MODULE 2

Understanding the Impact of Trauma

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"What helps me (deal with trauma) is professionals who have the ability to take care of themselves, be centered, and not take on what comes out of me—not hurt by what I say—sit, be calm and centered and not personally take on my issues."
—Survivor from Maine

"Traumatic experiences shake the foundations of our beliefs about safety and shatter our assumptions of trust."
—David Baldwin

Learning Objectives

Upon completion of this module the participant will be able to:

- Define trauma and describe how it can impact consumers in mental health settings.
- List common reactions to trauma and identify how trauma affects the brain.
- Understand how hospitalization/seclusion/restraint can be retraumatizing for consumers.
- Incorporate trauma assessment and de-escalation forms into current practices.
- Recognize and utilize positive coping mechanisms to deal with secondary traumatization.

MODULE 2: UNDERSTANDING THE IMPACT OF TRAUMA

Background for the Facilitators **5**

Presentation (3 hours) **9**

Overview 9
Exercise: Trauma Background (25 minutes) 11
Definitions Related to Trauma 12
Common Reactions to Trauma 14
Exercise: Common Reactions to Trauma (20 minutes) 14
Effects of Trauma on the Brain 15
Differential Response to Threat 16
Assessment of Trauma 17
Exercise: Assessment of Trauma (20 minutes) 20
Retraumatization via Hospitalization 21
De-Escalation Preferences 22
Exercise: De-Escalation Preferences (20 minutes) 23
What Survivors Want in Times of Crisis 24
Staff Trauma (Secondary Traumatization) 25
Healing from Trauma 25
Grounding Techniques 26
Exercise: Grounding Techniques (10 minutes) 27
Journal/Take Action Challenge (15 minutes)

Handouts for Participants **28**

Journal Topics and Take Action Challenges for Modules 1 and 2 28
National Association of State Mental Health Program Directors (NASMHPD) Position Statement on Services and Supports to Trauma Survivors 29
Excerpts from Kate Reed's Speech 31
NAC/SMHA Position Paper on Trauma and Abuse Histories 35
What Can Happen to Abused Children 41
Some Common Reactions to Trauma 50
Trauma Assessment for Department of Mental Health Facilities/Vendors 51
Guidelines for De-Escalation Preference Form 54
De-Escalation Form for Department of Mental Health Facilities/Vendors 55

Excerpts from *Dealing With the Effects of Trauma: A Self-Help Guide* *59*
Grounding Techniques 62
Web Sites Related to Trauma. 64
Resources on Secondary Trauma 65
References 67

BACKGROUND

BACKGROUND FOR THE FACILITATORS: UNDERSTANDING THE IMPACT OF TRAUMA

Overview

A useful resource you may wish to read is *In Their Own Words: Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps, and What Is Needed for Trauma Services* (Maine Trauma Advisory Groups Report, 1997). All of the consumer quotes used in this module are from this source. For copies, please call the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, Office of Trauma Services at (207) 287-4250.

Adult survivors of trauma are disproportionately represented in the mental health system. Research suggests that at least half of all women and a substantial number of men who are diagnosed with a mental illness have a history of physical or sexual abuse or both (Brennan, 1997). Data on children and adolescents suggest even higher percentages (Massachusetts Department of Mental Health, 1995). Traditional treatment modalities, including the use of seclusion and restraint, are not always appropriate for trauma survivors, and may in fact be retraumatizing. "Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individual involved" (NASMHPD, 1998). It is important for staff to recognize the impact trauma can have on people diagnosed with a mental illness. Understanding how seclusion and restraint can in fact retraumatize and further abuse individuals who are already coping with a number of issues is vital to the elimination of the practice of seclusion and restraint.

Definitions Related to Trauma

(Source: www.childtraumaacademy.com)

Trauma can be defined as extreme stress that overwhelms a person's ability to cope. Some of the behaviors that developed in response to the initial trauma were survival strategies that no longer work. Many factors affect how any one person responds to trauma, including life experiences before and after the trauma, the age at which the trauma first occurred, the length and frequency of the trauma, the coping skills developed to deal with the trauma, who caused the trauma, and what help was provided after the trauma. Symptoms of trauma can include self-injury, assaultiveness, suicidality, substance abuse, impaired interpersonal relationships, repeated victimization, flashbacks, dissociation, and disturbances of mood and self-esteem.

Flashbacks are reoccurring memories, feelings, or perceptual experiences of a past event. Most times, flashbacks are traumatic and the person may lose awareness of present reality. The person re-experiences the past as if it were happening right now.

Dissociations are a wide range of responses that are usually some form of numbing or "tuning out." The person is disconnected from full awareness of self, time, and or/external circumstances.

Triggers are clues that remind a person of the trauma (often unconsciously) and start the response of re-experiencing or avoiding the trauma. Identifying triggers and realizing they are a normal response to trauma is part of the healing process. People who have experienced trauma often refer to themselves as "survivors."

Common Reactions to Trauma

Common reactions to trauma can include physical reactions such as nervous energy, muscle tension, grinding one's teeth, and upset stomach. Mental reactions to trauma may vary from a heightened sense of awareness of surroundings to a lessened sense of awareness or even disconnection from oneself. Difficulty making decisions and difficulty concentrating are also common. Fear, inability to feel safe, loss of trust and self-esteem, and feeling chronically empty are common emotional reactions. Finally, behavioral reactions include changes in eating habits, an increase or decrease in sexual activity, becoming withdrawn or isolated from others, and becoming confrontational.

Effects of Trauma on the Brain

(Source: www.childtraumaacademy.com)

We are just beginning to understand and recognize the physiological, neurological, and cognitive responses to trauma. Trauma in childhood can permanently alter neuron response and cognitive pathways in the brain. Trauma also affects the autonomic nervous system, which reaches into every major organ of the body. Trauma may be associated with abnormal activation of the amygdala, abnormal levels of cortisol, epinephrine, and norepinephrine, and structural changes to the hippocampus. All of these brain structures and neurochemicals play key roles in regulating our emotional, behavioral, physical, and mental health. Finally, the incidence of other serious illnesses, including chronic pain with no medical basis and cardiovascular and digestive problems, is higher among people who have experienced severe trauma. They are also more likely to have high blood pressure, atherosclerotic heart disease, abnormal thyroid and other hormone functions, and to be more susceptible to infections and other immune system disorders.

Differential Response to Threat

(Source: www.childtraumaacademy.com)

Research indicates that people generally respond in one of two ways to a perceived threat: dissociation or hyperarousal (Perry, www.ChildTrauma Academy.com). People who dissociate become detached, numb, compliant, have a decreased heart rate, and experience a suspension of time, de-realization, "mini-psychoses," and fainting. People who respond with hyperarousal may become hypervigilant, have anxiety, be reactive and have an alarm response, have an increased heart rate, and experience either fight (terror) or flight (panic).

BACKGROUND

Understanding and using a trauma paradigm can be significant in creating and sustaining cultural change on a unit. A trauma paradigm includes examining how a person with a mental illness might be retraumatized, particularly by the use of seclusion and restraint. People who have been sexually assaulted have said repeatedly that the retraumatization of being stripped and strapped down by staff was unbearable and caused further harm. *"After they unlocked the door and they dragged me in there, they said, well you can't keep your clothes for danger issues. And they made me strip down. They kept a video on me the whole time. For a girl who is awkward and is in there for issues of abuse at home, all that did was extend my hate."*

A trauma paradigm helps both staff and persons with a mental illness understand and change behaviors that no longer work. For all people who have a background of experiencing trauma, a clinical assessment of specific circumstances that elicit potentially harmful behaviors and what responses may help de-escalate problem behaviors is necessary and required by Joint Commission on Accreditation of Healthcare Organizations standards (JCAHO, 1995).

Assessment of Trauma

Accurately diagnosing trauma early on in hospitalization can significantly decrease the use of seclusion and restraint. Misdiagnosis is common and can lead to inappropriate medication, and wrong or ineffective treatment. Consumers are often reluctant to disclose a history of trauma because they are fearful of being judged, invalidated, or not believed. It is important for staff to recognize that how they ask about a history of trauma can significantly influence how a consumer responds. It is recommended that trauma history questions be asked routinely as part of a standard interviewing process, and the information, once obtained, be used to help guide treatment choices and recovery. In addition, staff needs to be trained in understanding behavior from a trauma paradigm.

Gayle Bluebird, a nurse and a consumer, developed tools for assessing trauma and de-escalation preferences for consumers with trauma histories. Similar forms have been developed by the Massachusetts Department of Mental Health Services and are available as handouts. We strongly encourage participants to take these forms back to their facilities and adapt them for their own use. An essential step to include is how this information will be used on a daily basis once it has been gathered.

Retraumatization via Hospitalization

Consumers often view hospitalization itself as retraumatizing, not to mention the use of seclusion and restraints. *"You are terrified and you try to get away from them and you strike out to protect yourself. Then they call you 'assaultive' and that follows you to the next hospital and they say to you, 'I hear you hit someone.'"* Unfortunately, people who are labeled as the most difficult clients often end up getting restrained or secluded. It is important to recognize the secondary traumatization of seclusion and restraint for both consumers and staff.

De-Escalation Preferences

Gathering information, in advance, from consumers about what helps and what hurts during times of crisis is key. Consumers can often tell staff specifically what works for them and what triggers them in advance of a crisis. This information needs to be readily accessible for staff and discussed well in advance of any crisis. An example of a de-escalation preference form that can be used as a template is included in the handouts.

What Survivors Want in Times of Crisis

In general, if staff thinks about what they would want in times of crisis, the same would hold true for consumers. It is often the simple things. For example, *"I want someone who can BE with me when I am in distress; be present with me when I am in pain." "I want someone who will acknowledge my pain without trying to 'fix' it. This takes someone who knows his/her own pain and is not afraid of it or of yours."*

Staff Trauma (Secondary Traumatization)

Staff members can experience both primary and secondary traumatization in their work environment. We know that 60 percent of all direct care staff are injured at some point in their work, which is a type of primary traumatization (JCAHO, 1999, George Blake testimony). Secondary traumatization is known by many names: compassion fatigue, secondary or vicarious traumatization, and burn out. The symptoms of secondary traumatization are usually less severe, but can affect the livelihoods and careers of mental health workers. It is important for staff to examine their own trauma, recognize their own symptoms and triggers, and develop their own plan of self-care in this demanding line of work. Finally, we cannot forget secondary traumatization that may occur for consumers and staff as they witness the violence (seclusion and restraint) that may happen on a unit. This is an area that needs much more exploration in the literature.

Healing From Trauma

Sue Coates from Turning Points, an agency in Grand Rapids, MI, in a presentation listed the following five elements necessary for healing from trauma: safety, empowerment, creation or restoration of positive self-regard, reconnecting to the world, and intimacy.

