Trauma-Informed Systems Transformation:

Recovery as a Public Health Concern

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As members of the Department of Behavioral Health's Trauma Task Force, we believe that a recovery-focused transformation of behavioral health is essential to the improvement of the mental health, substance abuse, and social service systems in Philadelphia. We agree with the President's New Freedom Commission on Mental Health that for the most part, behavioral health systems around the country are not oriented to the single most important goals for people receiving services – recovery and community integration. However, we do not believe that the President's New Freedom Commission sufficiently outlines the magnitude of the transformation that must occur, including transformation in basic assumptions that underlie the present treatment of people who present to the mental health, substance abuse, criminal justice, and social welfare systems. We believe that trauma-informed knowledge – a body of knowledge only recently researched and accumulated – potentially holds the key to a truly transformative recovery framework.

As the philosopher Santayana has pointed out, *"Those who do not remember the past are condemned to repeat it.* History demonstrates a repetitive cycle in mental health treatment of protest, reform and regression – without transformation. The original Blueprint report starts with the history of the recovery movement, but focuses on recent history. The New Freedom Commission report notes only four reform periods. We believe there have been more reform efforts than just those four but though each effort has made progress, there has always been a significant reversion back to old and frequently abusive methods for dealing with people who have emotional problems.

As advocates of the recovery movement have pointed out, we are up against social experience and prejudices that are stubbornly resistant to change and that continually arise in the form of stigma against the mentally ill. In this document we will briefly review the long history of just a few of the reform efforts of the human service system over the last few centuries in service of seeing what we can learn from not just the successes, but the failures. The study of very traumatized people has taught us that if we are to avoid repeating our previous mistakes, then it is vital that we struggle to see the patterns of repetition, and honor the past before we can

change those patterns to create a different future. As Dr. Judith Herman has so clearly stated, *"the knowledge of horrible events periodically intrudes into public awareness but is rarely retained for long. Denial, repression, and dissociation operate on a social as well as an individual level. The study of psychological trauma has an 'underground' history. Like traumatized people, we have been cut off from the knowledge of our past. Like traumatized people, we need to understand the past in order to reclaim the present and the future. Therefore, an understanding of psychological trauma begins with rediscovering history"*(p.2) [1]

We now stand on the edge of another reform effort, this time cast as not reform but "transformation". So what is this transformation about and what makes it different than former efforts at system reform? Making optimistic theoretical statements about recovery is not sufficient to repel longstanding social pressures and stigma. Transformation can only occur if there is truly a shift in paradigms – the underlying mental models that are the foundation of any body of knowledge and from which all else follows. Mental models determine what questions can be asked, what approaches can be taken, what problems can be defined [2]. The framework described as "recovery" can actually be viewed as a hoped-for result of a potential change in mental models that has not yet occurred. Our fear is that without a significant change in mental models – the basic assumptions that structure thought - the recovery movement is doomed before it completely gets off the ground. Transformation is about *revolution*, even while it may take an evolutionary course, and what has thus far been described in the system transformation efforts are not revolutionary yet because those efforts are derived from reaction against the established mental model – frequently referred to as the medical model - rather than changing the paradigm itself.

From our point of view, unless you start with a sound and unshakeable theoretical foundation, reform efforts will remain vulnerable to the combined forces of 1) social denial of the enormity of need, 2) collective fear, 3) social resistance to change and 4) shifts in economic priorities. In this document we will offer some suggestions for the ways in which a trauma-informed theoretical basis for mental illness changes the basic mental models for thinking about and reacting to all forms of emotional problems and is, therefore, potentially transformative.

Then we will begin to outline a very different paradigm for viewing virtually all of the clients who present to the human service system. From that different paradigm we will discover that transformative efforts must be aimed simultaneously at the clients, their families, the staff, the administrators, and the systems-as-a-whole if we are to truly bring about change. We believe this is possible because the members of this Task Force speak not just from theoretical but from personal and organizational experiences with transformative change. We know that the transformative change we address, although at times frightening and verging on the chaotic, is also exciting, stimulating and gratifying. We want to help bring about similar change throughout the service delivery system in Philadelphia so we write this document in the hope of sharing what we have learned along the way.

The History of Systems Transformation in Philadelphia

First of all, "recovery" from what?

"Can the mentally ill recover from their illnesses?" Tension around the question has been a source of innovation and reform in the mental health and social service community for at least the last five hundred years. Just as the entire notion of human rights has been an evolutionary process that has waxed and waned over the centuries but that gained increased momentum in parallel with the enormity of human catastrophic self-destructiveness of the twentieth century, human rights for the mentally ill has followed a similar cycle of protest, reform and regression. If Philadelphia is to truly transform its system, it may benefit us to briefly look at the reform efforts that have preceded the present for the simple reason that *they did not last*, or did not have the full impact or logical progression that should have occurred and it is this lack of progress, regression, and resistance that we are bound to address through the transformation efforts today.

According to the proposed "Blueprint for Change", The New Freedom Commission says they *"envision a future when everyone with a mental illness will recover…. Traditional mental health programs orient to lifetime dependency. They rely on diagnosis, force, medications and maintenance…."* But why is this now – and for the most part always has been – the case? Mustn't we assume that despite reform efforts, there must be something in our implicit understanding of mental illness that promotes control disguised as treatment and that repeatedly undermines attempts to treat people with the respect and dignity they deserve as human beings?

It is difficult to properly address a problem that needs to be changed unless you have properly defined the problem. And herein lies a fundamental issue that has not yet been fully addressed in the mental health field. There is an essential conflict over the roots of mental illness that has remained unresolved since the time of the ancient Greeks, has never yet been resolved and is critically important when we are addressing the issue of recovery, i.e. "recovery from what?" [3]. Likewise there has been significant historical controversy over the origins of addictive disorders as diseases or character defects. This conflict is evident in the varying definitions of what people mean by "recovery".

Seeing the Patterns of the Past

The dichotomy of madness as moral trauma and madness as disease goes back at least to the Greeks. Throughout the Middle Ages, the mad were often executed as witches, thrown into prisons, or banished and sent to roam outside of their towns. Some towns would charter entire ships - "Ships of Fools" - to take those considered to be insane and uncontainable in the community to distant and uninhabited places and abandon them [4, 5]. Such treatment was justifiable in the minds of those perpetrating these acts because the insane were considered to be

evil, possessed by demons, difficulties probably attributable to sinful acts on the part of themselves or their families. They were outside the realm of normal human explanation and therefore could be placed outside the realm of normal existence.

An exception however, was the reform movement that became localized in Gheel, Belgium. Beginning in the 15th century people came to Gheel from all over the world for psychic healing. Local residents welcomed people into their homes, and many stayed on to form the world's first "colony" of mental patients. Gheel is considered the forerunner of today's community mental health programs.

Throughout the centuries leading up to the Enlightenment, the notion that mental illness was evidence of sin alternated or intertwined with the notion that mental illness was criminal behavior and thus locking people up, punishing them, and keeping them in chains was considered a necessary response to criminal behavior in service of maintaining social order.

The Enlightenment: Protest, Reform, Regression

PROTEST: It was the Enlightenment, and its emphasis on human rights, that had widespread influence on the treatment of and attitudes towards people with emotional and behavioral disturbances. Philippe Pinel, widely considered the “father” of modern psychiatry, was a physician born in 1745 who took a special interest in mental illness after a close friend had developed a ‘nervous melancholy’ that had ‘degenerated into mania’ and resulted in suicide. He became haunted by the unnecessary tragedy and gross mismanagement of his friend and began working in private sanatoriums to learn about mental illness. Pinel discarded the long-popular equation of mental illness with demoniacal possession, regarding mental illness as the result of excessive exposure to social and psychological stresses, and in some measure, of heredity and physiological damage. When the mentally ill were described as animals, Pinel quietly replied, *“It is my conviction that these mentally ill are intractable only because they are deprived of fresh air and their liberty.”* Pinel did away with such treatments as bleeding, purging, and blistering and favored a therapy that included close and friendly contact with the patient, discussion of personal difficulties, and a program of purposeful activities. Pinel's psychiatric therapeutics came to be known as "traitement moral," or in English, “Moral Treatment” (the word “moral” historically here referring to “emotional” or “psychological”).

REFORM: Pinel’s example and the basic philosophical tenets of the Enlightenment rapidly influenced progress in the treatment of the mentally ill throughout Europe, in England and the United States. After a young mentally ill woman who was a member of the York Meeting of Friends, died from maltreatment in a local asylum, a Quaker community in York, England- led by a businessman named William Tuke - created the first center for Moral Treatment in the United Kingdom Similar to Pinel’s personal experience, the members of the York Meeting were so profoundly influenced by this experience that they created the York Retreat and began to articulate a very different approach toward the treatment of people with behavioral problems. The new asylum was to be *“a place in which the unhappy might obtain a refuge - a quiet haven in which the shattered bark might find the means of reparation or of safety”* [6]. Physical coercion and restraint were deplored and were replaced with relationships with attendants who were carefully selected to offer

inmates guidance and treat them humanely. Patients were to be treated with respect, as adults, not as children, and were to be urged in the direction of self-restraint and self-control [6]. Environmental factors were seen as playing an important role in the etiology of the mental problems. Attention to the social milieu largely replaced physical methods of treatment. The mentally ill were not seen as animals, but as suffering humans who had gone astray and who could be led back to the right path through kindness, compassion, and rational conversation. Moral treatment was a profoundly social form of treatment. The experience of madness was to be corrected by placing people in humane and caring social environments that emphasized social interaction and the cultivation of latent faculties and healing processes, but that were away from the stresses and demands of the person's previous existence. Moral Treatment had far-ranging effects on the face of institutionalization in Europe and in America. The book that William Tuke's son, Samuel Tuke wrote about the York Retreat spurred the investigation and reform of "madhouses" throughout the Continent [7].

Philadelphia became the first site of Moral Treatment in the United States. Founded in 1813 by Quakers, Friends' Hospital's original missions was to *"provide for the suitable accommodation of persons who are or may be deprived of the use of their reason, and the maintenance of an asylum for their reception, which is intended to furnish, besides requisite medical aid, such tender, sympathetic attention as may soothe their agitated minds, and under the Divine Blessing, facilitate their recovery"* Quakers saw the mentally ill as brethren capable of living a moral, ordered existence if treated with kindness, dignity, and respect in comfortable surroundings.

In the early days of Moral Treatment in this country, the recovery rates were astonishing – what one historian has termed, "the forgotten success in the history of psychiatry" [8]. In a time when there were no medications in use, at least one site of Moral Treatment kept good records over a twenty year period. Of 2, 267 patients who were ill less than one year prior to admission, 1,618 were discharged as recovered (66%) or improved (5%) [8]. Given the dismal period of treatment that would follow the end of the Moral Treatment era, we must not cease to remind our patients and our colleagues that recovery is – and always has been –quite possible.

REGRESSION: As is clear from the historical record, Moral Treatment was not abandoned because it failed as a method. Indeed it did produce remarkable results. But despite its successes it was not succeeded by broad innovations that transformed the mental health system of its day. Instead, the deaths of the original innovators, the enormous and relatively sudden increases in the general population and all the problems that went along with those increases, the failure to train sufficient numbers of younger people in the methods of Moral Treatment, the failure to build a sufficient number of small hospitals that could properly use those methods, the increase in the number of impoverished immigrants and the continuing stigma against the mentally ill all combined to produce a regression in the treatment of the severely mentally ill represented by the sprawling system of state hospitals.

