A resource for service organizations and providers to deliver services that are trauma-informed

Trauma-informed

The Trauma Toolkit

Second Edition, 2013

Klinic Community Health Centre

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"Everyone has a right to have a future that is not dictated by the past."

Karen Saakvitne

Introduction

This toolkit aims to provide knowledge to service providers working with adults who have experienced or been affected by trauma. It will also help service providers and organizations to work from a trauma-informed perspective and develop trauma-informed relationships that cultivate safety, trust and compassion.

Traumatic events happen to all people at all ages and across all socio-economic strata in our society. These events can cause terror, intense fear, horror, helplessness and physical stress reactions. Sometimes the impact of these events does not simply go away when they are over. Instead, some traumatic events are profound experiences that can change the way children, adolescents and adults see themselves and the world. Sometimes the impact of the trauma is not felt until weeks, months or even years after the traumatic event.

Psychological trauma is a major public health issue affecting the health of people, families and communities across Canada. Trauma places an enormous burden on every health care and human service system. Trauma is not only a mental health issue, but it also belongs to every health sector, including primary/physical, mental and spiritual health. Given the enormous influence that trauma has on health outcomes, it is important that every health care and human services provider has a basic understanding of trauma, can recognize the symptoms of trauma, and appreciates the role they play in supporting recovery. Health care, human services and, most importantly, the people who receive these services benefit from trauma-informed approaches.

Trauma is so prevalent that service providers should naturally assume that many of the people to whom they provide services have, in some way or another, been affected by trauma. Although trauma is often the root cause behind many of the public health and social issues that challenge our society, service providers all too often fail to make the link between the

trauma and the challenges and problems their clients, patients and residents, and even co-workers, present.

From the time the trauma occurs, people can experience the effects in all stages of their life and in their day to day activities - parenting, working, socializing, attending appointments - and interpersonal relationships. It should be noted that most people who experience traumatic events do not go on to develop symptoms of Post-Traumatic Stress Disorder. However, for many people, poor mental and physical health, depression and anxiety can become the greater challenge.

People who have experienced trauma are at risk of being re-traumatized in every social service and health care setting. The lack of knowledge and understanding about the impact of trauma can get in the way of services providing the most effective care and intervention. When retraumatization happens, the system has failed the individual who has experienced trauma, and this can leave them feeling misunderstood, unsupported and even blamed. It can also perpetuate a damaging cycle that prevents healing and growth. This can be prevented with basic knowledge and by considering trauma-informed language and practices.

Traumatic events happen to everyone; it is part of the human experience. Accidents, natural disasters, wars, family conflicts, sexual exploitation, child abuse and neglect, and harmful social conditions are inescapable. However, how a person responds to these circumstances is unique to that individual's social history, genetic inheritance and protective factors that may be in the person's life at the time.

This toolkit will explore these issues and identify how health care and social services can become trauma-informed, set policies, and encourage interactions with clients that facilitate healing and growth.

Table of Contents:

What is Trauma? 9

- Who Can Be Traumatized? 12

Trauma-informed Practices 15

- What is Trauma-informed Practice? 15
- Organizational Checklist 22
- Policies and Procedures 24
- Monitoring and Evaluation 29

Post-Traumatic Stress Disorder (PTSD) 30

- Three Elements of PTSD 31
- Trauma Continuum 33

Types of Trauma 36

- Interpersonal and External Trauma 36
- Developmental Trauma: Child Abuse 38
- The Experience of Immigrants and Refugees 40

Historic Trauma: The Legacy of Residential School 45

- Residential Schools 45
- Impacts 47
- Hope and Resilience 51

Cultural Teachings/Healing Practices 52

- The Seven Sacred Teachings 54
- Role of the Elder 56

The Far Reaching Effects of Trauma: Prevalence 59

The Effects of Trauma 65

The Neurobiology of Trauma 70

The Experience of Sexualized Trauma 74
- Issues for Men Affected by Childhood Sexual Abuse 77
- Effects of Sexual Abuse 81

Co-occurring Disorders: Substance Abuse and Trauma 85

Trauma Recovery 89
- Important Aspects of Trauma Recovery 90
- Other Aspects of Trauma Recovery 93

The Resilience of People Affected by Trauma 95

Service Providers
- Qualities and Characteristics Essential to Working with People Affected by Trauma 98

Self-Compassion 104

Guidelines for Working with People Affected by Trauma
- Strengths-based Perspective 108
- Post-Traumatic Growth 108
- How We Talk to People Affected by Trauma 110
- Important points to consider 110
- Language and assumptions 111
- Asking About Traumatic Experiences 113

Effects on Service Providers: Trauma Exposure Response
- Terminology 122
- 16 Themes of Trauma Exposure Response 124
- Risk Factors 124
- Managing Trauma Exposure Response 125
- Organizational & Workplace Responsibilities 126
- The ABCs of Addressing Vicarious Trauma 128

List of Resources
- Community and Provincial 129
- Training for Service Providers 129
- Recommended Websites and Books 131
- Appendix 134
- References 141

Notes 149

What is Trauma?

A traumatic event involves a single experience, or enduring repeated or multiple experiences, that completely overwhelm the individual's ability to cope or integrate the ideas and emotions involved in that experience.

Recent research has revealed that psychological emotional trauma can result from such common occurrences as an auto accident, sudden job loss, relationship loss, a humiliating or deeply disappointing circumstance, the discovery of a life-threatening illness or disabling condition, or other similar situations.

Traumatizing events can take a serious emotional toll on those involved, even if the event did not cause physical damage. This can have a profound impact on the individual's identity, resulting in negative effects in mind, body, soul and spirit.

Regardless of its source, trauma contains three common elements:

- It was unexpected.
- The person was unprepared.
- There was nothing the person could do to stop it from happening.

Simply put, traumatic events are beyond a person's control.

It is not the event that determines whether something is traumatic to someone, but the individual's experience of the event and the meaning they make of it. Those who feel supported after the event (through family, friends, spiritual connections, etc.) and who had a chance to talk about and process the traumatic event are often able to integrate the experience into their lives, like any other experience.

> **"Trauma is when we have encountered an out of control, frightening experience that has disconnected us from all sense of resourcefulness or safety or coping or love."**
>
> Tara Brach, 2011

Traumatic events often cause feelings of shame due to the powerlessness they create, which can lead to secrecy and further embed the experience of shame. It then becomes something to be greatly feared and avoided. It is at this point that negative coping behaviours may start and may continue until a person decides to face the difficult emotions that surround the traumatic experience.

The impact of these events does not simply go away when they are over. Instead, traumatic events are profound experiences that can shape the way a person sees themselves, others and the world.

Because the traumatic experience was so terrible, it is normal for people to block the experience from their memory, or try to avoid any reminders of the trauma; this is how they survive. However, the consequences of these survival mechanisms are a lack of integration of the traumatic experience, such that it becomes the experience in a person's life, rather than one of many. The trauma becomes the organizing principle from which the person lives their life always trying to cope with and/or avoid the impact of the trauma. This can be both a conscious and unconscious awareness/experience. This lack of processing of the trauma means that it is ever-present for the individual, and they feel as if the trauma happened yesterday when it could have been months or many years since.

Who Can Be Traumatized?

Anyone can be traumatized. No one is immune. It is widespread throughout the world and affects every part of the population. Numerous studies, such as the Adverse Childhood Experiences Study by Vincent Felitti M.D. and Robert Anda M.D. (www.cdc.gov/ace/prevalence.htm), suggest that at least 75% of the population has experienced at least one traumatic event in their life.

Individuals of all ages, socio-economic status, cultures, religions and sexual orientations (including lesbian, gay, bisexual, transgender and two spirit*) can be profoundly affected. [**The term "two-spirit" is an Aboriginal term referring to those who have both male and female spirits.**]

Families can be traumatized by an event happening to one or more of its members. Even people who did not directly experience the trauma can be impacted by it, especially if they have a close relationship to the individual who experienced the trauma.

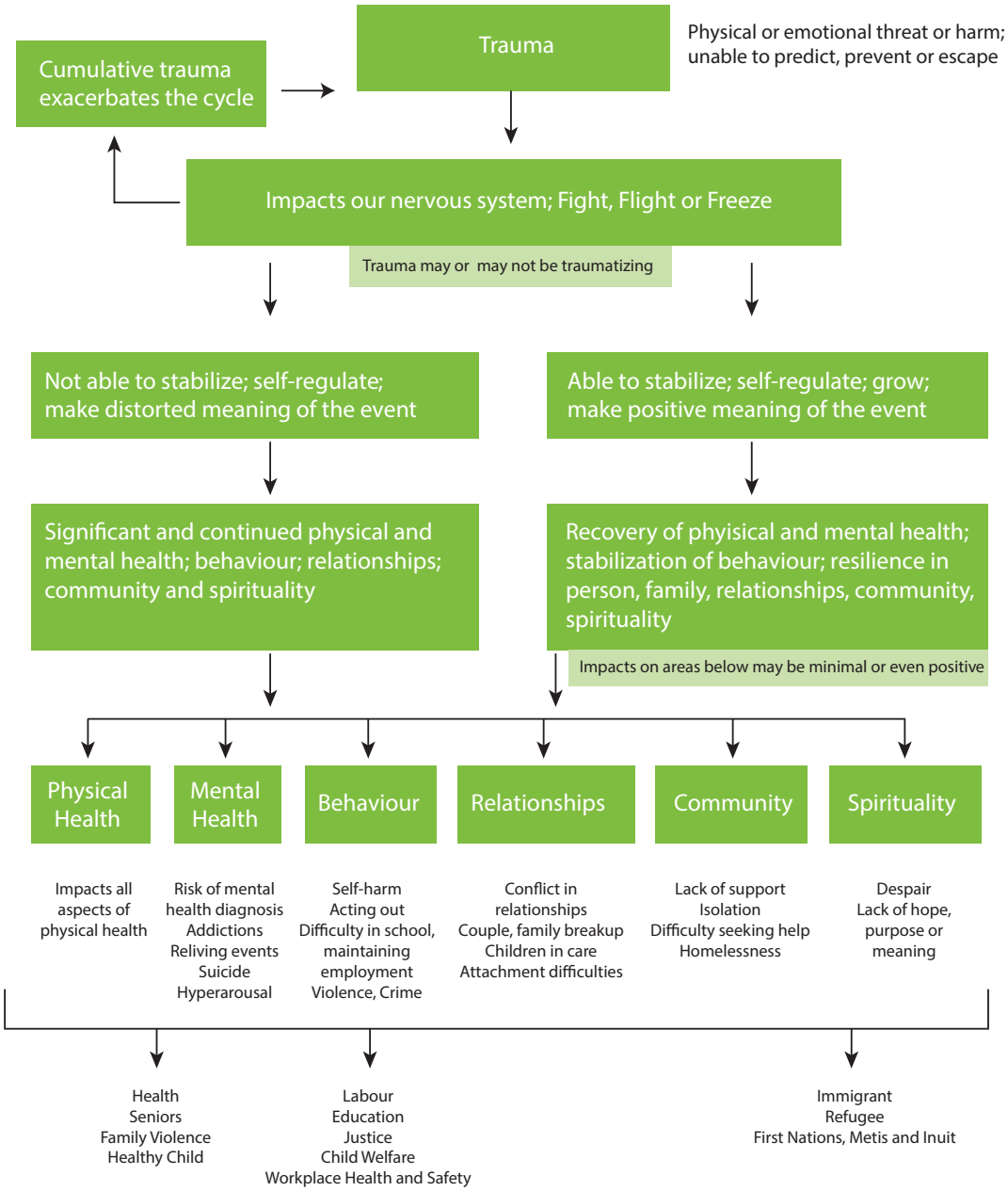
Communities can be traumatized when events effect any of its members.

Cultures can be traumatized when repeated denigration, attempts at assimilation and genocide occur. First Nations communities in North America continue to live with the impact of the intergenerational trauma of colonization and the residential school system. Following 9/11, the North American culture became organized around fear and terror as a direct result of the trauma experienced from that event. In addition, other countries have experienced trauma that has impacted their culture, including Sudan, Rwanda, Syria and Cambodia.

Service providers can be traumatized after hearing the stories and witnessing the suffering of clients who have experienced trauma. This is called "vicarious trauma" or "trauma exposure response," and it happens when the provider is regularly

confronted with traumatic content.

Institutions and organizations can be negatively impacted when going through times of significant change or outside scrutiny (i.e., downsizing, restructuring, inquiries). Individual staff members may become inadvertently traumatized as a result of this process, and/or their own trauma histories may be triggered by the events if the process is not sensitively and compassionately handled.


Cumulative trauma exacerbates the cycle
Trauma
Physical or emotional threat or harm; unable to predict, prevent or escape
Impacts our nervous system; Fight, Flight or Freeze
Trauma may or may not be traumatizing
Not able to stabilize; self-regulate; make distorted meaning of the event
Able to stabilize; self-regulate; grow; make positive meaning of the event
Significant and continued physical and mental health; behaviour; relationships; community and spirituality
Recovery of phyisical and mental health; stabilization of behaviour; resilience in person, family, relationships, community, spirituality
Impacts on areas below may be minimal or even positive
Physical Health
Mental Health
Behaviour
Relationships
Community
Spirituality
Impacts all aspects of physical health
Risk of mental health diagnosis
Addictions
Reliving events
Suicide
Hyperarousal
Self-harm
Acting out
Difficulty in school, maintaining employment
Violence, Crime
Conflict in relationships
Couple, family breakup
Children in care
Attachment difficulties
Lack of support
Isolation
Difficulty seeking help
Homelessness
Despair
Lack of hope, purpose or meaning
Health
Seniors
Family Violence
Healthy Child
Labour
Education
Justice
Child Welfare
Workplace Health and Safety
Immigrant
Refugee
First Nations, Metis and Inuit

Trauma-informed Care and Practice

What is Trauma-informed Care and Practice?

Regardless of its mandate, every system and organization is impacted by trauma and will benefit from being trauma-informed. Service organizations are confronted by the signs and symptoms of trauma every day, and yet often fail to see it and make the necessary connections. Trauma hides in plain view. Every system and organization has the potential to retraumatize people and interfere with recovery, and to support healing.

People affected by trauma from abusive relationships will frequently encounter services that mirror the power and control they experienced in those relationships.

Trauma-informed services do not need to be focused on treating symptoms or syndromes related to trauma. Rather, regardless of their primary mission – to deliver primary care, mental health, addictions services, housing, etc - their commitment is to provide services in a manner that is welcoming and appropriate to the special needs of those affected by trauma (Harris & Fallot, 2001).

"Although trauma may be central to many people's difficulties and awareness of it pivotal to their recovery, in public mental health and social service settings their trauma is seldom identified or addressed." (Harris & Fallot, 2001)

"The symptoms that are the creative and necessary adaptations to the effects of trauma are often not recognized as associated with the prior trauma by survivors or clinicians." (Harris & Fallot, 2001)

Having an awareness of how trauma impacts people is essential to the healing process. Subsequently, working from a trauma-informed orientation has an impact on this healing and the quality of service provided.

At its core, the trauma-informed model replaces the labelling of clients or patients as being "sick," resistant or uncooperative with that of being affected by an "injury." Viewing trauma as an injury shifts the conversation from asking "What is wrong with you?" to "What has happened to you?"

Trauma-informed systems and organizations provide for everyone within that system or organization by having a basic understanding of the psychological, neurological, biological, social and spiritual impact that trauma and violence can have on individuals seeking support. Trauma-informed services recognize that the core of any service is genuine, authentic and compassionate relationships.

A trauma-informed service provider, system and organization:

- Realizes the widespread impact of trauma and understands potential paths for healing;
- Recognizes the signs and symptoms of trauma in staff, clients, patients, residents and others involved in the system; and
- Responds by fully integrating knowledge about trauma into policies, procedures, practices and settings.

The core trauma-informed principles are:

- Acknowledgement – recognizing that trauma is pervasive
- Safety
- Trust
- Choice and control
- Compassion

- Collaboration
- Strengths-based

When systems and organizations are committed to integrating these principles at every level, they should consider the following:

- Power and control – whose needs are being served, and do policies empower those being served or those providing the service (e.g., is emphasis being placed on control rather than the comfort of those being served)
- Doing with and not doing to
- Explaining what, why and how
- Offering real choices
- Flexibility
- Understanding and being able to identify fight, flight and freeze responses
- Focusing on strengths, not deficits
- Examining power issues within the organization and promoting democratic principles (Poole, 2013)

Sandra Bloom M.D. (The Sanctuary Model - www.sanctuaryweb.com) identified seven commitments that trauma-informed organizations make. These are commitments to:

- Non-violence – helping to build safety skills and a commitment to a higher purpose
- Emotional intelligence – helping to teach emotional management skills
- Social learning – helping to build cognitive skills
- Open communication – helping to overcome barriers to healthy communication, learning conflict management, reducing acting out, enhancing self-protective and self-correcting skills, teaching healthy boundaries
- Social responsibility – helping to build social connection skills, establish healthy attachment relationships, and establish a sense of fair play and justice

- Democracy – helping to create civic skills of self-control, self-discipline, and administration of a healthy authority
- Growth and change – helping to work through loss and prepare for the future

Trauma-informed organizations also place a priority on teaching skills in the following areas to clients, patients, residents and staff:

- Self-soothing
- Self-trust
- Self-compassion
- Self-regulation
- Limit setting
- Communicating needs and desires
- Accurate perception of others

Emerging practice standards for working with people who have experienced trauma are rooted in the following areas:

- Build relationships based on respect, trust and safety.
- Use a strengths-based perspective.
- Frame questions and statements with empathy, being careful not to be judgmental.
- Frame the client's coping behaviours as ways to survive, and explore alternative ways to cope as part of the recovery process.
- Respond to disclosure with belief and validation that will inform practical issues related to care (Havig, 2008).
- Help the client regulate difficult emotions before focusing on recovery.
- Acknowledge that what happened to the client was bad, but that the client is not a bad person.

