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With the recognition that large numbers of men and women receiving services in the mental health and addictions systems are the survivors of sexual and physical abuse, practitioners need to become informed about the dynamics and the aftermath of trauma.

Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift

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When a consumer seeks services in the mental health or substance abuse treatment systems, it is rarely because he or she wants treatment for current or past sexual or physical abuse trauma. The presenting problems are more immediate and more obviously tied to the stated mission of the service agency. Yet 56 to 63 percent of women seeking inpatient psychiatric services (Bryer, Nelson, Miller, and Krol, 1987) and 40 percent of women in outpatient mental health treatment (Surrey, Suett, Michaels, and Levine, 1990) report some history of abuse in childhood. Victimization rates for a lifetime exposure to trauma among women substance abusers range from 55 to 99 percent (Najavits and others, 1998). And the picture does not look much different for men. Stein and others (1988) report that men with histories of childhood sexual abuse are significantly more likely than their nonabused counterparts to develop a substance abuse disorder; in addition, almost half of them experience a clinical depression at some point in their lives.

Systems *serve* survivors of childhood trauma without *treating* them for the consequences of that trauma; more significant, systems serve individuals without even being aware of the trauma that occurred. This lack of awareness can result in failures to make appropriate referrals for trauma services. It can also result in inadvertent retraumatization when a service system's usual operating procedures trigger a reemergence or an exacerbation of trauma symptoms, as the following examples show:

- A man seeks help because he is anxious and has begun having panic attacks. He is given medication and may be referred to a counselor for therapy sessions, but no one asks him if he was physically abused as a child. The

clinic to which he is referred is a large, crowded facility in the center of town. The man must take two buses during rush hour to get there. He goes once but feels too vulnerable and frightened of the clinic environment to continue. After two months, the clinic closes his case.

- A woman and her children seek help because she is feeling overwhelmed and depressed. She has just lost her housing, has been drinking heavily, and cannot concentrate well enough to fill out a job application. She is referred to a family shelter, is given an appointment to meet with a psychiatrist, and talks with an addictions counselor; no one asks her about current domestic violence, much less about any history of childhood sexual abuse. She begins attending an addictions treatment program, but the confrontational style leaves her feeling ashamed and frightened. She loses track of time and misses her appointments. The counselors call her, but she feels too bad about herself to return. After a little more than a month, her case is closed at the addictions program. She is deemed to be insufficiently motivated for treatment.
- A woman is receiving case management services and medication for her schizophrenic illness. She collaborates in her treatment and attends all scheduled meetings. After the Christmas holidays with her family, she begins missing appointments. Her case manager suspects that she is no longer taking her medications. When several attempts to make contact fail, the case manager requests that an emergency psychiatric team go to her home and evaluate her for possible hospitalization. During the evaluation, she becomes verbally abusive; she is restrained, handcuffed, and taken to a state psychiatric hospital. At the hospital, she appears frightened, does not speak, and spends hours staring into space. She remains hospitalized for several weeks. No one who is part of her inpatient or outpatient treatment team knows that she is a survivor of sexual or physical abuse.

In each of these three instances, treatment might have proceeded very differently if the treatment teams had been informed about trauma. By "informed about trauma" we mean two very specific yet different things. First, to be trauma informed means to know the history of past and current abuse in the life of the consumer with whom one is working. Such information allows for more holistic and integrated treatment planning. But second, and more important for this volume, to be trauma informed means to understand the role that violence and victimization play in the lives of most consumers of mental health and substance abuse services and to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate consumer participation in treatment.

A trauma-specific service is designed to treat the actual sequelae of sexual or physical abuse. Grounding techniques help trauma survivors manage dissociative symptoms, desensitization therapies help to render painful images more tolerable, and certain behavioral therapies teach skills for the

modulation of powerful emotions. For a consumer to participate in trauma-specific services, he or she must be aware of a trauma history and recognize current symptoms as sequelae of that trauma. An alert provider may facilitate that awareness and be instrumental in making appropriate referrals.

Trauma-informed services are not designed to treat symptoms or syndromes related to sexual or physical abuse. Rather, regardless of their primary mission—to deliver mental health or addictions services or provide housing supports or employment counseling, for example—their commitment is to provide services in a manner that is welcoming and appropriate to the special needs of trauma survivors.

Perhaps an analogy will make the distinction between a trauma-specific service and a trauma-informed system clearer. The Americans With Disabilities Act (1990) mandated that a wide range of civic and cultural organizations construct their environments so that events are accessible to persons with a range of special needs. As a result, concerts and museums now provide wheelchair access, most theaters have at least one performance that is signed for the hearing impaired, and convenient parking at restaurants is set aside for patrons who cannot walk long distances. These organizations are not delivering specific services for persons with disabilities. Instead, by becoming "disability informed," they are making their services truly available to all people.

Requirements for Creating a Trauma-Informed System of Care

Certain conditions need to be in place for a trauma-informed system to be established. Those conditions reflect the structure and the culture of the organization, and they predate any actual changes in clinical services.