Given the radical increase in the U.S. population throughout the second half of the 19th century and the first half of the 20th, the sheer numbers of patients demanding care resulted in the massive growth of these enormous and impersonal mental institutions, thus defeating the original premises of Moral Treatment.

Hospitals designed to accommodate small patient populations were faced with demands for admissions of anyone considered deviant or unmanageable, including people with dementia and incurable neurological diseases. As the management of these unwieldy institutions became more and more bureaucratized, the care became more impersonal, controlling, neglectful, and cruel. The funding of asylums became a hot political potato. Legislatures grew increasingly unwilling to fund the asylums. Charismatic and inspired Moral Treatment facility directors died and gave way to men with the political savvy to attempt political bargaining with state legislatures but who did not necessarily understand the initial goals of Moral Treatment [9-11]. Administrations became increasingly corrupt, until by 1891, Burdett, an English physician surveying American institutions, depicted *"overcrowding, deteriorated physical facilities, extensive use of physical restraint and manipulation, and only occasionally a hospital with a therapeutic orientation"* [12]. These asylums were the huge and impersonal institutions that we began disassembling in the 1970's.

19th – 20th Century – Protest, Reform, Regression

PROTEST: Throughout this period, many recovering patients who had survived the state hospital system, pushed for significant reforms. They represent the predecessors of the consumer advocates of today. Mrs. E. P. W. Packard was involuntarily committed by her abusive husband to a state hospital in Illinois and after her release kept campaigning until in 1873 she got the governor of Illinois to appoint a committee to investigate her charges against the superintendent of the mental hospital in which for years she had been mistreated [13, 14]. When the committee found every one of her charges valid, the superintendent was forced to resign and Mrs. Packard spent decades as a very effective activist for the rights of women.

In 1908, Clifford Beers published *A Mind That Found Itself*. He had been psychotic and when he recovered, he detailed the experiences he endured while hospitalized and dedicated his life to helping psychotic people and to the improvement of conditions in mental hospitals everywhere. He founded the first outpatient treatment program in the U.S., was an originator of the reform movement known as "mental hygiene", and campaigned for the rights of the mentally ill until he retired in 1939.

Beginning in the mid-19th century and extending throughout the 20th, many former patients like Clifford Beers and Mrs. Packard documented their experiences in and out of the mental health system, many of which were compiled by an internist, Walter Alvarez in his 1961 book, *The Minds That Came Back.* He summarized his impressions when he wrote, *"A word of hope. ….What cheers me is that so large a percentage of the persons whose experience with a mental breakdown is here described came out of their spell, either cured or almost well. Another point that cheers me much is that usually when one of these persons recovered, perhaps after years of mental confusion, he found that his mind was not injured: it was as clear as it had ever been. Also, most of these people say that even when they were badly confused, a part of their mind retained its sanity, and it was this good part that helped them to get well* (p. 15-16) [15].

By the early decades of the 20th century, the testimony and experience of these early pioneers in recovery was being understood through the lens of psychoanalytic thought. Freud and his colleagues introduced revolutionary ideas into the existing mental health field. They indicated that people's behavior – even that of the very disturbed and confused – could be understood if you understood the context of that person's experience and inner life; that people were motivated by ideas, feelings and desires that were sometimes conscious and many times unconscious; that symptoms had meaning and were a form of communication; that you could figure out how to help people if you really listened to them. Once again, efforts to reform the mental health system gained momentum and accelerated vastly after the cataclysms of two World Wars.

In the world of substance abuse – initially referring largely to alcoholism - the temperance movements that began in the 19th century were significantly enhanced by the development of Alcoholics Anonymous- founded in 1935 and the 12 step programs, self-help recovery movements that functioned outside of the mental health system. The Oxford group, a religious organization founded in the early part of the 20th century, and influenced (like Moral Treatment) by the Quakers, Mennonites and Amish, endorsed a strong work ethic, mutual concern, honesty, unselfishness, self-examination, acknowledgement of character defects, making restitution for harm done, and working to help other people. The Oxford movement strongly influenced the later development of AA and the concept therapeutic communities that developed to treat people with substance abuse problems. The recovery principles of AA embodied in the 12 steps and 12 traditions emphasize values that would later prove to be consistent with the trauma recovery movement as well – admission of the problem, self-examination, making amends to other and helping others to engage in a similar process of recovery [16].

REFORM: After World War II and the Holocaust, mental health workers became insistently concerned about the social conditions that gave rise to individual and social maladaptive behavior. Many people had become convinced that the individual could not be treated as separate from the society and that the society contributed greatly to the development of mental disorders. For a time, social psychiatry and preventative psychiatry dominated the psychiatric profession and social psychiatrists, social psychologists and social workers began to optimistically outline proposals that they hoped would guarantee treatment for those most hurt by society's injustices and their own biological vulnerabilities. One social psychiatrist wrote that "*Social psychiatry is etiological in its aim, but its point of attack is the whole social framework of contemporary living*." The goals of social psychiatry were extremely broad: "*To include all social, biological, educational, and philosophical considerations which may come to empower psychiatry in its striving towards a society which functions with greater equilibrium and with fewer psychological casualties "* [17].

Influenced by a burgeoning number of voices critical of the existing service delivery system who recognized that the diagnostic labels that were given people could cause more problems than were solved [18] and the astonishingly negative impact of institutionalization [19, 20]; feminist analyses that looked at gender inequality and systematic oppression [21]; the civil rights movement that emphasized the negative impact of racism and poverty; and general system theory that provided

demonstrations of the interconnected nature of reality [22], social psychiatry entered the mainstream.

The principles of social psychiatry were summarized in six postulates that seem today rather eerily related to the present recovery principles: 1. Human behavior can only be understood in the context of the total social and other energies (including living and inert physical matter) of this universe; 2. A person should always be a subject and never an object of an interpersonal transaction; 3. There is meaningful interrelationship, a relativity, between the behaviors of one individual and all social and mythological institutions and groups; 4. Social problems, including individual, institutional and group deviant behaviors, cannot be solved without collaboration between all the institutions and disciplines of human knowledge, influence, and action; 5. Values of compassion, caring, and consideration for all human beings are essential to the operations of social psychiatry; 6. Human behavior acquires purpose and meaning in reference to and by virtue of adherence to these postulates [23]. Adherents of social psychiatry tried to place the patient and his or her symptoms within a total sociopolitical context. *"The mentally ill person is seen as a member of an oppressed group, a group deprived of adequate social solutions to the problem of individual growth and development"*[24].

Two of the most significant outcomes of the social psychiatry movement were the development of the democratic therapeutic community movement and the community mental health movement. The therapeutic community - or its adapted and shorter-term version, the therapeutic milieu - concept was one attempt to apply the tenets of social psychiatry and systems theory to the institutional treatment of various kinds of emotional problems. The hospital was seen as being a microcosm of the larger society, an experimental laboratory for social change [25]. Originating in the United Kingdom initially as a method to treat combat trauma, the first therapeutic community in the U.S. was created by a psychiatrist named Harry Wilmer at the Oakland Naval Hospital. Dr. Wilmer refused to use any control other than social control, and the staff were taught to establish the firm expectation that the patients could and would control themselves. This required the staff to learn ways of managing difficult problems without using the usual forms of external control - seclusion, restraint, and punishment. The result was that many patients who had been hostile, belligerent, and assaultive in other settings were treated in the therapeutic milieu without resorting to violence.

The most striking characteristic of the therapeutic milieu was that the community itself - and all the individuals who constituted it - were the most powerful influence on treatment. Unlike many other settings, many of the values that formed the underpinnings for every milieu were clearly articulated: egalitarianism, permissiveness, honesty, openness, trust. All therapeutic communities rested on several assumptions: patients should be responsible for much of their own treatment; the running of the unit should be more democratic than authoritarian; patients were capable of helping each other; treatment was to be voluntary whenever possible, and restraint kept to a minimum; psychological methods of treatment were seen as preferable to physical methods of control. Psychotherapy, individual therapy, and various forms of group therapy were used routinely and were usually psychoanalytically informed [12, 26-31]. The therapeutic milieu concepts exerted a powerful influence on the treatment of children as well as adults. Therapeutic

schools and treatment settings began reporting positive results with both emotionally disturbed and delinquent children [32-34].

Similarly, as drug use and abuse and the criminalization of increasing numbers of drugs became a significant social factor throughout the 1960's and 1970's treatment programs for addictions were created and Twelve-Step self-help groups multiplied. The mental health system and the substance abuse treatment system evolved along very separate lines with little theoretical or practical connection between the two. The substance abuse community developed a much stronger emphasis on a viable path of recovery that required extensive commitment and personal change. From the beginning, people who had demonstrated that they were able to maintain sobriety and were working the 12 steps were included as treatment professionals.

The generally optimistic post-war environment also encouraged a restoration of the rehabilitative approach to criminal justice in prison and outpatient settings. Many prisons adopted therapeutic community approaches, considered to be especially appropriate to people convicted of crimes related to substance abuse.

The therapeutic milieu movement exerted a powerful influence on mental health treatment in the Philadelphia region. By the 1970's the number of acute care beds in general hospitals had significantly increased as had the number of private psychiatric facilities in academic settings, urban and suburban hospitals. For the most part, these programs had open-door policies and the use of restraint and forced medication was kept to a minimum. In Pennsylvania, the Mental Health Procedures Act of 1976 guaranteed that patients who needed treatment were to receive the "least restrictive" level of care possible and the conditions of involuntary confinement were strictly limited.

As it became clear that patients with mental illness diagnoses could be treated in short-periods of time and then returned to their homes and communities, reformers turned to the disassembling of the large state hospital systems and the development of alternative systems of care within the community – the community mental health movement and deinstitutionalization. Philadelphia-area psychiatrists, nurses, psychologists, social workers and creative therapists pioneered many of these early innovations. The suburban Penn Foundation outside of Philadelphia was one of the original models for community mental health centers that were created nationally as one of the initiatives of the Kennedy administration and one of the first urban community mental health centers was created as part of the Temple University Hospital's Department of Psychiatry.

REGRESSION: Not many years had passed, however, before the voices of reform within the human service professions were once again silenced. Biological psychiatry rapidly became the dominant voice in mental health treatment throughout the country. Social psychiatrists, psychoanalysts, family therapists, and social workers were turned out of academic departments and other treatment settings. Funding began to diminish for the community mental health centers even while the chronically mentally ill were still being ejected from closing state hospitals, and they began to populate the acute care units, boarding homes, the streets, and the prisons. The march of managed care began to wreck havoc on the funding systems throughout the country, taking a much larger bite out of mental health care than physical health care. And the notion of "least restrictive care", although still legally

upheld, began to erode in practice. How could one institute “least restrictive care” when all care had become “restrictive”?

It didn’t take long before once again, open-door mental health units were locked or eliminated, general hospital programs and private hospital settings closed, programs lost funding, the number and length of therapy sessions became tightly controlled, therapy began to look more like case management, and many mental health professionals began to forget that any other way of treating people was even possible. As these larger social forces impacted the professions, many experienced professionals left the public sector and took their knowledge with them. Substance abuse programs began struggling to keep their doors open and lengths of stay were dramatically cut back. With the increase in a social desire for retribution in its guise as a tough law-and-order approach, the rehabilitation notions as applied to juvenile and adult criminal justice populations evaporated, even while the prison population was growing and the size of the criminal justice industry exploded. Increasing numbers of substance abusers were imprisoned and with the closing of the state hospitals, increasing numbers of mentally ill patients were arrested and sent to prison.

