

Safety, Strength, Resilience and Recovery

Trauma-informed Systems and Communities

Of all the public health crises our nation faces, perhaps the most central is the role of toxic stress and trauma in the basic vulnerability of individuals, families and communities. These conditions can contribute to a host of acute and chronic—and often interwoven—physical, psychological, developmental, educational, occupational, economic, medical, behavioral, social, spiritual, cultural and legal challenges.¹

The numbers vary from population to population and study to study, but they are often grim. For example, in 2008 an estimated 772,000 U.S. children were abused² and six out of ten youth reported that they had been exposed to violence in the past year.³ Between 15% and 25% of women and girls have been sexually abused, and 9% to 44% of women have been victims of domestic violence.⁴ Estimates of trauma-related challenges among veterans vary widely, with one large 2008 study reporting that 18.5% of recent veterans suffered from posttraumatic stress disorder or depression.⁵ Among youth and adults with behavioral health challenges or child welfare or criminal justice involvement, estimates of trauma—particularly childhood trauma—run much higher.⁶

Unaddressed trauma often leads to more stress and trauma—within an individual life, within a community, within a generation and between one generation and the next. However, just as the sources and consequences of trauma are often interconnected, so are the solutions. From the teachers and first responders who may be the first to spot signs of trauma to the service systems that address the challenges that follow, each individual, family, organization and system plays its own essential role. This paper explores the nature and consequences of trauma and the concept of trauma-informed systems and communities as a springboard for hope and action.

Resilient Systems and Communities

For individuals, families, communities, cultures, organizations and service systems, resilience—the ability to “bounce back” from stress and overcome adversity⁷—is a product of many elements. Two of the most important of these are human connection and access to resources.

Human Connection: Beginning with the critical importance of safe, loving connection with caregivers in the development of basic attachment and coping skills—key components of resilience—human connection remains our strongest asset in preventing and healing the effects of extreme stress and threat.⁸ Connection (e.g., communication, collaboration, support) is equally important in fostering resilient families, communities, cultures and service systems.

Access to Resources: The human being is born with genetic strengths and vulnerabilities and the need for a number of basic social and economic resources. The absence or presence of key resources can have powerful effects on an individual’s ability to cope with stress, respond to threat, resist illness and injury, overcome adversity and maintain psychological balance.⁹ A few examples of these “social determinants of health”:

- The concept of “weathering” provides a useful metaphor for the ways in which chronic poverty and discrimination can contribute to ill health across the life span, from low birthweight¹⁰ to premature aging.¹¹
- In individuals, families, communities and cultures, levels of social, material, emotional, spiritual and economic resources are important predictors of health, resilience and recovery from adversity.¹²



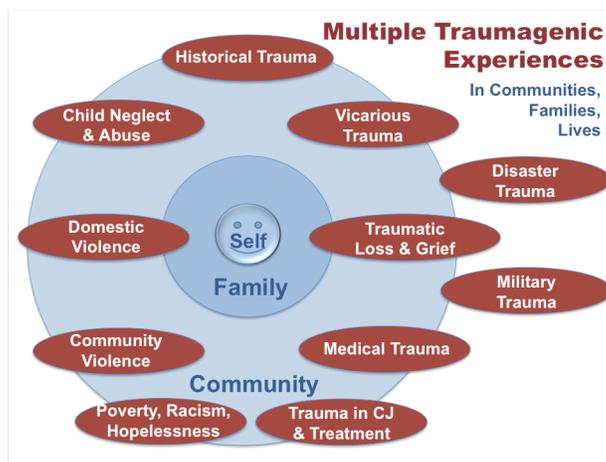
- In organizations and service systems, access to human and financial resources can make the difference between effective and ineffective practices, between merely “scratching the surface” and truly fulfilling community needs and between an openness to collaboration and a fear of losing “turf.”

The Experience and Effects of Trauma

From the smallest neighborhood to the largest city, the strength of each community is challenged by the effects of toxic stress and trauma, even—perhaps especially—among its youngest and least powerful members.

