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**‘A‘OHE PAU KA ‘IKE I KA HĀLAU HO‘OKĀHI
[ONE CAN LEARN FROM MANY SOURCES]**

HONOURING THE FIRST TERRITORY: INTEGRITY

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ABSTRACT

Wellbeing is the framework for realizing the recovery journey. This framework moves from first level (personal) change to second level (community and society) change, with an emphasis on creating and accessing community resources and social relationships that are needed to develop and exercise the person-based capacity to recover. Recognizing and understanding the intersect of predominantly Western/Eurocentric understanding of recovery and native/ indigenous approaches to wellbeing is an emerging challenge and opportunity. Creating space for the application of Native Hawaiian and other indigenous ways of knowing, traditional wisdoms and ancestral and modern-day communal resilience in partnership with research-based Western recovery practice advances and validates worldviews of wellbeing. Such practice honours the first territory: integrity. Coercion undermines integrity and thus wellbeing. Going "Force Free" is the vision and challenge we need to embrace. Among the core strategies to getting there are a trauma-informed system of care and supports, including elimination of restraints and seclusion as well as micro-aggressions, and helping relationships that work, including true shared decision making and risk taking. The heart of our system needs to be re-awakened. When decision-makers act contrary to our informed lived experience and natural ways of wellbeing, we must act contrary to decision-makers.

INTRODUCTION

*E ho mai ka ike mai luna mai e
[Grant us wisdom, guidance, and inspiration from above]
O na mea huna no'eau o na mele e
[The secret wisdom in our songs, chants, prayers]
E ho mai, E ho mai, E ho mai
[Grant us, Grant us, Grant us]*

To the powers that be and voices of past present and future - I greet you. To the house that stands here and the earth upon which its foundations sit - I greet you. To the elders (women and men) - I greet you. To all our descendents who have passed on - I greet you. To all of you present here today, representing the four winds (all around the world) - greetings! My name is Steve Onken. I am from a small farm in Carroll County and a small town called Pocahontas in Iowa. My heart is grateful and I am privileged to be here with you all at this place and time. I greet each and everyone of you. Good morning. Kia ora. Aloha.

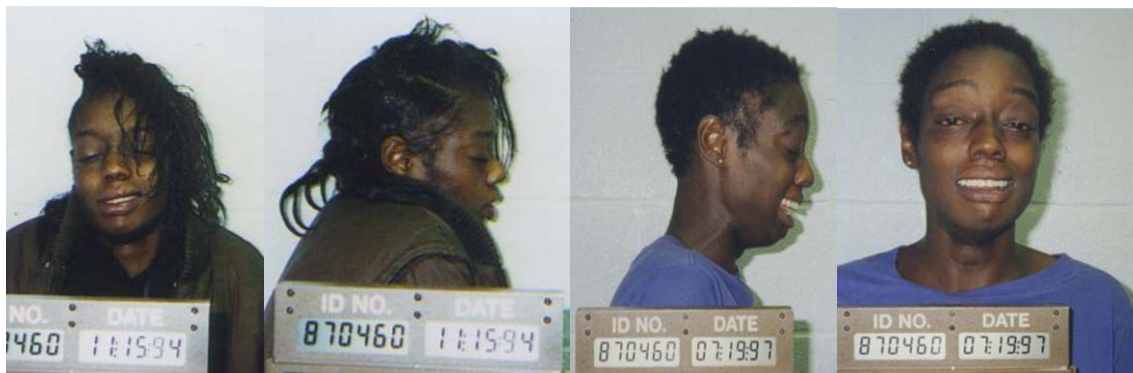
I recently had the privilege of working with Tonier Cain. Tonier and I are both involved in an American initiative to eliminate the use of restraints and seclusion. She is a respected national speaker on the impact of trauma and the importance of trauma informed care. Here is Tonier with her daughter.



Tonier told me of a 17 year old girl in an adolescent mental health care facility on the American Mainland. Staff found her in violation of a house rule for having a personal possession. They demanded that she give it to them. She refused. The situation escalated and at some point the staff determined that there was a need to restrain the girl and take away the possession. In the course of the restraint, this young girl suffocated. The possession that she was clinging to – the only picture she had of her family. I am dedicating my presentation today to this young girl. I am going to talk about some things that may be difficult for you to hear – how some of the things we do in the name of treatment is in fact coercive and violent. These things may not be easy to hear. But I ask that you listen with an open heart and an open mind in respect for this young girl.

When You Change the Way You Look at Things, The Things You Look at Change

Antony Sheehan, Wednesday's keynote, identified four scandals in our response to people with mental illnesses: exclusion, disrespect, inequality and stigma. In the United States and I suspect elsewhere in the world, I need to add a fifth scandal and that is the scandal of the criminalization of mental illness. Take this woman for example. She started drinking at 12, when she first experienced sexual assaults. By 18 she became addicted to crack, and eventually ended up on the streets. She survived through any means she could, including prostitution. She was arrested 83 times and convicted 66 times. Not only was she in and out of jail, but also mental institutions. She endured repeated beatings, assaults and rapes. She lost custody of the three children she birthed. Take a closer look at this person. What do you see?