At the same time, the poor were getting poorer, the middle-class was slipping in its ability to keep up with rising costs, divorce rates were increasing, efforts to bring about racial integration slowed, the educational system deteriorated, increasing numbers of children had diminished supervision and attention from overworked parents, more children – particularly African-American children – regularly began visiting family members in jail, and violence increased. Washington policies and globalization were combining to create an increasing likelihood that the most vulnerable members of the society – including children and adults with a wide variety of emotional, cognitive, physical, and behavioral problems – would “fall of the edge” and the social safety net that had been gradually put into place over the previous few decades, was frayed and unable to hold them.

It is this dismal social situation that we now hope to transform with little except the power of our own hearts and minds since the social conditions described still prevail and the economic consequences are predicted – if anything- to get worse.

Understanding Trauma as a New Paradigm

History demonstrates a repetitive cycle in mental health treatment of protest, reform, and regression. We now stand on the edge of another reform effort, this time cast as not reform but “transformation”, a word that indicates revolutionary change. So what is this transformation about and what makes it different than former efforts at system reform? To understand what could make it different we need to articulate more about the notion of “trauma-informed and trauma-sensitive treatment”.

The field of traumatic stress studies evolved from a number of different areas of traumatic experience and must be viewed in the context of a late twentieth century social movement aimed at raising consciousness about the roots of violence by enacting and reacting to that violence everywhere. Dr. Judith Herman has pointed out the ways in which the study of what has happened to people is dependent on the

social context: "*The systematic study of psychological trauma depends on the support of a political movement"*(p.9) [1].

The traumatic stress field was born out of the clashing ideologies that became so well articulated in the 1960's and 1970's. *"War crimes, war protests and war babies; child abuse, incest and women's liberation; burning monks, burning draft cards and burning crosses; murdered college kids and show trials of accused radicals; kidnappings, terrorism and bombings; a citizenry betrayed by its government and mass protests in front of the Capitol in Washington – all play a role in the backgrounds of the people"* who founded the field [35]. One remarkable aspect of the traumatic stress studies field is the extent to which the founding mothers and fathers have had personal experience with trauma and are and have been themselves in recovery from traumatic experience [35, 36].

The movement got its initial momentum through the combined work of Vietnam veterans, their families, mental health professionals and clergy. What was arguably the first national meeting was financed by the Missouri Synod of the Lutheran Church who also hosted the meeting at its seminary in St. Louis, appropriately situated right in the middle of the country. According to one observer, about 130 people attended the conference: "*. . . 60 vets, 30 shrinks, 30 chaplains, and 10 central office people* [VA] *who came on at the last minute* [37]. The first meetings of the International Society for Traumatic Stress Studies and the International Society for the Study of Dissociation occurred in the mid-1980s and brought together clinicians and researchers working with a variety of traumatized groups: combat veterans, Holocaust survivors, rape and domestic violence victims, child abuse victims, refugees, accident survivors, torture survivors, victims of crime and victims of natural and man-made disasters.

It became clear why the study of trauma has been so beset by periods of active investigation alternating with periods of oblivion, of social amnesia for the causal roots of so many individual and social problems. *"To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events. When the events are natural disasters or "acts of God", those who bear witness sympathize readily with the victim. But when the traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator. It is morally impossible to remain neutral in the conflict. The bystander is forced to take sides* (p.7) [1]

Throughout the 1980's and the 1990's a large body of research accumulated about the connections between a past history of trauma (particularly exposure to childhood adversity), substance addictions, and mental illness [38]. Programs to specialize in the treatment of trauma-related disorders burgeoned throughout the country and results of these programs began to be published [39, 40]. Although most of these specialty programs were swept away by managed care, many key texts were written about the process of recovery from trauma and the elements within the treatment context necessary to promote recovery [1, 36, 41-48].

The Adverse Childhood Experiences study demonstrates a clear relationship between the extent of exposure to childhood adversity – the trauma dose – and many substance abuse, mental health, physical and social problems [49-53]. Many studies have demonstrated that there is a high degree of comorbidity between

substance abuse, exposure to trauma, depression, self-harming behavior, suicidality, personality disorders, and ADHD [54]. In a homeless, mentally ill population, exposure to violence is so high that it can be considered a normative experience. The chronically mentally ill are an extremely vulnerable population, easily made the target of exploitative violence.

In fact, there is really no way to clearly differentiate between the problems that confront someone considered to be chronically mentally ill, trauma survivors, and substance abusers. There is simply too much documented interactive problems so that the mentally ill are more likely to be substance abusers and trauma survivors, survivors of chronic and repetitive exposure to trauma are more likely to develop problems that are diagnosed as mental illness, and substance abusers are more likely to have survived traumatic experiences and to have mental health problems. And, for that matter, what can be more traumatic than "losing one's mind" – even if only for awhile and even if it a result of damaged neurons and not violence at someone else's hand? Out of this research and experience a new notion of mental disorder, character problems, physical disorder, and both behavioral and substance addictions began to emerge that is in itself *transformative* for the clients and for the staff when organizations become truly trauma-informed.

So What is "Recovery"?

In the literature on recovery there is some degree of semantic confusion because the term can be applied to a) those who are labeled with chronic mental illness who seek the right to more self-determination than is currently encouraged, b) to those recovering from the immediate and long-term consequences of addiction, and c) to those recovering from the effects of immediate or repetitive exposure to childhood adversity and other forms of trauma. The confusion is understandable given the fact that these represent very different forms of human dilemmas that require different approaches to treatment and to recovery – not all injuries are the same. Someone who has experienced the injurious effects of a first psychotic episode will require a very different approach from someone who is experiencing their first treatment for substance abuse and both situations present very different challenges from those presented by someone who has already spent the last four years in and out of substance abuse rehabilitation programs, or in and out of psychiatric facilities. Someone with a history of sexual abuse who has been starving herself or who is repetitively self-mutilating, may require a quite different approach from someone who was recently arrested for shoplifting, or assault, Finding some universal principles that apply to all nature of problems but that still offer some meaningful guidelines for intervention and the prevention of further problems is a daunting challenge.

An important dialogue has been occurring among innovators in the area of recovery from serious mental illness, some of them members of the recovery movement, some of them health care professionals, and many of them belonging to both. This dialogue hints at the need for change in the underlying assumptions that we have referred to above. Davidson and his colleagues have addressed the varying frameworks for recovery and in doing so place the recovery notion in four major categories 1) a return to a normal condition; 2) an act or process of recovery; 3)

something gained or restored in recovering; and 4) the act of obtaining usable substances from unusable sources. These four aspects of recovery then are related to 1) physical recovery from an acute condition; 2) trauma recovery; 3) recovery from substance-use disorders; and 4) recovery in the cases of severe mental illness. They also conclude that all four variants of recovery may coexist and/or interact within each individual's life [55]. In their article they quite usefully refer to a vision of recovery that would be more consistent with the notion that people with mental illnesses deserve the same consideration as those with physical disabilities as reflected in the Americans with Disabilities Act of 1990. Although, this is completely consistent with a trauma-informed notion of recovery, it is our position that saying it doesn't make it so. Those of us working in the field, who have watched people who could be categorized in all four notions of recovery do exactly that – recover - may not have any argument with the goodness of this idea. We do propose, however, that it is simply not a strong enough argument yet to overcome the centuries-long stigma attached to anyone still considered by the society as "sick" or "bad".

Critics of the recovery movement have raised important concerns that must be addressed if the movement is to truly bring about transformative change. Concerns include: "It adds to the burden of already-stressed mental health resources"; "it only happens after long treatment"; "it rarely happens and is unfair to those with serious disabilities"; "the existing services cannot be changed enough to accommodate a different vision; "it devalues the role of professionals; "it increases providers' exposure to risk and liability"[56]. At the same time, recovery advocates insist that people with mental illness and those who care for them should be led – like those with physical disabilities – to embrace a vision that focuses on the fundamental rights of people with disabilities, primarily rights to self-determination and community inclusion. But to have cognitive, emotional and behavioral problems bracketed and supported by the society with the same commitment as are physical disabilities will require more than a social movement of vocal recovered people. It will require a change in fundamental social assumptions and any effort directed at transformation must address these basic assumptions.

Change In Fundamental Assumptions

The previous reforms mentioned above remained largely confined to the human service system and when funding streams changed, or key leaders left or died, the reforms were not sustained. It is, in fact, difficult to sustain change that is not built on a solid and provable foundation. For the most part previous reform efforts have been based on humanitarian pleas for better treatment, much as the present reform effort which continues to lump together people with problems labeled as schizophrenia, those with severe characterological disturbances, those with addictions, and those with combinations of all three, defining the people more by the institution they get assigned to then the actual etiology of their problems. But pleas for better treatment tend to be ignored or silenced when the treatment is costly and when the problems can be reframed as problems of individual choice and responsibility. Hence, in the last several decades, treatment has often become defined by the money available, not by what the patient may actually need and many

of the people with problems that formerly would have landed them in hospitals now end up in prison or homeless on the streets.

This reversion to what is easier, more economical, or simpler is more likely to happen in the treatment of the mentally ill than the physically ill. Although many attempts have been made, and are still being made, to compare mental health care to physical health care, the reality is that the problems exist at different levels of meaning. A blockage in one of the coronary arteries is a blockage, it is a fact not open to interpretation. We are able to establish etiology for the heart attack, and in physical illness if we do not yet know the cause, science assures us that someday we will. Physical illnesses – as long as they are not caused by behavior that is considered to be wrong (i.e. AIDS, other sexually transmitted diseases, alcohol and drug-related medical disorders) usually arouse compassion and do not bring down upon the victim's head a host of character judgments. In contrast, a mental illness, or a behavior management problem, or an emotional disorder – or whatever euphemism we use – is never as clear and seems always subject to interpretation and judgment.

In contrast, mental illnesses are at least in part, socially constructed and therefore subject to the same influences as any other socially constructed idea – personal and cultural interpretation and meaning. The mentally ill tend to direct attention to the problems that the society does not really want to address and would far rather deny, embarrassing problems such as child abuse, domestic violence, community violence, poverty, consumerism, classism and racism. As consumer activists have pointed out, applying the medical model to mental health serves to *"deny that other contributing stressors (e.g. abuse, poverty, loss, violence and trauma) are factors. Perpetrators are thereby overlooked, children are overmedicated, and society ignores the culturally sanctioned epidemic of violence* (p.135) [57].

At present there are basically three ways that our society defines "deviant" behavior and these definitions implicitly run throughout the recovery literature. If someone engages in behavior that deviates from an expected and acceptable norm we say that they are either: 1) sick; 2) bad; or 3) sick AND bad. The sick get funneled into the mental health system; the bad tend to wind up eventually in the criminal justice system; and those labeled sick and bad are likely to bounce back and forth between the two – or get no treatment at all.

