A Perfect Fit: MI in Trauma-Informed Work with Women

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FACILITATED BY

DEE-DEE STOUT, MELINDA HOHMAN,

KATIE SLACK & CRISTINE URQUHART

MINT FORUM

Outline

- Interconnections
- Guiding framework
- Integrating MI within framework
- MI & DV study
- Reflections & discussion

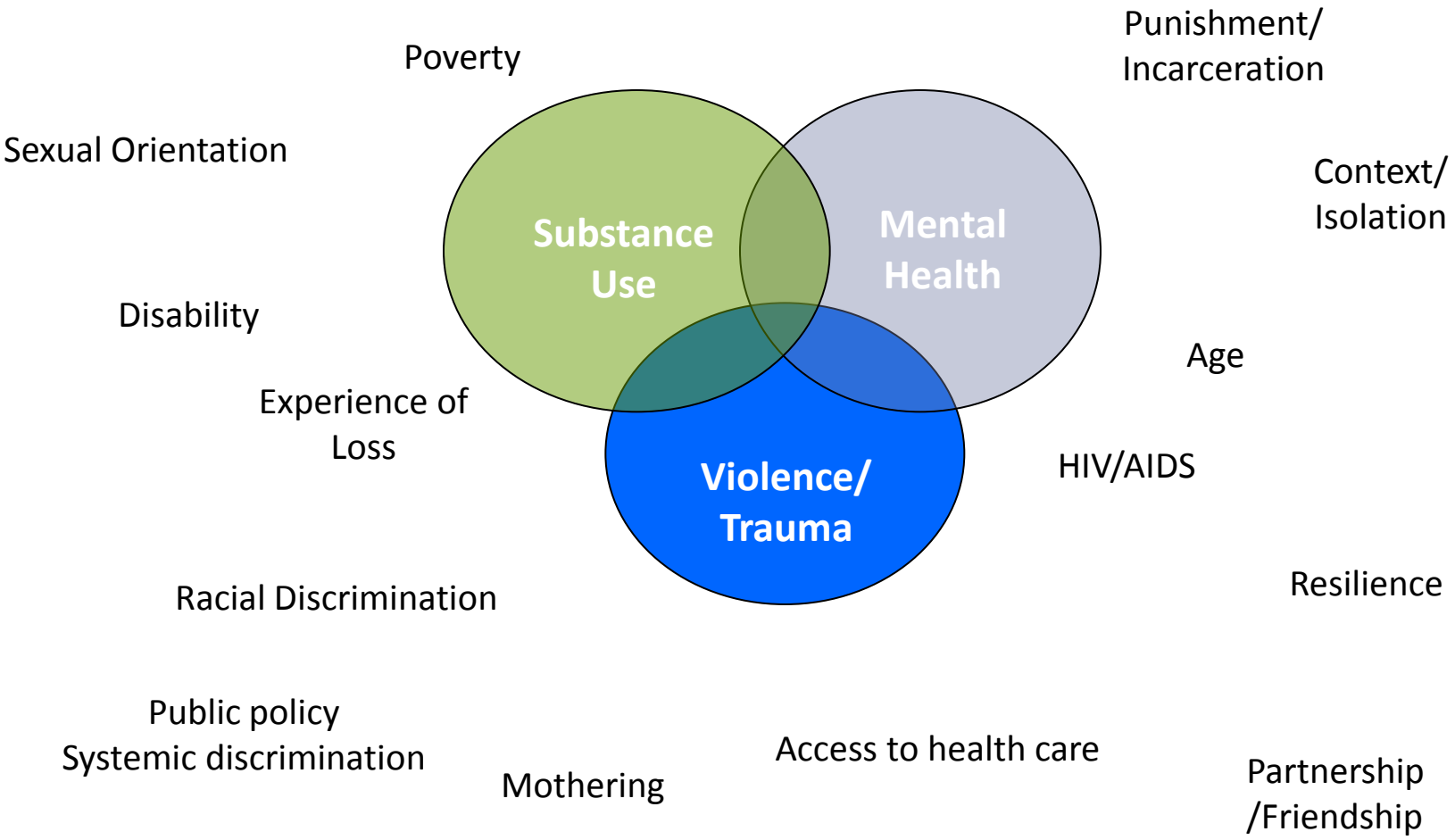
INTERCONNECTIONS

What is her story?

“They constantly tell their stories…sometimes even with words.”

LISA NAJAVITS, *SEEKING SAFETY*

Making the Links



What do we know about the connections?

