Introduction:
Empowerment as a Response to Trauma

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The stories at the heart of this book are from the lives of people who have moved forward with their lives with resilience, courage, and hope following horrific and traumatic experiences. Trauma changes the course of a person's life. Following traumatic experiences, each survivor faces the question of how to fit those events, whether a one-time occurrence or an ongoing situation, into new understandings of life's meaning and purpose.

Salome (all names and some details of client lives in the case examples have been changed to respect confidentiality) experiences each day the reminders of the historical trauma of the massacres of her American Indian ancestors. The Wilsons are survivors of torture, flight, refugee camps, and resettlement. Tay is an adolescent survivor of childhood incest. Frank was a batterer; Joan, his wife, ended their marriage, and Frank now attends a program to understand why he did what he did so that he will never again behave in that way. Beth lives each day facing direct and indirect acts of discrimination against her because of her sexual orientation. Amory, a war veteran, confronts daily memories of atrocities that are unimaginable to those who have never experienced war. Claire lives with memories of being sexually assaulted by a male participant in her day-treatment program,

while those she thought were her friends stood by watching. Four-and-a-half-year-old Nicolas reshapes his understanding of safety and acceptance after a vicious dog attack to his head and face. These people, along with the others described in these pages, give us a glimpse of the enormous courage required to survive oppression, discrimination, and terror while being robbed of one's previously known life.

These narratives do not end, however, with mere survival. Through the strength of their own resilience and the empowering support of others, these survivors speak about their change, of what transformed their lives after surviving a traumatic event or after living for years in the midst of ongoing trauma. They acknowledge those helpers who supported them through the confusion, those who created buffers of safety, who offered understanding and respect, sandwiches and water, Kleenex and cleansing. They speak of these advocates of compassion, literally those who "suffer with," as ones who encouraged them to remember and to grieve, not to avoid or deny what happened. These are the people who helped the survivors find their footing again in relationships, in restoring familiar routines for each day, in trusting the simple pleasures. They were there when anger, despair, confusion in thought and speech, and even deeper despair, fear, and countless repetitions of the survivor's trauma story drove others away. These helpers are the authors of the chapters that follow or they are the ones who are described by the authors.

The idea for this book grew from the simultaneous work on two writing projects. The first was a program proposal for the Trauma Response Certificate Program at the University of Denver, and the second was a book, *Empowerment Practice with Families in Distress* (Wise 2005). Weaving back and forth between these two projects, the possibility of a book on trauma response for the Empowerment Series emerged. Without question, the empowerment framework, in thought and practice, has much to offer as a response to trauma.

As *Empowerment Practice with Families in Distress* went to press, the certificate program proposal completed its evaluation process at the various levels of academic review. The words from conversations with trauma specialists over two decades are central to the content of that proposal. These are individuals who work tirelessly to help colleagues and students understand that a person's *response* to trauma takes the form of a recognizable process, geared toward healing and restoration of functioning that is similar to or that even reaches beyond the level of functioning before the trauma. They insist that most often, a trauma response is not a "disorder,"

regardless of the widespread use of several diagnoses bearing that designation. It is to these empowering thinkers that credit is due for the use of the term *trauma response* in the program's name.[1] Their clarifying perspectives sharpened my three and a half decades of curiosity about the helping process in various roles as practitioner, researcher, educator, administrator, and supervisor.

Definitions of Key Terms

Each chapter in this volume provides an illustration of how trauma transforms through resilience and empowerment. Definitions of *trauma*, *transformation*, *resilience*, and *empowerment* serve as a background for the work presented by the contributing authors. Volumes written on each of these terms are readily available to those who wish to read further in a particular area. Though the following definitions are by no means exhaustive, they have been carefully selected because of their relevance to this present work.

Trauma is a universal experience. It is no respecter of rich or poor, of profession or occupation, of country of origin or family of origin, of talent or personal purpose. "In short, anyone can be traumatized, from the most well-adjusted to the most troubled" (Everstine and Everstine 1993:7). Experiences of trauma affect not only the individual's emotional well-being but also "the systems of attachment and meaning that link individual and community" (Herman 1997:51).

