Creating Trauma Informed Systems of Care for Human Service Settings

What is Trauma and Why Must We Address It?

Joan Gillece, PhD
National Center for Trauma Informed Care
What is Trauma?

- **Definition** (*NASMHPD, 2006*)
  - The experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters

- **DSM IV-TR** (*APA, 2000*)
  - Person’s response involves intense fear, horror and helplessness
  - Extreme stress that overwhelms the person’s capacity to cope
Definition of Trauma
Informed Care

Mental Health Treatment that incorporates:

- An appreciation for the high prevalence of traumatic experiences in persons who receive mental health services

- A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual

(Jennings, 2004)
Prevalence of Trauma
Mental Health Population – United States

- 90% of public mental health clients in have been exposed to trauma
  \( \text{(Mueser et al., 2004, Mueser et al., 1998)} \)

- 51-98% of public mental health clients in have been exposed to trauma
  \( \text{(Goodman et al., 1997, Mueser et al., 1998)} \)

- Most have multiple experiences of trauma
  \( \text{(Mueser et al., 2004, Mueser et al., 1998)} \)

- 97% of homeless women with SMI have experienced severe physical & sexual abuse – 87% experience this abuse both in childhood and adulthood
  \( \text{(Goodman et al., 1997)} \)
Prevalence of Trauma
Child Mental Health/Youth Detention Population - U.S.

- Canadian study of 187 adolescents reported 42% had PTSD
- American study of 100 adolescent inpatients; 93% had trauma histories and 32% had PTSD
- 70-90% incarcerated girls – sexual, physical, emotional abuse

(DOC, 1998, Chesney & Sheldon, 1991)
Prevalence of Trauma
Substance Abuse Population – U.S.

- Up to two-thirds of men and women in SA treatment report childhood abuse & neglect
  (SAMSHA CSAT, 2000)

- Study of male veterans in SA inpatient unit
  - 77% exposed to severe childhood trauma
  - 58% history of lifetime PTSD (Triffleman et al., 1995)

- 50% of women in SA treatment have history of rape or incest
  (Governor's Commission on Sexual and Domestic Violence, Commonwealth of MA, 2006)
Other Critical Trauma Correlates: The Relationship of Childhood Trauma to Adult Health

- Adverse Childhood Events (ACEs) have serious health consequences
- Adoption of health risk behaviors as coping mechanisms
  - eating disorders, smoking, substance abuse, self harm, sexual promiscuity
- Severe medical conditions: heart disease, pulmonary disease, liver disease, STDs, GYN cancer
- Early Death  
  (Felitti et al., 1998)
Adverse Childhood Experiences

- Recurrent and severe physical abuse
- Recurrent and severe emotional abuse
- Sexual abuse

Growing up in household with:
- Alcohol or drug user
- Member being imprisoned
- Mentally ill, chronically depressed, or institutionalized member
- Mother being treated violently
- Both biological parents absent
- Emotional or physical abuse

(Fellitti et al, 1998)
“Male child with an ACE score of 6 has a 4600% increase in likelihood of later becoming an IV drug user when compared to a male child with an ACE score of 0. Might heroin be used for the relief of profound anguish dating back to childhood experiences? Might it be the best coping device that an individual can find?”

(Felitti et al, 1998)
Is drug abuse self-destructive or is it a desperate attempt at self-healing, albeit while accepting a significant future risk?"

(Felitti, et al, 1998)
ACE Study

“Addiction is not a brain disease nor is it caused by chemical imbalance or genetics. Addiction is best viewed as an understandable, unconscious, compulsive use of psychoactive materials in response to abnormal prior life experiences, most of which are concealed by shame, secrecy, and social taboo.”

(Felitti et al, 1998)
Sexual Trauma and Addiction

- 208 African-American Women with histories of crack cocaine use
- Women with history of sexual trauma (n=134) reported being addicted to more substances than those who had not been sexually traumatized (n=74)
- Women with trauma histories reported more prior treatment failures than those without.

(Young & Boyd, 2000)
What does the prevalence data tell us?