- Recognize that the client had no control over what happened to them. Let them know that the way they survived during the traumatic experiences was actually their way of resisting what was happening to them and of saying no, even if it did nothing to stop the person behaving abusively.
- Provide an appropriate and knowledgeable response to the client that addresses any concerns they may have about the services offered to them, and then use this knowledge to guide service delivery.
- Watch for and try to reduce triggers and trauma reactions.

When providing and receiving information:

- Inquire about trauma history, and facilitate a supportive discussion with the client while keeping it focused on the present moment.
- Make sure the client is comfortable with the conversation and knows they do not need to answer questions and/or go into detail.
- Check in with the client to make sure the discussion of trauma feels safe and not overwhelming.
- Make time for questions and concerns that the client may have.
- Write things down for clients who may dissociate during encounters.
- Provide a suicide risk assessment where indicated and follow up with the client when the risk has passed.
- Inquire about a possible history of trauma if a client has behaved or is currently behaving abusively themselves.

To create a climate of hope and resilience:

- Acknowledge the client's abilities to survive and even grow from adversity.
- Acknowledge the strength it takes to get to where the client currently is.

- Refer to the client as "someone who has experienced trauma," and who is more than what has happened to them. Focus on healing and recovery as "possible."
- Move beyond mere survival to the context of a healing process, and let the client decide what their path to healing consists of.
- Let the client know that you believe in them and support their efforts to heal.

When providing choices:

- Involve the client in the decision-making process with regard to treatment/service options.
- Inquire about counselling in the past and offer referrals if indicated.
- Ensure that the client feels comfortable during invasive assessments and procedures, and make adjustments to these processes when the client requests it.
- Allow the client to set the pace, slow down and take breaks as required.
- Continually inform the client of what is happening during healthcare encounters and assessments (Havig, 2008).
- Where possible, give the client choices about referrals.
- Involve other service providers that are already involved in the client's care.
- Strive to be culturally appropriate and informed.
- Learn about and develop skills to work within the client's culture by asking them about it, and understand how your own cultural background can influence transactions with the client (Elliot et al., 2005).
- Understand the meaning the client gives to the trauma from their own cultural perspective.
- Understand what healing means to the client within their cultural context.
- Be open to learning and asking questions about the client's culture.

- Be open to referring clients to traditional healing services, and become educated in traditional Aboriginal healing ways.
- Become involved in the cultural community that is being served.
- Advocate on behalf of clients who speak English as a second language or are new to negotiating Canadian human services.
- Work through historical distrust – issues may exist from the past that interfere with effective service provision. Understanding that this is normal and not personal will help to build a strong relationship (Brokenleg, 2008).
- Teach Western ways as skills, not as identity replacement (Brokenleg, 2008).

Organizational Checklist

For most organizations, a commitment to trauma-informed practice can represent a shift in culture and values. A widespread commitment to trauma-informed practice ensures that all people will encounter services that are sensitive to the impact of trauma. Every organization should have a clearly written policy statement or paper that publicly declares its commitment to trauma-informed services, and makes it clear that incorporating these practices is a priority issue for the organization.

The organizational checklist outlined here is based on one developed by Nancy Poole, Rose Schmidt and their colleagues at the British Columbia Centre of Excellence for Women's Health. The checklist included here has been modified and added to for general purposes of this Trauma Toolkit. The checklist is a tool that can be utilized by organizations as a guideline for the implementation of trauma-informed practice. It has been developed as a starting point for the ongoing process of becoming a trauma-informed system or organization.

Overall Policy and Program Mandate Criteria

- Clearly written policy statement
- Your organization has a policy or position statement that includes a commitment to trauma-informed principles and practices
- The policy/position statement identifies the relationship between trauma and programming, and the implications for service access and design
- The policy/position statement is endorsed by leadership

Evidence-informed practices

- Services are based on an optimistic, strengths-based and evidence-informed, trauma-informed model

Overall leadership style

- Program directors and clinical supervisors understand the work of direct care staff as it relates to the provision of services to people who have experienced trauma
- Leadership allows staff time and other resources (e.g., space, money) to focus on implementing trauma-informed services
  - leadership is aware of the impact that trauma has on its workforce, and that many of its employees have been affected by traumatic events in their lives
  - leadership promotes democratic principles

Collaboration

- Collaboration and shared decision-making is a key part of leadership style. Collaboration is inclusive of consumers in the development of trauma-informed approaches
- Clients/patients/residents (C/P/R) and staff are encouraged to provide suggestions, feedback and ideas, and a structured and transparent process is in place

Point of Responsibility

- There is a clearly defined point of responsibility for implementing trauma-informed services. This may involve a trauma "initiative," committee or working group that includes consumers and is fully supported and endorsed by administration

Policies and Prodedures

Trauma in job description/interview

- Job descriptions include knowledge, skills and abilities to work with people affected by trauma
- Job interviews include trauma content and questions about knowledge and skills related to trauma-informed practice

Training to promote general awareness

- All staff at all levels receive basic foundational training and continued training (as appropriate) that furthers their understanding of trauma, including a basic understanding of the psychological, neurological, biological, relational and spiritual impact that trauma has on people
- Staff members are released from their usual duties to attend training

Staff receive training on the following topics:

- Links between mental health, substance use and trauma (and co-occurring disorders)
- Cultural competency, including different cultural practices, beliefs, rituals, different cultural responses to trauma, and the importance of linking cultural safety and trauma-informed practice
- How gender influences the types of trauma experienced, and the individual and systemic responses to trauma
- Communication and relationship skills, including non-confrontational limit setting, "people first" language (e.g., people who are experiencing homelessness, reflective listening, skills, etc.)
- Minimizing retraumatization, including psycho-educational framing, coping mechanisms, a cultural safety lens, de-escalation strategies, grounding and emotional modulation techniques
- Vicarious trauma, how it manifests and ways to minimize its effects, including self-care, resiliency and personal/professional boundaries
  - understanding and being able to recognize fight, flight and freeze responses
  - developing the capacity to be self-soothing and self-compassionate through various means (i.e., mindfulness-based stress reduction or other mindful practices)

- understanding and appreciating the mind/body/spirit connection
- suicide prevention

Staff receive training that promotes:

- Awareness of trauma-specific services in the mental health system
- Awareness of the range of specialized services outside of mental health and substance use systems that support people with trauma, such as anti-violence services, services for refugees and victims of torture, veterans' services LGBTTQ* services, Aboriginal healing services, and gender specific support groups

Regular Supervision

- All staff that work with clients with trauma histories have structured, strengths-based supervision from someone who is trained in understanding trauma

Staff Meetings

- Regular staff meetings include opportunities for knowledge exchange on working with trauma
- Staff are encouraged to discuss ethical issues associated with defining personal and professional boundaries

Peer Support

- Opportunities for peer support and consultation are regularly offered

Support for All Safety

- Regular supervision is devoted, in part, to helping staff understand their own stress reactions
- Self-care is encouraged among staff, and issues related to safety/self-care are addressed at staff meetings

- The organization regularly seeks input from staff about their safety, and/or assesses staff safety through other mechanisms, and makes improvements wherever possible
- The organization provides appropriate supports to staff that have experienced vicarious trauma
- The organization promotes a psychologically safe work environment for staff and volunteers

Universal Screening

- The intake policy clearly states the purpose of screening for history of trauma, and how that will be used to inform service planning as it applies to all consumers, regardless of how they enter the system ("which door")
- The screening and assessment process is fully discussed with C/P/R, and C/P/R choice and control of what will be disclosed is emphasized throughout
- The potential for retraumatization during screening and assessment is formally acknowledged by the organization, and policies are in place to minimize the potential for retraumatization
- The screening and assessment protocol is informed by currently available academic and practice evidence about being trauma-informed

Location for intake assessment

- Intake is conducted in a private, confidential space
- Appropriate interpreters are provided as needed (e.g., not a family member or an interpreter untrained in trauma)

Follow-up

- Screening is followed-up (as appropriate) with the opportunity for consumers to become aware of how trauma is connected to mental health and substance use concerns, to learn coping skills, and to disclose their history of trauma at their own pace

- Supports are in place for consumers after assessment if trauma history is discussed

Policies and Procedures Criteria

Overall

Your organization ensures that all current policies and protocols are not hurtful or harmful to clients, are respectful, and promote safety, trust and flexibility

Consumer Choice

- C/P/Rs are given full choices in what services they receive, and are allowed to make decisions about their level of participation and the pacing of these services
- C/P/Rs are encouraged to make informed choices through the provision of educational materials, and the discussion about potential services available to them, as well as the benefits, limitations and objectives of each

Survivor Involvement

- People who have been affected by trauma are involved in the creation and evaluation of policies and protocols
- C/P/Rs are able to suggest improvements in ways that are confidential and anonymous and/or public and recognized

Cultural Competency

- All policies respect culture, gender, race, ethnicity, sexual orientation and physical ability

Privacy and Confidentiality

- All staff and consumers are aware of what is involved in the informed consent process, including the extent and limits of confidentiality, what is included in the records, and where the records are kept

A psychologically healthy and safe workplace has been defined as "a workplace that promotes workers' psychological well-being and actively works to prevent harm to worker psychological health including in negligent, reckless or intentional ways."

www.workplace strategiesfor mentalhealth.com

- Established processes are in place that support consumer awareness and the understanding of informed consent

Safety and Crisis Planning

- All C/P/Rs have individualized safety plans that are fully integrated into the programs' activities. Include a list of stressors, specific helpful strategies, specific non-helpful strategies, a strategy for coping with suicidal thoughts, and a list of persons that they feel safe around
- A service policy is in place that informs how individual safety plans are used in a crisis. This policy should be reviewed when necessary

Avoiding Retraumatisation

- Policies or procedures are in place to minimize the possibility of retraumatization

Supportive/Emotionally Safe Program

- C/P/R rights are posted in visible places
- The program avoids involuntary or potentially coercive aspects of treatment (e.g., involuntary medication, seclusion, restraints)

Physical Environment

- The space around the program building is safe (e.g., parking lot and sidewalks are well lit, directions to the program are clear)
- The physical environment is attuned to safety (e.g., calming and comfortable)

Referrals

- Based on intake assessments, C/P/Rs are referred to accessible and affordable trauma-specific services as necessary

- C/P/Rs are engaged in the decision about any referral to external programs, if appropriate, and are informed about what to expect from the referral agency
- C/P/Rs are supported throughout the transition to external services

Monitoring and Evaluation Criteria

Monitoring

- Information on C/P/R experiences of trauma is gathered and used to inform service planning

Evaluation

- The evaluation of trauma-informed policies and practices are conducted as part of the regular review and planning process, and this information is used to inform and adjust practice

Post-Traumatic Stress Disorder (PTSD): The Aftermath of Trauma

People respond to traumatic events in their own way and according to their individual coping skills and available support systems. Research on the impact of trauma on various populations indicates that the great majority of those not immediately and personally affected by a terrible tragedy sustain no lasting damage. Most of those involved in witnessing or being a part of devastating events are able, in the long term, to find ways of going on with their lives with little change in their capacity to love, trust, and have hope for their future.

People can develop PTSD when, out of necessity, they react to and survive traumatic events by emotionally blocking them during and after the trauma. This allows the experience to dominate how they organize their lives, and often causes them to perceive subsequent stressful life events in light of their prior trauma. Focusing on the past in this way gradually robs their lives of meaning and pleasure.

The description and symptoms of PTSD go all the way back to Ancient Greece. However, it was not until 1980 that the cluster of symptoms classified as a mental illness after the suffering of Vietnam War veterans was incorporated into the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.

The severity of the impact of trauma depends on the age and development of the person and the source of the trauma, i.e., whether the trauma was relational and caused by a close other, someone outside the family, a natural disaster, or war, etc.

Three Elements of PTSD

The diagnosis of PTSD usually focuses on three elements:

1. The **repeated reliving** of memories of the traumatic experience in images, smells, sounds, and physical sensations. These are usually accompanied by extreme physiological states, as well as psychological stress that may include trembling, crying, fear, rage, confusion, or paralysis – all of which lead can lead to self-blame.

2. The **avoidance** of reminders of the trauma, as well as emotional numbing or detachment. This is associated with an inability to experience pleasure and with a general withdrawal from engagement with life.

3. A pattern of **increased arousal**, as expressed by hypervigilance, irritability, memory and concentration problems, sleep disturbances,,and an exaggerated startle response. Hyperarousal causes traumatized people to become easily distressed by minor irritations. Their perceptions confuse the present and traumatic past, such that traumatized people react to many ordinary frustrations as if they were traumatic events.

The core issue of PTSD is that certain sensations or emotions related to traumatic experiences are dissociated, keep returning, and do not fade with time. People with PTSD seem unable to put an event behind them and minimize its impact. They may not realize that their present intense feelings are related to the past, so they may blame their present surroundings for the way they feel.

PTSD can be placed on a continuum from minimal traumatic impact to moderate effects, and to high or complex PTSD that includes additional symptoms associated with severe

long-term childhood trauma, i.e., sexual and physical abuse, residential school experience.

In general, the more prolonged the trauma and the more interpersonal in nature, the more severe the impact will be.

Trauma Continuum

It can be helpful to look at the experience of trauma and the associated impact as being on a continuum.

Traumatic Event

Single event - Prolonged Family Violence - Colonization/Historical - War

Single Event:

- A one-time experience
- One event that has a beginning and an ending (i.e., car accident, surgery)

Prolonged Family Violence:

- Physical, sexual and emotional abuse
- Neglect
- Witnessing violence in the household

Colonization/Historical:

- Disconnecting certain cultures from their families, relationships and cultural practices
- Residential school
- Holocaust
- Ethnic Cleansing
- 60's scoop

War:

- Exposure to living in ongoing violence attributed to antagonists in armed conflict, systemic rape, arbitrary arrests, shortage of necessities and executions.

Impact of Trauma

Traumatic Stress - PTSD - Delayed PTSD - Complex/Developmental PTSD

Traumatic Stress:

- An initial stress response where the body regulates itself relatively quickly after the event

PTSD:

- Reliving of memories
- Avoidance of reminders
- Increased arousal
- Symptoms are ongoing
- Becomes the organizing principle of how the person lives

Delayed PTSD:

- Symptoms of PTSD
- Occur sometime after the event (weeks, months,or even years)
- Can be frightening and confusing because there might not be a clear connection to the symptoms and the traumatic event

Complex/Developmental PTSD:

- Most severe symptoms
- Trauma has been experienced at an early age in development
- Trauma was chronic

- Impacts brain development
- Impacts attachment
- Trauma involved an individual close in relationship (i.e., parent, caregiver, person in position of authority)
- Profoundly disruptive
- Impacts all relationships of individual

Those who have fewer traumatic experiences and were able to address the impact of the event either at the time it occurred or sometime later, will be closer to the lower end of the continuum. As the frequency and duration of traumatic events increases, so do the negative impacts and symptoms. When children experience trauma and their caregivers address it shortly after it occurred, the likelihood of developing PTSD is lower.

Complex PTSD is at the far end of the continuum and is characterized by a history of severe, long-term trauma that usually includes exposure to caregivers who were cruel, inconsistent, exploitive, unresponsive or violent. People who have experienced trauma struggle with more chronic self-destructive behaviours like self-harm, substance abuse and suicidal behaviours.

Types of Trauma

Interpersonal and External

Interpersonal Trauma:

- Childhood abuse: sexual, physical, neglect, psychological, witnessing domestic violence
- Sexual assault: any unwanted sexual contact
- Historical trauma: colonization and the residential school experience of forcible removal from the family home, and destruction of culture and language
- Domestic abuse: physical, sexual, financial, spiritual, cultural, psychological
- Loss due to homicide
- Torture and forcible confinement
- Elder abuse: physical, sexual, financial, spiritual, cultural, psychological

External Trauma:

- War: combat, killing, fear of being killed, witnessing death and extreme suffering, dismemberment
- Being a victim of crime (which can also be interpersonal)
- Sudden death of a loved one
- Suicidal loss
- Loss of a loved one to homicide
- Sudden and unexpected loss of a job, housing, relationship
- Living in extreme poverty
- Natural disasters
- Accidents: vehicle, plane, etc.

