WHO ARE TRAUMA RECOVERY CENTER CLIENTS?

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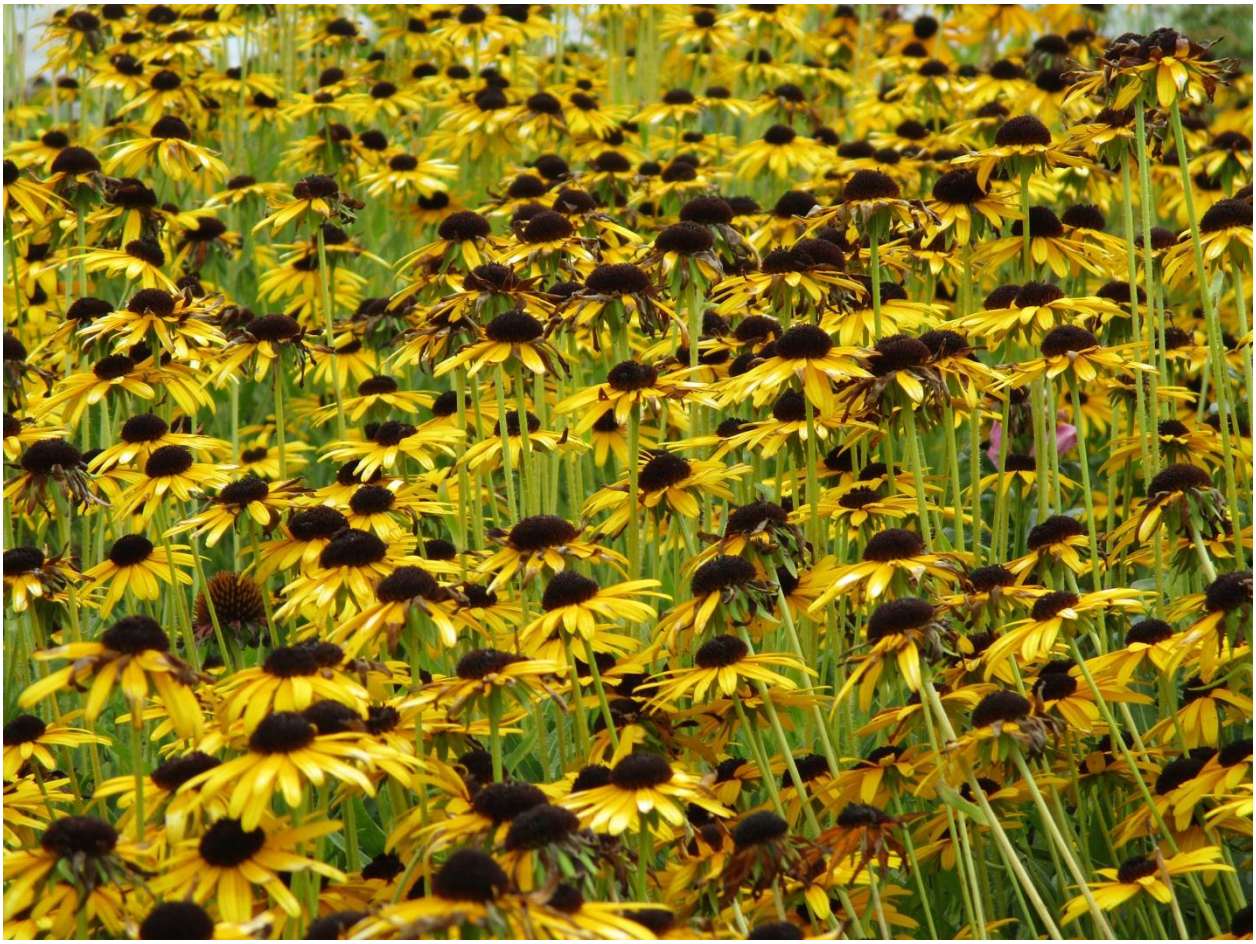

Photograph by Ezme Kozuszek

"Blessed are the hearts that can bend;
they shall never be broken."