Grounding Techniques

Grounding refers to methods for stopping the re-experiencing of a trauma, or related symptoms, and getting back to the here and now. When a consumer reports/appears unusually anxious or vulnerable, is nonresponsive, or is reacting in other ways suggestive of re-experiencing trauma, try to help him or her focus on something in the present using one or more of the five senses: sight, smell, hearing, taste, or touch. For example, looking at a calendar with a current date on it may be helpful.

PRESENTATION

PRESENTATION

Welcome participants and review names. Make sure everyone has a nametag or name tent. It may be helpful to provide a quick review of Module 1: The Personal Experience of Seclusion and Restraint. Then go over the learning objectives.

Learning Objectives
Upon completion of this module the participant will be able to:

- Define trauma and describe how it can impact consumers in mental health settings
- List common reactions to trauma, and identify how trauma affects the brain
- Understand how hospitalization/seclusion/restraint can be retraumatizing for consumers
- Incorporate trauma assessment and de-escalation forms into current practices
- Recognize and utilize positive coping mechanism to deal with secondary traumatization

Overview

- This module is an overview of trauma and how trauma can impact working with consumers and direct care staff. Included is how hospitalizations, seclusion, and restraint can be retraumatizing to consumers and/or direct care staff that have a history of abuse or trauma.
- Adult survivors of trauma are disproportionately represented in the mental health system. Depending on how the research was conducted, it appears consistently that approximately 70 to 80 percent of consumers diagnosed with a mental illness also have a history of trauma. Trauma is often underdiagnosed. Little research is available on the rates of direct care staff with histories of trauma.
- Early childhood trauma actually physiologically impacts brain development. Many of the behaviors associated with trauma may be a result of this altered brain functioning.
- "Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individual involved" (NASMHPD, 1998).
- When working from a trauma paradigm, difficult behaviors are not pathologized, but rather are seen as brilliant coping mechanisms developed as a response to previous trauma.
- Ideally, trauma would be assessed and included in the treatment plan for all consumers/survivors, and direct care staff would be aware of and trained in issues of trauma.

PRESENTATION

- The quotes and information from consumers in this module come from *In Their Own Words: Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps, and What Is Needed for Trauma Services.* The Maine Trauma Advisory Groups compiled this report in 1997.

> *"Being a survivor is feeling isolated, not daring to share that part of my life (trauma) with people for fear of being rejected, feeling defective, feeling powerless, lack of understanding from professionals that whatever behaviors we took on was our way of calling for help even if it doesn't fit society's view of what is 'normal' behavior." Survivor from Maine*

- For consumers, there is a real fear of sharing trauma histories with direct care staff, because oftentimes it negatively impacts how they are treated.

> *"What helps me (deal with trauma) is professionals who have the ability to take care of themselves, be centered, and not take on what comes out of me – not hurt by what I say – sit, be calm and centered and not personally take on my issues." Survivor from Maine*

- Consumers are really asking for direct care staff to be present with them—not to fix the trauma or its outcome, but to really listen and be present.
- Trauma often feels like a loss of control. For consumers, being in the hospital also feels like loss of control. Being secluded or restrained really feels like loss of control.

PRESENTATION

Exercise/Discussion—Module 2

Trauma Background

OBJECTIVE: Familiarize participants with trauma paradigms.

PROCESS: Divide the class into four groups. Assign each group a different one of the four articles listed below and distribute copies to each participant. Have each group report to the large group on the article they read. They should tell the group who wrote the article and which stakeholder groups the author(s) represents. Then they should share three key points they think are the most important things to know about the information in the article they read. Facilitate a discussion.

DISCUSSION QUESTIONS:
What was most compelling to you about these articles?
What do you disagree with?
What has your experience been dealing with trauma survivors?

MATERIALS REQUIRED: Copies of each article for each participant to take home:

- National Association of State Mental Health Program Directors—Position Statement on Services and Supports to Trauma Survivors
- Excerpts from Kate Reed's speech
- National Association of Consumer/Survivor Mental Health Administrators—Position Paper on Trauma and Abuse Histories: The Prevalence of Abuse Histories in the Mental Health System
- What Can Happen to Abused Children When They Grow Up—If No One Notices, Listens, or Helps? (Maine Office of Trauma Services, 2001)

APPROXIMATE TIME REQUIRED: 25 minutes

Definitions Related to Trauma

It is important to be on the same page using the same language about trauma. This training will use the following definitions related to trauma:

Definition of Trauma:

Extreme stress that overwhelms someone's ability to cope.

Flashback

A recurring memory, feeling or perceptual experience of a past event, usually traumatic, including losing awareness of present reality. The person feels like they are re-experiencing the past as if it were happening right now.

Dissociations

A wide range of responses that are usually some form of numbing or "tuning out." The person is disconnected from full awareness of self, time, and/or external circumstances.

Triggers

Cues that remind a person of the trauma (often unconsciously) and start the response of re-experiencing or avoiding the trauma. Identifying triggers and realizing they are a normal response to trauma is part of the healing process.

PRESENTATION

Exercise/Discussion—Module 2

Common Reactions to Trauma

OBJECTIVE: Familiarize participants with common reactions to trauma.

PROCESS: Ask participants to think of people they have worked with who are trauma survivors and then ask them to brainstorm common reactions to trauma. Keep track of the list on the overhead/chalkboard/paper. Once they have listed as many as they can think of, hand out the *Some Common Reactions to Trauma* article.

DISCUSSION QUESTIONS:
Which common reactions to trauma did we miss?
Which common reactions to trauma do you most frequently deal with on the unit?
Which common reactions to trauma are the most difficult to deal with and why?

MATERIALS REQUIRED: *Some Common Reactions to Trauma* by Mary S. Gilbert, Ph.D.

APPROXIMATE TIME REQUIRED: 20 minutes

PRESENTATION

Effects of Trauma on the Brain

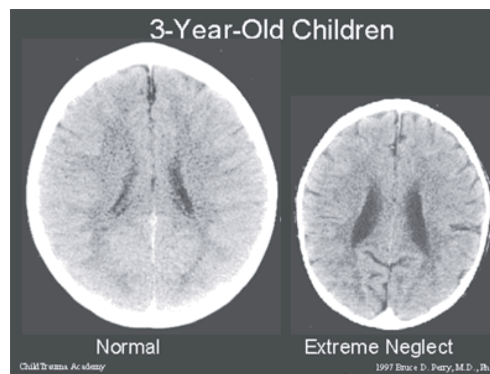
Science is just beginning to understand the physiological, neurological, and cognitive responses to trauma. The following information is from www.childtraumaacademy.com.

Effects of Trauma on the Brain

- Trauma can activate various systems in the brain that actually change neuron response and cognitive pathways.
- Children can develop systems in their brains that cause them to be constantly hyperaroused and hypervigilant or dissociate.
- Trauma affects the autonomic nervous system.
- Trauma may be associated with abnormal activation of the amygdala, abnormal levels of cortisol, epinephrine, and norepinephrine, and structural changes to the hippocampus.
- The incidence of other serious illness, including chronic pain with no medical basis, cardiovascular and digestive problems, is higher among people who have experienced severe trauma.

Effects of Trauma on the Brain

www.ChildTrauma.org



- "These images illustrate the negative impact of neglect on the developing brain. In the CT scan on the left is an image from a healthy 3-year-old with an average head size. The image on the right is from a 3-year-old child suffering from severe sensory-deprivation neglect.

This child's brain is significantly smaller than average and has abnormal development of cortex." These images are from studies conducted by a team of researchers from the Child Trauma Academy (www.ChildTrauma.org) led by Bruce D. Perry, M.D., Ph.D.

Differential Response to Threat

(Source: www.childtraumaacademy.com)

- Many factors affect one's response to trauma, including life experiences before and after the trauma, age at which the trauma occurred, length and frequency of the trauma, coping skills, who caused the trauma, and help that was available after the trauma.
- Responses to threat vary greatly from individual to individual.
- The flight (panic) or fight (terror) response is a well-documented reaction to danger. Our bodies have the same physiological reactions to dangers, whether it is a charging tiger or an episode of restraint.
- Other responses to trauma include dissociation and hyperarousal or a combination of the two.
- Children may not be able to fight or flee during times of threat—and may therefore use dissociation as a coping mechanism.
- We all use dissociative mental mechanisms even when we are not threatened—for example, daydreaming.

Differential Response to Threat

Dissociation	Hyperarousal
Detached	Hypervigilance
Numb	Anxious
Compliant	Reactive
Decreased Heart Rate	Alarm Response
Suspension of Time	Increased Heart Rate
De-realization	Freeze: Fear
Mini-psychoses	Flight: Panic
Fainting	Fight: Terror

Source: Perry, M.D., Ph.D. www.childtraumaacedemy.com

Assessment of Trauma

- Misdiagnosis of trauma may lead to ineffective treatment.

Assessment of Trauma

- Mental health professionals cannot develop appropriate treatment plans or interventions for clients in the absence of knowledge about their histories of physical or sexual abuse (JCAHO, Accreditation Manual for Mental Health, 1995).
- All clients need to be asked about their history of sexual, physical, and verbal abuse in all clinical settings.

- When doing an assessment, it is important to gather accurate information. At the same time, it is important not to reopen a traumatic event without having the resources available to adequately deal with it. This can be a source of tension on short stay units. However, it is important to ask the questions about trauma directly.

"Never being asked about trauma is like the abuse as a child."

Survivor from Maine

- The following material and quotes were taken from *In Their Own Words*, a work of over 200 women and men in the State of Maine who hope that the truth and wisdom of their work will be heard by those who are in power.

PRESENTATION

- Both survivors of abuse and professionals they trust gave voice to their experiences with the individuals, organizations, and systems that have been shaped and influenced in such a way that they frequently harm, instead of help, consumers.

Survivors and Trusted Professionals Speak About Recognizing (or Avoiding) the Prevalence, Indicators, and Impact of Trauma: What Hurts

- *The way questions were asked was impersonal, cold, and intimidating. (Survivor)*
- *It is fearful to disclose the abuse.*
  - *"You risk being judged, being penalized, being discredited, invalidated, and having your feelings minimized." (Survivor)*
  - *"When you get a mental illness label, you lose all credibility." (Survivor)*
- *The consequences of misdiagnosis include wrongful medication, over-medication, tardive dyskinesia and other reactions to medications, inappropriate and ineffective treatment. (Professional)*
- *Stigma in the mental health field is a problem. It takes a longer time for men to disclose abuse than women.*
- *"Men do not disclose their histories of sexual and physical abuse because of the stigma attached to being a male survivor." (Professional)*

Survivors and Trusted Professionals Speak About Recognizing (or Avoiding) the Prevalence, Indicators, and Impact of Trauma: What Helps

- Staff who are calm, who will sit and listen in a relaxed manner, are essential. *(Survivor)*
- The person doing the intake should understand the fear (of disclosing abuse).
  - *"Threats from the past are still present. If you tell, you will die, your sister will die." (Survivor)*
- Training is needed in looking for, identifying, assessing, and treating mental health clients in the framework of trauma. *(Professional)*
- Training is needed in putting aside one's own beliefs and expectations, and meeting clients where they are at, rather than where I think they may be. *(Professional)*

- Massachusetts has worked extensively in this area and has developed a Trauma Assessment Form that can be used as a guideline for obtaining trauma histories.
- Once the information has been collected, it is critical to do the next step of designing treatment plans using the trauma information.
- It is also critical to obtain information from the consumer on what strategies have been effective to reduce or avoid the use of seclusion and restraint. This includes identifying interventions that might further traumatize them.
- Massachusetts has developed a Restraint Reduction Form that is also included in the intake session with a consumer.
- It is important to know the gender of the perpetrator and give consumers a choice about who will be with them during and after a restraint episode.
- In summary, it is critical to obtain information relevant to (1) history or abuse, (2) de-escalation strategies that have worked, and (3) what forms of seclusion/restraint are most helpful and least traumatic.