Administrative Commitment to Change. Those who control the allocation of resources within an organization must make a commitment to integrating knowledge about violence and abuse into the service delivery practices of the organization. In the past several years, national initiatives have made it easier for local administrators to do just that. In 1998, the federal government, through a collaborative initiative of the Center for Mental Health Services, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention, funded fourteen sites in the United States to develop integrated services for women who were the victims of violence and were also diagnosed with both a psychiatric illness and a substance abuse problem and for their children. By funding such an initiative, the federal partners were doing more than declaring their interest in violence and victimization in the lives of dually diagnosed women; they were suggesting that violence, addiction, and mental health problems form a complex and interrelated network of connections within the lives of women and within the experience of any given woman. By launching this venture, the federal government made it easier for administrators in

public and private agencies around the country to make integrating a trauma perspective an agency priority.

In December 1999, the National Association of State Mental Health Program Directors unanimously passed a resolution recognizing the pervasive impact of violence and trauma. The state directors asserted that recovery from trauma is a fundamental value of mental health providers. Among other things, they were calling for the delivery of trauma-specific services within mental health agencies. Although they did not mention trauma-informed services, they stressed the need for an open discussion and exchange within the public mental health system on the issue of trauma. Such a unanimously passed resolution serves to empower local program directors and providers to emphasize and respect the role that trauma has played and continues to play in the lives of women and men who seek services.

Administrators can declare their intent to make an understanding of the impact of violence and victimization an integral part of the mission of their agencies. This does not necessarily mean that an organization will begin delivering direct trauma services. It simply means that a trauma perspective will be integrated into how staff members understand people and their problems. An administrative commitment to becoming trauma informed begins when the people who allocate resources, set priorities, and sponsor or design programs assert trauma and its aftermath are an important part of what ails people. This statement resonates much more loudly when it is backed up by training, changed policies, new hiring, and enhanced services. But those changes must be preceded by an administrative commitment to change.

Universal Screening. Regardless of their primary mission, all human service agencies can begin by screening individuals seeking services to determine whether they have a trauma history. The screening, administered as quickly as is feasible after an individual enters the service program, can be relatively brief and nonthreatening. An instrument developed at Community Connections in Washington, D.C., consists of only eight items (Fallot, 1999). New enrollees of mental health, addictions, residential services, and homeless outreach programs are asked about witnessed violence, physical abuse, sexual assault, or unwanted sexual touch and threatened violence. An intake worker, a case manager, or a peer advocate can administer the simple screening in a few minutes.

A universal screening furthers the cause of making a system trauma informed in several ways. First, it gets all participants thinking about trauma. Staff members must be conscious of trauma issues because they have to ask the questions, and consumers begin to think about the role that trauma has played in their personal stories. Consumers may also come to see the treatment agency in a more favorable light because staff members care enough to ask about violence and the role that it has played in their lives. Asking about trauma may also lead to more thoughtful referrals for services to trauma-specific treatments.

The very act of asking begins the process of institutionalizing trauma awareness within an agency. The agency—staff, consumers, and administrators—sees itself as a place where histories of violence and victimization matter. Even before the agency knows what to do with the information it gathers, it has become a place where questions that once were taboo are now asked with regularity and openness and where the stigma surrounding sexual and physical abuse is beginning to erode.

Training and Education. Regardless of the professional training they have received, all staff members in a human services agency can benefit from introductory information about trauma.

When an organization has a commitment to provide trauma services, the program directors often begin by developing a cadre of trained clinicians who can deliver those services. Specialized training is made available to those clinicians through seminars, continuing-education efforts, and ongoing supervision. Although these efforts make trauma-specific services available, they do not make the entire system trauma informed. Instead, information about trauma is seen as the special purview of an elite group of clinicians.

The agency that is determined to inform all of its staff about trauma dynamics would do well to postpone the intensive training for a few in favor of a more general introduction for the many. A trauma survivor who seeks services may interact with a dozen individuals before actually sitting down with a clinician trained to provide trauma services. A woman will have to make an appointment and speak with a receptionist. A man will have to enter the agency and walk past a security guard or a maintenance worker. A family may stop for a snack at the hospital cafeteria. Once they are in the agency, they may encounter office workers, intake personnel, trainees, and anonymous clinicians. Any one of these individuals has the opportunity to make a consumer's visit to the service agency inviting or terrifying.

With just a brief introduction to trauma dynamics, all of the personnel at a service agency can become more sensitive and less likely to frighten or retraumatize a consumer seeking services. That is not to say that the person working the elevator should be providing therapy. It is to say, however, that if a man on the elevator begins to dissociate and forgets what floor he is looking for, the operator should not treat him with scorn or harshness but should gently guide him to the appropriate office.

Several curricula exist to introduce human service workers to trauma-related issues. The "What Is Trauma?" presentation developed at Community Connections (1999a) is a half-day introduction to the symptoms, feelings, and responses associated with trauma. The more in-depth *Risking Connection* (Saakvitne, Gamble, Pearlman, and Tabor Lev, 2000) has been used in several state-wide trainings and outlines the RICH guidelines for working with the survivors of abuse. RICH stands for the four principles that are essential in any interaction with a trauma survivor: respect, information, connection, and hope. The curriculum gives learners a basic understanding

of trauma and its impact and suggests ways in which the RICH guidelines can be part of even the briefest interactions.