—Saint Francis de Sales

The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and Transforming Services for Survivors of Violent Crime. Edited by Stacey Wiggall, LCSW & Alicia Boccellari, Ph.D. Produced in collaboration with Allen/Loeb Associates
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The clients of Trauma Recovery Center Services are survivors of interpersonal violence, including sexual assault, domestic violence, physical assault, gunshots, stabbings, vehicular assault, gang violence, human trafficking, and hate crimes. In addition, TRC serves family members of homicide victims. Unlike programs that were developed to provide services for a specific type of violence, the TRC model seeks to provide compassionate, effective treatment to any survivors who have recently experienced interpersonal violence. This is based on recognition that: 1) Most evidence-based treatments for trauma-related mental health sequelae are symptom-based, not based on a type of crime; and 2) Many survivors of crime have experienced a lifetime of polyvictimization that defies categorization. For example, even though a client may have been referred for a recent physical assault, he or she may have experienced other types of violent incidents such as domestic violence, childhood abuse, and losing loved ones to homicide, and the long-term effects of this polyvictimization need to be taken into account as treatment is planned and delivered.

ENTRY CRITERIA. Each agency's specific program entry criteria will implement the TRC Core Elements according to their circumstances, such as service capacity, geographic region, etc. Services are typically limited to those individuals experiencing post-traumatic distress who are not receiving other mental health care in order to avoid duplication of services.

PSYCHOSOCIAL FACTORS. The same circumstances that put people at higher risk of experiencing violent crime can also be obstacles to recovery. These include being homeless or marginally housed, living in poverty, and living in communities with high rates of violent crime. People of color are also over-represented in the TRC client population, due to current and historical inequities that prevent access to resources such as safer neighborhoods, quality education, better-paying jobs, and a strong political voice. While being a survivor of a violent crime is extremely disruptive to anyone, regardless of their demographics or income level, it can be easier to cope if one has a broad, high-functioning social support system, access to high-quality medical care, and financial reserves. Most, though not all, people who require TRC services have very few such resources to help them cope with the physical and psychological consequences of trauma.

CO-OCCURRING PROBLEMS. Many TRC clients have co-occurring psychiatric disorders, substance use issues and medical problems, which are discussed below. These are understood as both a potential correlation and a consequence of trauma, sometimes lifelong or even intergenerational. **Co-occurring substance use, or psychiatric disorders that do not prevent participation in treatment, should not be exclusionary criteria for TRC services.**

PSYCHOLOGICAL PROBLEMS. A person who experiences severe interpersonal violence usually has to cope with correlated psychological problems. Many clients experience symptoms of posttraumatic stress disorder (PTSD), such as flashbacks of the traumatic event, nightmares, insomnia, intrusive memories of the trauma, feelings of depression, anger and fearfulness. Survivors may isolate themselves. They can develop avoidance-related fears, such as being afraid to leave their homes to venture out into public. They may have difficulty concentrating, have trouble making decisions, and become suicidal. Increased abuse of both legal and illegal substances often follows trauma as clients seek to medicate themselves for anxiety and sleep disturbance. In addition, some TRC clients have a long history of psychological problems such as major depression, bipolar disorder, or schizophrenia, as these conditions put people at greater risk of being victimized. After trauma, people's psychological problems often intensify. TRC helps reverse this downward spiral by treating both the trauma and the pre-existing psychological problems at the same time.

SUBSTANCE USE PROBLEMS. The circular link between trauma and substance abuse has been well documented. Many clients have pre-existing and co-occurring substance use problems that put them at risk for being victimized, and also function to self-medicate trauma-related symptoms. Some clients who did not have substance problems before may turn to alcohol and other drugs to medicate themselves for trauma-related symptoms. For example, it is common for people who drink alcohol to increase their drinking post-trauma in order to numb their anxiety. Pain medications prescribed as a result of clients' physical injuries offer another pathway to substance abuse. TRC accepts that many traumatized people will need help related to their substance use in order to benefit from psychotherapy and other services, which is why substance abuse interventions such as Motivational Interviewing (Miller & Rollnick, 2012) and a harm reduction philosophy (Marlatt, Larimer, & Witkiewitz, 2011), are integrated within the model.