PRESENTATION

Exercise/Discussion—Module 2

Assessment of Trauma

OBJECTIVE: Familiarize participants with one method of assessing trauma.

PROCESS: Direct participants to pair up. One person will role-play a consumer. It may be helpful for staff to think of a specific consumer to use as a model for this role-play. Have the person role-playing the consumer think of what kind of trauma (known or unknown) might be present for the consumer. The consumer is not allowed to look at the form as the staff person is filling it out.

Use the *Trauma Assessment for Department of Mental Health Facilities/Vendors* and have the person role-playing a staff person fill out the form. Facilitate a discussion.

DISCUSSION QUESTIONS:
What worked well about this kind of assessment form?
What concerns do you have about using this type of form?
How is this similar or different from intakes you currently do on your unit?

MATERIALS REQUIRED: *Trauma Assessment for Department of Mental Health Facilities/Vendors* handout

APPROXIMATE TIME REQUIRED: 20 minutes

PRESENTATION

Retraumatization via Hospitalization

Survivors Speak About Retraumatization via Hospitalization - Creating Safe Places for Healing: What Hurts – pg 1

- There is a lack of knowledge/training for survivors and staff regarding therapeutic approaches and the link between trauma histories and the presenting symptoms causing the need for hospitalization. *(Survivor)*
- There is a general disrespect for patients as human beings that should be valued as full partners in the treatment and recovery process.
- *"They take your clothes away and watch you take showers." (Survivor)*
- Insurance payments control the length of hospitalization.

Survivors Speak About Retraumatization via Hospitalization - Creating Safe Places for Healing: What Hurts – pg 2

- *"You're sick enough to stay when you have insurance. You're suddenly improved enough to leave as soon as your insurance runs out."*
- Seclusion and restraint techniques are retraumatizing and inhumane approaches to managing symptoms.
- *"I would rather die than go back to the hospital."*
- *"It involves 5-6 guys chasing you down, holding you down – just like rape. So you are terrified and you try to get away from them and you strike out to protect yourself. Then they call you 'assaultive' and that follows you to the next hospital and they say to you, 'I hear you hit someone.'" (Survivor)*

Survivors and Trusted Professionals Speak About Retraumatization via Hospitalization - Creating Safe Places for Healing: What Helps

- Training needs to be offered that addresses all the aspects of trauma recovery (staff and client issues).
- *"Training needs to be done in (1) how the staff can avoid being reactive; (2) recognizing when the staff or the client is in a state when they cannot receive information, for example because of high anxiety; and (3) when the staff should be interactive." (Professional)*
- Survivors need training also.
- *"When asking survivors about seclusion and restraint, ask them about what responsibility they have in the situation. Do not automatically put the person in a victim role." (Survivor)*

De-Escalation Preferences

- Gathering information about what helps and what hurts consumers during times of crisis is useful.
- Consumers can often tell staff specifically what works for them and what triggers them in advance of a crisis.
- If this information is gathered in advance, and all staff are aware of the information, it can be very helpful in defusing a crisis situation.

Exercise/Discussion—Module 2

De-Escalation Preferences

OBJECTIVE: Familiarize participants with one method of determining de-escalation preferences.

PROCESS: Direct participants to pair up in the same pairs as in the previous exercise. This time, switch roles; one person will play a consumer and the other will play a staff member.
Hand out the *Guidelines for De-Escalation Form*.
Have the person role-playing a staff person fill out the *De-Escalation Preference Form*.

Facilitate a discussion.

DISCUSSION QUESTIONS:
What worked well about this kind of preference form?
What concerns do you have about using this type of form?
What do you see as the pros and cons of asking consumers these types of questions?

MATERIALS REQUIRED:
Guidelines for De-Escalation Form handout
De-Escalation Preference Form handout

APPROXIMATE TIME REQUIRED: 20 minutes

PRESENTATION

What Survivors Want in Times of Crisis

- Think about a time you were in crisis. What did you want? Have the group brainstorm ideas out loud.

Survivors: When I am in crisis, I need persons:

- "Who can BE with me when I am in distress; be present with me when I am in pain."
- "Who will acknowledge my pain without trying to 'fix' it. This takes someone who knows his/her own pain and is not afraid of it or of yours."
- "Who is not afraid of my sexual abuse. I don't need someone else's fear."
- "Who has worked with their own sexual abuse – another survivor can do this."

Survivors: When I am in crisis, I need persons: (pg 2)

- "Who will ask what would help and trust I know whether or not I need hospitalization."
- "Who understands the coping role of suicidal thoughts, as a relief, and end to the pain, as giving a sense of some control."
- "Who knows the difference between "I want to die" (despair, hopelessness) and "I want to kill myself" (anger, defiance)."
- "Who will understand, control, and prevent me from hurting myself when I am in danger, but still give me options and choices, and respect me in a way that doesn't treat me like an animal."

- What consumers and direct care staff want in times of crisis is universal. We all want the same things.

Staff Trauma (Secondary Traumatization)

- Working in mental health is a demanding career that impacts all of us. Whatever happens on the units, impacts direct care staff and consumers.
- Secondary traumatization is known by many names: compassion fatigue, secondary or vicarious traumatization, absenteeism, and "burn out."
- Secondary traumatization affects primarily the workers who help trauma and disaster victims—including mental health staff.
- The symptoms of secondary traumatization are usually less severe than Post-Traumatic Stress Disorder like symptoms (e.g., hypervigilance, flashbacks to previous trauma, difficulty concentrating), but they can affect the livelihoods and careers of mental health workers.
- Secondary traumatization can also occur when one is a witness to violence. For example, other consumers watching a forceful escort to the seclusion room might experience secondary traumatization. Staff members watching another staff member get hurt in a take down could also experience secondary trauma.

Healing From Trauma

- Sue Coates, from Turning Points, an agency in Grand Rapids, MI, in a presentation listed five necessary elements for healing from trauma. (See slide.)

Five Necessary Elements for Healing From Trauma - "Turning Points" by Sue Coates

- Safety
- Empowerment
- Creation or Restoration of Positive Self Regard
- Reconnecting to the World
- Intimacy

- Safety includes physical needs such as food, clothing, and shelter. It also includes feeling psychologically and emotionally safe with those around you—knowing you will not be abused or harmed. If consumers are witnesses to other consumers' seclusion and restraint, this may impair their feelings of safety.
- Empowerment restores the hope that one has the potential and ability to recover. Consumer-driven supports, such as the Wellness Recovery Action Plan, the advance psychiatric directive, and peer mentoring are examples of empowerment.
- Creation or restoration of positive self-esteem naturally flows from empowerment. As consumers learn to rely on their own abilities and skills, their outlook on their lives and future improves and enhances their positive self-esteem.
- Reconnecting to the world gives consumers a sense of normalcy.
- All human beings need intimacy or closeness with another human being. Establishing positive relationships adds to a consumer's ability to heal from trauma.
- The Center for Mental Health Services, within the Substance Abuse and Mental Health Services Administration, published a booklet, *Dealing With the Effects of Trauma: A Self-Help Guide*. To see the complete publication, go to the Web at www.mentalhealth.org/publications/allpubs/SMA-3717/default.asp.
- Assisting consumers to develop their own coping mechanisms around trauma can be very empowering.

Grounding Techniques

Distribute the handout Grounding Techniques *by Mary Gilbert and take 10 minutes to do the exercise on grounding techniques.*

Journal/Take Action Challenge

Give participants time to write on one to two Journal topics and at least one of the Personal Take Action Challenges and one of the Workplace Take Action Challenges. They will use these Take Action Challenges extensively on the last day of the training.

PRESENTATION

Exercise/Discussion—Module 2

Grounding Techniques

OBJECTIVE: Familiarize participants with grounding techniques.

PROCESS: Have two volunteers do a role-play. One person will play the role of the consumer who is having flashbacks and/or dissociating. If possible, pick a person to play the role of the direct care staff member who has experience in grounding techniques. Facilitate a discussion.

DISCUSSION QUESTIONS: What types of things were most helpful in this role-play for grounding techniques?
What concerns do you have about using these types of techniques?
Which of these techniques do you typically use on a regular basis on your unit?

MATERIALS REQUIRED: *Grounding Techniques* by Mary S. Gilbert, Ph.D.

APPROXIMATE TIME REQUIRED: 10 minutes

HANDOUT

JOURNAL TOPICS AND TAKE ACTION CHALLENGES FOR MODULES 1 & 2

Journal Topics

Pick one or two questions and respond. Your responses are confidential.

1. Consider the impact that using seclusion and restraints has had on you as a staff member. Write about your first experience with seclusion and restraint. Describe the incident in as much detail as possible and how it made you feel.
2. How have you personally changed as a result of secluding and restraining others?
3. What do you see as the pros and cons of using seclusion and restraints?
4. Write about your own trauma or secondary trauma.
5. How could you incorporate stress management skills into your life and/or your workplace?
6. How would your daily work change if the mental health system wholeheartedly adopted the underpinnings of a trauma model?

Personal Take Action Challenges

Pick one topic and develop a plan. You will use this plan on the last day of training.

1. Make a list of three things that you personally can commit to every day at work to prevent the use of seclusion and restraint. Make a detailed plan of how you will implement these changes.
2. Find one area in your life where you could work recovering from trauma. Make a list of two things you can personally commit to in your daily life to move you forward in your own journey of recovery from trauma.

Workplace Take Action Challenges

Pick one topic and develop a plan. You will use this plan on the last day of training.

1. Make a list of three things that you can personally commit to doing when you get back to work to help change the system to eliminate seclusion and restraint.
2. Who has the power to eliminate seclusion and restraint in your facility? How could you design an alliance with them?
3. How could you utilize the trauma assessment form and/or de-escalation preference form in your workplace?

