At The Crossroads

VSI ©: An Exploratory Model for Complex Trauma Specific Treatment

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Abstract

Trauma-specific services must serve as a cornerstone of any service directed to the prevention and/or intervention with those who have experienced or witnessed varying degrees of trauma or suffer from traumatic stress.

VSI © is a three stage, mullti-dimensional, interdisciplinary, client friendly, flexible model for individuals who present with trauma. Collaboration is essential in building on existing inherent resiliency or developing resilience by assimilating victimization and survival while moving toward integration. The relationship between individual and therapist is the cornerstone in assisting the consumer to regain, relearn and develop healthy skills that promote adaptation to a normalized lifestyle. Inclusion of family and/or significant relational others remains stage oriented and applicable where and when appropriate. This article focuses on the model and program for treatment with an identified population of female adolescents with co-morbid substance abuse/process addiction symptomology corresponding to an identified history of traumatic stress and/or PTSD.

Introduction:

In recent years, the mental health community has moved from a medical model to a recovery oriented approach for the treatment of complex trauma. More recently, this paradigm shift has expanded to integrate the concept of resiliency as a standard for best practice. Trauma treatment is at a crossroads. With an abundance of research to guide and support evidence based practice in the area of trauma informed services and trauma specific treatment, community social service agencies may continue to engage in a business as usual practice or begin to shift to integrate and implement resiliency and recovery which supports both trauma informed and trauma specific approaches to treatment and practice. Another concern is that "trauma" may be evolving into a "catch phrase" or "buzzword" to elicit funding without science. This in turn contributes to:

- high levels of staff turnover and practitioner burnout,
- potential re-victimization of individual's with symptoms of complex traumatic stress,
- ineffective and/or inappropriate treatment,
- a lack of resources.

Because the features of varying levels of traumatization possess similarities the recovery process also must follow a common pathway which includes establishing safety, affect regulation, reconstructing the trauma story, processing grief and loss related issues, and restoring the connection between survivors and their community by processing the

impact of the elements of trauma on the survivor's life in the here and now (Bloom, 1997, Herman, 1992, Gray, 2003). Identification, acknowledgement of the injury(ies), and permission to grieve what has become recognized as a multitude of layers of ambiguous issues related to grief and loss associated with betrayal validates the experience of the individual(s) harmed by the trauma(s) and assists in the process of recovery and revival of the soul unto the self.

As research in the area of trauma has evolved from hysteria to the recognition of PTSD, and the current construct of complex trauma, models have developed that serve as evidence based practice. For example, Harris' Trauma, Recovery and Empowerment Model © (TREM ©), (1998); Linahan's Dilectical Behavioral Therapy Model© (DBT ©), (1993); Najavits' Seeking Safety Model © (2007, 2006, 2004, 2003); as well as the utilization of various Cognitive Behavioral Therapeutic Techniques/models and/or creative modalities, such as art, guided imagery, meditation, journal process writing, along with goal directed therapeutic exercises designated to promote critical thinking and effect change remain effective applications to practice. Though Linahan's DBT © Model is effective in assisting in building coping skills, recognizing negative behavioral and affective triggers and operates along an effective means of outcome based recovery oriented wellness, it fails or its clinicians fail [or refuse] to acknowledge, address and implement the model as a co-occurring model associated with varying degrees of traumatic stress; from simple, single incident PTSD to complex PTSD, further complicated Dissociative Disorders and varying elements of AXIS I and II co-morbidity.

This validates the continued concern that research and practice are not integrating in both application and orientation. Herman (1992) indicates that one must recognize and validate the commonalities between the effect of a single overwhelming incident to the more complicated effects of prolonged and repeated abuse. This lag creates a chasm where mental health professionals are not being provided with the resources or opportunities for specialized trauma specific training. Additionally, many providers who receive specialized training on the level of "trauma informed" as opposed to "trauma specific" respond with a level of ambiguity relating to utilizing the knowledge into application based on feared incompetence or inadequacy to provide such services combined with violating ethical boundaries by practicing outside of one's secure knowledge based area of training [hence the case related to Linahan's DBT© model]. Another issue related to the "trauma informed" vs. "trauma specific" approaches and/or understandings remain to be the quality of care through the guise of best practice models and implementation as well as resources available or not available or appropriate for that matter, to serve chronic clients suffering from a complex traumatic stress condition. Issues concerning managed care fiscal responses continue limit providing appropriate and best practice services to clients fitting this criteria through the restriction of access to treatment to using only licensed providers as opposed to approving specialized, credentialed trauma service providers who are more qualified to treat such clients. This creates a dilemma for consumers who are subjected to relying on services provided by individuals licensed but not qualified.

