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A Framework of Caring:

Person-Centered
Trauma-Informed
Recovery-Oriented

A Framework of Caring

Caring, which is sometimes confused with curing or fixing, is relational at its core. It is a way of *being* with someone as much as, if not more than, *doing* for someone.

Providing care, in the context of this guide, essentially is an offering of oneself to come respectfully and mindfully alongside someone experiencing homelessness. It is an act of invitation, not of imposition. Initially, the task of caring is to build trust and rapport. Listening to the person's story and concerns over time, a partnership forms to determine possible next steps. Caring also involves helping persons to enhance their readiness and confidence to address the needs they identify.

This section describes a framework of caring that emphasizes three key aspects of providing effective care for people experiencing homelessness: a person-centered, trauma-informed, and recovery-oriented approach. While these three perspectives overlap a great deal, the pages that follow explore them as separate approaches. We hope that this framework of caring will inform and infuse the work of all who provide services to people experiencing homelessness, no matter what your title or discipline.

Person-Centered *versus* Provider-Centered

Once a man strayed into a faraway land where he saw a number of people fleeing in terror from a field where they had been trying to harvest wheat. "There is a monster in that field," they told him. Upon close examination, the man saw that it was a watermelon.

The stranger offered to kill the monster for them. He walked into the field, cut the melon from its stalk, took a slice, and began to eat it. Now the people were more terrified of him than they had been of the melon. They drove him away with pitchforks crying, "He will kill us next, unless we get rid of him."

Years later a second man strayed into this same land and the same thing happened to him. But, instead of offering to help the people with the monster, he agreed with them that it must be dangerous, and by tiptoeing away from it with them he gained their confidence. He spent a long time with them in their houses until he could teach them, little by little, the basic facts that would enable them not only to lose their fear of melons, but even to cultivate them.

A Chinese Folk Tale

Person-Centered Care

Person-centered care represents a major shift away from traditional paternalistic models in which the care provider "knows best."

What is person-centered care? What does it look and feel like? When you eat at a restaurant, check into a hotel, or get a haircut, how do you know if you receive person-centered care? When others seek services from you, what lets them know you have a person-centered focus? Often described as "meeting people where they're at" or "starting where the client is," this approach, also known as patient-centered or client-centered, is fundamentally important in reaching out to people who may be reluctant to engage in care.

Person-centered care represents a major shift away from traditional paternalistic models in which the care provider "knows best." It does not make assumptions about who people are, what they need or should value, or what motivates them.

Person-centered care is collaborative. It begins with the recognition that the individual already possesses certain strengths, knowledge, skills, hopes, and inner resources. The provider seeks to understand and build upon these attributes.

A person-centered approach is relational *and* goal-oriented. Relationally, the characteristics of the provider's style and attitude are openness, genuine respect, and interest in the well-being of the other. People are more likely to change in the context of a safe, trustworthy relationship in which they can consider their situation and explore possible change steps. Hence, the provider's role is to draw out people, examine options and resources with them, ask what might get in the way of taking a particular action, help to explore ambivalence, provide useful information and assistance, and support them along the way.

People are most likely to make positive change decisions, heed advice, and adhere to recommendations when they receive respectful treatment and have options from which to choose. We cannot underestimate the importance of choice. The provider's role is primarily to serve as a consultant, resource person, and facilitator. There is a fundamental recognition that individuals rightfully have the authority and responsibility to make decisions about their own lives, unless there is severe impairment of capacities.

Person-Centered Approach

Genuine, accepting, empathic

Sensitive to individual's worldview

Individualized, holistic

Emphasizes full participation by the individual

Draws on consumer's strengths and inner resources

Emphasizes partnership between individual and provider of care

Individual receiving care determines focus and pace

Promotes consumer choice and self-determination

Person defines outcomes based on own strengths and available supports

Goal-oriented

Decision-making control belongs to the individual

Interventions are consistent with the person's readiness to change

Care is culturally competent

Trauma-Informed Care

Under Construction

I used to have no trespassing signs all over my body
Some people don't know the meaning of boundaries
One day they came [and] busted down my door
They came in violating code
They tore up my floors and gutted my soul
They put a jackhammer through my walls
And a sledgehammer to my head
I have enough yellow police tape to hang myself

Heidi H.

There is almost nothing about homelessness that is not traumatic—the lack of safety, extreme poverty, uncertainties of meeting basic needs, exposure to the elements, lack of access to services, and the loss of meaning and hope. For many people, serious medical conditions, mental health problems, addictions, and/or childhood histories of abuse and neglect from which they suffer compound the trauma of homelessness.

Constant exposure to multiple causes of traumatic stress—poverty, illness, violence, and disenfranchisement—has a profound, potentially damaging effect on all aspects of one's being, yet recovery remains possible due to the remarkable resiliency of the human spirit.

Trauma-informed care is an integral aspect of person-centered care. Care providers who have a trauma-informed perspective are likely to be more effective in their ability to listen with compassion and understanding, and to be bearers of hope as they help others move in the direction of recovery and healing.

Trauma-informed care providers seek to understand the causes and impact of trauma. They are able to "look beneath the surface" of a person's life to try to understand why someone may be reluctant to allow touch, finds it difficult to trust, is fearful or angry, detaches emotionally, has unstable relationships, carries unwarranted shame, or has other affects of the occurrence of traumas. Moreover, trauma-informed providers of care also possess the knowledge, skills, and hope of a recovery-orientation.