HANDOUT

National Association of State Mental Health Program Directors

Position Statement on Services and Supports to Trauma Survivors

The National Association of State Mental Health Program Directors (NASMHPD) recognizes that the psychological effects of violence and trauma in our society are pervasive, highly disabling, yet largely ignored. NASMHPD believes that responding to the behavioral health care needs of women, men, and children who have experienced trauma from violence is crucial to their treatment and recovery and should be a priority of State mental health programs. The goal of recovery from trauma is a fundamental value held by NASMHPD and its individual members, State mental health authorities. Toward this goal, it is important to develop an understanding of the resiliency factors, and the kinds of treatment, services, and supports that contribute to recovery.

The experience of violence and trauma can result in serious negative consequences for an individual's mental health, self-esteem, use of substances, and involvement with the criminal justice system. Indeed, trauma survivors can be among the people least well served by the mental health system as they are sometimes referred to as "difficult to treat" —they often have co-occurring mental health and substance use disorders, can be suicidal or self-injuring and are frequent users of emergency and inpatient services.

Trauma is an issue that crosses service systems and requires specialized knowledge, staff training, and collaboration among policymakers, providers, and survivors. Study findings indicate that adults in psychiatric hospitals have experienced high rates of physical and/or sexual abuse, ranging from 43 to 81 percent. Other research recently has found that 92 percent of homeless women and 81 percent of non-homeless women in poverty had been physically and/or sexually abused. Trauma is also frequently experienced as highly stigmatizing and often can create a reluctance to seek help. There is reason to believe that men may significantly under-report childhood abuse.

Services for trauma survivors must be based on concepts, policies, and procedures that provide safety, voice, and choice as defined by consumers/survivors. Trauma services must focus first and foremost on an individual's physical and psychological safety. Services to trauma survivors must also be flexible, individualized, culturally competent, and promote respect and dignity. Innovations in trauma services are becoming a focus of increased discussion and change within the public mental health system. A number of State mental health authorities have begun to address the needs of trauma survivors in the mental health system by revising seclusion and restraint guidelines to prevent the repetition of the experience of trauma, adopting clinical guidelines for people with serious mental illnesses who have histories of trauma,

Page 1 of 2

HANDOUT

NASMHPD Statement (continued)

developing statewide strategic action plans, producing training materials, and empowering statewide committees to develop and improve trauma services.

NASMHPD is dedicated to furthering the understanding of the effects of physical and/or sexual abuse and increasing its treatment within the public mental health system. State mental health authorities are committed to recognizing and responding to the needs of trauma survivors with mental illnesses and their families. It should be a matter of best practice to ask persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives. NASMHPD recognizes that some policies and practices in public and private mental health systems and hospitals, including seclusion and restraint, may unintentionally result in the revictimization of trauma survivors, and therefore need to be changed.

NASMHPD is committed to working with States, consumers/survivors, and experienced professionals in the trauma field to explore ways to improve services and supports for trauma survivors. These efforts may include, but are not limited to, developing improved methods for reducing stigmas related to trauma; developing and disseminating information and technical assistance on best practices; providing forums for a national dialogue on the needs of trauma survivors; and cooperating with other State and national organizations to develop prevention and education initiatives to address the issue of trauma.

Passed unanimously by the NASMHPD membership on December 7, 1998.

Page 2 of 2

Excerpts from Kate Reed's Speech

Feeling safe is really hard….and this is the one place where I feel really unsafe because I work in the system. I can sit up here and share my experience, but in the back of my mind I wonder if I approach one of you in the Department for a job, you might take that and hold it against me…..

I'm very moved by being here. I feel teary. There's a lot of emotion because this is something that I lived with in silence for 35 years of my life. To be sitting here and seeing other women and men share their experiences, and know that it takes an enormous amount of courage to live in terror on a daily basis and just put your feet on the floor every morning. But there are many people who are not here who did not live through it and I want to say that I hold them in memory now, too….

I was incested at the age of 2 ½ and it lasted until the time I was 8. It was by my paternal grandfather who lived right next door. It lasted for approximately 8 years and the incest progressively got worse and later on it involved bodily penetration. Those are the criteria that sort of set people up for having long-term psychological problems. Judith Hermann, an incredible feminist psychiatrist who writes about trauma issues, says that a single source of trauma like rape of an adult with an existing healthy personality can abrade that personality, can start eroding the health. But for women who have multiple traumas throughout child-hood, the trauma itself both forms and deforms the personality. What we are hearing from women talking about their experiences is the amount of reconstruction work you have to do. This is not the walking wounded. I was lucky to come out with my life. I had multiple sui-cide attempts. I overdosed and wound up in intensive care. To me, suicide held out a hope that the terror, the pain, all of it would stop. I had some control. If that's the only control I had I knew at some point I would say I'm not going to commit suicide today, maybe I will tomorrow. That's the reality. I had emotional problems right from the start. I struggled with depression. I struggled with low self-esteem that was off the charts. I mean low self-esteem is putting it mildly when you think of yourself as evil, as bad, as holding some energy that is incredibly dark.

I think I lived with just an enormous amount of terror. I was victimized again and again by my grandfather and I lived in terror. I didn't know when he was going to start again. I didn't know where. I was always on the lookout for what was coming; what was going to broadside me, and my body remembers that terror. I could forget. I could say that my childhood was fine, but my body remembered in a way that I could not forget, and my body reminds me frequently that it's still in charge. The post-traumatic stress is for me the hyperarousal level where your arousal level, your base line of anxiety level might hover around a 4 or 5. So that anything that happens can spike me into panic in an instant.

Page 1 of 4

HANDOUT

Kate Reed's Speech (continued)

I lost most of my life to trauma. I made choices out of the lie that I was forced to live, and my marriage was a victim of my healing process. I was hospitalized at the age of 21 and it took me 3 or 4 years to come out of that bout. What happened is that I got triggered into a string of post-traumatic stress where it was like getting tumbled over and over again in a wave; every time I tried to come out something else would hit me and I'd go back into the terror and I'd come back out and I'd go back into the terror and I lived that way pretty much daily, suicidal, in an enormous amount of pain and shame for probably 3 years at the first round. Then I managed to crawl out kind of like by the skin of your teeth and your nails to a place where I got married, had children. That was sort of a quiet period for a while and then my marriage was unraveling and I got incest memories at the same time.

When I say I have made multiple suicide attempts and been hospitalized many times, I worry about what some of you do with that in your head. Because I think that what happens in the system that has historically happened – is that they look at me or any of us who spoke and said what's wrong with you; what is wrong with you! I want to say it takes an enormous amount of courage to do what we have all done and I'm really grateful to be in the presence of women who have been creative and survived by hook or by crook in whatever way we could. When I look at myself, I think today I can be an incredibly compassionate judge of myself and others. I can be very nurturing; I have nurturing skills. I have an incredible ability to figure out how to heal myself in the face of a system that only retraumatized me, and I've hooked up with other people who were healing. I have wonderful people in my life today. I'm in a graduate program; I hope to have a private practice where I will treat incest survivors. My life to me is very hopeful today.

I want to talk a little bit about how I got here. I think one of the things that helped me to heal was to not label myself, because I needed to be a human being with human feelings, even if they were in the kind of extreme range of intense emotions. When my divorce was happening and I was getting a lot of incest memories, I had always had a few picture memories but I never had the affect. Then, it was like strap your seat belt; put your crash helmet on and hold on because now here come the pictures WITH the affect. There was an enormous amount of rage; there was an enormous amount of grief; there was an enormous amount of terror, and that went on for 3 or 4 years while I was getting the memories. What helped for me is my husband and I had built a house on the backside of Peaks Island. It was oceanside and it was a beautiful, beautiful setting and I had the backside of the island pretty much to myself. I would be flooded with grief and I would be on the floor in a fetal position just sobbing for hours and then in the middle I'd sort of stop and kind of try to regroup. Then I had my way of a rage that would go on and this process went on for a long, a long time. I had two Escort wagons where the dashboard was broken on both of them because I would be in the car and the rage would just be…like it was too much to contain the intensity of the emotion of the

Page 2 of 4

HANDOUT

Kate Reed's Speech (continued)

experience that I was going through; just to try to have it tip all the scales of what I could possibly cope with.

What I did was I got a therapist who was herself a survivor and she believed very simply that the baseline was that we can heal ourselves; that we have an internal healer and given the proper environment, we can initiate a healing process that will take us to where we need to go. It didn't take any fancy technology; for me it didn't take any medication; it didn't take any psychiatric diagnoses.

I want to put in perspective how the psychiatric community can come to use and try to help us; try to be of service to us. I got rid of as many of the system pieces in my life as I could because I realized that for the last 3 years I've been healing from the "help" that I got. I was thrown into restraints when I was suicidal; I was thrown into a straight jacket. I was coming out of an overdose and somebody said to me "What do you want do" and I said, "I want to go out to dinner" and they said "No." I was in a State hospital for a while and I've been in the fashionable Institute of Living in Hartford, Connecticut.

What really worked for me was to frame my experience not in a diagnosis but in a spiritual experience. It became a spiritual journey for me. I just let the feelings go. I tried to learn to trust my process and trust my inner healer and that worked for me. I danced a lot; just a dance that would sort of ground the enormous energies that were moving through me. I did a lot of externalization of the internal energy. I did Elizabeth Kübler Ross work where you basically get in a room with 80 people and they throw mattresses on the floor and it's like being in Dante's Inferno, but it's all of that dark stuff that we hold on to. It's all of the rage; it's all of the grief; it's all of the stuff that's actually very fertile because I think if you mind those emotions that what you come out with is an incredible gift, and I do believe that there are gifts in the experience of healing from incest, for me, I will say. I think you have to be in a certain place in a certain time in your recovery to acknowledge that, and some people may never want to and that's their choice, but for me there have been an enormous amount of gifts in the process. too.

I went to a 12-step program. I had a lot of shame and what worked for me was for somebody else to listen to me talk and to just accept who I was at that moment. To look back at me as another human being and to say, by the way they were holding me with their expression, that I was okay.

So I guess what I want to say is there's no technique stuff that's really the total answer. To me the people who were most powerful in my life were other people who could be with me in the intensity of my pain and just acknowledge that they were there. They didn't necessarily

Page 3 of 4

HANDOUT

Kate Reed's Speech (continued)

know how to help me sometimes but that they were there with me and I didn't have to be in terrified place alone.

I also had trouble getting a therapist. I also had trouble paying for my therapist because she was not reimbursable and she was my therapist of choice. I worked with her for 5 years and I had to pay out of pocket.

I just want to say I'm glad that everyone is here; I'm glad that the topic is on the table. I think it kills people all of the time and it's time to start ending the silence around it. Thank you.