Systems can use one of the existing curricula or can devise one more specific to the mission of their agency. A welfare-to-work program, for example, might be most interested in how trauma dynamics look in the workplace. Ultimately the goal might be to assist employment counselors in becoming sensitive to how trauma survivors present themselves to prospective employers as a result of having trauma histories.

For many agency staff, the most powerful training comes from men and women who have experienced and survived trauma. The forty-minute *Women Speak Out* video (Community Connections, 1999b) gives women the opportunity to share how trauma has affected their lives, what symptoms and vulnerabilities they have had to endure, and an opportunity to describe what has been helpful in promoting recovery. When agency staff watch such a video or witness a panel discussion led by trauma survivors and have a chance to ask questions and discuss what they have seen and heard, they move toward becoming trauma sensitive and trauma informed without needing professional-level or in-depth training.

When administrative staff require that all personnel receive a minimum level of training about trauma, the word goes out that making the agency a safe place for trauma survivors is not solely the responsibility of a few clinicians but of everyone who works for the agency and comes in contact with consumers.

Hiring Practices. One obvious way to make a system more trauma informed is to hire workers and clinicians who already have a basic understanding of trauma dynamics. For most agencies, other than those just opening their doors for the first time, such a practice is unfeasible. It is possible, however, to hire one or two trauma champions.

A champion understands the impact of violence and victimization on the lives of people seeking mental health or addictions services and is a front-line worker who thinks "trauma first." When trying to understand a person's behavior, the champion will ask, "Is this related to abuse and violence?" A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—be a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues.

At Community Connections, a private, not for profit mental health and substance abuse treatment agency in Washington, D.C., a small group of clinicians—one or two on each of several clinical teams—managed to help change the culture of an entire agency. These clinicians, supported by agency directors, reminded all staff of the importance of trauma. In treatment meetings, during collaborations with other agencies, and while attending agency-wide trainings, they could be counted on to ask questions about trauma and suggest ways to support trauma survivors in their recovery efforts. At times

they seemed overly zealous, but over time their clear message influenced the practices of others. It became natural for staff other than the champions to include considerations about trauma in their everyday practice.

Review of Policies and Procedures. As a treatment system increases its awareness about and sensitivity to issues of trauma and abuse, it makes sense for administrators, clinicians, and consumers to undertake a careful review of policies and procedures to determine whether any are hurtful or even harmful to trauma survivors—for example, the use of seclusion, physical restraints, strip searches, and involuntary hospitalizations (Carmen and others, 1996). Such policies can be replaced with less intrusive alternatives such as voluntary time-outs, one-on-one support during times of crisis, and advance directives that respect a consumer's preference for how to handle crises.

For many consumers, intrusive practices are both damaging in the moment and painful reminders of past abuses. Psychologist and parent Ann Jennings (1997) describes the flashbacks and numerous setbacks that her daughter Anna experienced as she was retraumatized by standard mental health inpatient practices. Anna Jennings, who had been sexually abused as a child, relived her abuse at the hands of treatment providers who restrained her, stripped her, and secluded her much as her original abuser had.

Even a cursory review of practices and policies might reveal the obvious interventions that are damaging. Review committees also need to be vigilant to identify practices that may replicate trauma dynamics in more subtle ways. For this, the system will need at least one staff member who understands abuse and the systems that, at times unwittingly, support it.

In particular, providers need to be aware of the dynamics that characterize abusive relationships in general and make sure that those same dynamics are not being unwittingly replicated in helping relationships. The following themes characterize abusive relationships:

- Betrayal occurs at the hands of a trusted caregiver or supporter.
- Hierarchical boundaries are violated and then reimposed at the whim of the abuser.
- Secret knowledge, secret information, and secret relationships are maintained and even encouraged.
- The voice of the victim is unheard, denied, or invalidated.
- The victim feels powerless to alter or leave the relationship.
- Reality is reconstructed to represent the values and beliefs of the abuser. Events are reinterpreted and renamed to protect the guilty.

A policy review committee needs to look at current practices and evaluate whether there are traumatic reenactments masquerading as benign practice. For example, outpatient commitments, which make it almost impossible for consumers to leave treatment relationships, may feel to the consumer like the same trap that characterized abusive relationships in childhood when the individual felt powerless to leave or alter the situation.

For systems in which a systematic review of policies is not feasible, two administrative directives might suffice:

Adopt a universal assumption of inclusion; that is, assume that all consumers receiving services are trauma survivors. Clinicians who work in a public sector mental health or addictions program will be only slightly off in terms of an actual head count. Such an assumption might result in the universal elimination of certain aggressive practices that most consumers, trauma survivors or not, find frightening and demeaning. It might also mean that all consumers are treated with more honesty and respect.

Adopt the physicians' credo, *Primum non nocere:* "Above all else, do no harm." Clinicians and other direct service staff should be encouraged to ask themselves whether what they are about to do with, for, or to a consumer might cause harm or, at the very least, more harm than good. Such self-regulation might lead clinicians to question their behavior and thus avoid damaging interactions.

