



The Key

ASSISTANCE REPORT

FOCUS ON TRAUMA

National Mental Health Consumers' Self-Help Clearinghouse

IN THIS ISSUE

- *What is Trauma?*
- *Trauma-informed Care*
- *Men and Trauma*
- *Confronting Personal Trauma*

Of all the challenges confronting individuals working toward recovery, trauma remains one of the most formidable – and one that has traditionally not been well addressed by the mental health system.

“I’m a trauma survivor, ex-patient, mental health consumer, peer – whatever you want to call it,” said Cheryl Sharp, MSW, special advisor on trauma-informed services at the National Council for Community Behavioral Healthcare. “While I found recovery from drug addiction in the early 1980s, I never had a chance to address the core issues of what was going on with me. I had been in and out of psychiatric hospitals, rehabs; I’d attempted suicide. It was only later . . . that I began to recognize and address the trauma in my life. That . . . changed everything.” At that point, Sharp went back to school and began a career focused on trauma-informed care. “Before then, I’d had no idea that there was a trauma movement, but it became my life’s work.”

Mary Blake, a public health advisor at the Substance Abuse and Mental Health Services Administration (SAMHSA), works with the National Center for Trauma-Informed Care (NCTIC), a



SAMHSA technical assistance center. “I am a consumer and I am a trauma survivor, and for many years my trauma history wasn’t asked about or acknowledged by the services I received. In order to recover,” Blake recalled, “recognition and validation of my traumatic experiences – and services and supports to respond to them – were key. Part of my recovery was understanding who I was in the context of what had happened to me. . . . Coming to terms with my experience gave me a sense of validation about my life and helped me feel a little more in control.”

Sharp and Blake are now part of a larger movement to develop trainings for peers, advise providers and work with systems on service delivery – all

with a better understanding of trauma and the needs of trauma survivors.

WHAT IS TRAUMA?

“The best definition I have heard for trauma came from a woman in one of my trainings,” said Beth Filson, a certified peer specialist, curriculum developer and trainer. “This woman said, ‘Trauma is something that happened to you that still haunts you today or, if it doesn’t still haunt you, it sure did for a long, long time.’ Our culture equates trauma with PTSD [post-traumatic stress disorder], but that is only one response to trauma.”

Trauma can occur as a result of physical, sexual, or emotional abuse in childhood or adulthood, extreme neglect, domestic or criminal violence,

war, or natural disasters. But it can also stem from seemingly less dramatic events, such as surgery in childhood, sudden loss of a loved one, a car accident, profound betrayal, emotional and spiritual abuse, neglect, bullying, or even witnessing violence. It can be a one-time event or it can be ongoing. It often passes down from one generation to the next. Either way, it's not only a matter of the events themselves but also how the person interprets those events that make them traumatic. Childhood traumas can have a particularly severe effect.

Psychological symptoms of trauma include feelings of shock, denial or disbelief, anger or mood swings, guilt and self-blame, sadness and hopelessness, confusion, anxiety, the desire to withdraw from others, and disconnectedness. Trauma often elicits feelings of shame, betrayal, and a lack of trust, especially in the context of abuse at the hands of a trusted person. Physically, trauma might manifest as insomnia or nightmares, racing heartbeat, aches and pains, fatigue, difficulty concentrating, edginess and muscle tension. In the Adverse Childhood Experiences Study conducted by the Centers for Disease Control and the HMO Kaiser Permanente Department of Preventive Medicine in San Diego, childhood trauma has also been found to correlate to adult diseases, including heart disease, liver disease, obesity and hypertension, as well as health risk behaviors and social and emotional problems.

TRAUMA-INFORMED CARE

One of the most important aspects of creating a trauma-informed system is raising awareness. "As I travel around the country, what strikes me is that even those who [understand] their own trauma experience don't understand how big an issue trauma is in the larger world," Sharp said.