Do you see Tonier? This is more or less how Tonier looked four years ago – pregnant, imprisoned, and on the verge of suicide. Take a look at the first picture I showed you. Now look at these others. What did you see in the latter? Did you see the talent and potential of Tonier in these pictures? A belief in recovery demands that we do. When you change the way you look at things, the things you look at change. What has made the difference in Tonier's life is that she got herself into the TAMAR program. TAMAR stands for Trauma, Addictions, Mental health and Recovery. Tonier is drug and alcohol free, has a secure attachment with her daughter, is medication free, a national spokesperson and trainer, an advocate helping mentally ill and addicted homeless people, a home owner, and board member.

A focus on wellbeing gives us the framework to work on our recovery. It requires valued-based practice. I have found indigenous models of wellbeing very helpful in capturing such values. In Hawai'i, for example, the concept of lōkahi and pono speaks of balance, harmony and unity for the self in relationship to the interconnectedness of the mind (Ka mana'o), the body (Ke kino), the spirit (Ka'uhane) and the rest of the world (Ka honua) – represented as intersecting circles. It is a holistic approach to wellbeing. Recovery requires such a holistic approach.

Before I go any further, I want to step back and define recovery. Unfortunately, it has become a term coopted or colonized by the formal service system - a new label to attach to slightly revised ways of doing the same old things. But a knowledge-informed definition of recovery is possible, one centered in the qualitative research and personal stories of the lived experiences of people on recovery journeys. Recovery is the ongoing, interactional process/ personal journey and outcome of restoring a positive sense of self and meaningful sense of belonging while actively self-managing psychiatric disorder and rebuilding a life within the community (Onken et al, 2007). Recovery is life – a life complicated by the very difficult challenge of the psychiatric disorder itself AND the way society responds to people with this label.

RECOVERY PRACTICE FRAMEWORK

This ecological perspective incorporates both the individual and the environment and focuses on the relationships between the two, with emphasis on interactions and transactions. Thus recovery can be viewed as facilitated or impeded through the dynamic interplay among characteristics of the individual (building recovery knowledge, skills and competencies), characteristics of the environment (facilitating recovery enhancing opportunities), and characteristics of the exchange between the individual and the environment (promoting empowering exchanges).

Embedded in recovery writings is the notion of change. Recovery is about change, and to better understand the forces of change, it is useful to articulate first and second order change. First order change occurs within a given unit changes within a system but the system itself remains unchanged. When an individual recognizes that recovery is possible, a first order change has occurred. A second order change brings about a change within the system itself. Incorporating and honoring advance directives as a routine component of care and treatment would constitute second order change. The ecological framework adds the interactional dimension, that is, change in one part will have an impact on other parts of the system and potentially on the system itself.

Person-Centered Elements of Recovery

There is much recovery knowledge and experience in this auditorium, so I am going to cover the person-centered elements rather quickly. You know this – the challenge is to practice it.

Hope - the feeling that what is desired is also possible, that things will turn out for the best. Hope is critical and core to recovery – it is the foundation. If a person cannot identify “at least one person who believes in me” you know that this is your starting point, and you become that believing person. Fostering hope triggers motivation, it involves:

- A Temporal Dimension, that is, it is future focused;
- A Potentiality Dimension, that is, what you seek/desire is achievable;
- An Agency Dimension, that is, yours (and others) goal-directed determination (influenced by past experiences, present circumstances and future possibilities);
- A Pathway Dimension, that is, there are ways available and accessible to reach what you seek/desire; and
- An Interconnectedness Dimension, that is, it links you to some one or something beyond yourself.

Sense of Agency - Recovery is often characterized as rooted in a sense of agency, that is, goal-directed determination. In Euro-American thought this is often identified as self-agency but many cultures have many ways of being, and often sense of agency is just as much rooted in family or ‘ohana (our physical and spiritual support network). We gain awareness of and confidence in our ability to face the challenges posed by the psychiatric disability, treatment, and the stigma imposed by the wider society.

Decision Making Control/ Self-Determination – Decision-making control means exercising meaningful choice among meaningful options free from undue external influence or interference. Decision-making control plays prominently in the recovery process as we must have the freedom to design our own life paths to engage in the work of recovery. Recovery is not possible in coercive service systems.

Meaning and Purpose - Recovery is about supporting the capacity of the person to find and pursue meaning and purpose in his or her life. Unfortunately, this is an often unaddressed area in mental health services, and funding for one approach - helpful talk therapy - is being cut. In the recovery framework, it is a given that a person with a psychiatric disability can pursue and undertake productive activities of interest, such as education, employment, family life, parenting, intimate partnerships, and community involvement. For many, spirituality plays a role in the achievement of a sense of meaning as well, infusing meaning in daily life and linking one to broader contexts of humanity and nature.

Awareness and Potentiality - Individuals in the recovery process must have the opportunity to develop an awareness that positive change is possible and the notion that one is capable of engaging in change. I find the Transtheoretical Change Model (Prochaska & DiClemente, 1983) useful in understanding where people are in the process of change. It is also applicable to both first level – personal – as well as second level – community – change.

- Precontemplation (not yet thinking seriously about recovery/change)
- Contemplation (beginning to desire to recovery/change),
- Action (taking necessary steps to realize recovery/change),
- Maintenance (sustaining recovery/change over time), and
- Set Back (struggling with the episodic nature of psychiatric disorders as well as with symptomatic responses as a person opens up to more vulnerabilities, as well as with withdrawal, grieving and healing from traumas and hurt).

It is critical to match a person’s stage of change with your efforts to be supportive of that person. When we don’t match, our efforts often fail. Historically, most treatment programs have been designed for the action and maintenance stages of the model with little thought to the actual

stage the person in, especially people new to the program. How much of what is labelled as lack of client motivation is our own lack of matching change stages?

