Trauma Informed Practice

Objective: This module describes how trauma informed care is a systematic approach to ensure all people receive care that is sensitive to the impact of trauma.

Trauma – Informed Care

There are hundreds of thousands of women and men who pass through our programs every day with painful histories of personal trauma (Rosenburg, 2011). The power of traumatic life events to destabilize individuals has often not been identified or acknowledged (Power, 2011). Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of clients served by addiction and mental health service systems (Jennings, 2004). For example:

- 90% of mental health clients have been exposed to and most have actually experienced multiple experiences of trauma (Mueser et al., 1998)
- 75% of women and men in substance abuse treatment report abuse and trauma histories (SAMHSA/CSAT, 2000)
- 97% of homeless women with mental illness experienced severe physical and/or sexual abuse, 87% experienced this abuse both as children and as adults (Goodman et al., 1997)
- Nearly 8 out of 10 female offenders with a mental illness report having been physically and sexually abused (Smith, 1998)

Fink, Read, and colleagues found that "psychiatric patients subjected to childhood sexual and physical abuse have earlier first admissions and longer and more frequent hospitalizations, spend longer time in seclusion, receive more medication, are more likely to self-mutilate, have high symptom severity and are more likely to attempt suicide" (Campbell, 2007, p. 10). The traumatic experiences of individuals with the most serious addiction and mental health problems are usually interpersonal in nature, intentional, prolonged and repeated, occur in childhood and adolescence, and may extend over years of a person's life (Jennings, 2004).

The Adverse Childhood Experiences (ACE) study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being (CDCP, 2012).The ACE study assessed retrospectively and prospectively, the long-term impact of abuse and household dysfunction during childhood on the following outcomes in adults: disease risk factors and incidence, quality of life, health care utilization, and mortality (Felitti et al., 1998). In their detailed study of over 17,000 middle-class American adults of diverse ethnicity, researchers found that the compulsive use of nicotine, alcohol, and injected street drugs increases proportionally in a strong, graded, dose-response manner that closely parallels the intensity of adverse life experiences during childhood (Felitti, 2004). Addiction is functionally viewed as an understandable, unconscious, compulsive use of psychoactive

materials in response to abnormal early life experiences, most of which are concealed by shame, secrecy, and social taboo. These experiences also increase the extensive range of health risks including chronic lung disease, ischemic heart disease, cancer, mental health problems, autoimmune disease, teen pregnancy, victimization, and liver disease (Felitti et al., 1998; Felitti, 2004). Felitti recommends routine screening at the earliest possible point for adverse childhood experiences and a treatment focus on underlying causes. He pointed out that addiction is more experience-dependent than substance dependent and compulsive use of only one substance is actually uncommon.

The figure below illustrates a lifetime perspective on how Adverse Childhood Events may lead to social, emotional, and/or cognitive impairment which contributes to an individual adopting health-risky behaviors ultimately leading to disease, disability, and social problems which could end in early death. The ACE study showed that risk factors for disease, disability, and early mortality are not randomly distributed but are directly influenced by experience.

Figure 1: Potential influences throughout the lifespan of adverse childhood experiences
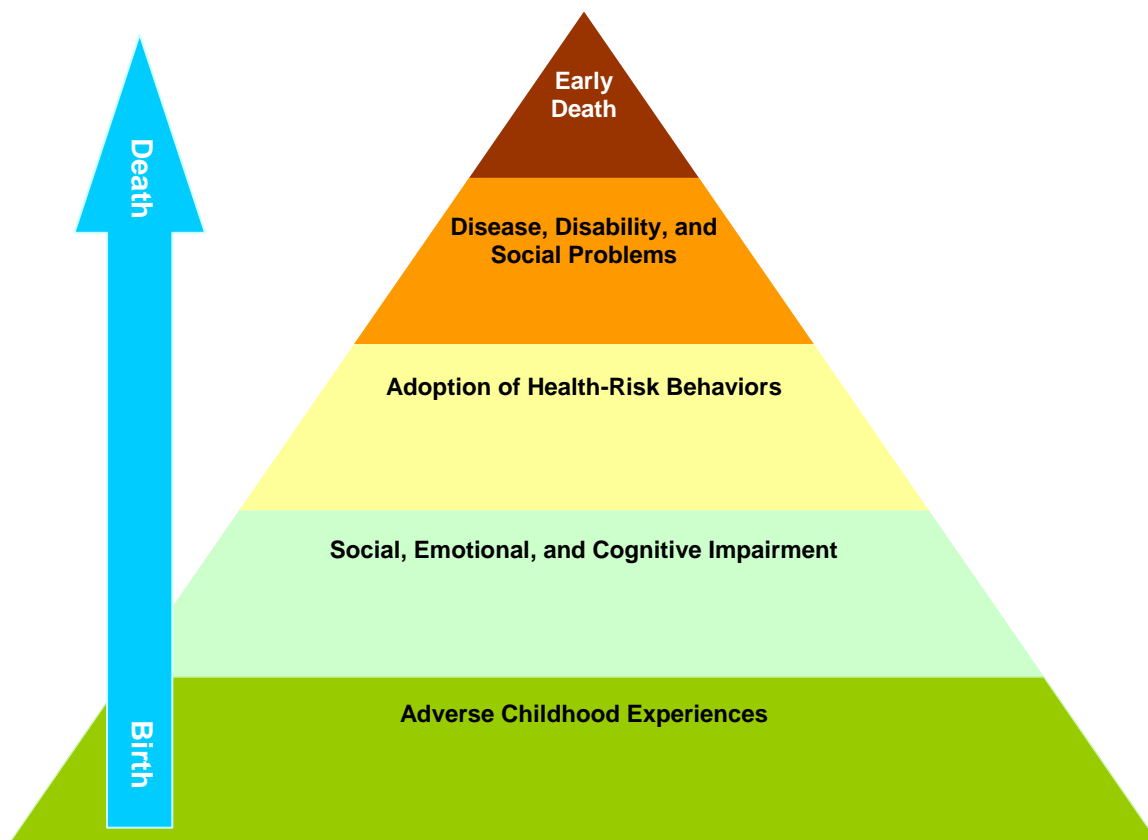
Adapted from Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventative Medicine, 14*(4), 245-258.