Developmental Trauma:

- Child abuse and neglect
- Witnessing violence in the home

It is important to understand that while traumatic experience at any time can disrupt attachment, it is not a given. The child may experience a trauma, but have a number of strong attachments and thus their sense of attachment is not impaired.

Developmental trauma includes sexual, physical and psychological abuse, neglect (withholding love, affection, and the necessities of life), and witnessing violence in the home. These experiences happen during the developing years of infancy, childhood and adolescence, and are commited by trusted adults, caregivers and/or older figures in the person's life.

Given that children are completely dependent on the adults in their lives for survival, trauma that occurs at this stage of life deeply impacts identity and shapes beliefs about self and the world. Development is severely affected and can result in challenges across the lifespan.

For further information on the impact of developmental trauma, you may refer to the following link:

www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/child-development-and-trauma-specialist-practice-resource

The experience of many Aboriginal people in Canada due to forced attendance at residential schools encompasses all types of developmental traumas.

For more information on historical trauma, see page: 44

Basic Assumptions

The basis of normal human development is attachment.

Anything that interferes with the attachment of a child is experienced as traumatic and affects development.

Traumatic experience at any time disrupts attachment.

Disrupted attachement can interfere with every human capacity and that interference looks different in different people.

Sandra L. Bloom, M.D., 2009

"I came to Canada to find peace. I've climbed the ladder of peace and I thought that would be all. I ran from flames, but now I'm faced with hidden flames. Integration is like that."

Somali refugee

The Experience of Immigrants and Refugees

Immigrants and refugees are a significant and growing part of our Canadian population. Therefore, it is crucial that service providers and service systems acknowledge trauma in these groups by being knowledgeable about their experiences in their home country and their experience of migration and settling in Canada.

An immigrant is a person who has been granted the right to live in Canada permanently by Canadian immigration authorities. There are many different classes of immigrants, depending on the circumstances under which the immigrant has come to Canada.

Citizenship and Immigration Canada's definition of a Convention Refugee is based on the United Nation's definition: A person who, by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is (a) outside their country of nationality and unable, or by reason of that fear, unwilling to avail themselves of the protection of that country; or (b) not having a country of nationality, is outside the country of their former habitual residence and unable, or by reason of that fear, unwilling to return to that country.

Immigrants and refugees may share similar experiences in their home countries and in the process of settling in the new country. However, because refugees are fleeing extremely traumatic conditions, almost all of them have experienced losses and may have suffered multiple traumatic experiences, including torture. Their vulnerability to isolation may be exacerbated by poverty, grief, and the lack of education, literacy and skills in the language of the receiving country (Robertson et al., 2006).

Immigrants (non-refugee status) may have faced the same issues as refugees, and the two groups share the same experience of having to settle in a foreign country. Issues related to trauma that they have already experienced can be compounded by the following circumstances and challenges faced in the integration process:

- Not understanding dominant cultural norms
- Feeling that the host country doesn't understand their culture, or make any efforts to do so
- Facing constant racism
- Feeling unwelcome
- Finding adequate employment
- Learning English or French
- Lack of recognition of education
- Finding adequate housing
- Few family supports
- Dealing with bureaucracy
- Feeling isolated
- Inadequate childcare
- Difficulties enrolling children in school
- Grief of missing family in their home country and not seeing family for years at a time
- Finding themselves living in lower living standards due to low income
- Lack of societal acceptance of religious beliefs and practices
- Facing continued family violence
- Dealing with negative comments by politicians, the media, or in private conversations that reflect negative public opinions about immigrants and refugees

For those who faced discrimination, punishment and torture in their home country, some additional issues may include:

- Continued discrimination
- Distrust of the government because it could have been responsible for their maltreatment in the home country
- Feelings of shame
- Feeling guilty for having survived when other family and community members may have been killed
- Feeling they need to prove how bad the situation was at home to stay in Canada and the associated fear of deportation
- Living with the physical, psychological and emotional consequences of trauma, while trying to negotiate settlement and integration (Canadian Council for Refugees, 2002)
- Living with little or no information about the welfare of family members in life-threatening situations
- Constantly wondering when they will be reunited with their families
- Being stuck for years without permanent status

All of these issues may contribute to a difficult transition into Canadian society. The process of transitioning into a new culture may trigger past and/or unresolved trauma. Additionally, people who have survived trauma may not feel comfortable asking for help due to the lack of understanding of their culture by service providers and/or the image of weakness that this may invoke in their own culture.

As service providers, we can be helpful even though we do not understand the specifics of every culture represented in Manitoba. If we understand people who have experienced trauma and their challenges from their perspective, and make a concerted effort to understand their cultural interpretations of

the traumatic events, then that will guide our work with them. It is how they interpret the trauma that is important and helps us understand the impact of the trauma now and how we can be helpful.

In summary, service providers working with individuals who have experienced trauma have a responsibility to be aware of the many challenges that immigrant and refugees face as they try to integrate into Canadian society. In addition, it is important to be aware of the cultural practices that may be important to their recovery. Displaying this knowledge and willingness to learn will help form a solid helping relationship that is essential to trauma recovery.

The purpose of residential schooling was to assimilate Aboriginal children into mainstream Canadian society by disconnecting them from their families and communities and severing all ties with languages, customs and beliefs. To this end, children in residential schools were taught shame and rejection for everything about their heritage, including their ancestors, their families and, especially, their spiritual traditions.

Deborah Chansonneuve, 2005.

"Our dignity was taken away … and a lot of people don't realize that. They don't really understand about how our dignity was taken away from us, how we were taught to be ashamed to be Natives. Then our self-respect was gone. Once you lose your self-respect, how can you respect someone else? Then you take your frustrations out on other people."

(Elder)

Historic Trauma: The Legacy of Colonization and Residential Schools

Historical trauma has been defined as "The cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma" (Yellow Horse Brave Heart, 2003).

The experience of many Aboriginal people in Canada due to colonization and forced attendance at residential schools encompasses all types of develop mental trauma.

Residential School:

- The last federally run residential school closed in 1996.
- There are 80,000 people alive today who attended residential schools (First Nations and Inuit Health, 2013).
- The average age of claimants for compensation is 57 years old (Assembly of First Nations).

The term "Aboriginal" includes First Nations, Inuit and Métis, regardless of where they live in Canada, and regardless of whether they are "registered" under the Indian Act of Canada.

Given the high population of Aboriginal people living in Manitoba, it is crucial that service providers have an understanding of the profound effects colonization has had on Aboriginal people. Colonization itself is a collectively experienced trauma. There are important historical factors that surround the experience of being Aboriginal in Canada.

Many thousands of Aboriginal children were taken from their families and enrolled in the residential school system during its existence. While the majority of these children were status Indians, attendance also included many Inuit, Métis and non-status Indians.

Regardless of the precise number of people involved, Aboriginal people across the country have paid a high price, both individually and collectively, for the government's misguided experiment in cultural assimilation (Aboriginal Healing Foundation, 2003).

In 1867, Canada instituted a policy of Aboriginal assimilation designed to transform communities from "savage" to "civilized." Canadian law forced Aboriginal parents under threat of prosecution to send their children to the schools. The residential schools prohibited the use of Aboriginal languages and the observance of their traditions, teachings, practices and customs. Children did not see their family members for months and even years at a time.

From the mid-19th to mid-20th centuries, residential school was the norm for Aboriginal people. They were operated by religious orders in the earlier years and then moved to total governmental control in later years.

Abuses that occurred in schools are numerous, including physical abuse, neglect, torture, and sexual abuse at the hands of the staff. Despite the fact that abuses were directed toward specific individuals, they were part of a larger project to suppress Aboriginal culture and identity in its entirety. Aboriginal communities continue to feel the impact of what some call attempted "cultural genocide."

The Archbishop of St. Boniface wrote in 1912 of the need to place Aboriginal children in residential schools at the age of six, since they had to be "caught young to be saved from what is on the whole the degenerating influence of their home environment." (This was a common sentiment from the dominant culture of that time.).

Impacts

The impacts of the residential school experience are intergenerational – passed on from generation to generation. Parents who were forced to send their children to the schools had to deal with the devastating effects of separation, as well as the total lack of input in the care and welfare of their children. Many of the children suffered abuse atrocities from the staff that were compounded by a curriculum that stripped them of their native languages and culture. This caused additional feelings of alienation, shame and anger that were passed down to their children and grandchildren.

The effects of trauma tend to ripple outward from those affected by trauma to those who surround them. Among residential school survivors, the consequences of emotional, physical and sexual abuse continue to be felt in each subsequent generation. Deep, traumatic wounds exist in the lives of many Aboriginal people who were taught to be ashamed just because they were Aboriginal.

What has also been a significant factor in the healing process of this trauma is that because of colonization, the Elders and Healers of the communities who would have played a vital role in the healing process were not replaced or were undermined by the missionaries. So those who experienced the trauma of the residential schools were essentially denied access to resources that would have provided them with significant assistance. "Each generation of returning children had fewer and fewer resources upon which to draw" (Truth and Reconciliation Commission, 2012).

A significant factor to consider is how the attachment relationship between the children, their parents, their natural community and their cultural supports was violated. The experience of being taken away from their caregivers would have been traumatic and significantly impacted the children's development. Attachment to a responsive, nurturing, consistent caregiver is essential for healthy growth and development. Many children of the residential school system did not have this experience after they were taken from their families, and subsequently they struggle today because of the trauma of being taken away from attachment figures.

The impact of these disrupted attachments is felt at individual, family, and community and culture levels:

Individual:

- Isolation/alienation
- Shame
- Anger toward school and parents

- Self-hatred
- Internalized racism
- Fear of authority
- Low self-esteem
- Self-destructive behaviours (substance abuse, gambling, alcoholism, suicidal behaviours)
- Acting aggressively

Family:

- Unresolved grief
- Difficulty with parenting effectively
- Family violence
- Loss of stories
- Loss of traditions
- Loss of identity

Community and Culture:

- Loss of connectedness with languages, traditions and cultural history
- Loss of togetherness and collective support
- Loss of support from Elders
- Lack of control over land and resources
- Increased suicide rate
- Lack of communal raising of children
- Lack of initiative
- Dependency on others
- Communal violence

Because the impacts of residential schools are intergenerational, many Aboriginal people were born into families and communities that had been struggling with the effects of trauma for many years. The impact of intergenerational trauma is reinforced by racist attitudes that continue to permeate Canadian society.

"There are a large number of First Nations and Inuit communities and individuals who have the capacity to cope effectively with crisis and to minimize the negative effects of trauma. These are the communities and people that we must learn from when attempting to understand trauma in indigenous communities. Without doing so we create the impression that the capacity to cope with trauma does not exist within indigenous communities and we fail to learn what we so desperately need to know…." (Connors, 2013).

We know the building of relationships is important for healing trauma. As service providers, our focus and responsibility is to develop genuine and authentic relationships with those who have experienced trauma.

This includes safety, compassion, respect, kindness, hopefulness and trust. And that trust must be earned. As the Truth and Reconciliation report identifies, "reconciliation implies relationship. The residential schools badly damaged relationships within Aboriginal families and communities, between Aboriginal peoples and churches, between Aboriginal peoples and the government, and between Aboriginal and non-Aboriginal peoples within Canadian society" (They Came for the Children, 2012).

"The legacy of the schools became joblessness, poverty, family violence, drug and alcohol abuse, family breakdown, sexual abuse, prostitution, homelessness, high rates of imprisonment, and early death."

(They Came for the Children, 2012)

As service providers, we need to be aware of the impact of the residential school system on the clients we work with, and to consider how it has played a role in the current difficulties and challenges with which they may be struggling. Indeed, non-Aboriginal service providers working with Aboriginal clients who have experienced trauma are responsible for educating themselves and being open to considering and hearing how the residential school system has been an impact.

By understanding intergenerational trauma, service providers can enhance their capacity to be compassionate and collaborative, view behaviour within a larger context, challenge belief systems and attitudes that can have adverse effects in terms of establishing positive and healthy relationships, and to create safer helping environments.

Despite the legacy of residential schools, there are many reasons to be hopeful. For some Aboriginal people, the experience of residential schools has strengthened their identity and caused communities to come together. Healing initiatives have been implemented that address aspects of the residential school legacy. Resilience is evident in the steps Aboriginal people have taken to counteract negative outcomes. Many former students have found support in Elders and healing circles. They have also opted to share memories and stories with other former students, pursue further education, relearn Aboriginal languages, and follow spiritual paths to reinforce Aboriginal identity (Aboriginal Healing Foundation, 2003).

The cycle of trauma is being broken as the stories of trauma are being told and as the many strengths of Aboriginal cultures are being used to heal.

Hope and Resilience

"It will take time and commitment to reverse this legacy. The schools operated in Canada for well over a century. In the same way, the reconciliation process will have to span generations. It will take time to re-establish respect. Effective reconciliation will see Aboriginal people regaining their sense of self respect, and the development of relations of mutual respect between Aboriginal and non-Aboriginal people."

Truth and Reconciliation Commission, 2012

Cultural Teachings and Healing Practices

Being trauma-informed involves having cultural competence regarding the traditions and practices of any specific culture. When working with First Nations, an understanding of their cultural practices is essential in promoting and understanding the healing process. Traditional healing practices are localized and culturally specific.

"There are 617 First Nations and 53 Inuit communities in Canada. As of the 2006 census, over one million Canadians identified themselves as Aboriginal. Within the First Nations there are more than 50 Aboriginal languages. Among the Inuit population there are differences in language, beliefs and cultural practices across the northern territories. The Métis populations across Canada demonstrate similar diversity. Although there is a common perspective or holistic worldview that binds Indigenous populations together, there is also great diversity in languages, beliefs and cultural practices throughout the country" (Connors, 2013).

Therefore, it is necessary for all service providers to participate in cultural competence and understanding as it relates to the Indigenous populations they serve.

It is very important to not make any assumptions when considering the individual's experience and practices with respect to cultural teachings and practices. It is also the responsibility of service providers to become culturally aware and competent when working with First Nations, Inuit and Métis clients. For agencies working with these populations, it is essential that program planning and policies be culturally informed and competent. The following information may not be specifically relevant to the clients you are working with, but it is important to be curious about cultural beliefs and practices when working with clients.

First Nation traditional concepts of respect and sharing are the foundation for their way of life and are built around the seven natural laws, or Seven Sacred Teachings. These teachings honour the basic qualities for a full and healthy life (Saint Elizabeth website, Elder Care curriculum, 2013).

The Seven Sacred Teachings are represented by animals that represent the embodiment of that particular teaching. The animal world teaches everyone how to live connected to the earth and how to respect all life (www.thesharingcircle.com; website accessed, 2013).

The Seven Sacred Teachings

LOVE (Eagle)

The Eagle is able to reach the highest point of all creatures. This teaching recognizes that true love is connected to the Creator. Love that is given to the Creator is expressed through love of self because without the love of self, it is impossible to love others.

RESPECT (Buffalo)

The Buffalo is highly respected by First Nations because it gives its life to and shares every part of its being with the people. It is a reciprocal relationship of respect. It provides the gifts of shelter, clothing and utensils. Native peoples developed a sustainable relationship with the Buffalo, resulting in a relationship that was rooted in utmost respect.

COURAGE (Bear)

The Bear is both gentle and ferocious and teaches us the importance of having the mental and moral strength to overcome fears that may prevent us from living our true spirit as human beings.

HONESTY (Sabé)

Long ago there was a giant called Sabé who walked among the people to remind them of the importance of being honest to both the laws of the Creator and to one another. Honesty is when we are able to keep the promises made to the Creator, self and others.

WISDOM (Beaver)

The Beaver uses its gifts as a way to survive. If the Beaver did not use his teeth to build his home, they would grow until they were no longer useful to him. The Beaver teaches us that communities are built upon the gifts of each of its members. These gifts, which are given by the Creator, are important and necessary to use when creating communities of health and peace.

HUMILITY (Wolf)

To recognize and acknowledge the higher power of the Creator is considered to be truly humble. By expressing deference and/or submission to the Creator, we recognize and accept that all beings are equal. This captures the essence of the spirit of humility. The consideration of others before ourselves is also an expression of humility. The Wolf teaches us all these lessons. He bows his head out of deference in the presence of others and will not take food until it can be shared with the other members of his pack. The Wolf lacks arrogance and has respect for his community, which is the Aboriginal way.

TRUTH (Turtle)

To know the truth is to know and understand and be faithful to all of the original laws as given by the Creator. Grandmother Turtle was present when the Creator made man and gave him the seven sacred laws. It was Grandmother Turtle who ensured that the laws would not be lost or forgotten.

THE MEDICINE WHEEL

First Nations across the country use various forms of the Medicine Wheel (also referred to as Sacred Hoops or Circles) in their ceremonies and teachings (Saint Elizabeth website, 2013). Variations of the Medicine Wheel are dependent upon the culture and/or the teacher. It is important when working with clients to be curious about which Medicine Wheel teachings they connect with, so as not to make assumptions about their beliefs and values.