MEDICAL PROBLEMS. While specific physical issues vary according to the type of injuries a client sustained, some clients have serious medical problems and need ongoing medical care. Many TRC clients face barriers to accessing ongoing medical care after being discharged from the hospital, both because of practical problems and psychological symptoms. Clients may need case management to help them arrange transportation and child care so they can attend follow-up appointments. If clients are afraid to leave their homes—a fear which may be a reaction to trauma, and/or may be well-justified—they need help addressing this problem in order to access medical care.

Case Examples

Below are three examples of TRC clients. They provide an overview of the services clients received, and describe how the TRC Clinician provided an integrated approach, using case management and psychotherapy to help clients move towards post-traumatic growth. Treatment is trauma-informed and culturally relevant, with use of evidence-based, trauma-specific interventions as indicated.

Example 1. Homicide of a family member

Vanessa is a 51-year-old Samoan American woman. Her 26-year-old daughter, her 20-year-old son and her 2-year-old grandson were all shot during a drive-by shooting. Her daughter died and her son and grandson were left with serious injuries. Vanessa was left raising her daughter's four children as well as her own three children. Vanessa was forced to quit her jobs as a sales clerk and a part-time taxi driver in order to take care of this expanded family.

At entry to TRC, Vanessa was completely overwhelmed by the sudden and violent loss of her daughter, and having to quit her jobs to manage and care for seven children. She was suffering from acute stress disorder, bereavement, and depression, and was having daily debilitating panic attacks which affected her ability to drive. She began having sleep difficulties, and was fearful of allowing the children outside due to her concern that they were in danger as well. She was preoccupied by painful images of her daughter's death.

How TRC helped

Priorities for Vanessa's treatment included reducing her debilitating symptoms, helping her learn coping skills to manage the panic and depressive symptoms, and medication management. The Clinician incorporated Cognitive Behavioral Therapy (CBT) strategies to address both panic and depression; after Vanessa's sleep problems were improved by medication, she had an easier time carrying out her regular life activities and participating in TRC treatment. The TRC Clinician helped her apply for State of California Victim Compensation Board (VCB) benefits. The TRC Clinician also assisted her in applying for Section 8 Housing so she could move into a house that would accommodate the newly expanded family. Most importantly, from the initial point of engagement throughout the provision of services, the TRC Clinician used a strengths-based approach to highlight examples of Vanessa's capacity for resilience, which included being a dedicated and loving mother and grandmother.

Vanessa's daughter had been driving her mother's car the day of the homicide and her vehicle was impounded by the police as evidence. Rather than relying exclusively on government entitlements, the TRC Clinician leveraged community support and received a donation of a SUV for this family. This donation allowed her to take all of the children to their various schools, therapy and medical appointments and the multitude of agencies she had to deal with. Additional private fund-raising efforts by the TRC Clinician led to the donation of new clothing for the children and a carload of toys for Christmas.

Another priority was assisting Vanessa to gain legal custody of all the children, and supporting her as she worked closely with the Police Department around her daughter's homicide.

Vanessa was heartbroken by her daughter's murder, but needed to "stay strong" for the children, so therapy was one of the only places she could fully grieve and talk about her sadness, anger, and despair. The TRC Clinician helped her to reconnect to her church, and to some childcare support and assistance with meals. The Clinician also eventually helped her move to a new, safer community where the family is now residing. There, the children can safely walk to school, and they have a yard and friends in the neighborhood. After one year of treatment, Vanessa returned to work as a sales clerk.

Under the usual system of care, Vanessa would have needed to wait to receive services until her Victim's Compensation Board (VCB) application was approved. VCB benefits would not have included case management services or coordination of care across multiple agencies, practical services so vital in helping this family heal. The TRC model's combination of assertive outreach, trauma-focused psychotherapy, and case management to bring about close coordination amongst medical, law enforcement and social service agencies was essential for Vanessa's recovery.