An added concern remains the failure to recognize these services as "specialized" in nature and not compensating providers appropriately for the amount of time and experience involved in providing services. This contention remains to be recognizable and validated by trauma specified researchers and practitioners who indicate that despite the understanding and knowledge associated with copious complications related to traumatic stress, aside from the obvious elements coupled with Post-Traumatic Stress Disorder (PTSD), recognition of the relationship between traumatic stress and other associated symptoms evident as occurring with early and prolonged trauma has received minimal attention and focus in both practice and research. For example, PTSD literature typically fails to address psychiatric issues that do not fit within the framework of PTSD and generally refer to such issues as being "co-morbid conditions." Such references remain misleading and infer that these problems occurred independent from PTSD symptomology. Spinazzola, Blaustein, and van der Kolk (2005) indicate that "by relegating them to seemingly unrelated "co-morbid" conditions, fundamental trauma-related disturbances may be lost to scientific investigation and clinicians may run the risk of applying treatment approaches that are not helpful." Thus, diagnostically approaching treatment based on fragmented, separate symptomology as opposed to adjusting the lens to encompass these aspects as representing parts of a whole remains to be another area of practice in serious need of more research, literature reviews, and expansion of knowledge utilizing a more comprehensive ethical basis for "best practice."

Though normalization has served as a viable measure to validate one's experience as it relates to varying levels and layers of trauma, it may also serve to minimize and invalidate the degree of experiences of those on the more severe continuum of exposure, vulnerabilities and victimization. Similarly, providers who do not validate and normalize the survivor's experience as viable often reinforce invalidation, betrayal and shame on the spectrum of the double edged sword. Freyd (1996) explains:

> "Betrayal is the violation of implicit or explicit trust. The closer and more necessary the relationship, the greater the degree of betrayal. Extensive betrayal is traumatic. Much of what is traumatic to human beings involves some degree of betrayal."

Briere (1989) supports this view indicating that "…discovering at an early age that safety is not guaranteed and that betrayal can occur at any moment, many [sexual abuse victims] become preoccupied with what may be described as 'the reality of danger'." Similarly, Terr (1985) indicates in a more generalized description that "[traumatized children] so sharply fear many directly trauma-related and mundane items that they demonstrate massive interferences with optimism and trust." Perceived or actual invalidation may reinforce such entrenched betrayal responses. Traditional treatment often follows a medical model which is illness as opposed to injury focused and oftentimes serves to re-traumatize individuals through the use of a variety of confrontational, disempowering and shame-based techniques. While Linahan's DBT © (1993) and Miller's Motivational Enhancement Therapy © (MET ©) (1995) remain to be

a complete departure from the techniques that are utilized in traditional treatment models, there are apparent weaknesses to such use with these individuals that the Victim, Survivor, Integration (VSI ©) Model© takes into account. VSI © is a multi-dimensional, client friendly, gender-specific, flexible model of working with individuals who present with trauma through a relational narrative approach that focuses on authentic and mutual collaboration with the individual to build on existing inherent resiliency or developing resilience as a means of assimilating victimization and survival and moving to integration (Gray & Pabon, 2007).

Blizard (1997) states, "the primary motivator in humans was not biological drives, but a relationship or attachment to another human being." Sheehy's work acknowledges gender differences and the impact of the women's movement on the paradigm shifts in psychology. Levinson (1996) presents a combination of an Eriksonian stage theory and the Stone Center Relational Model.

VSI © incorporates Bowlby's Attachment theory, gender-specific approaches through a socio-cultural relational model as demonstrated through the object-relations oriented Stone Center Scholars supporting and validating the importance of the relationship which exists between the primary caregiver (typically the mother) and the infant. The concept of relational fulfillment demonstrated through the therapeutic paradigm remains the validation of the need for the establishment and maintenance of a proactive relationship with the expectation of continued relational fulfillment manifested through connection and disconnections throughout the life cycle. In a therapeutic modality this is effected

through the transference along with mutuality and authenticity within the context of the established relationship to promote healing, growth, empowerment, wellness and change as evidenced through the conceptualization of VSI ©.

To be human is to be social. To be social, we need to be securely attached to a reliable, benevolent, and trustworthy base, the specific nature of which evolves throughout life but never becomes unnecessary (Miller, 2002).

VSI© utilizes the developmental research and theories regarding treatment of traumatic stress and more specifically, gender oriented treatment of traumatized women and girls in its focus and application.