For information about other Medicine Wheel teachings, see the following links:

www.dancingtoeaglespiritsociety.org/medwheel.php
www.fourdirectionsteachings.com/main.html

Role of the Elder

It is an essential consideration to involve the Elder of specific communities when developing programming related to First Nations, Inuit and Métis populations. It is also important to work collaboratively with the Elder in understanding the specific teachings and beliefs for that community as it relates to trauma recovery and healing.

There are various definitions of an Elder, including:

- "Elders" are those people who are recognized by their community to be first and foremost "healthy" - spiritually, psychologically and mentally. These are often highly "ethical" people. They may be very "spiritual" people, but this does not seem to be a requirement of recognition. An "Elder" in this sense can refer to respected people in the community, regardless of age.
- "Elders" are those people in a community who have lived a long time, and as a result have much cultural wisdom.
- "Elders" are culturally regarded as teachers, mediators, advisors, medicine people, stewards of their lands, and the keepers of their culture and way of life.
- "Elders" used to be known as "the Old Ones" – a term of respect that means those people in a community who have lived a long time and, as a result, have much cultural wisdom, experience and guidance to share (BC Association of Aboriginal Friendship Centres, 2010).

The role an Elder plays in a community can include:

- Cultural advisor
- Historian
- Social activist (Saint Elizabeth website, 2013)

As a service provider, there may be situations or circumstances that may require you to access the support of an Elder. It is important to consider the community and the cultural beliefs and practices when approaching an Elder for assistance. The

following are a list of general protocols to consider when approaching an Elder:

- Be respectful
- Ask permission
- Seek clarification if there is something you don't understand
- Display a sense of humility – many Elders believe humility needs to be reflected through the way individuals present and interact
- Wear appropriate attire based on community practices and situation
- Being loud, interrupting and rushing the conversation can be considered rude (Saint Elizabeth website, 2013)

If an Elder has a "helper," ask the helper what would be appropriate for the specific Elder. The Elder's helper will also provide direction with respect to offering the Elder a gift of tobacco (National Aboriginal Health Organization, 2009).

Tobacco is considered a sacred plant. The gift of tobacco offered to an Elder recognizes the wisdom the Elder has to offer. Tobacco can be given as "cigarettes, pouch tobacco, or tobacco ties (loose tobacco wrapped in a small square cloth)" (National Aboriginal Health Organization, 2009).

In the Inuit culture, the Elders do not expect tobacco because it is not used in their ceremonies. Instead, a small gift may be given as an offering for the Elder's time, support and guidance (National Aboriginal Health Organization, 2009).

Ceremonies

First Nations Elders prefer that no photos or recordings be taken or made during spiritual ceremonies. It is also inappropriate to touch any of the sacred items an Elder may use during a ceremony, including pipes or medicine pouches,

unless the Elder gives permission. It is also essential that permission be asked of the Elder to photograph any of these items.

Elders request that everyone participate in the ceremonies in the same way.

Honour songs are performed to honour a person for various reasons. It is expected that everyone stand and remove any headwear during an honour song.

Smudging is a prayer ceremony where specific medicines (plants) are burned as an offering to the Creator and the Earth. (Saint Elizabeth website, 2013)

Teachings

Historically traditional teachings were shared by the Elders to the community for the development of spiritual, social and educational reasons. It is important to know that First Nations teachings provided at a public event, such as a conference or workshop, are not considered public information. Therefore, it is necessary to ask permission of the Elder or the organizers to use this information (Saint Elizabeth website, 2013). For further information in working with Elders, see Jonathan H. Ellerby's work "Working with Indigenous Elders" (2005).

The Far-Reaching Effects of Trauma: Prevalence

Many statistics are available in Canada and the U.S. on sources and the prevalence of trauma, such as war and family violence. Incidences of violence and abuse are generally underreported, especially in the areas of sexual abuse and sexual assault. It has been well established that, because of the stigma and shame associated with trauma, current statistics only reflect reported data and not necessarily the actual number of cases. The following statistics are primarily drawn from national and provincial sources, and are only intended to provide a general understanding of trends.

PTSD:

- According to the Canadian Mental Health Association, about 1 in 10 people in Canada have been diagnosed with PTSD.
- Most people can experience symptoms without developing PTSD.
- Canadian research also identifies combat veterans, peacekeepers, terrorist attack survivors, and Aboriginal populations as being at a higher risk to develop PTSD (Sareen et al., 2007).

Canadian Forces:

- As of July 2011, 30,000 Canadian service personnel have been deployed to Afghanistan.
- Symptoms of PTSD often appear many months or years after the event(s) that preceded them. Accordingly, it is estimated that over the next five years, 2,750 service personnel will suffer from severe PTSD, and 6,000 will suffer from other mental illnesses diagnosed by a professional.

A Canadian study identifies women as twice as likely as men to develop PTSD

(Van Ameringen et al., 2008)

- 90% of people with PTSD have a co-occurring diagnosis of depression, anxiety, substance abuse or suicidal ideation.
- Given the present lifetime occurrence of operational stress injuries (OSI), it is expected that 30% of soldiers who see combat will present with PTSD or clinical depression.
- "At the moment three quarters of veterans taking part in Veterans Affairs Canada rehabilitation programs following their release for medical reasons are suffering from mental health problems" (Rodrique-Pare, 2011).

Correctional System:

- 80% of women in prison and jails have been victims of sexual and physical abuse.
- Many adults convicted of violent crimes were physically or sexually abused as children.
- The majority of those convicted of homicide and sexually related offences have a history of child maltreatment (Jennings, 2004).
- At the time of admission, 62% of Correctional Services of Canada inmates were identified as requiring follow-up mental health services (Annual Report of the Office of Correctional Investigator, 2011-2012).
- In the past 10 years, the number of Aboriginal inmates has increased by 37.3%, while the non-Aboriginal prison population increased 2.4% (Annual Report of the Correctional Investigator, 2011-2012).

Refugees:

- For the fifth consecutive year, the number of forcibly displaced people worldwide exceeded 42 million, a result of persistent and new conflicts in different parts of the world. By the end of 2011, the figure stood at 42.5 million (UN Refugee Agency, 2012).

- In 2011, there were 24,981 applicants for refugee status in Canada. More than 15,000 of these applications were finalized (Immigration and Refugee Board of Canada, 2012).
- Refugees come to Canada primarily from war-affected countries such as Africa, the Middle East and South America. Between 2000 and 2010, Manitoba accepted 11,215 refugees at a rate of about 1,100 a year (Province of Manitoba, 2010).

Immigrants:

- Manitoba marked the arrival of almost 16,000 immigrants (permanent and/or temporary residents) in 2011 (Citizenship and Immigration, 2012).
- Manitoba's top immigrant source countries were Asia, Africa and the Middle East, Europe and UK, and South and Central Americas (Province of Manitoba, 2012).
- Newly arrived immigrants and refugees often experienced trauma in their home countries. As a result, 9% are estimated to have PTSD, and 5% suffer from clinical depression.
- Of those who present with depression, 71% also have PTSD.
- Physicians are encouraged to look for sleep disorders, social isolation, and other signs of underlying trauma, rather than probing for details which could be retraumatizing.
- Before referring to direct services targeting trauma, focus on practical help with regard to settlement and building up relationships of safety (Rousseau et al., 2011).

Sexual assault:

- There were 22,000 reported sexual assaults in Canada in 2010 (Statistics Canada, 2011).
- According to General Social Survey, nine out of ten sexual assaults are not reported (Statistics Canada, 2011)
- One in four women will be sexually assaulted in their lifetime (Sexual Assault Canada, 2012).

Family Violence

All data in this section is taken from Statistics Canada 2011 for data collected in 2009.

Partner Violence:

- Six percent of Canadians with a current or former spouse reported being physically or sexually victimized by that spouse.
- Similar proportion of males and females reported having experienced spousal violence in the previous five years.
- Many victims of spousal violence reported recurring incidents. Slightly less than one-half of victims who had experienced an incident of spousal violence in the previous five years stated that the violence had occurred on more than one occasion. Females were more likely than males to report multiple victimizations, at 57% and 40%, respectively.
- Younger Canadians were more likely to report being a victim of spousal violence than were older Canadians. Those aged 25 to 34 years old were three times more likely than those aged 45 and older to state that they had been physically or sexually assaulted by their spouse.
- Those who self-identified as gay or lesbian were more than twice as likely as heterosexuals to report having experienced spousal violence, while those who self-identified as bisexual were four times more likely than heterosexuals to self-report spousal violence.
- Victims of spousal violence were less likely to report the incident to police than in 2004.
- Aboriginal women (First Nations, Inuit and Métis) are more than eight times more likely to be killed by their intimate partner than non-Aboriginal women (Status of Women Canada, 2012).
- Close to one in five Canadians aged 15 years and older (17%) reported that their current or ex-partner had been emotionally or financially abusive at some point during their relationship, a proportion similar to 2004.

57% of Aboriginal women have been sexually abused

(Sexual Assault Canada, 2012).

- Emotional abuse and/or controlling behaviour are often pre-cursors to violence in a relationship.
- Emotional or financial abuse was 2.5 times more common between partners than physical violence. Both women and men reported emotional and financial abuse.
- Being called names or being put down is one of the strongest predictors of family violence.

Child Abuse:

- Police-reported data indicate that children and youth under the age of 18 were most likely to be sexually victimized or physically assaulted by someone they knew (85% of incidents).
- Nearly 55,000 children and youth were the victims of a sexual offence or physical assault, about three in ten of which were perpetrated by a family member.
- Six in ten children and youth victims of family violence were assaulted by their parents. The youngest child victims (under the age of three years) were most vulnerable to violence by a parent.
- The rate of family-related sexual offences was more than four times higher for girls than for boys. The rate of physical assault was similar for girls and boys.
- According to the Canadian Incidence Study of Reported Child Abuse and Neglect 2008, which consisted of reports from Child Welfare workers, substantiated cases of child abuse broke down in the following percentages:
  - neglect: 34%
  - exposure to intimate partner violence: 34%
  - physical abuse: 20%
  - emotional maltreatment: 9%
  - sexual abuse: 3%

Older Adults:

- 2,400 reported violent crimes against seniors (ages 65 and over) were committed by a family member.
- The only violent offence for which senior females experienced higher rates than males was for sexual assault.
- Senior women experience higher rates of family inflicted abuse.
- Most senior victims know the person behaving violently.
- An adult child and/or spouse commit most family violence against seniors.

The Effects of Trauma

The effects of being traumatized are very individual, and people who have experienced trauma are impacted physically, emotionally, behaviourally, cognitively, spiritually, neurobiologically and relationally.

Trauma can result in:

- Changes to the brain
- Compromised immune systems
- Increased physical and mental stress
- Decreased trust
- Attachment difficulties and conflictual relationships
- Hyperarousal and hypervigilance
- Rigid or chaotic behaviour

Service providers most often see hyperarousal and hypervigilance, but may not relate back to trauma and could be misinterpreted. This misinterpretation or misunderstanding of behaviour, and failing to recognize fight, flight and freeze responses, can contribute to judgmental behaviour on the part of a service provider, and lead to the development of conflict or adversarial relationships. It is important to remember that trauma impacts the manner in which a person does or does not approach helping relationships and their interactions with service providers. The effects of trauma are felt across the life span.

According to a Canadian study, PTSD is "associated with several physical health problems including cardiovascular diseases, respiratory diseases, chronic pain conditions, gastrointestinal illness and cancer" (2007). It is important to recognize that experiences of trauma can have negative effects on a person's health, regardless of a diagnosis of PTSD. This further supports the ACE (Adverse Childhood Experiences) study that identified the direct connection between adverse childhood experiences and the increase in serious physical and mental health problems (1998).

The ACE study identified that the more adverse the experience, the greater the increase in risk for the following:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

Emotional:

- Depression
- Feelings of despair, hopelessness and helplessness
- Guilt
- Shame
- Self-blame
- Self-hatred
- Feeling damaged
- Feeling like a "bad" person
- Anxiety
- Extreme vulnerability

- Panic attacks
- Fearfulness
- Compulsive and obsessive behaviours
- Feeling out of control
- Irritability, anger and resentment
- Emotional numbness
- Frightening thoughts
- Difficulties in relationships

Behavioural:

- Self-harm such as cutting
- Substance abuse
- Alcohol abuse
- Gambling
- Self-destructive behaviours
- Isolation
- Choosing friends that may be unhealthy
- Suicidal behaviour
- Violence and aggression toward others

Cognitive:

- Memory lapses, especially about the trauma
- Loss of time
- Being flooded by and overwhelmed with recollections of the trauma
- Difficulty making decisions
- Decreased ability to concentrate
- Feeling distracted
- Withdrawal from normal routine
- Thoughts of suicide

Spiritual:

- Feeling that life has little purpose and meaning
- Questioning the presence of a power greater than ourselves
- Questioning one's purpose
- Questioning "Who am I," "Where am I going," "Do I really matter"
- Thoughts of being evil, especially when abuse is perpetrated by clergy
- Feeling disconnected from the world around us
- Feeling that as well as themselves, the whole race or culture is bad

Neurobiological:

- An overproduction of stress hormones that do not return to normal after being activated, and can endure for hours or days in ways identified below:
  - Jittery, trembling,
  - Exaggerated startle response
- Alarm system in the brain remains "on," creating difficulty in reading faces and social cues, misinterpreting other people's behaviour or events as threatening, difficulty sleeping, avoiding situations that are perceived as frightening
- Part of the brain systems change by becoming smaller or bigger than they are supposed to be
- Fight, flight, freeze response (which may look different from person to person)
- Responses are involuntary

Relational:

- Difficulty feeling love, trusting in relationships
- Decreased interest in sexual activity

- Emotional distancing from others
- Relationships may be characterized by anger and mistrust
- Unable to maintain relationships
- Parenting difficulties

It should also be noted that there are overlaps between the categories.

The Neurobiology of Trauma

The body's reaction to traumatic events sets up a number of changes in the brain. When we perceive danger, the limbic system (located in the midbrain, above the brain stem) acts as our internal alarm. When we sense danger, it goes into action and cues the adrenal glands to release stress hormones. These hormones increase blood flow to the major muscles, sharpen our senses, and ready us for a fast response. When the crisis is over, the body eliminates the stress hormones and we go back to normal.

If the trauma occurs early in life and lasts a long time, as in childhood abuse and neglect, the effects are more persistent. The limbic system is primed to remain on alert. With an alarm system stuck on "high," people impacted by trauma startle easier, have trouble accurately reading faces and social cues, have difficulty sleeping, and tend to avoid situations that increase stress. Since lots of everyday problems increase stress, at least in the short term, problems pile up. Avoidance of difficulties and the emotional pain that accompanies them can lead to phobias and other psychological disorders (Linehan, 2012).

The thinking part of the brain, the prefrontal cortex, may find it hard to break in and help the limbic system calm down. As well, there may be more activity, as measured by blood flow, to the right prefrontal cortex, which research has shown to be associated with pessimism and depression (Davidson et al., 2003). So thoughts can get stuck in a rut of ruminating on the past, especially the traumatic past, which in turn keeps the hyperarousal of the limbic system going.

Evolution designed stress hormones to prepare our bodies to escape from danger. When the crisis has passed and the stress hormones are no longer needed, they are broken down. However, when we are chronically activated, stress hormones become toxic to the brain, interfering with our ability to learn new things and then remember what we have learned.

The hippocampus, which is part of the limbic system and is involved in organizing memories, is actually smaller in people who have experienced long-term trauma. Cortisol causes cell death in the hippocampus. Given these outcomes, it's easy to see how problem solving can be difficult (Badenoch, 2008). People impacted by trauma find it hard to even think things can be better or be aware of moments of well-being. All the little good things in life just slide by their awareness (Hanson, 2009).

Not everyone responds to traumatic events in the classic fight or flight response. Instead, some people's limbic system shuts the body down. People in a freeze response can become numb and dissociative, and may actually faint when in the midst of a serious crisis (Porges, 2012). This is the unconscious application of the ancient strategy of playing dead so that a predator will lose interest and go away. Losing consciousness is at the extreme end of the freeze response. It is more common for people impacted by trauma to bounce between hypervigilance and dissociation (van der Kolk, 2012).

It is important to remember that these responses to trauma are involuntary. Trauma lives in the nervous system. The body reacts immediately to perceived danger before our thinking brain can accurately name what is going on. These responses are triggered by cues in our daily lives that are associated with the original distressing events. We may not have to look out for actual predators, but loud noises, the look on a loved one's face, or a hundred other incidents can send people impacted by trauma into a tail spin.

An added difficulty is that many people's ways of managing negative emotions add to their ongoing tally of traumatic events. Using drugs and alcohol to excess can lead to increased stress from accidents, financial problems, work and school problems, unsafe sex and unhealthy relationships. These circumstances continue to change our bodies and the structure and function of our brains. As mentioned earlier, the hippocampus grows smaller when chronically exposed to stress hormones. But these same hormones increase the size of

the amygdala, creating a feedback loop that makes the limbic system even more sensitive to environmental cues and internal body sensations associated with trauma.