- The majority of adults and children in psychiatric treatment settings have trauma histories.
- A sizable percentage of people with substance use disorders have traumatic stress symptoms that interfere with achieving or maintaining sobriety.
- A sizable percentage of adults and children in the prison or juvenile justice system have trauma histories.

What does the prevalence data tell us?

- Growing body of research on the relationship between victimization and later offending
- Many people with trauma histories have overlapping problems with mental health, addictions, physical health, and are victims or perpetrators of crime
- Victims of trauma are found across all systems of care

Therefore…...

We need to presume the clients we serve have a history of traumatic stress and exercise “universal precautions” by creating systems of care that are *trauma-informed*

*(Hodas, 2005)*
<table>
<thead>
<tr>
<th><strong>Trauma Informed</strong></th>
<th><strong>Non Trauma Informed</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of high prevalence of trauma</td>
<td>Lack of education on trauma prevalence &amp; “universal” precautions</td>
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<tr>
<td>Recognition of primary and co-occurring trauma diagnoses</td>
<td>Over-diagnosis of Schizophrenia &amp; Bipolar D., Conduct D. &amp; singular addictions</td>
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<td>Assess for traumatic histories &amp; symptoms</td>
<td>Cursory or no trauma assessment</td>
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<td>Recognition of culture and practices that are re-traumatizing</td>
<td>“Tradition of Toughness” valued as best care approach</td>
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<tr>
<td><strong>Trauma Informed</strong></td>
<td><strong>Non Trauma Informed</strong></td>
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<tr>
<td>Power/control minimized</td>
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<tr>
<td>- constant attention to culture</td>
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<tr>
<td>Caregivers/supporters – <em>collaboration</em></td>
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<tr>
<td>Address training needs of staff to improve knowledge &amp; sensitivity</td>
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<tr>
<td><strong>Keys, security uniforms, staff demeanor, tone of voice</strong></td>
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<td><strong>Rule enforcers – <em>compliance</em></strong></td>
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<td>“Patient-blaming” as <em>fallback</em> position without training</td>
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Trauma Informed

- Staff understand function of behavior (rage, repetition-compulsion, self-injury)
- Objective, neutral language
- Transparent systems open to outside parties

Non Trauma Informed

- Behavior seen as intentionally provocative
- Labeling language: manipulative, needy, “attention-seeking”
- Closed system – advocates discouraged

(Fallot & Harris, 2002; Cook et al., 2002, Ford, 2003, Cusack et al., Jennings, 1998, Prescott, 2000)
Trauma Informed Care

Contact information

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Between Stimulus and Response

Sensory Thalamus

(LeDoux, 1996)
Between Stimulus and Response

Sensory Thalamus → Amygdala

LeDoux, 1996
Between Stimulus and Response

Cortex

Hippocampus

Sensory Thalamus

Amygdala

(LeDoux, 1996)
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Sensory Thalamus

Amygdala

Response

(Selten, 1996)
Play and Fear

(Panksepp, 1998)
Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint

Prevention Tools

A Core Strategy ©

A Primary Prevention Tool
Seclusion/Restraint
Prevention Tools

Developing Crisis Prevention Plans

Improving the Environment & Using Sensory Approaches

Module created by Stromberg, LeBel, Bluebird, Huckshorn, 2003
Updated 2006
Individual Crisis Prevention Plans

Define
Clarify Use
Discuss Elements
What is a Crisis Prevention Plan?

- An individualized plan developed proactively by consumer and staff before a crisis occurs
  - A therapeutic process
  - A task that is trauma sensitive
  - A partnership of safety planning
  - A consumer-owned plan written in easy to understand language
Why Are They Used?

- To help consumers during the earliest stages of escalation before a crisis erupts
- To help consumers identify coping strategies before they are needed
- To help staff plan ahead and know what to do with each person if a problem arises
- To help staff use interventions that reduce risk and trauma to individuals
In 1995, a consumer activist, Laura Prescott and a mental health attorney, Susan Stefan approached the DMH/MA commissioner.