Trauma is defined using eight general dimensions and six specific distinctions. The eight general dimensions identified are threat to life or limb; severe physical harm or injury, including sexual abuse; receipt of intentional injury or harm; exposure to the grotesque; violent, sudden loss of a loved one; witnessing or learning of violence to a loved one; learning of exposure to a noxious agent; and causing death or severe harm to another (Wilson and Sigman 2000). The more direct the exposure and the longer and earlier the onset, the greater the risk for emotional damage (van der Kolk, McFarlane, and Weisaeth 1996).

The six specific distinctions that clarify the definitions of *trauma* that are used in the chapters to follow are physical trauma, psychological trauma, social trauma, historical trauma, ongoing trauma, and vicarious or secondary trauma. *Physical trauma* refers to a "serious and critical bodily injury, wound, or shock . . . that resulted from an external source." External

sources may include, as in the story of Nicolas, the attack of an angry dog. They also may include such events as airline and auto accidents, physical and/or sexual assaults by strangers, the violence of one's own family members, natural disasters, and terrorist attacks. *Psychological trauma* refers to any critical incident that causes people to experience unusually strong emotional reactions that involve physiological changes and that have the potential to affect their ability to function at work, at home with family members, or in other areas of their lives (van der Kolk et al. 1996). This category of trauma includes repeated verbal and emotional abuse as well as neglect. Recent studies in brain research provide evidence of the physiological change of decreased blood flow in the parietal lobe of the brain following trauma (Hipskind and Henderson 2002).

Social trauma refers to any social condition that perpetuates forms of oppression against vulnerable populations—war, hate crimes, discrimination in education or employment, poverty, homelessness, physical and verbal violence, addictions—and the social institutions that either do not address the condition or blame those who are affected. *Historical trauma*—such as the massacre of American Indian/Native American tribes; the institution of slavery for African Americans; the Holocaust for Jews; hate crimes against lesbians, gays, bisexual, and transgendered people; and the internment of Japanese Americans in concentration camps—plays a particularly devastating role in cross-generational trauma recovery for many people in these groups. *Ongoing trauma* refers to forms of trauma that, instead of being identified with a single event, continue day after day. Examples of ongoing trauma include poverty, chronic illness, addiction, and all forms of prejudice and discrimination because of ethnicity, age, gender, sexual orientation, religion/spiritual beliefs, differing ability, and language. The overlap among these various definitions of trauma offers the reminder that multiple forms of trauma may be experienced simultaneously.

Vicarious trauma (VT) or secondary traumatic stress (STS) is the stress experienced by the helpers (family, friends, professionals) as a result of their empathy while assisting and caring for survivors who have been directly affected by the devastating forces of traumatic events or ongoing trauma. "Trauma is contagious" (Herman 1997:140). Another term used to describe secondary trauma is *compassion fatigue*—that is, "the process of attending to the traumatic experiences and expression may be traumatic itself" (Figley 1999:9). These helpers may experience a variety of responses—intense fear, recollections and re-experiencing of the traumatic event, a sense of helplessness, avoidance, numbing, detachment, sleep

disturbances, difficulty concentrating, startle responses, and irritability—all of which are similar to the responses of those with the immediate, or primary, experience of the trauma (Figley 1999:12). Sensing isolation from supporters is also noted as another response by helpers who are suffering from secondary traumatic stress. STS, which "can emerge suddenly and without much warning," is different from burnout, "which emerges gradually and is a result of emotional exhaustion" (17). Empathy and exposure are at the heart of compassion fatigue, rendering trauma workers at high risk for developing the behaviors mentioned above. "Unresolved trauma of the worker will be activated by reports of similar trauma in clients" (21) and may present the necessity of an ethical decision on the part of the worker to remove himself or herself from the helping role if the impairment from reactivated past trauma interferes with providing the best possible service to the client (Bula 2000).