It is also important to consider when things are going well and the functions of an "Integrated Brain," which include:

- Body awareness
- Able to attune to others
- Able to balance emotions (neither chaotic or rigid)
- Able to calm fears
- Able to pause before acting
- Capable of insight and reflection
- Able to feel empathy
- Capable of having a sense of morality, fairness and the common good
- Able to be intuitive (Siegel, 2010)

Chronic stress compromises immunity. It becomes more difficult to ward off illnesses. The ACE study, which examined the histories of thousands of patients in California, found that those who reported more adverse events in childhood were also much more likely to suffer from serious illness (Felitti et al., 1998).

Other factors, such as social status, also play a significant role by adding to a person's sense of being unworthy and discounted by the society in which they live (Baer, 2012). Even more egalitarian cultures that strive to make access to health care universal have difficulty lessening the stigma of poverty's impact on morbidity and mortality (Sapolsky, 2005).

HEALTH AND SOCIAL RISKS ASSOCIATED WITH ACE

HEALTH DOMAINS	CONDITIONS ASSOCIATED WITH ACES
Medical Conditions	Heart, lung, liver diseases, cancers, sexually transmitted diseases, and skeletal fractures
Risk Factors for Common Disorders	Smoking, alcohol abuse, illicit drug use, promiscuity, obesity, poor self-rated health, high perceived risk of AIDS
Behavioural Health	Depression and anxiety disorders, PTSD, eating disorders, substance abuse, personality and dissociative disorders, hallucinations, suicide
Sexual and Reproductive Health	Early age at first intercourse, sexual dissatisfaction, teen pregnancy, unintended pregnancy, teen paternity, fetal death
General Health and Social Problems	High perceived stress, poor job performance, relationship problems, spouse with alcoholism

(Jeannie Campbell, Executive Vice President, National Council for Community Behavioural Healthcare, 2012)

"My uncle sexually abused me from age 8 to 23. I spent those years living in constant fear, and there was no one to talk to because I was afraid my family wouldn't believe me and [would] blame me like he did. He's dead, and it was a long time ago, but I still feel like I'm back there sometimes. I feel like a damaged, used-up person. I just want to feel whole instead of all over the place."

Individual affected by trauma

The Experience of Childhood Sexual Trauma

Individuals who have experienced sexual abuse can experience additional effects due the sexual nature of their experiences – additional shame, self-blame and self-hatred. They can describe feelings of being "damaged," "different," "tainted," or that something is deeply wrong with them. This can be a direct result of the abusive messages directly given to them and/or their interpretation of the experience. The abuse can occur over a period of time in secret, is perpetrated by a trusted adult, and is a deep, dark secret the person may have hidden for a very long time. It is also the case that it can be so completely terrifying to consider that someone who is supposed to care for you is at the same time hurting you. This can result in a child blaming themselves for the abuse in order to protect their relationship with the attachment figure.

To be "informed about trauma" when working with individuals who have experienced abuse means to know the history of past and current abuse in the life of the person with whom you are working. This does not necessarily mean the person needs to go back and provide details of the abuse. However, being trauma-informed means understanding the role that violence and victimization plays in the lives of those who have experienced trauma, and allows for more holistic and integrative services (Harris & Fallot, 2001).

People who behave violently and abusively often make recurring statements to their victims that blame them and place them at the centre of the responsibility for the abuse. They say things like "You deserve this," "I know you want this," and "You asked for this." Sometimes they say nothing, sometimes they apologize, make promises it won't happen again, and even do kind and caring things for the child/adolescent. This can be extremely confusing and can often create significant feelings of shame.

Children cannot ask to be sexually abused, nor can they say "No!" to an adult or older person who has total control over them. Individuals who experience sexual abuse often live in fear, or are threatened in terrifying ways to ensure that they do not disclose the abuse. Often the threats can be more subtle and indirect. In a young person's world, this may be all that they know. They obey the person who is abusing them because in many cases their very well-being and/or survival depends on it.

In addition, shame can also be a powerful component to maintaining silence. In some situations, disclosures can be met with disbelief and ridicule, which can then play a role in future disclosure.

These feelings and fears can be carried into adult life, as can the behaviours the person who experiences sexual abuse used to survive. Many individuals who experienced child abuse define themselves by these abusive experiences, and still live from day to day as if they are just surviving and are living in fear of further harm.

Self-destructive behaviours are common survival mechanisms. Self-harming, for example, is a coping mechanism developed to manage intense emotional pain resulting from the experience of being abused by those who were the most important people in the child's life. Self-harming activities, such as cutting, burning and bruising parts of the body, can provide a temporary relief of the emotional pain. Following this short-term relief is an added layer of shame related to the self-harming behaviour.

The horrific memories can accompany victims of child abuse throughout their lives, and are often manifested in nightmares and flashbacks that make them feel as if the abuse is happening again. This is the brain's way of dealing with overwhelming experiences and feelings that must be processed, but individuals often avoid dealing with these feelings out of fear of losing control. A loving relationship is what is longed for, but can also be the most terrifying because

of the impact of the abuse on trust and intimacy. Navigating relationships can be very difficult and challenging for people who have experienced sexual abuse as a child. They often feel and behave in a way that makes them seem "unstable" because they have great difficulty regulating their emotional states, which swing from one extreme to another.

Complex Post-Traumatic Stress Disorder (Complex PTSD) has been defined as the result of prolonged abuse that involves "characteristic personality changes, including deformations of relatedness and identity" (Herman, 1992). More recently, Complex PTSD has been defined as "cumulative forms of trauma and retraumatization that deprive victims of their sense of safety and hope, their connection to primary support systems and community, and their very identity and sense of self" (Courtois & Ford, 2013). Complex PTSD has also been described as what "occurs during a critical window of development in childhood, when self-definition and self-regulation are being formed" (Courtois & Ford, 2009).

Complex PTSD can occur:

- the earlier the abuse was,
- the more prolonged it was,
- the closer the relationship with the person who acted abusively, and
- the more severe the violence.

Chronic suicidal behaviours, self-harming behaviours, relationship problems, addictions and depression are commonly associated with this experience.

Issues for Men Affected by Childhood Sexual Abuse

It is difficult to know how widespread male sexual abuse is because it is less researched in the literature and often goes unreported. However, studies reveal that more than 50% of men have been exposed to at least one traumatic event in their lives (Kessler et al, 1995). Men with severe mental illness are at even higher risk than the general population. 35% of these men reported childhood sexual abuse and 25% reported violence in adulthood (Muesler et al. 1998)

In our society, there is cultural pressure on men to be viewed as strong, unemotional, tough, and heroic, and there is great pressure on them to maintain this image, even at the risk of neglecting their own emotional needs. For men who have experienced sexual abuse, getting help is difficult and often avoided for fear of appearing weak or vulnerable. Men often are slower to disclose and often present with more externalizing symptoms of anger, substance use, and impulsive self-destructive behavior than women.

Men may be even more developmentally prone to shame because of the gender strain of not being able to sustain the cultural expectations of men in the wake of interpersonal trauma. In fact, shame effects are among the most potent motivators of male character armour "machismo", "cool", strong and silent", "poker-faced" and other familiar poses" (quoted in Fallot and Bebout, 2012).

It is important to differentiate the effects of sexual abuse on men because they are more likely to be overlooked. Men also tend to bottle emotions, and disconnect from relationships which may require a different therapeutic approach.

- Boys encounter different types of abuse than girls.
- Boys are more likely to experience childhood sexual abuse from older boys in residential schools and juvenile offender contexts, less likely to suffer childhood sexual abuse in the family context and more likely elsewhere.
- Boys may respond differently than girls, because they associate their abuse with homosexuality and are more likely to have physical abuse coupled with the sexual abuse (Feinauer et al, 2007).

There are many myths in our society about men being victims of abuse. If service providers believe in these myths, this will prevent them from providing knowledgeable and sensitive services to men who experienced sexual abuse. These myths hold a lot of power and may create obstacles for men to talk about their experiences.

Common myths about men as victims of abuse include:

Myth: Men can only be sexually abused by other men.

Fact: though not well researched, men can be sexually abused by both genders, and there may be more secrecy and shame when sexually abused by women. In fact, sexual abuse by older women has often been glorified in the media.

Myth: Men who have been sexually abused will eventually sexually offend against others.

Fact: Most people who have been sexually abused do not abuse children as adults. It is a small minority of men who eventually go on to perpetrate sexual abuse.

Myth: Most sexual abuse is perpetrated by "dirty old men."

Fact: Sexual abuse is perpetrated against boys by anyone in a position of power in relation to them.

Myth: Men who have experienced sexual abuse are, or will become, gay or bisexual.

Fact: Sexual abuse is an act of violence where sexual acts are the weapon.Sexual abuse impacts sexuality. There is no research that identifies it being responsible for sexual orientation. Living in a homophobic social context is more directly related to this fear.

Myth: Childhood sexual abuse rarely happens to boys.

Fact: Research estimates that 20% of women and 16% of men experienced sexual abuse as children (2010).

Myth: Boys sexually abused by an adult female enjoyed it.

Fact: Abuse is nonconsensual and violating, but because the body is designed to respond to stimulations, physical reactions such as ejaculation can occur. This is not under the individual's control and can contribute to shame and self-blame.

The Impact of These Myths on Boys and Men

It is impossible to effectively work toward trust and safety with a person who has experienced trauma if service providers believe these myths that are prevalent in our society. These myths cause harm to people who have experienced trauma, and as long as they continue to be believed and replicated, men who have experienced sexual abuse will be less likely to get the recognition and help they need. As a result, the cycle of guilt, shame, anger and silence will continue.

For any man who has been sexually abused, overcoming these myths is an essential part of recovery. This can only happen, however, with providers who are willing to educate and support men in their healing process.

Effects of Sexual Abuse

Although not necessarily an inclusive list, the impact of sexual abuse may include:

Physical:

- Pain in the genital areas or anywhere on the body where abuse occurred
- Extreme discomfort in medical exams
- Chronic pain
- Unexplained medical problems
- No sexual pleasure
- Shakiness
- Nervousness

Emotional:

- Depression
- Suicidal thoughts
- Anger
- Helpless and ineffective
- Worthless
- Guilt
- Shame/self-blame
- Feel like a "bad" person
- Feel unworthy of love and respect of others
- Feel like an outsider/misfit
- Self-hatred
- Fear of authority
- Loss of faith/spiritual self

Behavioural:

- Avoidance of intimate relationships/pursuing many relationships

- Isolation
- Substance abuse
- Over-engaging in relationships/refusal to connect to friends and family
- Self-destructive behaviours
- Suicide attempts
- Aggression and hostility
- Breaking the law
- Missing appointments

Cognitive:

- Thoughts of suicide
- Dissociation
- Lack of concentration
- Overthinking

see "Effects of Trauma" section (page 64)

Spiritual:

- Feeling permanently damaged
- Lacking a sense of identity outside the abuse context
- Change in belief system (e.g., may have believed in God but this changes as a result of trauma)
- Feeling soulless
- Feeling evil
- Stops practicing faith

The effects of trauma depend on both the developmental level of the individual at the time the trauma occurred, and who participated in committing the abuse. Some people may have been abused as far back as they can remember, while others will remember times before the abuse started. If a person had some support and understanding from

significant people in their lives at the time the trauma occurred, the impact will most likely be less than someone who had no support or understanding when the abuse was disclosed to the family and community. In our role as service providers, we do not want to continue with the denial of trauma. When we acknowledge its presence, we can make a difference for someone in pain.

"I started using drugs and alcohol, or anything I could get my hands on, when I was 13. I found it was the only way that I could deal with my Mom's temper, and it took the edge off of the anger and sadness, but now I'm really messed up, and find that the memories are still there and so are the feelings I had when I was 13, but I'm 42. I've never felt so stuck…."

Individual affected by trauma

Co-occurring Disorders: Substance Abuse and Trauma

The term "co-occurring disorder" refers to the abuse/dependence of substance use and mental disorders.

Co-occurring disorders are so common with people affected by trauma that they should be considered expected rather than an exception. They are associated with a variety of negative outcomes, including high relapse rates, hospitalization, violence, incarceration, homelessness and serious infectious diseases (CODI, 2004).

It is currently estimated that one in five Canadians will experience a mental illness in their lifetime. The remaining four will have a friend, family member or colleague who experiences mental illness.

About 20% of people with a mental disorder have a co-occurring substance use problem.

One in 10 Canadians aged 15 and over report symptoms consistent with alcohol or illicit drug dependence.

Only one-third of those who need mental health services in Canada will actually receive them (Centre for Addiction and Mental Health, 2012).

Persons diagnosed with co-occurring disorders have one or more mental disorders, as well as one or more disorders relating to alcohol or substance abuse.

People with a lifetime history of PTSD have elevated rates of co-occurring disorders. Among men with PTSD, the highest rates are for co-occurring alcohol abuse or dependence. Research also shows that PTSD is a risk factor for substance abuse and addiction.

Substance abuse is very common amongst individuals who have experienced trauma because it is a quick way to numb feelings and avoid their profound emotional pain and suffering. When an addiction is present, assessment should consider any existing traumatic impacts.

In mental health programs, it is estimated that 25 to 50% of people have a substance use disorder. This is mirrored in drug treatment facilities where it is estimated that 50 to 75% of people have a mental disorder.

The two issues cannot be separated because they are so closely interwoven. If the person was not dealing with trauma, they would not feel the need to use substances to cope. One issue triggers the other. For example, sobriety often reveals unresolved memories and emotional pain that can flood the addicted individual who then uses substances, alcohol and addicting behaviours to regulate and numb their emotions.

Many mental illnesses are born out of unresolved trauma from childhood. For many people, disorders such as depression, personality disorders, and anxiety disorders are directly related to a history of unresolved trauma. What can often happen is treatment addresses only the current symptoms of the "disorder" and not the root cause. According to Judith Herman, "Survivors of childhood abuse, like other traumatized people, are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete" (Herman, 1992).

This demonstrates the strong link between trauma, mental illness and substance abuse. If and/or when the root cause is not addressed, people use substances to manage the pain and push down the memories and negative feelings associated with the trauma. This becomes a negative cycle that keeps the person stuck until both the trauma and the substance abuse issues are treated. There can also be a tremendous amount of shame associated with substance use, and not being able to quit is then layered upon the shame the individual may

experience in association with the original trauma.

These issues can and should be treated at the same time so the individual who experienced the trauma doesn't work on one issue while the other is being neglected. The source of the psychological pain must be addressed to positively impact reduction of substance use. When this doesn't happen, people who have experienced trauma often fall through the cracks of the social service and health systems and receive poor care. The attitude of "you must get clean before you can work on your trauma issues" keeps them stuck.

Dr. Wendi Woo's (2012) review of patient histories at Homewood in Guelph, Ontario, points out that trauma issues are not resolved through sobriety alone. Skills in emotional regulation and coming to terms with past traumas are necessary to lessen their impact. Lisa Najavits (2002) developed a series of modules that address the combined challenges found in both addiction and trauma, and then designed interventions that help clients gain mastery over relapse, social isolation, underlying anxiety and emotional volatility.

Similar interventions that focus on developing awareness, self-soothing practices and non-judgmental appraisal of thoughts and emotions are also helpful. Mindfulness Based Relapse Prevention, a group model piloted by G. A. Marlatt and Marsha Linehan's Dialectical Behavioural Therapy, can be helpful in both addictions and trauma. These therapies teach clients to directly address the troubling symptoms that lead to further negative ways of coping (Bowen & Vieten, 2012; Hayes & Levin, 2012).

It is important to let people affected by trauma know that it's normal to use substances to cope with the overwhelming emotions, and that help exists for reducing or stopping substance use and for addressing the traumatic issues.

CODI

The Co-occurring Mental Health and Substance Use Disorders Initiative of Manitoba (CODI) was undertaken as a partnership project of the Winnipeg Regional Health Authority, the Addictions Foundation of Manitoba and Manitoba Health. For further information, see the WRHA website.

"It's like I can live without fear of being harmed again. Sometimes I still feel scared, but I know that I am stronger now and I'm a better person for having gone through it. I feel like my recovery is well on its way now." -Individual affected by trauma

Trauma Recovery

Recovery is the primary goal for those who have experienced trauma, their families and their care providers. Recovery does not necessarily mean complete freedom from post-traumatic effects. Rather, it is an individual experience that will look and be different for everyone. In general, recovery is the ability to live in the present without being overwhelmed by the thoughts and feelings of the past.

In a trauma-informed system, it is acknowledged that everyone plays a role in supporting recovery, from the person at reception to the CEO.

What May Help

It is impossible to sweep the world clean of triggers. There will always be difficult problems to solve, events that are unsettling and experiences that are unpleasant. It is a much better strategy to enhance our ability to cope. We now know that even deep patterns of neural firing can be changed through the ability of the brain to change itself (Davidson, 2003).

Through the nurturing of healthy relationships, attending to basic physical needs (i.e., sleep and nutrition), having adequate housing and food security, people have a greater opportunity to engage in trauma recovery. The mind, body and spirit will respond to these positive factors, which maximizes the potential for healing.