- Expressed concern about the negative impact of R/S on survivors of trauma. Task force formed.
- The CPP emerged out of the task force report - tool to manage crises and avoid use of R/S.
Essential Components

- Triggers
- Early Warning Signs
- Strategies
First, Identify Triggers
No, not *that* Trigger …

*Trigger, Roy Rogers’ Horse*
These Triggers

- A trigger is something that sets off an action, process, or series of events (such as fear, panic, upset, agitation)
- Also referred to as a “threat cue” such as:
  - bedtime
  - room checks
  - large men
  - yelling
  - people too close
More Triggers: *What makes you feel scared or upset or angry and could cause you to go into crisis?*

- Not being listened to
- Lack of privacy
- Feeling lonely
- Darkness
- Being teased or picked on
- Feeling pressured
- People yelling
- Arguments
- Being isolated
- Being touched
- Loud noises
- Not having control
- Being stared at
- Room checks
- Contact w/family
More Triggers:

- Particular time of day/night
- Particular time of year
- Contact with family
- Other*

* Consumers have unique histories with uniquely specific triggers - essential to ask & incorporate
What are my triggers?

You may not know unless you ask me.
Second, Identify Early Warning Signs
Early Warning Signs

- A signal of distress that is a physical precursor and/or manifestation of upset. Some signals are not observable, but some are, such as:
  - restlessness
  - agitation
  - pacing
  - shortness of breath
  - sensation of a tightness in the chest
  - sweating
Early Warning Signs
What might you or others notice or what you might feel just before losing control?

- Clenching teeth
- Wringing hands
- Bouncing legs
- Shaking
- Crying
- Giggling
- Heart Pounding
- Singing inappropriately
- Pacing
- Eating more
- Breathing hard
- Shortness of breath
- Clenching fists
- Loud voice
- Rocking
- Can’t sit still
- Swearing
- Restlessness
- Other ___________________
Third, Identify Strategies
Strategies

- Strategies are individually-specific calming mechanisms to manage and minimize stress, such as:
  - time away from a stressful situation
  - going for a walk
  - talking to someone who will listen
  - working out
  - lying down
  - listening to peaceful music
What do strategies and a kitchen sink have in common?
Have you tried everything but the kitchen sink to help your anxious patient? (Noble Hospital, Westfield, MA)
Strategies:

What are some things that help you calm down when you start to get upset?

- Reading a book
- Pacing
- Coloring
- Hugging a stuffed animal
- Taking a hot shower
- Deep breathing
- Being left alone
- Talking to peers

- Therapeutic Touch, describe ________
- Exercising
- Eating
- Writing in a journal
- Taking a cold shower
- Listening to music
- Molding clay
- Calling friends or family (who?)
More Strategies

- Blanket wraps
- Using cold face cloth
- Deep breathing exercises
- Getting a hug
- Running cold water on hands

- Ripping paper
- Using ice
- Having your hand held
- Snapping bubble wrap
- Bouncing ball in quiet room
- Using the gym
Even More Strategies

- Male staff support
- Female staff support
- Jokes
- Screaming into a pillow
- Punching a pillow
- Crying
- *Spiritual Practices:* prayer, meditation, religious reflection

- Touching preferences
- Speaking with therapist
- Being read a story
- Using Sensory Room
- Using Comfort Room
- Other
If a person is getting agitated, don’t forget to use **HALT**.

**ARE THEY**…

**H**ungry?

**A**ngry?

**L**onely?

**T**ired?

If it prevents just one restraint, it was worth it!
When you are Upset?

- Being alone
- Not being listened to
- Being told to stay in my room
- Loud tone of voice
- Peers teasing
- Humor
- Being ignored
- Having many people around me
- Having space invaded
- Staff not taking me seriously

“If I’m told in a mean way that I can’t do something ... I lose it.”

-- Natasha, 18 years old
Sensory-based Approaches

- Calming self-soothing activities:
  - hot shower/bath
  - Wrapping in a heavy quilt
  - decaf tea
  - rocking in a rocking chair
  - beanbag tapping
  - yoga
  - drumming
  - meditation
Soothing and Grounding Options

Converted seclusion room now offers: a net swing, rock climbing wall, mini-trampoline

Everett House, Boston, Ma
Simple Sensory Enhancements

Add calming, attractive features:
- art work; wall mural
- plants
- curtains
- music
- comfortable seating options
- bedrooms with new bedspreads
- place to exercise
- low lighting (dimmer switches)

Cooley-Dickinson Hospital
Unit renovations, 2005
Sensory Room: Definition

- Appealing physical spaces painted with soft colors & filled with furnishings and objects that promote relaxation and/or stimulation.