Re-Authoring Elements of Recovery - The re-authoring process is the task of recasting the life experience in a manner through which the person is able to reclaim a positive self-identity that incorporates but does not center on the psychiatric disorder and associated traumas. We need to make sense of what has happened to us – to our dreams and plans - our life script - no matter how fuzzy – we held prior to being striped of them by the diagnosis of mental illness and the subsequent ways people lessen their expectations of us. Re-authoring is related to acceptance and integration.

- **Coping** - Coping is how a person survives and hinges on the individual's ability to identify unique techniques that enable him or her to weather the illness.
- **Healing** - The healing process involves overcoming the harm incurred through an individual's experience with the illness as well as with the associated trauma, stigma and discrimination.
- **Wellness** - Wellness encompasses the development and use of proactive skills to promote health and navigate the challenges presented by the psychiatric disability and life stressors. It involves the ability to care for oneself in a holistic way - mental, emotional, physical and spiritual wellness.
- **Thriving** - Thriving is a process in which individuals' experiences of dealing with traumatic life events lead them to become better off than they were beforehand. When thriving, individuals rebuild their lives through the Re-Authoring Process, creating lives that are broadened rather than limited by the experience of mental illness.

The elements of the Re-Authoring Process are interlinked, with differences between them being largely a matter of degree, that is, a person may be incorporating pro-active techniques that modulate the effects of the illness (wellness strategies) or may be just starting to realize the ways in which he/she is surviving (coping skills). Re-authoring is a critical and unique part of the process of mental health recovery and is most often ignored in our systems of care. We have the same needs as others, however, to understand how we experience and make sense of the world. And practitioners and carers have an even greater need to learn this understanding from us. What are our basic story lines and narratives?

There are many approaches to support this exploration – intentional interviewing, narrative therapy, motivational interviewing, consciousness raising – to name a few. At the core of this process is encouraging and supporting people to tell their stories, listening for and pointing out the positive assets in their stories (the ways they survived), supporting them in re-storying their stories given that they do have positive assets (strengths and capabilities), all of which frees up new energy to take action towards further recovery. People can be agents of power – we can reclaim our self-definition. In essence telling our stories facilitates first order externalizing, that is, separating the person from the problem in such a way as to make the problem the problem, challenging the assumptions that locate the problem within the person, and no longer submitting and monitoring ourselves accordingly to “the mentally ill way to be.”

Community Capacity Building Elements of Recovery

I now want to shift our focus to the environment, to our organizations, communities and societies. Too often the only elements of recovery that are focused on are those involving the

person and personal change. But if a person wants to work and no one will hire her due to misconceptions about psychiatric disorders, then the work of recovery must be in organizational/ community change. Yes, I am talking about social justice and our responsibility to build recovery enhancing communities. The heart of our system needs to be re-awakened . . . When decision-makers act contrary to our informed lived experience, we must act contrary to decision-makers.

Let's begin with the need to provide basic instrumental or material supports, such as housing, meaningful activity (jobs), substantial livelihood (salary and benefits), and physical health care. You know, it is damn hard to work on one's recovery when you are homeless and hungry. Frankly, New Zealand and Australia are more advanced in providing such community supports than in the United States. We are a nation in disgrace.

Take physical health disparity, which I see as the sixth scandal regarding our response to people with mental illnesses. What is the difference in the life span between an average American and an average American with severe and persistent mental illness? Twenty-five years! We die on the average 25 years before the rest of our population! What was the difference in life spans 20 years ago? Fifteen years. So in the last 20 years, American society has successfully shortened the life span of people with severe and persistent mental illness by 10 years. And let's face it - along with poverty - medications do play a role in this shorten life span. I am not anti-medication, the right kind at the right and most minimal dosage, that is consistently and correctly monitored and adjusted as the person grows and changes can be a very helpful tool in one's recovery. But chemicals introduced into our bodies often by their very nature are toxic. In the U.S. the federal government has announced the 10 in 10 campaign. The goal is to regain 10 years in our life span in 10 years. Well what about the other 15 years? Do our lives have so little value? Where is the outrage? Would our society find it acceptable if, on the average, white males had a 25 years shorter life span?

When it comes to providing instrumental supports, such as housing, employment, health care, etc. instead of talking about eligibility and benefits, we need to be talking about human rights. Each country in this auditorium, including the U.S., is a signer of the International Declaration of Human Rights. This declaration clearly establishes these rights. Our countries are quick to use the International Declaration of Human Rights to shame other countries. Isn't it about time that we as citizens starting using the International Declaration of Human Rights to shame our own countries as to the care of treatment of our own citizens?

Citizenship – now that is a powerful concept. Recovery is about having valued roles and status in our communities. For this to occur, we must include in our recovery practice a strong focus on building the social and ecological capital of our communities.

