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Cutting Through the Chaos — Trauma and Abuse Recovery

By Kate Jackson

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An innovative program in the nation's capital gives women with mental illness and substance abuse issues the tools to understand the impact trauma has on their lives.

Picture a young woman who, as a child, was raped repeatedly by her father. Perhaps she was told she caused it, deserved it, or imagined it. When she was beaten, she called the experience “discipline,” if she called it anything at all. Somewhere deep down inside she knew it happened because she was bad. Told not to discuss it “or else,” she retreated into silence and wondered whether what she remembers actually happened.

Over time, she experiences anxiety and bouts of depression. Nagging headaches go untreated. It's where she feels entirely safe and no one whose company brings her comfort. She turns to alcohol or marijuana, for solace and escape. Still, she experiences flashbacks, hears voices, and seems to be unable to hold down a job and has no health insurance. She ricochets from one abusive boyfriend to another until she confronts one whose brutality lands her in the hospital. Physical wounds healed, she's released because she hasn't formed safe, nurturing friendships, she has nowhere to turn and ends up living one experience after another pushes her farther into the margins of society.

It's disenfranchised women such as these who find their way to Community Connections. Established as a private not-for-profit provider of mental health, substance abuse, and trauma services in Washington, D.C., “Generally, when women come to us, it's almost always a crisis. They're on the edge of losing their children, they've been court-ordered to receive mental health treatment, or they're homeless,” explains clinical supervisor Jo-Ann Leitch, MSW, LICSW. “For many years, these women have been barely holding it together, just living on the edge, but then some sort of crisis happens, and they fall off the edge. That's when we see them.”

Jerri Anglin, MSW, LICSW, another clinical supervisor who leads a team of social workers that provide trauma-informed case management services, says, “We'll help them with applications for financial assistance, we'll make a Medicaid application so we can get them some health insurance, we'll get them set up for an initial psychiatric evaluation with our psychiatrist.” They come for these services, Leitch says, but after their fundamental needs are met, they receive help for a problem they don't understand that they have.

Until clinicians at Community Connections developed a model for trauma recovery services for the general population, these powerless women not only fell off the edge but through the cracks of the social system. Untreated, says Anglin, many may have landed in prison or problematic relationships, with drugs, or in prostitution. “They'd have been left treading water,” she says, with no opportunity to escape their dire straits.

The Trauma Recovery and Empowerment Model (TREM) is a group intervention created in the



Community Connections Trauma Work Group. Led by the organization's codirector, Maxine H clinicians, with input from clients, devised a comprehensive group intervention to serve women physical, emotional, and sexual abuse—those whose marginal social status and mental illness h them access to or made them unlikely candidates for traditional recovery work. Building on suc model, it then devised variations for men (M-TREM) and adolescent girls (G-TREM); a four-se for women on short-stay units; and a roster of companion interventions for individuals with spee example, those with HIV or substance abuse issues.

Today, Community Connections trains social workers and others nationwide to lead TREM gro model is used in a range of settings including prisons, welfare to work programs, outpatient and substance abuse programs, outpatient mental health facilities, and domestic violence and homel Although TREM was designed as a group model, its core principles and techniques can also gui clinicians working one-on-one with clients in trauma recovery.

Program guidelines are detailed in a manual for group leaders, *Trauma Recovery and Empower Clinician's Guide for Working with Women in Groups*, written by Harris and the Community C Trauma Work Group. TREM strategies are also explored in a self-help workbook called *Healin Abuse: A Woman's Workbook*, written by Mary Ellen Copeland and Harris, that can be used by to participate in a group.

Why a New Model?

Before the advent of TREM, women on the fringes of society in the nation's capital who suffere aftereffects of trauma were likely to go untreated thanks to a triad of failures: of the women affl in general, and the larger social service system. The TREM model, in various ways, addresses e associated weaknesses and arose in recognition of the obvious truths that underlie them: It's diffi person who cannot ask for help because she doesn't understand the true nature or extent of her p difficult for a person who can't acknowledge a problem to get help when those charged with car don't ask about or acknowledge the problem. And, finally, it's challenging to offer trauma recov people whose lives have been so derailed by abuse that their circumstances or symptoms pose o treatment.

A Failure to Understand

Many women who've experienced abuse do not perceive it as being at the root of their problem: challenges may be so many and so complex that the root issues have long been obscured. They i the laundry list of complaints that Community Connection clinicians call aftereffects of trauma : anxiety, depression, pain, sleep disorders, self-medication, other forms of self-harm, and, in som homelessness, addiction, and prostitution. But for various reasons, they've never tethered these to the acts of abuse from which they so often arise.

