TRAUMA MATTERS

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TRAUMA-INFORMED AND RECOVERY-ORIENTED?

As part of its Trauma Center of Excellence program, the Northwest Mental Health Authority has been focusing in recent months on developing a more "trauma-informed" service system. Trauma-informed approaches take into account knowledge about the impact of trauma and trauma recovery in all aspects of service delivery. This perspective emphasizes that, in addition to offering trauma-specific interventions like TARGET, TREM, or Seeking Safety, the service system as a whole needs to be welcoming and responsive to the very large proportion of consumers who are survivors of interpersonal abuse or violence. A recurring question has emerged in this initiative's early planning sessions: What is the relationship between "trauma-informed" and "recovery-oriented" services?

The short answer is that these two approaches are thoroughly compatible with each other. They share certain core values and commitments. Both emphasize, for example, the goal of consumer empowerment and the necessity of hope. Both recognize the importance of consumer choice in services and consumer roles in planning and evaluating the service system. Both recommend a strengths-based model that draws on the unique skills consumers bring to, and can develop in, the course of recovery. Both highlight the need for individualized supports based on each consumer's specific experiences and goals.

However, because trauma-informed and recovery-oriented service models have emerged from different aspects of many consumers' experiences—the former with interpersonal violence and the latter with mental health and/or substance abuse problems—the two approaches put different questions and needs in the foreground. Trauma-informed approaches are built on what we know about common responses to physical, sexual, and emotional abuse. For instance, because trauma survivors have been particularly sensitized to potential signs of danger, ensuring emotional and physical safety in the service context is a top priority. Because trauma so often involves the abuse of power in relationships that were supposed to be caring ones, the trauma-informed system prioritizes collaboration, shared decision-making, and clear roles and boundaries in the services relationship. Because traumatic stress is part of so many individuals' lives, including many providers', and because vicarious or secondary traumatization is a real risk, a trauma-informed system also emphasizes the safety and support needs of service providers.

The pervasiveness and broad impact of trauma therefore raises distinctive questions and focuses our attention on somewhat different systems and services modifications than a recovery-oriented approach. Though the overarching goals of trauma-informed and recovery initiatives overlap to a significant degree and can certainly be mutually reinforcing, the two initiatives highlight unique concerns on the road to a safe, engaging, responsive, and helpful human service system.

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FALL TRAINING CATALOGUE

The Connecticut Women's Consortium, a statewide policy, training and advocacy organization specializing in women's behavioral health, is pleased to present our fall 2005 training catalogue, which is a reflection of our commitment to the provision of gender responsive, trauma informed and culturally sensitive services. In support of work being done through the Department of Mental Health and Addiction Services (DMHAS) Trauma Center of Excellence, we have added two trauma-related workshops and are bringing back two nationally recognized experts in trauma, Dr. Stephanie Covington and Dr. Kenneth Hardy. For more information, please call 203-498-4184 ext. 30 or you can access the training catalogue at www.womensconsortium.org.

Watching the News Is Traumatic Witnessing

I grew up thinking that it was important to know what is going on in the world, so I began watching the nightly news and reading the daily paper at a young age, a habit that I have continued into adulthood. Many Americans share my habit. However, the satisfaction I know that I am supposed to feel from being informed has, lately, been overwhelmed by what can best be described as traumatic witnessing. The desire to know, in other words, has become supplanted by an even more powerful compulsion to remain ignorant of the horrors that human beings seem quite willing to commit against others.

Among the pieces of information communicated through recent news stories are: Natalee Holloway went missing in Aruba on the last night of her senior class trip. Serial sex offender, Joseph Edward Duncan III**,** kidnapped eight-year old Shasta Groene from her Idaho home. A fifteen-year old boy was convicted of killing his grandparents when he was twelve. More than 1100 new cases of priest sexual abuse were leveled against the Catholic Church this year. Across the country, foster parents starve and neglect children in their care. Students bring weapons to school, sometimes injuring or killing their teachers and other students. Public school teachers have been convicted of statutory rape of their students. It took 41 years for Edgar Ray Killen to be convicted for the murders of three civil rights workers. 2.3 million people die from AIDS related causes each year in Sub-Saharan Africa. 35.9 million people in the United States live in poverty; 45 million have no health insurance. After September 11th 2001, firefighters and police have retired with disabling PTSD. The recent Asian tsunami took over 150,000 lives; some children orphaned by this disaster have been forced into prostitution. College professors and students have been prosecuted for downloading child pornography. Date rape on American campuses has been largely dismissed and, therefore, not prosecuted. Incest proves tragically ineradicable. News stations broadcast suicide bombings, deaths resulting from military actions, hostage taking and beheadings, and Iraqi citizens anguished by their losses. Over 370 American service men were accused of rape this year, triple the rate a year ago. Psychologists estimate that, as a result of their wartime experiences, one out of three service people will return to the United States with debilitating psychiatric disorders.