In addition, the practice of mindfulness can also play a significant role in trauma recovery by helping to restructure parts of the brain that have been the most compromised by trauma. Mindfulness is paying attention in the present moment to body sensations, emotions and thoughts without judgment (Williams et al., 2007). Mindfulness is a skill based on thousands of years of practice in various meditative traditions. The most popular modern versions are Mindfulness Based Stress Reduction, yoga, and qi gong.

Definitions of Recovery

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." (SAMHSA)

"Mental health recovery is a journey of healing and transformation for a person with a mental health condition to be able to live a fulfilling and meaningful life in communities of his or her choice while striving towards personal goals." (US Department of Veterans Affairs)

Safe relationships and the development of mind/body practices calm the limbic system. Recent studies that look at changes in the brains of people who have been practicing meditation, even for a short time, show that their limbic systems are less reactive and the neural connections between the prefrontal cortex (thinking brain) and the limbic area (reactive brain) had increased (Davidson, 2012). These changes show that meditators are more likely to pause before reacting and, when stressed, choose a wiser course of action.

Other studies have shown that cognitive behavioural therapy combined with mindfulness practices can help prevent a relapse in people prone to clinical depression (Williams et al., 2007), obsessive compulsive disorder (Schwartz, 1996) and addictions (Marlatt, 2010).

Not all mindful practices involve sitting still. Bessel van der Kolk's team at his centre for people impacted by trauma in Massachusetts showed that women with "treatment resistant" PTSD improved after participating in several weeks of yoga. Almost half of them no longer had the symptom requirements for a diagnosis of PTSD (see yoga article at www.traumacenter.org). While these are early days, the emerging literature would suggest that there are many ways to heal from trauma.

Important Aspects of Trauma Recovery

Dr. Judith Herman (1992) conceives trauma recovery to proceed in three stages:

- Safety and stabilization
- Remembrance and mourning
- Reconnection

Safety and Stabilization

The central task of recovery is safety. Clients may feel they lack control over their emotions and other issues that stem from the unresolved trauma. Helping clients to realize what areas of their life need to be stabilized, and how that will be accomplished, will help the client move toward recovery. For example:

- A person who has experienced trauma may struggle to regulate difficult emotions in everyday life, which they might not necessarily associate directly to the trauma.
- A service provider can help the client learn to regulate these emotions.
- They work together as a team to stabilize the emotions so the individual who has experienced trauma can move on with the recovery process. This process takes time and varies from person to person.
- Some people who experienced trauma, particularly complex trauma, find that speaking about their experience or about the impact of their experience emotionally overwhelming. Recently, both therapists and researchers have been exploring nonverbal ways to foster emotional regulation. Several studies have suggested that Mindfulness Based Stress Reduction (MBSR) groups and the use of acupuncture for clients with PTSD reduce negative emotions and promote a calmer appraisal of life situations (Hollifield, 2007; Davidson et al., 2003). These practices work well with more traditional talk therapies and allow greater stability throughout recovery. Auricular acupuncture has the added advantage of reducing cravings for alcohol and drugs, as well as promoting better sleep and clearer thinking among clients who receive it regularly (Stuyt, 2005). It is also well suited for supporting work with refugees and immigrants in that it is nonverbal and closer to the methods of traditional medicine found in their own cultures.

Remembrance and Mourning

When clients feel stable, the task shifts to recounting the trauma, putting words and emotions to it, and making meaning of it. This process is usually undertaken with a counsellor or therapist in individual and/or group counselling. It might not require or be necessary to spend a lot of time in this phase. It is necessary, however, to continue to attend to safety during this phase. Attending to and establishing safety allows the client to move through this phase in a way that integrates the story of the trauma, rather than responding to it from a fight, flight and freeze response.

Pacing and timing are also crucial, and the point is neither to "re-live" nor avoid the trauma. This phase also includes exploring the losses associated with the trauma, and providing space for the client to grieve and experience the sadness associated with these losses.

Metaphor for creating safety:

"The experience of emotional overwhelm is similar to that of a shaken bottle of soda. Inside the bottle is a tremendous amount of pressure. The safest way to release the pressure is to open and close the cap in a slow, cautious and intentional manner so as to prevent an explosion."

Rothschild, 2010

Reconnection

The final stage of recovery involves redefining oneself in the context of meaningful relationships. When they are able to see the things that happened to them and understand that those events do not determine who they are, many people who have experienced trauma are able to gain a different perspective and meaning of the traumatic experiences. The trauma is no longer the organizing principle of their lives. It becomes part of their story, but they are not living in it or from it.

In many instances, people who have experienced trauma find a mission through which they can continue to heal and grow, such as talking to youth or peer mentoring. Successful resolution of the effects of trauma is a powerful testament to the resiliency of the human spirit.

Other Aspects of Trauma Recovery

- Assist the client in connecting with services that are central to recovery, such as health and mental health services, addictions services, therapeutic services, crisis services, culturally appropriate/relevant services and traditional healing services.
- Partner with the client as they define what recovery means to them.
- Consider the client's cultural context and include social supports that help them connect to the community.
- Encourage and assist the client in connecting in a meaningful way with themselves, safe family members, friends, culture and community.
- Assist clients in identifying activities that would provide a sense of purpose and meaning

"Being a trauma survivor means that I have remarkable coping skills, intuition, and resiliency. Contrary to what many (including other survivors) may think, trauma survivors can be, and often are, highly functioning individuals. Even though we sometimes have an inability to care for ourselves and make safe choices, this does not mean we are strangers to ourselves and do not know our needs."

Individual affected by trauma

The Resilience of People Affected by Trauma

Too often, programs focus so intently on the problems that they miss the strengths and resilience people bring to the human service setting. Just as we spend time and energy focusing on the impact of trauma, we must spend equal time on how people survived the experience, the strengths they have developed from having survived it, and how that resiliency has or will help in their recovery.

The most common approaches used by health care providers highlight pathology or illness, and inadvertently give the impression that there is something wrong with a person rather than that something wrong was done to the person (Elliot et al., 2005). When working with people who have experienced trauma, it is crucially important to make the distinction between who they are as human beings and what has happened to them.

Trauma should be viewed as an "injury" that requires time and support to heal. It can be very challenging for individuals affected by trauma to believe that their experience does not define them or their lives, and that the trauma did not occur because there was something wrong with them. The task of service providers is to assist them in making this distinction more accessible to them.

Trauma-informed practice recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important, even when past coping behaviours are now causing problems. Understanding a symptom as an adaptation reduces the guilt and shame that is so often associated with trauma. It also increases a person's capacity for self-compassion, and provides a guideline for developing new skills and resources so that new and better adaptations can be developed for the current situation (Elliot et al., 2005).

The language we use when speaking with or about people who have experienced trauma should also reflect resilience rather than simply being a description of them. This toolkit intentionally omits terms like “victim” and “survivor” because those terms imply who someone “is” rather than recognizing that they were impacted by a specific experience.

Working from a resilience-minded perspective helps people who have experienced trauma to realize that they do have the skills they need to heal and recover. To identify and access these skills, they need to reframe their coping behaviours and knowledge from weakness to strength. As service providers, we play a very important role in assisting individuals to develop a new trauma-informed lens of practice.

"A big part of my recovery and decision to start dealing with my past was talking to my Minister. He helped me to feel comfortable, like I was normal, and I was accepted by him unconditionally, even though I talked about doing drugs and crime. He seemed to really listen and I never felt bad or stupid around him. This was a new experience for me. I still keep in contact with him and do talks at the AA meetings at the Church."

Individual affected by trauma

Service Providers

Qualities and Characteristics Essential to Working with People Affected by Trauma

Working with people who have experienced trauma is difficult work, and can be emotionally draining. It can also trigger our own trauma histories. The stories and situations that they may describe can make a provider feel many emotions, including sadness, pity, frustration, hopelessness, anger and disbelief. The skills and characteristics outlined below are essential in building strong relationships with people affected by trauma. Strong provider/client relationships are the foundation of helping and recovery.

Empathy

Individuals who have experienced trauma need to feel supported and understood, not pitied. Pity creates shame while compassion creates connection (Briere, CODI keynote address, 2012). So rather than being sympathetic, providers need to demonstrate empathy and compassion by communicating their own feelings to the individual. For example, "I get the sense that you are feeling sad and hurt by what happened." This statement does not imply judgment, but rather that you are trying to understand where they are coming from.

Compassion

Compassion is as important for our clients' recovery as it is for our own well-being. It is a skill that can be taught and nurtured by our organizations and agencies, and it is demonstrated in how we treat our colleagues, how managers treat employees, and, of course, how we interact with our clients. Compassion

has been defined as "feeling the suffering of others with a felt desire to help." In other words, the helper feels a sense of equality and common humanity with the suffering of another (Briere, CODI keynote address, 2012).
See the section on Self-Compassion for more information on cultivating this important skill, pages 104 - 107

Able to Talk Openly

In order to help people who have experienced trauma, service providers need to be able to talk openly about issues, feelings and experiences related to the trauma. It is up to the individual who has experienced the trauma to disclose these things, and there is no right way to do this. The amount or nature of the information is not relevant. What is relevant is that if you come across as uncomfortable or unable to say certain words, it communicates to the individual that you don't want to hear it. The ability to engage with the clients suffering creates opportunity for healing.

Self-Aware

It is essential that service providers have an understanding of their own trauma histories. It is also essential that they are aware how it relates to their own beliefs, values, theories and biases related to trauma. Regardless of whether a service provider has experienced trauma or not, it is essential for them to have a level of self-awareness that will allow them to have a sense of themselves and their process when working with clients.

Providers who are self-aware of their feelings, thoughts and how they come across are more likely to invite clients who have experienced trauma to discuss their feelings more openly. Individuals who have been affected by trauma will sense this, leading to a stronger helping relationship and connection.

Clinical supervision can be a fundamental component to the process of self-awareness because it provides space that allows service providers to explore their own experiences with clients and that, in turn, helps promote healthy boundaries and connections.

Self-Care and Wellness

Attending to our own wellness is important because it plays a significant role in our ability to attune to our clients in a meaningful and engaged way. It is not only our own individual responsibility to care for ourselves, but also the responsibility of our agencies to create an environment where it is possible and expected.

Flexible

Providers must be flexible when working with people who have experienced trauma so that they can demonstrate care and concern for those people. This can include a willingness to accommodate some clients' difficulties with, for example, medical exams or office space by changing normal routines or procedures.

Comfortable with the Unknown

Someone else's experience of trauma may not be something with which the provider can directly relate. This can provoke feelings of discomfort and uncertainty. It is important to strive to remain open and grounded. This allows the relationship to remain intact and the potential for solutions and possibilities to emerge.

Willingness to Learn from Clients

Providers are often considered experts. However, when providers position themselves as experts in relation to their clients, it makes clients feel inferior, This can ultimately replicate the power dynamic that may have been present during the original trauma. You are not the expert of your clients' lives; they are the experts, and you must be willing to learn from them. Letting them teach us about their world is the best way to become knowledgeable.

Willingness to Connect Emotionally with the Client's Experience of Trauma

In order to make an effective and meaningful connection with people who have been affected by trauma, providers must make a connection beyond only facts and symptoms. Feelings and emotions play a central role in their work with clients. This type of connection allows them to feel accepted, understood and genuinely cared for.

Willingness to Step into the World of the Client

During the time they share together, providers must be willing to step into the shoes of the individual who has experienced trauma. This will make a strong connection and create a solid understanding of what it is like for that person to live with the trauma. Feeling understood has an impact on the nervous system. The experience of being understood by another person triggers the same response in the brain as a secure attachment (Briere, CODI keynote speaker, 2012).

Able to Regulate Own Emotions

Given the intense emotions that can result from discussions with clients who have experienced trauma, providers need to be able to regulate their own emotions and stay grounded during and after working with their clients. Being able to do this requires an awareness of self and their own nervous system, and what is required to regulate it. The ability to develop this level of self-awareness can then create opportunity for the service provider to use their own nervous systems as a tool to assist and support their clients.

Clients who have experienced trauma themselves may present as unable to regulate their emotions, so it is the providers job to stay calm and demonstrate emotional regulation. The provider's regulated nervous system has the potential to regulate the nervous systems of others.

Able to Treat the Client as an Equal and Collaborator

In order not to pathologize clients who have experienced trauma, providers need to treat clients as equals and not act on a belief system that they are weaker and less resourceful. When clients who have been affected by trauma are treated as equals, their strengths and resources are highlighted. It is not an "us" or "them" concept. When we make ourselves other than our clients, we can replicate the dynamic of the trauma. Being able to communicate a sense of relatedness allows for greater connection, communication and ultimately healing.

Good Listener

Providers must be willing to actively listen to clients by focusing solely on what they are saying and showing genuine interest. This will encourage the client to open up and share information and feelings that will help in healing and recovery. Being a good listener also requires that we be comfortable with silence.

Willingness to Debrief

If the provider is to be successful in processing the experience, it is important that they be able to debrief with co-workers about their contacts with clients who have experienced trauma. It is normal to be left with difficult feelings after conversations about trauma or its impact. You are more helpful when you can share your feelings and thoughts with others.

Self-compassion is defined as "kindness directed toward the self." At its core, trauma affects a person's capacity to be self-compassionate, so trauma recovery is about nurturing and growing that ability.

Self-Compassion

To effectively support recovery, service providers are required to develop their own capacity for self-compassion. Our ability to be compassionate depends on our ability to be self-compassionate.

As mentioned elsewhere in this toolkit, safe, trustworthy and authentic relationships are the heart of recovery. The relationship we have with ourselves is just as crucial to healing as our ties to the people around us.

However, treating ourselves kindly can be quite a foreign concept. Cutting ourselves some slack can be viewed as making excuses for ourselves or encouraging self-pity (Neff, 2011). Our critical thoughts judge our weaknesses and struggle in ways that we would never express toward a friend. We say things to ourselves that are quite shocking. Just like abuse from others, self-hostility impacts our ability to manage stress, and is associated with a host of mental health problems (Gilbert, 2008).

Rather, self-compassion is linked to less anxiety and depression (Neff, 2011). Some people are naturally kinder to themselves and can step outside our society's endless quest for perfection. For those people who struggle with being kind to themselves, Kristen Neff and Christopher Germer, two key researchers and therapists working on understanding self-compassion, have noted that self-compassion can be taught (Germer, 2009; Neff, 2011).

Neff has developed an eight-week group intervention that helps people engage in self-compassion practices that incorporate aspects of mindful meditation and build on the age-old Buddhist practices of "Loving Kindness."

In these practices, through the development of mindful awareness, the practitioners learn to notice when their thoughts drift into self-blame or hostility, recognize that this is a moment of suffering and everyone's life contains difficulties,

and gently turn hostile thoughts toward a more compassionate view of our actions and circumstances (Neff, 2011).

In the Buddhist tradition, loving kindness practice is one of the foundations of mindfulness and an essential component of spiritual progress. In psychotherapy, it has been known for a long time that people who ruminate on their failings and circumstances are more prone to depression (Williams, 2007). Also strong negative emotions associated with self-loathing, such as shame, contribute to social isolation and feelings of helplessness (Gilbert, 2009).

A person capable of self-compassion knows that they have not been singled out for periods of struggle and unhappiness. We are creatures who experience difficulties by the very fact that we have been born. By allowing ourselves to experience loving kindness, not as an idea but as a felt sense, we are able to address difficulties directly, learn from them and, if possible, take some wise action to change them.

Harsh self-criticism, like bullying by others, undermines our ability to learn. Most victims of bullying want to hide. Self-compassion allows us to soften our hearts and minds in the midst of trouble and to see what can be done to change things, or to find the wisdom to accept what cannot be changed (Germer, 2009). It is the beginning of experiencing ourselves as worthy of kindness.

Perhaps the most important outcome of self-compassion is the increased capacity to care for others. If we are more aware that everyone is in the same boat, the same reality of human struggle, we can feel for the plight of others. The great wisdom traditions of the world understood that the beginning of loving others is to love ourselves.

Compassion is different than pity. Its old Latin root means that to have compassion is to "suffer with" others, not to simply observe their pain. True compassion goes further than

an emotional connection; it ignites the desire to relieve the suffering, to do something about it (Neff, 2011).

For more information on the development of self-compassion, visit Neff and Germer's links, which also have some downloadable guided practice meditations:

www.self-compassion.org
www.mindfulselfcompassion.org
www.klinic.mb.ca

"Focusing on their strengths engages clients in their own process of change by instilling hope about the ultimate possibility of changing and creating a better life for themselves and their family."

ARC Community Services, Madison, WI

Guidelines for Working with People Affected by Trauma

Strengths-Based Perspective

Focusing on strengths instead of weaknesses is a basic tenant of working with everyone, but especially with people who have experienced trauma and who may see themselves as inherently weak due to their experiences. Working from a strengths-based perspective is part of the process of relationship and trust building. A trauma-informed perspective that views trauma as an injury shifts the paradigm away from "sickness" to "impact" and moves the conversation away from "What is wrong with you?" to "What has happened to you?"

Post-Traumatic Growth

As service providers, it is also important to be aware that people who have experienced trauma can go on to not only "survive" the trauma, but also experience what has been identified in the literature as "Post-Traumatic Growth." Understanding that this is possible is an important element that contributes to fostering hope.

