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A Culture of Support: looking beyond the concept of best practices in the treatment of survivors of interpersonal violence.

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A Culture of Support: looking beyond the concept of best practices in the treatment of survivors of interpersonal violence.

My Study is entitled, "A Culture of Support: looking beyond the concept of best practices in the treatment of survivors of interpersonal violence." I'd first like to give a quick "activation warning." This is a discussion of interpersonal violence involving various types of abuse and assault. This presentation won't be graphic, but it will be frank. If you have a sensitivity to subjects of violence I invite you to please take care of yourself: leave the room if you need to, stand and stretch, etc. Please note that I will also alternate between referring to interpersonal violence and its acronym, IPV.

I am a former social services professional and survivor of childhood interpersonal violence, myself. As a coordinator of youth violence prevention programs during the late 90's and early 2000's, I knew a number of mental health practitioners working in trauma treatment. Being an unlicensed professional, my credentials were my trauma and recovery history, and I spoke freely about my experiences in order to educate and support others with similar histories. However, I only knew of a few others in the field who spoke of being survivors or of their own histories with violence. As is frequently the case with survivors of IPV I often felt that I was the only one. Though I wasn't hindered by it, I was aware of a stigma surrounding the existence of survivor-practitioners. Conventional thought was that they would be ineffective due to their own issues, or that they'd exploit their clients in order to process their own trauma. Consequently, they remained largely invisible.

Today the cultural discourse around interpersonal violence and trauma has expanded dramatically. One published report suggests that between 30-50% of mental health practitioners are survivors of IPV. As such, I sought to know if the stigma persists or if survivor-practitioners now felt empowered to allow their trauma history to inform their work. And if so, what the benefits to their clients might be. My initial research question emerged around the idea that survivor-practitioners might be more highly attuned to the needs of their survivor clients due to their own trauma history.

The word "trauma" is used interchangeably for three related circumstances: to describe a traumatic event(s) or to describe an acute trauma response such as PTSD. It is also conventionally used to refer to a condition of traumatic stress; a chronic reaction to multiple or repeated traumatic events, or to an event that has not been psychologically resolved by the survivor. This condition may be exacerbated by a deep sense of shame, denial or dismissal, either on the part of the survivor, or those in their family or community. Dr. Judith Herman, in her book Trauma and Recovery, describes this circumstance as a "festering" of the trauma response. This is what I will refer to today as "trauma".

In 1997, the Adverse Childhood Experiences study, also known as the ACE study, was released. Funded by Kaiser Permanente, the ACE study revealed links between health issues such as cardiovascular disease, diabetes and emphysema, and

childhood adversities such as physical or sexual abuse, or parental alcoholism. This resulted in a dramatic paradigm shift. In one fell swoop IPV-related trauma had been re-conceived from that of a neurotic mental health pathology to a circumstance that, with early intervention, could significantly reduce adult morbidity and mortality. This perspective ushered in a new awareness and sense of urgency around the subject of trauma, and new funding streams opened up for its treatment.

In the early 2000's the "Trauma Informed Care" (TIC) model of psychosocial services emerged. The fields of mental health, chemical dependency and social welfare began integrating a stronger and more focused awareness of the specific impacts of trauma into their services. This represented another shift as trauma had been previously considered as its own domain, and not widely linked to other mental health disorders or to substance abuse. Trauma-specific protocols began being incorporated into service organizations at every level and, theoretically at least, survivors were being invited to add their voices and perspectives to service delivery and design. Now, several years later, believing that the TIC model is actively practiced in these fields, I felt it was time to see what advances survivor-practitioners had made, and how they were now being perceived in their fields.

I developed a qualitative study using a phenomenological design – one intended to provide insight into the lived, professional experience of psychosocial practitioners; both survivors and non-survivors alike, who work specifically in the treatment of IPV-related trauma survivors. My intention was to extrapolate the strengths and innovations of survivor-practitioners from the contrasting philosophies and practices of non-survivor practitioners. I implemented an anonymous, online questionnaire and a series of in-person interviews. To date I've collected 21 complete questionnaires and six interviews. Thus far this is a small sample.

My first two interviews were with non-survivor practitioners. Both reported a long-term commitment to working exclusively with IPV-related trauma survivors, and both provided me with many of the data points, practices and philosophies that I thought would specifically have come from survivor-practitioners. A day-long, trauma training for practitioners yielded similar results. Of the six presenters, the two who proposed the majority of the more progressive and innovative perspectives and treatment strategies were non-survivors as well. This led me to rethink my research question. As the data began to reveal a number of uncommon mental health treatment approaches, I started to wonder if unique practices and approaches to treating trauma were being developed by practitioners working exclusively with IPV-related trauma survivors regardless of their own trauma history.

Returning to the Trauma Informed Care (TIC) model for a moment, many who referenced this model spoke of the difficulties in implementing these strategies institutionally, and of varied interpretations of TIC within many agencies. While TIC

appears to be the new “buzz-word”, it remains an emerging phenomenon with few clear standards of care and a great many disparities in treatment quality.

In terms of actual tools while Cognitive Behavioral Therapy (CBT) was the most popular choice, many spoke of an increasing need for myriad tools and modalities beyond those considered in the field to be “best practices.” As effective as any tool or modality may be, their application is frequently rigid with a limited applicability to specific populations, as noted by my respondent’s comments:

- “One size does not fit all.”
- “These practices don’t often generalize across populations.”
- “You have to be flexible when working with survivors.”

According to my findings the crucial element in successful treatment has less to do with the tools used than in the perspective and approach of the practitioner. The traditional therapist-client model conveys authority to the practitioner, and is frequently underscored by a presentation of professional objectivity known as the “blank mirror approach.” This approach often serves to alienate survivors and can reinforce their sense of isolation. Many of my respondents expressed that they employ what they consider to be a more humanistic, “person-first” approach, and believe this to be a crucial element that supports their efficacy in working with survivors. In his book, Tools for Transforming Trauma, Robert Schwarz termed this phenomenon, “Person-as-Therapist.” Here are a few examples:

- “Clients don’t need models of perfection or professionalism. They need models of humanity.”
- “I’m not a sexual assault survivor, but I’m sure there’s not a person in this room who hasn’t survived something.”
- “I have to be able to stand in the totality of my experience, and that means being able to recognize, understand and talk about the ways in which trauma presents in my own life.”

Another said, “Respond. React. Be human.”

Complimenting this approach, there is evidence of a re-emerging practice that was strongly endorsed in the early trauma literature: survivor-specific, group therapy along with individual treatment. Exposure to fellow survivors who are experiencing similar struggles and triumphs can significantly reduce the pervasive sense of isolation which appears to complicate recovery. There was a lot of attention given to this practice at the training conference, and a couple of my respondents spoke of this as an essential component in their own treatment protocols.

In closing, if practitioners approach IPV-related trauma as a problem they can solve with the appropriate tools, it appears that they may not be very successful. However, if a practitioner approaches their work from the standpoint of a “Person-as-Therapist”, reflecting their shared humanity with their client, and supporting them in finding a group or community that can provide them with a sense of belonging, then they will likely lead that survivor effectively to a place of healing. Thank you.