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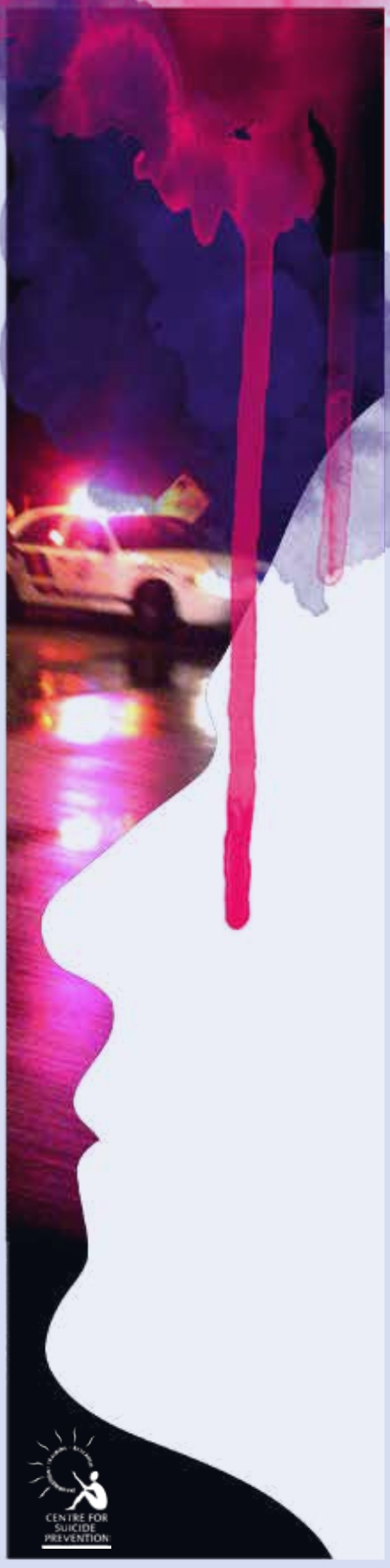
# Trauma Informed Care:
## Trauma, Substance Abuse and Suicide Prevention


By Robert Olson, Librarian, BA, MLIS

Mental health professionals tell us that both the severity of trauma that some people experience and the number of trauma survivors is much greater than most people realize. In fact, the majority of clients who end up in human services systems are trauma survivors (Elliott, 2005). One in ten Canadians has experienced trauma in some form; **sexual abuse, physical abuse by caregivers, exposure to war, suicidal loss, homicidal loss,** and **accidents** are just a few of the many risk factors for trauma (Klinic, 2013). Many victims will process the traumatic events, recover to a certain degree, and successfully move on with their lives. Resiliency can be a powerful human characteristic. Many others are not so fortunate and, thus, will deal with their traumatic experiences in any way possible.

Trauma has been defined as "A horrific event beyond the scope of normal human experience" (Greenwald, 2007, p.7). A person who experiences a traumatic event may feel like their life has been threatened. They may also have feelings of **helplessness**, along with **horror, fear,** or **disgust** (Greenwald, 2007).

The typical symptoms of someone suffering traumatic distress include **re-experiencing the event, avoidance and emotional numbing, changes in sleeping patterns, and hyperarousal** (Huckshorn, 2013).

Additionally, trauma can cause co-occurring disorders such as **substance use disorder.** In these cases, the trauma victim abuses alcohol or drugs in an attempt to numb the pain caused by the memory of the trauma. When co-occurring disorders combine with other illnesses - depression, for example - they can make an individual more susceptible to suicidal ideation or suicidal actions. (I will use trauma survivors and Post-Traumatic Stress Disorder (PTSD) survivors interchangeably for our purposes here, but it is of note that in some mental health sources subtle differences between the two are stressed. Expanding on these differences, however, would exceed the scope of this paper.)