For the mental health system, the ever-expanding Diagnostic and Statistical Manual attempts to categorize the various forms of "sickness" so that the logic and order that dominates the realm of physical illness can be applied to the "sick" in the hope that they can get "well" – proper diagnosis should lead to proper treatment and then an appropriate and hopefully beneficial outcome. This is the realm where the mental health system has traditionally been comfortable. This is what we do – we diagnose and treat people. Never mind that we have to shove patients into diagnostic boxes that they rarely neatly fit. Never mind that even with all the biological advances, we still cannot do a test to find out the nature or anticipated course of bipolar disorder, or major depressive disorder, or mania, or schizophrenia – whatever it really is. Never mind that we have an overall absence of evidence-based knowledge about how what we do actually helps people. Society demands of us that we keep the social problems that the mentally ill create away from everyone else. Let's be honest:

our formerly huge state hospital systems were built far out in the country to keep our patients out of society and it has been and still is an uphill battle to reintegrate them into society. When someone diagnosed as mentally ill injures him or herself or anyone else, the person who is in a treatment relationship with that person is likely to be held legally responsible even more than the person himself. The paternalistic system that the recovery movement rightfully criticizes was sustained, but not created by the mental health system – the larger society created the mental health system to contain the problems posed by people it does not want to see; a society that does not want to be held accountable for the pain and suffering it imposes on its members.

For those who are labeled "bad" the situation is, if anything, more dire. Badness encompasses the world of addictions, character problems of all kinds, including people who have difficulties distinguishing between right and wrong and obeying society's laws. Badness is largely seen as a matter of choice, unlike sickness, and therefore people who are bad are punished for the bad choices they have made – and are still making – in their lives. Badness in people arouses little sympathy as can be witnessed in the life-threatening and soul-suffocating conditions that prevail in many U.S. prisons. Although the attitude towards some addictions shifted – at least for a time – beginning in the 1970's as the addiction treatment community grew and defined addictions as "disease", this social tolerance has greatly remitted in the last decades so that are prisons are now overflowing with men and women who have committed non-violent drug offenses.

To be mentally ill AND to do bad things launches a person into a nowhere land straddling the worst of both worlds and poses a significant threat to the progressive forward movement of the recovery movement. The society will not tolerate individual outsider violence for long and this definitional tension - "is this person sick or is this behavior just intentional?" – can easily undo progress as soon as the next disastrous situation involving a mentally ill person who is in recovery hits the headlines. The search will be on for someone to blame and the more retributive voices in society are likely to blame both the recovery movement and the foolishly naïve mental health workers who don't recognize sick/bad people when they see them. When the forces of legal retribution then are brought to bear on individual clinicians and institutions, it is likely that the reform efforts once again, will spiral into regressive – and repressive – positions.

For the recovery movement to really bring about transformative change, there must be a transformation at the level of very *basic assumptions*. In the past, reformers could muster little defense against the powerful social forces of containment, control, and cost because the theoretical foundations of the work they did were always a bit shaky. When faced with threats to the social order including escalating costs, talking about being nice to people is not enough. The appeal to human rights is a strong one but only insofar as the humans under consideration are considered to be truly human. As long as the definitions that describe them put them outside of the circle of normal human existence, that argument too is likely to topple back into paternalistic treatment and condescending disregard and the stigma attached to mental illness will persist.

Bringing mental illness back into the full circle of human problems, rather than being seen as the result of individual defects or individual choice, requires a

true public health approach. The powerful trend in presenting mental illness to the public in the last few decades has been to situate the problems squarely within the problematic individual. It is time to restore the social context to our shared understanding of how people develop the complex problems that put their wellbeing - and the wellbeing of others - at risk. The public needs a way of understanding the entire spectrum of problems we define as "mental illness" - including those that involve socially inappropriate, addictive, and criminal behavior – as problems that can potentially be alleviated if not solved, by concerted, preventative social action. An ounce of prevention is worth a pound of cure or so the folk saying goes, and most of the human dysfunction that we see was at some point in time, preventable. When the public can understand the basic premises of a problem – i.e. lead-based paints as a source of brain dysfunction, unwashed hands as a source of bacterial infection, cigarettes as a cause of lung cancer – enormous resources can be mobilized to address the problem and true transformation in practice can occur.

Moving From Sickness/Badness to Injury: A Public Health Approach

In the last few decades, an enormous body of clinical and experimental research has demonstrated that a prior exposure to childhood adversity in all of its forms has enormous implications for long-term physical, emotional, and social health. The next decades should bring about a scientific integration of this knowledge with genetic, immunological, and neurochemical advances in how the brain works and how the brain and the body work together, all constantly influenced by the past and the present environment.

What is emerging from these advances in knowledge is a different paradigm for viewing virtually all of the mental, emotional, and social problems that plague human society – and many of the physical problems as well. Advocates of this changing point of view often called it the "trauma model" but the use of the word "trauma" is a bit of a misnomer that has arisen largely because these same advocates learned a different way of viewing the world through their contact with very traumatized children and adults.

At its core, the so-called trauma model replaces the older notions of "sickness" or "badness" with that of "injury". This simple change in terms has deep and far-reaching implications for practice. Sickness is mysterious, the province of experts who in the mental health professions take on the aura of priests, mediating between the unknown and largely unknowable sources of mental anguish. In the face of sickness, the sick person can do little except surrender him or herself to the hope of alleviation of pain, if not cure, that is dispensed by the experts. The notion of "empowerment" in such cases has little utility and can be a dramatic interference with the ability of experts to do what they are good at doing.

The notion of "sickness" in practice implies an etiology that is within the individual and the person's context – past events, the meaning they have drawn from those events, their spiritual and moral beliefs, their social relationships - is largely irrelevant. Since the problem is located within the sick person, the society within which this person is embedded and the representatives of that society have no real responsibility in whether or not the sick person gets the care required to address

the problem. Therefore the society can endorse policies that make recovery far more difficult because recovery is not an interactive phenomenon between the ill person and the relationships in his or her life. Instead, recovery is purely determined by the nature of the mysterious "illness" and since no one knows exactly what the illness is, what causes it, or how to cure it, recovery becomes more a matter of individual happenstance than thoughtful social policy.

Similarly, the notion of "badness" justifies social retribution and permanent exclusion. Because bad behavior continues to be considered a matter of individual choice – in many cases now even applied to the very young – any implication that the person is not wholly responsible for their choices threatens to undermine the entire basis of the justice system. At least those considered mentally sick may arouse social compassion for their plight. Social compassion directed at those labeled "bad" is denigrated as being "soft on law-and-order", foolhardy and most likely dangerous. The notion of "recovery" has not penetrated the strongholds of social containment we know as prisons except as it enters the world of recovery from addictions, where the 12 step programs will encourage both individual accountability and social forgiveness.

Among the mentally ill, the notion of individual blame is carefully hidden behind the screen of pseudomedical diagnosis but continues to rear its head as "stigma" and the inequity that goes along with that stigma will not go away simply because concerned professionals and recovering people would like it to. Among those labeled bad, blame and shame are out front, direct and unrelenting. Those labeled both "sick" and "bad" inhabit a netherworld full of mysterious causality and individual blame.

The notions of "sickness" and "badness", firmly rooted in the historical notions of possession by demons and bad blood are not significantly altered by the more recent mental health emphasis on disrupted neurotransmitters. Regardless of whether we say the person is demonically possessed or mentally ill, we still conveniently drop the social context out of the situation and the problem is located largely within the individual. There is no need, therefore, to change the social conditions which may promote the further development of more sickness and badness. The individual is accountable but the society is clearly not accountable. This *divorce of social context* is exactly what the present recovery movement has not yet sufficiently addressed.

Universal "Injury" Precautions

One of the frameworks that has been used as a kind of compass for trauma recovery employs an acronym "SELF" – safety, emotional management, loss and future. If we apply this acronym first to physical injury and then to emotional injury, it may offer some guidelines for recovery that could be universally employed whether we talk about complete recovery, partial recovery, or recovery with some disability that to which the person must learn to adapt.

Safety: The first guideline to follow after someone is injured is to *respond to the immediate injury but do no more harm.* If someone is bleeding, the first priority is to staunch the flow of blood. If someone has broken a limb, the bones must be set. Safety is and must always be an initial and universal primary concern and

encompasses the notion of recovery if safety is defined in physical, psychological, social, and ethical domains. A person who is threatening suicide is not safe, nor is someone who is hallucinating voices that are giving him/her instructions that are dangerous. A person addicted to drugs or to alcohol is not safe, nor is someone engaging in behavior that could lead to an arrest. Measures must be taken to ensure safety in the face of the immediate threat, but the measures taken must do no more harm.

It is important to remember a basic trauma theorem: "hurt people hurt people". A vital part of minimizing all forms of violence is to recognize that violence always occur within a social context that either supports the exercise of violence or discourages it. If someone is acutely in danger of hurting him/herself or others, harm must be prevented, but prevented in a way that does the minimum amount of harm to everyone involved including unnecessary limitations on the exercise of freedom and the individual rights of the threatening person along with the simultaneous analysis of the social context within which the violence threatened to occur. Human beings rather easily become violent when we are threatened, and the threat can come from other people, as when people we trust betray us or from inside ourselves, as when distressing feelings, thoughts, or memories threaten to emerge into conscious awareness.

The second guideline necessitates *nursing the injury for awhile* and *creating a healing context.* People who have sustained a recent injury often need special care and the alleviation of responsibilities. Nurses, doctors, medicine, comfort, quiet, rest, withdrawal, stress reduction are all concepts easily associated with this part of recovery from physical injuries. Simple nursing of an injury may suffice to help someone get back to normal, but sometimes adjusting to an injury may create secondary problems that require new adaptations on the part of the injured person. People who have experienced such things as an acute psychotic episode, an attempt on their own life, a traumatic experience, acute illness, a terrible loss cannot be expected to just "get back to normal" after a two or three-day stay in a hospital or other sheltered place. It is essential that injured people are given the care they require at a pace that promotes healing without encouraging disability.

Creating a context for healing is important for all of the stages of recovery but is perhaps most acutely necessary when someone is at their most vulnerable – when their injuries are fresh. This is also the time when people are most likely to encounter professional help. Human beings are social animals and we need other people. Researchers Hubble, Duncan and Miller have thoroughly reviewed the therapeutic literature looking for the essential elements in all forms of therapeutic intervention that determine whether or not someone is actually helped – and not hurt – by therapy. They have determined that 40% of a person's outcome is a result of what that person brings into the therapeutic environment – basically the nature and extent of the person's psychological injuries. Another 30% is determined by relationship factors within the healing context: accurate empathy, positive regard, nonpossessive warmth, and genuineness [58]. These relationship qualities are not taught in graduate school and therefore are potentially available from a wide variety of people in a support system.

It is essential, that after an injury, the injured person and those close to him/her learn everything they can about how to promote healing and recovery.

Depending on the extent and the nature of the injury, this may require providing extra protection for the injured part, aids to promote the reassumption of function, and clear guidelines that promote healing without reinjury. *Reinjury* can result from either overprotection – not putting enough stress on an injury – or underprotection – subjecting an injury to too much stress too soon.

Just as it is after a physical injury, the proper pace is established by evidence of *movement.* According to the researchers mentioned above, another 15% of client outcome is determined by the therapeutic or healing rituals that provide an explanation for the client's difficulties; that establish strategies or procedures to follow for resolving difficulties; that prepare clients to take some action to help themselves and that set expectations that clients will do something different, i.e. develop new understandings, feel different emotions, face fears, alter old patterns of behavior [58]. If injuries are not healing, then the reasons for continued immobilization or even regression must be sought – not just within the injured person but within their social context. A powerful aspect of the recovery movement is that it provides a concept of *recovery*, a vital ingredient that has been missing for many people.