This model of relationships addresses separation, individuation, connection and reconnection as occurring within mutually empathetic and mutually enhancing therapy relationships. "Mutuality does not mean sameness, nor does it mean equality; rather it means a way of relating, a shared activity in which each (or all) of the people involved are participating as fully as possible" (Miller & Stiver, 1997). Jordan (1991) explains, "when empathy and concern flow both ways, there is an intense affirmation of the self, a sense of the self as part of the larger relational unit.." Gilligan (2002) refers to the therapeutic relationship as a "confiding relationship" where one can speak one's heart and mind freely, and sees this relationship as being the best protection against most forms of psychological trouble, especially in times of stress. Miller (1976) states that "women's sense of self becomes very much organized around being able to make and then to maintain affiliation and relationships."

To Jordan (1997), mutuality involves openness to change and healing on both sides of the therapeutic relationship. She believes that therapy involves mutual trust, respect and growth. While the therapist exercises certain kinds of authority and the client moves to a place of vulnerability, the attitude is one of empowerment rather than "power over." The client's position of vulnerability is at all times respected and protected; the therapist is there to serve the client's needs. Thus, the therapy relationship should never include an attitude of superiority; both members of the interaction/relationship must be open to influence by the other. Goals of therapy concern the development of an increased openness to learning and growth as well as an increased capacity to tolerate tension and conflict so that movement into isolation and fragmentation does not occur.

Although DBT ©, MET © and VSI © are based on collaboration, being non-judgmental, client readiness for change and self-determination, the guiding principle behind each model is quite different (Linahan, 1993; Miller, 1995; Gray & Pabon, 2007). In MET©, interviewing occurs in a way that aids a client in exploring the discrepancies between the individual's perception and his/her behavior (Miller, 1995). Linehan's DBT© promotes self-awareness through an integrated skills-based orientation that requires honesty and reflectiveness (1993). VSI © remains to be a strength-based approach that focuses on *resiliency*. It does more than begin where the client is. In the VSI © Model, the therapist assists the client to discover and embrace the authentic person that he or she is and recognize the skills that they already possess (Gray & Pabon, 2007). This separates VSI © from DBT © in that DBT © remains to be skills focused (Linahan, 1993). VSI © builds on awareness of the strength and validation in survivorship to

reframe distorted cognitions into a positive framework utilizing such skills, as demonstrated in DBT ©, to assist the individual to move "beyond survivor," into an integrated frame of reference that promotes a lifestyle change (Gray & Pabon, 2007). For example, in the VSI © Model, drug seeking behavior would be reframed in order to examine the individual's problem-solving abilities. Where DBT © identifies these aspects through diary cards that assist in cognitively connecting thought into action, VSI © similarly can work hand in hand with DBT© elements to assist the client into processing such triggers, behaviors and associated trauma induced stress reactions and/or process addictions.

Another glaring difference between MET ©, DBT © and VSI © remains that the latter model is a more intensive service of longer duration (Miller, 1995; Linahan, 1993; Gray & Pabon, 2007). The therapeutic relationship is pivotal to the process as a catalyst for learning how to develop trust and feeling safe with themselves, others and the world around them. Due to the brief nature of MET © treatment, individuals do not have the opportunity to assimilate victimization and survival and move toward integration (Miller, 1995; Gray & Pabon, 2007). Similarly, DBT© will address trauma and traumatic stress *after* participating in DBT © skills based focused individual and group therapies (Linahan, 1993). Short term treatment only serves to heighten the population's sense of rejection, abandonment and distrust. The VSI © process differentiates from the DBT © approach while utilizing appropriate contextual aspects of skills building and choice oriented reframing of distorted thoughts and impulsive actions while addressing the

issues related to how the impact of the [past] trauma interferes or plays a role in current dysfunction and distress (Gray & Pabon, 2007; Linahan, 1993).

Since the core elements of VSI © are safety, health, wellness and empowerment, this model has the ability to address the treatment needs of individuals who have experienced trauma and potentially have co-occurring substance related and/or process addictions/disorders. The integration of the aforementioned elements into the authentic self is essential in the healing process for individuals who are experiencing both of these issues. VSI © takes into account that these issues are simultaneous in nature and can be treated using a parallel process.

Jordan (1997) describes the experience of shame as being a "heightened sense of vulnerability where our sense of initiative falters; in interpersonal failures we attribute personal responsibility and unworthiness to ourselves." Shame is often viewed as the opposite of narcissistic pride, loss of self-respect or self-esteem, and is more importantly a felt sense of unworthiness to be in connection, a deep sense of un-lovability, with the ongoing awareness of how very much one wants to connect with others. Shame results in response to many different events, ranging from feelings of defectiveness, weakness, being out of control, foolish, babyish, dirty, stupid, awkward, betrayed or when in a love relationship, being more involved or vulnerable than the other person. Sometimes, merely being different becomes a source of shame. What occurs is a loss of a sense of containment of being in control, thus the effect of shame is global and immobilizing, and

results in one moving into hiding or secrecy in response to the feelings of being perceived as un-loveable. Extreme shame contributes to dissociation and inner fragmentation as the person struggles to be free of the experience of personal defectiveness. The VSI© Model assists the consumer in understanding the core elements and bases of shame, validating the experience, "catching" the triggers, diffusing with a positive and more appropriate reframing of the truth and an overall validation of one's growth with the relationship one has with one's self.