I'd like to return to the Hawaiian concept of lōkahi and pono – of balance, harmony and unity. Recall one intersecting circle is that of the rest of the world – Ka honua – the sense of physical place/ habitat to which we are connected. There is much that “developed” societies have to learn from our indigenous peoples. Similarly to how poorly we treat people with psychiatric disorders (or any difference that we fear), we have not been good stewards of the earth. Native Hawaiians talk about the value of malama aina - caring for environment, remaining connected to the mountain or valley that you come from by caring for the place that you are currently sharing. Ahupua'a were self-sustaining communities extending from the mountains to the sea. Native Hawaiians, recognizing the finite resources of the islands, implemented this concept of sharing and sustaining resources from the land and sea to feed the community it contained. This physical connection also provided a sense of, connection to place - who you are, where you come from, your name, your genealogy. Many of you in this auditorium know what I am talking about as you come from strong indigenous peoples. In Hawai'i for example, we have learned

that unique opportunities can emerge to explore recovery when people are working together in a taro patch. For some people, it is a safe space to open up. Does this work for everyone? No, but it does work for many – quilting, gardening, pet care, planting, harvesting – respecting our physical spaces can be an external way of starting to respect ourselves internally. Let us explore how the Declaration on the Rights of Indigenous Peoples, much like the International Declaration of Human Rights, can be used to advance community recovery. (I am embarrassed to acknowledge that the U.S. did not sign Declaration on the Rights of Indigenous Peoples – one of a handful of countries.)

We can build citizenship through proper care of our land and our sense of place, and through a strong emphasis on social capital development. I find the capacities approach as developed by Nussbaum (2001) to very helpful. Everyone possesses capacity – if you are breathing you are surviving and if you are striving you possess capacity – and capacity fosters action. Circumstances and opportunities in the community, however, must be in place in order to discover, develop and exercise the person-based capacity to act. As Nussbaum points out in her international studies of girl and womanhood development – denying a young girl education is denying her the circumstance and opportunity to develop her own capacity to take action – for herself, for her family, for her community. This may clash with the cultural values of some societies, but such clashes do not remove the need to examine such cultural values. We have discarded many destructive ways of being in the past, such as slavery or frontal lobotomies, and gain much from constructive examination, change and growth. I am not implying that our communities need to keep up with every new idea and approach to thrive; they just need to keep open.

The notion of substantive freedoms also comes into play. Substantial freedom, first conceived by Nobel Prize Laureate Amartya Sen (1999), is the notion that freedom, even when legally codified, is effectively restrained when there is a lack of psychological, social, and monetary resources available to achieve goals and live a meaningful life. Substantial freedom is predicated on individual values and preferences and in this regard it is mediated by the capacity a person has to develop and act on meaningful choices. Substantial freedom is increased by creating a support system that is as flexible as possible, while providing the assistance necessary for the person to obtain critical resources, including social, psychological, financial, and material resources. The notion of substantial freedoms - that freedoms guaranteed by law are not necessarily an accessible part of life unless the environment is one that includes access to the benefits of such freedoms - is one that reflects the critical role of social circumstances in the pursuit of recovery. Substantive freedoms include life, bodily health, bodily integrity, reason, emotion, imagination, social connectedness, affiliation, social respect, nature and play, and, of course, citizenship (the latter including both political and material control).

This inclusion of substantive freedoms in recovery practice thus demands that we work to eliminate stigma, a barrier to social opportunities on many levels. The ability to participate fully in the community by building on strengths and reintegrating is critical in recovery, and one's close social network and the community at large become resources in the recovery process. Integration is vital - both the integration of the psychiatric disability into one's sense of self and of the individual into a welcoming community. A person with a psychiatric disability is as capable of living a full life as anyone else, working collectively with others in their communities to achieve desired goals.

Burdenhood becomes citizenship. What constitutes burdenhood - shamed/blamed, isolated/invisible, not normal, unworthy, alienated, inadequate, powerless, stripped rights, a life of poverty, stigmatized, dehumanized – is replaced by what we value in citizenship –

embraced, connected, diverse, valued, involved, capable, powerful, full rights, quality of life, celebrated, actualized.

INTEGRITY: HONOURING THE FIRST TERRITORY

The concept of replacing burdenhood with citizenship brings me to the theme of my talk - Integrity: Honouring the First Territory. Central to all of our professional codes of ethics is this notion of integrity, of conducting ourselves with integrity and treating others with integrity. This integrity begins with honouring of the first territory, that of the territory of one's body. Recovery practice demands integrity – integrity of not only the body, but also the mind, the spirit and one's place in the world. Integrity cannot exist in a space that contains violence.

What is Violence? In my anti-violence work, I define violence as both direct attacks on a person's physical or psychological integrity and destructive actions that do not involve a direct relationship between the victims and the perpetrators. This definition treats individual, group, institutional and societal violence equally and includes socially sanctioned, unintended, subtle, nonphysical, covert, and long-term consequential forms of violence, such as dehumanization. It includes any avoidable action that violates a human right or that prevents the fulfilment of a basic human need. I realize this is a very comprehensive definition and you may be pushing back at its breadth. But can we create safe sanctuaries in which people can heal and recover if we allow any form of violence to be manifested – intentional or not? Let's consider the very real issue of trauma.

Trauma

Trauma is the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, including terrorism and disasters (NASMHPD, 2004). A person's response to trauma involves intense fear, horror and helplessness; extreme stress that overwhelms the person's capacity to cope (DSM IV-TR APA, 2000). The prevalence and impact of trauma in the lives of people with serious mental illness in contact with various human service systems is significant. Studies in the U.S. and Canada show prevalence of trauma in 60-98% of persons with serious mental illness (90% for girls and women) in publicly funded and hospital settings (Goodman et al., 1997; Mueser et al., 1998, Saxe et al, 2003). The formal service system, however, largely overlooks the central experience of trauma in psychiatric disorder. It is incumbent for us to acknowledge:

- Trauma is violence.
- Trauma is pervasive.
- The impact of trauma is very broad and touches many life domains.
- The impact of trauma is often deep and life-shaping.
- Interpersonal trauma is often self-perpetuating.
- Trauma is insidious and preys particularly on the more vulnerable among us.
- Trauma affects the way people approach potentially helpful relationships.
- Trauma has often occurred in the service context itself.