This guide seeks to encourage all providers, no matter what their role or discipline, to adopt a "universal precautions" approach to trauma. That is to say, it is an expectation that trauma plays a prominent role in the lives of people experiencing homelessness. Therefore, it is incumbent upon workers to prepare themselves well in this regard. A primer on trauma follows that briefly describes

what trauma is, how it affects people, the need for a trauma-informed approach, and what care providers can do.

Trauma 101

The unexpected loss of a loved one, a car accident, or exposure to a violent experience is familiar to many of us. Everyone reacts to such events, but the responses vary widely, ranging from numbness and withdrawal to crying, nervousness, and agitation.

There is no "right" way to respond to or recover from a traumatic event. Over time, some people are able to integrate these experiences and begin to heal. For others, this process is considerably more difficult. Some responses to trauma are intense and prolonged, and interfere with a person's ability to function.

Because traumatic events are prevalent, cause profound suffering, and may lead to life-altering responses, it is imperative that caregivers have the knowledge and understanding to respond skillfully and compassionately to people exposed to traumatic stress.

What is trauma?

Trauma involves some sort of **overwhelming experience** that goes beyond usual day-to-day stressors.

It typically **involves some sort of threat** either to oneself or to a loved one. This threat can be physical or emotional.

The experience overwhelms our usual systems of coping and results in a profound **sense of vulnerability and a loss of control.**

This experience leaves people **feeling helpless and fearful**, and over time, may **adversely affect their relationships and ways of thinking about the world.**

Traumatic experiences occur in **many forms**, including:

- Unexpected loss of a loved one
- Loss of job or home
- Accidents
- Community or school violence
- Domestic violence
- Neglect
- Physical and sexual abuse
- Man-made and natural disasters
- War and acts of terrorism

It is important to remember that while there are some life events that most people would describe as "traumatic," what one person considers traumatic may not be traumatic for someone else. What may leave one person feeling helpless and out of control may not lead to those same feelings in another person.

Trauma generally falls into two categories:

- ***Single incident traumas (or acute traumas)*** occur as a one-time event such as an earthquake, bombing, assault, or car accident.
- ***Multiple traumas*** refer to the layers of ongoing trauma that people sometimes experience over their lifetime. Multiple traumatic experiences can occur because of a single event such as a natural disaster that leads to loss of loved ones, loss of home, or separation from family, or from a lifetime of traumatic experiences that may include childhood abuse and adult experiences of domestic violence.

The body's response to trauma

Our brains have a built in alarm system designed to detect potential danger and help us to respond quickly and effectively to a threatening situation. In general terms, here is what happens when our brains and bodies face threatening or dangerous situations.

How the alarm system works

To understand how the brain responds to stress, we will talk about the **doing** and **thinking** parts of the brain. The doing part of our brain acts like a smoke detector. Its purpose is to detect anything that might potentially be dangerous (e.g., hearing a sudden, loud noise). The purpose of the thinking part of the brain is to check things out when the doing brain sounds the alarm, to see if there is actual danger.

Information comes into the brain through the senses (sight, touch, sound, smell, and hearing). At the same time that the doing brain takes in the information it also goes to the thinking brain. It is the **thinking** brain's job to evaluate the situation and decide whether the danger is real (e.g., whether the loud noise is just a door blowing closed in the wind or if that noise signals a danger that you have to escape from). If the thinking brain determines that there is no actual threat, it sends this message to the doing brain to shut the alarm off so that you can return to your prior activity.

If the thinking brain decides that there is real danger, it sends this message to the doing brain, and the doing brain takes action. When this happens, the thinking brain gets shut off because it is no longer necessary and the doing brain starts the release of chemicals that prepare you to respond to keep yourself safe.

When our brains perceive danger, we are likely to react in one of three ways:

- Fight
- Flight
- Freeze

Everyone has intense physical and emotional responses to threatening or dangerous experiences. We all feel the rush of adrenalin as our brains release those chemicals and we choose to fight, flee, or freeze. The more intense the situation, the longer it may take those chemicals to come back into balance and for us to feel "normal" again.

An experience becomes "traumatic" when it overwhelms this physiological system of coping. In the face of trauma, we fight, flee, or freeze, and yet, we do not achieve the desired result. The intensity of a person's emotional response to a threatening event will depend on how overwhelming or "traumatic" the individual perceives the event to be.

Events perceived to be particularly threatening may lead to a longer time for the body to return to normal after facing the threat or danger. In such cases, the release of chemicals and the body's attempts to fight, flee, or freeze may continue once the threat subsides. Some people may perceive an experience as so "traumatic" that their bodies continue to respond in ways that have an impact on daily functioning, and additional help and support may be necessary in order to recover and regain control. Many factors influence a person's ability to recover from trauma without developing significant difficulties. We will discuss these factors later in this section.

The intent of the design of the brain is to keep us as safe as possible. The brain is always finding new ways to adapt and change in order to protect us best from danger. Therefore, when we experience traumatic events, our brains remember many aspects of these events (e.g., sights, sounds, and feelings) so that if we face similar experiences, our bodies can respond very quickly, going into automatic fight, flight, or freeze mode without having to use the thinking brain to check things out.