Just as is the case for physical injuries, emotional injuries can be both subjectively and objectively assessed for improvement. A person may still be quite symptomatic but in relationship to their previous limitations, there may be significant improvement and this can indicate that a course of treatment is working to promote a recovery process. Likewise, the injured person may subjectively report an absence of psychological pain, but continue to deteriorate in their level of function. This should cause a reassessment of the recovery process, as the lack of functional improvement may indicate the development of secondary injuries, much as someone who sprains his right ankle and therefore favors the right, develops tendonitis in the left ankle as a response. Freedom from internal conflict or distress does not necessarily mean that someone is "in recovery" – sometimes it means just the opposite.

Emotional Management: When someone is healing from physical injuries, they must learn to tolerate a wide array of unpleasant emotions that may otherwise further compound the injuries. A man who is hospitalized after a heart attack may precipitate further and sometimes fatal damage to his heart if he cannot surrender some control to the health care providers in the ICU. The woman on crutches or in a wheelchair must learn to tolerate helplessness, dependency and asking for help if she is to heal – or in the case of permanent disabilities – achieve her maximum level of function. Everyone who sustains any kind of physical injury must learn to adapt to the losses secondary to the injury and for people permanently affected, they must grieve for their former life in order to open themselves to full function in their new reality. So a fundamental part of healing from anything is learning how to successfully manage anger, sadness, shame, fear and guilt without doing further harm to oneself or others. People who sustain injuries secondary to all forms of acute and chronic mental illness – some of which spring from disordered genes, some from disordered neurotransmitters, some from the effects of toxic substances, and many from human-induced trauma - have difficulty managing distressing emotions. This is not surprising since all humans seem to have difficulty managing distress.

The degree of stress tolerance can ultimately only be decided by the injured person since they are the one that experiences the distress and loss of function secondary to the injury. However, because of the pain involved in healing, people recovering – especially those recovering from severe injuries – often require other people who can coach, mentor, and support them through the pain and stress that is associated with recovery. The nature and extent of the injuries usually determine how long and intensive such a relationship needs to be and the level of necessary expertise of the coach. At the same time as injured people often need expert help, it is inspiring and sustaining to build relationships with other people who have already walked the road you are on, who are intimately familiar with the progress and regression, hope and frustration that is typical of the process of recovery.

While recovering from a crushing leg injury, the injured person usually needs to see a physical therapist – quite frequently in the early stages of healing and with decreasing frequency over time. And that relationship is likely to be filled with mixed feelings. In the case of physical injuries, physical therapists evoke pain that was not present before the person entered the office. Pain causes powerful emotional reactions that are sometimes directed at the physical therapist, but if the injured person knows that the pain is in the service of the resumption of better function, they are likely to grow in their tolerance of both the pain and the physical therapist. In a very similar way, healing from emotional injuries causes pain. Whether people are traumatized by the experience of losing control over their minds, losing control over their alcohol or substance use, or violence inflicted by another person – being helpless and surrendering control is a toxic experience for humans and we will do virtually anything to avoid contacting that pain – even if it is pain lingering from the past. Pain in a broken limb causes contractions of function. Pain in a broken psyche similarly causes contraction of function and any attempt that other people make to unfreeze that contraction and thus promote movement are not generally welcomed. It is in the context of the therapeutic relationship, often over an extended period of time, that psychologically injured people become willing to surrender some control, learn to trust other people, build relationships, resolve conflicts, and begin to make the changes in their lives that though painful, result in movement and better function.

Loss: Regardless of whether the injury is physical or emotional, every injured person must surrender some degree of control in order to get help. The pain of loss is an inevitable part of injury, which is an inevitable part of life. The more profound the loss, the greater the impact on function, the greater the social estrangement, the more difficulty the injured person is likely to encounter in working through the grieving process. One of the fundamental ways that human beings avoid dealing with loss is to keep doing the same things over and over, even though doing the same thing prevents healing and may even deepen the extent of the injuries. And the human grieving process is not just an individual but a social process. The importance of peer support throughout the process of healing cannot be overestimated, particularly in offering social support throughout the grieving process

Some injuries will result in long-term and sometimes permanent forms of vulnerability and therefore may require more permanent changes and adaptation to a changed life. Developing a schizophrenic disorder in late adolescence requires very

different adaptations from experiencing combat trauma at twenty-nine, or the traumatic loss of a spouse at fifty, or repetitive sexual abuse from age three to twelve. Everyone heals at their own pace and although other people can promote or negatively influence the healing process, the process itself is the responsibility of the injured person. To the extent, however, that one person's injuries endanger other people, that person's influence must be constrained, while every effort is made not to further compound their injuries.

Future: Every person has to make choices about their own immediate, intermediate and long-term future and must therefore assume responsibility for the choices that they make along the way. At the same time, we learn through our mistakes and people who have sustained severe injuries must often relearn, or learn for the first time, by making different choices and by taking risks to do things differently. When someone who is learning to walk again after sustaining a serious injury, falls, we do not punish them for falling – we help them to get up if they need the help. Similarly, it is absurd to punish people who are psychologically injured for "falling" – they need to take some risks in order to learn how to change. To engage in the difficult and painful work of recovery whether from physical or psychological injuries, people need to have a vision of what they can accomplish, hope for a better future, even while they may experience what has been termed a "foreshortened sense of future", an inability to imagine a way out of their despair. But for all of us, working our way through each day is an act of imagination. We anticipate and plan because we imagine ourselves into our lives. For many people who have experienced repetitive terror, pain, and injury, opening the door to imagination only lets in monsters. So they shut those doors and seal them tightly. The end result is that they must live in the present moment, haunted by the past, and unable to plan for the future. Thus they live without hope. Healing requires opening those doors, unsealing the amazing human imaginative power that determines what comes next. Healing requires beginning to hope for something better and then working to make that hope come alive. According to Hubble, Duncan and Miller, the researchers mentioned earlier, after the person's individual factors, relationship factors, and therapeutic model factors, the last 15% of outcome can be determined by HOPE. It is one thing to have your therapist or psychiatrist hold out hope for your recovery. It is quite another thing to talk to someone who has been on a similar voyage and can embody hope in his or her own example.

Trauma and Recovery

The scientific body of knowledge that falls under the twin rubrics of "trauma studies" and "attachment research" has clearly demonstrated that exposure to adversity and stress – particularly when it is repetitive and begins in childhood – has long-term consequences that span the entire gamut of "sick" and "bad" behavior [49]. We can see now that you can injure a human being in an almost infinite variety of ways. Human injury may be genetic, developmental, immunological, neuroanatomical, neurochemical, emotional, cognitive, behavioral, social, relational, political, spiritual, moral – and in any combination. These injuries may be transient

and entirely resolvable or they may lead to permanent disabilities. But regardless of the nature of the injury, it occurs within an individual and social interactional field that cannot be divorced from that injury. If maximal healing – recovery – from injury is to occur, then the individual clients, their families, the professionals involved, and the society they represent are all interactively responsible and accountable.

We know enough now to assert that neither mental illness nor criminal behavior arise within the vacuum of individual existence. As a local example, in 2002, under the auspices of Community Behavioral Health, the Women's Law Project published a report summarizing the extensive findings of a study addressing gaps in services for pregnant and parenting women suffering from substance abuse disorders in Philadelphia. The results culled from consumers of services and providers of a wide variety of social services demonstrated the interconnected nature of violence-induced trauma and behavioral problems of all kinds. We found that the problems encountered by this population are systemic and rooted in a lack of public policy that addresses the needs of vulnerable women and their children. To quote from the report, "*Philadelphia's health and human service delivery system does not address the specific needs of women, does not integrate the linkage of trauma, violence, and substance abuse in service delivery, lacks cross-system training, and fails to fully comprehend the long term needs of families affected by trauma, violence and substance abuse"* [59].

Until the general public recognizes the chain of events or circumstances that lead to the wide variety of problems we characterize as mental illness, adequate responses aimed at tertiary prevention (those already affected), secondary prevention (those already at risk) and primary prevention (everyone) remain elusive and probably impossible. How can we understand the ways in which psychological injuries can lead to a vast spectrum of behavioral, physical, and social difficulties and the barriers these difficulties pose for recovery? Through a trauma-informed lens, the problems are not made simpler but are at least describable enough to allow us to "get on the same page" as consumers, as family members and as professionals. Let's look for a minute at some of the potential injuries our clients have sustained and from which they must recover. And then in parallel, let's look at the organizational barriers that contribute to the current inflexibility and rigidity of the systems originally designed to help, not hinder, recovery.

Recurrent Stress Produces Individual Barriers to Recovery

Clients presenting in mental health, substance abuse, and other social service settings are likely to have been exposed to chronic stressors and significant experiences of childhood adversity. As a result they have been repetitively exposed to danger and now may have difficulty keeping themselves safe – sometimes physically safe, and even more commonly, psychologically, socially, and morally safe. Despite the fact that clients' backgrounds are filled with repetitive, often unrelenting stress, trauma, and pain, they are frequently reluctant to talk about the most traumatic aspects of their past and in many case, have amnesia for the worst aspects of their experience because of the ways in which the human brain processes overwhelming stress. Clients who have been repetitively hurt within the context of close, interpersonal relationships, often have difficulty discerning who can be trusted and

who cannot because failures of trust characterize their interpersonal history. The greater the exposure to childhood adversity, the more likely it is that clients will have physical problems secondary to that exposure and they may have great difficulties – for a number of reasons – providing proper self-care for themselves.

As a result of the exposure to chronic stress, clients are frequently chronically hyperaroused, responding to even minor stressors as major stressors. These fundamental biological changes may be greatly compounded by a pre-existing genetic vulnerability such as schizophrenia. One of the responses to chronic hyperarousal in our clients may be an increase in aggression toward self and/or others. Repetitively traumatized clients have significant difficulties managing distressing emotions. They may have adopted substance or behavioral addictions in order to cope with distressing emotions. As a result, drug and alcohol abuse; sexual acting-out, promiscuity and addiction all may be a part of the clinical picture.

Clients may have fragmented mental functions because of traumatic dissociation and amnesia, learning problems, and reenactment. Clients who are raised in situations of significant family adversity may not learn how to work through problems, partly because they cannot manage the intense emotions that one must tolerate to do adequate problem-solving. Under recurrently traumatizing conditions, it is difficult to maintain a clear and healthy sense of identity. As a result, clients often appear to be contradictory: they often do not act on what they think, or their actions contradict what they say. Their strongly held moral beliefs may not consistently guide their actions.

As a result of their toxic experiences with other people, clients frequently lack good communication skills and have difficulty in being both direct and diplomatic. As a result, their communication style may be indirect and covert and may end up creating more problems than it solves. Having experienced repetitive violation of physical and psychological boundaries, repetitively traumatized people may violate other people's boundaries, fail to protect their own, or have such rigid boundaries that they cannot ask for help, allow help to reach them, or extend themselves to connect to others, in other words, their boundaries do not necessary let the right information in and do not operate sufficiently to screen out bad information.

Clients exposed to recurrent threat and the violation of boundaries may find themselves unable to protect themselves from revictimization and unable to mobilize necessary resources to keep danger out of their lives. To be effective in the world, each of us must develop a response to external authority and a sense of internal authority that helps us both comply with authority and exert our own authority. Clients who have grown up in abusive relationships are likely to have difficulty with both domains. They may be overly obedient to authority and fail to develop critical thinking, or they may be unwilling to comply with any authority and end up plunging themselves into many unnecessary situations of conflict and punishment. They also are likely to have difficulties in exerting their own authority by being able to take control of situations by leading, not through bullying or passivity.

