

**ADVANCING PREVENTION** PROJECT

# **Trauma-Informed & Resilient Communities: A Primer for Public Health Practitioners**

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The Advancing Prevention Project at The New York Academy of Medicine provides technical assistance, tools and resources to local health departments and their partners in the chronic disease and mental health and substance abuse priority areas of the NYS Prevention Agenda, in consultation with the New York State Department of Health, the NYS Office of Mental, the Suicide Prevention Center of NY, and the NYS Office of Alcoholism and Substance Abuse Services.

<sup>1</sup> The authors recognize that the philosophy and practice of “trauma-informed care” often occurs under different names. Those working on a community level rather than in an organizational or direct service setting may refer to the principles of trauma informed care as “trauma sensitive” practice. For simplicity, we use the term “trauma-informed care” throughout the factsheet with the recognition that there is a need for common terms and understanding.

# INTRODUCTION

## Public Health & Trauma

There is growing consensus across disciplines on the severe physical and mental health effects of trauma. Unfortunately, exposure to potentially traumatic experiences is common. In New York State, an estimated 60% of adults have experienced at least one adverse, or potentially traumatic, event. Of these, nearly 70% had exposure to violence<sup>1</sup>.

Despite the prevalence of traumatic experiences and knowledge about their link to poor health, much of current practice in physical and behavioral health and social services does not take a trauma-informed approach. Yet we know that there are evidence-based interventions and universal approaches to deal with trauma, build resiliency, and prevent re-traumatization.

Public health practitioners are critical players in promoting the diffusion of trauma-informed and trauma-specific programs and practices because of several unique assets. These include:

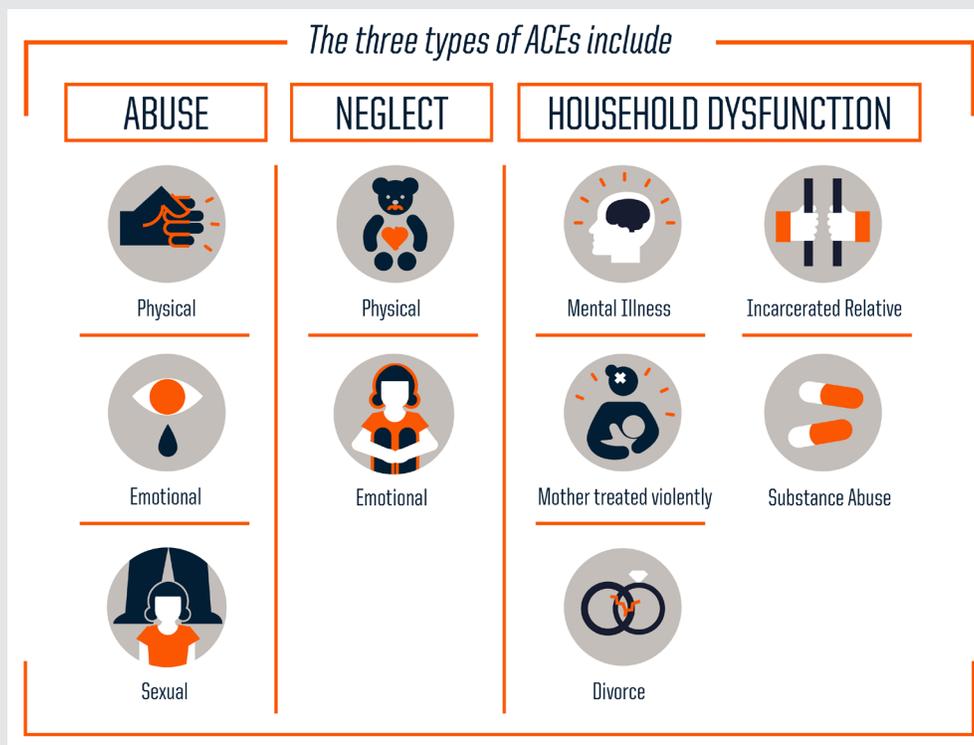
- Expertise in data and surveillance
- Interaction with at risk populations
- Focus on prevention and harm reduction and evidence based initiatives

This resource is intended to help public health, medical, educators and other social service professionals to better understand trauma, its connections to health, and the strategies that can be used to promote healing and resilience at the community level.