- A room that provides opportunities and choices for consumers to experiment with different sensory activities to determine:
  - what stimulates
  - what promotes calming
  - practice using sensory interventions to develop skill at self-calming
Sensory Room Equipment

- Lava & fiber-optic lamps / motion objects
- Gliding/rocking chairs
- Padded mats
- Weighted blankets
- Quiet Music
- Large balls - bouncing
- Small balls - pressure
- Aromatherapy: scent machine/oils
- Fish tanks
Sensory Room: Guidelines for Use

- Select fire resistant items, latex free, generally safe and washable
- Place selected items in locked cabinet
- Create policies and procedures for use and maintenance of room and equipment
- Train staff and supervise for appropriate use
- Schedule access 7-days/week & across shifts
- Use sensory room items on the Individual Crisis Plan (Safety Tool) (Champagne, 2003)
Examples of Sensory Rooms
Cohannet Academy I RTP  
Taunton, MA - “The Getaway”
“Sensory Modulation Room”
Cooley-Dickinson Hospital, Northampton, MA
Lowell Youth Treatment Ctr.
Lowell, MA

Staff need a little comfort, too
No Room for a Sensory Room?

Sensory interventions don’t have to be in a dedicated room.

Develop your own mobile sensory cart ("Self Soothing Cart")

Interventions may be brought to different locations where people need them.

Franklin Medical Center
Greenfield, MA

(Robyn Miller, 2005)
Snoezelen
Sensory Rooms

Developed in the 1970's by 2 therapists in Holland who learned of positive responses from severely challenged clients after they were exposed to a sensory environment.

- “Snoezelen” is a blended term meaning to relax & explore/ seek out

- Used to stimulate, relax, calm or energize. It can provide a multi-sensory experience or single sensory focus.
Snoezelen Sensory Rooms

- Used in more than 30 countries in many care settings for people with:
  - autism spectrum disorders
  - dementia
  - mental illness
  - chronic pain, challenging behaviors, acquired brain injury, and more
Comfort Room

Definition

- A room that provides sanctuary from stress, and/or can be a place for persons to experience feelings within acceptable boundaries.

- It is a preventative tool that may help to reduce the need for seclusion and restraint.
**Comfort Room**

The Comfort Room is set up to be physically comfortable and pleasing to the eye, including a recliner chair, walls with soft colors, murals (images to be the choice of persons served on each unit), and colorful curtains.

*Citrus Health Care “The Rainforest”*  
Pembroke Pines, FL
Names of unit-specific Sensory Rooms

- Snoezelen Rooms
- Sensory Integration Rooms
- Multi-sensory Rooms
- Sensory Gardens
- Comfort Rooms
- The Soothing Room
- Peace Rooms
- Chill Rooms
- “Chillville”
- “Zen Falls”
- The Sanctuary
- The Retreat
Evaluating Sensory Approaches
Cooley-Dickinson Hospital Quality Improvement Study
(Tina Champagne, OT/L, Edward Sayer, Psy.D.)

Data collected on the effects of sensory-based treatment

- delivered in the sensory room
- 46 people with varied diagnoses and cognitive abilities
- 96 sensory sessions conducted
Hospital

Quality Improvement Study

(Tina Champagne, OT/L, Edward Sayer, Psy.D.)

Results:

- 89% reported: + results
- 1% reported: - change
- 10% reported: no change

- 75% reduction in R/S over two year period (2001 – 2003)
Incorporating Sensory Approaches into Treatment
How are sensory approaches being integrated into treatment?

- Incorporated into:
  - daily activities
  - individual treatment plan
  - crisis plans (MA survey -75%)
  - groups

- Resource available upon consumer or staff request
- In place of PRN’s
- Help with detoxification
- Integrated into DBT skills building (i.e., distress tolerance)
- To soothe agitated older individuals
Innovative Strategies Used?

