Risking Connection: Helping Agencies Embrace Relational Work with Trauma Survivors

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ABSTRACT. Risking Connection, a mental health training curriculum, empowers clinicians, counselors and other direct-service providers to respond to the complex needs of trauma survivors within the framework of growth-promoting relationships. The program enhances success by teaching providers to notice and use their own reactions to working with traumatized individuals and to attend to their own self-care, with a focus on empowerment, collaboration, hope, and optimism. Building on constructivist self-development theory (CSDT), Risking Connection teaches the philosophy of relational therapy in the context of accessible, experiential learning, enabling its ready transfer into practice. This paper will discuss how, by modeling the model, collaborative relationships have nurtured the development, application, and follow-up of Risking Connection.

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KEYWORDS. Child abuse, collaboration, connection, empowerment, Posttraumatic Stress Disorder, relational therapy, relationships, self-care, trauma, training

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Risking Connection is a relational framework for understanding the effects of trauma and for responding helpfully in a variety of treatment settings. Growing out of the relational therapy work of the Stone Center at Wellesley College, it is based on constructivist self-development theory (CSDT), a unifying personality theory that integrates psychoanalytic with social learning and other developmental cognitive theories (McCann and Pearlman, 1990; Pearlman and Saakvitne, 1995).

The Risking Connection model is a philosophy of treatment, not a specific technique or methodology in itself. It is intended to provide an underlying framework that will support and enhance a variety of techniques or modalities of trauma treatment—Dialectical Behavior Therapy (DBT), Trauma Recovery and Empowerment (TREM), Cognitive Behavior Therapy (CBT), Prolonged Exposure (PE), Eye Movement Desensitization and Reprocessing (EMDR), etc.—making these methodologies more effective across treatment settings. Risking Connection explains the effects of interpersonal violence and abuse perpetrated in relationships on the behavioral, emotional, and spiritual lives of survivors. Helpers learn that by demonstrating growth-promoting relationships in their interactions with clients and with colleagues, they foster hope, and can more effectively help clients repair their disrupted ability to connect in nurturing ways. This relational framework empowers both the client and the care-giver to build therapeutic alliances, self-awareness and self-care skills. The concepts are simple to grasp, but challenging to apply, as they often require a change in systematically ingrained ways of thinking about people diagnosed with mental illness.

Because most mental health treatment is currently provided in the context of a behavioral or medical treatment model, this approach challenges participants to consider how the power dynamics inherent in interpersonal trauma relate to the power dynamics in the systems in which they work and to explicitly explore potential resistance to Risking Connection. These include the following:

- Minimizing the effects of trauma on an individual, which leads to blaming clients (e.g., she/he only wants attention),
- Pathologizing treaters’ compassion and commitment to trauma work, which leads to blaming treaters (e.g., you’re overinvolved or gullible),
- Limited resources in the system (money, programs, people),
- Limited stamina, personal resources of treaters and adjunct professionals (e.g., people are already overtaxed and tired),
• Desire for simple answers to complicated questions (e.g., trauma always causes this symptom which is cured using this technique), etc.

The overarching construct in Risking Connection is that connection, the active ingredient in healing relationships, requires willingness to take risks on both ends of the relationship. The basic tenets are the following:

• Symptoms are meaningful, adaptive responses to traumatic stress (even when providers don’t understand the meanings).
• A RICH relationship (one that embodies Respect, Information, Connection and Hope) is the key to healing from trauma.
• Managing (and preventing) symptoms and crises requires building self-capacities, (or feelings skills) in both helpers and survivors, which are as follows:
  ○ Maintaining an inner connection with positive others
  ○ Feeling worthy of life (self as deserving)
  ○ Ability to manage feelings.
• The helper’s internal responses are essential tools and must be noticed and used constructively.
• Trauma work affects the person of the helper; self-care and attention to meaning are crucial (Saakvitne, Gamble, Pearlman, & Lev, 2000).