## WHAT ARE ACES AND WHY DO THEY MATTER?

The Adverse Childhood Experiences (ACEs) study, led by the CDC and Kaiser Permanente is one of the largest known investigations on health risk and childhood trauma. Over 17,000 adults were enrolled in the study from 1995–1997, during which time they were administered a physical exam and survey which formed baseline data on their health conditions, symptoms, behaviors, and adverse childhood experiences (ACEs). These participants are still being followed today, and the source of much ongoing research.

ACEs are potentially traumatic events that occur during childhood that can have negative, lasting effects on health and wellbeing. These experiences range from physical, emotional, or sexual abuse to parental divorce, substance use, or incarceration.



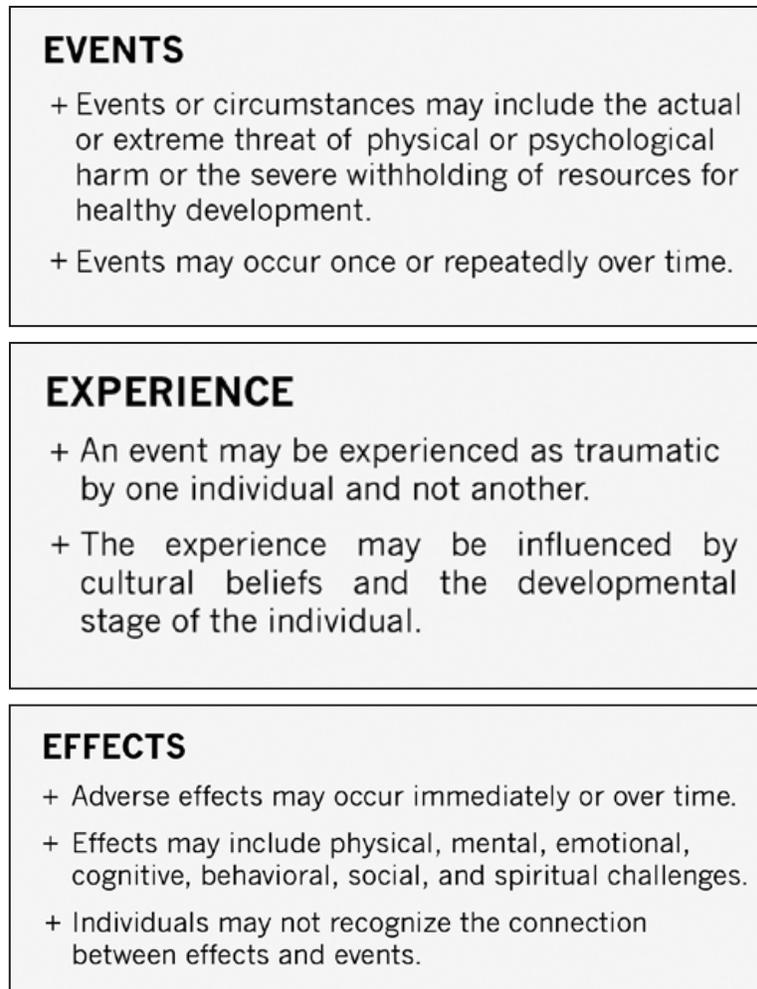
[Source: Robert Wood Johnson Foundation. The Truth About ACEs Infographic. Retrieved from: <http://www.rwjf.org/en/library/infographics/the-truth-about-aces.html>]

ACEs were linked to a variety of physical and mental health conditions, including diabetes, depression, suicide, STDs, heart disease, cancer, stroke, and COPD. While some of the increased risk of disease could be explained by an increase in risky health behaviors like substance use, smoking or lack of physical activity, one of the landmark ACE findings was that disease risk was not fully explained by risky behaviors. Additionally, this study led to the understanding of a dose response or cumulative risk relationship between trauma exposure and poor health outcomes. In other words, as the number of ACEs, risk for poor health later in life increases dramatically. For example, a child with exposure to 6 or more ACEs has a 4600% higher risk of becoming an injecting drug user<sup>2</sup>.