As chronic stress increases and permeates every aspect of a client's life, the internal psychological environment – sometimes reflected in the external environment – may become increasingly more disordered, contradictory, and chaotic. Because of deficits in emotional management and problem-solving, clients often are in situations where they make very poor judgments and make bad decisions about

what they should do. When clients try to communicate but fail to convey the information they seek to convey, the interpersonal relationships they have may tend to become increasing compromised as misunderstanding piles upon misunderstanding. Since they are unlikely to have good conflict resolution skills, distressing emotion mounts and conflicts are not resolved.

Because of the nature of the traumatic wounds, clients frequently lack words for feelings. Words, representing the conscious content of an experience, become separated from feelings - the affective content of an experience - and the emotional content tends to get acted-out or re-enacted in present relationships. All forms of therapy focus on the resolution of internal and external conflicts. Resolving conflicts is a fundamental way we learn from our experience. Clients exposed to repetitive and unrelenting stress may become chronically helpless, failing to make changes that are indeed within their power to make. Clients, desperate for relief of distress, often engage in behavior that puts them in situations of unnecessary risk, but are simultaneously afraid to take risks that could lead to positive and constructive change. Failing an understanding of the nature and extent of their psychological injuries, clients will often direct their aggression inwardly in the form of self-destructive behavior, or outwardly in the form of some kind of violence. Lacking adequate adult role models, clients frequently lack the ability to control their impulses and to impose self-discipline. As a result, when in a caregiving environment, they are likely to become more stressed, and impulse control problems may increase. Since violence can take many forms, clients may be able to control physical forms of violence but may engage in psychologically or socially tormenting themselves and/or others.

Given the “cloaking” nature of previous trauma and the nonverbal level at which many symptoms operate, outside of the limits of conscious awareness, many chronically stressed clients do not see the role they are playing in the development of their on-going difficulties and are unable to get on a self-correcting course. Clients who have been exposed to maltreatment in childhood are unlikely to be able to recognize their successes, often have poor self-esteem, and may repeatedly subject themselves to shame, guilt, and punishment for real or imagined failures. Repetitively traumatized clients have sustained a series of losses for which they have never been able to adequately grieve because the losses are stigmatized or disenfranchised and because they do not have sufficient emotional management skills to endure the overwhelming nature of grief.

Unresolved grief manifests in a number of ways typical of chronic trauma disorders including chronic depression and suicidality, chronic pain, addictive disorders, hopelessness, and helplessness. A common problem for chronically traumatized clients is their tendency to compulsively repeat an experience from the past that has not been fully incorporated into the full narrative of people’s experience. This is commonly termed “traumatic reenactment” and in a treatment or community environment offers both a dilemma and an opportunity for change that can be seized by people that know how to be catalysts for positive change. In a client, constant reenactment is a sign of unresolved grief.

Clients often seek- or are sent – to receive care when they are at their most helpless, when they have lost faith in the possibility of recovery. Chronically traumatized clients are likely to experience depression, physical exhaustion, cynicism

about the possibility of positive change, and bottomed-out self-esteem. Clients who have been repetitively traumatized are likely to experience a fore-shortened sense of future and become hopeless about a positive vision of the future, instead living moment-to-moment without hope.

Recurrent Stress Produces Organizational Barriers to Recovery

While a new paradigm for treating people with a very wide variety of problems has been rapidly emerging over the past several decades out of the field of traumatic stress studies and now further prodded by the consumer recovery movement, our helping systems have had great difficulty taking up the challenge of change. The revolutionary findings about the impact of recurrent stress still remain largely untaught in graduate studies and have not been well integrated into mental health service delivery, child protection agencies, domestic violence and homeless facilities, or substance abuse programs. Why is this the case?

We believe that there are parallel processes in play between chronically stressed and traumatized clients, stressed organizations, and a larger social and economic climate that is still in denial about the basic causes – and preventability – of our major social problems. As a result, our helping systems are now chronically stressed while the draft Blueprint anticipates even more challenges ahead. The mental health system, particularly, has experienced radical downsizing and what could be considered collective systemic trauma. Not only are our systems of care frequently unsafe for the clients but they may be unsafe for our staff and administrators as well – sometimes physically unsafe, but even more commonly psychologically, socially, and morally safe. Recovery begins with safety and without simultaneously addressing organizational change we fear the recovery movement will not have the impact it must have for true transformational change. There is an important role for peer support and community-based approaches to care, but too many people present with problems that are simply too complex to eliminate the need for professional help, particularly in the acute and early stages of recovery. But that means that everyone needs to "be on the same page" and right now, that is certainly not the case. Often the gateway to understanding the ways in which chronic and unrelenting stress has so impacted our clients is through understanding the ways in which chronic and unrelenting stress impacts everyone.

Organizations manage emotions through regular and productive meetings, retreats and an atmosphere of participatory management, all of which ceases to regularly or productively occur under the influence of chronic stress. At the organizational level, the failure to cope with workplace emotions and conflict may promote a situation that covertly supports substance abuse and sexual misconduct in the workplace.

Erosion of trust in the workplace has become a major barrier to instituting trauma-informed care. Workers do not trust that responding to the past traumatic experience in clients, and empowering them to make decisions for themselves, will enable the workers to feel safe. Administrators cannot trust that the decisions they make about the well-being of their institutions will be respected by their superiors or by funding sources. Many of our caregiving systems are crisis-driven, hypersensitive to even minor threats and respond to any threats with counteraggression, together

producing more injuries to staff and clients and more coercive measures, escalating the lack of safety and the level of fear in the environment for everyone.

Our systems of care run in parallel with the clients' dissociative problems by failing to ask about the clients' trauma histories, or failing to incorporate the information into ongoing treatment planning, and by failing to recognize that most of the staff have also been subjected to childhood adversity and may have significant difficulties managing their own emotions and reactions that get triggered in the therapeutic environment.

Service delivery becomes increasingly fragmented under stress as communication breaks down, organizational amnesia increases, and learning from mistakes grounds to a halt. Chronically stressed systems of care engage in faulty and inadequate problem-solving under stress, usually reverting to old ways of doing things, even if the old ways no longer work. Identity confusion in organizations is evident in the recurrent conflicts between theory and practice, various professional groups, management and workers, clients and staff. It all represents a failure to "get on the same page", to engage in processes that increase the likelihood of synthesis, convergence, and emergence.

Under stress, the communication network within caregiving organizations tends to break down. Formal lines of communication become more rigid and convey less information, while the slack is picked up by the grapevine which may – or may not – convey accurate information. Stressed organizations frequently substitute rules for process resulting in fixed expectations and consequences that punish clients for the problems that bring them into treatment in the first place. Or, organizations can become so confused about boundaries that they do not have clear role definitions. As a result interpersonal and intra-organization boundaries become confused and overly permeable. Or organizational boundaries may be so rigid that no useful information gets in at all.

Chronically threatened caregiving environments have been unable to mobilize any coordinated defense enabling them to protect staff, their organizations, or the ability to provide the care for clients that they recognize as necessary. Chronic stressors in systems take a significant toll on formal leaders who may not have learned how to apply different leadership styles commensurate with different demands. Under stress, leaders are likely to resort to the style they are most comfortable with and for some this may be authoritarianism which minimizes the critical thinking of everyone lower in the hierarchy and diminishes the possibility of organizational learning. In the worst case, authoritarian leaders may become petty tyrants. For others the leadership style may be laissez-faire, for others passive-resistance or just passive acceptance. Under these conditions, when leaders fail to lead, informal power will be used – and sometimes abused – to fill the leadership vacuum by others lower in the hierarchy. Likewise, chronic stress can produce disorder, hypocrisy and chaos in workplace environments.

Chronically stressed systems likewise make poor judgments, particularly when they silence dissent, refuse to listen to alternative points of view, and minimize or eliminate participatory processes. As stress increases and participatory processes are eliminated, both individual and group decision making are likely to become progressively compromised. Likewise, in an organization where lines of communication are broken and people are becoming afraid of each other,

interpersonal conflicts increase and are not resolved because the system lacks adequate conflict resolution skills. This failure of communication and conflict resolution in the system may emerge as a "collective disturbance" which flows down from the original source of unspoken conflict and manifests in problematic behavior, first in the staff and later in the clients.

In organizations, "collective disturbance" represents this separation of cognitive and emotional content of an experience. Problems cannot be honestly, openly and safely discussed. Secrets exist at many levels, or at least an air of secrecy and a lack of transparency is felt by everyone. Little differentiation is made between privacy and secrecy, so secrets may be kept while privacy is invaded. Conflicts at the level of the administration or the staff then are unconsciously projected upon the clients who then act-out the affective element of the conflict while no one understands or grapples with the cognitive content. Organizations that cannot surface, explore, resolve and transform conflict cannot learn from experience and are likely to make the same mistakes over and over instead.

In a similar way, staff in chronically stressed systems may become increasingly helpless about the possibility of change in their clients, themselves, or their systems. When challenged to empower themselves and "be the change you want to see", they may helplessly wait for someone else to "tell them what to do".
Chronically threatened organizations become extremely risk avoidant in trying to control clients' risky behavior and in doing so may virtually eliminate the expectation that clients' need to take risks in order to change – and so do the staff within any organization that hopes to promote change.

Stressed systems may fail to see the larger issues that are clouding vision and impairing performance and instead attempt to address problems using a system of rewards and punishment that do not address the core issues and that may be perceived as aggressive responses and may evoke counteraggression in response.
The parallel– and interactive - process reflecting this problem occurs when stressed staff act-out through absenteeism, poor performance, errors and counteraggression.
More psychological forms of violence in an organization may emerge as an increase in vicious gossip and malicious rumors.

Likewise, caregiving organizations under stress may become oblivious to the most obvious question, "Is what we are doing working?" Instead, quality assurance issues will focus on the more mundane aspects of the environment, like completed paperwork and adequate fire alarms, while neglecting the most vital aspects of quality care – catalyzing positive change in clients, staff, and the living system as a whole.

Organizations have difficulty paying attention to their successes, thus capturing and rewarding what they do well. Far more attention is routinely given to shortcomings and failures, then doing a job well. Friends and colleagues leave or are laid off, leaders depart, programs close or are greatly diminished, and clients do not respond to interventions in satisfactory ways. Everyone in the system experiences losses that no one is permitted to fully address. The lack of attention from above that the effects of these losses are having below conveys the attitude that there is nothing to be gained by working through loss – so no one does. As a result, loss is compounded upon loss, further contributing to the atmosphere of demoralization and depression.

Chronically stressed organizations tend have significantly lowered abilities for creative change and instead, tend to mirror the clients' reenactment behavior by reenacting failed treatment strategies that do not work while remaining unaware of the repetitive nature of their interventions. In a system, constant reenactment is a sign of unresolved grief. The result may be the development of successful failure or permanent failure of the purported organizational mission.

In chronically stressed organizations, staff often become progressively hopeless, helpless and demoralized about the work they are doing and the possibility of seeing significant change in the clients, failing to recognize that much of their hopelessness and helplessness is related not to the clients but to the larger systems within which they are all embedded. Chronically stressed organizations may be controlled top-to-bottom by people who are "burned out" – emotionally exhausted, cynical about their clients, doubting any personal efficacy. This foreshortened sense of future in organizations presents as a loss of vision, of true purpose, of hope that the organization and all of the staff together can play a significant role in helping people to recover.

