From Trauma to Transformative Recovery

By William L. White, MA

Between 1986 and 2003, I served as the evaluator of an innovative approach to the treatment of addicted women with histories of neglect or abuse of their children. Project SAFE eventually expanded from four pilot sites to more than 20 Illinois communities using a model that integrated addiction treatment, child welfare, mental health, and domestic violence services. This project garnered considerable professional and public attention, including being profiled within Bill Moyers' PBS documentary, *Moyers on Addiction: Close to Home*. My subsequent writings on recovery management and recovery-oriented systems of care were profoundly influenced by the more than 15 years I spent interviewing the women served by Project SAFE and the Project SAFE outreach workers, therapists, parenting trainers, and child protection case workers. This article offers a few reflections on what was learned within this project about the role of trauma in addiction and addiction recovery.

Trauma, particularly physical/sexual abuse, was ever present in the lives of the women served by Project SAFE, but one must be cautious in over-interpreting trauma as the etiological agent in addiction and related problems. After all, multitudes of women have experienced childhood and adult trauma without developing the severity, complexity, and chronicity of problems commonly experienced by the women in Project SAFE. So an early challenge within Project SAFE was to understand what distinguished the trauma resilient from the trauma impaired. Our collective experience with thousands of women across diverse community and cultural contexts led to the conclusion that the resilient and the impaired differed in two fundamental ways. They differed in the nature of the trauma they had experienced, and they differed substantially in the recovery capital that influenced their capacities for resilience.

What separated community populations of women and our clinical population of women was not the presence of trauma but the characteristics of such trauma. A cluster of traumagenic factors distinguished the clinical group from the more resilient community group. Trauma in the former was more likely to:

1) begin at an earlier age (marking less developmental resources to cope with the trauma),
2) involve more physically and psychologically invasive forms of victimization,
3) take place over a longer period of time (e.g., multiple events over days, months, or years rather than a single point-in-time episode),
4) involve multiple perpetrators over time (confirming lack of safety, personal vulnerability, and suspicion that the cause lies within oneself),
5) involve perpetrators drawn from the family or social network (marking a greater violation of trust),
6) involve physical injury/disfigurement or threats of such if event(s) disclosed, and
7) generate environmental responses of disbelief or victim blaming when victimization disclosed.

Women with histories of perpetration of violence against their children, partners, or others also had experienced three additional factors: serial episodes of abandonment, desensitization to violence through prolonged horrification (witnessing violence against persons close to them in their developmental years), and violence coaching (transmission of a technology of violence and praise for violence from the family and social environment). Combinations of these potent traumagenic factors dramatically increased the risk of a broad cluster of problems in personal and interpersonal functioning.

The second conclusion we drew was that women experiencing one or more of these traumagenic factors in community and clinical populations differed widely in the their level of adult functioning, with some exhibiting profound impairments and others exhibiting extraordinary levels of resilience and positive personal and social functioning. While some of this difference could be accounted for by variations in the number and intensity of traumagenic factors, there was another quite influential force that often tipped the scales from pathology to resilience. Women exhibiting the greatest resilience had experienced trauma, but they also possessed high levels of *recovery capital*—internal and external assets that could be mobilized to initiate and sustain recovery from trauma and its potential progeny of related problems. Such resources fell into three categories: personal recovery capital, family recovery capital, and community recovery capital, with each arena constituting a potential focus of policy development and service programming.

In contrast to this resilience profile, women served by Project SAFE were collectively marked by the combination of multiple traumagenic factors and low recovery capital. That combination predictively produced distorted thinking about oneself and the world, emotional distress and volatility, migration from self-medication to addiction, assortative mating (recapitulation of developmental trauma in toxic adult intimate relationships), addiction to crisis, impaired parenting, and chronic self-defeating styles of interacting with professional helpers.

The first challenge in Project SAFE was for the outreach workers, therapists, case workers, parenting trainers, and others not to be personally paralyzed in response to the horror contained in the stories of the women they were serving. The second challenge was not to be professionally paralyzed by the number, severity, complexity and chronicity of the problems presented by the women entering Project SAFE and the resulting multitude of community agencies involved in their lives. Through training, skilled clinical supervision, and mutual professional support, those twin challenges were overcome, traditional models of clinical sense-making and intervention were cast aside, and new understandings and approaches were forged that have been described in a series of reports and training manuals.

So let me now share the rest of the story—the story of recovery. As a long-tenured addiction professional and the evaluator on this project, what most intrigued me was that so many women who were given little chance of success achieved levels of health and functioning that no one, most importantly the women themselves, could have predicted. Equally intriguing were the processes involved in that achievement. Here are just a few of the lessons of Project SAFE that still have salience today.

Hope, not pain or consequence, is the critical ingredient to successful treatment and recovery of traumatized women.

Women with multiple traumagenic factors and low recovery capital don't hit bottom, they live on the bottom. They have incomprehensible capacities for physical and psychological pain. What is catalytic is not pain, but the discovery of hope within relationships that are personally empowering—experienced sequentially within Project SAFE with outreach workers, SAFE clinical staff, a community of peers in recovery, and then within a larger community of recovering women. In project SAFE, this process most often began through a process of assertive outreach during what I have called a stage of precovery. The move from precovery to recovery initiation was marked by exposure to women in recovery with whom they could identify and who made recovery contagious by the examples of their own survival and transformed lives.