HISTORY OF THE RISKING CONNECTION MODEL

In 1988, a court order known as the “Augusta Mental Health Institute (AMHI) Consent Decree” required the Department of Behavioral and Developmental Services and the Department of Human Services in the State of Maine to establish and maintain a comprehensive mental health system that is responsive to individuals’ needs. In 1996-1997, based on this class action, adult survivors of childhood abuse and other severe trauma histories, who were consumers of state mental health services in Maine, challenged the lack of trauma services in the state. Informed by several statewide needs-assessments of consumers and professionals, and data from a variety of sources, Maine Department of Behavioral and Developmental Services identified trauma as a key public health issue. The department established the Office of Trauma Services (OTS), and became the first state in the nation to develop and implement a strategic plan to build capacity within the existing system of care to respond
more effectively to the needs of recipients of services with trauma-related problems (Jennings, 2001).

As part of the comprehensive strategic plan, the AMHI Consent Decree Court Master approved several major areas of focus to produce lasting systemic and clinical practice change in regard to trauma services. One of these was professional training to enable providers to respond with specialized knowledge and skill to traumatized clients, increasing accurate diagnoses and appropriate treatment, and decreasing the retraumatization of clients caused by practices which inadvertently reenact original abuse experiences.

Dr. Ann Jennings, Director of Trauma Services for the state of Maine, turned to Sidran Institute (then known as Sidran Foundation) to develop a basic framework, curriculum, and training program to educate clinical staff and other frontline personnel of state hospitals, community hospitals, and community mental health centers about how to help traumatized individuals in their system. Sidran Institute was known to Dr. Jennings as a nationally focused nonprofit organization dedicated to supporting people with traumatic stress conditions, providing education, and training on treating and managing traumatic stress, and developing curricula, books, and other publications for trauma survivors, family members, and professionals.

The tasks for Sidran appeared daunting. There was a lot of motivation in Maine, driven by the consent decree, survivor activism, statewide policy support, and strong organizational expertise. But Maine, as a state, was too small to provide the budget and diversity required for developing a curriculum to teach a trauma framework in public mental health service agencies. Partnership with a larger, more diversely populous state, where an interest in trauma had also been demonstrated at the state level, was sought. New York was chosen, and Janet Chassman, who at the time was Trauma Coordinator in the Office of Mental Health, Training Bureau, secured approval of the proposal from the state and arranged a funding contract through the Mental Health Association of New York State (MHANYS).

Development was strengthened even more in 1998, when on the recommendation of trauma therapist and researcher Beth Hudnall Stamm, PhD., Sidran contracted the Trauma, Research Education and Training Institute (TREATI), the nonprofit arm of the Traumatic Stress Institute in South Windsor, CT (led by project content manager Karen W. Saakvitne, PhD), to author the curriculum. The TREATI staff had decades of cumulative clinical experience working with traumatized clients in private practice and had developed a well-established theoretical
and clinical frame. They were anxious to meet the challenge of helping to develop a practical approach that would be useable by public systems and community agencies. This collaboration proved to be the best combinations of resources, skills, and passion.

**RELATIONAL PROCESS INFORMS THE DEVELOPMENT OF THE MODEL**

The *Risking Connection* project encountered many challenges and, ultimately, the shared process of finding solutions was a vital force of project development, powerfully demonstrating key aspects of the model. Project development itself required a relational approach, and ultimately the *Risking Connection* process directly informed the creation of the products. A diverse editorial advisory board was convened, including consumer/survivors, case managers, clinicians, and public sector mental health administrators from Maine and New York; several individuals who were both consumers of mental health services and professionals who had worked in the systems; trauma researchers and clinicians; an attorney specializing in mental health law, and Sidran personnel. The Muskie Institute at the University of Southern Maine was brought into the project to coordinate initial field testing and the train-the-trainer program.