After experiencing a traumatic event, people may hear, smell, taste, see, or feel something that reminds them of a past traumatic experience. These reminders are "triggers." When a person faces a trigger, the brain automatically assumes there is danger, because the brain associates these signals with being in danger previously. The thinking part of the brain automatically shuts off and the doing part of the brain takes over and prepares the body to respond.

Chronic exposure to trauma actually changes the way the brain functions. If the world we live in is consistently dangerous, the brain decides that it can more efficiently protect us by assuming that everything is dangerous. In other words, rather than the thinking brain checking things out when the alarm goes off, as we talked about earlier, the doing brain always assumes that the body is in danger and responds accordingly. Because the thinking part of the brain shuts off automatically at the first sign of danger, people lose their ability to assess accurately whether the present danger is real. The alarm system becomes faulty because people lose their ability to tell whether a danger is presently real or is just a reminder from the past. A "false alarm" happens when people's bodies respond as if they are in danger, even when they are not.

People with experiences of chronic trauma have significant lists of triggers, making the whole world a dangerous and scary place for them. Because chronic trauma survivors learned to pay close attention to signals for danger, these triggers are often subtle and can be difficult to detect. Ordinary things become triggers, which can lead to intense fight, flight, or freeze responses that may appear confusing and out of place to others (intense responses to smells, colors, sounds, etc.).

Effects of trauma

Traumatic experiences are often shattering and life-altering for children and adults. These experiences may affect all levels of functioning and result in an array of distressing responses:

- ***Physical***. Increase in physical complaints such as headaches, stomach aches, nausea, nervousness, fatigue, palpitations, pain, difficulty sleeping, nightmares, and worsening of existing medical problems. Longer-term physical issues such as ulcers, asthma, heart disease.

- ***Emotional***. Fear, anxiety, panic, irritability, anger, withdrawal, numbness, depression, confusion, hopelessness, helplessness. Difficulty managing, understanding, and regulating feelings.

- ***Cognitive***. Difficulty focusing, concentrating, thinking, planning, problem-solving. In the face of chronic threat, people focus on survival, which can lead to problems concentrating, difficulty learning, and struggles at school or work.

- ***Relational***. Difficulty maintaining relationships, trusting others, maintaining a sense of self in relationship to others. Perceive the world and others as unsafe. Includes emotional barriers between parents and children, distrust and feelings of betrayal and relationship difficulties (i.e., attachment problems) between parents and children.

Nearly all trauma survivors have acute symptoms following a traumatic event, but these generally decrease over time. Various factors influence the recovery process:

- ***Previous exposure to trauma***. This exposure may include neglect, physical abuse, sexual abuse, or abrupt separation from a caregiver or partner.

- ***Duration of exposure to trauma.*** A one-time exposure, such as a car accident, results in very different responses than exposure over several years, such as domestic violence. The longer the exposure, the more complex the healing process.

- ***Severity of exposure***. An incident that happens directly to someone or in a person's presence will have a different impact than an incident that happened to someone else or that a person learned about later. The more severe the exposure, the more difficult it will be to heal.

- ***Prior emotional and behavioral problems.*** Pre-existing behavioral problems or a prior history of depression or anxiety may complicate a person's response to a traumatic event.

- ***Strengths/coping skills***. The more strengths people identify and the more coping skills they master and are able to use consistently in the face of distress, the greater the likelihood that they will be able to recover from a traumatic event without experiencing long-term difficulties.

- ***Stage of development***. Where we are in our development when we experience trauma can have a significant impact on how we respond and how severe an impact a traumatic experience may have. Adults experiencing trauma throughout their lifespan, beginning in childhood, may not have the opportunity to master certain skills in childhood and adolescence. These adults may struggle to hold jobs, raise children, and manage day-to-day stressors.

- ***Cultural background.*** While the brain's response to trauma is consistent for all trauma survivors, cultural context plays a significant role in the types of trauma experienced, the risk for continued trauma, how survivors manage, express, and make meaning of their experiences, and which supports and interventions are most effective. Violence and trauma have different meanings across cultures, and healing can only take place within one's cultural and "meaning-making" context.

- ***Nature of relationships and social supports.*** The quality of our early relationships with caregivers influences our ability to form relationships in adulthood. Early trauma can make forming adult relationships difficult. It decreases our ability to trust, seek out safe supports, etc. As a result, we are likely to have decreased social support and therefore, the impact of another trauma on our lives can be more disabling.

- ***Care provider's response after the exposure***. It matters whether a care provider validates someone's experience or blames the person, or if the worker is able to provide comfort and reassurance instead of having difficulty responding to the person. When a provider of care experiences a high level of distress, the other person often responds similarly. The care provider's support is one of the most important factors in someone's recovery from trauma.

The need for trauma-informed services

The effects of repeated exposure to traumatic experiences can be long-term and pervasive. The impacts can involve all areas of a person's life, including biological, cognitive, and emotional functioning, social interactions and relationships, and identity formation. Simply stated, people who experience multiple traumas tend to relate differently to the world than those without significant trauma histories.

Many people endured multiple traumas prior to being homeless and because of becoming homeless. These experiences significantly affect their understanding and perception of themselves, their environment, and the people around them. Consequently, these individuals require specific types of services that are sensitive to their status as trauma survivors. In addition, individuals need to have access to therapeutic relationships and experiences to promote trust, coping, and healing.