To more fully understand the impact of trauma, we need to understand how trauma experiences affect the functioning of our brains. (Mindful of the time, this is a brief orientation and it does not do justice to the incredible work going on in the field.) There are three critical organs in our brains that play a role in understanding trauma. First is the amygdala. The path between stimulus and the amygdala is very fast and the amygdala sets off our flight, fight, or freeze response. The second path the stimulus takes is to the hippocampus. This is a slightly slower path. The hippocampus provides the context of the stimulus. The third path takes the stimulus through our cortex. This is also a slightly slower path. The context provides memory. For

example, when I slam my hand against the microphone unexpectedly, your first response is to startle. This is your amygdala, i.e., startle as the first stage in flight, fight or freeze. But almost immediately, your hippocampus provides a context, that of a speaker in an auditorium. Your cortex throws in past memories of hearing hands knocking into microphones, and the crisis as to how to handle the stimulus is now over. Your response is to relax.

I pull out a gun and shoot it. Now what is your response to the stimulus? You are going to go instantly into flight, fight or freeze! The hippocampus doesn't help as you have no context for a gun shot in auditorium. By the time the stimulus makes it through your cortex, your response may become even more driven by the amygdala, as you recall vague memories of gun loving Americans shooting up people in auditorium or classroom settings! The amygdala rules – flee, fight or freeze! Now imagine how you would approach the experience of being in an auditorium if on more than one occasion you were subject to gun fire.

You are a child. The door slams – your father, drunk, angry, beating everyone is slight - violence. This happens a second time. The sound of the door becomes the stimulus that sets off your amygdala. You either freeze and get beaten, fight to protect yourself (or siblings) and get beaten, or run (leaving the other members of your family to fend for themselves). This pathway becomes engrained in your brain. Soon the slamming door stimulus is no longer limited to home – it happens in school. Your amygdala takes over as a means of self-preservation. Your flight, fight or freeze response gets you into more trouble. The slamming door stimulus mutates into any loud noise and sets off your amygdala. Each reinforcement further limits the hippocampus and cortex; these pathways become weaker. Today, you are sitting quietly in the common room of the treatment facility. The staff member behind you starts laughing loudly. This loud noise – this stimulus is “the slamming door” – it sets off your engrained amygdala pathway and you respond by instantly getting threatening – fight! The staff wonders where did that come from? – nothing was going on. A confrontation ensues, then escalates – isolation, meds, restraints and/or seclusion.

Our primary way of responding to the pattern I have just identified is through neuroregulatory interventions. We use psychopharmacology to deaden the impact of the stimulus on the amygdala and in other ways to help the brain function differently in terms of how it is reacting to the stimulus. We also use psychotherapy interventions (another type of neuroregulatory intervention) to help to re-activate and strengthen the stimulus pathways through the hippocampus and cortex such that the stimulus is understood in a neutral or non-threatening context and the response is more appropriate. Often these two approaches both come into play. Meds – the right kind, at the right level (smallest dosage while still effective), constantly monitored to adjust for the changes in our brains, body and behaviours - may help us be in place where we can then benefit from the psychotherapy interventions.

A major shortcoming, however, is that this traditional approach - neuroregulatory interventions – is focused on the post-stimulus circumstance; the stimulus has already occurred and has triggered the engrained pathway shaped by the amygdala. We have been slow to develop and use a second set of interventions, that of social-environmental interventions targeting the stimulus before it happens. For example, service users on an inpatient unit creating a safe, quiet place that minimizes the possibility of loud noises – a comfort room.

What I have just walked you through is a oversimplification of complex dynamics occurring in a multifaceted and constantly changing environment. But it is critical to our understanding if we are to engage recovery. Many providers assume that trauma experiences, such as abuse or dehumanization, are additional problems for the person, rather than the central problem (Hodas, 2004). It is incumbent, however, to keep in mind this centrality of the trauma experience and

what trauma does. It changes a person's parameters in regards to affect, thought, behavior, sense-of-self, and consciousness. Trauma shapes basic beliefs about our identity, world view, and spirituality. Consequences of trauma include faulty control methods, such as over-control, self-blame, passivity, addictive behaviour, self-harm. Trauma can result in impaired attachments, such as warmth by friction and interpersonal skill deficits. More trauma consequences include self inflicted injuries, dissociation, aggressive arousal, avoidance, and/or intrusive re-experiencing.

Look at this list of trauma consequences again. We identify and label these as symptoms of mental illness. But for trauma-impacted people - the overwhelming majority of people in our mental health systems of care - these are ADAPTATIONS. When you change the way you look at things, the things you look at change. Symptoms? Or adaptations?

We must acknowledge that some (more than some?) of our behaviors and "helping" practices serve to be the very stimuli that set off the trauma responses and subsequent adaptations. Isolation, forced medication, restraints, seclusion, rights stripping, non-compliance labelling – these are coercive actions. Coercion manifests itself as violence. Paraphrasing my colleague Amy Long, "You can force me into treatment, you can force me into restraints, you can force me into medication, you can force me into seclusion, you can force me into a rights-stripped state of non-personhood, but you can NEVER force your way into my mind, nor into my heart. That you must earn."