# SECTION 1

## The Spectrum of Trauma

FIGURE 1<sup>3</sup>



While there is no one universally agreed upon definition of trauma, one commonly used definition is from the Substance Abuse and Mental Health Services Administration (SAMHSA):

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional or spiritual wellbeing”.<sup>4</sup>

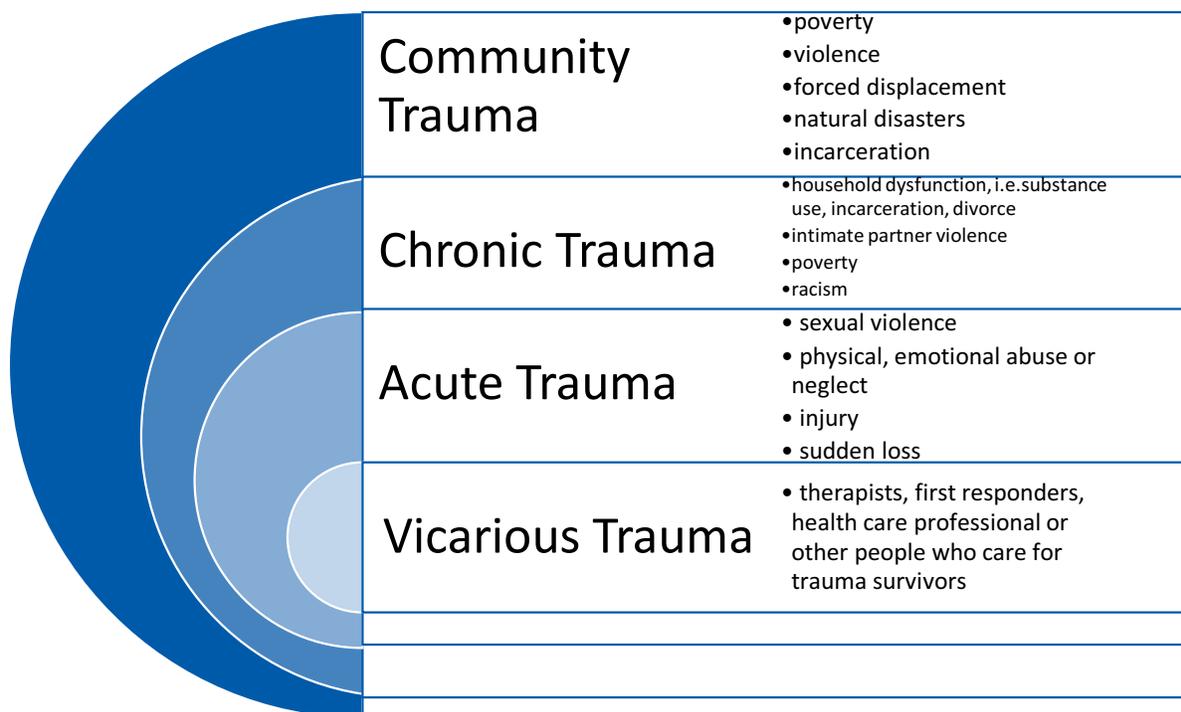
This definition recognizes trauma as a complex, multifaceted phenomenon that is the sum of three necessary components: events, experiences, and effects. This concept is often referred to as the **three E’s of trauma**. Trauma is not simply experiencing a traumatic event like violence, but involves individual, familial, community and environmental factors including an individual’s

temperament, past exposure to traumatic events, family history, coping skills, cultural beliefs, as well as adverse effects that may occur immediately or over a period of time. What is common across all forms of trauma is that it can have a significant impact on development, health and well-being.

It is also important to keep in mind that traumatic events can sometimes go unnoticed because of the misconception that everyone will respond similarly to particular events. As described above, depending on an individual's experience of the event and other intrinsic (e.g., personality) and extrinsic (e.g., community) factors, some seemingly normal life experiences may be experienced as traumatic. These may include, but are not limited to: injuries, surgeries, car accidents, humiliating experiences, or diagnosis with a life-threatening or disabling condition.<sup>5</sup>

## Events

FIGURE 2



As illustrated in figure 2, a host of events and exposures can lead to traumatization, and often occur on multiple, overlapping levels. At the individual level, **acute trauma** corresponds to episodes like sexual or physical violence, sudden loss of a caregiver, or a devastating illness or injury. Acute traumatic events that occur repeatedly can be characterized as **chronic trauma**, wherein an individual is exposed to ongoing abuse, household dysfunction, or other stressful conditions like poverty, incarceration or racism on an continuous basis. You might hear these kinds of exposures to trauma referred to as **toxic stress** or **complex trauma**.