Summing Up Parallel Processes of Recovery[1]

At this point in time, there is little we can do immediately about many of the chronic stressors plaguing the mental health and social service systems. The only solution to these problems is organized, coordinated and mutual activism on the part of people who use these services and those who work within these sectors. So how can you help be an agent of positive change?

It is useful to think about parallel processes of recovery because in reality, we cannot stop the systems from functioning in order to fix what is broken. The flow of clients who need services has not and will not stop in any world that we can realistically anticipate today. So we have to mend our broken systems at the same time that we are providing services to the people who need them. As daunting a process as this may seem it is consistent with both the recovery movement and the drive for trauma-informed care. What needs to be added is a heightened awareness of the interconnected, living nature of all of our systems and a recognition that significant changes in one part of the corporate "body" can only occur if the whole body changes as well. Let's briefly summarize what a parallel process of recovery needs to include.

Recovery from Chronic Stress and Collective Trauma

INDIVIDUAL HEALING: Knowledge is power and clients need a different framework to understand what has happened to them, a different mental model for viewing reality – the movement heretofore summarized as change from a "sickness/badness" mental model to one of "injury". Effective problem-solving relies on accurate problem definition. This makes universal trauma assessment a vital component of good care and includes a broad definition of what is traumatic. When applied to people with

[1] Excerpt from Bloom, S. L. Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation. Available at http://www.nasmhpd.org/publications.cfm

problems that create psychosis, is there anything more traumatic than "losing your mind" and the life before the disorder began? An intensive psychoeducational program that teaches clients about the effects of overwhelming experience on their ability to manage emotions and stay safe in the world, think clearly, regulate aggression, work through grief, and plan for the future becomes a keystone for good treatment.

ORGANIZATIONAL HEALING: The ability to respond to chronic stress and collective trauma is significantly improved if a group of people can pull together and move in the same direction. The only real buffer against overwhelming stress is social support. But to achieve unified action on a consistent basis, people have to be on the same "page". Getting on the same page, despite the diversity of experiences, education, culture, ethnicity, gender and age in every setting requires universal training in psychobiology; therapeutic relationships; individual, group and organizational dynamics; attachment theory; trauma theory; and knowledge creation.

Commitment to Basic Safety

INDIVIDUAL HEALING: Clients need to agree on a definition of what safety is and make a wholehearted commitment to acquiring the safety skills that will begin the process of healing. This requires an understanding of the physical, psychological, social and moral elements that go into creating a truly safe lifestyle. The development of individual safety plans and a shared language for safety is a critical aspect of this domain of recovery. As safety skills are developed, the individual clients can move at their own pace in developing the other skills necessary to work through previous traumatic experiences, using safety towards self and others as a guidepost in how to pace the tasks of recovery. While the psychological work is being started it is critical to also pay attention to the ways in which chronic stress has jeopardized the health and safety of the body and clients need to develop a good self-care plan to restore physical health as well as psychological health.

ORGANIZATIONAL HEALING: Organizations-as-a-whole and every individual working within the organization must make a wholehearted commitment to nonviolence – physical, psychological, social and moral safety. Every staff member needs to develop a safety plan for staying safe, even under stress. The chronically stressful and frequently traumatic origins of the clients' histories must be kept in the forefront of treatment planning and day-to-day interactions and discussions. Organizations must also attend to the disturbing effects this attention to trauma may evoke in staff members and create the social supports necessary to contain these experiences. This includes taking concrete steps to build a sense of community and shared social responsibility in staff and clients together. Since building and sustaining trust is such an important aspect of developing health relationships, previous breaches of trust between management and staff, members of staff, and staff and clients must be addressed in a constructive way that provides community members with opportunities to restore relationships. The physical plant reflects the attitudes people have toward each other and the work they are doing together so the environment

must be assessed, not just for physical safety concerns but for psychological, social and moral safety as well.

Development of Emotional Management Skills

INDIVIDUAL HEALING: The first step in managing chronic hyperarousal is to recognize it, so part of the psychoeducational program is helping clients to recognize the signs of chronic hyperarousal and how to begin developing skills for managing the problem more effectively. The inhibition of destructive methods for managing emotions - i.e. substance abuse, self-mutilating behavior, compulsive sexual behavior - is a vital step in learning how to more effectively manage distressing emotions, but clients must have substitute behaviors that can help them achieve abstinence goals successfully. A wide variety of cognitive-behavioral tools are helpful in teaching clients these skills. Psychopharmacological interventions may be helpful in reducing the extreme startle responses and others symptoms related to hyperarousal as well as providing relief for acute psychotic symptoms. Becoming more aware of the connections between external stimuli, internal arousal and aggressive behavior is the beginning of developing better control over those impulses. Developing words for feelings and integrating thoughts with feelings are some of the markers along the way to developing higher levels of emotional intelligence. Community meetings, group therapies, psychoeducational groups all assist in the process of developing a higher level of emotional intelligence.

ORGANIZATIONAL HEALING: There is no avoiding the need for time, time, and time. Organizational healing *cannot* occur without devoting time and resources to allowing management and staff to reconnect with the organizational history, losses, and mission. Leadership must make a clear and non-negotiable commitment to reducing every kind of violence within the organization, including the counter-aggression that masquerades as "treatment" and results in physical and psychological injuries to staff and clients, as well as social and moral injuries to the therapeutic community as a whole. To do this, however, it is not enough to tell staff to simply stop whatever behavior is problematic. Management must recognize the legitimate fears that are aroused by this kind of work and find ways to support and sustain significant change while still affording the staff a sense of safety and mastery that is reflected in the way the staff consistently treats the clients and each other. This requires sufficient conversation, discussion and dialogue so that all members of the community have a voice, and learn together how to manage intense and distressing emotions that are inevitably aroused in helping injured people to heal from their injuries. Secret relationships or destructive behaviors in the past or the present, on the part of anyone, must be brought to light, aired, and breaches in trust repaired. Meetings must be guided by the notion of constantly creating a learning organization that demands an ever-increasing level of emotional intelligence.

Reintegration of Function

INDIVIDUAL HEALING: In order to overcome a tendency to spontaneously dissociate under stress, clients must learn grounding techniques that help them learn how to

stay focused in the present and soothe themselves. They may require specific, trauma-resolution techniques to minimize the occurrence of post-traumatic intrusive experiences like flashbacks and nightmares and to overcome post-traumatic amnesia and/or emotional numbing. In the case of problems related to serious mental illness, post-traumatic symptoms may be closely intertwined with pre-existing or emergent psychotic symptoms and treating the trauma-related symptoms may also help psychotic symptoms become more manageable. Cognitive-behavioral techniques can help to address the deficits in problem-solving and emotional management that are secondary to the developmental insults they have experienced. Corrective emotional and relational experiences, as well as many kinds of peer and community interventions that reinforce self-mastery can help clients develop better self-esteem and a less fragmented sense of identity.

ORGANIZATIONAL HEALING: Getting everyone on the same theoretical "page" makes meaningful dialogue and planning more possible because everyone is "speaking the same language". This reduces the fragmentation that is so currently symptomatic of our helping systems. Recovering lost knowledge is vitally important but can be difficult once significant numbers of people have left an organization, taking with them the tacit wisdom they carry about the system, about former ways of working together, and about therapeutic wisdom that has been lost from the system. Nonetheless, with time and effort most systems are able to recapture and honor their lost history which enables them to make new attempts to incorporate what was valuable from the past into the needs and constraints of the present.

Opening Up Communication

INDIVIDUAL HEALING: In the context of individual and group experiences, clients can learn how to communicate their thoughts and feelings directly, honestly, and kindly. In the context of corrective emotional and relational experiences with staff and peers, they can learn about how to respect their own boundaries, protect themselves, and respect other people's boundaries, while remaining open enough to relate to others. In the context of community and peer support they can learn how to ask for help and how to offer help to others. They become able to mobilize sufficient resources and awareness to keep themselves out of dangerous situations and thus avoid revictimization.

ORGANIZATIONAL HEALING: Managers recognize that communication along the grapevine will never disappear, but they can make efforts to make information that travels the grapevine more accurate and less malicious by providing abundant and accurate information to people, as early as possible. Managers set an example for open communication and staff can observe in practice that there are few subjects that are "undiscussable". Managers and staff make efforts to insure that the system remains flexible and responsive to individual needs, while still guaranteeing fair treatment for everyone in the system. They do this by focusing less on making new rules for every new situation and instead commit themselves to engaging in processes that examine, assess, and evolve adequate responses to complex individual and group situations. In this way, the organization remains open to new

information- to learning – and it can readily and spontaneously engage in processes of information sharing and knowledge creation that allow it to mobilize complex responses, even in emergency situations.

Redefining Authority Relationships

INDIVIDUAL HEALING: Within the context of a community, clients learn how to be fairer to themselves and others, how to use their own personal power to become personally empowered and take control of their lives, while not abusing the power they have and seeking to control others. Clients learn to "speak truth to power" without putting themselves in harm's way. In this way they learn to use their own internal authority constructively and develop more successful and socially astute ways for dealing with external authorities.

ORGANIZATIONAL HEALING: Organizational leaders discourage authoritarian structures and teach the skills necessary for responsible, more democratic participatory structures. After assessing one's own leadership style, managers and supervisors make efforts to develop different styles of leadership to match different situations. There are many different ways of describing ideal leadership attributes but one that most adequately fits the social service and mental health sectors is called "authentic leadership" The four basic dimensions of authenticity include self-awareness; balanced processing of information that considers the perspectives of others and is free from distortions, denials or ignorance; relational transparency, and behavior that is aligned with one's values, needs and preferences [60]. Authentic leaders choose authentic behaviors even when strong external pressures and incentives exist to act inauthentically. Their authenticity is a response to internal desires to behave with integrity, not to societal pressures to conform to certain standards [61].

Improved Problem-Solving and the Welcoming of Dissent

INDIVIDUAL HEALING: As clients begin to give up self-destructive habits, develop better emotional management skills, and begin to rely instead on constructive social support, cognitive processing improves and judgments become sounder. Order evolves out of previous chaos and clients' lives become less turbulent, more structured, and safer. Clients learn to look before they leap and in this way, stay out of many troubling and potentially dangerous situations. They learn the difference between aggression and assertiveness and are able to voice their own opinions, dissent from the majority opinion, negotiate, compromise and agree to disagree. Their problem-solving becomes far more complex and they are able to anticipate difficulties before they arise.

ORGANIZATIONAL HEALING: Organizational learning improves as routine participatory processes are put into place. The increased diversity of opinions requires more thoughtful and meaningful conversations and debates over tasks. Consensus is sought because it is seen as demanding the most complex, although challenging, group decision making abilities. Dissent from the majority opinion is actively solicited

and encouraged in order to minimize groupthink, conformity, and group polarization effects. Even under stress, the organizational norm is to deliberately maintain the same participatory processes that are effective under less stressful conditions.

Cultivation of Relationships

INDIVIDUAL HEALING: Since re-establishing the capacity to trust is recognized as a vital element in healing, individuals are challenged to develop new relationship skills that allow meaningful and safe explorations. Through various forms of therapeutic encounters in individual psychodynamic and cognitive behavioral interventions, in creative expressive therapies, and in peer support and community contexts, clients learn conflict resolution techniques that enable them to give words for feelings. They learn how to recognize the dynamics of reenactment behaviors in their own lives and in the lives of other people. They learn to see every conflict as an opportunity to learn and to practice new skills.