What services providers can do

- Adopt a "trauma-informed" approach to service provision and care. This approach means viewing the lives of people through a "trauma lens" that provides a way to understand their behaviors, responses, attitudes, and emotions as a collection of survival skills developed in response to traumatic experiences. Otherwise, the impact of trauma gets lost amid other mental health, substance use, health, employment, and housing issues in people's lives.

- Within shelters, all aspects of programming require examination to ensure sensitivity to the needs of traumatized individuals including atmosphere and environment; policies and procedures; assessment and service planning; and staff development and training.

- Involve consumers who are survivors in the development and implementation of programs and services.

- Shelters and service delivery sites should be trauma-informed spaces for individuals. Such spaces meet basic needs and create a safe environment in which routines and responses are consistent and predictable. Along with creation of a safe service setting is the need to create an emotional environment that enhances the consumer's sense of safety. This environment includes a demonstrated tolerance for the consumer to express a range of emotions. Tolerance for emotional expression enhances the survivor's internal sense of security and ability to regain self-control.

- Regardless of the response that a trauma survivor exhibits under stress, the provider must understand the individual's reactions in order to provide support. Providers working with trauma survivors should have an understanding of how traumatic experiences affect the brain and the body, and how trauma survivors exhibit different reactions in the present due to their experiences in the past.

- Providers need to be able to recognize how extreme responses of dissociation or overreaction are in fact adaptations helpful to trauma survivors while managing their traumatic experiences, but may be ineffective and unhealthy in the present. This recognition requires ongoing training and trauma education for providers that allows them to identify someone's experience and why the person may respond in particular ways.

- When providers understand trauma responses, they can help survivors better understand their experiences, provide opportunities for them to practice regaining self-control, and utilize techniques to de-escalate difficult situations. Important components of support for trauma survivors involve helping them:

    - identify specific triggers
    - understand how their brains and bodies respond
    - ground themselves in the reality of the present situation
    - develop self-soothing techniques and coping skills to manage feelings associated with past traumatic experiences

- By keeping in mind the potential triggers for trauma survivors, providers can examine their agencies and programs to identify and eliminate daily practices, policies, or ways of responding to people that might result in loss of control or power and feeling re-traumatized.

Points to remember

- All people respond to traumatic events
- Responses range from numbness and withdrawal to crying, nervousness, and agitation
- There is no "right" way to react to or recover from a traumatic event
- Over time and with support, most people heal

Adapted from: Bassuk, E., Konnath, K., & Volk, K. T. (2006). *Understanding traumatic stress in children.* Newton, MA: The National Center on Family Homelessness. Retrieved from http://www.familyhomelessness.org/media/91.pdf

Assumptions of a Trauma-Based Approach

Healing is strength-based and individualized

The energy for healing lies with the person engaged in the recovery (discovery) process

Healing starts with the individual, no matter how "vulnerable," "symptomatic," or "hopeless" the person's situation may seem to others

Give as much control over the process as possible to provide the best support to hurt and betrayed people

Practices of force are detrimental to healing

Understanding context (culture, race, language) is essential to healing

Relationship building and decreasing power imbalances are important for healing

People do the best they can at any given time to cope with the impact of trauma

Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). *A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Traumatic Stress Network, and the W. K. Kellogg Foundation. Available from www.homeless.samhsa.gov

Recovery-Oriented Care

Recovery is a personal choice. It is often very difficult for health care providers who are trying to promote a person's recovery when they find resistance and apathy. Severity of symptoms, motivation, personality type, accessibility of information, perceived benefits of maintaining the status quo rather than creating life change (sometimes to maintain disability benefits), along with the quantity and quality of personal and professional support, can affect a person's ability to work toward recovery. Some people choose to work at it very intensively, especially when they first become aware of these new options and perspectives. Others approach it much more slowly. It is not up to the provider to determine when a person is making progress—it is up to the person.

Mead, S. & Copeland, M. E. (2000). *What recovery means to us.* New York: Plenum Publishers.

Although it is encouraging that Western medicine is beginning to acknowledge the central role of a positive belief in recovery in the area of physical illness, it is disturbing that psychiatry does not see the wisdom of such an attitude for mental illness.

Daniel B. Fisher, M.D., Ph.D.

The term *recovery* has different meanings depending on the context. For example, in **medicine,** recovery commonly refers to the process of healing and recuperation from illness or a medical procedure. It can also refer to the stabilization of symptoms related to a chronic condition. Patients sometimes achieve full or partial recovery from certain conditions.

In the **addictions field**, recovery most often refers to the process of gaining and maintaining abstinence from using substances. People with substance use disorders who are abstinent are "in recovery," commonly viewed as a life-long process.

For persons diagnosed with a **major mental illness**, recovery is commonly restoration to some optimal level of functioning within the limitations of one's impairment or disability, whereas others talk about achieving full recovery from even the most serious mental disorders such as schizophrenia, bipolar disorder, and schizoaffective disorder.

For people impacted by **trauma,** recovery is generally the process of regaining the sense of safety, control, connection, and meaning disrupted because of the trauma.

Recovery from **homelessness** is commonly the process of maintaining stable housing and restoring one's sense of purpose and a meaningful place in the community.

What these various perspectives have in common is that recovery is a process, and in many cases a long-term process, though not necessarily life-long; that hope and a belief in recovery is critical; and that recovery is consumer-driven, not something imposed.