At the interpersonal and community level, **community trauma** can be defined as “the product of the cumulative and synergistic impact of regular incidents of interpersonal, historical, and intergenerational violence and the continual exposure to structural violence”.<sup>6</sup> **Vicarious trauma** or **secondary trauma** refers to exposure to others’ traumatic experiences, usually among those who routinely help trauma survivors such as counselors or clergy.

## Prevalence of Trauma

Nationally, exposure to traumatic events is highly prevalent with at least 25% of the population experiencing a traumatic event by the onset of adulthood, and most of the population experiencing a traumatic event by the age of 45.<sup>7</sup> Among children ages birth through 17 years, an analysis of data from questions extracted from the 2011–12 National Survey of Children’s Health by Child Trends researchers estimated that, in New York State, 34% of children had one or two ACEs compared with 35% nationally; 8% had more than three ACEs compared with 11% nationally.<sup>8</sup>

### Inequities

Though exposure to potentially traumatic events is prevalent among the general population, certain groups experience higher rates and deserve special attention. Research has shown that exposure to violent trauma is more common in communities of color than in the general population.<sup>9</sup> Greater exposure to community violence, poverty, incarceration and institutional and overt racism compound these inequalities, particularly in African American communities.<sup>10</sup> Poverty, especially urban poverty, is also independently associated with greater prevalence in exposure to traumatic events. Not only are families living in urban poverty more likely to experience multiple traumas, they are less likely to have the resources to cope with traumatic experiences.<sup>11</sup> Both racism and poverty can also be considered forms of traumatic stress in and of themselves.

Youth and adults with substance use disorders and mental health conditions also carry a heavy burden of exposure to trauma. For instance, about 60–90% of children in the community mental health system report being exposed to trauma.<sup>11</sup> Substance use has been identified as both a risk factor for experiencing trauma and a consequence of exposure to traumatic events.<sup>12</sup> Military and veteran families and children are also more likely to experience potentially traumatic events through deployment-related disruptions in families, sudden loss, or the military parents’ own traumatic exposures while deployed. Within military families, some groups are more at risk than others, including young children, children with preexisting health issues, children with limited resources, single-parent families, and female veterans.<sup>13</sup>

# The Effects of Trauma

A breadth of research has demonstrated that exposure to traumatic events has negative effects on multiple aspects of health, from mental and behavioral health to chronic disease. The original Adverse Childhood Experiences (ACE) Study found that people who had four or more childhood ACEs had a 4-to-12 fold increased health risk for alcoholism, drug abuse, depression, and attempted suicide [2]. Traumatic experiences need not only occur in childhood to negative effect adult health—across the age spectrum exposure to traumatic events can negative impact health.

Other effects of traumatic experiences on multiple aspects of health include:

## Physical health effects

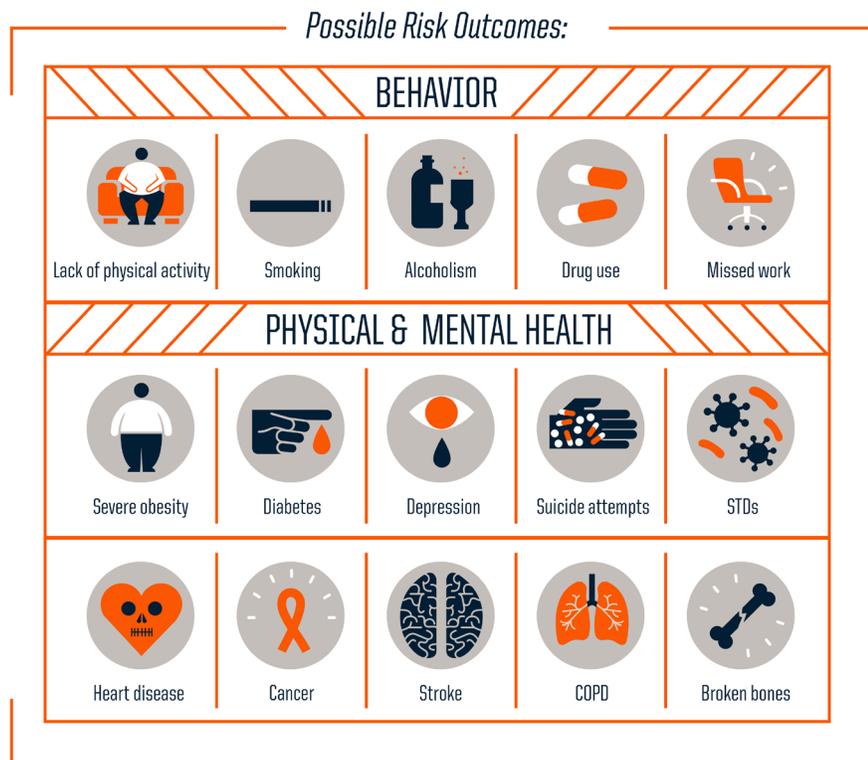
- Obesity
- Diabetes
- STDs
- COPD
- Stroke
- Cancer
- Heart disease

## Behavioral health effects

- Substance use
- Self-harm
- Smoking

## Mental health effects

- Depression
- Suicide effects



[Source: Robert Wood Johnson Foundation. The Truth About ACEs Infographic. Retrieved From: <http://www.rwjf.org/en/library/infographics/the-truth-about-aces.html>]

# SECTION 2

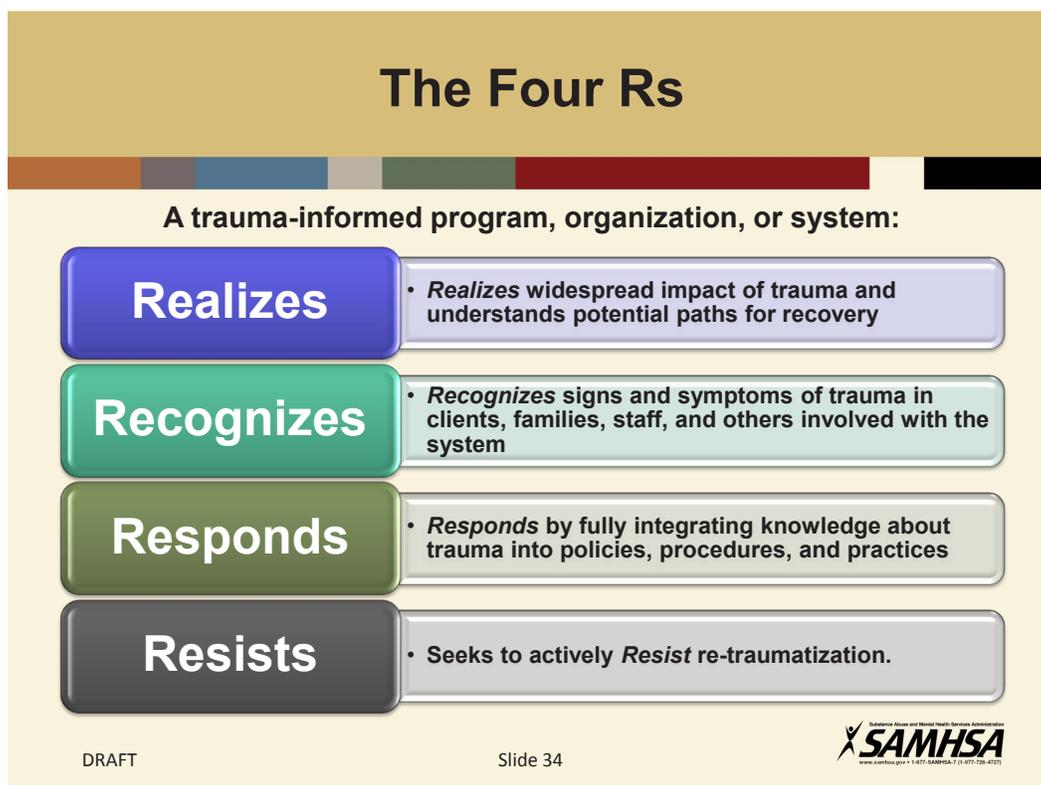
## What Does it Mean to be Trauma-Informed?