According to Rebecca Wolfson Berley, MSW, director of trauma education, "most women do n mental health service programs with any kind of chief complaint of trauma or specific incidents Instead, they may seek help for the aftereffects or arrive in search of concrete services such as h housing. Seldom do they perceive their past traumatic experiences to be catalysts of their curren

A Failure to Ask

Trauma, observes Wolfson, "can be a very scary topic for clinicians"—one that causes a great d hesitancy. Once someone opens the door to acknowledging abuse, women have a fairly easy tin are trauma survivors, she says, adding that many social workers and other mental health profess open that door. "There's a real fear that, by asking questions about trauma, they're going to mak and open a can of worms." Consequently, many clinicians in mental health programs don't ask : of trauma during initial assessments or identify the connections between symptoms and issues r

"We very much believe that some presenting symptoms may be related to trauma, either as copi for dealing with memories of trauma or as ways for women to survive in the world." At Commu Connections, clinicians do ask about trauma and are mindful of the connections between abuse : "If someone has complaints about losing a lot of time and spacing or tuning out, that may be a p may be dissociation, which comes from a history of trauma," says Wolfson Berley. As a result, "we usually view women through a trauma lens when we think about where some of the symptc from."

A Failure to Accommodate or Embrace

When Community Connections was developing TREM, says Wolfson Berley, the women in its weren't considered "a good match" for existing treatment options. Adds training specialist Lori MSW, LICSW, they were thought to be too vulnerable and too lacking in ego strength to do the was that they'd unravel further and decompensate. "We were sweeping a huge issue under the r looking at their trauma and abuse."

There weren't options that could embrace women with mental illness, had any psychosis, cognit those who couldn't attend a group 100% of the time, explains Wolfson Berley. "Since our popu time had lots of women with diagnoses of schizophrenia and schizoaffective disorder who were diagnosed and would probably be going in and out of hospitals or detox during the course of a l group, we knew we needed a model that would not kick people out for missing three groups in a would tolerate and account for the fact that some women would sit in the room and have momen tuned out." Together, the clients and clinicians built a better model that embraces and accommo marginalized women.

The Program

Far from a psychodynamic approach, TREM succeeds through cognitive restructuring, psychoe skill building. Its cornerstones are empowerment, peer support, and practical skill building. The psychoeducational focus teaches women to recognize the deleterious effect of trauma on their li tools for self-help.

The intervention, originally composed of 33 weekly, 75-minute sessions, now involves 29 leade sessions, during which an individual topic is explored through structured conversations, questio experiential exercises. The sessions are divided among three core topic sections.

The overarching theme of the introductory section is empowerment: helping women protect and themselves, set physical and emotional boundaries, and increase self-esteem. Group leaders intr notion that disempowerment and diminished self-esteem are linked with a history of trauma and women's feelings about womanhood and their bodies, while examining the distortions that offer perceptions. In this safe environment, leaders foster healthy attitudes about boundaries—physic: emotional. These discussions also allow participants to understand that behaviors they or others negatively, such as drug or alcohol use, dissociation, or self-mutilation, were skills that helped t Then, leaders can introduce positive ways that participants can soothe and comfort themselves.

Typically, says Anglin, participants were never soothed properly by a parent or caregiver becau abused or neglected, so they never received comfort. The extreme methods they often use—gett cutting themselves—may get them through the night but ultimately take a toll. TREM leaders, h remove all judgment and let women know that they shouldn't blame themselves for such extren

Says Anglin, "We tell them from the very start, 'We're glad you did all those things. Had you n hypervigilant when you were a kid, you wouldn't have been watching out for yourself, and you around today. If you didn't soothe by getting high to get yourself through, you might have killee wouldn't be here today. If you hadn't dissociated when your father was raping you, it may have painful to stay in your body.'" TREM leaders relabel those behaviors as survival tools, and, says these women less costly strategies—a repertoire of activities—they can use to take care of them they experience stress."

In the second section of sessions—trauma recovery—the spotlight begins to shine more directly isn't a platform for a continual retelling or reliving of incidents of abuse nor for uncovering "bu of trauma. Rather, it focuses both on helping women recognize the link between abuse and its co the life chaos and the physical, emotional, and social symptoms—and then providing the tools a which they can combat the repercussions of trauma. "One of the unique things about our model not need to regress and recount every memory. You really need to know you were traumatized, need to remember the events minute by minute." Beyer recalls a woman who came to a group a help to retrieve childhood memories. "My response was no. I said, 'If that happens, it happens, l about recreating memories or helping you unearth exactly what happened. Rather, this treatmen about what symptoms and behaviors you're having now and how you would like to function.'"