The process involved “risking connection” by building relationships across many polarized points of view: theory versus application, private practice versus public sector, consumer versus provider, rural versus urban, professional versus paraprofessional, university versus technical college. Issues were aired regarding elitism and classism, power balance between consumer/survivor and clinical input, and resistance to change from all players. Even the language was up for debate: For example, *professional helper, staff member, treater, clinician, trauma worker, mental health worker, therapist, counselor, and provider* were used to refer generically to the wide variety of people who work with trauma survivors in agencies. To enhance the curriculum’s universal appeal and demonstrate respect for multiple points of view, it was necessary to shape the content to span a variety of learning styles, professional disciplines, educational and organizational levels, and to consider policies affecting adoption by provider agencies, schools, and in-service educational programming.

These developmental discussions, debates, and controversies were a window into the challenges of teaching a paradigm shift to lead a di-
verse workforce toward a more congruent treatment approach. About halfway through the process, the authors and other participants began to notice that the *Risking Connection* philosophy was at work within our team. The consistent, common, and passionate objective of all the very diverse stakeholders was to create a training curriculum to improve trauma services in public systems. Success required the willingness of participants to explore their own resistance to change and to invest in RICH relationships.

Consumer/survivors, public sector treatment and administrative personnel, and the authors alike had to rethink their strongly held positions, acknowledge the expertise of the others, and take the risk of trusting those they previously believed could not understand their point of view. Each group had to risk doing things and integrating ideas in a different manner than they had anticipated. While maintaining boundaries and professionalism, each group had to “be real” enough in their interactions to reveal their fears and vulnerabilities, so that those could be addressed in the material.

For example, the consumers and survivors on the board made it very clear that the forced medication, seclusion, restraint, and other forms of coercive behavioral control they had experienced in the course of “treatment,” were retraumatizing reenactments of their original victimization experiences. Their anger was palpable as they insisted that their parallel victimization experiences had to be directly addressed in the curriculum material. Simultaneously, state psychiatric hospital staff and administrators were adamant that their peers would reject the trauma model outright, if they were told that, rather than helping, the hard work and treatment approaches they have traditionally used had compounded their patients’ pain and disability. These were both valid concerns that were in direct opposition to one another. In addition, many of the stakeholders were mistrustful of the authors’ “ivory tower” and “elitist” private practice orientations and the authors, as leading experts in the trauma field, expected that their approach would be respected and readily embraced by the team of content consultants.

These issues were resolved through the use of the model itself. In discussions and correspondence with the editorial workgroup members, the authors addressed feelings/fears of alienation, disconnection and experience of others as dangerous and adversarial; attention was paid to including each point of view as valid and deserving of inclusion; and everyone had ample opportunity to practice tolerating and modulating strong feelings. All interactions between the authors, state personnel, Sidran, and the board members actively attempted to embody Respect,
Information, Connection, and Hope. Ultimately, the curriculum reflects the reality of all the participants, relating various points of view as examples of how the model works.

*Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse* (Jennings, 2001) was successfully field-tested in Maine and New York in 1999, revised and published in 2000. An advanced level, master trainer’s workshop was subsequently developed and a teaching manual, *Relational Teaching, Experiential Learning*, was published in 2001. Teaching others to teach *Risking Connection* (a “train-the-trainers” model) empowers agencies to sustain system change achievements over time. Since publication, *Risking Connection* has been used extensively in the mental health systems of Maine and New York, as well as in at least seven other states, as of this writing. The model has also been taught and implemented by professional and frontline staff who work with substance abusers, domestic violence victims, individuals with developmental disabilities, incarcerated women and a variety of other vulnerable populations in which traumatic stress conditions are prevalent. An adaptation for use by congregational clergy (Day et al., 2006) was published in January 2006, and another that specifically addresses domestic violence issues is in development.

**Relational Teaching, Experiential Learning: The Training Experience**

As the name of the master training manual implies, *Risking Connection* trainings are relational in nature. One of the fundamental messages inherent in the educational process is that the same therapeutic components that are healing for survivors are necessary for helpers as well. As such, it is the goal of every *Risking Connection* training to understand participants’ responses and resistances as meaningful and valuable, to provide a RICH relationship in the training experience, to support self-capacities in participants, and to model and teach self-care. All of this is accomplished within the context of a RICH learning environment.