The research suggests that between 30 and 70% of individuals who experienced trauma also report positive change and growth coming out of the traumatic experience (Joseph & Butler, 2010). Post-traumatic growth is defined as the "experience of individuals whose development, at least in some areas, has surpassed what was present before the struggle with crises occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond the status quo" (Tedeschi & Calhoun, 2004). Individuals have described profound changes in their view of "relationships, how they view themselves and their philosophy of life" (Joseph & Linley, 2006).

What is essential to keep in mind is that post-traumatic growth is not a direct result of trauma, but rather is related to how the individual struggles as a result of the trauma (Tedeschi & Calhoun, 2004). There are a number of things that people who have experienced trauma and subsequent growth identify as significant to their struggle. These include having relationships where they felt "nurtured, liberated or validated" in addition to experiencing "genuine acceptance from others" (Woodward & Joseph, 2003). The ability of the service provider to assist and support a client who has experienced trauma through active, attentive and compassionate listening can lead to the client making meaning of the experience, which can foster post-traumatic growth.

It is important as a service provider to be cautious not to minimize the trauma in an effort to promote post-traumatic growth. Indeed, attaining post-traumatic growth is not always the outcome for individuals who have experienced trauma, and so it's important not to imply any failure or to minimize the impact of the trauma. It is also important to be aware that even in the presence and development of post-traumatic growth, it doesn't mean that there is an absence of distress. Both can occur simultaneously.

Post-traumatic growth can be considered both an outcome and a process. It is about maintaining a sense of hope that not only can a person who has experienced trauma survive, but they can also experience positive life changes as a result. Keeping in mind it is not the event that defines post-traumatic growth but what is able to develop from within the person. and service providers can play a significant role in this process.

Conversations with individuals who have experienced trauma should be non-judgmental and occur within a context of compassion, empathy and humanity. The primary focus is on rapport and relationship building, as well as the client's own capacity for survival and healing.

This non-authoritarian approach views the client as the expert in their own life, and as a whole person rather than just an illness or mental health label. As a result, the treatment of their trauma symptoms encompasses their mind, body and spirit.

How We Talk to People Who Have Experienced Trauma

In any verbal message, the part of language that has the most impact is how we say it. We need to be mindful of the words we choose, the tone we use, and how our statements and questions are phrased.

Important points to consider

Some important points on language and what we need to consider when working with people affected by trauma are:

- When English is a second language, make sure that people who do not speak English as a first language understand the recovery process.
- Use appropriate language that matches the client's level of understanding.
- Don't use jargon.
- Acknowledge non-verbal communication as verbal communication. Some people communicate more through behaviour than with words.
- Acknowledge silence as a way of communicating. Some people can't speak about it, or need time to feel comfortable.
- Clarify anything you do not understand or are confused by. Some people will speak indirectly about trauma. For example, "He was bothering me" could mean "He was abusing me."
- Use language that does not denote assumptions or judgments. Your inner assumptions should never be reflected in your language.

- Don't always refer to the person who abused them as "he," and victims as "she," or vice versa. We know that victims and those who behaved abusively can be both sexes.
- Be careful about the labels "offender," "perpetrator," "batterer," etc., because it could describe a beloved parent or family member that abused them. It is more helpful to refer to behaviour rather than characterizing a person and defining them by using a label. It is suggested to use language such as "behaved abusively."

Language and Assumptions

If we want individuals who have experienced trauma to hear us and be open to sharing their feelings and needs, then it is important to watch the language we use and assumptions we make. If we approach clients with a belief system based on negative assumptions, we will perpetuate the cycle of retraumatization and add to the problem. Following is a list of commonly held assumptions that service providers may unwittingly promote, as well as suggestions for turning these unhelpful responses into helpful belief systems that will assist the person with their recovery.

"This person is sick."	"This person is a survivor of trauma."
"They are weak."	"They are stronger for having gone through the trauma."
"They should be over it already."	"Recovery from trauma is a process and takes time."
"They are making it up."	"This is hard to hear, and harder to talk about."
"They want attention."	"They are crying out for help."
"Don't ask them about it or they will get upset."	"Talking about the trauma gives people permission to heal."
"They have poor coping methods."	"They have survival skills that have got them to where they are now."
"They'll never get over it."	"People can recover from trauma."
"They are permanently damaged."	"They can change, learn and recover."

Asking About Traumatic Experiences

Having knowledge about the experience of past trauma is important. Equally important is knowing how, when, where and why to ask about it, to acknowledge it in a way that feels comfortable and genuine, and is appropriate in the current circumstances. There are times when asking about trauma is not appropriate, and/or the provider must be mindful of guiding the conversation in a way that doesn't lead the client to feel overwhelmed.

Adopting universal precautions would suggest that we relate to everyone based on an assumption that they have had traumatic experiences. The matter of universal screening is another important issue for which each organization must establish its own protocol. We can ask people about whether they have had traumatic experiences without encouraging them to describe these events in detail. In doing so, however, it is important that people know why the questions are being asked and to understand that they do not need to answer them.

Following are a series of scenarios outlining how to appropriately ask about trauma and respond in different circumstances.

How do I ask about trauma when a person doesn't come out and say it, but gives other indications that they are having difficulties?

SCENARIO:

You are having a conversation with someone who is talking about feelings, behaviours and thoughts that indicate they could be dealing with unresolved trauma, but they do not say that this is an issue for them. You are not sure how to address it, but feel it should be addressed.

APPROPRIATE RESPONSE:

Ask for clarification or for the individual to help you understand why the feelings, etc., are present. Invite them to explore further. Some examples include "What are your thoughts about what these feelings might be connected to?", "I'm wondering if you could say a bit more about the thoughts and feelings you have mentioned so I can understand how to be helpful," "How long have you felt this way?", and "It's important and okay to go slow and take the time you need."

INAPPROPRIATE RESPONSE:

Not providing a context for why you are asking. "You must have been abused" or "Was it a traumatic experience in your past that you haven't dealt with yet that is causing these feelings?"

What if I ask about the trauma and say the wrong thing and make it worse?

SCENARIO:

An individual is describing traumatic experiences at the hands of their mother during their childhood. They are very emotional, and you feel quite moved and saddened by their experiences. You take your time to decide how you would like to address this because you want to help them feel accepted and comfortable.

APPROPRIATE RESPONSE:

You will not make the situation worse if your response is validating, non-judgmental, and accepts the person's feelings and their right to feel that way. For example, "Sounds like you are going through a hard time, and that makes sense given what you've already gone through."

INAPPROPRIATE RESPONSE:

Making discounting statements or ignoring their strong feelings can make the situation worse for the individual because it reinforces negative belief systems. For example, "That was a long time ago. Let's move on."

What if I say something that comes out wrong and what I really mean gets lost?

SCENARIO:

A woman is describing a painful traumatic experience involving witnessing killings in her village in her home country. You feel empathy and support for her situation, but what you say is…

APPROPRIATE RESPONSE:

You see the discomfort on her face, and realize what you said was just phrased improperly. You say, "I'm sorry. That came out wrong. What I meant to say was, that was a terrible experience, and I'm so glad you were able to find safety." This response shows the woman that you are human and able to admit when you've made a mistake.

INAPPROPRIATE RESPONSE:

"That's awful. Aren't you glad you live in Canada now?" This discounts her situation and makes an assumption that things are better now.

What if someone discloses trauma and they want to tell me all about it, but it's not my role or responsibility to be a counsellor?

SCENARIO:

A young woman discloses that she was sexually assaulted a few months ago. She goes on at length about the situation, asks for your advice, and says that she feels she needs to work on the impacts she is only now acknowledging. She says she feels comfortable talking with you.

APPROPRIATE RESPONSE:

Acknowledging the feelings and courage it takes to disclose trauma is important, but it is not necessary for you to counsel people if it falls outside the realm of your role. A more appropriate response is to refer them to the service that is right for them and their situation, and that they are willing to use. For example, you could say, "This is a hard time for you, and I thank you for sharing this with me. Sounds like you have a lot to talk about and I'm wondering if counselling is an option for you right now?" It would be important to highlight the trust the client has shown in sharing this information with you, and to encourage them to "trust" you further in making a recommendation for a referral to another counsellor.

INAPPROPRIATE RESPONSE:

Shutting a person down by cutting off the contact: "I'm not a counsellor, so I can't help you, but here's the number for some services." Or conversely, trying to provide counselling that is outside your role: "I'm not a counsellor, but I can try and give you the best advice I can."

How do I ask men about trauma in a way that may help them feel more comfortable in discussing their feelings and experiences?

SCENARIO:

You are speaking with a man in his mid-40s who says his childhood was really hard, and that he lived in fear of his father for most of it. You ask him if his father abused him, and his reply is, "Yeah, he was really mean and he'd let you know with his fists when he was angry. He also knew how to take it to the next level of humiliation in my room at night." You feel he is referring to sexual abuse.

APPROPRIATE RESPONSE:

Acknowledge his reference to sexual abuse and validate the experience. For example, "You described physical abuse by your dad, and I know abuse can often be sexual, too. Is that what you mean by the humiliation in your room?" The man says, "Yeah, he did stuff to me and I hated it, and I never told anyone about it because I was afraid they'd think it was my fault and I was gay." Responding to this appropriately would allow you to invite the man to acknowledge the harsh judgments as a societal myth. For example, "Abuse is never the fault of the child; you were in a situation where you had no choices. Sexual abuse cannot make you gay because it is used as a weapon, but society sure seems to send us that message. It's not easy to talk about this stuff. I appreciate your sharing it with me."

INAPPROPRIATE RESPONSE:

Not acknowledging the sexual abuse reference sends the message that you don't want to hear about it. For example, "I know a lot of guys who were beat up as kids; good thing you've moved on from that now." This response does not acknowledge the sexual abuse, but does assume he's over it.

Are there times when I shouldn't ask about the trauma?

SCENARIO:

You are speaking with a woman whose emotions of panic, anxiety and hopelessness are very strong. She seems overwhelmed, distracted, and in need of immediate help. She states that she's been bombarded with memories and flashbacks recently, has missed work, is crying a lot, and isn't really feeling she's in reality. She needs help now.

APPROPRIATE RESPONSE:

Acknowledge her feelings and fears and assess her current situation as someone who is in crisis and having difficulty containing her emotions and dealing with daily functioning. This individual is not physically or mentally able to function properly, so asking about the trauma may exacerbate the situation by adding to her inability to cope. Instead, you could ask, "How can I help you now? What needs to happen to help you feel more under control now?" Also, "Let's take some deep breaths together." Panic and anxiety can often be reduced by intentional deep breathing.

INAPPROPRIATE RESPONSE:

"Sounds like you are dealing with trauma. Do you have time to talk about the memories and how they are impacting you

now?" This response ignores the immediate needs of safety and stabilization this woman needs, and focuses instead on issues that are longer term.

Do I need to get all the details of the trauma in order to understand where the individual is coming from and for them to heal?

SCENARIO:

You are speaking with a veteran who states that the war is still with him in his mind. He feels like he just left Afghanistan yesterday. He wonders if the pain will ever go away.

APPROPRIATE RESPONSE:

Acknowledge his statement, but do not ask for specific details or the whole story of the trauma, unless the person indicates that this is an important part of recovery for him. Just asking about the feelings and impacts of the trauma is all that is necessary to encourage healing and recovery. For example, "Seems that an experience like war can really stay with you. How does it impact your life today? What do you notice in yourself as you talk about it right now?" This focuses on the impact of the trauma, which is current.

INAPPROPRIATE RESPONSE:

Focusing on getting the whole story of the trauma, including details of specific incidents, calls for too much information that may not be necessary for recovery. For example, "Can you please start from the beginning and tell me in detail about your experiences that are still painful?" This may actually set the individual back because the memories are still too painful.

What if I become frustrated with people because I sense they are trying to be difficult by withholding information?

SCENARIO:

You are speaking with an Aboriginal man in his 50s who suffers from depression. He says very little about his feelings, and does not make eye contact. When you ask him about his depression, he provides little information and seems uncomfortable, like he doesn't want to be there, even though he came voluntarily. You become frustrated, low on patience and wonder why he can't just be "normal."

APPROPRIATE RESPONSE:

Ask about his discomfort and what you can do differently to accommodate him so he can benefit from the meeting. Understand what his "normal" way of communicating is and place your work with him in that context.

INAPPROPRIATE RESPONSE:

Being judgmental, and allowing your emotions to interfere with service. For example, "I can't help you if you don't give me information."

"This huge panic came over me and all I could think was 'Please let me get to my car, please… I started running; all the while visions of me being raped were going through my head. I heard someone call my name, and it was my co-worker running after me with my purse. The fear I felt that day scared me. I was never like that before."

Guidance counsellor

Effects on Service Providers: Trauma Exposure Response

Working with people who have experienced trauma is hard work. As with anything, there are the good aspects – strength and resilience building, personal growth, and being a witness to incredible progress and change – and the difficult aspects – knowing about human cruelty, suffering and vulnerability, and the devastating impact it has on the people we work with.

There have been many ways to identify what is commonly known as Vicarious Trauma. Historically, "the transformation that takes place within us as a result of exposure to the suffering of other living beings or the planet" (van Dernoot Lipsky, 2010) has been identified in various ways.

Terminology

Burnout:

Occurs over a long period of time and is usually related to work place/environmental stressors (i.e., not having adequate resources to do your job, downsizing, increase in paperwork, the organization not acknowledging the impact of being exposed to trauma), rather than specifically related to working with clients who have experienced trauma.

Compassion Fatigue:

Is outdated/inaccurate terminology that suggests having too much "compassion" can have negative impacts. What we know now is that working from a place of compassion for self and others can be a protective measure against Trauma Exposure Response.

Secondary Trauma/Vicarious Trauma:

Suggests it is something you "catch" from working with people who have been affected by trauma like the cold or flu.

Trauma Exposure Response:

The experience of bearing witness to atrocities that are committed human against human. It is the result of absorbing the sight, smell, sound, touch and feel of the stories told in detail by survivors who are searching for a way to release their own pain (Health Canada, 2001). In the case of service providers, Trauma Exposure Response is the impact of working directly with individuals who have experienced or been affected by trauma.

Just a primary experience of trauma transforms clients' understanding of themselves and the world around them, so too does bearing witness to it, sometimes in very profound ways. Service providers become affected by the trauma experiences of their clients and are exposed to the terror, shame and sadness of their clients. Providers are vulnerable because of their empathic openness, which is a necessary and essential part of the helping process. However, service providers must be mindful of the balance between empathy and the impact of the exposure to the clients' trauma.

Trauma Exposure Response can be seen as an occupational hazard that is almost unavoidable when hearing about traumatic experiences. Just as PTSD is on a continuum, so is Trauma Exposure Response. The more traumatic material the provider is aware of, the more likely they are to develop a Trauma Exposure Response, especially if their capacity to process the information is limited as a result of an overload of traumatic experience (either through their work or their own trauma history). The impact/effects and changes that result from exposure to trauma can be slight and perhaps barely noticeable, while others can be profound and life-changing. This is normal and is completely manageable with strong workplace and social supports.

It's not "if" but "when" and "how" we will be affected by our exposure to our client's trauma.

16 Themes of Trauma Exposure Response

(From Trauma Stewardship, Laura van Dernoot Lipsky, 2009)

These are some of the ways that working with people affected by trauma can impact service providers. A service provider may experience one or two or even many of the themes included in this list:

- Feeling hopeless and helpless
- A sense that one can never do enough
- Hypervigilance
- Diminished creativity
- Inability to embrace complexity (black and white, right and wrong, "us" and "them" thinking)
- Minimizing
- Chronic exhaustion/physical ailments
- Inability to listen/deliberate avoidance
- Dissociative moments
- Sense of persecution
- Guilt
- Fear
- Anger and cynicism (negative thinking)
- Inability to empathize
- Addictions
- Grandiosity

Risk Factors

It is important and relevant to recognize that service providers will bring their own trauma histories to their work. What we know is that this increases the risk of further traumatization. It is imperative that service providers recognize and acknowledge how their own trauma histories can be a relevant factor when working with people who have also experienced trauma. As with PTSD, shame and secrecy can/will increase the suffering.

Other factors that increase risk for Trauma Exposure Response:

- Having a past history of trauma
- Overwork
- Ignoring health boundaries
- Taking on too much
- Lack of experience
- Too much experience (being in the job for many years)
- Working with large numbers of traumatized children, especially sexually abused children
- Working with large numbers of clients who suffer with dissociative disorders
- Having too many negative clinical outcomes (Bloom, 2003)

Managing Trauma Exposure Response

Preventing Trauma Exposure Response is very much dependent on the level of commitment an organization or system has made to being trauma-informed. Being trauma-informed means placing a high regard on creating a culture of safety and trust for staff and service providers, as well as clients, patients or residents.

A trauma-informed organization places a high regard on staff health and wellness and in helping staff to develop the same self-soothing, self-regulation, self-compassion and self-care skills as is being offered the people to whom they are providing services. Adequate levels of supervision is essential, especially from supervisors who are knowledgeable about trauma.