Principles and Philosophy of a Trauma-Informed System

Certainly an administrative commitment to change, the adoption of universal screening practices, training and education for staff, sensitive hiring practices, and a review of policies and procedures assist a system in becoming trauma informed. But true change occurs when the people who make up the system share a philosophy about trauma, services and the service relationship, and consumers that reflects a sensitivity to trauma and its importance in the lives of men and women who seek services.

Understanding Trauma. How clinicians choose to understand trauma will determine to a large measure how they envision the overall treatment of trauma survivors.

The Traditional Approach. Trauma is usually understood as a single event, albeit one with profound impact. The single event that we label as trauma involves actual or threatened death, serious injury, serious harm, or a threat to one's personal integrity. The response to such an event, often diagnosed as a posttraumatic stress disorder, includes intense fear, helplessness, and a sense of unreality or horror (American Psychiatric Association, 1994).

When practitioners talk about the impact of trauma, they generally expect that the impact will be felt in predictable areas of functioning. For example, following a car accident, we might expect that fear and anxiety will be associated with riding in or driving a car. We also expect that responses will follow expected courses. Periods of shock, denial, anger, grief, acceptance, and coping are the loosely organized stages by which individuals come to terms with traumatic events. If the processing of such events exceeds specified time periods, then the conclusion might be that an

individual is experiencing a posttraumatic syndrome requiring treatment. And such trauma-specific problems would most likely be treated in mental health clinics, where specially trained practitioners would provide services.

The Trauma-Informed Approach. The understanding of trauma that we are proposing for a trauma-informed system is really quite different. When an individual is bombarded with repeated traumas that constitute threats to his or her personal integrity and worldview, then that individual comes to question even the most fundamental assumptions about the world. In the wake of trauma, that person must construct a new theory of how the world works and how people behave.

Humans seek to make sense out of their experiences, no matter how horrific or bizarre that experience might be. We want things to have meaning, and when events occur that challenge our view of the world, then we must struggle to find a new way to organize and understand our experience.

Consider the case of a young boy who lives with his mother and father. His father dies suddenly one day while driving home from work. The boy and his mother must move to a new apartment because there is now less money for rent. The boy's mother finds a job working evenings and leaves him at home with an aunt, who drinks heavily. One night the aunt's boyfriend gets drunk and begins to beat the boy. When the child tries to defend himself, the man rapes him to "teach him a lesson." The rapes and beatings continue for several months until the mother finds out, and the boy and his mother make other arrangements for his care.

This child initially believed in the safety and security of his world. He viewed adults as caring and protective and events as manageable and predictable. Then tragedy strikes, and the old explanations no longer make sense. The world is dangerous, unsafe, and confusing. The boy must find a new way to explain what has happened. He decides that he is bad and that God is punishing him for misdeeds. He promises himself that he will try to be perfect in every way so that the curse that has befallen him will be lifted and his previous good life will be restored.

As an adult looking at the explanations of a child, we might be tempted to think that he is using magical thinking and that he is assuming almost delusional responsibility for events that are quite obviously out of his control. But the child is not an adult; he is a child, and he is doing his best to make sense of his world.

Many years later, when this same boy, now a young man, seeks services for his overwhelming anxiety and episodic drinking, his view of the world may still reflect some of the explanations he constructed for himself many years earlier. He is a trauma survivor, but he does not seek services for that reason or for anything obviously connected to his abuse history. The early trauma and his attempt to understand it began a complex pattern of actions and reactions that have a continuing impact over the course of his life.

In a trauma-informed system, trauma is viewed not as a single discrete event but rather as a defining and organizing experience that forms the core

of an individual's identity. The explanations about abuse, the far-reaching impact, and the attempts to cope with the aftermath come to define who the trauma survivor is. Some trauma survivors report that they feel as if they have lived two lives—one before the trauma occurred and one after—and those two lives seem very different from one another.

Because trauma serves to organize experience, it is misguided for clinicians and consumers to look for its impact in only the obvious places. It makes sense to assume that a girl who was repeatedly raped by a babysitter would have sexual and relationship difficulties. The difficulties of a girl with such a history may be farther reaching and less obviously connected to the abuse, however. If she learned to cope with the abuse by drifting away and dissociating while it was happening, then she may have begun a pattern of losing connection to her experience that, while it served her well during the abuse, may become problematic as she tries to learn algebra or drive to a friend"s house after school. She may now come to a clinic because she has been diagnosed with learning problems, not because she is a trauma survivor. And she may well be treated for those problems without anyone beginning to question how her problems with concentration began.

In a trauma-informed system, practitioners assume that when trauma has occurred, it changes the rules of the game. An individual constructs a sense of self, a sense of others, and a belief about the world after trauma and abuse have occurred that incorporates and is in many cases based on the horrific event or events. That meaning system then informs other life choices and guides the development of particular coping strategies. The impact of trauma is thus felt throughout an individual's life in areas of functioning that may seem quite far removed from the abuse, as well as in areas that are more obviously connected to the trauma.