Self-care for trauma workers through balancing the workload with a variety of clients who are at different steps in the recovery process, through engaging in diverse work-related activities with colleagues, and through individualized relaxation routines is a necessity (Pearlman 1999:62). Many agencies contribute to the ongoing care of their trauma workers through VT groups, in which helpers can safely report their experiences and receive support from others. The development of strengths in self and other, the ability to create life-affirming connections, ongoing use of creativity and communication, the ability to confront one's own fears of death, and personal psychological and spiritual maturity have been identified as requirements for trauma workers (Serlin and Cannon 2004:319–320).

Any discussion of "trauma" is incomplete until the diagnoses of posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) have been addressed. As briefly mentioned earlier, there is a specific constellation of behaviors that must be present before a diagnosis of PTSD or ASD is applied. Using these specifications reveals that PTSD is a rare condition, affecting an estimated 8 percent to 10 percent of the people who experience trauma (Naparstek 2004).

The diagnosis of PTSD requires exposure to an extreme stressor and a set of symptoms that last for at least one month. Experiencing, witnessing, or confronting an event or events involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others, plus a response that involves intense fear, helplessness, and/or horror are characteristics of extreme stressors (American Psychiatric Association 1994:427–429). Examples of extreme stressors include serious accident or

natural disaster, rape or criminal assault, combat exposure, child sexual or physical abuse or severe neglect, hostage/imprisonment/torture/displacement as a refugee, witness of a traumatic event, and sudden unexpected death of a loved one. Three main types of symptoms occur for a person with PTSD: (1) re-experience of the traumatic event through intrusive memories, flashbacks, nightmares, and/or triggers; (2) avoidance and emotional numbing, evidenced by such behaviors as loss of interest, detachment from others, and restricted emotions; and (3) increased arousal indicated by sleep difficulties, irritability, outbursts of anger, difficulty concentrating, hypervigilance, and exaggerated startle responses (Foa et al. 1999:69).

When the symptoms last one to three months, the condition is referred to as "acute PTSD." If symptoms last longer than three months, it is described as "chronic PTSD." Usually the symptoms begin immediately following a traumatic event, but sometimes they can appear months and even years later. "Delayed PTSD," as this is called, is most likely to occur on the anniversary of the original event, if or when another trauma is experienced (Foa et al.1999:71), or, as sometimes happens in cases of child abuse, when the survivor's children reach the age the survivor was when he or she suffered the original abuse.

Acute stress disorder (ASD) is the diagnostic term used "when symptoms last for less than one month, but are more severe than what most people have. This is too brief to be considered PTSD but increases the risk of later developing PTSD" (Foa et al. 1999:70). Factors that affect the likelihood that a person will develop PTSD are the severity of the trauma, how long it lasted, how close the person was to the traumatic event, how dangerous it seemed, how many times traumatization occurred, whether the trauma was inflicted by other people, and whether the person gets negative reactions from friends and family members (Foa et al. 1999:71).

Trauma response (Everstine and Everstine 1993) is the term proposed for all post-trauma behaviors that do not fit the constellation of symptoms required to arrive at a diagnosis of post-traumatic stress disorder or acute stress disorder. " 'Response' is used to connote the nonpathological aspects of what the DSM calls 'disorder.' . . . When the reaction to trauma is envisaged as part of a restorative process and not as abnormal behavior, a new incentive to helping the victim recover is gained. It is a simpler task to aid a natural process than to cure a disorder" (12–14). An essential task, then, is a carefully rendered differential assessment to determine whether

the appropriate descriptor is "disorder" or "response," for the interventions chosen for one may not be effective with the other.

Transformation is change, change that involves being strengthened, rather than destroyed, by trauma. Several times during the work on this book I have been asked the question, Why is it that some people move through their trauma and go on with their lives with a sense of growth and meaning and others get stuck, remaining bitter and angry long after the traumatic event?

