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As the world becomes trauma–informed, work to do

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The term trauma–informed is trending. Google searches for the term trauma-informed care have been measurable since at least 2004, with a noticeable uptick since 2011. Google trends also show a disproportionate interest in the United States, perhaps in part because of national efforts from the National Center for Trauma-Informed Care and the National Child Traumatic Stress Network, both funded by the Substance Abuse and Mental Health Services Administration, and other national efforts (Hanson & Lang, 2016). Google also shows more people searching for trauma-informed care, particularly in a few states that include Wisconsin and Oregon, perhaps in part because of the efforts of public health agencies in these states to promote trauma-informed mental health services.

This growing awareness of trauma is associated not just with mental health care but with a wide variety of systems, including child welfare services, the criminal justice system, the physical health care system, the military, schools and universities, and society generally (e.g., Trauma Informed Oregon, http://traumainformedoregon.org/). For trauma victims/survivors who for so long have had their experiences denied in so many different settings, trauma-informed systems carry incredible potential for good.

However, to protect and nurture that potential, we readers of the Journal of Trauma & Dissociation must work together with our colleagues to critically engage with the devils in the details. As we Journal of Trauma & Dissociation readers know, and numerous scholars have documented so well, cultural awareness of trauma and its effects waxes and wanes (e.g., Brown, 2004; Freyd, 1996; Herman, 1997; Lipstadt, 2016). As these tides of awareness affect everything from research funding, to the kinds of mental health treatment available, to individuals’ very experience of trauma, this is reason enough to be vigilant about the popularity of the term trauma-informed. Another reason is that often expensive training programs are proliferating, with virtually no research on the quality of the information being disseminated (Bloom, 2016; DePrince & Newman, 2011; Hanson & Lang, 2016). There is still another equally important and more subtle reason to pay attention. Because trauma is inextricably linked to systems of power
and oppression, history tells us to pay particular attention to how trauma is defined, who is and who is not defining trauma, and how victims/survivors are affected by those definitions, even when there is an apparent blossoming of societal awareness (Bloom, 2013; Moffat, 1991; Tseris, 2013). Without this critical engagement with the systems behind the trauma-informed movement, there is a risk of perpetuating the same victim-blaming, silencing, shaming, and retraumatizing practices “simply by another name” (Tseris, 2013, p. 153).

I started by getting a better idea of how the term trauma-informed is used in different real-world settings. Using Google, I found a very long list of examples of trauma-informed practices, mostly from training materials posted for various audiences. What follows is an abbreviated list, in no particular order, of ideas, practices, and services taught as trauma informed:

Positive behavioral intervention and supports
Meditation
Journal writing
Universal trauma exposure and trauma symptom screening
Universal Adverse Childhood Experiences (ACES)/adversity screening
Alternatives to seclusion and restraint
Pet therapy
Peer specialists
Sensory strategies
Cognitive behavior therapy
Trauma-focused cognitive behavior therapy
Sanctuary model
Comfort plans
Seeking Safety curriculum
Child-friendly decorations and materials
A building that is clean and sprayed for bugs
Gardens
Trauma-informed drama therapy
Young adult court
An absence of staff-only bathrooms


This list must be broad, given how pervasive and varied both traumatic events and their effects are. Still, this list is too broad. Some of these suggestions are part of culturally or developmentally competent practice or just plain common sense. Anyone is likely to agree that effective
alternatives to seclusion and restraint are welcome; that clients prefer to meet in clean, bug-free buildings; and that children (like adults) prefer furniture that fits their bodies. Likewise, there may well be value to young adult court processes that take human development into account, positive behavioral supports, cognitive behavior therapy, and many other good ideas that are not necessarily especially beneficial for trauma survivors. As Hanson and Lang (2016) have written, building too big of a tent makes it impossible to communicate about, implement, and evaluate trauma-informed practices. These authors did the world of youth-serving organizations a service just by providing a table of published definitions of trauma-informed care along with descriptions of providers’ views of what components should be and actually are included in real-world settings. Those of us with expertise in trauma and dissociation can help just by following the lead of these authors, cleaning up and making visible definitions through our own formal and informal conversations and writing.