**BASIC PRINCIPLES OF THE TRAINING PROGRAM**

Although published in book form, *Risking Connection* is truly a curriculum, created to be taught—and learned—in a live, interpersonal, relational workshop or classroom. The goal is to teach the approach by practicing the approach in the training setting. Practicing the approach in any setting with any audience requires a thorough knowledge of the
curriculum itself, and a practice of using its principles on a daily basis. To teach the philosophy, one must believe in it. This means that trainers have a solid grasp of the trauma framework, a relational approach, and a commitment to collaboration-based empowerment. Being well-grounded in these principles ensures the ability to apply them to any example or situation that might arise in the training itself. The RICH model is employed assiduously throughout the training to convey the paradigm to participants.

To convey Respect, trainers address every question as reasonable, keep to the time frame promised, assume there are survivors and consumers among the training participants, acknowledge the expertise of the participants, and ask the group to agree to observe confidentiality for clinical and personal material shared during the training. Risking Connection trainings generally develop a very distinctive atmosphere. The constant attention paid to respectful interaction may sound taxing; however, it is exactly the opposite. When trainers demonstrate respect, participants feel less defensive and more receptive to the material. Similarly, the trainers feel more receptive to comments and challenges by participants. The atmosphere is experienced as very relaxing, safe and supportive by both trainers and participants. This is especially important because it explicitly models the dynamics that participants will eventually use with their own clients and patients.

To support shared Information, trainers provide resource lists to participants, give examples of the more abstract principles, solicit the expertise of participants to help answer questions or give examples, and are not afraid to say when they do not know something. Risking Connection trainings are genuinely collaborative, using the expertise of participants and actively seeking opportunities to encourage their input. All participant questions are taken seriously and attended to by the trainers, but also responses are encouraged (within budgeted time boundaries) from other members of the group. Many of the concepts are demonstrated through role-plays. Often, the trainers play the roles themselves and allow participants to consult and assist whomever may need suggestions during the role-play. These role-plays can be very compelling for all in the training, and participants welcome the opportunity to critique and debrief them.

To facilitate Connection trainers endeavor to be real, let the participants get to know them, maintain a willingness to share their vulnerability and mistakes, listen to audience feedback and be willing to make changes, have participants introduce themselves and build networks (relationships), and most importantly have a sense of humor and willingness to laugh at themselves. These trainings have a unique feature
whereby a group of 50 people become connected with one another and with the trainers in such a way that they feel they’ve always known each other. Master trainers receive periodic phone calls and e-mails from participants who want to let them know how they are applying the model, how they are doing teaching it to others, and asking for consultation on particular applications. It is a testament to connection that participants keep in touch this way.

Risking Connection supports Hope when the trainers convey the belief that survivors can heal and the belief that people and systems can change. Trainers listen for the participants’ success stories, participate in the experiential exercises along with the group, and include exercises to address vicarious traumatization. Hope cannot be faked. One Risking Connection exercise asks participants to consciously hold their hope and their despair together—despair has never yet won out during this training exercise. Trainers are challenged, not to boost participants’ hope, but rather to support the self-awareness that puts people in touch with the hope that brought them into the work to begin with. Because the self-awareness exercises and worksheets are included in the curriculum manual, participants are able to remember them and renew themselves on a regular basis. In many ways, this training is a cleansing that helps participants shed accumulated baggage in the form of burnout, anxiety, and beleaguered beliefs about healing and recovery. Once they have done that, they find hope right where it has always been, in abundance.

Trainers assume that survivors and consumers are present in every setting, and explicitly acknowledge this to the group. No one is asked to make disclosures; rather, the stigma of trauma is addressed by being clear about the prevalence of trauma in groups of helpers. This is also a way to encourage all participants to use good self-care practices by taking extra breaks when needed. Survivors have commented repeatedly about how relieved they felt that this was discussed explicitly and how much more respected and relaxed they felt as a result. Trainers maintain a stance of mindfulness and respect, creating an environment that encourages personal self-care for all present. Risking Connection training offers protection from vicarious traumatization by avoiding graphic descriptions of traumatic experiences, telling participants that graphic language will not be used and why, and requesting that participants do not give graphic detail when discussing their own clinical material.