- As many as 2/3 of women with substance use problems have a concurrent mental health problem (e.g., PTSD, anxiety, depression) (Zilberman, et al., 2003)

- Many women with substance use problems have experienced physical and sexual abuse either as children or adults (Ouimette, et al., 2000; Martin et al., 1998)

What do we know about the connections?

- Poor and homeless women are particularly likely to have had historical and/or current experiences of violence (between 84-92%) (Bassuk, et al., 1996)
- Mothers of children with fetal alcohol syndrome report very serious histories of violence, high levels of mental health problems and controlling partners who do not want them to quit drinking (Astley, S. J., Bailey, D., Talbot, C., & Clarren, S. K. , 2000).
- Violence during pregnancy is responsible for more deaths in pregnant women than any single medical complication (Liebschutz et al., 2003)

Girls who experience physical & sexual abuse by dating partners are more likely to be at risk for harmful substance use.

(Note: Odds of 2.0 mean a girl is twice as likely to engage in the behavior as one who was not abused.)

Behavior	*Odds*
Heavy smoking (within 30 days)	2.5
Binge drinking (within 30 days)	1.7
Cocaine use (ever)	3.4
Diet pill use (within 30 days)	3.7
Laxative use & / or vomiting (within 30 days)	3.7
More than three sex partners (within 90 days)	3.3
Pregnancy (ever)	3.9
Considered suicide (within 1 year)	5.7
Attempted suicide (within 1 year)	8.6

Silverman, J. G., Raj, A., Mucci, L. A., & Hathaway, J. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behaviour, pregnancy, and suicidality. *The Journal of the American Medical Association, 286*, 572-579

Media representation of mothers who use substances & those with mental health and partner violence problems

(Canadian print media May 1999 to May 2000)

Representation of women's responsibility:

Mental illness	Woman abuse	Substance use
Out of woman's Control	Within her control	Deliberate

Representation of the system's responsibility:

Mental illness	Woman abuse	Substance use
System failing	Limited system failure	Not system's fault

Greaves, L., Varcoe, C., Poole, N., Morrow, M., Johnson, J., Pederson, A., et al. (2002). A Motherhood Issue: Discourses on mothering under duress. Ottawa, ON: Status of Women Canada.

Recreating Dynamics of Power and Control

- Interactions with healthcare providers **can reproduce dynamics of power already experienced in a woman's relationship** and perpetuate a sense of powerlessness
  - Ignoring issues of safety
  - Minimizing illness and inappropriate diagnoses and labels that are women blaming or pathologizing
  - Ignoring context of abuse, poverty, racism and impact on health
  - Expecting compliance with experts and with treatment
  - Uncaring and unsupportive
- The meaning of exchanges between women and providers when a woman has or is being abused is different – increased vulnerability
- Shame and judgement can play a central role in the continued use of substances