TREM stresses skill building because trauma typically destroys opportunities for developing life tactics. “If you’ve experienced childhood abuse,” explains Anglin, “you missed out on so many necessary skill acquisition experiences that we all have growing up, everything from how to have a relationship, how to develop a secure self-identity, to how to accurately label situations and feel

Part three, advanced trauma recovery, continues with the exploration of practical coping and self-healing strategies and is followed by sessions for self-assessment and planning that will help women build healing strategies they learned in the program.

A four-year National Institute of Mental Health study is underway to assess the effectiveness of the program, promising preliminary studies indicate an impressive level of engagement among participants and a significant reduction in deleterious behaviors. A large majority of women report finding the program helpful. Roger D. Fallot, PhD, director of research and evaluation at Community Connections, says the study showed that approximately 70% of women enrolled completed more than 70% of the sessions. “People who are often reluctant to engage in services, this is a very high rate of participation,” he says. In the study, he adds, TREM participants showed greater improvement with respect to trauma-related drug and alcohol abuse than those who received only the usual social services.

Bridges of Hope

Leitch views the model as a way to get beyond what she sees as an “us and them” mentality. Through TREM, she suggests, people are at the extreme end of a spectrum of life problems experienced by all. Some start a little further up on the side of impairment, but they can move down to become more functioning individuals.”

The work Leitch and her colleagues do lays a foundation that can be built upon. Women may enter the program with grandiose expectations that the trauma will be behind them. But those who complete the program, she says, are likely to come away with an understanding of what has happened to them and are prepared to integrate these experiences into their lives in healthier ways. “We begin to see women stop their addictions, thinking through their responses to problems, and choosing healthier soothing strategies.”

“Helping women deal with trauma in a safe way, and sometimes giving them the chance to move on with life as they never could before can be an incredibly rewarding part of one’s career,” says Wolfson for most people here at Community Connections who do trauma recovery work, it’s one of their proudest achievements of the job.” It can be the hardest, she adds, but “it’s also the area where we feel very proud to be

Anglin agrees: “I never question what I’m doing or that what I do has meaning. I know what I do means.”

Progress may be measured in inches, rather than miles, but it can nonetheless be life-changing. “It means very different things to participants. While one may learn how to set small limits and boundaries with family or husband, another may gain insights that will let her do more of the activities she enjoys. Still others may come to accept the limitations their histories have imposed on them so they can make goals and appropriate decisions. “We can’t ever take this experience away—it’s part of them,” says Anglin. “But we can help them cope better and help it be less destructive.”

For more information, visit www.communityconnectionsdc.org.

— *Kate Jackson is a Los Angeles-based freelance writer and editor and former staff writer for Social Work Today.*

Giving Men a Voice for Their Feelings

Community Connections’ Trauma Recovery and Empowerment Model for men (M-TREM) is a model for women, but the content is tailored to men’s unique needs and the model spans 24 weeks.

According to Rebecca Wolfson Berley, MSW, director of trauma education, “Women often have been disempowered and don’t feel a great deal of personal strength.” But once given the opportunity,

difficulty acknowledging that they have been victims. Men, she says, are less disempowered but more trouble with the notion of being a victim. According to Jerri Anglin, MSW, LICSW, clinic traumatized men have had to wear many masks in society. “They’ve had to assume a certain kind of help them power through, and they’ve never been allowed to acknowledge vulnerability or that happened.”

In M-TREM, the emphasis doesn’t need to be on empowerment but rather on helping men establish emotional vocabulary with which to understand and express their experience and feelings. “Men understand ‘No, I’m angry,’ but they can’t necessarily connect as much with a host of other emotions. Early sessions in the men’s model are about getting in touch with what else there is in the world besides anger,” says Wolfson Berley. The first session, she explains, is about male myths (men don’t cry, lots of sex, men are the breadwinners), what it means to be a man, and some of the societal expectations and pressures that affect men. By and large, Wolfson Berley observes, “if you are a man with major responsibilities, you’re not living up to those expectations.” The initial task with men, Anglin suggests, is to help them take down the masks a bit. In many ways, she says, “men have a steeper hill to climb.”

— KJ

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