This selection is excerpts from a speech by Kate Reed, Maine, trauma survivor and mental health professional, from In Their Own Words: Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps, and What Is Needed for Trauma Services, *Maine Trauma Advisory Groups Report, 1997.*

Page 4 of 4

HANDOUT

National Association of Consumer/Survivor Mental Health Administrators

Position Paper on Trauma and Abuse Histories
The Prevalence of Abuse Histories in the Mental Health System

In the last decade, the mental health system has begun to demonstrate some awareness of the prevalence of abuse histories among its clientele. Studies consistently confirm a 50-80 percent prevalence rate of sexual and physical abuse among persons who later acquire diagnoses of mental illness (Breyer, 1987; Beck & Van der Kolk, 1987; Rose et al, 1992; Craine et al, 1988; Stefan, 1996). While many professionals in the field still deny the validity of work documenting these histories, the mental health system is beginning to catch up with groups that have addressed violence toward women, child abuse, and runaway adolescents in realizing the connections between abuse and later difficulties (Alexander & Muenzenmaier, 1998; Smith, 1995; Harris, 1994; New York State Office of Mental Health, 1993; Mental Health Association in New York State & New York State Office of Mental Health, 1994).

Among consumers/survivors/ex-patients (C/S/Xs) themselves, the commonality of abuse histories has begun to be acknowledged. With that acknowledgment, the irrelevance of much of their "treatment" in the mental health system has begun to make sense in a new way. Many whose treatment focus has changed from medical model interventions to trauma-oriented therapies, whether professional or peer-run, have recovered in ways once considered impossible.

It would seem, therefore, that the mental health system's recognition of abuse histories would be welcome news among C/S/Xs. However, for many who know the system well, the news is greeted with deep ambivalence. For some, it is somewhat ironic, given the history of silence among most mental health professionals about abusive treatment that is often routine in mental health settings. Others are deeply relieved by professionals' long-overdue recognition of trauma as a primary issue to be addressed therapeutically, but fear that a system so entrenched in punitive ways will not be able to incorporate the kind of work necessary to heal from trauma (Kalinowski & Penney, 1998).

Some C/S/Xs have learned that the abuse in their histories has been the primary formative factor in what was called their "mental illness." Others see abuse or trauma as part of what affected them, but also believe that their symptoms had a variety of origins, including socio-economic, spiritual, and/or biological causes. Whatever view individuals hold concerning the role of trauma and abuse in the etiology of their problems, their experiences in the mental health system may color their reaction to the system's new-found interest in trauma and abuse. Many people have spent years in the system without being asked about their trauma

HANDOUT

NAC/SMHA Position Paper (continued)

history or other aspects of their personal stories; their behavior, rather than their experience, has been the focus of treatment. Many have also felt constantly threatened with the loss of autonomy and civil rights (Blanch & Parrish, 1993). For these individuals, it may be difficult to appreciate the professional world's "discovery" of a new theory of mental illness, regardless of its relevance to the majority of people caught up in the mental health system.

Until recently, the term "survivor," as used within the C/S/X movement, meant one who survived the irrelevance and frequently the harm of psychiatric interventions. Commonly, individuals have needed to recover from the effects of being labeled and institutionalized in order to begin addressing the issues that led to their encounter with psychiatry. Now that the term means "survivor of abuse" to many practitioners, C/S/Xs seek evidence that the abuse perpetrated by the mental health system itself is also recognized. They are deeply skeptical of trusting clinicians who have never questioned the criteria for involuntary commitment and deprivation of civil rights for so many diagnosed persons. People who have experienced trauma and abuse perpetrated by the very system which purports to help them may have a hard time believing that this same system is now willing and able to assist them in overcoming the effects of trauma.

Thus, C/S/Xs who advocate against forced and punitive treatment as traumatizing violations of their humanity, now point out that the majority of diagnosed individuals are actually being retraumatized in psychiatric settings (New York State Office of Mental Health, 1993). In the words of one C/S/X, if one was not a trauma survivor before entering the mental health system, one is sure to become one once labeled and locked up. In other words, no matter what theory an intervention is based on, unless the coercive culture of psychiatry is radically altered, many persons will continue to be traumatized, whether or not such experience is repetitious of their pasts.

In regard to the theory itself, some C/S/Xs are relieved by the long-overdue recognition of trauma and abuse as primary factors in the development of symptoms that were once adaptive coping strategies. Believing that this recognition must preclude further violations, they want to do therapeutic work on the issues that trauma and abuse created. Their choice might be to work on this and only this in individual or group work with professionals and/or peers. Others see the traumatic aspect of their histories as part of what affected them, but also believe they have biological or socioeconomic reasons for "symptoms" as well. Thus, they see multifaceted approaches as the only viable way to work.

Regardless of what C/S/Xs believe about the etiology of their difficulties, they want what they have always stated to be important: to be heard and treated as individuals and to have

Page 2 of 6

NAC/SMHA Position Paper (continued)

their subjective experience and self-perception respected. Also consistent with C/S/Xs' stated wishes over the years is the desire to be perceived and treated with hope (Zinman, Harp. & Bead, 1987; Campbell, 1989; Chamberlin, 1990; Knight, 1991; Fisher, 1994; Penney, 1995). It is difficult to count on a system that has routinely dashed hope to now operate from a belief that recovery is possible. But this is essential to any therapeutic plan and one seldom emphasized in professional training.

C/S/Xs frequently report that they were never asked about trauma or abuse, and if they were, divulging such history did not yield a specifically responsive result. Most believe the relevance of abuse and trauma should be communicated sensitively, early, and consistently throughout encounters with the system. However, it must be understood that such an approach is still only theory until chosen as useful by the individual consumer/survivor.

Given the documentation that the majority of people with psychiatric diagnoses are abuse survivors, many C/S/Xs think the most effective way to address trauma and abuse histories is to assume that all C/S/Xs are potentially abuse survivors. It should be considered integrally important to one's development up to assessment/admission, and the process of encountering the mental health system can be assumed as potentially retraumatizing or at least "triggering" of previous experience. If trauma were presumed, anyone entering the system would be subject to a more humane, considerate, and relevant approach. Importantly, this would eliminate the need for separate units for "trauma survivors" as if they were different people from those called "mentally ill." Interventions such as restraint and seclusion would be deemed too traumatizing for anyone in crisis, not only for one whose trauma history is known.

This becomes more of an issue as mental health professionals begin to address how to treat abuse survivors, particularly on an inpatient basis. Indeed, the "trauma models" they use often appear much more humane and respectful of the person than do traditional approaches to people with psychiatric diagnoses, and some who specialize in this area believe the new paradigm should dominate the field, regardless of what has brought a person to a mental health crisis. However, as psychiatry gains a foothold in the area, a new division of "patients" can be seen: trauma survivors, with diagnoses like Dissociative Identity Disorder (DID) and Post-Traumatic Stress Disorder (PTSD) vs. (and sometimes co-occurring with) more standard diagnoses of mental illness. In this context, the system continues to employ inhumane methods, such as forced medications or restraints, with some diagnosed persons, while an effort is made to avoid "retraumatizing" others.

This division is disturbing to C/S/Xs who see a new hierarchy of oppression forming before their eyes after years of fighting for the full human rights of all who cross the path of the

NAC/SMHA Position Paper (continued)

mental health system. They do not wish to see two groups of diagnosed individuals set up in opposition to each other, one treated with concern and compassion because of their trauma histories, the other treated in coercive, inhumane ways because they are thought to have a biological illness.

The issue of power differentials is crucial here. Abuse is about one person subjugating another—the violent assertion of one's will over another. Traumatic experiences, while not always interpersonal, similarly leave people feeling as helpless victims whose control was usurped by a more powerful condition or event. The risk for anyone entering the mental health system is fundamentally a loss of power. Even voluntary admissions to in- or out-patient services are governed by the coercive power held by psychiatry. The loss of power over one's life, which usually accompanies a diagnosis, is traumatizing for all people, whatever their past history of trauma or abuse.

Most C/S/Xs want to believe that practitioners care about outcomes beyond cost efficiency and behavior control. Thus, it is crucial in their opinion that practitioners be aware of the often dramatic improvements in the lives of C/S/Xs that result from being listened to and treated as individuals. This also means not forcing a trauma-related diagnosis or trauma-model services on individuals who are not comfortable with that approach. Again, individuals need to be listened to; while it might be useful to have theories suggested, no success is possible when one is imposed.

Mental health professionals would do well to consider how survivors managed all the years their abuse histories remained hidden. The strengths of individuals, peer support, and self-help gain new respect when it is recognized that for many, these have been the only avenues that have been available to them for support. The incorporation of trauma theories into the design and delivery of mental health services can provide a new opportunity to consider the integration of peer-run and other community resources as equally important to professional interventions.

Possibly the most important area being explored in services specific to trauma is one that C/S/Xs have also been exploring and advocating for years—that of advance directives (Backlar & McFarland, 1996; Sherman, 1994). Out of efforts to avoid retraumatizing survivors of abuse, some mental health assessments now include questions about what triggers difficulty for individuals and what they find most helpful in especially troubled moments. Perhaps this is because trauma survivors are seen as more capable of knowing themselves and what helps them, but it is a way of planning in partnership with professionals that C/S/Xs have long been aware of and supported. Many would go so far as to say that recovery is only possible where this kind of partnership is built and honored.

Page 4 of 6

HANDOUT

NAC/SMHA Position Paper (continued)

Given the dominance of the medical or biological model of mental illness in the field at this time, C/S/Xs are eager to use what is effective from the framework of trauma survival. A great deal of difference could be made in the lives of individuals if this growing body of information were used to support holistic and hopeful views of what is happening to them and what is possible for their futures. As one C/S/X put it, perhaps the "Decade of the Brain" could give way to the "Decade of Recovery"—recovery only being possible when all aspects of a person's development in context are given equal value, and a spectrum of healing possibilities are offered as real choices.

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HANDOUT

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HANDOUT

What Can Happen to Abused Children When They Grow Up—If No One Notices, Listens, or Helps?

Some Statistics from the Research

For purposes of this document, "abuse" and "trauma" are defined as interpersonal violence in the form of sexual abuse, physical abuse, severe neglect, loss, and /or the witnessing of violence.

If no one notices, listens, or helps, childhood abuse can lead in adult years to—

SERIOUS MENTAL HEALTH PROBLEMS

The mental health system is filled with survivors of prolonged, repeated childhood trauma.