A very high percentage of people we encounter confront many, if not all, of these issues—homelessness, physical illness, trauma, mental disorders, and addictions. Not surprisingly, a recovery orientation on these various fronts presents daunting challenges. Nonetheless, people can and do experience recovery, thanks to their own determined efforts and the supportive care provided by other people in their lives, clinicians and non-clinicians alike.

This guide seeks to emphasize the importance of a recovery-orientation in all aspects of one's work. A recovery perspective is hopeful. It sees possibilities. Buckminster Fuller once said, "There is nothing about a caterpillar that tells you it's going to be a butterfly." It is challenging sometimes to see the possibilities of healing and recovery for people we meet. Yet, we need to hold out this hope. It is common for people experiencing homelessness to forsake hope as a means of survival. Hence, it becomes the task of the provider to make hope available for others to borrow until they can reclaim it for themselves.

While common to the fields of medicine, addictions, and trauma in particular, the concept and language of recovery are relatively new to the mental health field. Their inclusion is largely due to the influence of the burgeoning mental health consumer movement. Consumers joined together to learn from one another and to advocate for a healthier mental health system that is strengths-based and promotes wellness. As a result, there is a significant shift toward a recovery-orientation. Notably, the President's New Freedom Commission on Mental Health report (2003) makes recovery a central tenet for the future direction of mental health care and services in the United States.

Although the mental health system (and the larger culture for that matter) has yet to embrace fully this shift in awareness and perspective, there is progress. In an article "What Recovery Means to Us," Shery Mead, M.S.W. and Mary Ellen Copeland, M.S., M.A. note this movement:

> Recovery has only recently become a word used in relation to the experience of psychiatric symptoms. Those of us who experience psychiatric symptoms are commonly told that these symptoms are incurable, that we will have to live with them for the rest of our lives, that the medications, if they (health care professionals) can find the right ones or the right combination, may help, and that we will always have to take the medications. Many of us have even been told that these symptoms will worsen as we get older. Nothing about recovery was ever mentioned. Nothing about hope. Nothing about anything we can do to help ourselves. Nothing about empowerment. Nothing about wellness….Now the times have changed. Those of us who have experienced these symptoms are sharing information and learning from each other that these symptoms do not have to mean that we must give up our dreams and our goals, and that they don't have to go on forever. We have learned that we are in charge of our own lives and can go forward and do whatever it is we want to do. People who have experienced even the most severe psychiatric symptoms are doctors of all kinds, lawyers, teachers, accountants, advocates, social workers. We are successfully establishing and maintaining intimate relationships. We are good parents. We have warm relationships with our partners, parents, siblings, friends, and colleagues. We are climbing mountains, planting gardens, painting pictures, writing books, making quilts, and creating positive change in the world. *And* it is only with this vision and belief for *all* people that we can bring hope for everyone. (2000)

Daniel Fisher, M.D., Ph.D., executive director of the National Empowerment Center, states in his article, "Healing and Recovery Are Real":

> We who have recovered from mental illness know from our personal experience that recovery is real. We know that recovery is more than remission with a brooding disease hidden in our hearts. We have experienced healing and we are whole where we were broken. Yet we are frequently confronted by unconvinced professionals who ask, "How can you

> have recovered from such a hopeless situation?" When we present them with our testimonies, they say that we are exceptions. They call us pseudo-consumers. They say that our experience does not relate to that of their seriously, biologically ill, inpatients. (Retrieved from www.power2u.org/articles/recovery/healing.html)

Dr. Fisher and many other consumers, and a growing number of health care professionals, counter the prevailing notion that people with mental illness cannot recover. Dr. Fisher describes below the characteristics of a person recovered from mental illness:

Seven Characteristics of a Person Who Has Recovered from Mental Illness

1. Makes their own decisions in collaboration with other supportive people outside the mental health system
2. Has a meaningful and fulfilling network of friends outside mental health professionals
3. Has achieved a major social role/identity other than consumer (such as student, parent, worker)
4. Medication is one tool among many freely chosen by the individual to assist in their day to day life (used as the chronically normal use medication)
5. Capable of expressing and understanding emotions to such a degree that the person can cope with severe emotional distress without it interrupting their social role and without them being labeled symptoms
6. A Global Assessment of Functioning Scale score of greater than 61: "functioning pretty well, some meaningful interpersonal relationships and 'most untrained people would not consider him sick'"
7. Sense of self is defined by oneself through life experience and interaction with peers

Fisher, D. (2010). *Healing and recovery are real.* Recovery Empowerment Center. Retrieved from www.power2u.org/articles/recovery/characteristics.html

The pages that follow present some guiding principles to foster a recovery-orientation, typical recovery strategies employed by consumers, and some questions for reflection for health care professionals. In addition, there are many ideas, tips, and recommendations throughout this guide that point the reader toward a recovery-orientation, including the preceding information in this section about person-centered and trauma-informed care. As we all seek to increase our understanding of what it means to be recovery-oriented, it is worth remembering that consumers are our best teachers.

Two particularly useful websites on mental health recovery include:

- Copeland Center for Wellness and Recovery www.copelandcenter.com/
- National Empowerment Center www.power2u.org

Guiding Principles to Foster Mental Health Recovery

- The consumer directs the recovery process; therefore, consumer input is essential throughout the process.

- The mental health system must be aware of its tendency to enable and encourage consumer dependency.