In order to understand some of the unique challenges of teaching this curriculum, it is important to appreciate the context of modern mental health treatment. Traditional views of mental health have been based on the medical model that looks for symptoms and prescribes treatments
that are symptom-focused. Traditional models of mental illness have emphasized what is wrong with the individual. By contrast, this trauma model shifts the focus away from symptoms and addresses the whole context of the survivor’s experience. It acknowledges the survivor as an expert in his/her own experience, and sees the therapeutic alliance as a partnership. Similarly, trainers also acknowledge Risking Connection participants as experts in their own realms, and invite partnership. Naturally, an effort to instill a paradigm shift may lead to conflict in persons who are strongly affiliated with the old paradigm. It is the job of the trainer to “model the model” by maintaining a respectful, understanding, and connected stance with all participants. The beauty of this use of self is that there is no need to defend the model, one has only to embody it, and that conveys its worth to others. Maintaining a RICH relationship with participants is disarming and allows for an exploration of conflicts and disagreement without rancor.

In the words of the teaching manual,

It will be important for you to be sensitive to the anxiety and concern of those whom you are teaching, while at the same time encouraging people to be open to consider the core principles of the curriculum. This will mean that you, the teacher, may have to maintain hope, optimism, and respect while fielding tough questions and even hostile challenges from participants. This balance will require you to use your clinical skills as well as teaching skills; in other words, in addition to responding to the content of people’s questions, respond to the process, the unspoken feelings, and the relationship with you. (Saakvitne, Gamble, Pearlman, & Lev, 2001, p. 8)

Trainers have commented that this non-defensive stance actually reduces their own anxiety, which reduces the participants’ anxiety as well. Even as trainers encourage participants to consider clinical work from a non-authoritarian paradigm, trainers are teaching from the same model. This can be tremendously comforting to those who feel anxious about the paradigm.

**USE OF SELF AND THE FRAMEWORK**

The Risking Connection tenets pervade all aspects of the training, from time management and logistics to the tools and techniques used to convey the material. Trainers are meant to put the relationship first in
order to assure the best environment for teaching the material. Participants feel enormously respected by adherence to good time boundaries and attention paid to their needs and preferences. The framework teaches that the relationship between the trainers and participants is the best tool for meeting teaching goals. This reflects the curriculum philosophy that the therapeutic alliance is healing in and of itself, and is the best tool for facilitating growth and recovery.

A typical Risking Connection training lasts three days or 20 hours. Each of the five modules is covered using a combination of lecture, role-play, discussion, large and small group work, and experiential exercises. Before embarking on the training, trainers gather as much information as possible about the participants. It is important to understand the social, personal, business, and treatment climates in which they work. Everyone has an opportunity to introduce him/herself, and trainers spend much of the first day learning the names of all participants. This is quite a challenge when training a group of 40-50 people, but it is imperative to the process of conveying respect and developing a relationship with the participants. This is the first demonstration of the trainers’ commitment to a relational mode of teaching. Participants feel both surprised and pleased to be called by name, and learning the names creates a different mindset in the trainers as well. Everyone becomes an individual rather than a number. The first day begins with a discussion of the Risking Connection philosophy, which allows exploration of conflicts, resistances, and common ground.