With trauma existing at such prevalent rates both nationally and in New York State, it is critical to develop policies and procedures in organizations, systems, and communities that recognize and respond to the effects of trauma – and which avoid re-traumatization.

Adopting a trauma-informed approach in multiple settings including but not limited to health care and social services can prevent re-traumatization, promote healing, and promote the identification of trauma by following several key assumptions and broad principles developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), referred to as the Four R's and the Six Key principles of Trauma-Informed Care.

The Four Rs developed by SAMHSA (described in table 1 below) outline four components of organizational or systemic cultural change that result from it becoming more trauma informed. They highlight the importance of moving beyond mere knowledge of trauma. Instead, ongoing and organizations and systems must be proactive and reflexive in developing policies, procedures and practices both responds to knowledge about trauma and resists re-traumatization.

TABLE 1<sup>14</sup>



With the goal of establishing a common framework and language and with input from national experts and trauma survivors, SAMHSA developed six principles to guide a trauma-informed change process. These value-based principles include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues. Each principle is described in table 2 below.

**TABLE 2. THE SIX KEY PRINCIPLES FOR A TRAUMA-INFORMED APPROACH**

<b>PRINCIPLE</b>	<b>DESCRIPTION<sup>5</sup></b>	<b>THE PRINCIPLE IN ACTION</b>
<b>SAFETY</b>	Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority	<i>Ask if it's okay to close the door during an interview</i>
<b>TRUSTWORTHINESS AND TRANSPARENCY</b>	Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.	<i>Promise to never show up to a client's home without telling them first</i>
<b>PEER SUPPORT</b>	Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."	<i>Recruit employees with lived experience</i>

(continued on P10)

<b>PRINCIPLE</b>	<b>DESCRIPTION<sup>15</sup></b>	<b>THE PRINCIPLE IN ACTION</b>
<b>COLLABORATION AND MUTUALITY</b>	<p>Importance placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: “one does not have to be a therapist to be therapeutic.”</p>	<p><i>Collaborate with a client to create a plan that works for them</i></p>
<b>EMPOWERMENT, VOICE AND CHOICE</b>	<p>Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery. Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.</p>	<p><i>Avoid mandating elements of service delivery</i></p>

<b>PRINCIPLE</b>	<b>DESCRIPTION<sup>15</sup></b>	<b>THE PRINCIPLE IN ACTION</b>
<b>CULTURAL, HISTORICAL AND GENDER ISSUES</b>	The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender- identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.	<i>Avoid acting “color-blind” and instead validate the devastating impact of racism</i>

A key feature of trauma-informed approaches is that it is a highly individualized process that involves constant reflection and work. As with any type of cultural shift, trauma-informed processes are more about a “way of being” than about following a pre-specified protocol or clinical interventions for working with everyone. They can be understood as a way of taking “universal precautions” with all individuals an organization interacts with.

While grounded in similar guiding principles, **trauma-specific services** or interventions are on the other hand evidence-based treatment modalities to address the consequences of trauma. Examples of these interventions include the Sanctuary Model and trauma-focused cognitive behavioral therapy (CBT).<sup>16</sup>

## **SECTION 3**

### **Fostering Resilience**

Contrary to popular belief, resilience is not an immutable personality trait but a response to a situation that may change depending on the situation; it is a skill that can be developed. Resilience is the capacity to cope with stress, overcome adversity and thrive despite, and perhaps even because of, challenges in life.<sup>17</sup> Consistent and unconditional social support is the common thread that weaves together protective factors that can enhance a person's ability to cope with adversity.