Trauma is a set of human responses to experiences that overwhelm our ability to cope. The world holds many such experiences, including:

- The neglect, abuse and bullying that are integral parts of too many children’s lives
- The sexual and domestic violence that many girls and women, and some boys and men, endure on a regular basis
- The shock and pain following car crashes
- The devastation left behind by mass casualty events
- The violence that rips through many communities night and day
- The fear, pain and uncertainty of chronic or life-threatening illnesses and invasive medical procedures
- Frustration and hopelessness carved out by poverty and racism, often intensified in difficult economic times
- The extreme and chronic stress, threat and loss that many service members and their families experience
- The pain of losing a loved one, particularly in violent circumstances or if the loss comes early in life
- The vicarious trauma that can affect human service providers, first responders and (particularly in violent urban areas) family and community members exposed to others’ traumatic experiences



Trauma is often called “a normal reaction to an abnormal situation,”¹³ because it begins with the mobilization of powerful natural processes designed to keep us alive and functioning. Under heavy stress and threat, these processes are thrown off balance, pushed to extreme levels that can exact a high price long after the threat has passed.¹⁴ Mild and temporary stress can build resilience, just as a vaccination builds resistance to an illness, but extreme, repetitive or chronic stress or threat often has the opposite effect, more like that of an autoimmune disorder. It wears down our resilience, so that each experience leaves us more vulnerable to the next.¹⁵

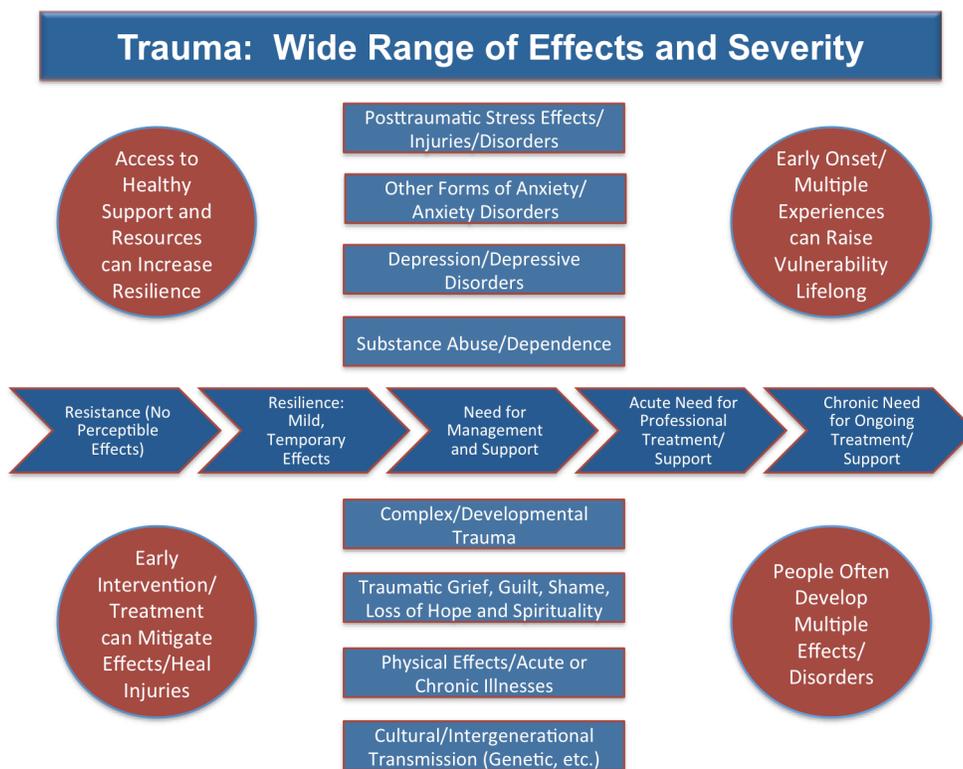
It would be much simpler if most trauma survivors had to live through only one or two isolated incidents, but the reality is that many individuals, families, communities and cultures have been subjected to multiple, often chronic traumagenic circumstances.¹⁶ These circumstances can injure the body, the mind and the spirit; set up complex reactions and consequences; damage relationships; interfere with physical, psychological and spiritual balance; and threaten or destroy the resources most necessary for healing.