In the Public Eye

Jailed teen to testify against boyfriend

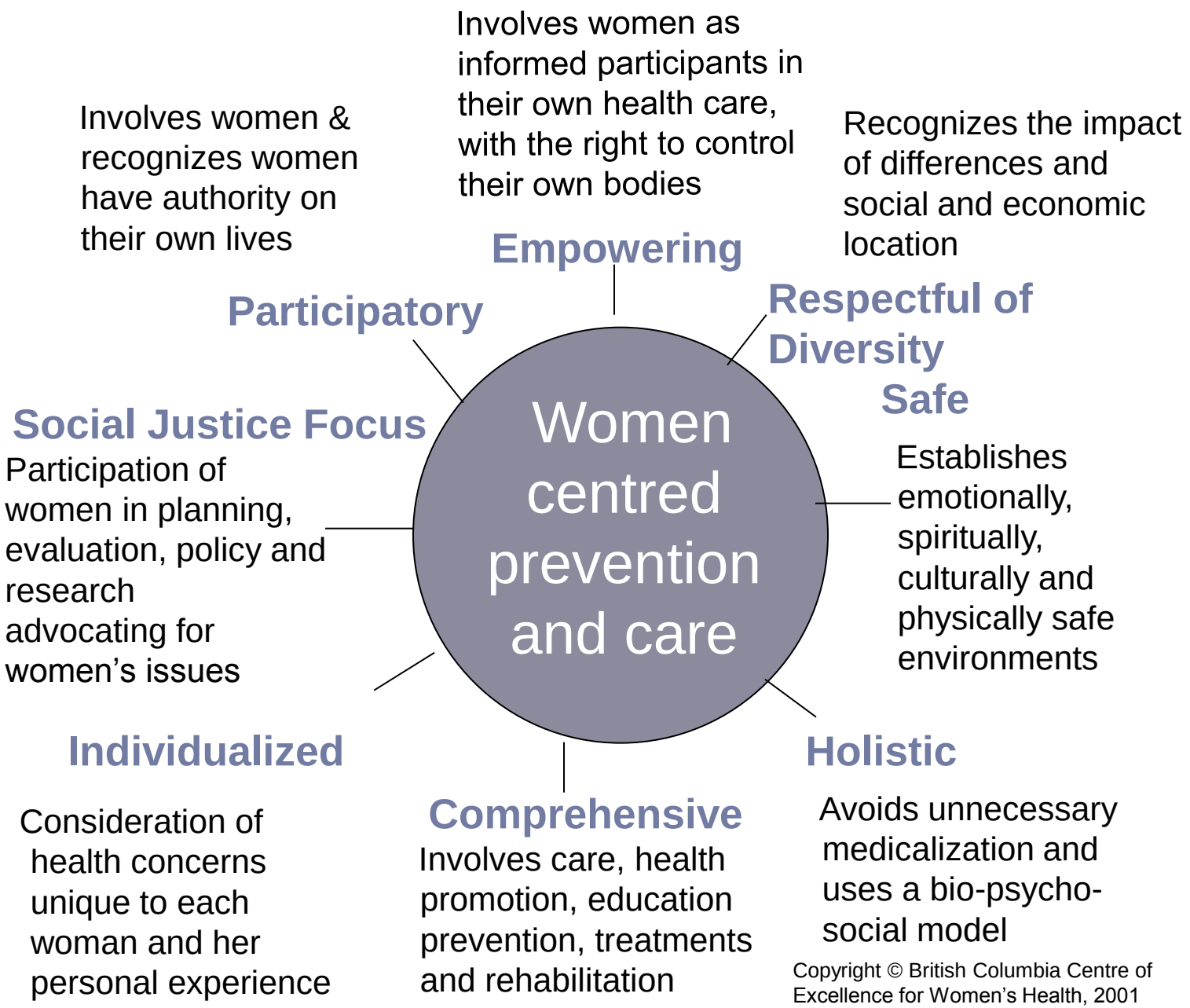
"Moellee Mowatt was placed in jail a week ago when she refused to testify against her boyfriend who had beaten her. Mowatt is pregnant and due to give birth any day… Earlier this week Mowatt, 19, vowed never to call the police again for help".

From eCanadaNow, April 11th 2008

Don't jail the victims

"Nobody's called, nobody's come to see me, nobody's done anything," Ms. Mowatt told reporters in a jailhouse interview. The problem, in the end, might not be so much in how the system goes after accused abusers but how the system supports victims of violence. If Ms. Mowatt didn't feel so abandoned, perhaps she'd have the courage – and the trust – to let police protect her and her baby". *The Ottawa Citizen, April 11th 2008*

Guiding Framework: Women-Centred & Trauma-Informed



Trauma-Informed Services…

- Sees the whole person, understanding the context of all behaviors/coping strategies
- Provides respectful & accurate empathetic listening to best enter the world of the consumer
- Focus is on the *consumer* – not the symptoms, behavior or problems - & reduction of symptoms not treating an illness

10 Principles of Trauma-Informed Services

1. Recognize the impact of violence and victimization on development and coping strategies
2. Identify recovery from trauma as a primary goal
3. Employ an empowerment model
4. Strive to maximize a woman's choices and control over her recovery
5. Are based in a relational collaboration

Elliot et al. (2005). Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women Journal of Community Psychology, 33(4), 461–477.

10 Principles of Trauma-Informed Services

6. Create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance
7. Emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology
8. The goal is to minimize the possibilities of retraumatization
9. Strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background
10. Solicit consumer input and involve consumers in designing and evaluating services

Elliot et al. (2005). Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women Journal of Community Psychology, 33(4), 461–477.

