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

Awareness:

A

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.

Balance:

B

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

Connection:

C

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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