The Wellness as a Resource Model from the Robert Wood Johnson Foundations “Are the Children Well” Report is particularly helpful in understanding ways to promote resilience. Defining wellness broadly as more than the absence of sickness, encompassing a continuum of coping that ranges from “struggling” to “flourishing.” To promote an individual’s capacity to thrive despite adversity, wellness can be thought of as a bank account: “wellness increases as ‘deposits’ are made into the account, and it decreases with each ‘withdrawal’ made in order to achieve goals and adapt to challenges ... resulting in an ever-changing ‘wellness account balance.” Two crucial forms of wellness “deposits” for children include the presence of **caring relationships** and **wellness-promoting routines and practices**. In fact, much of the research has demonstrated that the single most influential protective factor to overcoming adversity in children is the presence of a protective and caring adult. Some specific examples of how to cultivate resilience at both the individual and community level are outlined below.

## Examples of Resilience:

To promote resilience in individuals, the American Psychological Association (APA) suggests 10 ways to build resilience.<sup>18</sup> Some of these include:

**TABLE 3**

<b>WAYS TO BUILD RESILIENCE</b>	<b>EXAMPLES</b>
<b>HELP BUILD CONNECTIONS WITH OTHERS</b>	<i>Participation in civic groups or mutual support groups</i>
<b>ENCOURAGE SELF-CARE</b>	<i>Exercise or relaxation techniques</i>
<b>PROMOTE MINDFULNESS AND EMOTIONAL REGULATION</b>	<i>Meditation</i>
<b>ENCOURAGE GOAL-SETTING</b>	<i>Practicing daily SMART (specific, measurable, achievable, realistic, time-bounded) goals</i>

The Protective Factors Framework<sup>19</sup> offers five essential factors to build family strengths and buffer risks to reduce childhood adversity. These include promoting:

**TABLE 4**

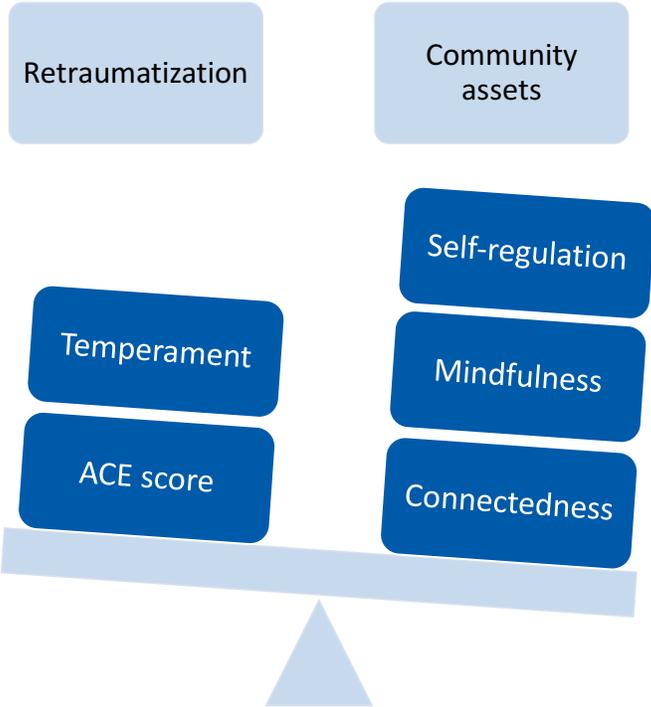
<b>FIVE ESSENTIAL FACTORS IN THE PROTECTIVE FACTORS FRAMEWORK</b>	<b>EXAMPLES</b>
<b>PARENTAL RESILIENCE</b>	<i>Peer support, transportation, access to child care</i>
<b>SOCIAL CONNECTIONS</b>	<i>Connecting to networks of mutual support</i>
<b>KNOWLEDGE OF PARENTING AND CHILD DEVELOPMENT</b>	<i>Promoting “warm but firm” strategies</i>
<b>CONCRETE SUPPORT IN TIMES OF NEED</b>	<i>Linking to support services like a food pantry during a crisis</i>
<b>CHILD SOCIAL AND EMOTIONAL COMPETENCE</b>	<i>Early identification and assistance, like Head Start</i>

Just as trauma can be experienced at a community level, so too resilience can be understood as a community level construct that can be developed and promoted in a variety of ways. Here are some examples of ways to promote your community’s resilience:

- Plan ahead of time for crises in schools and communities. For example, develop a plan for “Postvention” in the event of a suicide or other traumatic loss. See [link](#) for more on postvention.
- Enact campaigns to reduce the stigma of mental illness and substance use disorders and promote the use of services.
- Make community events parent-friendly by providing child-care services.
- Map the assets in your community to uncover strengths and resources such as libraries, recreation centers, local businesses, and nonprofits that might otherwise be overlooked. Disseminate your findings to community members. See [link](#) for more on asset mapping.
- Adopt trauma-informed policies and procedures in systems like schools, health care, and social services.
- Encourage peer involvement in service delivery and policy advocacy

To summarize, resilience can be fostered to shift the balance to recovery & growth:

FIGURE 3



## SECTION 4

# From Surviving to Thriving: Post-Traumatic Growth & Vicarious Resilience

The very mental and behavioral health services designed to help trauma survivors can often re-traumatize survivors. Factors mediating re-traumatization include the sense that providers are not learning from trauma survivors' experiences, that providers themselves experience vicarious traumatization, or treating the trauma survivor only as a victim without opportunities to be productive or help others.

However, there is a growing body of evidence that in addition to the well-established health risks that trauma survivors face, there is also the potential to make positive meaning, and transition from surviving to thriving, in the wake of trauma. While not everyone experiences nor should be expected to experience positive change after trauma, awareness of this potential can give trauma survivors a sense of control over their future. Additionally, this can facilitate a transition in provider thinking from looking for deficiencies to highlighting strengths and positive aspects of responses to trauma.<sup>20</sup>

In particular, the phenomena of *post*-traumatic growth, and vicarious resilience describe the positive psychological changes that can happen after trauma, and how these positive effects can be experienced by people who didn't directly experience the trauma itself, such as providers, friends, and family members.

## Post-Traumatic Growth

Post-traumatic growth (PTG) is "the experience of positive psychological changes that occur in the wake of a traumatic event as a result of the ensuing (psychological) struggle with what happened".<sup>21</sup> PTG usually happens in five general areas including:

- The perception of better relations to others
- New possibilities in life
- Enhanced personal strength
- An increased appreciation of life
- Spiritual growth

PTG introduces the possibility that after a traumatic event, trauma survivors can not only survive but thrive. Given that many people in their lifetime may experience a traumatic event, it is important to identify the possibility for PTG following traumatic experiences in trauma-informed care.

There is an important distinction between post-traumatic growth and resilience. Resilience is the capacity to cope, adjust, and recover from trauma. Resilience is the ability to adapt after trauma and return to “the psychological strength and functioning abilities available to the person prior to the trauma”.<sup>20</sup> In contrast, PTG goes beyond the ability to adapt back to ordinary life after trauma, but to make meaning of the traumatic experience, and experience positive growth in response to the trauma.

## Vicarious Resilience

The negative psychological effects of working with trauma survivors has been well-documented among providers. Experiencing vicarious traumatization, secondary traumatic stress, empathic stress, and compassion fatigue is common in workplaces with frequent exposure to survivors of trauma. The positive effects that can occur are less documented, but do exist. Vicarious resilience describes the positive effects that therapists, first responders, health care professional or other people who care for trauma survivors can experience in response to trauma survivors' own resiliency.

These positive effects include increased agency to cope with stress and overcome adversity in *providers* as a result of learning about overcoming adversity from the trauma survivors that providers treat. Researchers have conjectured that the following factors contribute to the development of vicarious resilience, specifically in the context of a therapy setting<sup>22</sup>:

- Core empathic capacities: Tolerance, resistance, endurance, capacity
- Dynamics of the therapist-client relationship
- Nature and extent of the clinician's connection with their clients' growth, resilience, and pain
- Empathic attunement with the client

Providers who are aware of the possibility for both vicarious trauma and vicarious resiliency “may find opportunities to grow both personally and professionally”.<sup>23</sup> Vicarious resilience can help providers find and foster positive meaning through learning from the trauma survivors they work with.

# For More Information...

Visit the Advancing Prevention Project website at [www.advancingpreventionproject.org](http://www.advancingpreventionproject.org) where you can:

- Find additional resources, factsheets, presentations, and toolkits
- Learn about upcoming training opportunities
- Watch previous APP webinars
- Schedule a one-on-one technical assistance appointment

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