Example 2. Domestic violence

Sylvia, a 48-year-old, Mexican, monolingual Spanish-speaking woman, was referred by the inpatient medical staff at the hospital following a domestic violence-related incident. TRC staff began the engagement process with Sylvia bedside at the hospital, where she remained for several days due to the severity of her injuries. Her husband, from whom she was separated, had broken into her home in the middle of the night and chased her with an axe, threatening to murder her in front of their children, an adolescent and young adult. In order to escape from him, Sylvia jumped from a second-story window. The hospital treated her for a severe concussion, broken ribs, internal injuries, and a broken arm sustained in the referring trauma. Sylvia suffered from post-trauma anxiety symptoms that included intrusive memories, insomnia, and intense fear for her personal

safety and the safety of her children. She also experienced major depressive symptoms because her spouse, for whom she still cared, had attempted to end her life. In addition, Sylvia felt overwhelmed by the emotional responses of her children, including their own post-trauma symptoms, and their anger at her for allowing their father, a chronically violent man, to remain in their lives for as long as he had.

How TRC helped

Sylvia was matched with a Spanish-speaking TRC Clinician who oriented her to TRC services, provided normalization of her symptoms in the context of the extreme violence she had experienced, and helped her overcome language barriers by providing assistance accessing other resources as needed. The Clinician incorporated Cognitive Behavioral interventions to help Sylvia reduce her anxiety and depression, and connected her with a TRC Psychiatrist for medications to help with debilitating insomnia and other symptoms. The Clinician also supported Sylvia in her physical recovery by accompanying her to follow-up medical appointments until she no longer felt that she needed the Clinician present in order to participate. Although Sylvia's husband was incarcerated pending the trial, the Clinician assisted her in obtaining a domestic violence restraining order in case of his release. Because Sylvia was attending sessions regularly, benefitting from services, and had the significant, ongoing trauma-specific stressor of a lengthy legal process, her treatment was extended to 32 sessions. The TRC Clinician was then able to support her throughout the criminal prosecution, accompanying her to meetings with the District Attorney and to court, and sitting with her on the stand during her difficult testimony. Because Sylvia was undocumented, her Clinician also linked her with legal support for the U-Visa process and provided supporting documentation. In addition, the Clinician supported Sylvia in processing her complex feelings about her abusive partner, and what it meant to her to separate from him.

When Sylvia felt ready to participate in group treatment, the Clinician referred to her to a Spanish–language domestic violence peer support group facilitated by a TRC community partner, a local domestic violence agency. The group helped to break down the isolation that Sylvia had been experiencing and reduce her feelings of shame about her complex feelings regarding her abusive partner. The TRC Clinician also linked Sylvia's young adult child with his own TRC Clinician, and linked the adolescent with other age-appropriate services.

By the 40th session, the majority of her debilitating symptoms were significantly decreased or eliminated altogether, so that Sylvia was able to return to work, to all of her parenting duties, and to feeling a sense of hope about her ability to have a happy future, and she attributes these successes to the services she received at TRC.

Example 3. Sexual and physical assault, substance abuse

Linda was referred to the TRC after receiving treatment in the Emergency Department following a sexual assault. She was a 47-year-old African American woman with four adult children, as well as two infant grandchildren whom she often cared for. She was receiving General Assistance and food stamps. Linda reported an extensive trauma history—including being physically and sexually abused as a child, witnessing domestic violence between her parents, and experiencing two prior sexual assaults. She also reported a history of dependence on crack cocaine and had last used this drug for a 7-day period following the recent assault. Linda said that she began to use multiple substances in high school—including alcohol, marijuana, and cocaine—in an attempt to cope with feelings related to the abuse she experienced as a child. At the time of her intake, Linda was suffering from significant post trauma anxiety and depressive symptoms—including passive thoughts of suicide—and met criteria for Post-Traumatic Stress Disorder, Major Depressive Disorder, and Cocaine Use Disorder. Linda initially expressed some ambivalence about entering treatment. She told the TRC Clinician that she had been referred for services elsewhere after one of her previous sexual assaults, but had not followed through at that time because she felt unworthy of help, and that in any case no one would believe that she had been raped.