Life-limiting mottoes for living must be experientially disconfirmed for recovery to proceed.

The mottoes that women brought to their involvement in Project SAFE included: I am unlovable; I am bad; there is no safety; everybody's on the make—no one can be trusted; if I get close to people, they will leave me or die; my body does not belong to me; and I am not worthy or capable of recovery. The triple challenges in providing effective addiction treatment to traumatized women are to: 1) avoid confirming these messages by recapitulating processes of victimization (e.g., problems rather than solutions focus, emotional battering via confrontation techniques, or emotional or sexual exploitation) and abandonment (e.g., acute care that provides brief stabilization without continued support or disciplinary discharge from treatment for regressive behavior), 2) experientially challenge these messages (e.g., providing enduring support within frequently tested relationships that unequivocally convey acceptance, regard, respect, safety, and security), and 3) forge new mottoes for living within the processes of story reconstruction and storytelling.

The most powerful catalyst for healing trauma is the experience of mutual identification and support within a community of recovering people.

Such an experience within Project SAFE marked the transition from toxic dependencies on drugs, people, and enabling institutions to healthy interdependence and mutual accountability within a community of recovering women and children. This suggests that recovery outcomes in traumatized women may be as contingent on community recovery capital (welcoming recovery landscapes) as one's personal vulnerabilities and resources. Systematically increasing community recovery capital involves expanding beyond intrapersonal, clinically focused models of recovery support to encompass models for building strong cultures of recovery and models of recovery community building and recovery community mobilization.

Effective parenting is contingent upon experiencing the essence of such parenting.

Parents cannot authentically give to their children what they have not personally experienced. In Project SAFE, the journey to effective parenting involved an emotional/relational component (active resistance, emotional regression/dependence, reparenting of mothers by

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Project SAFE staff and volunteers; and a subsequent focus on selfhood and mutual help) and a skill component (parental modeling, training, and coaching with SAFE clients and their children).

Effective parenting emerges in middle-to-late stage recovery.

While abuse and neglect of children often remit upon initial recovery stabilization, effective parenting and the larger arena of improved family health must be preceded by heightened recovery stabilization and maintenance and the subsequent transition to an enhanced focus on the quality of personal and family life in long-term recovery. This suggests the need for structured supports for the developmental needs of children during early recovery (via indigenous peer and professional support) and the need for scaffolding for the whole family from these same supports during the early recovery process.

Project SAFE began with a focus on the psychopathology of the women it served but quickly shifted its emphasis to the creation of a healing community within which the potential and transformative power of recovery was nurtured and celebrated. I remain in awe of the stories of these women and what they were able to achieve.

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1. Multitudes of women have experienced childhood and adult trauma without developing the severity, complexity, and chronicity of problems commonly experienced by the women in Project SAFE.
   a. True
   b. False

2. Traumagenic factors such as _____ distinguished the clinical group from the more resilient community group in Project SAFE.
   a. begin at an earlier age (marking less developmental resources to cope with the trauma)
   b. involve more physically and psychologically invasive forms of victimization
   c. take place over a longer period of time (e.g., multiple events over days, months, or years rather than a single point-in-time episode)
   d. involve multiple perpetrators over time (confirming lack of safety, personal vulnerability, and suspicion that the cause lies within oneself)
   e. involve perpetrators drawn from the family or social network (marking a greater violation of trust)
   f. involve physical injury/disfigurement or threats of such if event(s) disclosed
   g. generate environmental responses of disbelief or victim blaming when victimization disclosed.
   h. All of the above

3. Women with histories of perpetration of violence against their children, partners, or others also had experienced which of the following?
   a. serial episodes of abandonment
   b. desensitization to violence through prolonged horrification
   c. violence coaching
   d. All of the above

4. What is recovery capital?
   a. internal and external assets that could be mobilized to initiate and sustain recovery from trauma and its potential progeny of related problems
   b. money needed to pay for treatment
   c. connection with parents during recovery

5. Which of the following is not a resource of recovery capital?
   a. Personal recovery capital
   b. Family recovery capital
   c. Community recovery capital
   d. Financial recovery capital

6. Multiple traumagenic factors and low recovery capital predictively produced which of the following?
   a. distorted thinking about oneself and the world
   b. emotional distress and volatility
   c. migration from self-medication to addiction
   d. assortative mating
   e. addiction to crisis
   f. impaired parenting
   g. chronic self-defeating styles of interacting with professional helpers
   h. All of the above

7. _____ is the critical ingredient to successful treatment and recovery of traumatized women.
   a. Pain
   b. Consequence
   c. Hope

8. Which of the following is an example of a life-limiting motto for living that must be experientially disconfirmed for recovery to proceed?
   a. I am unlovable.
   b. I am bad.
   c. There is no safety.
   d. If I get close to people, they will leave me or die.
   e. My body does not belong to me.
   f. I am not worthy or capable of recovery.
   g. All of the above

9. Which of the following is NOT a challenge in providing effective addiction treatment to traumatized women?
   a. confirming these messages by recapitulating processes of victimization and abandonment
   b. experientially challenging these messages
   c. forgetting the trauma ever happened
   d. forging new mottoes for living within the processes of story reconstruction and storytelling.

10. Effective parenting emerges in the _____ stage or recovery.
    a. Early
    b. Early-to-middle
    c. Middle-to-late
    d. Late