Understanding the Consumer Survivor. Within human service systems, the recipient of services has been referred to as a patient, a client, a member, and a consumer. These terms reflect the changing view of the person who seeks services, a view that influences all aspects of the service relationship.

Traditional Approach. In most human service settings, the consumer and her problem are synonymous. If someone seeks help for an anxiety disorder, then her identity at the clinic is as a person with symptoms of anxiety. An appreciation of the whole person is often blocked by the importance of the particular, isolated problem.

A woman who had experienced repeated sexual abuse in childhood at the hands of her grandfather sought treatment for anxiety. She had recently been diagnosed with breast cancer, and the medical diagnosis had caused her to become anxious about her health; as important, it had also caused her to revisit the abuse that had included her grandfather's fondling her breasts. When she presented at a mental health clinic, she revealed that she had been drinking to help her get to sleep at night. Within two weeks of seeking help, she was being seen by three separate providers: her surgeon, who saw her as a breast cancer

patient; a psychiatrist, who was seeing her to prescribe medication for her anxiety; and a substance abuse counselor, who saw her as a borderline alcoholic. Each provider saw her as the embodiment of certain medical and psychological problems, but none of them saw her as a whole person whose symptoms were interconnected and embedded in her trauma history.

In addition, they approached her problems as if they had a life of their own, independent of context. The self-soothing with alcohol, for example, was seen as substance use on the slippery slope to abuse. No one considered the fact that the use was connected to anxiety over the medical diagnosis and to flashbacks of the sexual abuse. In the traditional approach, symptoms are more likely to be seen as rooted in either biology or character pathology than as responses to particular contexts and circumstances.

There is also a blurring of the distinction between a problem and a symptom in the traditional approach. Many human service providers are trained to treat symptoms rather than to solve problems. If, for example, a man comes to a clinic complaining of sleeplessness, his symptom of sleeplessness may also be considered his problem. The practitioners decide to treat the symptom, which they believe will solve the problem. A careful assessment may reveal, however, that the sleeplessness is in response to the violent behavior of his domestic partner. His symptom is indeed sleeplessness, but his problem is that he is in a violent relationship that he does not know how to get out of. Treating the symptom will leave the problem untouched.

With the emphasis on individually based symptoms in the traditional approach, it is not surprising that the allocation of responsibility to the consumer is often either too great or too little. At times, the consumer is seen as a passive player who must learn to cope with symptoms that are beyond his control. At other times, the consumer is given all the responsibility for solving problems that are embedded in a complex social context. In both cases, the individual is left feeling confused over just how much responsibility she should shoulder.

Trauma-Informed Approach. In a trauma-informed approach, the emphasis is on understanding the whole individual and appreciating the context in which that person is living her life. Rather than asking, "How do I understand this problem or this symptom?" the practitioner now asks, "How do I understand this person?" This approach shifts the focus to the individual and away from some particular and limited aspect of her functioning, and it gives the message that her life is understandable and that behaviors make sense when they are understood as part of a whole picture.

Often trauma survivors think of themselves as a "mess." Events do not seem to make sense, and these survivors see themselves as a chaotic and unpredictable collection of symptoms and responses. As much as needing the solution to a particular problem, trauma survivors need to believe that their behavior is intelligible and capable of being brought under their control. A holistic and trauma-focused understanding gives consumer-survivors a structure for organizing and understanding their experience.

Imagine, for example, trying to read a book that has no plot. There are no organizing themes, no recurrent patterns. Every page has a new and unpredictable set of events that seem unconnected to the events on the previous page, and there is no way of guessing, much less predicting, what will happen next. At first the book might seem entertaining and even exciting, but eventually it just seems like too much effort to read. Now imagine that that book is your life. Nothing makes sense, and you cannot plan or take control of even the simplest activities.

Faced with such a predicament, trauma survivors feel confused, defeated, and depressed. Some become anxious and paranoid because nothing seems to make sense. When presented with a holistic look at their life and struggles, most trauma survivors feel some combination of relief, gratitude, and heightened efficacy. Confusion is replaced by comprehension, and they feel that they can begin to solve individual problems with the belief that their solutions will make sense.

Two related tenets of a trauma philosophy make this transformation possible and plausible. First, trauma-related symptoms arise as attempts to cope with intolerable circumstances, and second, those symptoms emerge in a context of abuse. Consider a young boy whose father beats him for no apparent reason. The father comes home from work, encounters his son playing video games, and flies into a rage. He beats his son hard enough to raise welts on the boy's skin. The boy tries to understand what he did wrong. Maybe he should not have been playing games and instead should have been helping his mother fix dinner. So the next night he is in the kitchen washing vegetables when his father comes home. His father looks at him, flies into a rage, and once again beats him. The boy is frightened and confused. He becomes anxious, hypervigilant, and somewhat suspicious of his father's every move. As he gets older, he discovers that smoking a little marijuana helps him to relax and be less anxious. His behavior, the anxiety, the suspicion, and the substance use all make sense as attempts to cope with his father's irrational behavior.