What is Trauma?

Trauma is an experience that overwhelms an individual's capacity to cope (CNSUAP, 2012). Trauma expert, Stephanie Covington (2003), suggests thinking of trauma as a response to violence or some other devastatingly negative experience. The diagnosis of Post Traumatic Stress Disorder (PTSD) has specific criteria. It is estimated that only 8-10% of those who experience trauma may meet the criteria for the diagnosis of PTSD Wise, 2007).

There are different types of trauma that might affect an individual at any time within their life. Wise (2007) defines and describes trauma using eight general dimensions and six specific distinctions. The eight general dimensions identified are:

1) Threat to life or limb;
2) Severe physical harm or injury, including sexual abuse;
3) Intentional physical harm or injury;
4) Exposure to the grotesque;
5) Violent, sudden loss of a loved one;
6) Witnessing or learning of violence to a loved one;
7) Learning of exposure to a noxious agent; and
8) Causing death or severe harm to another.

The six specific distinctions that clarify the definitions of trauma include (Wise 2007):

1) **Physical trauma** refers to a serious and critical bodily injury, wound, or shock…that resulted from an external source.

2) **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).

3) **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.

4) **Historical trauma** refers to events in history that were degrading and devastating to particular racial groups such as the massacres of Native American tribes, and the Holocaust for the Jews to name a few.

5) **Ongoing trauma** refers to forms of trauma that, instead of being identified with a single event, continue day after day.

6) **Vicarious trauma** is the stress experienced by the helpers 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. Another term often used is 'compassion fatigue'.
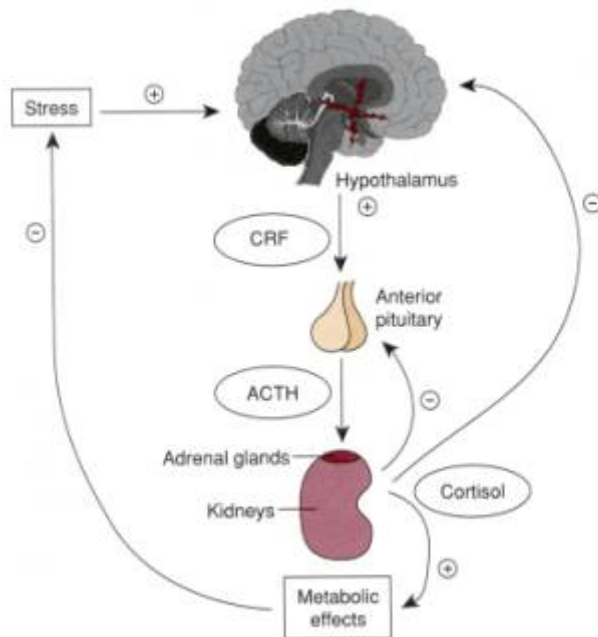
Impact on the Individual

Trauma has no respect for rich or poor, profession or occupation, country of origin or family of origin, of talent or personal purpose (Wise, 2007). Anyone can be traumatized. 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, p 51). Bloom (2005, cited in Barton, Gonzalez, and Tomlinson, 2012) explains how traumatic events in childhood can develop into adult pathology:

> Recent research on childhood trauma is helping to understand how children's exposure to overwhelming stress is transformed over time into adult psychopathology. As evidence accumulates it becomes clear that the brain organizes itself in response to environmental pressure that may be far more potent than even genetic influences because the central nervous system is so vulnerable to stress (Garbarino, 1999). For children who are exposed to continuous trauma, what begins as an adaptive response to threat – a fear state – becomes instead a fear trait that they carry into adulthood (Perry et al, 2005).

> Children who are exposed to violence show disturbing changes in basic neurobiological and physiological processes and it is postulated that these disturbances may have profound developmental consequences.