- Consumers are able to recover more quickly when providers:

    - encourage, enhance, and maintain hope
    - define life roles with respect to work and meaningful activities
    - consider spirituality
    - understand culture
    - identify educational needs as well as those of their family/significant others
    - identify socialization needs

- There is consideration and value of individual differences across their life span.

- Recovery from mental illness is most effective with consideration of a holistic approach.

- In order to reflect current "best practices," there is a need to merge all intervention models, including medical, psychological, social, and recovery.

- The clinician's initial emphasis on "hope" and the ability to develop trusting relationships influence the consumer's recovery.

- Clinicians operate from a strengths/assets model.

- Clinicians and consumers collaboratively develop a recovery management plan. This plan focuses on the interventions that will facilitate recovery and the resources that will support the recovery process.

- Family involvement may enhance the recovery process. The consumer defines his/her family unit.

- Mental health services are most effective when delivery is within the context of the consumer's community.

- Consumer-defined community involvement is important to the recovery process.

Adapted from: The recovery process model and emerging best practices. Ohio Department of Mental Health. Retrieved from http://www.mhrecovery.com/overview.htm

Commonly Used Recovery Skills and Strategies

Reaching out for support—connecting with a non-judgmental, non-critical person willing to avoid giving advice, who will listen while individuals figure out for themselves what to do

Being in a supportive environment—surrounded by people who are positive and affirming, but at the same time are direct and challenging

Peer counseling—sharing with another person who has experienced similar symptoms

Stress reduction and relaxation techniques—deep breathing, progressive relaxation, and visualization exercises

Exercise—anything from walking and climbing stairs to running, biking, swimming

Creative and fun activities—doing things that are personally enjoyable like reading, creative arts, crafts, listening to or making music, gardening, and woodworking

Journaling—writing in a journal anything you want, for as long as you want

Dietary changes—limiting or avoiding the use of foods like caffeine, sugar, sodium, and fat that worsen symptoms

Exposure to light—getting outdoor light for at least one-half hour per day, enhancing that with a light box when necessary

Learning and using systems for changing negative thoughts to positive ones—working on a structured system for making changes in thought processes

Increasing or decreasing environmental stimulation—responding to symptoms as they occur by either becoming more or less active

Daily planning—developing a generic plan for a day, to use when symptoms are more difficult to manage and making decisions is troublesome

Developing and using a symptom identification and response system that includes:

- A list of things to do every day to maintain wellness
- Identifying triggers that might cause or increase symptoms and a preventive action plan
- Identifying early warning signs of an increase in symptoms and a preventive action plan
- Identifying symptoms that indicate the situation has worsened and formulating an action plan to reverse this trend
- Crisis planning to maintain control even when the situation is out of control

Excerpted from: Mead, S. & Copeland, M. E. (2000). *What recovery means to us.* New York: Plenum Publishers.

Supporting the Recovery Process: Questions for Health Care Providers

- How much of my own discomfort am I willing to sit with while someone tries out new choices?
- How do I continuously redefine my boundaries as I seek to deepen each individual relationship?
- What are the assumptions I already hold about this person, by virtue of his/her diagnosis, history, lifestyle? How can I put aside my assumptions and predictions in order to be fully present to the situation and open to the possibility for the other person to do the same?
- What are the things that might get in the way of both of us stretching and growing?

Adapted from:
Mead, S. & Copeland, M. E. (2000). *What recovery means to us.* New York: Plenum Publishers.

Connecting with People in Distress

Because trauma very often happens in the context of relationships, it is within relationships that healing must necessarily commence.

Laura's Story

I became homeless again later in life after running away from an institution. There were nights when I withdrew as far as I could into my coat, as far as I could retreat behind my eyes without disappearing altogether. I rocked back and forth to block out the cold that clawed at my fingers and feet, and repeated a series of words or sounds that filled my head with a constant hum to keep me company, to remind me I was still alive.

I had been coerced into treatment by people who said they were trying to help. I had been held down and forcibly disrobed when I refused to give people my clothes in emergency rooms. These things all re-stimulated the feelings of futility, reawakening the sense of hopelessness, loss of control I experienced when being abused. Without exception, these episodes reinforced my sense of distrust in people and belief that "help" meant humiliation, loss of control and dignity.

The more distressed I became, the more loudly the voices raged in my head taking up all the space. I wore my shame in thick layers of clothing, covering my body and sense of rawness I couldn't leave behind. I sweat heavily, but it was better than being exposed, having people know that I had no skin to live in anymore. I was given medication to decrease what people called paranoia. But it slowed down my reactions and made it harder to be alert and to protect myself.

No one ever thought to ask if someone was really pursuing me. It was assumed that those feelings and responses were symptoms of some psychological condition unrelated to be being stalked. It took fourteen years before anyone thought to ask….

Dan's Story

During my residency, a gifted teacher would conduct an interview with a consumer who was in their own reality. At the end he would say, "You see there is no one home." When I tried to start a conversation with a consumer, another teacher said, "You can't talk to a disease."

I was too afraid of being discovered in those days, so I did not tell them that I knew that was not true. I wish I had told them that no matter how unusual a person's appearance, behavior, or thoughts, there is always a person at home.