This list is not exhaustive; however, even incomplete, it makes the point: those of us who regularly watch and read the news absorb an inordinate quantity of traumatic content that, added to the experiences we bring to viewing and reading, provides indisputable evidence that, on **a** daily basis, we are witness to what Hannah Arendt terms "the banality of evil." Saturated by ongoing violence, suffering, and inhumanity, what have we become, as we gaze at the torture of others and are transported back to the memory of that time when we lost our faith? It seems that the banality of evil intoxicates its witnesses -- if it does not prompt a call to arms.

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"No More Secrets" Video and Guidebook

In October 2000, the Connecticut Department of Mental Health & Addiction Services (DMHAS) produced a video entitled "*Trauma: No More Secrets*". This is a documentary film based on the lives of four women who have experienced trauma and were introduced to the behavioral health system through their addiction and mental health issues. These inspiring women offer a frank discussion of their personal histories of childhood and adult trauma; their means of coping; their experience with substance abuse and mental health treatment providers; and their progress in recovery from a place of despair to one of hope.

The "*Trauma: No More Secrets*" video and guidebook are now available upon request from the CT Women's Consortium for a fee of $16.50 to cover reproduction and mailing costs. For a copy of the video and guide, please send a check/money order payable to The CT Women's Consortium. Mail to **The CT Women's Consortium, 205 Whitney Avenue, New Haven, CT 06511**. For more information please contact Joyce Crutchfield @ 203-498-4184, Ext. 33.

FEATURED RESOURCE:

National Center for PTSD

The National Center for PTSD " was created within the Department of Veterans Affairs in 1989, in response to a Congressional mandate to address the needs of veterans with military-related PTSD". (www.ncptsd.org) However, don't let this description deter you if you do not work with veterans. This website is full of fact sheets, information and has a database called "pilots" that will help you locate abstracts and full-text articles related to trauma and PTSD. Topical information is timely**.** For example**,** shortly after the bombing in London there was information available about bombings and terrorism as soon as you clicked on to the site.

Posttraumatic Stress Disorder: An Overview

A National Center for PTSD Fact Sheet

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A brief history of the PTSD diagnosis

The risk of exposure to trauma has been a part of the human condition since we evolved as a species. Attacks by saber tooth tigers or twenty-first century terrorists have probably produced similar psychological sequelae in the survivors of such violence. Shakespeare's Henry IV appears to meet many, if not all, of the diagnostic criteria for Posttraumatic Stress Disorder (PTSD), as have other heroes and heroines throughout the world's literature. The history of the development of the PTSD concept is described by Trimble. In 1980, the American Psychiatric Association added PTSD to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III) nosologic classification scheme. Although controversial when first introduced, the PTSD diagnosis has filled an important gap in psychiatric theory and practice. From an historical perspective, the significant change ushered in by the PTSD concept was the stipulation that the etiological agent was outside the individual (i.e., a traumatic event) rather than an inherent individual weakness (i.e., a traumatic neurosis). The key to understanding the scientific basis and clinical expression of PTSD is the concept of "trauma."

In its initial DSM-III formulation, a traumatic event was conceptualized as a catastrophic stressor that was outside the range of usual human experience. The framers of the original PTSD diagnosis had in mind events such as war, torture, rape, the Nazi Holocaust, the atomic bombings of Hiroshima and Nagasaki, natural disasters (such as earthquakes, hurricanes, and volcano eruptions), and human-made disasters (such as factory explosions, airplane crashes, and automobile accidents). They considered traumatic events to be clearly different from the very painful stressors that constitute the normal vicissitudes of life such as divorce, failure, rejection, serious illness, financial reverses, and the like. (By this logic, adverse psychological responses to such "ordinary stressors" would, in DSM-III terms, be characterized as Adjustment Disorders rather than PTSD.) This dichotomization between traumatic and other stressors was based on the assumption that, although most individuals have the ability to cope with ordinary stress, their adaptive capacities are likely to be overwhelmed when confronted by a traumatic stressor.

PTSD is unique among psychiatric diagnoses because of the great importance placed upon the etiological agent, the traumatic stressor. In fact, one cannot make a PTSD diagnosis unless the patient has actually met the "stressor criterion," which means that he or she has been exposed to an historical event that is considered traumatic. Clinical experience with the PTSD diagnosis has shown, however, that there are individual differences regarding the capacity to cope with catastrophic stress. Therefore, while some people exposed to traumatic events do not develop PTSD, others go on to develop the full-blown syndrome. Such observations have prompted the recognition that trauma, like pain, is not an external phenomenon that can be completely objectified. Like pain, the traumatic experience is filtered through cognitive and emotional processes before it can be appraised as an extreme threat. Because of individual differences in this appraisal process, different people appear to have different trauma thresholds, some more protected from and some more vulnerable to developing clinical symptoms after exposure to extremely stressful situations. Although there is currently a renewed interest in subjective aspects of traumatic exposure, it must be emphasized that events such as rape, torture, genocide, and severe war zone stress are experienced as traumatic events by nearly everyone.