Now consider his father's behavior. The father grew up with a highly critical grandfather who was disabled and stayed home all day. As soon as his grandson came home from school, the grandfather began a barrage of criticisms. The old man could not leave his chair, but he could unleash a verbal assault that was as vicious as any physical punishment. The boy tried staying late with friends, but his grandfather was waiting for him with a new attack. He asked his mother to intervene, but she passively responded, "You know your grandfather." Finally he started to attack first. His aggressive behavior managed to stifle his grandfather, but it produced conflict with friends and, eventually, his coworkers, and of course it was damaging to his son. If we go back even further, we uncover generations of abuse passed from father to son. And in each generation, we discover attempts to cope—desperate, sometimes irrational, sometimes even abusive—that all originated as attempts to survive and manage the abusive actions of others.

In these stories, we see behaviors as context and relationship dependent. We also see that symptoms begin as attempts to cope. This way of looking at behaviors allows trauma survivors to reclaim the positive coping aspects of their symptoms.

For many girls who were sexually abused, some form of dissociation becomes a way of surviving the abuse. While a girl is being raped, she takes herself, emotionally and psychologically, to another place. If she could, she would remove herself physically, but that is not a possibility, so she closes her eyes and escapes. To be fully present while one is being raped by a trusted schoolteacher is intolerable, so the girl vanishes. And she learns to remove herself easily from all types of unpleasant situations. Unfortunately, she has unleashed a powerful genie. The dissociation happens when she wants to be present—when she is studying for an exam, babysitting for a neighbor, driving home from school. The girl comes to blame herself for being stupid, absentminded, and careless. She does not recognize that that behavior, a creative and clever way to cope with abuse, saved her life a long time ago.

As women come to see the power in their defenses and coping strategies, they also come to believe that they have the strength and the wisdom to make changes in their lives.

Finally, within a trauma-informed system, the consumer-survivor reevaluates her responsibility for the changes and decisions she must make. She is not the passive victim who was abused back then and has no power now; nor is she the fully responsible adult who can take charge now and should have been more forceful back then. The trauma survivor recognizes that the blame for past abuse rests with the perpetrator and the system that allowed the abuse to go on. She also recognizes that the responsibility for change now lies with her and those she chooses to make collaborators in her recovery. The distinction between blame and responsibility allows a trauma survivor to assume balanced and appropriate authority for her future.

Understanding Services. The nature of services delivered by human service agencies can be defined quite narrowly or more broadly, depending on how the agency views its mandate.

Traditional Approach. In a cost-conscious environment, human service providers must define their service commitments within a narrow range. Services, for example, are frequently time limited, and that limitation applies to inpatient psychiatric services as well as to drug treatment programs and outpatient psychotherapies. Because of these limitations, the goal of services must be limited and circumscribed as well. In many cases, the only viable goal is stabilization. Once symptoms have been managed, the treatment ends. In the best of circumstances, the consumer has learned skills or received directives for how to manage the symptoms in the future, but in most cases the consumer leaves only to await a reoccurrence and then a certification for more services.

Not surprisingly, services are often crisis driven in such an environment. The only justification for services is an acute flare-up of symptoms. An alcoholic who is not drinking may be viewed as an inappropriate candidate for drug treatment services even if he is struggling with maintaining his sobriety. Only when there is a relapse will services be authorized and only with the goal of reestablishing sobriety. While the short-term economic justification for such a policy may be understandable, to a trauma survivor such crisis-driven services may recreate troubling dynamics from the past. Many trauma survivors report that as long as they were able to stumble through a day, they were told to "endure the abuse and just get on with things." Only when they felt absolutely desperate, and in many cases suicidal, did anyone pay attention to their distress.

In addition to the concern over costs, the provider in a traditional human services system must be mindful to minimize risk to the system. Some treatment options, which place more autonomy in the hands of the consumer and her network of friends and supporters, may seem overly risky. If, for example, a young woman who is feeling suicidal does not want to be hospitalized and instead wants to stay at home with a good friend who promises to keep her company throughout the night, a provider, worried about potential liability, may opt to go against her wishes and order an involuntary hospitalization. The potential cost to the system of a lawsuit far outweighs the individual's request for an alternative to hospitalization.

Services are thus content specific, time limited, and outcome focused. The individual is identified as suffering from a particular symptom or constellation of symptoms and receives a targeted treatment to address just that problem. Once the symptom is treated and managed, the treatment is over. The goal is stabilization in the most efficient manner with the fewest risks.

Trauma-Informed Approach. The goal of the trauma-informed service system is to return a sense of control and autonomy to the consumer-survivor. A trauma-informed system holds to the underlying belief that if consumers learn to understand and ultimately to control their responses, then they will need less, if any, help from service providers. Like the proverb, 'Give a hungry man a fish, and you feed him today, Teach him to fish, and you feed him forever,' the provider's job becomes helping the consumer to master the skills necessary to cope in healthy and constructive ways. Accordingly, the emphasis is on skill building and acquisition and only secondarily on symptom management. If we assume that some symptoms are misguided attempts to cope, then helping a woman to manage better will obviate the necessity for those symptoms. A woman in a trauma recovery group, for example, stopped using drugs to manage her symptoms when some of those symptoms muted and she concurrently learned other ways to soothe herself.