People’s reactions to potentially traumatic experiences run on a long continuum, from an apparent lack of effects (resistance) to serious and chronic effects. People often associate trauma with posttraumatic stress disorder (PTSD), an anxiety disorder that can include intrusive recall of the trauma (intense, intrusive memories, emotions, sensations, images, sounds, tastes, odors), re-experiencing (which might include repetition of traumatic circumstances in the present), hyperarousal (including increased anger and startle response, hypervigilance and/or difficulty concentrating or sleeping), numbing and avoidance of reminders of traumatic events.¹⁷ However, PTSD is only one of many conditions that might follow the experience of trauma.

A few examples begin to show the variety of additional post-trauma challenges:

- Trauma also raises vulnerability to other anxiety disorders and to depressive disorders, including bipolar disorder.¹⁸ Serotonin and other chemicals that regulate mood are among those that trauma tends to affect.
- The use of alcohol or drugs to “medicate” the pain of post-trauma effects can raise the risk of substance use disorders, affect many other areas of life functioning and place people in potentially traumatic situations.¹⁹

- People who experienced severe or chronic neglect and/or abuse in childhood are particularly vulnerable to symptoms of complex or developmental trauma, including troubled relationships, distorted self-image, unstable levels of trust and difficulty tolerating and managing emotions and responses to stress.²⁰
- Painful feelings that may be associated with traumagenic experiences—fear, grief, guilt, shame, loss of hope, sense of spiritual disconnection—can gain power from the body’s intense reactions to trauma.²¹
- When trauma has lasting physical effects on natural brain chemicals, hormones, muscle tension, heart rate, inflammation and immune functioning, these effects can raise the risk of many acute and chronic illnesses.²²
- Trauma in one generation can affect future generations, often through its effects on relationships and the resources available to the family, the community and/or the culture. The experience of trauma can also set in motion “epigenetic” changes in the way our DNA expresses itself, changes that can be passed from generation to generation.²³ Widespread trauma within a culture can affect the physical, emotional, behavioral, social and spiritual well being of the culture for generations to come, as witnessed by the experience of far too many cultures, including Jews following the Holocaust, African Americans in the wake of slavery and the many Indigenous Peoples who have been displaced and subjected to horrific treatment.²⁴



Post-trauma conditions can have many effects on health, development, education, employment, finances, faith, relationships, parenting and adherence to the law, and many people develop multiple conditions. These effects may bring people into contact with multiple civic, human service and justice systems, where they might present with deeply entrenched challenges that resist traditional efforts to help.

- If the many systems that address these challenges do so in isolation, they might miss important information and resources that only integrated, coordinated, collaborative efforts can provide.
- If approaches or practices within these systems (e.g., harsh confrontation, invasive procedures) create conditions similar to those that instilled trauma in people’s lives, they can re-open traumatic wounds.
- If people are forced to re-live traumatic memories, or persuaded to remember without skilled guidance and a solid grounding in stress and emotion management skills, their progress and well being may be jeopardized.
- If service providers are trained to focus first on problems, symptoms or “bad behavior,” they might miss the individual, family, community and cultural strengths that often provide their best opportunities to intervene.

Trauma-informed Systems and Communities

As overwhelmed as many systems and communities are by the economic and social challenges they need to address, it may be difficult to imagine how they might rally around the idea of a trauma-informed approach, something that at first sounds like a luxury. However, the realization that toxic stress and trauma are both causes and consequences of many of the challenges they face has inspired some systems and communities to explore how an inclusive trauma-informed approach might make a number of other solutions fall into place.

Andrea Blanch, PhD describes one community-wide effort in Tarpon Springs, FL. “Peace4Tarpon includes virtually every group and civic organization in the city—the mayor’s office and city council, the city manager’s office, the police and fire departments, the housing authority, the school system, health and human services, the business community, the faith-based community, and the local college, art museum, and library. These disparate groups work together with a common mission—to make Tarpon Springs a safe, healthy, healing, and productive community.”²⁵ This new movement is gaining strength, energy and national attention.