Diagram 1: Hypothalamus-Pituitary-Adrenal Axis (HPA axis)

Adapted from Deka Crossfit (2012). The real deal on adrenal fatigue. Retrieved Dec 20, 2012 from http://www.bing.com/images/search?q=hypothalmic+pituitary+adrenal+axis+stress&view=detail&id=7317CCEA 435407020A4CC0EE2BDB6730FC8B2518

The exposure to extreme stress, severe threats or traumatic events causes the paraventricular nucleus of the hypothalamus to release corticotropin releasing factor (CRF) and vasopressin. Vasopressin travels to the posterior pituitary and CRF travels to the anterior pituitary where they simultaneously stimulate the release of adrenocorticotropic hormone (ACTH). The ACTH then journeys to the adrenal glands that sit like top hats on the kidney, and kindles the release of the stress hormone referred to as cortisol. Normally cortisol mediates vigilance, catabolism, and immune and growth suppression (Scaer, 2012) however, when an individual experiences prolonged exposure to trauma (months/years), the elevated cortisol in the body has the potential to cause a condition called hypercortisolemia. Hypercortisolemia has neurotoxic effects especially on the anterior cingulate cortex and the hippocampus areas of the brain (Preston, 2012). Elevated cortisol affects the anterior cingulated cortex by causing dysregulation of autonomic (heart rate and blood pressure) and cognitive functions (decision-making, emotion, empathy, and the reward pathway) (Decety & Jackson, 2004; Jackson, Brunet, Meltzoff, & Decety, 2006). Also, the elevated cortisol results in decreased dendritic branching and neuronal death in the hippocampus (Scaer), which will create difficulties with spatial memory and navigation and transferring knowledge from short-term memory to long-term memory for the affected individual. For example, exposure to trauma can damage the brain (Scaer).

In addition, research has found that extreme stress, neglect, and early relational trauma can cause serotonin and oxytocin to plummet. The decrease in serotonin may contribute to the individual developing irritability, anxiety, impulsivity, ruminations, aggression, and suicidality (Olszewski & Varrasse, 2005) and oxytocin dysregulation has been linked with posttraumatic self disorders (eg. dissociation, somatization, and interpersonal sensitivity), posttraumatic stress disorders, and pelvicvisceral dysregulation disorders (eg. irritable bowel syndrome, chronic pelvic pain, interstitial cystitis, and hyperemesis gravidarum) (Seng, 2010).

Examining children's behavioral responses, Bruce Perry and his colleagues have observed persistent hyperarousal and hyperactivity, changes in muscle tone, temperature regulation, startle response, and cardiovascular regulation as well as profound sleep disturbances, affect dysregulation, specific and generalized anxiety, and behavioral impulsivity in children who have been traumatized.

Over time, these growing children proceed down a number of different pathways in order to help themselves adapt to disordered physiological stability and emotional dysregulation. Some may become addicted to drugs, alcohol or certain behaviors. Others may develop an eating disorder. For others, anxiety and depression will be the predominant presenting problem. Still others will have recurrent difficulties with relationships that will dominate the clinical picture, while

others manifest their underlying unresolved conflicts via bodily illness and dysfunction that can affect virtually any organ system. There is also a possibility for an individual to develop attachment disorders, sensory processing disorders (SPD), developmental trauma disorder (DTD), or disorders of extreme stress, not otherwise specified (DESNOS) (Scaer, 2012). As a result by adulthood, the presenting picture can look amazingly diverse and consequently, the common traumatic origins of the pathological processes of development can easily be overlooked or ignored.

Gender, Trauma and Process

Females and males experience and respond to trauma differently based on their socialization. As children, boys and girls suffer similar rates of abuse however, girls are more likely to be sexually abused and boys are more likely to be emotionally neglected and physically abused (Covington, 2012). As females and males develop and grow older, of those experiencing trauma, females commonly suffer abuse within their relationships perpetrated by the individual(s) to whom she is saying 'I love you', whereas males commonly suffer abuse through combat, being a victim of crime or by a person who dislikes them (Covington). Outlined eight elements within the process of trauma that an individual proceeds through when they experience trauma (Covington). Behavioral research shows that women survivors are more inclined to engage in 'retreat' and 'harm to self' behavioral pathways and male survivors are more inclined to engage in 'harm to self' and 'harm to others' behavioral patterns as a response to the trauma. Because there are gender-specific differences in the experience and response to abuse, Covington (nationally recognized clinician, author, organizational consultant, and lecturer) strongly promotes gender-responsive treatment when working with the sequelae of trauma (an example of trauma-specific care, to be defined shortly).

Figure 2: Process of Trauma

Traumatic Event		
Overwhelms the physical and psychological systems, intense fear, helplessness, horror		
Response to Trauma		
Fight, flight, freeze, altered state of consciousness, body sensations, numbing, hyper-vigilance, hyper-arousal		
Sensitized Nervous System Changes in the Brain		
Current Stress		
Reminders of trauma, life events, lifestyle		
Painful Emotional State		
Retreat	**Harm to Self**	**Harm to Others**
Isolation	Substance Abuse	Aggression
Dissociation	Eating Disorder	Violence
Depression	Deliberate Self-harm	Rages
Anxiety	Suicidal Actions	

Confounding trauma's prevalence is the fact that mental health services themselves may be experienced as traumatic (NASMP, 2011). The use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment, rather than empowerment and choice, often cause unintentional re-traumatization in already vulnerable populations (NASMP).