This approach lays the groundwork for discussing the five modules. The training usually moves in an easy rhythm where all participants have the opportunity to be known, heard, and to participate according to their preference. An ideal training utilizes two trainers, allowing the opportunity to use contrasting interpersonal and teaching styles and to have one observer to gauge the group and keep track of its needs, while the other trainer presents material or leads discussion. The genuine interactions between trainers have a warming effect in the trainings—especially when trainers feel free to use humor or to joke with one another. After all, trainers are encouraging use of self in the work, so their interactions model their individual styles. Brief evaluations are done verbally and in writing at the end of every training day so that trainers may alter the next day’s schedule to attend to the needs of the group. This evaluation procedure is essential for several reasons: (1) Participants learn a little more each day and are able to refine their sense of what they need, (2) There is far too much content to cover in three days so this allows trainers to be diligent about presenting the most relevant or difficult content in the training, and
(3) Daily evaluation model the kind of collaboration, empowerment and flexibility that the curriculum encourages in helpers.

By the end of the training, the group has a cohesive feel, and most participants feel connected in a profound manner. Vicarious Traumatization exercises often have the effect of moving people into self-reflection with opportunities to share wisdom and new insights. Many participants have not had previous opportunities to commiserate about the impact of the work. This training offers the chance to normalize experiences and receive support from others in a safe environment.

**RELATIONAL CHALLENGES**

One of the most important and challenging experiences in this training arises when participants have strong or oppositional reactions to the material. Similar to the treatment experience, trainers are most likely to lose the relational framework when in crisis. For example, in one training session, just as the training team was about to talk about managing crises, a confrontational panhandler come into the classroom insistently asking for money. The participants froze and waited to see what would happen. The trainers offered food and water to the man and also offered to talk with him outside of the room. The timing was so uncanny that participants actually asked whether the interaction had been staged! The trainers navigated it very well given the situation, and the group spent the next hour processing the experience. When the trainers debriefed, they reported having felt very anxious and unsure, but that the RICH model came to mind, and thereafter they felt they knew how to proceed in spite of their anxiety. This kind of situation is rare in the training room, but is not unlike the kinds of interactions faced by treatment providers every day. The “crisis” became an in vivo teaching tool, demonstrating that the curriculum supports trainers in the same way that it supports helpers. Trainers work hard to manage their self-capacities in order to be able to field tough questions and manage in unforeseen circumstances. As with survivors, managing in these situations requires the building of self-awareness and feelings skills. The training manual identifies the following principles for fielding tough questions:

1. Be nondefensive—you do not have to defend, persuade, or convince anyone. You are free to witness and validate participants’ process of grappling with (integrating, assimilating) the material. Try to remember that challenges are not about you and sometimes
not really about the curriculum, but instead reflect people’s fears about change.
2. Listen carefully and restate the core question—checking to make sure you understood.
3. Sometimes people have something very specific in mind, which they frame as question. If the person doesn’t seem satisfied with your or the group’s responses, you might say, “It sounds like you have something specific in mind” or “What are your thoughts about it?” Or “What do you think? What would you do?” Sometimes a person asks a question that she or he wants to answer themselves.
4. Agree when possible—people are generally more willing to listen when they feel heard and validated. When you can say “Yes, and...” instead of “Yes, but...” you invite a collaborative instead of contradictory (competitive) interaction. Also, if you start by disagreeing, usually the other person will be busy developing arguments to persuade you while you are speaking.
5. Do not feel compelled to have an answer—it’s okay not to know, or to say, “I haven’t thought about that before. I’d like to think about it first before responding.”
6. Keep track of the time, and limit discussion after a short time (unless the discussion seems to be of general interest and then note that you will take x amount of time to discuss this further).
7. Keep track of other participants’ reactions—use this information to assess the group’s needs relative to the expressed needs of the questioner.
8. Know the extent and limits of this curriculum—some questions are outside the scope of the curriculum. It is okay to say so.
9. Remember, you do not need to have all the answers or all the solutions to tough problems. You can share the dilemma with the participants—either the one asking, or the group at large. You do not need to solve it single-handedly (Saakvitne et al., 2001, pp. 124-125).