A longer-standing example with dramatic results is the story of Alkali Lake, the home of a Shuswap band of Original People near Vancouver, Canada. In the 1960s, ravaged by a century’s worth of land seizure, spiritual loss and the forcible removal of their children to highly abusive “boarding schools” where they would be stripped of all vestiges of their culture, the Alkali Lake community suffered epidemic levels of unemployment, child abuse and neglect, domestic violence, hunger and alcohol abuse and addiction. A community-wide sobriety movement started slowly in the early 1970s, including professionally led “alcohol awareness” sessions (later evolving into recovery meetings), tougher alcohol sales and enforcement policies, classes on Shuswap language and arts, reinstatement of healing cultural traditions and practices and contemporary human potential seminars. “Growing numbers of sober adults began to establish a new set of social norms,” wrote Craig Lambert, PhD. “By the mid-1980s, sobriety had become the rule, as it remains today.”²⁶

Many such successful movements begin with and continue to emphasize positive central themes, focusing on resilience and strength rather than on problems and trauma. A movement organized around building community strength will attract, energize and hold people who might be frightened off by a meeting on “trauma-informed communities” or might soon be discouraged by a process that emphasizes problems. If the topic is resilience, people will still bring up the subject of trauma, but they will address it within an overall framework of hope.

One large strength-based movement is Philadelphia’s Resilience-oriented Systems Transformation, begun in 2005. With recovery/resilience as its central focus, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services has used the input of diverse stakeholders within the community, the recovery community and the behavioral health field in a fundamental realignment of policies, practices and resources. The result is an integrated system of care organized around resilience, recovery and self-determination.²⁷



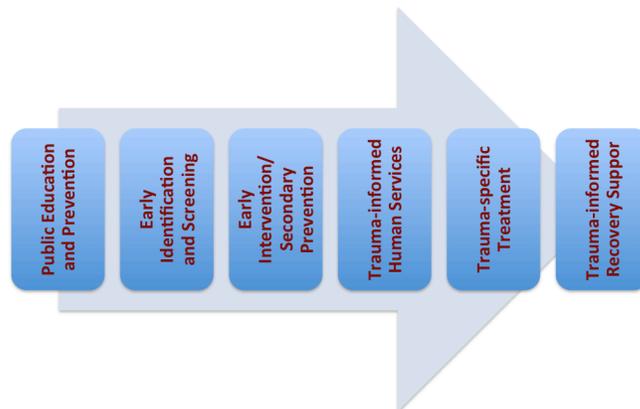
For the community interested in exploring its own possibilities, one first step might be a simple process of inclusion, envisioning and inviting the full range of potential partners, with the understanding that all have a stake and each one has something to contribute. A series of informal, collaborative “brainstorming” sessions might introduce the conversation and begin to frame it in the language, values and needs of local systems, cultures and communities.

The inclusive nature of this process affirms the fact that everyone is needed. Even the best service system cannot reverse the flow of trauma without the whole community at its side. By the time people’s troubles reach the point where they are ready to seek behavioral healthcare, their problems are often deeply entrenched, many aspects of their health have suffered and the lives of many more people have been affected.

What is needed is a community-wide safety net, with many points at which people's growing challenges can be noticed and addressed:

- Prevention and public education will raise community awareness and resilience.
- Respectful, non-stigmatizing screening will identify challenges in community settings.
- Early intervention services will help individuals and families cope and seek help.
- Trauma-informed systems and services will create safety and avoid re-traumatization.
- Trauma-specific treatment will help people heal and begin the process of recovery.
- Trauma-informed recovery support will provide ongoing safety and strength.