To answer this question, it is essential to set aside any categorizing of people's responses into an either/or: either moving on with growth and meaning or staying stuck with bitterness and anger. In fact, the fullness of a post-trauma response involves both. Healing from trauma is a process, one that takes months, sometimes years, sometimes decades. It is a "creative process, a process that ultimately embraces life while unflinchingly staring death in the eye" (Knafo 2004:585). Once the numbness of the initial shock has subsided, enormous fear is usually noticeable through exaggerated startle responses, intrusive memories and flashbacks, fear that may appear irrational to those who have not experienced the same or a similar trauma. Often a major loss is experienced as part of the traumatic experience, therefore initiating all of the well-known stages of response to loss: denial, anger, bargaining, sadness and/or depression, acceptance (Kübler-Ross 1969). Inherent in every post-trauma healing process is the person's telling and retelling and retelling and retelling (something that may get interpreted as "stuck") of "The Story" with all of its appropriate, though usually horrific, emotional content. Being in an environment that feels safe enough for expressions of anger, confusion, fear, and sadness to be released is one of the most crucial aspects in the process of trauma transformation. Those responding to the trauma of others, the helpers, watch for the signs of shock, for multiple retellings of the story, for fury at the oppressors and victimizers, for deep despair and sadness during which survivors may question their own reasons for living, and the helpers also watch for meaning-making and transformation unique to each person's history, ethnicity and culture, age, gender, sexual orientation, language, and religious or spiritual beliefs.

"Suffering ceases to be suffering *at the moment* it finds a meaning" (Frankl 1969:23; emphasis mine). I have chosen to emphasize "at the moment" because the suffering, as defined by the individual, must be allowed its due time. To impose a timeline on the act of finding meaning is to do a grave injustice to both the person and the process of healing during

the months and years of a post-trauma experience. The process cannot be rushed. It cannot automatically respond to anyone else's idea of what is a socially acceptable length of time to suffer before moving on. The person is not a victim because he or she is suffering. Facing daily reminders of the trauma that never leave is an act of courage. The survivor's suffering is an all too understandable, natural, emotionally fitting response to life-shattering events and painful ongoing experiences.

To repeat intentionally, for survivors to face their memories and to tell their stories takes enormous courage. They do go on to find meanings, such as stronger bonds with those they love, such as a rearranging of priorities about what is truly most important to them, such as never again taking freedom from violence for granted. The wish, and even the insistence, to be heard, to be believed and respected through all parts of their healing, to be surrounded by supporting family members, groups, and their community keep many survivors moving forward, strong and resilient.

Resilience is defined as "the capacity to rebound from adversity strengthened and more resourceful. It is an active process of endurance, self-righting, and growth in response to crisis and challenge. . . . Resilience entails more than merely surviving, getting through, or escaping. . . . The qualities of resilience enable people to heal from painful wounds, take charge of their lives, and go on to live fully and love well" (Walsh 1998:4). Emphasis is placed on returning "to a level of functioning equal to or greater than before the crisis" (Boss 2006:48), functioning that has been strengthened as a result of the integration and depth of meaning-making that has come from having weathered the trauma. Bonanno (2004), after an extensive review of the research on resilience, made three important observations: (1) there are multiple and sometimes unexpected pathways to resilience; (2) resilience is more common than we thought; and (3) resiliency is more than recovery—i.e., more than the absence of pathology. Walsh (1998) also recognized this last point, viewing resilience as ongoing healthy functioning with aspects of creativity and growth as well as positive outlooks and emotions. She identified key processes in family resilience: making meaning of adversity, positive outlook, transcendence and spirituality, flexibility, connectedness, social and economic resources, clarity, open emotional expression, and collaborative problem solving (133).

> They [survivors of trauma] possess a special sort of wisdom, aware of the greatest threats and deepest gifts of human existence. Life is simultaneously terrifying and wonderful. Their traumatic experience was undeniably

agonizing, and yet, having successfully struggled to rebuild their inner
world, survivors emerge profoundly and gratefully aware of the extraordi-
nary value of life in the face of the ever-present possibility of loss.