When using MI in a DV context it is vital to only focus on areas that a woman CAN control (Wahab, 2006)

Integrating MI within a Women-Centred, Trauma-Informed Framework

Integrated Framework: Guiding Principles

Motivational Interviewing	Women-Centred	Trauma-Informed
Collaborative	Partnership / Equality	Collaborative
Respect autonomy	Autonomy	Maximize choice
Evocative	Self-determination	Consumer input
Understand / Listen	Respect	Recognize the impact of trauma and violence
Empower	Empower	Empower
Resist the righting reflex		Emphasis on safety and avoiding revictimization

Trauma-Informed Approach

- Competence model; focus on strengths
- Sees traumas in context of consumer's life
- Appreciates that recovery is personal & must be defined by consumer not staff
- Staff is a guide not fixer; consumer is Change Agent
- Treatment is driven by consumers' needs

MI Principles in Trauma-Informed Services

- Build Empathy and Rapport
  - Emphasis is on whole person – how you lead your life.
    - "How can I more fully understand this person?"
  - Focus not just on functioning
  - Agency message becomes "your behavior makes sense given your circumstances."
  - Consumers begin to see their behaviors as coping and brave, not pathological or unhealthy; no character defects here
- Safety guarantee is from perpetrators, not other consumers
- Priority is on choice and autonomy

MI Principles in Trauma-Informed Services

- Coping skills & strategies lead to improved empowerment (support SE)
- Trauma viewed as complex PTSD resulting from chronic &/or repeated stressors (empathy)
- Strength-based approach (competence)
- Consumers actively involved in all aspects of treatment planning & services (RWR)
  - We are equal partners at best; consumer is in charge – we provide services; client is Change Agent (collaboration)

*Note: All above are **affirming***

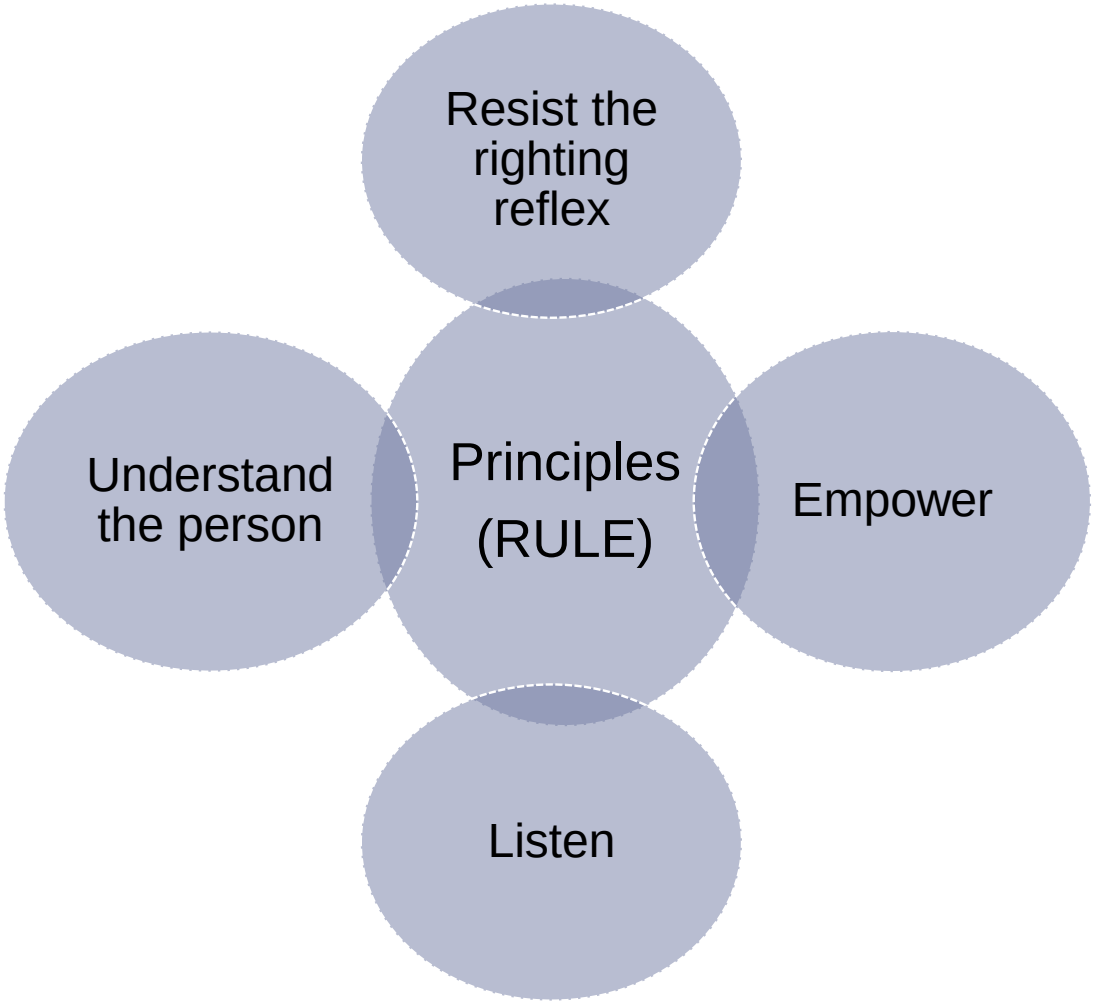
What MI can help us do

- Listen more than talk *(empathy/rapport)*
- Gently help consumers link SUDs & PTSD* *(develop discrepancy)*
- Discuss current problems – not past *(support SE)*