The above is an excerpt from a fact sheet available on www.ncptsd.org. To find the full text go to the website and to the left click on to "Overview of PTSD".

Safety Tips to Protect Your Credit

Cases of personal identity theft are increasing at an alarming number across this country. Below are a few tips for safe guarding your identity. Other tips and resources are available from Identity Theft Resource Center, a national nonprofit organization that focuses exclusively on identity theft. Located on the web at www.idtheftcenter.org.

- Watch for people who may try to overhear the information you give out orally (i.e. a phone number or other identifying information in a store).
- Carefully destroy papers you throw out, especially those with sensitive or identifying information. A crosscut paper shredder works best.
- Be suspicious of telephone solicitors. Never provide information unless you have initiated the call.
- If you have a minor child, occasionally check with the credit reporting agencies to make sure their social security number has not been compromised.
- You can reduce the number of pre-approved credit card offers you receive by contacting 1-888-5OPT OUT (they will ask for your SSN).
- Compare your earnings from your annual Social Security Administration report to make sure they are not overstated.
- Check your credit reports once a year from all three of the credit reporting agencies (TransUnion, Equifax & Experian).
- Guard your Social Security number. When possible, don't carry your Social Security card with you.
- Don't put your Social Security or drivers license number on your checks.

Getting into Trauma Matters

- You can access an electronic version of the "*Trauma Matters"* Newsletter at www.traumamatters.org; www.dmhas.state.ct.us; or www.womensconsortium.org
- Do you want to be placed on our mailing list or is there an event or topic you would like covered in this newsletter? Please call "*Trauma Matters"* editor Carol Huckaby at 203.498.4184, x25 or e-mail her at chuckaby@womensconsortium.org.

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PLAIN TALK ABOUT RECOVERY

Who Is In Recovery?

So what's all the talk about recovery and all the buzz about recovery initiatives? Isn't there enough work to go around and do either really matter? To help answer these questions, we need to understand that all of us are in recovery. That is, everyone can benefit from changing one's behavior to become a happier, healthier, and wiser (I couldn't help adding that one) person, to feel in more control of one's life, to be able to make decisions that lead to more positive outcomes, to cope better when "bad things happen," and to just plain enjoy life. Too often, it is tempting for us to differentiate ourselves from our clients, but all of us are on the same continuum.

Oh, so you don't think you're in recovery?

- *Never had anything terrible happen to you?*
- *Always do the right thing?*
- *Have no bad habits?*
- *Nothing you could possibly do differently that would result in a better life for yourself and for others around you?*
- *Always do what your doctor advises?*

Well, if not, then think change! Think doing what is good for you: emotionally, socially, physically, spiritually!

Let's look at some possibilities.

- *Have you or someone you love had a serious or debilitating physical illness?*
- *A severe accident necessitating a difficult hospitalization?*
- *How about the death of a loved one or the breakup of a relationship?*
- *Have you experienced war?*
- *Loss of a job or significant income?*
- *Have you or a loved one developed a chronic medical or psychological condition?*
- *Have you experienced physical, sexual or emotional abuse?*

Any of these events can set one back significantly and either create the need to get oneself on a path toward recovery or potentially stall one in a stressful and seemingly hopeless and devastating abyss from which escape seems impossible.

Let's try another set of scenarios. Some people need to recover from addictions and other self-destructive habits, and we're not talking here just of illegal drugs and alcohol. For instance, are you addicted to food, cigarettes, caffeine, gambling, shopping, overspending, or falling into debt? Many of us are in denial about these behaviors or know we need to change, have attempted to change, or have changed and relapsed. Sound familiar?

And finally, how many of us knowingly engage in unhealthy behaviors, which we choose to ignore, minimize, rationalize, or pretend won't really catch up with us?

What am I talking about?

You know; you've done it (or not done it)!

- *Do you exercise enough?*
- *Do you have a healthy and balanced diet?*
- *Are you at your ideal weight?*
- *Do you get sufficient sleep or rest?*
- *Do you drive too fast?*
- *Do you visit your dentist regularly?*
- *Do you get those annual physicals?*
- *When your doctor prescribes medication, do you really take those meds as prescribed?*
- *Do you have unprotected sex?*
- *Do you wash your hands as often as you should?*
- *Do you go through all those invasive screening procedures your doctor recommends?*

Most of us can probably identify at least a couple of unhealthy behaviors, addictive patterns, or major life events from which we need to recover. So our clients are not unique in needing to change: we can also improve our lives by staying on the path of recovery. But how do we help ourselves and others change?