If services are designed to promote growth and mastery, then it makes sense that service time limits are set in collaboration with the trauma survivor. There are certainly objective indicators that one is functioning better

and is more in control of one's behavior and one's environment, but for many women, the sense of having power is a subjective one. A woman has power and mastery in part when she believes that she has those attributes. In fact, telling a woman that she has control when she does not believe that she does reduces her sense of personal efficacy rather than enhancing it. Once again someone else is presuming to know her and what she needs better than she does.

Services in the trauma-informed approach are strengths based. The emphasis is on identifying the capacities a woman or man has used to survive and appreciating how to take those capacities and put them to even better use. If a woman has been guarded and hypervigilant in her approach to other people, then she has had to pay attention to details. She has learned to size up other people and get a quick sense of whom it is safe to trust. She has also demonstrated an ability to protect herself and a willingness to do what it takes to keep herself safe. In these capacities are the beginnings of skills that will help her choose relationships wisely and pay attention in school or on the job. In addition, there may be other skills, such as modulating her anxiety when she becomes frightened, that she will need to learn for the first time.

Ultimately the goal of the services is to prevent problematic behavior in the future—or at the very least to devise a plan for how to deal with crises when they arise. For this reason, initial service contacts may require more time and more intense collaboration than in a traditional approach, but ultimately the consumer-survivor will have the internal and external resources to manage events without the assistance of a service provider. It should be noted that plans to prevent or manage future crises are always driven by the needs and the capacities of the consumer. For some trauma survivors, the very act of devising a crisis prevention plan is sufficient to negate the need for such a plan. Knowing that she has some control over future events helps to decrease a trauma survivor's anxiety and may consequently work to deescalate a difficult situation.

The focus on prevention also has important implications beyond the person seeking services directly. Many trauma survivors come from families and communities where violence and victimization are passed from one generation to the next. When men and women learn to modulate their own responses and to comfort themselves in times of stress, they are better able to parent and protect their children. They may also be better able to recognize the signs of distress in their children once they have learned to identify those markers in their own behavior. Early intervention on behalf of high-risk children may help to end the heartbreaking cycle of transgenerational violence and abuse.

Finally, a trauma-informed system weighs risks to consumers along with risk to providers when making clinical decisions. In the case of a man expressing feelings of despair and talking about ending his life, a service provider may decide that the safest option is to have the man hospitalized.

The consumer, however, may have had a negative experience the last time he was taken to the hospital and may feel that a hospitalization is not only dangerous but also a failure of his own coping skills. Rather than being hospitalized, the man might feel that it is safer to spend the weekend with a good friend who had agreed to be with him and talk through his feelings. Choosing hospitalization minimizes risk to the system; choosing a more nontraditional community alternative minimizes risk to the individual. A collaborative trauma-informed approach would take both of these risks into account and devise a plan that was acceptable to all parties.

Understanding the Service Relationship. Because human services are delivered within the context of a relationship, how providers and consumers understand that relationship can have an important role in defining the services themselves.

Traditional Approach. In many traditional service systems, the consumer is viewed as the passive recipient of services. The specific providers and the care system in general are viewed as possessing superior knowledge and resources. In a mental health system, the providers have an understanding of symptoms, medications, and treatment approaches. They have usually received that knowledge by acquiring formal education and receiving a degree and some official certification such as a license. Because of their knowledge, they are accorded more status in the relationship with the consumer, and their perceptions and opinions receive more weight. Even when there is an attempt to collaborate around treatment decisions and to honor the consumer's choices for his or her life, most consumers perceive traditional mental health relationships as hierarchical.

Providers also hold the key to much-needed resources. They can make referrals to vocational and residential programs. They are often able to determine whether a consumer receives entitlement benefits by how they fill out social security forms. In residential programs, providers may determine whether a consumer has the opportunity to see her family or entertain guests in his room. And on inpatient wards, it is the provider who determines when the individual eats, sleeps, goes to the bathroom, or smokes a cigarette. With providers controlling so many of the resources, it is difficult to imagine real parity between caregiver and consumer. The parity that does exist is often granted by the provider, susceptible to being suspended if the provider feels that the consumer "no longer deserves such a privilege."

It is no wonder that in such a system, consumers often find themselves frightened and cautious. Paradoxically, the "good" consumer does what he is told so that he will be allowed to have a voice in his own care. In such a system, consumers feel that they are ignored and put down, but most learn how to play the game so that they can survive. The very nature of the service relationship makes real collaboration difficult at best.

Regrettably, a relationship with a powerful authority figure who controls all of the resources and whose opinions and wishes take priority over one's own is tragically reminiscent of the abuse dynamic in which the

trauma survivor was forced to accept an unequal relationship in order to avoid even worse treatment. The traditional service relationship replicates some of the most damaging dynamics of childhood trauma. The trauma survivor who was unable to stand up for herself as a child may be unable to have autonomous opinions and desires even if the provider assures her that her wishes will be respected.

