

Over the past few years, there’s been a lot of talk about providing “trauma-informed” services. This is an important move within the mental health system, but has often only concentrated on the use of restraints & seclusion or addresses individual trauma in one-on-one therapy.

At the same time, the sad and tragic murder of Stephanie Moulton, a mental health worker, by a person using DMH residential services has led to increased discussion and debate around “safety” and “risk.”

It’s unclear if these two topics are being discussed together. “Trauma,” “safety” and “risk” share the common thread of violence and its’ impact on people and communities. Looking through the lens of “trauma” to evaluate the needs of individuals and communities, including people using and providing services, creates the roadmap to increase “safety” and diminish “risk” in mental health settings.

The statistics tell the story. According to the National Center for Trauma Informed Care, 90% of people diagnosed with Borderline Personality Disorder or Dissociative Disorders, 80% of people using services in psychiatric hospitals, and 66% of people using services for substance abuse experienced or witnessed trauma and neglect. Boys who witnessed violence were also found to have a 1000 times greater risk of committing a violent crime.

Research also indicates that children and adolescents from minority backgrounds are at increased risk for trauma exposure and development of Posttraumatic Stress Disorder (PTSD). For example, African American, American Indian, and Latin American children are over-represented in reported cases of child maltreatment, and in foster care. (Department of Health and Human Services, Administration for Children and Families 2002).

In addition, many providers have their own trauma histories, and are witnesses to trauma on a daily basis in their work. This means that our treatment communities have a huge elephant in the room – the majority of people are viewing and responding to their world through the lens of trauma.

The trauma histories of people using (and often providing) mental health services tend to be repeated, long-term assaults on the person’s sense of safety in the world and in relation to others. Our brain, that always wants us to survive, actually rewires itself. Seeing that a person is repeatedly left on his/her own to find safety and cannot rely on others to protect him or her, the brain shifts to a “fight or flight” stance. This heightens a person awareness of the environment and allows the person to respond immediately, without thought, to any sign of danger. This danger response becomes a person’s usual response, and at the slightest perception of danger, a person responds by some form of “fight” or some form of “flight.”

Healing comes only through relationship and safety in the world. Loving, compassionate and understanding relationships is the only way that people can learn that others can be trusted, can be loving and not hurtful, and can be kind and not cruel. Being treated with human dignity, respect and humanity is the only avenue to healing the messages of abuse or neglect. Being allowed the right to make choices, learn through experience, and be mentored and supported through the trials and errors of human development is the only way that people can rewire their understanding of the world.

Speaking as a trauma survivor and someone who spent many, many years in hospitals in the greater Boston area, I can personally attest to the many ways that the environment, itself, increased my own level of isolation, fear, and disconnection, often leading to behaviors that were unsettling for myself, fellow “patients” and other staff. For example, when I was hospitalized in Faulkner Hospital as a result of self-inflicted violence, I was told I had to stay in the milieu area and couldn’t go to my room, despite my sensations that the noise and chaos of the room was overwhelming me and I needed to be alone. I had no words to describe my extreme distress. I didn’t understand then how this directly related to my own trauma. I acted in the only way that I knew at the time – I punched the wall.

I’m sure there was an immediate response, which I don’t remember. But an hour later, I was called to a “meeting” in a room down at the end of the hall. I walked in to find a number of guards, ambulance drivers, a stretcher that had restraints on it and all my belongings in bags. I was told that I could do this the easy way or the hard way, but I was going to Mass. Mental Hospital. I retreated inside myself and don’t remember anything until several days later as I lay in a bed on the floor of Mass. Mental with another man crawling in with me. It was a turning point to a downward spiral that lasted for years, and nearly ended my life. I had been so retraumatized by the situation. I was blamed and shamed for responses that I didn’t understand and didn’t know how to change. In the end, this only increased the very responses that staff was trying to alleviate.

Revisiting the factors that led to the tragic death of Stephanie Moulton is vitally important. But our response must be from the perspective of the prevalence of trauma in our service community. The question should not be, “how can we better control people?” Control simply increases everyone’s trauma response. It should be “what happened to you?” and how is this impacting the moment? Responding by retreating to services that increase control and rigidity will only heighten the very situation we’re trying to resolve.