- Relaxation
- Visualization
- Deep Breathing
- Self-Massage
- Sand Therapy
- Art Therapy
  - fabrics
  - painting
  - clay
- Frozen Oranges
- Mural of restful country scenes
- Quiet Dark Environment
- Physio Balls
- Vibration
- Clinical Aromatherapy
**Sensory interventions considered more helpful with certain disorders?**

<table>
<thead>
<tr>
<th>PTSD</th>
<th>Anxiety</th>
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<tbody>
<tr>
<td>Ice to wrists</td>
<td>Relaxation</td>
</tr>
<tr>
<td>Grounding</td>
<td>Aromatherapy</td>
</tr>
<tr>
<td>Breathing</td>
<td>Weighted Blankets</td>
</tr>
<tr>
<td>Relaxation exercises</td>
<td>Calming Methods</td>
</tr>
<tr>
<td>Weighted blankets</td>
<td>Music</td>
</tr>
<tr>
<td>Weighted vests</td>
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</tbody>
</table>
Sensory interventions considered more helpful with certain disorders?

Cognitive Limitations/Dementia/Very young

- De-stimulation - music, quiet
- Should not be sensory-deprived
  - Aromatherapy & Touch
  - Holding hands
  - Rocking chair
  - Folding & Sorting Laundry
- Warmed Blankets
Benefits of sensory interventions?

- MA Survey findings: (only 64% of adult units studied impact)
  - Restraint Use - 36%
  - Property Damage - 15%
  - Self-destructive Behavior - 31%
  - Physical assaults - 21%
Benefits of sensory interventions?

- Increased options for consumers in crisis & daily activities
- Increased alternatives for staff to offer/assist consumer
- Decreased agitation for consumers
- Clear, measurable way to decrease levels of distress (can do pain assessment before and after use)
- Improved quality of care & therapeutic experience
The “Sensory Summation”

- Offers a greater range of responses to individuals
- Useful in avoiding or resolving crises that could lead to R/S
- Expands the toolbox of therapeutic interventions
- Promotes self-awareness, self-care and self-regulation
- Strengthens the therapeutic relationship

*(Champagne & Stromberg, 2004)*
“Practice yourself what you preach.”

Titus Maccius Plautus, *Asinaria*
Roman comic dramatist
(254 BC - 184 BC)
Treating Trauma in the Lives of Consumers in the Criminal Justice System: Maryland’s TAMAR Program

Joan Gillece PhD
TAMAR PROGRAM

- SAMHSA Women and Violence Site
- Maryland only site addressing the needs of incarcerated women
- Began in 3 local detention centers
- Currently serving 10 sites in Maryland
- Piloting in 2 Ohio detention centers
- Provides mental health, substance abuse, and trauma treatment for men & women in detention centers and State psychiatric hospitals
Tamar’s Story

In the Old Testament, Tamar was a daughter of King David. Tamar’s half brother Amnon raped her. The author of II Samuel writes that afterwards she tore her clothes and retreated into her brother’s house. She is not mentioned in the Bible again.
TAMAR stands for:

- Trauma
- Addictions
- Mental health
- And
- Recovery
Preparing for Implementation

- Trauma training for community agencies
- Trauma training for Correctional Officers and staff
- Correctional Cross-training for TAMAR clinical staff
- Symptoms and behaviors are adaptations
The RICH Model

- Respect
- Information
- Connection
- Hope

(Saakvitne, et al, 2000)
R.I.C.H.

- Be an ally
- Safety and respect
- Boundaries work with survivors
- Use connection to help people manage their feelings and memories
TAMAR Program Components

- Administered by Master’s level, licensed mental health clinician
- Individual sessions
- Group sessions
- Linkage to case management and aftercare
How is TAMAR accessed?