ORGANIZATIONAL HEALING: There is a general recognition that it is the responsibility of every member of the organization to resolve interpersonal conflict in service of the greater good. The organization adopts methods that enable members to utilize clear guidelines in the routine resolution and transformation of conflict. There is also a general understanding that groups function on both conscious and unconscious levels and therefore the organization is able to recognize and respond to collective disturbance as *collective,* not individual, disturbance. Transparency exists at all levels and although all members of the organization respect individual privacy, there is a universal awareness that secrets spell trouble for the safety and well-being of the organization.

Empowerment and Mastery

INDIVIDUAL HEALING: After years of deprivation, abuse, and trauma clients learn that the only way out of chronic victimization is to overcome their learned helplessness and exert control over their own destructive behavior. They are able to look ahead and see a number of daily choices that they must make for themselves, choices that either result in them being “part of the problem or part of the solution”. They stop taking unnecessary and dangerous risks, but start taking risks to change that are actually more frightening and less predictable than their previous engagement in danger, at least initially. Social support through staff and peers supports their growing mastery skills.

ORGANIZATIONAL HEALING: Staff members realize that the only time that people - and systems - are incapable of change is when they are already dead. They recognize that their previous cynicism and helplessness about the possibility of individual and organizational change was actually a refusal on their part to take charge of their work lives and to become “part of the solution instead of part of the problem”. They realize that only when each one of them follows Ghandi’s prescription to “becomes the change you want to see” will the organization be fully empowered to bring about change. They also recognize that change always involves risk and that although

through careful processes of collaboration, knowledge creation, integration, and synthesis they can minimize the risks, life and people always remain ultimately unpredictable and life offers few guarantees.

Nonviolence and Social Responsibility

INDIVIDUAL HEALING: Although anger, frustration and the desire to retaliate are natural human emotions, clients who have been repetitively injured learn that they must harness the energy generated by these powerful emotions and transform them into something that serves both themselves and others. Dr. Herman has called this the development of a "survivor mission", a concept that is consistent with the notions of recovery as addressed in the consumer recovery movement and in substance abuse treatment [1]. Clients move toward seeking a higher level of integrity and engage in a search for meaning that helps them transcend their own individual wounds and see themselves as part of a larger historical movement for human rights.

ORGANIZATIONAL HEALING: Organizations recognize that a fixed system of rewards and punishments may inadvertently keep organizational members functioning at a lower moral level of development than is demanded by an organization seeking authenticity. As a result, the organization takes very seriously any rupture in the organizational fabric caused by individual or group dysfunction, but deals with it through a process that guarantees physical, psychological, social and moral safety to the best of its abilities. Individuals recognize they are role models for others, that they must "walk the talk" if the organization is to truly enable transformative change.

Griefwork

INDIVIDUAL HEALING: After developing skills to manage distressing emotions and the ability to sustain safety, even in the face of stress, clients recognize the need to mourn for all that has been lost, both tangible and intangible losses [62]. The work of grief often ends the tendency to engage in compulsive reenactments of the past as the past is given a full voice and the blank spaces in the person's biographical narrative are filled in.

ORGANIZATIONAL HEALING: In reviewing their own past, staff members recall all of the losses that have been experienced over the last two decades and honor what has been lost in the process. In working through the loss of what has been, organizational members become capable of reconsidering what is and what still carries on despite the changes that have occurred. Members are able to review the ways in which the organization has been failing to motivate change and has instead been repeating failed strategies while at the same time developing methods for honoring successes. The system begins to ask itself repeatedly, "is what we are doing working? Are we bringing about change in our clients and ourselves?"

Hope and Restored Meaning

INDIVIDUAL HEALING: Through the development of better emotional management, self-soothing, problem-solving, and relational skills clients who entered treatment demoralized and hopeless begin to unfold for themselves a new map of the future. The chronic feelings of depression and helplessness have lifted and they can see how much they have grown and changed. They know that the road ahead is unlikely to be consistently smooth, and they are prepared for signs of relapse, but they also know they can never return to what has been – they have moved on. Their injuries may have left them with some – or extensive – lingering effects, but they no longer see themselves as crippled victims but as survivors whose lives mean something. They count.

ORGANIZATIONAL HEALING: Through processes of participation and engagement, staff and management have co-evolved a vision of where they want to go together into the future. They fully recognize that the organization they are co-creating with their clients will never be perfect but they understand that it is up to each and every one of them to keep it alive, to work toward authenticity and integrity together. They have put in place hiring, training and orientation systems that introduce new members of the community to the organizational norms and expectations. They continue to embody their growing knowledge base in written archives and daily practice.

Radical Transformation

As mental health professionals, as social service workers, in the end, what is our mission? Is it simply to contain society's mentally wounded and prevent them from doing further harm? Is the mission, "recovery" as the consumer movement urges? Our helping systems have several important social roles. Yes, we must reduce harm where we can by helping people commit to nonviolence, by increasing emotional and moral intelligence, by improving relationships, and by being catalysts for the journey of recovery. We must create systems where emotionally injured people are offered realistic opportunities to achieve their maximum level of function.

But our role is larger than that. It is clear that there is no subset of traumatized people for whom we can build new structures, new institutions that will more adequately suit their needs. The world is a traumatized place and underlying what we now consider "normal" society are basic assumptions, beliefs, policies and behavior that if not transformed, may doom the entire species – and very possibly all living things – to utter annihilation. Like it or not, the coming years will determine whether or not reason can harness our biological urges with sufficient power to curb the self-destructiveness that threatens our survival. System transformation urged upon the mental health system, therefore, is not just about the mental health system. Since mental health encompasses the whole realm of what it means to be a human

being, transforming the mental health system may create a proving ground for much wider system transformation.

To illustrate the radical – *transformative* – change that could result from the kind of shift in perspective we have discussed here, imagine a society where the emotional and social analogues to wheelchair ramps, handicapped accessible buildings, remedial learning programs, and rehabilitation are universally available for the psychologically injured. Imagine racism, gender bias, poverty, gun violence, homelessness, warfare, child abuse, domestic violence, community violence, prostitution, lack of health care, lack of economic and educational opportunities, disrupted childhood attachment experiences all being universally recognized as major public health problems to which adequate resources must be devoted, legislative bodies that vote for such public health measures, and public coffers that fund them.

This is what *recovery* must truly be about if it is not just to become yet another failed reform effort, failing not because it is a wrongheaded concept but failing because we did not dare to dream about true transformation. Recovery concepts must not be limited to those already labeled "chronically mentally ill" but must instead be applied to all of us.

> *Without the context of a political movement, it has never been possible to advance the study of psychological trauma. The fate of this field of knowledge depends upon the fate of the same political movement that has inspired and sustained it over the last century. In the late nineteenth century the goal of that movement was the establishment of secular democracy. In the early twentieth century its goal was the abolition of war. In the late twentieth century its goals was the liberation of women. All of these goals remain. All are, in the end, inseparably connected* (p. 32) [1]

Some Trauma-Informed Suggestions for the "Blueprint for Change"

1) EXPAND HISTORY: Include in the history the history that clients and mental health professionals share in trying to improve the welfare of those afflicted with emotional and addictive problems. The present effort directed at transformation can most effectively be seen as a renewal of previous efforts to reduce stigma and create more justice for the emotionally disordered.
2) EXPAND INCLUSION: If this document is to address system transformation then it must include the entire system, beyond the chronically mentally ill and must therefore must include people with characterological problems, substance addictions and other behavioral problems, as well as the staff and administrators involved in the system transformation.
3) CHANGE DEFINITIONS: Recognize the various definitions of recovery including recovery from trauma and adversity and provide a common framework of recovery from "injury". To be trauma-informed does not mean believing that

everyone has had a traumatic experience – although the research indicates that a majority of people will and that a very high proportion of the chronically mentally ill have already experienced multiple traumatic experiences. To be trauma-informed means being able to respond to the needs of traumatized clients; being sensitive to the reality of traumatic experience in the lives of most people; being sensitive to the ways in which trauma has affected individuals, families, and entire groups (Native Americans, women, African-Americans, etc); and being sensitive to the ways in which chronic stress and traumatic stress impacts organizations and entire systems. Being trauma-informed means to change the underlying assumptions about what causes most major mental illness, or the complications of those illnesses; addictions, and social maladjustment – injury, often beginning in childhood.

4) REDUCE SILOS: Recognize that substantial proportions – possibly a majority – of treatment providers are recovering people themselves. System transformation requires the breaking down of silos, not the shoring up of the same problems.
5) RECOGNIZE SAFETY as core values for the entire system and extends to physical, psychological, social and ethical safety. People can and do recover within the context of home and community contexts that are safe from all forms of violence and discrimination. A commitment to achieving the ability to be safe with oneself and others is a necessary component of individual, organizational and systemic transformation. In mental health treatment, in addictions, in social service delivery of all kinds, and in the society as a whole, safety violations are NOT rare, and in the trauma recovery field it is well-recognized that the establishment of safety is the starting point of recovery.
6) DIFFERENTIATE BETWEEN EMPOWERMENT AND ABUSE OF POWER: Studies of traumatized people have shown us that there is often confusion about where personal empowerment leaves off and the abuse of one's own personal power begins, whether that is on the part of family members, clients, or professionals.
7) RECONNECT RIGHTS AND RESPONSIBILITIES: The study of oppressed and oppressing populations has shown us that rights cannot be separated from responsibilities without negative consequences. Making different choices is an vital aspect of recovery from any kind of injury. But the present document states, *"Each person's opinions, wants, needs and individual recovery pathway are respected and elevated above all other considerations"* assumes that each of our opinions, wants, and needs are safe, responsible, and legal. This is completely unrealistic. No one's opinions, wants and needs are above or outside of the constraints of safety, social responsibility and legal responsibility.
8) REINCORPORATE THE 12 STEP PRINCIPLES: The 12 step principles offer a relatively clear self-help method of recovery and that are applicable to virtually everyone. Through time-tested experience, the principles have demonstrated the importance of balancing rights and responsibilities and learning how not to be either a victim or a perpetrator.
9) EXPLAIN INTERFACE WITH LEGAL SYSTEM: It is difficult to imagine how the behavioral health system can successfully transform without a similar transformation on the part of the legal system. The issues of shared risk and shared responsibility must be addressed if the fear of change is to be minimized. Many of the abuses that occur – and that the recovery movement seeks to

address – have arisen in the past out of fear and legal intimidation. The ever-recurring nature of that fear is likely to continue to undermine transformation efforts and needs to be confronted.

10) EXPAND DEFINITIONS OF MULTIPLE PATHS TO RECOVERY: We now have fairly extensive knowledge about the pathways to recovery for trauma survivors, many addictive disorders, and a growing body of knowledge about recovery as applied to chronic mental illness. From a trauma-informed perspective there is an underlying commonality to this notion of recovery that can be applied to an individual client, family, and helping organization.

11) INCLUDE PARALLEL PROCESS IDEAS OF RECOVERY: It is impossible to transform a system when it is all "us vs. them" or even "us completely different from them". In the focus groups that were the basis of the Blueprint, the providers cite the problems they encounter deriving from the systems within which they are embedded. These problems can be seen to parallel the complaints of the recovering clients about the providers. Safety, hope, choice, empowerment, partnership cannot be successfully applied in only one domain, from provider to client. The same values must be applied administration to staff and government and regulatory officials to organizations.

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