All of these principles reflect the Risking Connection philosophy and framework. It is often useful to point out how these principles work in all relationships where collaboration is a goal. Teaching a relational model to practitioners is an incredibly rewarding and taxing experience, much like the work of therapy. It requires the development of participant/observer skills, confidence tempered with humility, and a solid grasp of the teaching material. The trainers do not ask the participants to do anything that the trainers haven’t done or will not do. It is the partner-
ship in the process that makes it work. And like the therapeutic process, a RICH relationship is the key to success and growth.

**Participants Experience in Applying the Model**

A survey was designed and distributed in 2002, which contributed to understanding the impact of Risking Connection training on practitioners and their practices. It was largely open-ended, encouraging respondents to volunteer their experience and insights after a time of applying the learning.

**METHOD**

**Participants and Design**

**Pre-Study Survey**

Twenty participants in a 3-day Risking Connection training participated in the first-stage design of the training experience survey. Most were clinicians working in the Anne Arundel County area of Maryland. They represented service agencies from the private and public sectors, including the Baltimore City School System, the YWCA in Arnold, MD, the Maryland Department of Mental Hygiene, and private hospitals in the area. The survey interviewer participated in the training, met each of the participants, and obtained their verbal agreement to participate in post-training research. It was explained that traditional program evaluation was not the focus of this follow-up; the focus was the participants’ experiences with the training and their application of the learning, post-training.

Participants were contacted within six months of the completion of the training (using their preferred method of contact, i.e., e-mail, telephone, etc.). They were asked to describe their original expectation of the training and their experience following the training. Typical responses were positive, and supportive of the Risking Connection approach, for example, “I remember RICH with every client now and it helps an incredible amount.”

**Final Study Design and Participants**

The study questionnaire was compiled based upon the responses of the pre-study survey participants and the researchers’ interest in under-
standing how the training was being applied. The survey contained 24 dichotomous statements and 4 open-ended statements. The dichotomous statements reviewed the content and application of the training (e.g., “I give my Risking Connection training the credit for making me better equipped to help my survivor clients”; “In my experience, collaboration is key to working effectively with the majority of my clients.”) Each opened-ended statement allowed personal experience descriptions, e.g., Risking Connection training made it possible for me to ____________.

Potential respondents received a packet including a cover letter, a questionnaire, and a SASE for returning the completed questionnaire. The packets were forwarded to the 122 providers who had completed Risking Connection training conducted in the Northeast since 1999. These participants had enrolled in training at three different sites. They were from Connecticut, Maine, Massachusetts, Michigan, Texas, Vermont, Rhode Island, California, and New York and represented a cross section of private and public practitioners. The surveys were mailed to the participants’ addresses, provided during their original training. (Excluded from this survey were an additional 108 participants who had completed both the advanced, Master Trainer’s program and the basic Risking Connection training.) Six surveys were returned for incorrect address, resulting in a usable sample size of 116. The final rate of response was 26% (30 usable returns).

RESULTS

The Risking Connection emphasis on self-care and relationship building was well received and positively applied according to the respondents’ reports on the survey. They were consistently enthusiastic in their support for the principles that underlie the Risking Connection philosophy. On each statement in the survey, the majority of respondents were positive in their descriptions of all aspects of the Risking Connection approach (i.e., no response received less than 50 percent positive response).