**Word of Caution:* Developing discrepancy *can be seen as blaming the victim or may be simply too intense at that moment. Try working on strengths first including signs of successful changers*

- 'Listen' to consumer behaviors *(RWR)*
- Appreciate that substances do solve PTSD/trauma sx *(empathy)*
- Get more training!

Principles



Rollnick, S., Miller, W.R., & Butler, C.C. (2008). *Motivational Interviewing in Health Care: Helping Patients Change Behavior* New York: The Guildford Press.

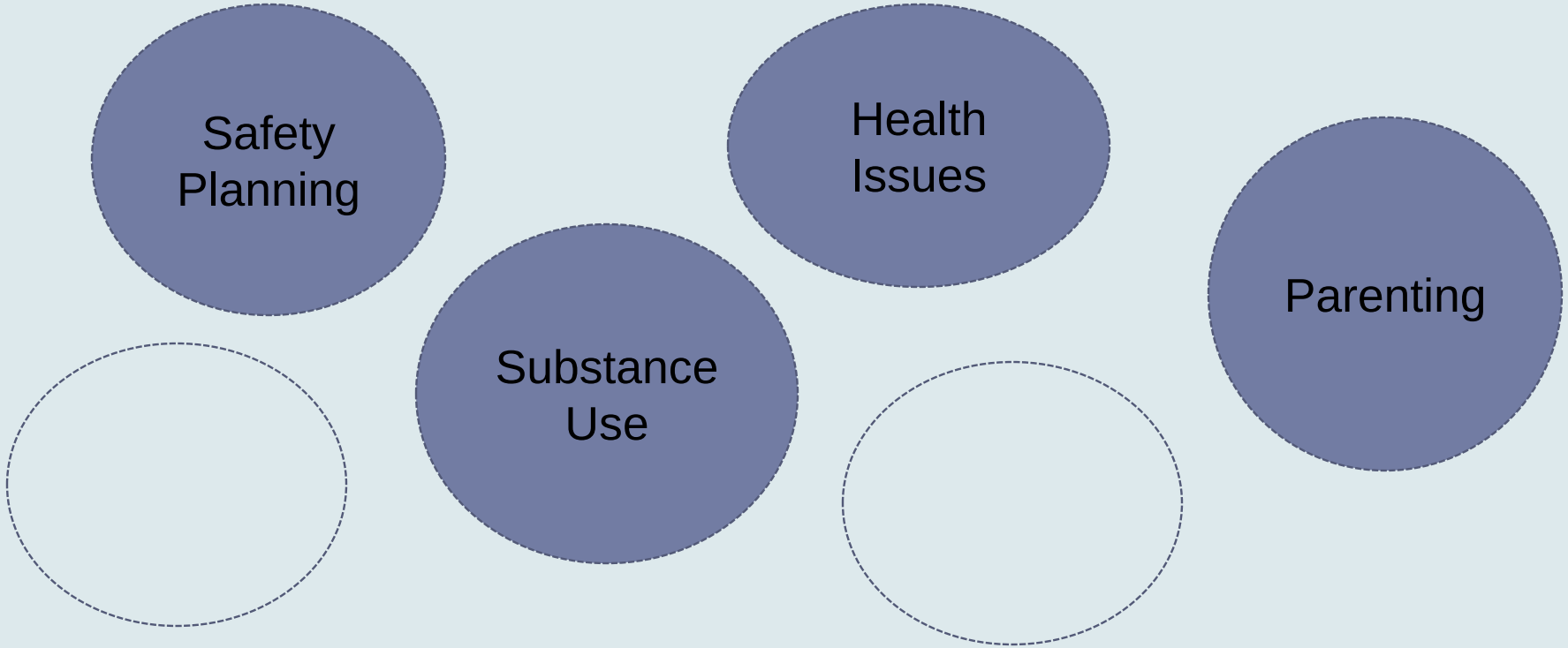
Ambivalence

MI offers a way to understand the role of ambivalence in change and how normal it is for women to feel two ways about making changes in their relationships or related health concerns.