Despite not engaging in services in the past, Linda seemed to really want to engage in treatment and said, "I'm here to see what services you have because I want to heal," and "I want to know why this keeps happening to me." Linda seemed to be at a stage of readiness where she was considering how her trauma and substance abuse history were connected and had some motivation to learn new ways to cope. Among the strengths she had at that time were a strong family support system and a desire to get better so that she could continue to be a part of the lives of her grandchildren.

How TRC helped

At her first individual therapy appointment, Linda described a recent physical assault by a former partner, which led her to relapse on crack cocaine again in an attempt "to numb me when I can't cope." She also expressed continued suicidal ideation, without a specific plan or intent. Linda only attended four appointments in the first three months of services, so engagement and tracking played a huge role in her initial treatment. Over the course of that time period, her Clinician conducted outreach with Linda including phone calls, letters, and home visits. At one point, Linda called in crisis with a plan for self-harm. During this encounter she abruptly hung up the phone, and San Francisco's mobile crisis team was sent to check in with her.

Linda continued to have difficulty engaging in services over the next two months. When she did have contact with the TRC Clinician, much of what they focused on was related to safety planning and coping. The Clinician began to talk to Linda about the possibility of taking medication to help alleviate some of her symptoms, but at that time she felt that doing so would mean that she was "crazy."

After four months of outreach, Linda began to benefit from the Clinician's Motivational Interviewing interventions and nonjudgmental, harm reduction approach. Consistent with Stage One: Safety and Stabilization (see Psychotherapy chapter), she and her Clinician then jointly identified treatment goals of: (1) Decreasing PTSD and depressive symptoms, (2) finding new ways to deal with emotional pain rather than using substances, and (3) increasing her involvement with safe people and activities, such as her church community. After they identified her goals, her attendance increased and during month four of treatment, the TRC Clinician saw her every week.

Linda's case is also an example of the rationale for extending a case beyond 16 sessions. Because of Linda's extensive trauma history and substance use, it took time and assertive outreach for her to build trust with the Clinician and fully engage in TRC services. Although it was clear that Linda could eventually benefit from referral to longer-term mental health services, the rapport she had built with the TRC Clinician was critical to her ability to participate in treatment, and a transfer of care would have disrupted that. Also, Linda needed trauma-specific services to get immediate help with reducing and managing the symptoms that interfered with so much of her life and relationships.

By month six of treatment, Linda agreed to meet with the psychiatrist and began taking an antidepressant to target her PTSD and depressive symptoms. These symptoms then began to diminish and she was no longer experiencing suicidal ideation. The TRC Clinician also used Motivational Interviewing techniques to help Linda look at how her drug use contributed to suicidal ideation and other problems. By this time, she had cut back her crack cocaine use significantly and then used for the last time.

By month seven of treatment, Linda met with a primary care doctor, and was diagnosed with ovarian cancer. After receiving this diagnosis, a significant shift in her suicidal ideation occurred and she stated, "God, please heal me and my addiction. I'm not ready to die." She also began attending the TRC Seeking Safety group.

Treatment over the next several months revolved around safety, stabilization, coping with her cancer diagnosis, preparing for her upcoming sexual assault court hearing, and tolerating negative emotions. Linda continued to express occasional suicidal ideation over this time period but was committed to utilizing her safety plan when necessary. By

month nine of treatment, Linda's sense of self-worth was growing and she stated, "I'm beginning to see a change in myself. I'm beginning to like myself and am becoming more accepting of my family and me. Before I was keeping clean for my grandchildren… Now it's for me. I want to see how much I can grow."

After Linda's cancer surgery and court date, the TRC Clinician worked with her to focus on stabilizing her life in other ways, including finding ways to pay overdue bills, dealing with issues related to her landlord, and obtaining Supplemental Security Income. They also continued to work on strengthening her motivation to remain sober and reinforcing the other gains she'd made thus far. At the end of treatment, Linda stated that she felt "seventy-five percent better than when I started coming here. I think clearer, I love myself, and I have things I want to do in the future."

In Summary

The clients of TRC are a diverse group, but all share the experience of being victimized by crime, often repeatedly. TRC services integrate trauma-informed, evidence-based psychotherapy and clinical case management in order to simultaneously address the many levels at which people are impacted by trauma and violence.

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