Impact Adverse Childhood Events can have on Relations with Clinicians

It is important to remember that during an encounter with a trauma survivor there may be specific emotional responses and behaviors that occur on behalf of the survivor as a result of their experiences. Understanding and anticipating these feelings can assist health care professionals in creating a safe trauma-informed interaction and environment for clients. Schachter, Stalker, Teram, Lasiuk, and Danilkewich (2009) discuss nine facets to consider when working with clients, as follows:

> **1. Distrust of authority figures.** Although this distrust originates in the past and should not be taken as a personal affront, survivors constantly scrutinize health care providers for evidence that they are taking active and ongoing steps to demonstrate their trustworthiness. It is crucial to recognize that some survivors may associate a health care practitioner's attempt to verbally assure them that they are safe with the perpetrator's empty assurance of safety during their abuse.
>
> **2. Fear and anxiety.** Many survivors spoke at length about their tremendous fear and anxiety during health care encounters. The experiences of waiting, being in close contact with authority figures, and not knowing what is to come all resonated with past abuse. Some survivor participants said that they were even afraid of being abused by the health care practitioner.
>
> **3. Discomfort with persons who are the same gender as their abuser(s).** For some survivors, the gender of a person in a position of authority is a powerful trigger that can leave them feeling vulnerable and unsafe. This strong reaction prevents some survivors from seeking care from practitioners who are the same gender as their abuser. When a client requests a health care professional of the opposite gender to the one that they were assigned, respect their wishes without hesitation and judgment.
>
> **4. Triggers.** Can include sights (clothing, mannerisms), sounds (raised voices, sobbing, phrases, tone), smell (cologne, tobacco, alcohol), touch (touch on certain body parts, touch that comes without warning), and taste (alcohol, certain foods, bodily fluids). Examinations or treatments may trigger or precipitate flashbacks. A flashback is the experience of reliving something that happened in the past and usually involves intense emotion. For example, intense emotions may comprise of fear, anxiety, terror, grief, or anger. Some survivors are particularly susceptible to flashbacks and some are overwhelmed by them.
>
> **5. Dissociation.** Dissociation is "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" that may be sudden or gradual, transient or chronic. Spiegal (1990) and Putnam (1989) liken it to a state of divided consciousness in which aspects of the self that are normally integrated become fragmented. Many believe that dissociation is an effective strategy for coping (in the immediate situation) with extreme stress such as childhood sexual abuse. However, if it becomes a long-term coping mechanism, it may contribute to a variety of mental health problems and interfere

with relationships, self-concept, identity development, and adaptive functioning. A number of survivors indicated that they do not have consistent control over this mechanism through which they escape from a current (usually stressful) situation; some even report that for many years they were unaware of their tendency to dissociate. When survivors are in a dissociative state, some individuals experience themselves as being outside their bodies, watching the present situation from a distance. Others simply go silent, stare blankly into the distance, or seem unaware of their surroundings. When the dissociative episode is over, individuals may have no memory of what occurred and may have difficulty orienting back to the present.

6. Ambivalence about the body. Many survivors feel hate, shame, and guilt about their bodies. As children, many believed that something about them or their bodies invited or caused the abuse. This belief is reinforced if the survivor enjoyed some aspects of the abuse (e.g., special attention, physiological arousal). This shame and guilt may lead some survivors to feel ambivalent about and disconnected from their bodies. The conflict between the need to seek health care and the ambivalence or dislike of one's body can affect treatment. For example, an individual may ignore symptoms that might contribute to an accurate diagnosis, explain an individual's response to treatment, or interfere with the ability to self-monitor effects of an intervention or medication.

7. Conditioning to be passive. Abuse can teach children to avoid speaking up or questioning authority figures. In adulthood, survivors may then have difficulty expressing their needs to a health care professional who is perceived as an authority figure.

8. Need to feel in control. The act of abuse involves the perpetrator exercising power over a vulnerable child. The relationship with a health care professional can feel very much like an individual having power over the survivor and could be a trigger. Thus, it is important to empower the client in a healthy therapeutic relationship.

9. Feeling unworthy. Trauma survivors often blame themselves, feel like it's their fault, and believe they deserved what happened. This thought pattern affects self esteem and often survivors don't believe they deserve to be cared for, to have good things in life, or even deserve to live. Shame and guilt are prominent emotions for trauma survivors.

What is trauma – informed care?

Being trauma informed means to have a systematic approach which ensures that all people who come into contact with the addiction and mental health care system will receive services that are sensitive to the impact of trauma (Rosenberg, 2011). It also means realizing that the vast majority of people we come into contact with have trauma histories (Rosenberg). Trauma must be viewed as an expectation not an exception.