## Trauma Informed Care

**Trauma Informed Care (TIC)** is an approach that the mental health community has adopted in recent years to attempt to deal with traumatic crises. Yeager, et al. define TIC as "Care that is organized around a contemporary, comprehensive

understanding of the impact of trauma that emphasizes strengths and safety and focuses on skill development for individuals to rebuild a sense of personal control over their life" (2013, p.595). "It is designed to be both **preventative** and **rehabilitative** in nature" (2013, p.65). This type of care is as much a philosophy as a service delivery approach.

TIC recognizes and emphasizes the vulnerability of many patients/clients; thus, the safety of the client is of paramount importance. Another defining characteristic of TIC is that everyone involved in the treatment must have a general awareness and understanding of trauma and its impact on survivors. Everyone, in this case, includes front-line staff, emergency workers, physicians and, of course, mental health professionals. "Trauma Informed Care is now the expectation - as opposed to the exception - in behavioral health treatment systems" (Rosenberg, 2011, p.428). The emphasis has shifted from **"What is wrong with you?"** to **"What happened to you?"** (Rosenberg, 2011). Individuals seeking help through TIC are encouraged to regain "personal control" of their lives (SAMHSA, 2013). Ideally, clients and practitioners act as equals as they work collaboratively to overcome the trauma. A culture of care is thus created - one in which the client is fundamentally respected and their dignity preserved. Client self-empowerment is TIC's ultimate aim.

This culture of care has not always been present in the mental health field. The researchers of one study have suggested that, historically in mental health, two assessment factors have contributed to the neglect of trauma concerns. One is the **under-reporting of trauma** by survivors due to a lack of trust, a fear of being stigmatized, or by a failure to recognize the symptoms of trauma by the survivors themselves. The second factor is the **under-recognition of trauma,** or a lack of awareness of traumatic symptoms by health care providers (Harris, 2001).

One of the main goals of TIC service delivery is to create an environment where all providers are well-informed about trauma related issues, and where the patient feels both safe and comfortable enough to offer full disclosure to all of his or her providers (Harris, 2001).

## Trauma and Substance Use Disorder

Can a compassionate philosophy and methodology such as TIC work beyond the traditional confines of mental health services?

I would like to examine the **substance abuse rehabilitation** industry to show that it is indeed possible to introduce new treatment ideas and practices that resemble certain principles of TIC.

I am choosing to examine this industry for two reasons. One, trauma survivors make up a significant proportion of individuals who attend rehabilitation facilities. The second reason is that, historically, the rehabilitation industry has endorsed and used only one philosophy and methodology of treatment. Treatment programs subscribing to this philosophy are often referred to as **12 Step Approaches,** and they have been used to treat somewhere between 90-95% of all substance abuse rehabilitation patients (Denning, 2004; Fletcher, 2013). Anyone familiar with this industry might be tempted to say that it is resistant to new ways of thinking, let alone a complete paradigm shift with regard to the way it operates.

As I mentioned above, trauma survivors often also have an alcohol or substance Use Disorder. For example, among women with PTSD, **28%** meet the criteria for

an alcohol use disorder, and **27%** for a substance use disorder. This is significant in that it is nearly **3** times the rate for women without PTSD. "The greater the trauma, the greater the risk (is) for alcohol abuse, illicit drug use, depression, suicide attempts, and other negative outcomes" (Rosenberg, 2011, p.428). **40 -59%** of women in substance abuse rehabilitation have PTSD (Gatz, 2007), **50%** of women have a history of rape or incest, and up to **2/3** of men and women report childhood abuse and neglect (Desanto, 2012).

The 12 Step model focuses on the abuse of the substance itself, not the underlying factors which may cause someone to drink or take drugs. In treatment centres that use this approach, the 12 Steps are the primary treatment in individual counseling as well as group therapy. This approach invites its participants to accept the idea that substance addiction is a disease that is progressive and incurable. The disease can only be controlled through ego-deflation, admittance of personal powerlessness, and the surrender of the individual will to a "higher power." According to this model, it is only by believing whole-heartedly and unquestioningly in these ideas that one has hope for recovery.