- Fifty to 70 percent of all women and a substantial number of men treated in psychiatric settings have histories of sexual or physical abuse, or both. *(Carmen et al., 1984; Bryer et al., 1987; Craine et al., 1988)*
- As high as 81 percent of men and women in psychiatric hospitals with a variety of major mental illness diagnoses have experienced physical and/or sexual abuse. Sixty-seven percent of these men and women were abused as children. *(Jacobson & Richardson, 1987)*
- Seventy-four percent of Maine's Augusta Mental Health Institute patients, interviewed as class members, report histories of sexual and physical abuse. (Maine BDS, 1998)
- The majority of adults diagnosed with Borderline Personality Disorder (81 percent) or Dissociative Identity Disorder (90 percent) were sexually and/or physically abused as children. *(Herman et al., 1989; Ross et al., 1990)*
- Women molested as children are four times more at risk for Major Depression as those with no such history. They are significantly more likely to develop bulimia and chronic PTSD. *(Stein et al., 1988; Root & Fallon, 1988; Sloane, 1986; Craine, 1990)*
- Childhood abuse can result in adult experience of shame, flashbacks, nightmares, severe anxiety, depression, alcohol and drug use, feelings of humiliation and unworthiness, ugliness, and profound terror. *(Harris & Landis, 1997; Rieker & Carmen, 1986; Herman, 1992; Janoff-Bulman & Frieze, 1983; van der Kolk, 1987; Brown & Finkelhor, 1986; Rimsza, 1988)*
- Adults abused during childhood are:
  - more than twice as likely to have at least one lifetime psychiatric diagnosis
  - almost three times as likely to have an affective disorder
  - almost three times as likely to have an anxiety disorder
  - almost two and a half times as likely to have phobias
  - over ten times as likely to have a panic disorder

HANDOUT

What Can Happen (continued)

- almost four times as likely to have an antisocial personality disorder *(Stein et al., 1988)*

- Ninety-seven percent of mentally ill homeless women have experienced severe physical and/or sexual abuse. Eighty-seven percent experienced this abuse both as children and as adults. *(Goodman, Johnson, Dutton, & Harris, 1997)*

SUICIDE AND SELF-INJURY

- There is a highly significant relationship between childhood sexual abuse and various forms of self-harm later in life, i.e., suicide attempts, cutting, and self-starving, particularly. *(van der Kolk et al., 1991)*
- For adults and adolescents with childhood abuse histories, the risk of suicide is increased 4- to 12-fold. *(Felitti et al., 1998)*
- Most self-injurers have childhood histories of physical or sexual abuse. Forty percent of persons who self-injure are men. *(Graff & Mallin, 1967; Pattison & Kahan, 1983; Briere & Runtz, 1988)*

ALCOHOL AND DRUG ABUSE

- Nearly 90 percent of alcoholic women were sexually abused as children or suffered severe violence at the hands of a parent. *(Miller & Downs, 1993)*
- Up to two-thirds of both men and women in substance abuse treatment report childhood abuse or neglect. *(SAMHSA CSAT, 2000)*
- Teenagers with alcohol problems are 21 times more likely to have been sexually abused than those without such problems. *(Clark et al., 1997)*
- Seventy-one to 90 percent of adolescent and teenage girls and 23 to 42 percent of adolescent and teenage boys in a Maine inpatient substance abuse treatment program reported histories of childhood sexual abuse. *(Rohsenow et al., 1988)*
- HMO adult members who had experienced multiple childhood exposures to abuse and violence had a 4- to 12-fold increased risk of alcoholism and drug abuse, and a 2- to 4-fold increase in smoking. *(Felitti et al., 1998)*
- Adults abused during childhood are more than twice as likely as those not abused during childhood to have serious substance abuse problems. *(Stein et al., 1988)*
- Fifty-five percent of Augusta Mental Health Institute class members with a dual diagnosis of mental illness and substance abuse report histories of physical and/or sexual abuse. *(Maine BDS, 1998)*

SERIOUS MEDICAL PROBLEMS AND HEALTH RISKS

- Medical impacts of childhood abuse include head trauma, brain injury, sexually transmitted diseases, unwanted pregnancy, HIV infection, physical disabilities (back injury, orthopedic, neck, etc.) chronic pelvic pain, headaches, stomach pain, nausea, sleep disturbance, eating disorder, asthma, shortness of breath, chronic muscle tension, muscle

Page 2 of 9

HANDOUT

What Can Happen (continued)

spasms, elevated blood pressure. *(Prescott, 1998; Cunningham et al., 1988, Morrison, 1989; Springs & Friedrich, 1992; Walker et al., 1988)*

- Adults who had experienced multiple types of abuse and violence in childhood compared to those who had not, had a 2- to 4-fold increase in smoking, poor self-rated health, 50+ sexual intercourse partners, sexually transmitted disease, a higher rate of physical inactivity, and severe obesity. *(Felitti et al., 1998)*
- A major HMO study reports adverse childhood exposures showed a relationship with the presence of adult diseases, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. *(Felitti et al., 1998)*
- Research reveals severe and prolonged childhood sexual abuse to underlie damage to the brain structure, resulting in impaired memory, dissociation, and symptoms of PTSD. *(Briere, 1997; van der Kolk, 1996; Perry, 1994)*

DELINQUENCY, VIOLENCE, AND CRIMINAL BEHAVIOR

Reenactment of childhood victimization is the major cause of violence in our society.

- Numerous-studies have documented that most violent criminals were physically or sexually abused as children. *(Groth, 1979; Seghorn et al., 1987)*
- Over 95 percent of perpetrators who sexually abuse female children and over 80 percent of those who abuse male children, are men. Most of these men were abused themselves in childhood. *(Fergusson & Mullen, 1999)*
- Children from violent homes are 24 times more likely to commit sexual assault than their counterparts from nonviolent homes. *(Dinzinger, 1996)*
- Of 14 juveniles condemned to death for murder in the United States in 1987, 12 had been brutally physically abused and 5 had been sodomized by relatives as children. *(Lewis et al., 1998)*
- A study of convicted killers reports 83.8 percent suffered severe physical and emotional abuse and 32.2 percent were sexually violated as children. *(Blake et al., 1995)*
- Eighty-five percent of boys and girls committed to the Maine Youth Center report a history of childhood trauma. *(MAYSI: Massachusetts Assessment Youth Screening Inventory Assessment, Sept. 1999)*
- Over 75 percent of juvenile girls identified as delinquent by courts have been sexually abused. When they run away from the abuse at home, they are often labeled as delinquent. *(Calhoun et al., 1993)*
- Eighty percent of women in prison and jails have been victims of sexual and physical abuse. These women are far more likely to be abused while in prison. *(Smith, 1998)*
- Without help, one-third of those abused in childhood may abuse or neglect their own children, perpetuating an intergenerational cycle of abuse. *(Kaufman & Zigler, 1987)*

Page 3 of 9

HANDOUT

What Can Happen (continued)

DEVELOPMENTAL OR PHYSICAL DISABILITIES

- Violence is a significant causal factor in 10 to 25 percent of all developmental disabilities. *(Sobsey, 1994; Valenti-Hein & Schwartz, 1995)*
- Three to 6 percent of all children will have some degree of permanent disability as a result of abuse. *(Sobsey, 1994; Valenti-Hein & Schwartz, 1995)*
- Between 20 and 50 percent of abused children suffer mild to severe brain damage. *(Rose & Hardman, 1981)*

SEVERE SOCIAL PROBLEMS

Homelessness

- Seventy percent of women living on the streets or in shelters report abuse in childhood. Over 70 percent of girls on the streets have run away to flee violence in their homes. *(Goodman, 1991; Chesney-Lind & Shelden, 1998)*

Prostitution

- Victims of child sexual abuse are at high risk of becoming prostitutes in adolescence or as adults. More than 50 percent of prostitutes were sexually abused as children. *(Silbert & Pines, 1981; Bagley & Young, 1987)*

Poverty and Welfare

- More than 40 percent of women on welfare with multiple persistent problems in leaving the welfare roles were sexually abused as children. *(DeParle, 1999)*
- Sixty percent of housed, low-income mothers on AFDC, experienced severe childhood physical abuse and 42 percent were sexually molested as children. *(Bassuk et al., 1998)*

Truancy, Running Away, Risky Sexual Behavior

- Childhood abuse has been correlated with increased adolescent and young adult truancy, running away, and risky sexual behavior. *(Briere, 1997)*

REVICTIMIZATION

Predators look for weak or vulnerable people. Having been abused as a child—especially having been sexually abused, makes one vulnerable to being revictimized.

- Women who are sexually abused during childhood were 2.4 times more likely to be revictimized as adults as women who were not sexually abused. *(Wyatt et al., 1992)*
- Sixty-eight percent of women with childhood history of incest reported incidents of rape or attempted rape after age 14 compared to 38 percent of a random sample. *(Russell, 1986)*
- Girls who experience violence in childhood are three to four times as likely to be victims of rape. *(Browne, 1992)*
- Childhood sexual assaults are associated with increased risk of adult assaults of both a physical and sexual nature, whereas childhood physical assaults, by contrast, were not related to adult victimization experiences. *(Newman et al., 1998)*

Page 4 of 9

HANDOUT

What Can Happen (continued)

- Twice as many women with a history of incest as women without such a history are victims of domestic violence, and twice as many also report unwanted sexual advances by an unrelated authority figure. *(Russell, 1986)*
- Victims of father-daughter incest are four times more likely than non-incest victims to be asked to pose for pornography. *(Russell, 1986)*

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Page 9 of 9

HANDOUT

Some Common Reactions to Trauma

by Mary S. Gilbert, Ph.D.

Physical Reactions	Mental Reactions	Emotional Reactions	Behavioral Reactions
Nervous energy, jitters, muscle tension Upset stomach Rapid heart rate Dizziness Lack of energy, fatigue Teeth grinding	Changes in the way you think about yourself Changes in the way you think about the world Changes in the way you think about other people Heightened awareness of your surroundings (hypervigilance) Lessened awareness, disconnection from yourself (dissociation) Difficulty concentrating Poor attention or memory problems Difficulty making decisions Intrusive images	Fear, inability to feel safe Sadness, grief, depression Guilt Anger, irritability Numbness, lack of feelings Inability to enjoy anything Loss of trust Loss of self-esteem Feeling helpless Emotional distance from others Intense or extreme feelings Feeling chronically empty Blunted, then extreme, feelings	Becoming withdrawn or isolated from others Easily startled Avoiding places or situations Becoming confronta-tional and aggressive Change in eating habits Loss or gain in weight Restlessness Increase or decrease in sexual activity

Commonwealth of Massachusetts
Department of Mental Health

Trauma Assessment for DMH Facilities/Vendors

This form is a guide to gathering information with clients about a possible trauma history. It is recommended for use as part of the intake assessment for all DMH clients in all settings (inpatient, outpatient, emergency/crisis, day treatment, etc.). It should be used in conjunction with the De-Escalation Form. After clinical review, information obtained should be incorporated into the client's treatment plan.

1. Do you have a history of physical abuse (e.g., hit, punched, slapped, kicked, strangled, burned, threatened with object or weapon, etc.)?

Yes___ No___ Don't Know ___

If yes, in childhood? ___ adolescence? ___ adulthood? ___

at present? ___

By whom?

stranger ___ acquaintance ___ partner/spouse ___

parents ___ other family member ___ ritual abuse ___

2. Do you have a history of sexual abuse (e.g., unwanted kissing, hugging, touching, nudity, attempted or completed intercourse)?