We emphasize the importance of being person-centered, trauma-informed, and recovery-oriented throughout this guide. But what does that really mean? In this section, we provide a brief overview of how to connect with people in distress, regardless of the source. Further, we describe how the underlying assumptions and principles of being person-centered, trauma-informed, and recovery-oriented can converge to support opportunities for healing.

Perhaps the most significant impact of trauma is the disruption of "control, connection, and meaning." In an effort to reassert a sense of control and equilibrium, people may develop a number of adaptations erroneously called symptoms.

For instance, many people will stay up all night because the evening reminds them of times they were vulnerable to prior perpetration. Some continually pace in order to throw off nervous energy

and avoid being in any one place too long. Others create constant conversation in order to mitigate the loneliness or to respond to an inner dialogue others cannot hear.

Some people develop extreme startle responses and find themselves jumping at loud sounds, sudden moves, or persons coming up behind them. Others injure themselves or put themselves at risk to see if they can invoke feelings because they are no longer sure they are alive. Theses adaptations all reflect ways people attempt to find meaning and to reconnect.

To become trauma-sensitive means learning to understand the extensive impact of trauma in the lives of people experiencing homelessness and to respond in ways that support people in becoming the central directors of their lives and healing. In order to be successful in providing any kind of interventions and to avoid inadvertently re-traumatizing those we attempt to help, it is imperative to remember: trauma first, diagnosis second.

In general, approach each person at the level of one human being to another, with an emphasis on connecting with the individual as deeply as possible, regardless of the person's symptoms or diagnosis.

Workers are more likely to make this meaningful connection if they understand the ever-present role trauma plays in undermining the foundation of trust and shattering relationships in the lives of people who are homeless. Because trauma very often happens in the context of relationships, it is within relationships that healing must necessarily commence.

To understand what helps in connecting with people living on the streets and in shelters, it is useful to examine what constitutes homelessness and recovery from it. The concepts of home, and therefore recovery from homelessness, are multidimensional. The mere presence of a house does not constitute a home. To be "at home" means to be comfortable in connection with oneself, with a spirit (however one defines it), and with others. The expression "home is where the heart is" certainly carries a great deal of wisdom.

Many people who are homeless and diagnosed with mental illness spent time in jails, prisons, and psychiatric facilities. These institutions are the opposite of home. The buildings are usually isolated and segregated from communities. They are places where, all too often, people refer to them by their diagnosis in life and bury them with only a number in plowed-over fields after they are gone.

This condition stands in stark contrast to home, where we feel fundamentally understood, appreciated, protected, and known at the deepest, most complex levels.

Ideally, home is the crucible of our sense of self and place, imprinting our individuality on it through collected items that remind us of our history there—the nest that nurtures meaning and love. In this sense, an essential aspect of recovery from mental illness and trauma is the creation of a home in the community that is both a physical manifestation of space as well as an emotional/spiritual internal world where we feel safe, connected, and accepted.

People tend to turn inward and away from the world, seeking refuge in the inner asylum of their minds, when the external world becomes too frightening, chaotic, and unpredictable. The losses are not static but rather live in dynamic relationship to one another, becoming compounded and

cumulative over time. In other words, the strain of chronic dislocation can lead to physical illness, relationship loss, and exposure to physical and sexual assault, and vice versa.

Supporting recovery, therefore, is predicative on our ability to foster connection and environments that are safe, eliminating threats of force and coercion while increasing the level of control people have in determining the course of their own lives. The process of recovery is not likely to begin unless the external world or temporary connection in relationship is safe enough for people to take the risk to return from their inner refuge.

Significant loss transforms people, making it impossible to go back, to return to the previous state of being. Thus, recovery is not so much a going back as it is a non-linear process of uncovering who we are in the context of our lives after experiencing significant loss, and discovering who we can be in the future.

In this context, the first contact workers make is critical. It can be an opportunity to begin the process at that moment of the person coming home in the relationship. The worker can begin to create the sense of safety and warmth that provides a glimpse of what a home might feel like.

The assumptions and principles that follow are crucial for workers to embody in attempting to foster genuine relationships and healing.

Believe in the person

This is an essential first principle of recovery and trauma-based care. It may appear that there is no one there when a person does not share in our consensual reality. When someone is in severe distress and is mute or talking to an unseen person, they are still there, inside, at home.

The most frequently cited factor among people who recover is that "someone believed in me." Despite trouble believing in themselves, another person was there whose belief sustained them.

Invite story

It is a basic human need to relate the stories of our lives, to find meaning in our experiences and to feel valued for whom we are. In having the opportunity to tell the story to one other human being in whatever language we use, the "I" becomes "we" and the exchange becomes its own story. And in the magic of those moments, we are no longer alone. An important aspect of providing care for people is inviting them to tell their story.

Understand the meaning of metaphor

In daily conversation, people relate on a superficial level, relying primarily on spoken words for meaning. When people are in severe distress, they yearn for a much deeper level of relating. This deep level of relating often takes place mostly at the emotional level. Therefore, the nonverbal elements of communication are the most crucial.

If the individual experienced interpersonal violence, the words themselves will often cease to have meaning. For example, many survivors of violent sexual and physical attack relate that the word "no" only brought on more violation, so that conversely, they experienced rejection and abandonment, and sometimes left to die when asking for something they needed. When this level of betrayal of trust occurs through violation, people will seek out other ways to communicate.