Trauma Exposure Response is manageable if the provider recognizes its negative impact, and takes immediate steps to address it. It is important that providers have a clear distinction between work and personal life. Although empathy and genuine connection are critical in working with trauma

survivors, providers need to be able to make a separation that allows them to nurture their mind, body, soul and spirit. If providers are not connected to themselves, then they will not be as effective in connecting with clients. Clients require service providers who are balanced and well, and this well-being of staff is the responsibility of both the service provider and the agency for which they work.

Just as providers encourage their clients to find ways to become more centred and grounded, providers themselves need to practice this.

Healing from Trauma Exposure Response requires awareness. It is no different than what is recommended for those who have experienced primary trauma. Service providers also need to access self-compassion, know how to relax, to self-soothe, to experience joy, and be able to "take in the good" (Hansen, 2005).

Link to Taking in the Good PDF and/or website all of which requires and demands self-awareness.
www.rickhanson.net/wp-content/files/PositiveEmotions.pdf

Organizational/Work Setting Responsibilities

Workplaces and organizations have a responsibility to create a psychologically safe workplace. This includes an environment that promotes trauma-informed principles such as safety and trustworthiness, not just for those receiving services, but also for those providing services. Trauma-informed workplaces place a high value on staff wellness, as well as open and respectful communication and, in so doing, makes an important contribution to addressing the impact and healing of Trauma Exposure Response. Ways they can accomplish this are:

- Accept stressors as real and legitimate, impacting individuals and the staff as a whole

- Work in a team
- Create a culture to counteract the effects of trauma
- Establish a clear value system within your organization
- Be clear about job tasks and personnel guidelines
- Obtain supervisory/management support
- Maximize collegiality
- Encourage democratic processes in decision-making and conflict resolution
- Emphasize a levelled hierarchy
- View the issue as affecting the entire group, not just an individual
- Remember the general approach is to seek solutions, not assign blame
- Expect a high level of tolerance for individual disturbance
- Communicate openly and effectively, ensure transparency
- Expect a high degree of cohesion
- Expect considerable flexibility of roles
- Join with others to deal with organizational bullies
- Eliminate any subculture of violence and abuse (Bloom, 2003)

www.workplacestrategiesformentalhealth.com

The ABCs of Addressing Trauma Exposure Response

A

Awareness:

Being attuned to one's needs, limits, emotions and resources. Heed all levels of awareness and sources of information, cognitive, intuitive and somatic. Practice mindfulness and acceptance.

B

Balance:

Maintaining balance among activities, especially work, play and rest. Inner balance allows attention to all aspects of oneself.

C

Connection:

Connecting with yourself, to others and to something larger. Communication is part of connection and breaks the silence of unacknowledged pain. These connections offset isolation and increase validation and hope (Health Canada, 2001).

List of Resources

Community and Provincial

On our web site, www.trauma-informed.ca, we will maintain a directory of appropriate international, national and provincial resources with links to their web sites. Below is an example of a provincial overview:

MANITOBA

CONTACT is Manitoba's community resource data warehouse. CONTACT community information is one of the most comprehensive listings of community resources in Manitoba.

- To locate counselling services for trauma survivors in your community visit CONTACT at: www.contactmb.org
- Click on "Find" and enter the type of service you are looking for. For example, by entering "Counselling and trauma" several services within Winnipeg and Manitoba are available with descriptions and links to the service's website if available.

Winnipeg Regional Health Authority:
Mental Health Programs:
www.wrha.mb.ca/community/mentalhealth

Regional Health Authorities of Manitoba:
www.rham.mb.ca

Trauma Specific Counselling Services in Winnipeg

Fort Garry Women's Resource Centre
Counselling for women
1150-A Waverley Street, Winnipeg, MB R3T 0P4
(204) 477-1123
www.fgwrc.ca

Klinic Community Health Centre
Counselling appointments (group and individual counselling) for adult survivors of trauma
870 Portage Avenue Winnipeg, MB R3G 0P1
(204) 784-4059
www.klinic.mb.ca/counsel-trauma.htm

Immigrant Women's Counselling Services
Provides counselling services to immigrant and refugee women in family violence, adaptation and post-traumatic stress
200-323 Portage Avenue Winnipeg, MB R3B 2C1
(204) 940-2172
www.norwesthealth.ca/mind-spirit/immigrant-womens-counselling-services

The Laurel Centre
Counselling for women with a history sexual abuse and addiction
104 Roslyn Road, Winnipeg, MB R3L 0G6
(204) 783-5460
www.thelaurelcentre.com

Men's Resource Centre
Counselling appointments for adult male survivors of trauma (group and individual counselling)
301-321 McDermot Avenue, Winnipeg, MB R3A 0A3
(204) 956-6562
www.mens-resource-centre.ca

Mount Carmel Clinic
Multicultural Wellness Program: Provides culturally appropriate counselling to immigrants and refugees who have experienced life crises
886 Main Street, Winnipeg, MB R2W 5L4
(204) 582-2311
www.mountcarmel.ca

Operational Stress Injury Clinic
A specialized outpatient program that exclusively serves veterans of the Canadian Forces, current Forces members, and eligible members of the RCMP Deer Lodge Centre
2109 Portage Avenue Winnipeg, MB R3J 0L3
(204) 837-1301
www.deerlodge.mb.ca/osi.html

24-Hour Crisis Lines

Klinic Crisis Line: (204) 786-8686

Toll free: 1-888-322-3019

Klinic Sexual Assault Crisis Line: (204) 786-8631

Manitoba Suicide Line: 1-877-435-7071

Domestic Violence Crisis Line: 1-877-977-0007

Training for Service Providers

Addictions Foundation of Manitoba (AFM): Regularly scheduled courses in addictions and co-occurring disorders.
www.afm.mb.ca

Applied Suicide Intervention Skills Training (ASIST)
Regularly scheduled workshops in suicide prevention provided in various locations in Manitoba.
www.livingworks.net/programs/asist

Co-occurring Disorders Initiative of Manitoba (CODI)
Nine clinical guidelines for clients with co-occurring disorders. These guidelines are intended for use by trainers, clinical supervisors and program administrators to support the training for clinical staff expected to work with persons who have co-occurring mental health and substance use disorders.

Crisis and Trauma Resource Institute Inc. (CTRI)
Provides professional training and consulting services for individuals, schools, communities, and organizations affected or involved in working with issues of crisis and trauma.
www.ctrinstitute.com

Klinic Community Health Centre
Workshops provided to service providers at Klinic and within the communities of Winnipeg and throughout the province on suicide prevention, family violence, women and transgender women working in the sex trade, working with adult survivors of sexual abuse, and auricular acupuncture.
www.klinic.mb.ca

Recommended Websites and Books

CANADA

Aboriginal Healing Foundation
www.ahf.ca

Canadian Mental Health Association Manitoba
www.manitoba.cmha.ca

Center for Mental Health and Addictions Canada (CMAH)
www.camh.net

Center for Suicide Prevention
www.suicideinfo.ca

Klinic Community Health Centre
Manitoba Provincial Forum on Trauma Recovery Forum Final Report:
www.klinic.mb.ca/docs/Provincial%20Forum%20Final%20Report%202007.pdf

Mental Health Resource of Canada:
www.mherc.mb.ca
www.trauma-informed.ca

UNITED STATES

The National Center for Trauma Informed Mental Health
www.samhsa.gov/nctic

The National Trauma Consortium (NTC)
www.nationaltraumaconsortium.org

Substance Abuse Mental Health services administration's National Mental Health Information Centre (SAMHSA) U.S.A.
www.samhsa.gov

The Trauma Center at JRI
www.traumacenter.org

Books for Service Providers and Those Affected by Trauma

The following website contains a comprehensive list of books on trauma in a variety of areas for service providers and survivors of trauma
www.parentbooks.ca/Booklists.htm

Appendix

Canadian and US Statistics for Exposure to Psychological Trauma in Various Populations
United States
Source: Blanch, Andrea and Shern, David, *Implementing the New "Germ" Theory for the Public's Health: A Call to Action*, paper published by Mental Health America, 2011.

"Trauma is the lifetime experience among people who use public mental health, substance abuse and social services as well as people who are justice-involved or homeless." (Blanch and Stern, pg. 10) Trauma histories have been evident among:

- 90% of people in psychiatric hospitals
- 92-97% of women who are homeless experienced sexual and physical abuse
- 75-93% of youth in juvenile justice systems
- 50-79% of men who experienced maltreatment before the age of twelve experienced serious involvement with the justice system
- Men who witnessed violence in the home are 3 times more likely to abuse their partners than men who were not exposed
- 80% of women in prison experienced sexual and physical abuse
- One California study found that 100% of men (n=16) on death row experienced profound abuse in their families of origin and further abuse in foster care
- The correlation between higher ACE scores and chronic physical and mental illness continues to be supported, the direct cost of these chronic conditions amounts to 84% of health care expenditure
- A male child with an ACE score of six or more is 46 times more likely to become a IV drug user that a child with a score of 0

Source: Gina Barton, *The Journal Sentinel,* November 11, 2012 "Infant stress may alter brain function of girls, study says. Article on a longitudinal study of mother/ infant pairs and maternal stress undertaken at the U. of Wisconsin. Dr. Cory Burghy, lead author. Published in Nature Neuroscience, November, 2012.

- Measures of cortisol were taken of mothers and infants at regular intervals during infancy and into early childhood
- When the children turned 18, brain scans where conducted to determine any structural changes that might be attributed to early exposure to maternal stress The scans of girls showed lower level of connectivity between the amygdale and prefrontal cortex which can compromise the down regulation of distress
- In interviews the girls reported higher levels of anxiety and depression
- The scans of boys did not show the same pattern, further study is needed to determine the gender differences in response to early exposure to stress

Source: Bifulco, Antonia et al, (2002) *Exploring psychological abuse in childhood: II. Association with other abuse and adult clinical depression,* Bulletin of the Menninger Clinic, 66(3)241-258.

- Sample taken of high risk communities in London, UK, n=204 adult women
- Retrospective analysis of childhood exposure to psychological trauma found a high correlation between early trauma and chronic depression in adulthood

Source: New York Times, Tina Rosenberg, *For Veterans, a Surge of New Treatment for Trauma,* September 26th, 2012.

- Recent RAND Corporation survey questioned a sample of the 2.4 million service personnel who served in US military operations in the Middle East since the first Gulf War, one third of the respondents reported suffering

from PTSD, Traumatic Brain Injury or major depression, 5% of these reported suffering from all three

- Only half of these sought treatment
- The rates of PTSD are expected to rise given that many symptoms are displayed
- Although VA treatment facilities have been devoting more money to treat vets with mental health concerns, only 10% of those in treatment are veterans of Iraq or Afghanistan, the rest are from previous conflicts, notably Viet Nam
- Dr. James Kelly, director of the National Intrepid Centre of Excellence notes that the nature of TBI makes the symptoms of PTSD worse as well as multiple deployments.
- Although 40% of personnel in treatment programs do improve or are cured of PTSD the dropout of rate is high due to the continued stigma of mental illness and the rigors of Cognitive Reprocessing and Prolonged Exposure therapy currently favoured by the military

Canada
Substance Use
Source: *Coalescing on Women and Substance Use Violence, trauma and Substance Use*, BC Centre for Excellence in Women's Health, 2010,
www.coalescing-vc.org

- Six women's treatment centres surveyed clients and found that 90% had experienced abuse either in childhood, adulthood or both
- 100% of birth mothers with children diagnosed with FASD had histories of sexual, physical and/or emotional abuse and 80% had an undiagnosed mental illness

Source: Woo, Wendi and Harry Vedelago, *Trauma exposure and PTSD among individuals seeking residential treatment in a Canadian treatment centre for substance abuse disorder,* The Canadian Journal of Addiction Medicine, 3(1), 2012.

- The paper cited a Winnipeg study (2000) which stated that 37% of people seeking treatment for addiction met the criterion for PTSD
- In a survey conducted by Homewood in 2011, n=187 with a response rate of 84%; men = 69%, women =30.9%, mean age 43
- 93% of respondents reported at least one traumatic experience
- 84.5% met the criterion A for PTSD, i.e. the event was perceived as life threatening
- 50.8% would meet the conditions for a current diagnosis of PTSD
- The study authors noted that the symptoms of PTSD are not resolved with sobriety

Source: Walton, G. et al., High prevalence of childhood emotional, physical and sexual trauma among a Canadian cohort of HIV-seropositive illicit drug users. AIDS Care, 2011, 23(6)714-21.

- Survey of 233 IV drug users; 35% where women
- 51% stated they experienced emotional abuse and physical abuse
- 36% experience emotional neglect, 46% physical neglect
- 41% experienced sexual abuse
- High rates of abuse were associated with high scores for clinical depression
- High rates of physical and sexual abuse were associated with higher rates of incarceration

Immigrants and Refugees
Source: Rousseau, C., et al, *Appendix II: Post traumatic stress disorder: evidence review for newly arriving immigrants and refugees,* Canadian Collaboration for Immigrant and Refugee Health, Canadian Medical Association Journal, 2011.

- Newly arrived immigrants and refugees often experience trauma in their home countries, 9% are estimated to have PTSD, 5% suffer from clinical depression
- Of those who present with depression, 71% also have PTSD
- Physicians are encouraged to look for sleep disorders, social isolation and other signs of underlying trauma rather than probing for details, which could be re-traumatizing
- Focus should be on practical help with settlement and building up relationships of safety before referring to direct services targeting trauma

Corrections
Source: Derkzen, D., et al, *Mental health needs of female offenders,* Psychological Services, 2012, doi: 10 1037/ a0029653

- the number of women in Canadian federal institutions who require mental health and substance abuse programming has increased dramatically
- 13% in 97/98 to 29% in 2008/2009
- Alcohol dependence is particularly evident among aboriginal women
- Adequate screening and program development is needed

Source: Annual Report of the Office of the Correctional Investigator, 2011-2012, Howard Sapers,
www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20112012-eng.pdf

- 62% of CSC inmates were flagged at admission for mental health follow-up service
- Offenders with a mental health diagnosis often had more than one designation, often a substance abuse disorder
- 50% of federally sentenced women report histories of self harm, 85% state having histories of physical abuse, 68% report sexual abuse

- The prison environment is very unsettling for inmates with a history of abuse and mental illness and can make their symptoms worse
- Double bunking and isolation cells are particularly problematic for this group of inmates
- 21.7% of the incidents where force was use to control behaviour involved an inmate with mental health concerns
- In the past 10 years the number of aboriginal inmates has increased by 37.3% while the non-aboriginal prison population increased 2.4%

Canadian Forces and Veterans
Source: Jean Rodrique-Pare, *Post-traumatic stress disorder and the mental health of military personnel and veterans,* Background Paper, publication No. 2011-97-E, Oct. 14th, 2011, Library of Parliament.

- As of July 2011, 30,000 Canadian service personnel have been deployed in Afghanistan
- Symptoms of PTSD often appear many months or years after the event(s) that proceeded them it is estimated that over the next five years, 2,750 service personnel will suffer from severe PTSD and 6,000 from other mental illnesses diagnosed by a professional
- 90% of people with PTSD have a co-occurring diagnosis of depression, anxiety, substance abuse or suicidal ideation
- Given the present lifetime occurrence of operational stress injuries (OSI), it can be expected that 30% of soldiers who see combat will present with PTSD or clinical depression
- "At the moment three quarters of veterans taking part in VAC (Veterans Affairs Canada) rehabilitation programs following their release for medical reasons are suffering from mental health problems.", pg. 7 of the above report.

- **Source: Bensimon and Ruddell, Research brief: veterans in Canadian Correctional Systems, 2010, No. B-46, Correctional Service of Canada**
  - 2.8% of male inmates in Canadian institutions have served in the armed forces, this is expected to rise as soldiers who served in Afghanistan return home
  - Veterans are more at risk for suicide than the general prison population

Homelessness
Source: *At Home/Chez Soi Interim Report*, September 2012, published by the Mental Health Commission of Canada. www.mentalhealthcommission.ca
"It has been estimated that 150,000 Canadians are homeless, and some suggest it is as high as 300,000."

511 people who were homeless in Winnipeg participated in a national pilot project to determine the effectiveness of making safe housing a priority. Of these:

- 70% are of aboriginal descent
- Most are middle aged with one in four being under 30 and one in six being over the age of 50
- 63% are men and 36% are women
- 40% are parents of children under 18 who are not under their care
- 40% had parents who attended residential schools and 12% attended these schools themselves
- Almost 50% were involved with Child Welfare as children and youth, many in foster care

Source: Van der Bree, M., et al., *A longitudinal Population-Based Study of Factors in Adolescence Predicting Homelessness in Young Adulthood,* Journal of Adolescent Health, 2009, 1-8.

- This British study found that a difficult family background, adjustment problems in school and experiences of victimization were the most often found factors that lead to homelessness in young people.

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Notes

Notes

Trauma-informed

Klinic Community Health Centre

Manitoba Trauma Information
and Education Centre

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Winnipeg, Manitoba
R3G 0P1

trauma-informed.ca