In her essay, entitled, *"Relational Development: Therapeutic Implications of Empathy and Shame,"* Judith Jordan (1997), explains that "a powerful social function of shaming people is to silence them. This is an insidious, pervasive mode of oppression. In a supposedly egalitarian society, shaming becomes a potent, indirect exercise of dominance to subdue certain expressions of truth." This is supported by Herman (2002), who describes the public attitudes of ambivalence toward both domestic and sexually victimized women, as well as toward offenders. She also appropriately notes that many victims of sexual and domestic violence still encounter dismissive, shaming or punitive attitudes from authority figures and from important people within the system and involved in their lives. Thus, many offenders can still reasonably expect tolerance for their behavior, if not frank encouragement form peers and authority figures. By creating silence, doubt, isolation and immobilization (through shame), the dominant social group assures that its reality becomes *the reality*.

Identifying, addressing shame based triggers remains to be one of the cognitive relational aspects of treatment associated with VSI © validated through use of the Stone

Center Relational Model within the conceptualized framework and application. Shame and betrayal remain difficult areas for consumers to approach in treatment. However, with an empathetic, informed, well trained therapist a mutual and authentic relationship can result once safety is established and reinforced in a non-judgmental, validating manner.

Rape continues to be the most under-reported of all violent crimes and the vast majority of rapists face no consequences for their actions (Herman, 2002). The social climate for tolerance against violence toward women has a profound effect on all of us. Habits of subordination are deeply engrained in mind and body—not only of victims, but of healers as well. She further indicates that it remains to be important to recognize, that many of these habits operate outside of full conscious awareness. When people are shamed and therefore, silenced by their shame, they cease trusting their own perceptions and sense of reality. Isolation enlarges the sense of self-doubt, uncertainty and "wrongness" (Jordan, 1997). Jordan believes that this renders individuals more vulnerable to other people's reality, leading them to further victimization. She explains that this accounts for some of the victimization that occurs with survivors of sexual abuse and contributes to the difficulty for many in leaving an abusive situation (p. 150). Thus, "shame prone" people are used to taking responsibility (or blame) for relational failures. She notes that in an interpersonal situation where there is injury, there are several responses:

1. getting angry and blaming the other;
2. taking personal responsibility (sometimes inappropriately);

3. getting angry and blaming the other;
4. taking personal responsibility (sometimes inappropriately);
5. to take both people into account and move towards understanding the relational patterns that lead to the failure, assuming a kind of relational empathy, similar to Kaplan's notion of "process empathy" (1988);
6. utilizing therapy to heal shame.

In summary, Jordan believes that healing shame essentially involves enhancing empathy for the self and the other, working to bring the person back into connection where empathetic possibility exists (1997, p. 153). Herman (2002) explains that pervasive, diffuse and unidentified experiences of fear and shame in daily life result in a habitual stance of appeasement. This stance prevents women from developing effective strategies of self-protection and renders survivors of early abuse particularly vulnerable to repeated victimization—even within the context of the therapeutic relationship. Jordan supports this notion with her description of a sense of "condemned isolation" as the primary source of human suffering. She contends that for survivors of sexual or domestic violence, the task of early recovery is to establish a reasonable degree of safety and self-care in daily life and explains that by identifying seemingly "minor" or "trivial" instances of bullying or shaming in daily life, and clarifying the client's automatic strategies of appeasement and conflict avoidance, may assist the client in moving from a position of immobilizing shame and helpless rage to a stance of effective resistance and self-defense (2002).

Authentic Accountability within the Therapeutic Relationship:

Jordan contends that in the context of therapy, establishing boundaries by setting specific limits with each individual, rather than putting (imposing) your boundaries on others, for the purpose of establishing a sense of authenticity as well as a sense of safety is paramount in averting disconnection. She explains that in treatment with survivors, the therapist needs to be aware that these individuals are inherently suspicious, guarded and cautious. These responses evolved as a result from previous interactions with others where invalidation or abusiveness occurred.