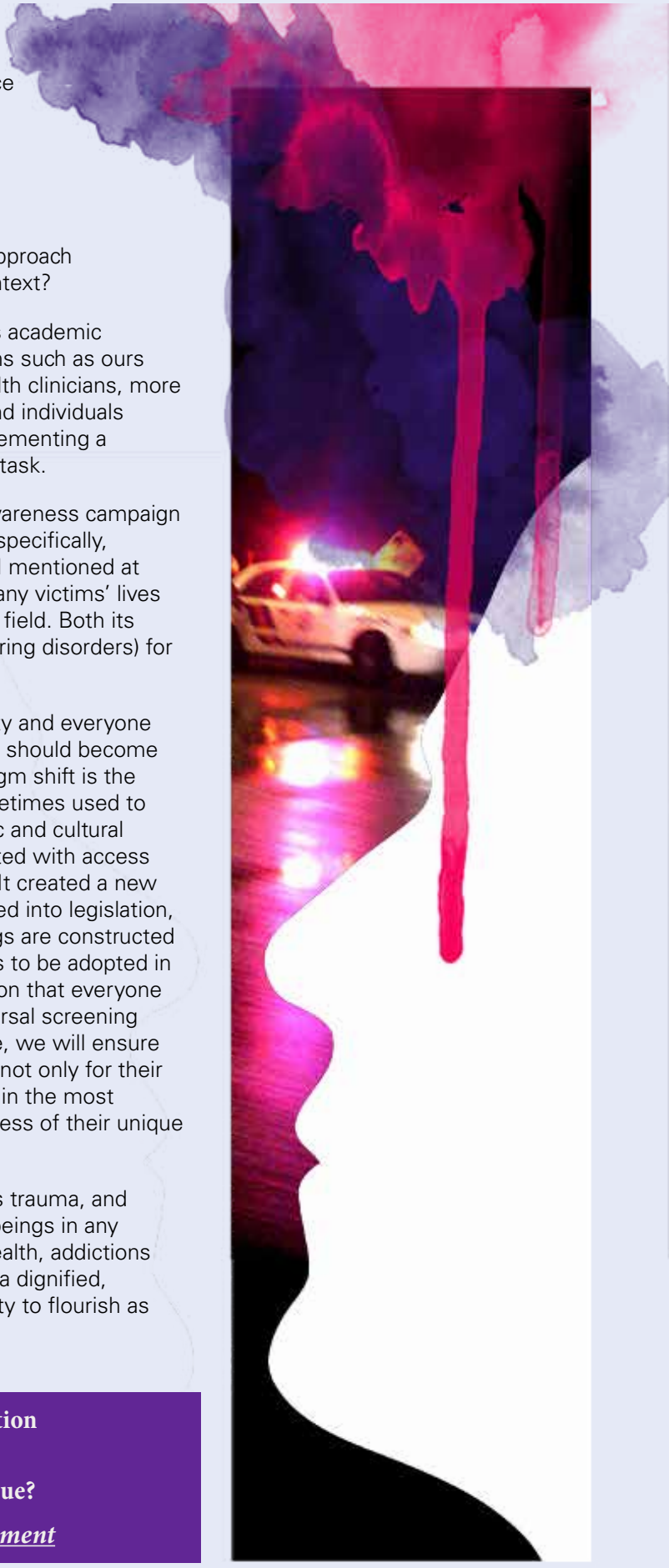
But for many - particularly trauma survivors and other vulnerable individuals - this 12 Step model can be a very ineffectual treatment. It is very common for someone who has been abused or victimized to develop an inherent belief in their own powerlessness. Thus, participating in a program that demands admitting and believing in their own powerlessness as its chief hallmark might ultimately be counterproductive to helping one get order in his or her life. Further, to "trust" in a "higher power" for direction when all somebody has known their entire life is betrayal, neglect, and abuse, might not be an objective easily achieved (White, 1998; Kasl, 1992; Apple, 2006).