Yes___ No___ Don't Know ___

If yes, in childhood? ___ adolescence? ___ adulthood? ___

at present? ___

Page 1 of 3

HANDOUT

Trauma Assessment (continued)

By whom?

stranger ___	acquaintance ___	partner/spouse ___
parents ___	other family member ___	

3. Have you ever been raped?

Yes___	No___	Don’t Know ___
If yes, in childhood? ___	adolescence? ___	adulthood? ___
	recently? ___	

By whom?

stranger ___	acquaintance ___	partner/spouse ___
parents ___	other family member ___	ritual abuse ___

4. Have you experienced an acute trauma such as a natural disaster, severe accident, or threat to life, or have you witnessed a death or violence to someone else, or been a victim of a crime?

Yes__	No __	Don’t Know ___

If yes, at what age and circumstances?

____

____

Page 2 of 3

HANDOUT

Trauma Assessment (continued)

5. If yes to any of the above, are you experiencing flashbacks, nightmares, insomnia, numbness, confusion, memory loss, self injury, extreme fearfulness or terror, etc., related to the trauma?

Yes ___ No___

If yes, describe.

____

____

Please incorporate the information obtained in the trauma assessment into the treatment plan for this client.

Page 3 of 3

HANDOUT

Guidelines for De-Escalation Preference Form

by Gayle Bluebird

1. The De-Escalation Preference Form should be completed within 24 to 72 hours of admission.
2. It is preferable that this form not be included in the admission packet or completed along with admission forms because most clients are not emotionally prepared to focus on these questions during that time.
3. The form may be administered during an individual interview or a group session. Even though the material is sensitive, it is often helpful to administer it in a group session. Persons sitting together at a table may feel more comfortable talking about the information while they answer the questions and may also encourage others to complete the form more thoughtfully. A group setting offers a more informational-type gathering as opposed to a clinical setting. If given during a group session, there should be several staff members present to help individuals who need support or assistance with reading, understanding, or answering the questions.
4. Careful consideration should be given as to who will administer the form. Ideally, it should always be the same person, someone who is both familiar and comfortable with the material. A consumer advocate employed by the hospital would be ideal, because peers are often less threatening than professional staff. It must be understood by the person administering the form that the form is not presented as treatment or therapy, but as helpful information that can be included in the treatment plan.
5. To effectively provide information, persons administering the form should be knowledgeable about the material. For example, it is helpful for a person to learn about additional efforts that are being made at the hospital to reduce seclusion and restraint and how this information will be used as part of that process. These persons should be able to answer questions about the request for sensitive information. For example, it is important that the information about touching at the hospital be presented as promoting appropriate, not inappropriate, touching.
6. When patients are not communicative enough to answer a question, they may be provided an opportunity to answer the question at another time, if they so desire.
7. Patients must always be given the option to decline answering a question.
8. The form, when completed, should be placed in the patient's file where it is known and used effectively by staff.
9. Persons served should be told how the form is to be used. They should be given a copy of the form to keep.

It may be helpful for the hospital to collect data on answers to these questions to

HANDOUT

identify patterns and trends that are important to patients.

Commonwealth of Massachusetts
Department of Mental Health

De-Escalation Form for DMH Facilities/Vendors

This form is a guide to gathering information with clients for the development of strategies to de-escalate agitation and distress so that restraint and seclusion can be averted. It should be used in conjunction with the Trauma Assessment Form. It is recommended for use in all inpatient facilities, psychiatric emergency rooms, crisis stabilization and other diversion units, when clinically indicated. Indications include a past history or likelihood of loss of control of aggressive impulses. After clinical review, the information obtained should be incorporated into the treatment plan for this client.

1. It is helpful for us to be aware of the things that can help you feel better when you're having a hard time. Have any of the following ever worked for you? We may not be able to offer all these alternatives, but I'd like us to work together to figure out how we can best help you while you're here.

- o voluntary time out in your room
- o listening to music
- o voluntary time out in quiet room
- o reading a newspaper/book
- o sitting by the nurses station
- o watching TV
- o talking with another consumer
- o pacing the halls
- o talking with staff
- o calling a friend
- o having your hand held
- o calling your therapist
- o having a hug
- o pounding some clay
- o punching a pillow
- o exercise
- o writing in a diary/journal
- o using ice on your body
- o deep breathing exercises
- o putting hands under cold water
- o going for a walk with staff
- o lying down with cold facecloth
- o taking a hot shower
- o wrapping up in a blanket
- o other (please list)

____

____

____

Page 1 of 4

HANDOUT

De-Escalation Form (continued)

2. Is there a person who has been helpful to you when you're upset? (Y/N)

Would you like them to come and visit you? (Y/N)

Can we assist in this process? (Y/N)

If you are in a position where you are not able to give us information to further your treatment, do we have your permission to call and speak to

________________________________ (name) __________________ (phone)? (Y/N)

If you agree that we can call to get information, sign below:

Client signature ________________________ Date _______________

Witness _______________________________ Date _______________

3. What are some of the things that make it more difficult for you when you're already upset?

Are there particular "triggers" that you know will cause you to escalate?

- o being touched
- o being isolated
- o bedroom door open
- o people in uniform
- o particular time of day (when?)
- o time of the year (when?)
- o loud noise
- o yelling
- o not having control/input (explain)
- o other (please list)

Page 2 of 4

HANDOUT

De-Escalation Form (continued)

4. Have you ever been restrained in a hospital or other setting—for example, in a crisis stabilization unit or at home?

	Physically/Mechanically	Chemically
When?		
Where?		
What happened?		

5. If you are escalating or in danger of hurting yourself or someone else, we may need to use a physical, mechanical, or chemical restraint. We may not be able to offer you all of these alternatives, but if it becomes necessary, we'd like to know your preferences.

- o Quiet room
- o Seclusion
- o Physical hold
- o Safety coat
- o Papoose board
- o 3-point restraint   Face up? ____   Face down? ____
- o 4-point restraint   Face up? ____   Face down? ____
- o Chemical restraint

6. Do you have a preference regarding the gender of staff assigned to you during and immediately after a restraint?

- o Women staff
- o Men staff
- o No preference

7. Is there anything that would be helpful to you during a restraint? Please describe.

____

____

Page 3 of 4

HANDOUT

De-Escalation Form (continued)

8. We may be required to administer medication if physical restraints aren't calming you down. In this case, we would like to know what medications have been especially helpful to you. Please describe.

____

____

9. We do room checks here to make sure you are okay at night. We are trying to make these room checks as nonintrusive as possible. Is there anything that would make room checks more comfortable for you?

____

____

Please incorporate the information obtained in the de-escalation form into the treatment plan for this client.

Page 4 of 4

HANDOUT

Excerpt from *Dealing With the Effects of Trauma: A Self-Help Guide*

Things You Can Do Every Day to Help Yourself Feel Better

There are many things that happen every day that can cause you to feel ill, uncomfortable, upset, anxious, or irritated. You will want to do things to help yourself feel better as quickly as possible, without doing anything that has negative consequences, for example, drinking, committing crimes, hurting yourself, risking your life, or eating lots of junk food.

- **Read through the following list.** Check off the ideas that appeal to you and give each of them a try when you need to help yourself feel better. Make a list of the ones you find to be most useful, along with those you have successfully used in the past, and hang the list in a prominent place—like on your refrigerator door—as a reminder at times when you need to comfort yourself. Use these techniques whenever you are having a hard time or as a special treat to yourself.
- **Do something fun or creative,** something you really enjoy, like crafts, needlework, painting, drawing, woodworking, making a sculpture, reading fiction, comics, mystery novels, or inspirational writings, doing crossword or jigsaw puzzles, playing a game, taking some photographs, going fishing, going to a movie or other community event, or gardening.
- **Get some exercise.** Exercise is a great way to help yourself feel better while improving your overall stamina and health. The right exercise can even be fun.
- **Write something.** Writing can help you feel better. You can keep lists, record dreams, respond to questions, and explore your feelings. All ways are correct. Don't worry about how well you write. It's not important. It is only for you. Writing about the trauma or traumatic events also helps a lot. It allows you to safely process the emotions you are experiencing. It tells your mind that you are taking care of the situation and helps to relieve the difficult symptoms you may be experiencing. Keep your writings in a safe place where others cannot read them. Share them only with people you feel comfortable with. You may even want to write a letter to the person or people who have treated you badly, telling them how it affected you, and not send the letter.
- **Use your spiritual resources.** Spiritual resources and making use of these resources vary from person to person. For some people it means praying, going to church, or reaching out to a member of the clergy. For others it is meditating or reading affirmations and other kinds of inspirational materials. It may include rituals and ceremonies—whatever feels right to you. Spiritual work does not necessarily occur within the bounds of an organized religion. Remember, you can be spiritual without being religious.
- **Do something routine.** When you don't feel well, it helps to do something "normal"—the kind of thing you do every day or often, things that are part of your routine, like

Page 1 of 3

Things You Can Do (continued)

taking a shower, washing your hair, making yourself a sandwich, calling a friend or family member, making your bed, walking the dog, or getting gas in the car.

- **Wear something that makes you feel good.** Everybody has certain clothes or jewelry that they enjoy wearing. These are the things to wear when you need to comfort yourself.
- **Get some little things done.** It always helps you feel better if you accomplish something, even if it is a very small thing. Think of some easy things to do that don't take much time. Then do them. Here are some ideas: clean out one drawer, put five pictures in a photo album, dust a book case, read a page in a favorite book, do a load of laundry, cook yourself something healthful, send someone a card.
- **Learn something new.** Think about a topic that you are interested in but have never explored. Find some information on it in the library. Check it out on the Internet. Go to a class. Look at something in a new way. Read a favorite saying, poem, or piece of scripture, and see if you can find new meaning in it.
- **Do a reality check.** Checking in on what is really going on rather than responding to your initial "gut reaction" can be very helpful. For instance, if you come in the house and loud music is playing, it may trigger the thinking that someone is playing the music just to annoy you. The initial reaction is to get really angry with them. That would make both of you feel awful. A reality check gives the person playing the loud music a chance to look at what is really going on. Perhaps the person playing the music thought you wouldn't be in until later and took advantage of the opportunity to play loud music. If you would call upstairs and ask him to turn down the music so you could rest, he probably would say, "Sure!" It helps if you can stop yourself from jumping to conclusions before you check the facts.
- **Be present in the moment.** This is often referred to as mindfulness. Many of us spend so much time focusing on the future or thinking about the past that we miss out on fully experiencing what is going on in the present. Making a conscious effort to focus your attention on what you are doing right now and what is happening around you can help you feel better. Look around at nature. Feel the weather. Look at the sky when it is filled with stars.
- **Stare at something pretty or something that has special meaning for you.** Stop what you are doing and take a long, close look at a flower, a leaf, a plant, the sky, a work of art, a souvenir from an adventure, a picture of a loved one, or a picture of yourself. Notice how much better you feel after doing this.
- **Play with children in your family or with a pet.** Romping in the grass with a dog, petting a kitten, reading a story to a child, rocking a baby, and similar activities have a calming effect which translates into feeling better.