"Holding perpetrators accountable is difficult. The quest for justice offers many potential benefits as well as risks to survivors. Therapists need to hold a vision of what accountability means, as well as some realistic appreciation of what is required to bring it about" (Herman, 2002, Learning From Women Conference). She further explains, that "the central task of accountability is to remove the burden of shame from the victim and place it where it belongs—on the perpetrator." The concept of re-integrative shaming, developed within the justice movement, approaches focus on acknowledgement of harm and the possibility of making amends instead of punishing the offender. She notes that these approaches do not operate from the stance of neutrality but seek to correct the imbalance of power and moral imbalance between the victim and offender (2002).

Amy Banks (2002), in her discussion entitled, *"Neuroimaging: A Record of Traumatic Disconnection,"* believes that the Relational/Cultural therapy is well suited for the treatment of trauma survivors. She explains that within this model, healing

occurs when the client is able to bring herself more fully into connection with the therapist and ultimately with other supportive people in her life. Banks believes that the therapist facilitates the process by being an authentic presence within the relationship, by teaching the client about the benefits of growth fostering relationships and by maintaining a sense of empathy throughout the many complicated therapy interventions.

"When a therapist understands the strategy of disconnection, both intellectually and affectively, she is more likely to remain a steady, non-judging presence who can help the individual move from the isolation of disconnection back into connection" (2002). She further explains that, "for many therapists, the strategies of disconnection seen with individuals who have been traumatized can feel frightening and out of control. The affect attached to the disconnection is usually intense—rage, desperation, devastating grief" (2002).

Banks notes that most trauma survivors "who have done their time in the mental health system, have accumulated their share of stories of maltreatment and misdiagnosis" (2002). This notion concurs with those of the other significant trauma researchers and clinicians. Bank explanation clearly explains what other clinicians stated in similar terms, that: "rather than presenting a discrete picture of simple PTSD (Post-Traumatic Stress Disorder), they may confound their therapy with a plethora of life stresses accompanied by a confused and disorganized attachment style that taxes even the most seasoned of clinicians" (2002). Thus, when treating trauma survivors, it remains clear that the very symptoms that could serve as clues to the legacy of their abuse all too often only act to

alienate and mislead their therapists. Frequently, an underlying dissociative disorder goes undetected as clinicians valiantly attempt to contain the varied external manifestations of the disorder. Banks identifies self-injury, somatization, intractable depression, anxiety, re-victimization and substance abuse as potential symptomology appearing in patients who also may appear quite functional by successfully negotiating some areas of daily living (2002). She asserts that "a closer view, however, reveals this external presentation to be devoid of emotion, amnesiac for the trauma and concerned solely with a mechanistic approach to existence" (2002). Underlying this aspect of the personality are the unintegrated, fixated emotional responses to the abuse, transmuted into parts of the mind that are then often dissociated from each other (2002). Jordan indicates (2002b), that the therapist needs to be safe by publicizing to some degree the relationship, thus averting and changing the triggers from secrecy and shame. She describes the transformative power of love within the context of the therapeutic relationship, noting that love is not always sexual or romanticized, and that it can be a powerful tool in healing.

The Stone Center Relational Model focuses on establishing an authentic therapeutic relationship with an emphasis on achieving a sense of mutuality and openness. Traditionally, research studies concerning women have been approached according to criteria defined and designated from the perspective of a patriarchal society, which emphasized a "power over" hierarchy mentality that essentially invalidated natural, authentic female behavior and needs. This resulted through tolerance of sexual and domestic violence, enabling perpetrators, and "blaming the victim." Shame, silence,

secrecy and isolation became identified aspects of traumatized women in an oppressive society. Healing these aspects of pain and shame can effectively occur through utilizing an authentic, empathetic approach that emphasizes the aspects of mutuality, present in the Stone Center Relational Model. Therapists who advocate using a non-engaging approach to therapy that adheres to non-responsiveness and neutrality, and attempt to treat trauma survivors with this method of clinically oriented "disconnection," can be perceived as potentially perpetrating further abuses through a sense of re-victimization on the already traumatized client, and therefore impede, not facilitate, appropriate healing in therapy.

Therapists, in setting boundaries need to openly share relational concerns with clients in order to establish trust with those who trust no one. Consumers must to be able to confront therapists on issues of concern, boundary violations in an effort to learn how to express his/her needs. Through establishing appropriate connections with others, the client can focus on establishing and maintaining safety, breaking dysfunctional connections through making positive connections, and fostering self-care with the collaborative assistance of an involved, authentic and non-judgmental therapist who actively participates and experiences growth and change along with the client.