Multiple Points of Intervention



The collaborative process of creating and using this safety net is a job for the whole community. For example:

- **Community, civic and cultural leaders** can provide their time, attention, openness and networking skills, and can gain valuable experience and improve the health of their communities.
- **Business leaders** can provide information on the impact of these challenges on the workforce, help raise resources, prepare systems to adopt smart business models and provide information to the workforce.
- **The philanthropic community** can help the growing movement raise resources and develop a plan for sustainability, and can help forge links between stakeholders in the for-profit and not-for-profit worlds.
- **Faith leaders and cultural spiritual leaders** can provide their knowledge, wisdom and compassion, and participation in community-wide networks can bring new skills and strengths to their communities.
- **The natural listeners and supporters** in the community can paint a deeper picture of the community and learn respectful responses to trauma and skills for helping people build safety and cope with stress.
- **Children, youth and families** can provide information about their strengths and challenges, learn about options for seeking help and learn skills that will help them manage stress and strong emotions.
- **Teachers and other school staff** can educate the community on trauma's effects on educational success, teach skills in stress and emotion management and perform evidence-based screening and identification.
- **Clinical staff in schools and other community settings** can provide expertise and perform evidence-based assessment and referral, family education/skills training and other early intervention services.
- **Primary medical care teams** can ask brief screening questions, continue to anticipate and address the physical effects of trauma and collaborate with behavioral health in an integrated healthcare response
- **Military and veterans' services** can collaborate with civilian communities and systems to close the gaps between services and create a "no wrong door" approach to the needs of military and veteran families.
- **First responders** can receive and provide training in identifying and responding to signs of trauma, build stronger referral networks and respond to individuals and families in compassionate, trauma-informed ways.
- **Child welfare staff** can contribute their wisdom to the community-wide understanding of the effects of stress and trauma and can create and embrace a comprehensive program of trauma-informed care.
- **Criminal and juvenile justice staff** can contribute their knowledge of the full consequences of untreated trauma and learn skills for identification and referral, stress management and trauma-informed services.
- **Behavioral health and social services** staff can provide consistently safe, respectful, trauma-informed services, including referral to and provision of evidence-based trauma-specific care by well prepared staff.
- **Peer-based communities of recovery** can contribute to the community's story of trauma and resilience, and recovery sponsors, mentors and coaches can provide strength-based, trauma-informed support.

Financial resources might be scarce, but within most communities, the collective knowledge, skill, wisdom and commitment of all stakeholders is an extraordinary source of strength. If they join forces in an inclusive, respectful, collaborative effort, they can and will create safety, strength, resilience and recovery. When the community moves to act as one, there is no child, no family, no neighborhood that cannot be healed.