Even in many addictions programs, where the providers may themselves be people in recovery, the newly admitted consumer will be asked to bend her will to the power of the program. The counselors possess elevated status by virtue of the longevity of their sobriety. They are living proof that their way is the right way. The consumer with too much willfulness will need to turn some of the control for her recovery over to a higher power. While the self-help mantra of many addictions programs has proven useful for many consumers, the model perpetuates the hierarchical service relationship characteristic of most traditional programs. And once again a program that perpetuates the consumer's belief that she does not have the power to help herself or that he does not know his own needs and desires replicates the dynamics of abuse in which a powerful perpetrator proposed to "know what was best."

Because providers in most service systems believe in the integrity and efficacy of their models, they assume that newly admitted consumers will trust the program and feel safe within its borders. Providers are often surprised to learn that rather than entering hospitals, clinics, and rehabilitation programs with a sense of trust and security, many consumers enter with a sense of suspicion and wariness. They may have a prior history of failed or troubled treatment at other service centers. Some feel that prior caregivers betrayed the promise of treatment, and others bring experiences of actual abuse at the hands of service providers. Even if past service experiences were positive, all trauma survivors bring a healthy suspicion of people in authority. Consequently, the provider's assumption of safety and trustworthiness is rarely, if ever, shared by the consumer.

Trauma-Informed Approach. The core of the service relationship in a trauma-informed system is open and genuine collaboration between provider and consumer at all phases of the service delivery. This means that consumers choose where, how, and when they will receive services, and they also have an active voice in deciding on the specific provider. Consumers help to set service priorities, determining which services will be delivered first. For example, a woman who feels that her housing and child care needs require attention before she seeks treatment for her depression will be given the opportunity to specify the order of the services that she receives.

This does not mean that providers will become silent partners in the service relationship. It does mean, however, that a provider will have to explain the rationale behind his or her decisions and that achieving a comfortable compromise with the consumer becomes more important than having one's way. It also means that providers may come to question the reasonableness

of doing things in the usual way. Often providers find that things are done the way they have always been done. Routine takes priority over revisiting procedures to determine the best way of delivering services for each individual consumer. Providers may find that in a trauma-informed system, they can be creative about how they deliver services.

When invited to be truly active participants in their treatment, some consumers respond enthusiastically from the beginning. Others are legitimately wary. The invitation to collaborate should always be genuine and must always remain open. Providers should not assume that some initial reticence is an indication that a consumer wants to turn the authority for her treatment over to someone else. It may simply mean that she is unaccustomed to being genuinely included in the plan for her own care.

Trust and safety, rather than being assumed from the beginning, must be earned and demonstrated over time. By beginning a new service relationship with an open question about what the consumer wants and what would help her to feel comfortable and safe, the provider takes the first step toward establishing safety. The provider should also make a clear statement about what he can and cannot do. By eliminating ambiguity and vagueness, the provider once again takes steps to establish trust. Providers realize that the style of interaction is as important in establishing a collaborative relationship as the content of the services delivered.

Providers should also assume that trust is earned over time and not given like a gift on the first meeting. Consequently, in initial meetings, providers should limit the amount of a consumer's disclosure and risk taking. In groups designed to address trauma issues specifically, consumers who disclose too much in the first session often do not return for subsequent sessions. The task of the provider is to make the group a safe place, and she can do that by letting consumers know that personal information is respected. By a simple comment like, "I'd like to hear about that, but why don't you wait until we know each other a little better," the provider demonstrates that she knows she must earn the consumer's trust. The provider also acknowledges that there are stages to a relationship and that closeness and sharing develop over time.

Finally, in a trauma-informed relationship, both parties are acknowledged for bringing valid sources of information and expertise to the relationship. Providers have access to the latest research and have knowledge about innovative clinical programming. They also have expertise based on academic training and eventually on years of practical experience. The provider's knowledge is generic; it applies generally to all consumers with a given history and diagnosis. The consumer's knowledge is, by contrast, very specific. She knows her own responses, her needs, and her history better than anyone else does. She knows, in the words of many consumers, what helps and what hurts. By respecting the consumer's knowledge and her insights about the course of her symptoms and the scope of her attempts to cope and bring order into her life, the provider allows for a truly collaborative service relationship.

Conclusion

The task of making a system trauma informed may at first appear daunting. The shift in philosophy amounts to nothing less than a paradigm shift within service delivery systems. At Community Connections in Washington, D.C., we began the process of becoming trauma informed in the mid-1990s. At first, thinking about trauma and its impact seemed like one more thing to be added to the clinician's assessment of every consumer. Slowly, however, in part because consumers responded so positively to our appreciation of the role that violence and victimization had played and continued to play in their lives, the focus on trauma seemed more integrative and less additive. It was impossible to hear a consumer's story without listening for the story of abuse. Once trauma moved to the center of our understanding, we wanted to develop approaches that would avoid retraumatizing and revictimizing consumers. Without even consciously intending to do so, we evolved the philosophy and principles of a trauma-informed system. It is now unthinkable to return to the traditional way of understanding services and the service relationships in which we participate.

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