VSI© Stage-Oriented Grid

Victim Trauma/Attachment	Survivor Beginning/Middle- with and without resilience End -without resilience	Integration (Beyond Survivor) Life/Hero
Hopeless	Sees hope	Has hope
Avoidant	Risks and avoids	Risks

Sees self, others and world through victim eyes	Sees self, others and world as part of victimization	No longer exhibits thinking, feeling and worldview from a victim stance perspective
Dissociative	Deals and dissociates	Can deal with, sit with and integrate trauma with self
Hostile/Rage	Acknowledges anger	Deals, heals from anger
Coping through unhealthy behaviors without justification and/or recognition	Recognizes unhealthy coping	Utilizes healthy skills for coping, living & relationships
Unhealthy Entitlement	Begins to see affects of self in world	Sees importance of self with world
Hurts others	Begins to show empathy to/for others	Has empathy for self and others
Self-absorbed	Begins to recognize world is not just self	Integrates self with others and world
Confused	Stuck	Copes

The three stage model of Victim, Survivor and Integration incorporates the stages of change in its application. When entering treatment, these individuals are typically stuck in the Victim Stance with both issues. In the Victim stage, individuals may either be in the pre-contemplation, contemplation or determination stages of change, however, they are operating from feelings, thoughts and behaviors that are disempowering, unsafe and unhealthy. In VSI© drugs and/or alcohol abuse, cutting, food restriction, overeating, stealing, sexual risk taking, and repeated victimization to physical, sexual, verbal and emotional abuse in relationships are viewed as behaviors that takes away the individual's personal power. These actions impede a person's abilities to exist authentically. Such actions interfere with one's ability to access the individual's existing inherent resiliency and in developing further resilience.

During the second stage of treatment, individuals have shifted from a Victim Stance to that of a Survivor. Individuals take actions that promote safety and health. An overall Wellness Plan is collaboratively developed (using the dimensions of clearly defined aspects of wellness). Relapses into use of substances or other unhealthy or unsafe behaviors within the VSI © model are viewed as opportunities for growth. Through the implementation of the Wellness Plan within the VSI © model, "there are no mistakes, only lessons (Evans. & Sullivan, 1995)." Affirming and validating life experiences, strengths and resiliency fosters internal communication with the individual's authentic self.

As individuals move from an external locus of control to an internal locus of control, they have begun the third stage of Integration work. They have reached the maintenance stage of change. The therapist facilitates empowerment as individuals internalize and generalize thoughts, feelings and behaviors that promote continued healthy choice and lifestyle. At this stage, individuals view themselves as being more than just the manifestation of their trauma or addiction. Individuals see their trauma and/or addiction recovery as a life-ling growth process and journey.

The adaptable elements of the VSI © Model permits evolution and application of concepts into viable system based best practice oriented programs which are strength-based recovery oriented. Additionally, these programs are equipped with outcome measures among the varying aspects of traumatized populations. The following narrative includes a sample program that addresses utilizing VSI © with adjudicated female adolescent offenders with a history of trauma and co-morbid issues related to process addictions, substance abuse and impulsive/compulsive behaviors that impact attachment, relationships and social competency.

Treatment Processes

The VSI © model program would be extremely intensive for 40 adolescent females emphasizing safety, grounding, relationships, empowerment, honesty, non-judgment, focus on strengths, collaboration, readiness, understanding of the impact of trauma in an individuals thoughts, feelings, perceptions and behaviors.

Program Structure

The VSI © program would deliver services to a minimum of 40 adolescent females, between the ages of 14 and 17 years old, referred from the local juvenile justice system.

Goals for adolescent females participating in the VSI© program include**:**

- Reduction in arrests for delinquent behavior and use of abusive substances (i.e, alcohol, and other drugs);
- Increased knowledge of the specific behavioral, intra-psychic, and interpersonal consequences of exposure to sexual, physical and prolonged emotional abuse;
- Increased awareness of the specific behavioral, intra-psychic, and interpersonal consequences of exposure to sexual, physical and prolonged emotional abuse;
- Allow individuals to develop some degree of resiliency; and Empowers individuals to practice and incorporate new skills into everyday quality of life activities**.**

Intake Processes**:**

It is important to get good information from the adolescent females on their needs, but it is equally vital to spare them any unnecessary anxiety and protect their privacy. Initially it was thought that having program staff do a face-to-face interview to look for kids who are heavy substance abusers would be optimal. However, it soon became clear that it was too difficult to control the quality of these interviews in

a 24-hour-a-day operation. In addition, confidentiality was at risk due to the close quarters in which intake was being conducted. The VSI © model would adopt a computer-based kiosk style interview because it is a more efficient and private way to do this first round of intake**.**

VSI © Researchers and clinicians employ a cutting edge approach to treatment which includes screening and ongoing assessment through the course of therapy. Through the use of a variety of structured, semi-structured and validated self report measures which identify events, separate single episode as opposed to multiple layers of trauma [including intergenerational familial trauma] and the association between early chronic interpersonal and severe ongoing pervasive exposure to traumatic elements.

