivors. May you practice with wisdom, compassion, and hope, knowing that healing is always possible.

**Certificate of Completion**

Upon successful completion of the final examination with a score of 80% or higher, participants will receive a certificate for 6 CEU hours in "Building a Trauma-Informed Practice & Telehealth."

This course has been designed to meet continuing education requirements for:

* Licensed Professional Counselors (LPCs)
* Licensed Clinical Social Workers (LCSWs)
* Licensed Marriage and Family Therapists (LMFTs)
* Licensed Psychologists
* Other mental health professionals as approved by their licensing boards

*Course Developer: [Your Organization]* *Last Updated: 2024* *Next Review: 2025*

**For questions about this course or continuing education credits, please contact:** [Contact Information]

**Technical Support:** [Support Information]

**Additional Resources:** [Resource Library Link]

*© 2024 - This course material is protected by copyright. Reproduction or distribution without written permission is prohibited.*