The following highlights the responses, which are discussed further in the Discussion section. (A copy of the full questionnaire and all responses, including the voluntaries, is available from the third author.) The basic tenets of the Risking Connection approach were very strongly supported:
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<tr>
<th>Tenet</th>
<th>Survey Statement</th>
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<tbody>
<tr>
<td>Symptoms as meaningful adaptive responses</td>
<td>Viewing symptoms as adaptations empowers me and my clients in our work toward more effective methods of coping. (100%)</td>
</tr>
<tr>
<td>A RICH relationship–key to healing</td>
<td>In my experience, a RICH ... relationship is key to recovery from trauma. (89%)</td>
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<td></td>
<td>The relationship I establish with my client makes all the difference in short- or long-term treatment. (90%)</td>
</tr>
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<td></td>
<td>In my experience, collaboration is key to working effectively with the majority of my clients. (97%)</td>
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<tr>
<td>Development of self-capacities</td>
<td>Identifying clients' strengths has a ... place in the Risking Connection framework. (97%)</td>
</tr>
<tr>
<td>Helping the helper</td>
<td>Risking Connection training improved my effectiveness as a treater. (97%)</td>
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<td></td>
<td>I am better able to recognize and address the effect of vicarious traumatization because of this training. (87%)</td>
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<td>Risking Connection training boosted my enthusiasm and level of hope regarding working with trauma survivors. (93%)</td>
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<td></td>
<td>Risking Connection training helped me realize—in new and more obvious ways—how trauma work affects the person of the helper. (90%)</td>
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<tr>
<td></td>
<td>This training gave me insight and direction about the necessity of self-care on the part of the helper/ treater and its critical role in preventing vicarious traumatization. (93%)</td>
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Furthermore, 87% reported that this training made them “better equipped to help ... survivor clients.” It gave them “the RICH model for establishing a collaborative healing relationship ...” (77%), gave them information that helped them improve their “crisis response skills” (73%), and gave them and their clients “a model that helps them cope more effectively than they might without using this model” (77%).

In the voluntary responses, survey participants were especially enthusiastic about Risking Connection:

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<tr>
<th>Tenet</th>
<th>Voluntary Responses to Open-Ended Statements</th>
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<tbody>
<tr>
<td>Symptoms as meaningful adaptive responses</td>
<td>It really offered an empathetic training that helped the practitioner to understand the attempts clients make (sometimes symptomatology) to deal with trauma.</td>
</tr>
<tr>
<td></td>
<td>(I) have greater empathy for the clients I work with regarding symptoms as adaptations!</td>
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<td></td>
<td>It gives a different perspective on how counselors view clients’ action and behaviors.</td>
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</tbody>
</table>
| A RICH relationship–key to healing                                                                 | It validated for me that the client/therapist relationship is invaluable.  
|                                                                                                 | It was very helpful particularly with the individual long-term therapy client-therapist relationship.  
|                                                                                                 | (It made it possible for me to) make a palpable connection to clients—which is what helps as much as anything.  
| Development of self-capacities                                                                 | It utilizes an empathic, non-judgmental frame in which to talk about and work on client's trauma and all of their relationships... including relationships with self and the therapist.  
| Helping the helper                                                                             | (This training included) many valuable concepts which are not necessarily included in other trainings I’ve been to, i.e., emphasis on self-care for therapists and understanding VT.  
|                                                                                                 | It taught me a great deal about looking at myself and the importance of self-care in order to care for others. I learned so much about trauma, crisis response and the importance of strong client relationships.  
|                                                                                                 | It gives the heath care professional a comprehensive tool to provide a therapeutic environment that does not completely deplete the provider.  
|                                                                                                 | (This training made it possible for me to) quite simply, become a better counselor and very importantly, learn how to protect myself from vicarious traumatization and subsequent burnout. I know how to empathize with myself so I can do a better job of it with my clients. |

One respondent summed it by describing this as “a very good model for understanding trauma... (where the) presenters model RICH relationships with the participants.”

**DISCUSSION**

The findings of the survey indicate that fundamental tenets of the model are imparted by the training. Participants were able to identify and retain the philosophy and framework months after the training. The content training goals of teaching helpers ways to more effectively support trauma survivors have been endorsed by respondents especially those related to the RICH model and self-capacity development. The process training goals of providing a RICH relationship in the training experience, supporting self-capacities in participants, and teaching self-care seem to have a lasting impact. Implied in the responses are a greater sense of connection, efficacy, and ability to manage the more painful as-
pects of the work. Each of these reflects fundamental self-capacity de-
velopment and enhancement in the participant group.

This information-sharing experience with Risking Connection partic-
ipants clearly indicated the value of this approach and model in the cli-
ent-therapist relationship. The goal of the training is to empower and
collaborate with helpers so that they can do the same with their clients.
This preliminary assessment offers support for the success of Risking
Connection.

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