Need to shift from "Why isn't she motivated?" to, **"For what is she motivated?"** (Miller & Rollnick, 2002)

COLLABORATING with women with violence and substance use concerns

It is vital to focus only on areas that a woman **CAN** control such as:



Wahab, S. (2006). Motivational Interviewing: A client centered and directive counseling style for work with victims of domestic violence. *Arete,* 29(2), 11-22.

1. Agency and participants
2. Measures
3. Data collection
4. Data analysis

MI & DV Study

Table 1. Participant Demographic Characteristics

Characteristics	Female (n=6)
Ethnicity	Hispanic/Mexican American = 4 Caucasian = 1, African-American = 1
Age	25-30 = 3 30-35 = 2 35+ = 1
Degree	Bachelor's = 4 Master's = 2
Years in Social Services Field	1-2 yrs. = 2 2-4 yrs. = 2 4-6 yrs. = 2

Results

Common Themes

- Theme I: MI- A Good Fit for DV Survivors
- Theme II: Putting the Client in Charge
- Theme III: Changes in the Advocate
- Theme IV: Effects of MI on the Advocate/Client Relationship
- Theme V: Helpful Elements of MI Training
- Theme VI: Necessary Adaptations of MI for Work with DV Clients

MI - A Good Fit for DV Survivors

"I think it's very very applicable, fits in very well with the work that we do…I think we generally, we've always done the active listening, but this just really took it to that next level. And I really think the MI approach very much fits in with the vision of the Battered Women's Movement, because it is empowering…"

Putting the Client in Charge

"By the end of using MI [to help a client resolve her ambivalence about going to a battered women's shelter], the client was completely motivated and was on the phone doing an intake to get into the shelter. She had said that everyone told me there were shelters, but I had no idea before, I was just so scared of it."

Changes in the Advocate

"I look forward to physically meeting with clients so I can use MI. I enjoy coming into work…I don't get stuck in a rut…it just makes the job better."

Effects of MI on the Advocate/Client Relationship

"I feel less personally invested in their decisions. I don't feel like it's gonna be my fault if they stay, I don't feel like I have to rescue them as much as maybe I did before. I have a lot more respect for their decisions cause now I have a better understanding of the change process from the training. The training really just kind of gave me a bigger picture."

Helpful Elements of MI Training

"You do your initial training and then you kind of go out there and try to do the best you can. You've actually gone out and talked to clients and then there are questions that come up that didn't come up before, since they're not staged scenarios."

Necessary Adaptations of MI for Work with DV Clients

"I've kind of found that for clients that are- I hate to use the word hysterical- but clients who really are very very upset- in crisis…that MI isn't always the best. But once they're a little calmer then I find it works really well."

Pilot Study of MI in DV Shelter

- Rasmussen, Hughes, Murray (2008), *Journal of Aggression, Maltreatment, & Trauma, 17* (3), 53, 296-317.
- N=20 clients; 10 received TAU; 10 received TAU by 2 counselors trained in MI
- Counselors trained; coded tapes (MITI) with feedback and coaching
- Measures: URICA and PROCAWS (Process of Change in Abused Women Scale)
- Results: Clients receiving MI-enhanced services significantly different on URICA, with 9 vs 4 in High Motivational Readiness at post-test (scores 11.1 vs 9.9). No difference on PROCAWS

Reflections & Discussion

Future Research Questions

1. What is needed for an advocate to learn and utilize MI?
2. What are the barriers to using MI with domestic violence survivors?
3. What adaptations to MI may need to be made for use with domestic violence survivors?
4. What are advocates' experiences of using MI with survivors?
5. What are the reactions of DV survivors to MI?

Systemic Considerations

- Standard assessments, screening (emphasis on data collection)
- Rules & policies
- Imposed system or program goals
- Measures of success
- Societal and justice system expectations (righting reflex)

“Sounds like you’ve started something here…”

COMMENT FROM TRANSITION HOUSE COORDINATOR AFTER A 2 DAY TRAINING

Contact Information

DEE-DEE STOUT
DDSTOUTRPS@AOL.COM

MELINDA HOHMAN
MHOHMAN@MAIL.SDSU.EDU

KATIE SLACK
KSLACK@PROJECTS.SDSU.EDU

CRISTINE URQUHART
CRISTINEU@HOTMAIL.COM