We must recognize that coercive interventions are contraindicated for people to recover. It is traumatizing and recapitulates victimization. We need to move from our controlling environments to collaborative supported environments. Alliance not Compliance.

Recall that dehumanization of people also constitutes violence. Look at this sign – "Staff Only." Now what is it really saying? How would we respond if it stated "Whites Only?" Let's call this message for what it is - a micro-aggression. The small little seemingly insignificant ways in which we create a sense of differentness, otherness, of "less than" in the people we serve. But micro-aggressions are not insignificant to those experiencing them – they occur over and over and build and build – reinforcing a sense of "not good enough", helplessness - a loss of personhood and humanness – a sense of never going to make it. This is the soft discrimination of low expectations. How often I have heard, "Recovery is great, but you don't work with the kind of people I do."

This dehumanization is not just limited to individual experiences. We must recognize the impact of multi-generational or historical trauma. I am talking about the cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences. General trauma literature (van der Kolk, McFarlane, & Weisaeth, 1996), Jewish Holocaust literature (Fogelman, 1988, 1991; Yehuda, 1999) and Native specific experience and literature in Canada, Central America, South America, Mainland United States, Hawai'i and Alaska, including Japanese American World War II internment camp descendants, African American descendants of slaves, and Latino survivors of colonization support the theoretical constructs underpinning the concept of multi-generational or historical trauma. New Zealand and Australia histories reflect similar occurrences in regards to indigenous and some immigrant communities. The constellation of features generally involving unresolved grief that accompanies such historical trauma often includes self-destructive behavior, such as substance abuse, suicidal thoughts and gestures, depression, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions (Brave Heart, 2003). We need to develop our awareness and responsiveness to such features and their intergenerational transfer.

The good news is that regardless of the underlying cause of the trauma, we can change the way we do things now. We can use a “universal precaution approach” as a core trauma informed foundational practice for changing our behavior. Presume that every person in a treatment and service setting has been exposed to abuse, violence, neglect or other traumatic experiences. Move from asking “What is wrong with you?” to “What happened to you?” This simple change in the way you interact with a person starts the recovery process and you will find that the things you look at will change. How many of you have heard, “He’s in denial about his mental illness and as a result we are stuck?” Denial can be a rather healthy adaptation/coping mechanism. We use it all the time. If you reframe to “Tell me what happened to you?” there is much opportunity to engage and move forward towards wellbeing, without needing to challenge the denial.

The goal of treatment is to help people to maintain calm and continuous engaged states; to prevent discontinuous states; and to build cognitive structures that allow choices in how to respond to the stimulus around us. This is important – this is how we want to set up our treatment environments – to help the people we serve learn how to maintain calm states, prevent discontinuous states, and build wellbeing promoting cognitive structures. In trauma care we call this expanding the “cognitive wedge” between the stimulus and our immediate reaction to it, re-engaging and strengthening the pathways through our hippocampus (constructive context) and cortex (helpful memories/thinking). The brain is remarkably adaptable. We are remarkably resilient. Many of us experience trauma without lasting effects. We can help clear the way for people to identify and tap into their own self-righting capacities.

For people to share with you “what has happened to me,” they need to feel safe. Just as hope is essential to recovery, safety is essential to trauma sensitively and intervention - social safety, emotional safety, moral safety, and physical/environmental safety. Often the latter is a good starting place – how much of a sense of safety does your work environment convey? Have glass partitions, “Staff Only” signs and other physical signs of micro-aggressions been removed? Are there posters and artwork celebrating recovery? Are your staff comfortable with disclosing their own lived experiences with severe emotional/psychological distress? What changes can you make to create a safe work environment? Other common sensible trauma interventions:

- Telling people what you are going to do before you do it.
- Recognizing a flashback and managing it with words instead of action.
- Seeing trauma responses as adaptations rather than manipulations.
- Developing and implementing personal safety planning (i.e., partnering with the person in identifying triggers – stimuli that trigger trauma pathway responses, recognizing early warning signs to these triggers so that the person and/or you can take preventive action, and identifying the strategies and coping mechanisms the person uses for such prevention and/or to stop the stimulus from triggering a no choice response).

I mentioned that I serve on the U.S. National Steering Committee for the Alternatives to Restraint and Seclusion grants. Do you know what we have documented to be the number one trauma trigger for most people in our public psychiatric inpatient system AND the number one reason for restraints and seclusions? Staff enforced rules. The number one means to sizably reduce the use of restraint and seclusion, and the corresponding injuries to both service users and staff, as well as to increase job retention, moral and tenure, and lessen the number of sick days taken? Give staff the freedom to lose the argument - to be flexible with the rules, even if it means breaking them. Johnny doesn’t want to be at group, but it’s the rule as no one is allowed back on the ward during group, you enforce the rule with Johnny, he escalates, you get coercive, his trauma is triggered – forced meds, restraint, seclusion or the like. Alternatively, Johnny doesn’t want to be at group; you work with Johnny to find an agreeable safe alternative

place for him to be during group. Imagine how things would have been different for that 17 year girl I am dedicating this presentation to if staff had allowed themselves to lose the argument. Might she be alive today? Was her death worth taking her family picture away so that a rule could be maintained? Who knows what her capacities were and how they may have benefited us.