(Janoff-Bulman 1999:320)

Empowerment is defined as "a process of increasing personal, interper-
sonal, or political power so that individuals can take action to improve
their life situations" (Gutierrez 1990:149). In recent decades, the term
empowerment has been used and overused to such an extent that the risk
of its becoming pointless is a real one. The pervasiveness of empowerment
thinking in nearly every aspect of human growth and activity speaks to its
wide acceptance. This same pervasiveness can also be viewed as contribut-
ing to its potential demise (Weissberg 1999). If the term is so inclusive that
it can be applied anywhere, anytime, in nearly every situation, then what
unique meaning can be derived from it? Both acceptance and criticism are
extensive. The former is grounded in a history of use that has withstood
the test of more than a century of application and expanding breadth
and depth. The latter—the criticism, conscientious critiques, and lessons
learned from those earlier applications—challenges us to be held account-
able for the ways in which we use this concept today, being mindful of
what empowerment can and cannot do (Wise 2005).

Empowerment is a word with *power* as its base. With this in mind, any
use of the word must encompass both the lighter and the darker sides
of power. Human relationship dynamics of power over and power under
immediately raise those realities to the level of abuses of power and pow-
erlessness experienced by those who suffer, often through traumatic events
and circumstances, as a consequence of such abuses. Concepts of power
with (Wise 2005) or "power as life" (Purvis 1993), on the other hand, pro-
vide clear connections with empowerment thought and practice.

Empowerment practice is practice that occurs simultaneously at the
personal, interpersonal, and social/community levels, including politi-
cal action. The chapters of this volume are organized into three parts,
each reflecting one of these levels: Part I, Transforming Trauma at the
Personal Level; Part II, Transforming Trauma at the Interpersonal Level;
and Part III, Transforming Trauma at the Social/Community/Political
Levels. Even though a narrative may begin with a story at the personal
level, the interpersonal and social/community/political levels will be evident
in the response to the trauma. Likewise, with the narratives that begin at

the interpersonal and social/community/political levels; the responses to the trauma describe all three levels of interaction.

To provide a structure for each chapter, one inclusive enough for the areas of expertise of the contributing authors yet specific enough to be useful to readers, we asked each author to organize the chapter according to the following guidelines: (1) provide a case illustration; (2) include background information about the particular trauma that will help readers understand its prevalence, social context, and supporting research and knowledge; (3) provide a practice section that shows how helping professionals responded to the trauma presented in the case illustration; (4) offer reflections on the principles of empowerment practice; (5) address the reality of vicarious trauma as experienced in this work; (6) explain how the trauma was transformed and provide recommendations. The principles of empowerment for reflection in the fourth section are (1) building on strengths while diminishing oppressions; (2) enacting multicultural respect (on the basis of the multicultural variables of ethnicity, age, gender, sexual orientation, socioeconomic class, religious/spiritual beliefs, differing abilities, and language); (3) working from an awareness of specific needs; (4) assisting clients—individuals, groups, families, organizations, communities—as they empower themselves; (5) integrating the support needed from others; (6) equalizing power differentials; and (7) using cooperative roles (Lee 2001; Wise 2005). No single recommendation for use of the empowerment principles was imposed. The creative application of each contributor's understanding of these terms gives a glimpse of the widely diverse potentials for strengthening practice represented by the contributors to this volume.

Practitioners in the helping professions will find this book useful for understanding a wide variety of trauma experiences and for learning how the contributors have responded to those experiences. The sections on vicarious, or secondary, trauma speak to all those who work in areas of trauma response, offering strategies for strengthening one's sense of self in order to remain effective in the face of the challenges inherent in trauma work. The volume is appropriate as a text for undergraduate or graduate level courses, both in the classroom and in field practice or internship settings. Excerpts can be useful in both individual and group work, for example, for those recovering from trauma. Hearing the stories of others who have faced and survived and transformed their own experiences of trauma serves as an inspiration for us all.

Note

1. The Trauma Response Certificate Program welcomed its first cohort of eighteen students in 2003. Following my retirement, the program continued to grow under the leadership of Ann Petrila, M.S.W., Nicki Dayley, M.S.W., and Marian Bussey, Ph.D., who now serves as the coordinator of the program. Forty students were accepted for the fall 2006 term.

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