But there are bigger problems with this list. There is an emphasis on responding more appropriately to *individual* pathology. This is in contrast to models of trauma-informed care, and a long history of clinical work and research, that emphasize connecting personal experiences to broader social systems that give rise to trauma and oppression, victim/survivor empowerment, and relationship building (Gómez, Lewis, Noll, Smidt, & Birrell, 2016; Rosenthal, Reinhardt, & Birrell, 2016). It appears that for many a key component of trauma-informed care is providing trauma-focused evidence-based mental health treatments (i.e., treatments designed specifically to address trauma symptoms, such as trauma-focused cognitive behavior therapy) or general treatments that are believed to benefit trauma survivors as well as the rest of the population (such as regular cognitive behavior therapy).

The long debate about the extent to which victims/survivors are served by treatments that pathologize trauma reactions and reduce symptoms applies equally well to other kinds of services. For example, McKenzie-Mohr, Coates, and McLeod (2012) described the failure of jobs, food, and housing programs to solve key problems for youth who are homeless. While acknowledging that trauma-informed practices such as hiring trauma-informed staff or providing trauma-focused treatment for youth who are homeless are necessary, these authors rightly argued that “trauma-informed interventions are required not only at the individual and organizational levels (which seek to reduce further traumatization and support recovery in individuals’ lives), but also through community and policy responses that redress inequalities in power and decision-making” (p. 139). Likewise, services on the trauma-informed list I generated with Google overwhelmingly fall into the category of individual treatments designed to reduce trauma symptoms and changes to
environments that reduce and contain individuals’ symptoms. Because they too site the problem within individuals, these programs often suffer from the same problems.

Do not forget: Not all attempts to contain individual symptoms are benign. The intent and context matters. Linking racism to poverty and other systems of oppression, Martin Luther King, Jr., said in a speech to the American Psychological Association, “All too many white Americans are horrified not with conditions of Negro life but with the product of these conditions—the Negro himself” (King, 1967). Because trauma is tied to oppression, it is natural that people respond similarly to trauma. All too often, society is horrified with trauma survivors; their symptoms; and the burdens it places on the health care, child welfare, criminal justice, and educational systems—and insufficiently horrified by the systems of oppression that underlie so much trauma, violence, and abuse. Just as Dr. King vowed to remain “creatively maladjusted” rather than numb as long there was discrimination, bigotry, income inequality, militarism, and violence, so might everyone reject those trauma-informed practices that leave individuals well adjusted but inactive in the face of oppression and trauma of all kinds while the individuals and systems that give rise to trauma and oppression operate as usual.

Even feminist programs that, at least rhetorically, go beyond individual responses to trauma victims/survivors have a history of morphing into programs just as damaging as or even more damaging than any other. One of the clearest examples is women-centered programming in Canadian women’s prisons (Pollack, 2005). The prison’s new program appeared ideal on paper, recognizing the high rates of child abuse, domestic violence, and sexual assault in the histories of incarcerated women. Administrators implemented reforms, such as providing dialectical behavior therapy, because it was viewed as empowering and less pathologizing. Still, in Pollack’s (2005) analysis, the efforts (like similar efforts before them) failed because dialectical behavior therapy came to be just a different way of labeling and managing problematic individual behaviors in ways that were not sufficiently linked to social conditions that gave rise to those same behaviors. Although well intentioned, the prison system was able to continue to pursue its own goals over the needs of incarcerated women in ways that, if anything, led to more institutional betrayal and harm.

What is to be done to prevent this cycle from repeating? It is clear that the expertise of Journal of Trauma & Dissociation readers is urgently needed both to explain issues that have been overly complicated and to complicate issues that have been overly simplified. Next I discuss a few possible starting points.

First, we must recognize that even the most progressive, well-considered trauma-informed models risk becoming cover for the status quo. When that
happens, there is a risk of blaming victims for not taking advantage of or appreciating the progressive services and shaming, silencing, and retraumatizing victims/survivors who are told that their needs are met when in fact they are not. Rhetoric alone will not work. Some models of trauma-informed care take on this challenge directly by concretely identifying processes to identify the inevitable situations in which practices do not live up to the ideals of trauma-informed care (e.g., Bloom, 2013; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). More work is needed to define more widely applicable practices. One model could be based on efforts to reduce implicit and explicit bias among members of hiring committees. Just as a mix of structural changes (e.g., rules about how candidates are interviewed), oversight (e.g., it is someone’s job to monitor institutional behaviors and the organizational climate), and personal reflection and education about one’s own implicit and explicit biases has transformed hiring committees, similar processes may be worth exploring to change systematic and individual biases and power differences that get in the way.