Earlier I mentioned staff disclosure comfort levels; we need to be mindful that trauma experiences impact treaters and carers. Doing a restraint traumatizes the staff as well as the person being subjected to the restraint. Please keep in mind that treaters and carers – you and your colleagues:

- Often have their own traumatic histories
- Will seek to avoid re-experiencing their own emotions when exposed to stimulus connected to such traumatic events
- May perceive a behavior as threat or provocation directed at them rather than as re-enactment of trauma
- Be unaware when other people's actions may serve as triggers for their own sense of loss, rejection, neglect, abuse and/or abandonment.

Do no harm – to ourselves, to others. We can live in accordance with this value if we transform into trauma informed systems of care. In such a system all services are directed by a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual, and an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services (Jennings, 2004). Trauma informed care systems:

- Are inclusive of the survivor's perspective
- Recognize that coercive interventions cause traumatization and retraumatization – and are to be avoided
- Recognize the high rates of PTSD and other psychiatric disorders related to trauma exposure in children and adults with severe mental illness
- Have early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness
- Recognize that mental health treatment environments are often traumatizing, both overtly and covertly
- Recognize that the majority of mental health staff are uninformed about trauma, do not recognize it and do not treat it
- Value the service user/consumer in all aspects of care
- Use neutral, objective and supportive language
- Have individually flexible plan approaches
- Avoid all shaming/humiliation
- Have awareness/training on re-traumatization practices
- Have institutions that are open to outside parties: advocacy and clinical consultants
- Have training and supervision in assessment and treatment of people with trauma histories
- Focus on what happened to you in place of what is wrong with you
- Ask questions about current abuse
- Address the current risk through safety planning and develop a safety plan for discharge
- Presume that every person in a treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences (summarized from Fallot & Harris, 2002; Huckshorn, Stromberg, LeBel, 2004; and Gillece, nd).

In addition, culturally and indigenous responsive trauma informed systems:

- Value Native and immigrant/refugee cultures and histories
- Understand the colonization inherent in many indigenous experiences
- Have an awareness of and training on multi-generational/historical trauma, and its intergenerational transmission
- Work to prevent or limit historical trauma transfer to subsequent generations through culturally congruent trauma interventions (adapted from Brave Heart, 2003).

A trauma sensitive and healing culture is one of: safety, openness, participation, belonging, citizenship and empowerment (Bloom, 2001). Now doesn't this sound a lot like the recovery practice I have been describing! Through our Alternatives to Restraint and Seclusion grants we are learning how the core strategies of leadership, use of data to inform practice, workforce development, use of coercion prevention tools, serve user infusion, and debriefing techniques help to create the cultural change that is needed to become trauma informed and engage the recovery process.

Exchange-Centered Elements of Recovery

Let's return to the recovery practice framework I started with; I have covered two of the three ecological components of my recovery framework for practice. Person-centered elements are critical, community-centered elements are critical, but the way we go about connecting these two components is essential. Another way of looking at this third and final component, the exchange, is considering "Do treatments cure disorders, or do relationships heal people?" I think you know the answer, and the trauma information I have shared with you should be re-enforcing your practice and/or lived experience wisdom. Cutting to the chase as I have run out of time, the exchange must be one of empowerment – service users igniting and utilizing their personal and collective power - power through participating in relationships with service providers and carers that really work, power through choice, power through interdependence, power through vital engagement, and power through peer-to-peer connections.

Norcross (2002), in his review of empirical research on psychotherapies (1000 controlled studies, including 300 meta-analyses), found that the largest chunk of positive outcome variance that is not attributable to preexisting client characteristics (25%) involves the therapy relationship (10%) and then the individual therapist (7%), regardless of technique or school of therapy. Together these latter two factors account for 17% of the chance for successful outcomes. This is a critical amount of variance that we can influence as most of the variance is not known (50%). If the relationship isn't working, no evidence-based practice is going to make much difference.

So what makes a relationship that works? Norcross (2005) and others identify relationships that:

- Customize the relationship to match, adapt and respond to coping style, stages of change, and expectations
- Pay attention to the alliance/relational bond – acknowledging and addressing resistance
- Convey empathy – the sensitive ability and willingness to understand the person's thoughts, feeling and struggles
- Convey positive regard, congruence and genuineness
- Constructively use feedback and self-disclosure, and
- Authentically partner.

Relations are experienced as authentic partnerships when the provider is experienced as collaborative, empathic, respectful, trusting, understanding, hopeful, encouraging and empowering (Adams & Grieder, 2005). The service plan is service user/consumer directed, with

agreement on goals, tasks, participation and roles. Examples include Pat Deegan's work in decision support tools (such as Common Ground: Shared Decision Making regarding medications), personal medicine, and the use of power statements. You all are aware of other examples, such as WRAP planning, and the use of advance directives.

Relationships that work include the involvement of natural relationships – non-paid people who are a part of your life. Often it is in these natural relationships that we gain a sense of secure relatedness through a core of active, connected, mutually supportive people. Relationships, when fueled by belief that recovery is possible and is being supported, foster intrinsic motivation, active engagement, and a sense of agency. Finally, relationships that work are characterized by enduring partnerships where one is respected as an equal.