A trauma survivor often turns to alcohol or drugs as a coping mechanism, and, in so doing, attempt to mask real pain that is not of their own making. With this in mind, there should be a thorough examination and treatment of the root causes- in this case, trauma- that drive an individual to become dependent on alcohol or drugs. This should be a main goal of a rehabilitation treatment program.

Non-12 step rehabilitation centres, which are becoming increasingly common, try to adopt this approach. These alternative rehabilitation centres often employ an approach based on the "Bio/Psycho/Social" model of treatment, which purports a holistic and individualistic approach to recovery. They treat the "whole person", not just the symptoms. They generally dismiss the idea that alcoholism or drug addiction is a disease, in favour of treating it as a behavioural disorder which can be overcome(the disease theory is far from universally accepted in the scientific community). The creators of this model suggest that there are myriad reasons why someone becomes an addict or alcoholic. Thus, in practice, various methods are employed to address the individual's plight, while firmly stressing that each person's situation is unique(DeSanto,2013). A facility that subscribes to this non-traditional philosophy and treatment model offers an option that has not often been seen before in the substance abuse rehabilitation industry. This option is, of course, choice. These alternative treatment programs emphasize the new idea that one size does not, in fact, fit all, and that each person should have their own "tailor-made" solution. This example mirrors the philosophical foundations of TIC in everything but name. It is a humanistic, client-centered philosophy that represents a major paradigm shift in the treatment of trauma.

Minnesota Alternatives in Spring Lake Park, Minnesota: http://mnalternatives.com/ and The Sunshine Coast Health Centre in Powell River, British Columbia: http://www.sunshinecoasthealthcentre.ca/ are two such programs that employ

non-12 Step, alternative recovery models. Both institutions also specialize in working with trauma survivors with substance abuse problems.



## Trauma Informed Care in Suicide Prevention

So how does all of this apply to suicide prevention? Is a TIC approach needed, and what does this type of approach mean in this context?

The field of suicide prevention is a diverse area which includes academic research (with its own interdisciplinary variations), organizations such as ours that are devoted specifically to suicide prevention, mental health clinicians, more informal groups that promote prevention in their own ways, and individuals formally trained to recognize someone at risk for suicide. Implementing a cohesive approach within this diverse community is a difficult task.

A TIC approach to suicide prevention should first involve an awareness campaign designed to inform and educate the general public and, more specifically, everyone who is in contact with potential trauma victims. As I mentioned at the outset, the severity of the problem that trauma plays in many victims' lives is still largely unknown by people outside of the mental health field. Both its seriousness and its status as a risk factor (along with co-occurring disorders) for suicide must be better and more widely conveyed.

Adopting the assumption that everyone assessed for suicidality and everyone treated for a suicide attempt has experienced personal trauma should become a more common practice. An analogy for this proposed paradigm shift is the enactment of The American Disabilities Act (1990); this is sometimes used to describe TIC. The American Disabilities Act mandated that civic and cultural organizations must have their physical environments constructed with access for the physically disabled, allowing for universal accessibility. It created a new baseline standard. As these changes were formally incorporated into legislation, the level of acceptability was raised and now all public buildings are constructed with universal access (Harris, 2001). The same approach needs to be adopted in suicide prevention: the baseline must be raised. The assumption that everyone has experienced trauma must become a formal part of a universal screening and assessment process. By making trauma screening routine, we will ensure that every person is assessed for past traumatic experiences, not only for their presenting symptoms. This will result in people being treated in the most humane, holistic and comprehensive manner possible, regardless of their unique personal history.

I believe that TIC should be viewed as a model that transcends trauma, and becomes the predominant model for interacting with human beings in any human services treatment area. Suicide prevention, mental health, addictions rehabilitation, whatever the area - people should be treated in a dignified, personalized and respectful way and be allowed the opportunity to flourish as individuals.

**We encourage your feedback and participation in the conversation of this topic.**

**Do you have any particular views on the issue?**

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