The use of metaphor is a particularly potent adaptation when there can be no direct expression or words cease to have meaning. It is important to assume that people do the best they can to communicate the truth of their lives even when it may seem obscure. They tell us something important. If we assume the use of metaphor is a "symptom" of mental illness and do not ask about its meaning, then we miss important opportunities to connect.

Do not give up

One of the effects of interpersonal violence and trauma is a sense of foreshortened future. Chronic and prolonged crisis leaves people with only enough energy to trust the immediate moment. Survivors often repeatedly see and hear that the future is unpredictable at best and the promise of tomorrow is tenuous.

This lack of predictability makes it even more imperative for workers to be persistent in their approach to people—being tenacious in supporting them and holding onto people's strengths even when they do not appear very strong. It is important to remind each other that there is renewed possibility as time silently moves one moment into the next, shaping a future previously unforeseen.

Support people in developing life purpose

A spiritual renewal often comes from being with and believing in another. Whether it is with a child, lover, pet, or person in need of help, there is deep meaning for people who can step outside of their own world to connect with someone else. This spirituality is one of the reasons twelve-step programs succeed over time. These programs build on a spiritual foundation, encouraging those in recovery to reach out to others and to share their experience, strength, and hope as part of a recovery process.

Some people perceive that individuals with severe emotional distress are not as competent in their ability to give back. And yet, an important part of recovery from substance use disorders, severe emotional distress, trauma, and experiences of homelessness is the opportunity to find meaning and purpose—to feel one's life is worth living, to share experiences with others, to pass on the messages of hope and that recovery is possible.

Be honest and authentic

Almost always, severe emotional distress involves a loss of trust in important relationships. The basis of building trust again is that the person is able to believe you, especially at an emotional level. To build a foundation of trust, one must be honest and authentic. This process may require re-examining the kind of training that defines professionalism in terms related to maintaining distance,

boundaries, and objectivity, especially around the expression of feelings by the worker. For example, if someone tells you something that makes you feel sad, it is all right to show and share some of that sadness (while staying in touch with yourself and not becoming too lost in the sadness).

Emotional reserve on the part of a listener can interfere with building trust, partly because the teller is often acutely aware of how the listener feels. In order to survive, many developed a heightened sense of awareness. Rather than creating a safe space for traumatized persons to connect, emotional distance creates a sense of distrust and disconnection.

There was a time when I was convinced that everyone in the world was a robot. I was expressing from my heart the distress over how seldom people communicate on a feeling level as well as how little I was capable of doing so as well.

Dan

The Power of Honesty

During one hospitalization, a nurse named Karen was assigned to be with me throughout the evening. I had been having a terrible time, struggling with extreme sadness, unbridled fury, dissociation, and self-injury. I couldn't tolerate being locked in or contained, touched, or crowded in any way.

Karen kept her back against the wall, looking up only to stare at me before returning to her notes. The more she observed at a distance, the more distressed I became. The voices of the past came crashing forth into the present. The experiences of being intruded upon and violated, watched while I dressed, showered, and changed, refused to be kept in the past...but rather blended into the person sitting at a distance with a clipboard.

I could feel the room prickle with unspoken electricity. I got up to pace. Maybe I could outrun the feelings, I thought, just walk so fast that they would be left behind. The more I paced, the more I sensed Karen's fear. So I sat down, but this only made my inner world more chaotic.

Realizing that something needed to shift, she took a deep breath, put down her notes, and changed positions so I could see her better. In a soft, direct, and quiet way, Karen took a risk to be authentic with me. She sat on the floor to make sure she wasn't standing over me or blocking any entries and exits, and then made eye contact. She told me she didn't understand what was happening when I went so far away and that watching the dissociation from the outside frightened her because it was so removed from her experience.

She asked me if I would be willing to describe it to her so she could better understand. "Perhaps," she said, "if I understand you won't be so alone." It has been fifteen years since then and her courage and honesty move me still. Because she took a risk to reach into my world, I began to trust her and to take a risk to come back into hers. Compassion knows no boundaries. It surpasses geography, language, age, culture, gender, space, and time to touch the spirit that resides in each human heart.

Laura

First and foremost, listen with all your heart

All too often, professionals experience pressure to prove their work is valid and "scientific" in order to stay on the cutting edge. There is encouragement for people to compete with one another over scarce resources instead of working together. In this atmosphere, it becomes a challenge to remember some very important things: we need to remember to pay attention to the wisdom of the heart and to the awareness that community, connection, validation, respect, and time are the ultimate healers.

When we open ourselves to others and listen deeply, we help people in distress learn to listen to themselves as well. We actually experience another person's heart with ours. Some people refer to this process as "tuning in" or "resonating" with the other person. This level of human connection includes a nonverbal language that allows us to converse across many artificial boundaries among people and cultures.

Minimize distractions

Persons in acute distress depend on the people around them to keep them connected to themselves and the world. Anything that distracts you as a worker when connecting with someone will break the connection and send the person back into distress. Distractions can include external mechanical distractions as well as internal thoughts and worries that you carry into the relationship. This risk is why practicing some form of centering or meditation can be quite valuable. Meditation enables a person to let go of the intensity of feelings generated by thoughts, allowing the heart to open up to others in a much broader fashion.

Support self-determination

Autonomy, the freedom to make one's own choices and decisions, is a stronger motivator than either external rewards or punishment. Therefore, any way that we can assist people in (re)gaining control over their lives will increase their motivation to be an active agent in that process.