- Screening administered at facility intake
- Trauma Specialist does in-depth assessment on those that screen “positive” for trauma
- Program is explained and offered to eligible individuals
Trauma Assessment Tools

- Trauma Symptom Inventory (TSI) by Briere
- Dissociative Experiences Scale (DES) by Carlson and Putnam
- Stressful Life Experiences Screening by Stamm
More Tools

- Traumatic Antecedents Questionnaire (TAQ) by van der Kolk

- Structured Interview for Disorders of Extreme Stress (SI DES) by van der Kolk

- Modified PTSD Symptom Scale by van der Kolk
More Tools - Child Specific

- Dissociative Features Profile (DFP) by Silberg
- Trauma Symptom Checklist for Children (TSCC) by Briere
TAMAR Groups

- Meet twice a week for 90 minute sessions
- Groups of 12-15 individuals
- Voluntary, no good time or credit earned for participation
TAMAR Treatment Manual

- The TAMAR Manual consists of 15 modules
- Modules incorporate psychodynamic therapy with expressive art therapy and psycho-educational techniques
Module 1

What is Trauma?

- Who Cares, Why Bother, What’s in it for Me?
  - Recognition of traumatic reactions makes management of survivors’ much easier
  - A little bit of trauma awareness goes a long way
  - Ongoing trauma treatment across a continuum of care is a major contributing factor to reducing recidivism in this population
Module 2

What is Abuse?

- Physical and Emotional
  - Goal is to recognize behaviors/actions that constitute physical and emotional abuse
  - Recognize the impact of physical and emotional abuse on their lives
Module 3

What is Abuse?

- Sexual Abuse
  - Goal is to recognize how sexual abuse has impacted their lives.
  - Recognize self-defeating thoughts and behaviors and begin to develop their right to a healthy self-concept
Module 4

Trauma and Addiction

- Goal is to recognize addictive/compulsive behaviors as coping mechanisms
- Make the connection between addictive/compulsive behaviors and their trauma
Module 5

Facts on HIV/AIDS

- Goal is to provide facts about HIV/AIDS as well as discuss myths and misconceptions
- Demonstration of behavior skills to reduce the risk of HIV/AIDS transmission
- This module may be triggering to many women and needs to be presented in a trauma context (i.e. presentation of overt sexual materials introduced with permission to feel and voice upset)
Module 6

Sexual Communication and Negotiation Skills

- Discuss what constitutes sexual communication (both verbal and non-verbal)
- Provides an opportunity to role-play negotiation skills (includes sexual assertiveness, safe sex, and refusal of unsafe sex)
Module 7

Containment

- Why containment instead of disclosure?
- Goal is to help members describe levels of consciousness and understand the different parts of memory.
- Increases self-awareness
Module 8

Containment II - Grounding

- Goal is to identify different grounding techniques.
- Members will be able to practice grounding techniques daily, outside of group.
Module 9

Tolerating Distress

- Each member will begin to distinguish the negative aspects of being unable to tolerate distress

Each member will be able to recognize and verbalize benefits to learning how to tolerate distress
Module 10

Self-Soothing

- Members will identify existing methods of self-comfort
- Each member will begin to distinguish healthy ways of coping from harmful/damaging ways
Module 11

Boundaries and Safety

- Members begin to develop a sense of how much or how little control they have over what happens to their bodies.
- Begin to understand how to set interpersonal limits.
- Boundary exercises (physical, verbal)
Module 12

Trust and Intimacy

- Members will be able to identify at least 1 barrier which inhibits their ability to trust other people.
- Members will be able to identify intimacy and see how it is separate from sex.
Module 13

Parenting

- Discuss how trauma, substance abuse, and mental health issues have affected their parenting choices and ability to parent
- How trauma affects attachment
Module 14

Life Story

- Group members are given the opportunity to share their life story with the group
- Members will understand how trauma has impacted their entire life
Module 15

Closing Ritual

- Members experience healthy closure
- Members will learn to delineate leavings and their importance to the group
- Helps members internalize messages from the group experience
While trauma may affect a person for the rest of his/her life, there are some criteria to assess recovery.

Source: Harvey, 1996
Recovery Criteria

- Physical symptoms of PTSD are within manageable limits
- Person is able to bear feelings associated with traumatic memories.
- Memories don’t limit what he/she chooses to do
- Memory of trauma is linked with feeling
- Damaged self-esteem is restored
- Important relationships have been reestablished
- Person has reconstructed a system of meaning & belief that encompasses the story of the trauma
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