> "Early chronic exposure predisposes to both complex PTSD and PTSD symptoms; however, 23-45% exhibited complex PTSD and not PTSD symptoms. CPTS captures trauma-based symptom and stress reactivity dynamics that may be outside of PTSD diagnosis (Miele, 2007)."

VSI© uses a CPTS [Complex Post Traumatic Stress] orientation to identify and prioritize treatment according to concern for safety as well as severity of presenting symptoms. This comprehensive assessment remains both cost effective time efficient along with demonstrating best practice oriented delivery through its identification of essential dynamics necessary to devise an appropriate treatment plan for the identified consumer.

The Drug Use Screening Inventory-Revised © (DUSI-R ©) is a validated, standardized screening instrument that assesses a variety of domains of functioning in adolescents and consists of 159 items that documents the level of involvement with a range of drugs as well as describing the severity of consequences related to such use and involvement (Tarter, 1998). VSI © staff and program facilitators would use only the drug-use section since drug use is the program's primary focus and this specific section works well as a stand-alone screening tool. Other domains are assessed in greater depth later in the intake process.

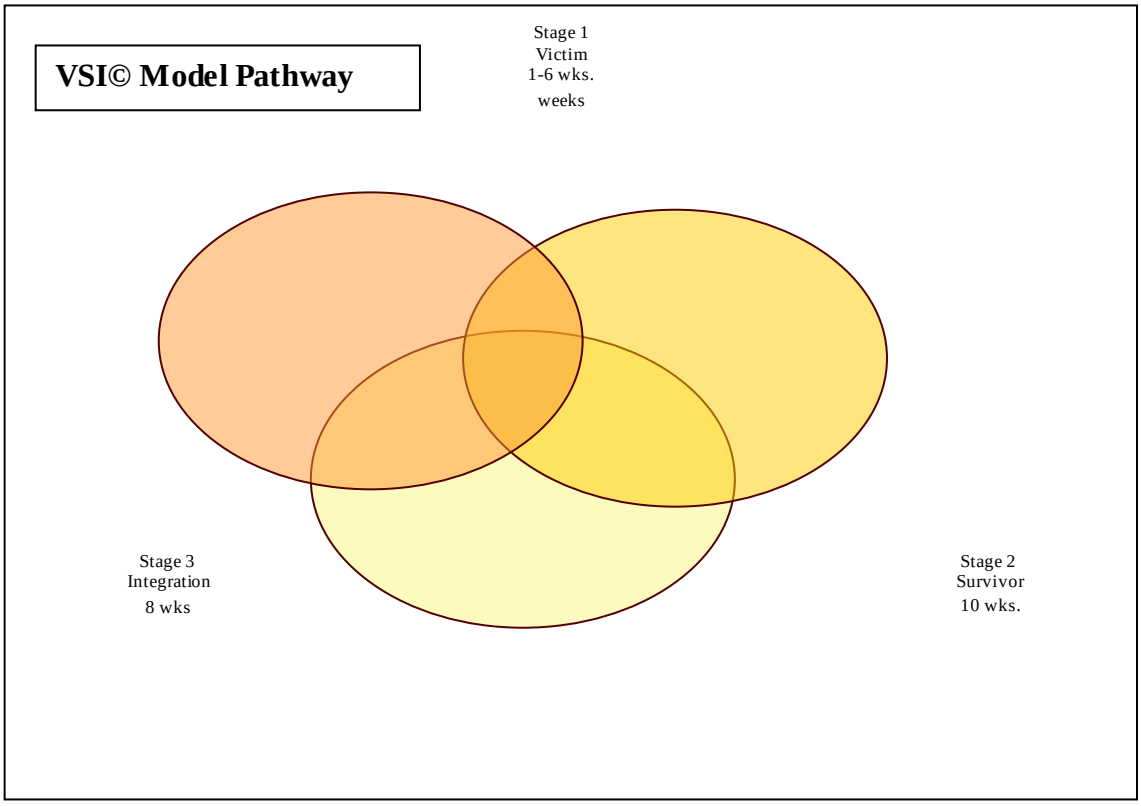
Additionally, VSI© staff would screen adolescent females using a computer-administered, voice-guided version of the DUSI-R© that is located in the admissions area of the residential and/or outpatient facility. During the intake process adolescent females would be asked by staff to sit at the computer and answer a brief set of questions from the DUSI ©. Adolescent females are asked to wear headphones so that they can hear the questions as they appear on the screen. All questions can be answered by clicking a mouse. Adolescent females with limited literacy can generally still do the interview since they are hearing the questions and are prompted verbally to select simple answers.