References

- ¹ Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245-258. Marans, S., Berkowitz, S.J. and Cohen, D.J. (1998). Police and mental health professionals. Collaborative responses to the impact of violence on children and families. *Child and Adolescent Psychiatric Clinics of North America*, 7(3), 635-651. Ko, S.J., Ford, J.D., Kassam-Adams, N., Berkowitz, S.J., Wilson, C., Wong, M., Brymer, M.J. and Layne, C.M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, 39(4), 396-404.
- ² U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2010). *Child maltreatment 2008*.
- ³ Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Results from the 2008 National Survey on Drug Use and Health: National findings*. Rockville, MD: SAMHSA.
- ⁴ Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Substance abuse treatment: Addressing the specific needs of women*. Rockville, MD: SAMHSA.
- ⁵ Tanielian, T. and Jaycox, L.H., Eds. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: The Rand Corporation.
- ⁶ Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Substance abuse treatment for persons with co-occurring disorders*. Rockville, MD: SAMHSA. Najavits, L.M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York: The Guilford Press. Ko, et al. (2008). Loc cit.. Carlson, B.E. and Shafer, M.S. (2010). Traumatic histories and stressful life events of incarcerated parents: Childhood and adult trauma histories.
- ⁷ Bonanno, G.A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 59(1), 20-28.
- ⁸ van der Kolk, B.A., McFarlane, A.C., and Weisaeth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: The Guilford Press. Siegel, D.J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York: The Guilford Press. Perry, B.D. (2001). Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood. Houston, TX: The ChildTrauma Academy. Scaer, R. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York: W.W. Norton & Company. Siegel, D.L. (2007). *The mindful brain: Reflection and attunement in the cultivation of well being*. New York: W.W. Norton & Company.
- ⁹ Dixon, J. (2000). Social determinants of health. *Health Promotion International*, 15(1), 87-89. Kilpatrick, D.G., Koenen, K.C., Ruggiero, K.J., Acierno, R., Galea, S., Resnick, H.S., Roitzsch, J., Boyle, J. and Gelernter, J. (2007). The serotonin transporter genotype and social support and moderation of posttraumatic stress disorder and depression in hurricane-exposed adults. *The American Journal of Psychiatry*, 164(11), 1693-1699. Marmot, M. and Wilkinson, R. (2009). *Social determinants of health*. New York: Oxford University Press. Koenen, K.C., Aiello, A.E., Bakshis, E., Amstadter, A.B., Ruggiero, K.J., Acierno, R., Kilpatrick, D.G., Gelernter, J. and Galea, S. (2009).
- ¹⁰ Patrick, T.E. and Bryan, Y. (2005). Research strategies for optimizing pregnancy outcomes in minority populations. *American Journal of Obstetrics and Gynecology*, 192(5), S64-S70. Collins, J.W. Jr., Wambach, J., David, R.K. and Rankin, K.M. (2009). Women's lifelong exposure to neighborhood poverty and low birth weight: A population-based study. *Maternal and Child Health Journal*, 13(3), 326-333.
- ¹¹ Geronimus, A.T., Hicken, M., Keene, D. and Bound, J. (2006). *American Journal of Public Health*, 96(5), 826-833.
- ¹² Paton, D. and Johnston, D. (2001). Disasters and communities: Vulnerability, resilience and preparedness. *Disaster Prevention and Management*, 10(4), 270-277. Norris, F.H., Stevens, S.P., Pfefferbaum, B. and Wyche, K.F. (2008). Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American Journal of Community Psychology*, 41(1-2), 127-150.
- ¹³ National Center for PTSD (2007). Effects of traumatic stress after mass violence, terror, or disaster: Normal reactions to an abnormal situation. (Retrieved April 25, 2013 from <http://www.ptsd.va.gov/professional/pages/stress-mv-t-dhtml.asp>)
- ¹⁴ van der Kolk, B.A. (1994). The body keeps the score: Memory and the evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry*, 1(5), 253-265. Ledoux, J. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Simon and Schuster. McEwen, B.S. and Wingfield, J.C. (2003).
- ¹⁵ van der Kolk, 1994, loc cit. Scaer, 2005, loc cit.
- ¹⁶ Yehuda, R., Ed. (2002). *Treating trauma survivors with PTSD*. Washington, DC: American Psychiatric Publishing, Inc.
- ¹⁷ American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Arlington, VA: American Psychiatric Association.
- ¹⁸ Heim, C. and Nemeroff, C.B. (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: preclinical and clinical studies. *Biological Psychiatry*, 49(12), 1023-1039.
- ¹⁹ Najavits, L.M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York: The Guilford Press.
- ²⁰ Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. and Vigilante, D. (1996). Childhood trauma, the neurobiology of adaptation, and use-dependent development of the brain: How states become traits. *Infant Mental Health Journal*, 16(4), 271-291.
- ²¹ Woll, P. (2009). *The power and price of survival: Understanding resilience, stress, and trauma*. Chicago, IL: Human Priorities.
- ²² Scaer, R. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York: W.W. Norton & Company.
- ²³ Yehuda, R. and Bierer, L.M. (2007). Transgenerational transmission of cortisol and PTSD risk. *Progress in Brain Research*, 167, 121-135.
- ²⁴ Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35, 7-13. Danielli, Y., Ed. (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press.
- ²⁵ Blanch, A. (2011). Peace4Tarpon knows it takes a village. *National Council Magazine*, 2011, Issue 2.
- ²⁶ Lambert, C. (2008). Trails of tears, and hope. *Harvard Magazine*, March-April, 2008.
- ²⁷ Philadelphia DBHIDS (2011). Philadelphia Behavioral Health Services Transformation Practice Guidelines for recovery and resilience oriented treatment. Philadelphia, PA: Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

About this Paper

This is the first in a series of three papers published by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, Arthur C. Evans, Jr., PhD, Commissioner. The Project Director was Deputy Commissioner (Retired) Sade Ali, MA, CADC, CCS, and the paper was written by Pamela Woll, MA, CADP. Special thanks to reviewers Steven Berkowitz, MD, Kamillah Jackson, MD, MPH and Ijeoma Achara-Abrahams, PhD.