While some experts support clinicians asking the client about past traumatic history, working in a trauma-informed way does not necessarily require disclosure of trauma (CNSAAP, 2012). Rather services are provided in ways that recognize needs for physical and emotional safety, as well as choice and control in decisions affecting one's treatment (CNSAAP). Safety, trustworthiness, choice, collaboration, and empowerment are the core values of a trauma-informed culture of care. If an organization can honestly

state that every contact, every activity, every relationship, and every physical setting reflects these values, then it is a trauma-informed culture (Fallot & Harris, 2011).

It is important that we shift our focus from asking the people who seek our help what is wrong with them to asking what happened to them (Rosenburg). This may entail that clinical staff ask clients that they work with about their trauma history (Rosenberg). Asking the question respectfully and being prepared to listen are prompts to open the discussion about this sensitive issue (Rosenberg). For example, "I know these things can be hard to talk about, but there is growing evidence that violence and abuse can affect a person's health and create difficulties during health care encounters…you don't have to discuss this with me if you don't want to…but if you do, I can work with you to ensure you are comfortable when you see me and to get the support/assistance you need" (Schachter et al., 2009). Power (2011) postulates that it should be best practice to ask persons who enter addiction and mental health systems at an appropriate time if they are experiencing or have experienced trauma in their lives. Understanding trauma, trauma survivors, the nature of services and the service relationship in a way that changes fundamental questions is the first step.

"What has happened to you?"
"How have you tried to deal or cope with it?"
"How can you and I work together to further your goals for healing and recovery?"

Adapted from Fallot, R. D. & Harris, M. (2011). Culture shock. *National Council Magazine, 2*, 28-29.

Although these questions are appropriate for a health care professional to ask their client, it is essential to remember that trauma-informed care does not require for the client to disclose. However, if a client chooses to disclose history related to trauma, Schachter et al. (2009) share effective trauma-informed responses for the health care professional to utilize, as follows:

> **1. Accept the information.** Clients need to know that their health care professional has heard them, has accepted the information, and believes children are never responsible for abuse. When survivors disclose their history of abuse, it is usually because they hope that something positive will come from it. If clinicians do not respond, survivors may interpret the silence as an indication of lack of interest, which may deter them from mentioning it again. Moreover, they may stop seeing that particular clinician or, in the extreme, avoid all health services.
> **2. Express empathy and caring.** Survivors also want to know that their clinicians care about them. Simple statements of empathy and concern can convey both compassion and interest.
> **3. Clarify confidentiality.** Health care professionals do not have a legal obligation to report past child abuse disclosed by an adult, unless, in disclosing his or her own experience, a client identifies a child who may be currently in need of protection (e.g., if a male patient who was abused by a family member tells the practitioner he has reason to believe that the same perpetrator is continuing to abuse children). All Canadian jurisdictions, except Yukon, have laws that mandate a duty to report cases of suspected abuse or neglect of children to child welfare agencies or to police.

4. Acknowledge the prevalence of abuse. Understandably, many survivors feel very isolated and alone in their experience. Having health care professionals demonstrate awareness about the prevalence and long term effects of childhood trauma normalizes the experience for survivors and may reduce their sense of shame. For example, a clinician might say, "We know that as many as one in three women and one in seven men are survivors of childhood sexual abuse. It is sad to realize that so many children have suffered in this way."

5. Validate the disclosure. Health care professionals must validate the courage it took to for the client to disclose and communicate that they believe what they have been told. Visible distress needs to be acknowledged (e.g., "I see that this is painful [distressing, disturbing] for you right now. What can I do to help?" or "It is okay if it takes more than one visit to do a complete examination"). Failure to validate the survivor's experience, silence, or judgmental comments can be shaming and contribute to a reticence to disclose in the future.

6. Address time limitations. Time pressures are one of the biggest impediments to disclosure. If clients disclose a history of abuse and the health care professional can spend only a few minutes with them afterward, it is important that the time constraints are communicated in a way that will not leave survivors feeling dismissed or that they have done something wrong by disclosing (e.g., "Thank you for telling me about being abused. I can only imagine how difficult things have been for you. I have another patient waiting – do you want to book a longer appointment later this week?").

7. Offer reassurance. Because individuals who have disclosed have shared some very personal information, they may feel vulnerable and exposed – both at the time of the disclosure and during future encounters with the health care professional to whom they have disclosed. To minimize this sense of vulnerability, health care professionals can reassure survivors that they commend the courage it took to talk about past trauma and that the information that has been shared will be useful in providing appropriate health care.

8. Collaborate to develop an immediate plan for self-care. Some survivors identified unsettled feelings or flashbacks of their trauma as an immediate after-effect of disclosure. Accordingly, health care professionals should caution individuals who have just disclosed to be prepared for these feelings. They should then work with survivors to make a specific plan for self-care (e.g., "Sometimes talking about past abuse stirs up upsetting memories. Tell me what you can do to look after yourself if this happens to you.").

9. Recognize that action is not always required. Survivors who have just disclosed may not necessarily expect clinicians to do anything except to be present with them in the moment. While it is important to ask survivors if there is anything they want prepared in relation to their disclosure, it may be preferable to identify a later time for discussion about what actions (if any) the survivors want from the health care professional.