What Can Recovery Initiatives Do For My Clients and I?

No one makes changes unless he or she is at a point where change is desired. As clinicians, our charge is to help people want to change, to convince people to believe that they can change, and to eventually help people effect positive changes in their lives.

Think about yourself for a moment! If you need or want to change something about your behavior and chose to seek out someone to help you (friend, family member, clergy, teacher, professional, etc.),

What kind of person would you seek help from?

- *Do you want to be scolded, made to feel stupid or lazy,*
- *or have your ideas dismissed as useless and worthless?*
- *Would you seek help from someone who told you that what you want for your future is foolish*
  - *or that you are bad in some way, shape, or form;*
  - *who put you down;*
  - *who admonished you to listen and to do what you are told;*
  - *who criticized, ridiculed, or demeaned you for not having done anything about the situation until now,*
  - *or who gave you an annoyed look for asking a question?*

Or would you prefer to work with someone who:

- *really listens to you,*
- *lets you talk,*
- *lets you know he or she truly understands what you are saying, how you feel, and what you are experiencing (accurate empathy);*
- *does not judge you or your behavior even though you know you have made many mistakes and a lot of not-so-great decisions;*
- *comes across as a genuine human being and respects you and what you want for your future regardless of your faults, shortcomings, and past failures?*

Now do some self-reflection! How do your clients see you: as the former or as the latter? Most likely they perceive you as some of both!

Clinical research repeatedly demonstrates that change outcomes significantly improve when there is a solid therapeutic relationship between the client and the treater regardless of therapeutic technique, school of psychotherapy, experience and degree(s). Outcomes always improve when the working relationship between client and treater is characterized by the latter description.

That description should sound familiar to many of you. If you remember "client-centered therapy" or Carl Rogers from your Psych 101 days, a bell should be going off; if you have some familiarity with "motivational interviewing," another bell should be sounding; and if you think "client-centered therapy" sounds suspiciously like "person-centered planning," then you should be shouting, "Bingo!"

Motivational Interviewing and Person-Centered Planning are key recovery concepts and will benefit us as staff, providing the means for improved understanding of and respect for clients, for improved job performance and satisfaction and for reduced likelihood of burnout. More importantly, these recovery concepts will benefit our clients by supplying us with the tools to increase clients' motivation, to improve their participation in and responsibility for treatment planning, to effect more and longer lasting positive change, to enhance clients' self-esteem, and ultimately, to help clients achieve more fulfilling and happier lives.

Divergence vs. Convergence

In reality many of us may have been utilizing these recovery concepts or may have known they exist for years. Many of us express the sentiments that underline these concepts already, and although at times it may feel like all the terms and concepts and "buzz words" are too complicated to understand, they all converge into a very cogent set of commonsense and effective ways to think about how we perform our work.

Yes, we are being asked to think about our clients in a different light and perhaps to work with them in new ways – exactly the same ways we would want our providers to work with us.

Maybe now is a good time to take stock of ourselves and to ask if we communicate clearly with our clients so that they really know what we are talking about – or do we use a lot of jargon and acronyms that we understand but that few others comprehend?

- *Do we validate and affirm our clients*
- *and help them believe that "better" is possible?*
- *Do we offer real choices?*
- *Do we truly see our clients as people we work* ***"with"***
- *as opposed to people we do things* ***"for"*** *or* ***"to"****?*

Well let's try to understand how these recovery concepts and initiatives converge:

- We need to meet our clients where they are in recovery, not where we think they should be.
- We need to use language, methods and approaches that correspond to clients' stages of recovery and that help them move through the stages of recovery at their own pace.
- We need to avoid berating clients if they fail at something or backslide.

If you use Motivational Interviewing or IDDT, you are heading in the right direction; if not, you need to get familiar with these protocols fast, but don't forget the Vocational IPS Model.

- We need to empower our clients, helping them regain control of their lives, and to work with our clients in partnership, fostering their independence.

Nobody said recovery was going to be easy for either our clients or for us. But thank goodness for WRAPs, Recovery-Oriented Language, Person-Centered Planning, IPS, the Recovery Guide Model, and especially for education and skill building.

- We need to be respectful and non-judgmental, to convey hope and optimism, to build confidence, and to avoid traumatizing or re-traumatizing our clients.

For this work, we should start using Recovery--Oriented Language as well as trauma-sensitive principles, and Motivational Interviewing techniques, which are covered in the IDDT training.

- We need to search out and adopt evidence-based practices that have been proven effective in helping people on the path to recovery.

This work might require learning both new knowledge and clinical techniques. Motivational Interviewing and IDDT are two such evidence-based practices.

- Finally, we always need to remember the professional mantra: "Never give up on the people with whom we work!"

Virtually all recovery-oriented practices incorporate this very basic and overriding concept, so if you don't already believe and follow this axiom, now is the time to start.

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