Second, we must do a better job attending to conflicts of interest, especially around the trauma-informed principle of empowering survivors to make their own choices. A common recommendation is to inform people up front about a mandate to report abuse, sexual harassment, or other kinds of events. Getting the disclaimer out early enough is hard enough and even then clearly silences victims/survivors. Even sexual assault advocates and clinicians who are not subject to mandated reporting laws on college campuses often are employed by the same institution that investigates and adjudicates student conduct cases and have a responsibility to shareholders or taxpayers to protect the university brand and avoid lawsuits. These employees may be covered by university liability insurance and represented by legal counsel only to the extent that they cooperate with the university’s requests. These conflicts of interest should be faced head on, the same way in which clinicians and researchers directly face other conflicts of interest. It is not possible to eliminate all conflicts of interest; it is just required that conflicts of interest and perceived conflicts of interest be discovered, disclosed, and managed. Some clinicians’ efforts to create more transparent informed consent for psychotherapy could serve as models (see http://kspope.com/consent/ for examples).

Another opportunity for trauma clinicians and researchers is to engage more fully in scholarship on the translation of science about trauma and practice in a wide variety of settings. Even the most experienced clinician or researcher cannot rely on intuition alone to create trauma-informed settings. Even something as seemingly benign as child-size furniture and decorations can have unintended negative effects. Years ago, I invited 4-year-olds to a lab to participate in a research study in a room outfitted with child-size furniture and decorations and a camera that allowed a parent in an adjacent room to
watch the child in the lab room. As soon as one 4-year-old entered, she had an extreme reaction, running to the corner and biting herself. The child’s guardian turned out to be an aunt who finally realized that the room resembled the child protective services office where the child had been interviewed about sexual abuse. This is why any number of generally reasonable recommendations—rocking chairs, pillows, calm music—may in fact be triggering. Indeed, a great number of trauma survivors were harmed by people they trusted in environments designed to make them feel comfortable. The solution is to more rigorously define and test trauma-informed practices in real-world settings, attending to individual differences.

Translational research takes a lot of time and resources (Bloom, 2016), and we can do better for trauma survivors now by taking more seriously the input of trauma victims and survivors. This too is a core principle of trauma-informed care, but clearly some additional work is needed to know how best to ensure that the voices of victims/survivors are truly included. Often it seems we inadvertently include some voices but do not do enough to include a representative sample, as in the case of advisory boards of former clients, students, or advocates that almost by definition include only satisfied clients and those who share similar goals as the organization. When I teach Psychology of Trauma, I routinely hear from students who have experienced trauma and visit a mental health professional who has advised them to do mindfulness activities to help with anxiety. These students tell me, compellingly, about their difficulties with relationships, trust, anger, and dissociation, making it clear that they can articulate their needs coherently. And they tell me that the mindfulness techniques they learned did not work or exacerbated their symptoms. When I ask why they are telling me and not their counselor, they say things like they do not feel comfortable telling the therapist, the counselor will never understand, and they are not going back—in other words, just the kinds of things that are consistent with a trauma-informed model that takes into account clients’ sensitivity to issues of trust, power, and stigma. Therefore, those interested in trauma-informed care could commence work on novel ways to surface and respond even to concerns of disgruntled clients, nonadherent clients/patients, and those who do not respond to client/patient surveys.

Today, in at least in some parts of the world, there are allies in every sector from kindergarten to Grade 12 education, higher education, criminal justice, mental health, and medical systems who want to make their practices more trauma informed. The list of trauma-informed practices is creative, and the scope is inspiring. For trauma researchers, clinicians, advocates, and victims/survivors everywhere, it is an incredible opportunity. We can draw on scholarship on trauma and dissociation to engage intelligently in the hard and complicated questions about what trauma is, how it affects people, and
what it means to be trauma informed so that trauma-informed practices continue to be healing and liberating.

References