Mary Blake has come to see trauma as a common denominator. "Does it mean that every single individual [with a mental health condition] has a history of abuse or violence? No, but it means that it is the single most common experience, regardless of a

person's diagnosis. As I was learning more about the prevalence of trauma I was learning more about how it would impact people across every domain of their experience: their spiritual selves, their physical selves, their relational selves. I was flabbergasted by what I saw, and not many of my peers were talking about it very much. We absolutely need to be."

For Blake, trauma has become a critical part of the human rights platform of the peer movement. She believes that services and supports need to be responsive to the needs of trauma survivors. "Whether this trauma happens early in life or at the hands of the mental health system, it is something we need to be dealing with as a movement."

One reason that peers were not talking about trauma was that many people didn't relate to the language, Blake said. They also had never been asked about their experiences by clinicians, who instead focused on their "illnesses" or "what was wrong with them," she continued. And many professionals erroneously believed that trauma was a factor in only a small subset of the population and required a clinical intervention. "For many in the field, trauma was brought up more in the context of prescribed treatment as opposed to a life experience that people needed to make meaning of," Blake said.

Beth Filson found a similar dynamic occurring for the certified peer specialists she was training. "Every time they'd get into a meaningful relationship with a peer, the issue of violence and abuse came up. They were told as peers to stop the conversation and make a referral to a therapist. An ongoing belief the system holds is that we as peers do not have the capacity to support each other's healing from abuse. I kept wondering, does the system really have

the capacity for all of these therapists? And if we are going to talk about the 'power of peer support to aid in recovery,' why are we excluding healing from trauma as part of our recovery?"

Later, through work in Georgia in the aftermath of Hurricane Katrina and assisting the local Vietnamese community, Filson witnessed firsthand how storytelling and the sharing of difficult experiences could help people engage with their past trauma and move forward. "As a community, we can bear witness to each other's pain," she said. "The belief that we are too fragile as peers, that hearing about someone else's experience will trigger us, has done us all an injustice."

On a wider scale, trauma is starting to become an important focus for peer support. "We're really just starting to bring the issue of trauma front and center," said Filson.

A new technical assistance tool, *Engaging Women Trauma Survivors in Peer Support: A Guidebook*, developed by SAMHSA's National Center for Trauma-Informed Care, "is the first product of its kind directed to peers on issues of trauma, and I know it's going to be important . . .," said Filson, who co-authored the manual with Dr. Andrea Blanch and Darby Penney, with contributions from Cathy Cave.

Filson is consulting with the Massachusetts Department of Mental Health and the Transformation Center, a peer-run training and advocacy center, to pilot guidelines for working with individuals who self-harm. "As a person who has used self-inflicted violence and who has been through many cycles of psychiatric crisis and stabilization and hospitalization," Filson said, "it's pretty awesome that I'm having this dialogue with providers about self-injury

"We have to learn not to dismiss our experiences; a lot of us say, 'I didn't have trauma,' when we might not be considering the whole picture."

and self-harm, which we know is the product of trauma.” She said that more peer-run respites, which have become a crisis alternative to hospitalization, are incorporating trauma services.

Mary Blake is optimistic. “Finally, we are connecting the dots in terms of how those experiences may play a part in our distress and how they may help us to recover and heal,” she said. “Trauma-informed care is not an intervention. In many respects, it’s a way of doing business – being knowledgeable about trauma and its impact, understanding how common it is among our peers, focusing on safety and trust, creating environments that allow us to name and describe our experiences, creating validation and support for ‘what happened to us,’ and recognizing the need for choice and empowerment – that helps people reconnect to themselves, their peers and their community in a safe and healing way.”

MEN AND TRAUMA

Pat Risser, an award-winning human rights and mental health advocate who has been active in the consumer/survivor/ex-patient (c/s/x) movement for decades, has focused particular attention on the plight of male trauma survivors. Interviewed on the red carpet before accepting a 2011 SAMHSA Voice Award, Risser said, “Men have trauma issues that look a little different from women’s trauma issues. The primary abuser for women is often male. The primary abuser for men or boys is often also male. So being abused by someone of the same sex creates a whole different dynamic that creates emotional difficulties to overcome.”