Confidentiality is maintained during the DUSI-R © interview by setting the computer at an angle that prevents other people in the room from seeing the answers. Additionally, each completed interview is automatically stored in the firewall-protected computer so that staff does not need to take any action to save the

interview.

VSI© staff and/or program facilitators would review the results of the DUSI-R © interviews the day after they are completed. Based on responses to the DUS-RI ©, staff and/or facilitators would determine which adolescent females should do a more in-depth, follow-up interview using the Global Appraisal of Individual Needs © (see *below)* (Dennis, Titas, White, Unsicker,& Hodgkins, (2003). DUSI-R © cutoff scores can be adjusted as criteria for follow-up interview depending on the desired severity level of clients.

The Global Appraisal of Individual Needs © (GAIN ©) is a full psychosocial interview, also validated and standardized and remains widely used in the United States, which means that the data gathered can be compared against a national sample (2003). The GAIN © is an adaptable tool; a site can make a number of changes to it without affecting its validity. For example, there were questions in the original GAIN © concerning use of heavy machinery found primarily in rural locations—such as cherry pickers and snowmobiles.



Once the youth has completed the GAIN ©, the interviewer can immediately determine if he meets the program criteria. Intake staff then asks the youth for his consent to enter the VSI © program. Her parents are contacted only if the youth agrees to participate and gives permission. Admission is complete once parents have consented; family members are generally seen within a few days following parental consent.

The three stage model of Victim, Survivor and Integration incorporates the stages of change in its implementation with each adolescent female. When entering treatment, these individuals will be typically stuck in the Victim Stance where they are operating with feelings, thoughts and behaviors that are disempowering, unsafe and unhealthy.

During the first stage which should last for 6 weeks, the adolescent female would begin to meet with a therapist at least once a week for the duration of the stage. In addition, the adolescent female would participate in a two and a half hour group wellness education session once a week for the six weeks.

The second stage of treatment typically shows a demonstrated shift for the consumer, from a Victim Stance to that of a Survivor where by the individual takes actions that promote safety and health. Upon completion of the group wellness education sessions, the adolescent female would participate in a two co-facilitator group empowerment group for the second stage which should last for at least 10-12 weeks. During this second stage, the adolescent female would continue to meet with the therapist once a week or biweekly depending on her needs and growth.

Finally, during the third stage of Integration, the adolescent female consumer should the have reached the maintenance stage of change. The client has internalized and generalized thoughts, feelings and behaviors that promote continued healthy choices and lifestyle. At this stage in VSI ©, individuals view themselves as being more than just a manifestation of their trauma and addiction. Individuals see their trauma and addiction

recovery as a life-long growth process and journey. Each adolescent female would proceed along the pathway of the stages at her own pace in accordance with her needs and growth with each stage requiring various degrees of intensity of structure. This third stage would involve continued individual sessions at a decreasing rate of occurrence and participation in a self directed maintenance empowerment group for at least 8 weeks or more.

The Wellness Education Group is built upon a six session curriculum which seeks to increase the client's cognitive understanding of the various aspect of a positive "quality of life" or wellness. It helps the client to begin to deal with a basic recognition of the "Victim Stance" and its implications for attitudes, feelings, and behavior. This phase of group treatment is designed to provide an understanding of how trauma is related to self-defeating behaviors, choices and relationships. This stage one group model works to assist clients in gaining an awareness of unhealthy survival skills while providing education for alternative skills building.

The second stage of the treatment process involves 10 sessions focusing on the sharing and examination of experiential experiences which highlight positive information processing and problem solving. At this stage, the emphasis is one building upon the cognitive skills as to wellness in developing positive responses to every day experiences to empower the adolescent to confront and adopt attitudinal and behavioral approaches to prior trauma experiences and to deal with current situations. Additionally, this stage two

group model works to assist clients in practicing, processing, reinforcing and incorporating healthier skills in their existing community and familial environments.

The third stage of the group model is based on resilience and empowerment. As such it is an ongoing peer support group run by the clients. Staff will be available as needed by the group for support and information. This phase of the group process builds on integrating resilience, empowerment, problem solving and healthy relationships. While it is structured for at least 8 weeks, it is probable that participation will continue beyond the program structured period as clients voluntarily develop relationships within themselves.

The VSI © Model approaches treatment through the recognition and validation of the need for specialized services to treat traumatized populations from an injury as opposed to an illness approach. It demonstrates best practice through an emphasis on recovery, confirmation of the impact of resiliency and experience as well as promotes overall wellness and empowerment from a viable stage oriented skills based cognitive-relational modality focused on attachment through healthy connections, healthy disconnections, identification of triggers, and the recognition of the impact of the past on the individual present in the here and now with hope for healing and change.

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