10. Ask whether this is the patient's first disclosure. By asking "Have you talked with anyone else about this?" health care professionals can get a sense of whether the survivor has previously taken any steps to address the trauma. An answer of "No, I have never told anyone before today," as compared to "Well, my counsellor knows and suggested that I tell you," can help clinicians to shape their next response. It may also help them learn what supports the clients have in place and what they may need.

Table 1: Responses to Avoid after a Disclosure

Trauma survivors identified the following responses from health care professionals after disclosure as not helpful:

- Conveying pity (eg. "Oh, you poor thing").
- Offering simplistic advice (eg. "Look on the bright side", "Put it behind you", "Get over it", or "Don't dwell in the past").
- Overstating or dwelling on the negative (eg. "A thing like that can ruin your whole life").
- Smiling (while you may hope that your smile conveys compassion, a neutral or concerned expression is more appropriate).
- Touching the survivor without permission even if you intend it as a soothing gesture.
- Interrupting (let the individual finish speaking)
- Minimizing or ignoring the individual's experience of trauma, the potential impact of the trauma, or the decision to disclose (eg. "How bad could it be?", "I know a woman that this happened to and she became an Olympic gold medalist", "Let's just concentrate on your schizophrenia", "What does that have to do with anything?"
- Asking intrusive questions that are not pertinent to the examination, procedure, treatment, or consultation.
- Disclosing your own history of abuse.
- Giving the impression that you know everything there is to know on the subject

If health care professionals think that they have inadvertently responded to the disclosure in an inappropriate way, or if the client's nonverbal feedback suggests a negative reaction to their initial responses, they should immediately clarify the intended message and check with their client for further reaction.

Schachter, C. L., Stalker, C. A., Teram, E., Lasiuk, G. C., Danilkewich, A. (2009). *Handbook on sensitive practice for health care practitioners: Lessons from adult survivors of childhood sexual abuse.* Retrieved December 21, 2012, from http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook_e.pdf

In a trauma-informed environment, everyone is educated about trauma and its consequences (Power, 2011). Individuals and organizations are alert for ways to make their environments more healing and less re-traumatizing for both staff and the individuals they serve (Power). Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive (SAMHSA, 2012). Healing and integrated care must respect, honor and validate survivors' experiences in a positive way.

Fallot (2011) and others have noted, in trauma-informed health services system:
- Repeated trauma is viewed as a core life event around which subsequent development organizes
- Treatment for individuals who have been traumatized recognizes both their vulnerabilities and their strengths

- Services for trauma survivors are based on the principles of safety, voice empowerment and choice as defined by the people we serve
- Trauma services are ethically, racially, and spiritually relevant to the individual and gender-specific
- Trauma treatment is coordinated across multiple service systems

Becoming trauma – informed may be a goal for many addiction and mental health systems currently, but it is important to remember the distinction between the similar terminology between trauma – informed care and trauma – specific care. To determine the difference between trauma-informed care and trauma-specific care, Fallot & Harris (2011) offer the following distinction:

> **Trauma-informed** is a setting that takes into account the prevalence of trauma, its broad and deep impact on survivors, and the complex and diverse ways in which people recover and heal from trauma. **Trauma-specific** services, on the other hand, focuses directly on the sequelae of trauma and facilitates recovery.

The implementation of systems of care that are trauma-informed is a cornerstone in building service systems that do not traumatize or re-traumatize services recipients or the staff that serve them (NASMHPD, 2011). Strategies exist to prevent traumatization and re-traumatization on behalf of clients and staff. Trauma-informed prevention strategies include reducing and eliminating the use of seclusion and restraint; using prevention tools such as trauma assessments, safety planning, advance directives, and identifying violence or self-harm risk factors; workforce training and development, and the full inclusion of consumers and families in formal and informal roles (NASMHPD).

Why is a focus on trauma-informed care important?

Rosenberg (2011) offers three reasons why trauma-informed care is an important focus for health care organizations:

1. Violence is pervasive. According to the United States Department of Health and Human Services Office on Women's Health, from 55 to 99 percent of women in substance use treatment and from 85 to 95 percent of women in the public mental health system report a history of trauma, with the abuse most commonly having occurred in childhood.

2. Physical and psychological consequences of violence are highly disabling. The ACE (Adverse Childhood Experiences) study found that the greater the number of adverse experiences, the greater the risk for negative outcomes. This statistical increase occurred in a strong and graded relationship. Almost two-thirds of the study participants reported at least one ACE, and more than one of five reported three or more ACE.

3. Trauma is often ignored because it is shrouded in secrecy and denial. We don't talk about trauma because often we aren't prepared to hear it or address it.

The following vignette provides an example of how one individual affected by trauma responded in order to survive remembering her past experiences.

Lindsay's Story: Now 30 years old, Lindsay provides a description of her experience of reoccurring memories of her traumatic experiences.