Empowering exchange is also characterized by having choices among meaningful options, competencies in making choices, and ultimate decision making power. Thus, access to relevant, accurate information is critical, as well as having true options - alternative paths that are accepted as legitimate or not blocked. There are opportunities for choice-making and to build choice making competencies (which may have been stripped away). Such competency building includes taking responsibility for choices - the right to take risks, make a mistake, to fail. Shared risk taking is one approach; the harm reduction model for guiding choice making is another. Decision-making control fosters self-governance, self-responsibility, resiliency and flourishing.

The ability to live among (and interact with) others - mutual positive interdependence - is a hallmark of a recovery supportive community and an underpinning of the recovery process. A focus on interdependence (as compared to independence) defines the problem not from what is wrong with the person, but from the context of limited supports to allow the person the opportunity to participate and advance - it repositions the problem to be deficit in service system and/or cultural-social structure by not having appropriate supports for full participation. Achieving independence moves from being measured by the quantity of tasks one can perform by him or herself, to that of the quality of life one can have with supports.

The power of vital engagement, having the opportunities for meaningful activities and engagement in life, is characterized both by flow, or enjoyed absorption (you lose the sense of time while you are engaged), and by meaning, or sense of significance. The dynamics of flow facilitates the stretching of capacities, to find flow in what one is doing is to grow – to build competency. One derives a sense of meaning and significance from vital engagement. An excellent example is meaningful, flexible employment - often described as the best therapy there is. Thus access to, and choice among work opportunities and career development becomes important. Other avenues of meaningful activity include knowledge development and educational opportunities. Intrinsic value is found in learning, volunteer work, and/or artistic expression. Engaging in advocacy can serve not only as a means to gaining voice, but also of moving towards decision-making control and recovery. Self-advocacy is integral to self-determination, while group advocacy activities can trigger referent power opportunities and provide people with a sense of being members of an extended community.

Peer-to-Peer Connection

“Revolutions begin when people who are defined as problems achieve the power to redefine the problem.” John McKnight, 1995

I end on the note of acknowledging the incredible value that peer-to-peer connection, a critical empowerment exchange, has in recovery. We build recovery capital through service user/consumer operated programs, self-help/mutual support groups, peer led addiction and

mental health recovery services, consumer networks/movement, trauma-informed peer support and peer-run crisis alternatives, peer-to-peer services, peer-to-peer education, mental health self-management, money in the hands of the person models (such as, self-directed services/personalization), advance directives, and consumer employment in 'traditional' mental health programs. Peer-to-peer connection provides opportunities of helping oneself through helping others, of experiential knowledge and self-help development, of role models and fellow recovery travelers imparting a sense of normalcy and understanding. Sharing our stories, our ways of surviving, helps to counteract internalized life scripts regarding chronicity, pathology, helplessness and replace those with life scripts that emphasize working through periods of setbacks and taking on responsibility, self-management, and wellbeing.

Peers also empower peers through taking collective action against the effects of oppressive forces in our lives. I am here at this place, delivering this keynote on recovery, though the grace of all of the service user activists that have spoken up before me. We the ancestors, will be remembered for our voice, not for our silence.

Bloom would characterize peer-to-peer connection as "deep democracy" and a requirement in our quest to create trauma free sanctuaries. Deep democracy consists of:

- Having a voice
- Being heard
- Respect
- Avoidance of shame and humiliation
- Control in what happens in treatment and services.

CONCLUSION

I have run over time and you have been very attentive. I have one last story to share. In the book "A Body Remembered", the author, Mary Steward I believe, tells of the following encounter. Mary has significant physical impairments impacting her mobility and a number of other body functions. She is also of short stature and uses a wheel chair to get around. Mary swims, though not anything like Michael Phelps (as an American I had to work him into this talk somehow). Mary was on holiday in Greece and decided to go for a swim. She motored her chair to the edge of the beach, climbed down and headed out into the bay. A fisherman across the way looked up and saw much splashing. He jumped into his boat, motored over, drew along side Mary and shouted: "You're drowning, I'm here to help." Mary looked up at him and smiled. She replied, "I'm not drowning, this is how I swim."

I tell this story because we live in a service system that sees only drowning. Symptoms, diagnosis, labels, treatment plans, progress notes, billing – we live in a culture of a reinforced pathology focus. You know what recovery is? Recovery is when we meet the person for the first time and we instantly see all the unique ways in which that person is swimming. And this is not to dismiss the challenges, the emotional/psychological distress, the stigma, the poverty. But if that person is living, that person is surviving, and if that person is surviving, that person is swimming. See it.

When you change the way you look at things, the things you look at change. "You are drowning!" "No, this is how I swim."

Recovery is not difficult to understand; I return to the writing of Pat Deegan (1996). The goal of recovery is not so much as that of becoming normal as to become more deeply, more fully human in whatever unique way one is meant to be. Recovery is not so much getting mainstreamed, but expanding the mainstream to incorporate the fringes.

Thank you. The Maori have a beautiful ritual of closing with a song, but my singing is hard on the ears. So I'll close with a poem which is, after all, a song of the soul.

Integrity

*It is not what we eat but what we digest that makes us strong;
not what we gain but what we save that makes us rich;
not what we read but what we remember that makes us learned;
and not what we profess but what we practice that gives us Integrity.*

Author Unknown

*Integrity is not a characteristic.
It is a way of life
It is what you do, and what you say, always.
It sets you apart from others.
It defines you as a person.
Treat others as you would be treated.
Be upstanding, be forthright, be conscious of your actions.
Remember, to always act with integrity.*

Gary Dodd, 2008

Mahalo!

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