Page 2 of 3

HANDOUT

Things You Can Do (continued)

- **Do a relaxation exercise.** There are many good books available that describe relaxation exercises. Try them to discover which ones you prefer. Practice them daily. Use them whenever you need to help yourself feel better. Relaxation tapes that feature relaxing music or nature sounds are available. Just listening for 10 minutes can help you feel better.
- **Take a warm bath.** This may sound simplistic, but it helps. If you are lucky enough to have access to a Jacuzzi or hot tub, it's even better. Warm water is relaxing and healing.
- **Expose yourself to something that smells good to you.** Many people have discovered fragrances that help them feel good. Sometimes a bouquet of fragrant flowers or the smell of fresh baked bread will help you feel better.
- **Listen to music.** Pay attention to your sense of hearing by pampering yourself with delightful music you really enjoy. Libraries often have records and tapes available for loan. If you enjoy music, make it an essential part of every day.
- **Make music.** Making music is also a good way to help yourself feel better. Drums and other kinds of musical instruments are popular ways of relieving tension and increasing well-being. Perhaps you have an instrument that you enjoy playing, like a harmonica, kazoo, penny whistle, or guitar.
- **Sing.** Singing helps. It fills your lungs with fresh air and makes you feel better. Sing to yourself. Sing at the top of your lungs. Sing when you are driving your car. Sing when you are in the shower. Sing for the fun of it. Sing along with favorite records, tapes, compact discs, or the radio. Sing the favorite songs you remember from your childhood.

Perhaps you can think of some other things you could do that would help you feel better.

Source: U.S. Department of Health and Human Services. (2002). *Dealing With the Effects of Trauma: A Self-Help Guide.* DHHS Pub. No. SMA-3717. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. www.mentalhealth.org/publications/allpubs/SMA-3717/things.asp

Page 3 of 3

HANDOUT

Grounding Techniques

by Mary S. Gilbert, Ph.D.

Grounding refers to methods for stopping the re-experiencing of a trauma, or related symptom, and getting back to the here and now. Often those with a trauma history experience such symptoms as flashbacks (a sudden, vivid memory of the event) or dissociation (various ways of disconnecting with traumatic experiences mentally, emotionally, or both by disconnecting in current reality). These symptoms happen against the consumer's will and feel out of control. A staff member can often help ground consumers by asking questions or directing them based on the suggestions below. Learning and applying grounding techniques are very important parts of consumers gaining some control over these symptoms.

When a consumer reports/appears unusually anxious or vulnerable, is nonresponsive, or is reacting in other ways suggestive of re-experiencing a trauma:

As an overall guide, mainly try to help the consumer focus on something in one or more of the five senses in the present: sight, smell, hearing, taste, or touch.

- Crucial to maintain visual contact with environmental cues.
  - Make sure the consumer is in a **well-lit area**—stay out of dark or dim areas, or turn on the lights. Recommend a night-light. (Beware of nighttime—darkness, fatigue, and a history of evening sexual abuse are often problems.)
  - **Don't allow hiding** in dark or confined places, even if s/he feels frightened or disorganized. Make sure **eyes** remain **open**.
  - Assist the consumer in looking at and **focusing on things around** her/him. For example, describe the color of the walls or carpet. Or, if s/he has a favorite object, like a stuffed animal, give that to her/him and assist the person in noticing how it looks, feels, and smells. (Focusing on familiar, comforting objects helps the consumer remain in or return to the present.)
  - Present previously developed **flashcards** that assist the consumer in recognizing s/he is only experiencing a flashback, not reality. (Statements on the cards need to come from the consumer.) These can also be placed on a mirror, for example, so you can direct the consumer's attention to them when necessary.
- Maintain personal contact with the consumer.
  - Say that **person's name** and **identify yourself**. Tell him/her where s/he is and the **full date**. Keep repeating this in reassuring, but **normal voice tones** (not soft or rhythmic). Tell the consumer you know s/he is frightened, but s/he is **safe**. Ask the consumer to look at your face and try to make direct, focused **eye contact** with the consumer. If frightened by eye contact, redirect to a different part of your body, like hair or shirt. Ask the consumer to **move her/his eyes** so as not to go into a daze. Be firm and direct.

Page 1 of 2

HANDOUT

Grounding Techniques (continued)

- **Remind** the consumer **of significant others,** such as a child or partner, if appropriate. (These interpersonal connections can be very grounding.)
- Direct the consumer to focus on a physical sensation.
  - Ask the consumer to start **naming what s/he sees** in the room, or what color her/his shirt is, etc.
  - Suggest s/he feels own **weight**, or the **chair** s/he is sitting on, or notices how his/her **feet** feel on the floor. Help the consumer **take a walk** (try stamping feet) around the room and **notice all that s/he sees and feels**. (These help remind the consumer that s/he is in reality here and now, not a part of a memory or reliving the event.)
  - Recommend the consumer get in the "in control" **body posture**.
- Focus on the present.
  - If not alarmed by it, help consumer **look in the mirror** and see that s/he is an adult, not a child in a traumatic situation.
  - Call the consumer's attention to a **calendar** and/or a **clock** and help him/her figure out what day and time it is. (Again, this can help the consumer realize s/he is not back in the midst of the trauma and return to the present.)
  - Ask the consumer **questions about the present**, like what TV shows s/he likes, or plans for the weekend, or the first thing s/he wants to do when s/he gets home.
  - Ask the consumer about her/his **interests or activities**, such as recreational activities or a pet. Don't choose anything emotionally charged or related to his/her trauma.
  - Direct and assist in **writing or drawing** about something positive. (These activities can often be soothing.)
- After a period of loss of control:
  - Help **reassure** consumer and **normalize** event/current situation.
  - If consumer is able, assist with **relaxation** techniques to help consumer further calm down.
  - Try to identify what causes the consumer's symptoms. Attempt to determine any possible **external triggers**. Help the consumer identify preceding **internal emotional events or states**. When possible and reasonable, help the consumer work out how to **avoid their triggers** until better able to ground her/himself and cope more effectively.
  - Determine body postures that accompany feelings of being flooded and/or overwhelmed, as well as **in control/adult body postures**. Help the consumer describe and practice the "in control" posture.
  - Plan new ways to attempt to **cope with stress** in the future (e.g., redirecting, transitional object, relaxation, etc.).
  - Develop a crisis response plan for the next occurrence. Plan a simple strategy and note what techniques worked best with consumer.

Source: Mary S. Gilbert, 2001. Partially adapted from *Rebuilding Shattered Lives* by Chu; and Courtois & Briere.

Page 2 of 2

WEB SITES RELATED TO TRAUMA

HANDOUT

www.rossinst.com
The Colin A. Ross Institute was formed to further the understanding of psychological trauma and its consequences by providing educational services, research, and clinical treatment of trauma-based disorders.

www.childtrauma.org
The Child Trauma Academy is a nonprofit organization based in Houston, TX. The mission of the Academy is to help improve the lives of traumatized and maltreated children and their families. The Academy encourages innovations in clinical practice, program development, and public policy. Many individuals and organizations share the Academy's vision and hopes for children; it is a central operating principle of the Academy to seek out, support, and work side by side with these individuals and organizations—both public and private.

www.sidran.org
The Sidran Institute is a leading provider of traumatic stress education, publications, and resources. It is a national nonprofit organization dedicated to supporting people with traumatic stress conditions, providing education and training on treating and managing traumatic stress, providing trauma-related advocacy, and informing the public on issues related to traumatic stress. Sidran is also a leading publisher of books about traumatic stress.

David Baldwin's Trauma Information Pages—www.trauma-pages.com
These pages focus primarily on emotional trauma and traumatic stress, including PTSD (Post-Traumatic Stress Disorder), whether following individual traumatic experience(s) or a large-scale disaster. New information is added to this site about once a month. The purpose of this site is to provide information for clinicians and researchers in the traumatic stress field. Baldwin's interests include both clinical and research aspects of trauma responses and their resolution. For example,

1. What goes on biologically in the brain during traumatic experience and its resolution?
2. Which psychotherapeutic procedures are most effective for which patients with traumatic symptoms, and why?
3. How can we best measure clinical efficacy and treatment outcome for trauma survivor populations?

Supportive resources supplement the more academic or research information of interest to clinicians, researchers, and students.

HANDOUT

RESOURCES ON SECONDARY TRAUMA

The Traumatic Stress Institute/Center for Adult and Adolescent Psychotherapy
Located in South Windsor, CT, the Traumatic Stress Institute has a dual mission: (1) to promote understanding and improve treatment of traumatic stress and (2) to promote psychology as a discipline and profession. This Institute has developed some very useful resources for professionals struggling with secondary traumatic stress.

The Traumatic Stress Institute
Center for Adult and Adolescent Psychotherapy
22 Morgan Farms Drive
South Windsor, CT 06074
(860) 644-2541
www.tsicaap.com

The Traumatology Institute
The Traumatology Institute is the home of psychologist Dr. Charles Figley, a pioneer in the field of compassion fatigue or secondary trauma. Dr. Figley is the founding editor of the *Journal of Traumatic Stress* and has written many articles and books on compassion fatigue or secondary traumatic stress.

The Traumatology Institute
School of Social Work
Florida State University
2407C University Center
Tallahassee, FL 32306-2570
(850) 644-4751
mailer.fsu.edu/~cfigley/TraumatologyInstitute.html

International Society for Traumatic Stress Studies (ISTSS)
ISTSS, founded in 1985, provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world. ISTSS is dedicated to the discovery and dissemination of knowledge and to the stimulation of policy, program, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences.

ISTSS
60 Revere Drive, Suite 500
Northbrook, IL 60062
(847) 480-9028
Fax: (847) 480-9282
www.istss.org

Page 1 of 2

Resources on Secondary Trauma (continued)

American Professional Society on the Abuse of Children (APSAC)
APSAC's mission is to ensure that everyone affected by child maltreatment receives the best possible professional response. This organization has many useful scholarly and clinical materials focused primarily at the professional audience. Nonetheless, caregivers working with abused or maltreated children may find this a useful resource.

APSAC
P.O. Box 30669
Charleston, SC 29417
(843) 764-2905
Toll-free: (877) 402-7722
Fax: (803) 753-9823
www.apsac.org

The National Center for PTSD
The National Center for PTSD is a program of the U.S. Department of Veterans Affairs and carries out a broad range of activities in research, training, and public information. The primary focus of the Center has been combat veterans and their families. Over the last few years, however, this focus has been expanded. The Center has many useful programs, activities, and resources for anyone interested in the effects of traumatic stressors.

The PILOTS database is an electronic index to the worldwide literature on PTSD and other mental health sequelae of exposure to traumatic events. It is available to Internet users through the courtesy of Dartmouth College, whose computer facilities serve as host to the database. No account or password is required, and there is no charge for using the PILOTS database.

The National Center for PTSD
www.ncptsd.org

Page 2 of 2

HANDOUT

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HANDOUT

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