In my teens, I had to deal with the reoccurrence of past traumas. These occurred in the form of flashbacks and sudden interruptions of my memory. If it wasn't for the patience and care I received during these times, I know for a fact that I would not be alive today to tell this story. My brain could not deal with or comprehend what was happening to me as a child so it switched itself off. Quite often a flashback experience would lead to feeling like I was in a dream or being unable to recall a specific period of time.

After one incidence, I had two deep cuts on my abdomen. I was bleeding and in shock. I felt such shame and fear from this incident that I did not tell anyone. I took myself to the doctor; I knew I needed stitches. I waited for hours at the doctor's, just sitting, alone and afraid that I couldn't even remember doing this to myself. I was numb to the core of my body. I couldn't say anything to the doctor. I just stood there and slowly lifted up my top, showing him the wounds on my abdomen. He gave me a letter and sent me to the emergency room across the street. I walked into the hospital in a daze. Still numb, I gave the lady at the counter the letter and they put me on a bed and stitched me up. I remember Daisy, my care-taker, coming into the room; she hugged me, kissed my head and told me it was going to be OK. I was safe and it was OK for me to feel the pain.
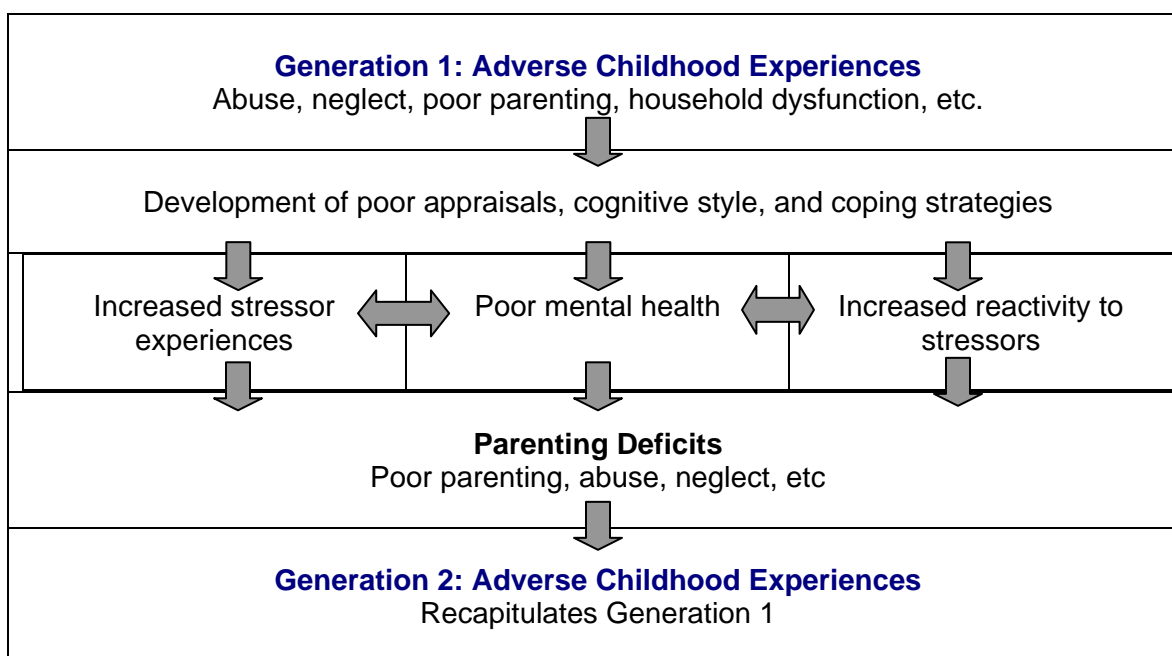
There were many times after this incident that I lost my memory; they were painful episodes and often brought back feelings and emotions from the abuse in my past. I have scars on my body that will never go away. I was hurt so much inside; the pain from cutting took it away. For that split second when the knife pierced the skin, all I could feel was the sensation, not the pain in my heart.

Note. Adapted from Author Uknown. (2012). Trauma-informed practice. In S. Barton, R. Gonzalez, & P. Tomlinson (Eds.), *Therapeutic residential care for children and young people: An attachment and trauma-informed model for practice* (48-67). Philadelphia, PA: Lighthouse Foundation

Intergenerational Trauma

Traumatic events, particularly if these occur in early life, can alter cognitive processes so that appraisals and the ways of coping with stressors are altered, thereby increasing vulnerability to pathological outcomes (anxiety, depression, post-traumatic stress disorder, addiction etc.) in response to stressors that are subsequently encountered (Bombay, Matheson, & Anisman, 2009). Such experiences may have profound intergenerational effects through altered parenting, which affects the appraisal and coping styles of the offspring (Bombay, Matheson, & Anisman). For example, the following table illustrates the pathway of how intergenerational trauma is transmitted behaviorally from parent to child and on through the generations.