At the same time, men are socialized very differently, which adds to their difficulties in coping with trauma, Risser said. “We’re sort of [told], ‘Suck it up and just get on and handle it.’ And when we reach the point where we can’t handle it anymore, we need a little extra help.”

Risser has advocated for many years to end the practice of seclusion and restraint, and is supported in this effort by those at the highest levels in mental health administration. “I’ve

been after the system to end the re-abuse and re-traumatization of people when they put them in seclusion and restraint, and I so appreciate that SAMHSA is leading the way to stop the trauma of treatment – to stop the hurt and the abuse that is happening in our community,” Risser said.

CONFRONTING PERSONAL TRAUMA

Those who have experienced trauma may eventually find it necessary to talk about it. In Filson’s case, the recovery journey always felt incomplete until she acknowledged the trauma that had been haunting her for years. “I knew why I was in the mental health system. I was seeking help for extreme distress that came out of actual events in my life. It blew my mind that I had to recreate my story through an illness lens, which was what was required in my therapy.”

For many who begin to grapple with past trauma, the shift can feel like a sea change. “I don’t subscribe to the idea that I have a brain disease,” Sharp said. “I might have had a genetic predisposition, but what happened to me as a young person had a profound effect on me which followed me through the rest of my life.”

Facing down traumatic experiences after many years of burying them can be daunting. Sharp advises starting slowly and deliberately. “. . . Most of my adult therapy discounted what happened, so I had no idea that what I’d experienced was actually trauma. . . . We have to learn not to dismiss our experiences; a lot of us say, ‘I didn’t have trauma,’ when we might not be considering the whole picture.”

Filson believes that whether you’re in therapy or talking to a peer, it is important to call attention to your own story. “If you feel like you have events and issues in your life that have not been addressed, it is your right to demand attention. As peers we understand the power of listening and connecting, and not silencing one another.”

Dealing with trauma may not be easy but it is rewarding. “Regardless of what

RESOURCE LINKS

The Adverse Childhood Experiences Study
www.acestudy.org

National Center for Trauma-Informed Care
<http://www.samhsa.gov/nctic/trauma.asp>

National Trauma Consortium
<http://www.nationaltraumaconsortium.org/>

Centers for Disease Control and Prevention: Coping with a Disaster or Traumatic Event
<http://www.bt.cdc.gov/mentalhealth/>

David Baldwin’s Trauma Information Pages
<http://www.trauma-pages.com/support.php#Trauma>

Healing Self-Injury
www.healingselfinjury.org

Help Guide on Healing Emotional and Psychological Trauma
http://helpguide.org/mental/emotional_psychological_trauma.htm

The Surviving Spirit
www.survivingspirit.com

Healing the Trauma of Abuse: A Women’s Workbook
<http://mentalhealthrecovery.com/store/healing.html>

The Anna Institute
<http://www.annafoundation.org>

Pat Risser at the 2011 SAMHSA Voice Awards
<http://www.youtube.com/watch?v=UihdgJUpBs>

has happened, as long as there’s breath, there’s life, and as long as there’s life, there’s hope,” Sharp said. “Healing from trauma is absolutely possible but people have to go at their own pace. It’s not about living in the past; it’s about looking towards the powerful future.” ■



The Clearinghouse welcomes all programs in which consumers play a significant role in leadership and operation to apply for inclusion in its Directory of Consumer-Driven Services. The directory, accessible at www.cdsdirectory.org, is searchable

by location, type of organization, and targeted clientele, and serves as a free resource for consumers, program administrators and researchers.

Apply online at www.cdsdirectory.org/ contact, via fax at 215-636-6312, or by phone at 800-553-4KEY (4539). To receive an application by mail, write to info@cdsdirectory.org or NMHCSH Clearinghouse, 1211 Chestnut Street, Suite 1100, Philadelphia, PA 19107.

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Clearinghouse Executive Director
Joseph Rogers

Writer
Elisa Ludwig

Editor
Susan Rogers

Design
Pamela Downes Lee
Downes Designs

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(800) 553-4KEY (4539) www.mhselfhelp.org info@mhselfhelp.org

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1211 Chestnut Street, Suite 1100
Philadelphia, PA 19107

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