Table 2: Mediators of the intergenerational transmission of trauma within families

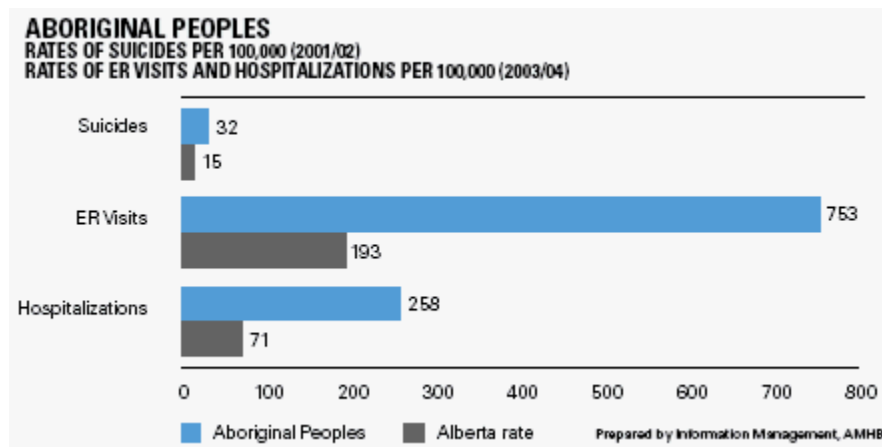| |
|---|
| **Generation 1: Adverse Childhood Experiences**
Abuse, neglect, poor parenting, household dysfunction, etc. |
| Development of poor appraisals, cognitive style, and coping strategies |
| Increased stressor experiences ⟷ Poor mental health ⟷ Increased reactivity to stressors |
| **Parenting Deficits**
Poor parenting, abuse, neglect, etc |
| **Generation 2: Adverse Childhood Experiences**
Recapitulates Generation 1 |

Adapted from Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. J*ournal de la Sante Autochtone*, Nov., 6-46.

Intergenerational trauma can occur within any family but when entire cultural groups are traumatized, the tragic effects are massive in scale. Historically, Canadian social policies, including the Indian Act, the residential school system, and child welfare legislation, have systematically negated Aboriginal culture and imposed values that are contradictory to the traditional ways of relating to one another (Proulx & Perrault, 2000). Social policy has been instrumental in creating institutions that have attempted to eliminate Aboriginal worldview and value systems that existed for thousands of years (Churchill, 1995), replacing them with doctrines that continue to disrupt life for Aboriginal peoples (Menzies, 2008).

Between 1840 and 1996, it is estimated that over 100,000 Aboriginal children were placed in the residential school system for the purpose of assimilation, segregation, and integration into mainstream Canadian society (Menzies). Children attending these institutions experienced many types of abuse including physical, psychological, emotional, sexual, and spiritual (Royal Commission on Aboriginal Peoples, 1996). The residential school experience was identified as a key component within the cycle of trauma experienced by Aboriginal peoples (Gagne, 1995). Further, the removal of children from the home for long periods of time has diminished opportunities for the transmission of family values, parenting knowledge and community behavior between generations (van de Sande, 1995). Many Aboriginal people passed the abuse suffered within these institutions on to their children, thereby perpetuating the cycle of abuse and dysfunction arising from elements related to the residential school system (Aboriginal Healing Foundation, 2001). Many of the problems facing Aboriginal people today – such as alcoholism, child abuse, suicide, and domestic violence are related to the long decades of forced assimilation and genocidal practices implemented by the federal government (Duran & Duran, 1995, p. 35).

When compared to the Alberta average, evidence suggests that Aboriginal people experience twice the rate of suicide (AMHB, 2006). In addition, the rate of concurrent disorders within the Aboriginal community is believed to be as high as 70 percent (First Nations and Inuit Mental Wellness Advisory Committee, 2005 cited in Menzies, 2008). Research suggests that intergenerational trauma contributes significantly to the issues faced by the modern day Aboriginal people. This indicator helps in understanding other social issues confronting Aboriginal peoples, such as family violence, school drop out rates, substance use, and mental illness.

ABORIGINAL PEOPLES
RATES OF SUICIDES PER 100,000 (2001/02)
RATES OF ER VISITS AND HOSPITALIZATIONS PER 100,000 (2003/04)

Suicides: Aboriginal Peoples 32, Alberta rate 15
ER Visits: Aboriginal Peoples 753, Alberta rate 193
Hospitalizations: Aboriginal Peoples 258, Alberta rate 71

Prepared by Information Management, AMHB

Excerpted from: Alberta Mental Health Board (2006). *Using Evidence to Inform Action in Alberta – Consolidated Evidence of At-Risk Groups.*

It is estimated there are 80,000 people alive today who attended residential schools. Stephen Harper stood in the House of Commons on June 11, 2008, to provide the first formal apology from a Canadian prime minister over the federally financed program. "The government now recognizes that the consequences of the Indian residential schools policy were profoundly negative and that this policy has had a lasting and damaging impact on aboriginal culture, heritage and language," Harper said.

Conclusion

Trauma is often hidden behind a range of emotional and physical disorders. Although hidden, it has a powerful influence. In clinical practice it is an expectation rather than an exception. Our actions and words need to be sensitive to the existence of trauma even if we are not directly addressing it. It is by this principle that we can offer trauma-informed services to our clients.

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