

A Call for the Integration of Trauma-Informed Care Among Intellectual and Developmental Disability Organizations

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Abstract Research exploring the occurrence of trauma among adults with intellectual and developmental disabilities (I/DD) has grown over the past decade. Yet there is a dearth of literature investigating the impact of organizational factors on the trauma experience despite this population's need for organizational supports. Trauma-informed care (TIC), a systems-focused model for service delivery, is a fast-developing interest among the broader field of trauma in the general population. It recognizes the prevalence and impact of trauma, and creates a culture of safety, trustworthiness, choice, collaboration, and empowerment. The author synthesized relevant literature from both the intellectual and developmental disabilities areas and integrated this with TIC and trauma literature drawn from the general population. Explored are the implications of organizations for service delivery and the potential assimilation of TIC within I/DD organizations. The effectiveness of TIC applications and their potential barriers are discussed and related to the philosophy of quality of life and organizational culture. The author notes that some individuals with I/DD comprise a vulnerable subgroup of the population that in large part relies upon the support of organizational services to foster quality of life. Given the implications of the focus on quality of life, he posits that TIC presents as a viable response for organizations, complimenting and augmenting current efforts.

Keywords: abuse, health services, intellectual disability, trauma, trauma-informed care

INTRODUCTION

There is a growing body of literature exploring the experience and impact of trauma in the lives of individuals with various intellectual and developmental disabilities (I/DD). Interestingly, despite the role of service organizations designed to help this population, there has been a lack of inquiry into how organizations address trauma and also any recommendations for an appropriate response at the organizational level. Although there is an advancing trend toward service provision in the community, organizations continue to be charged with the responsibility of developing and providing supports across varied environments, from group homes to individual and family homes. As such, because of the occurrence of trauma, there is a need for organizations and their respective practices to reflect and respond to the growing knowledge around trauma.

This article highlights the trauma literature in the I/DD field as well as relevant implications of organizations. Trauma-informed care (TIC), developed within the general population as a response for organizations serving those with trauma histories and trauma-related needs, is defined and presented with consideration for I/DD service organizations. Evidence supporting the

effectiveness of TIC is offered, and plausible obstacles to its integration are identified. The importance of quality of life and organizational culture is also discussed. It is suggested that although TIC focuses on a cultural shift within organizations, the current philosophy guiding I/DD services—quality of life—presents a viable foundation for the integration of TIC.

In light of the relatively new focus on trauma care within the I/DD population, there are gaps in the respective literature. In conjunction, given that much of what is known about trauma has been acquired through studies within the general population, the present article draws from this body of literature where relevant and necessary. However, given the vulnerability and cognitive limitations associated with I/DD, it is acknowledged that differences may exist between the general population and individuals with I/DD in their experiences of adverse events and trauma, especially when trauma is of an interpersonal nature (Hulbert-Williams & Hastings, 2008). Therefore, when information was drawn from the literature on the respective populations, it was noted, as appropriate.

Background

During the past decade we have witnessed the emergence of inquiry into the various facets of trauma among individuals with I/DD. Areas of research have included adverse life events (e.g., Wigham, Hatton, & Taylor, 2011a), complicated grief (e.g.,

Received September 19, 2012; accepted August 4, 2013
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Guerin et al., 2009), the relationship between abuse/trauma and psychological symptoms (e.g., Wigham, Hatton, & Taylor, 2011b), the application of current diagnostic criteria for post-traumatic stress disorder (e.g., Shabalala & Jasson, 2011), and trauma treatment (e.g., Lund, 2011). Although the advancement of this body of literature has been fairly recent (Wigham et al., 2011a), there has already been considerable growth in what is known about the interface between adversity, trauma, and having an I/DD.

Despite this growth, there remains a substantial gap in the literature exploring the implications and interactions of organizational factors with respect to individuals' trauma experiences, as well as any plausible organizational interventions or responses to address such concerns. This is worthy of consideration given the number of individuals with I/DD who, across the lifespan, seek necessary supports through organizations.

Trauma-informed care has been gaining momentum within the general population as an organizational response to the impact and prevalence of trauma in the lives of both service recipients and service providers (Harris & Fallot, 2001). Although this gain in momentum has not been the case in the I/DD field, there is opportunity for it to do so.

TRAUMA AND ADVERSE LIFE EVENTS

Trauma is generally defined as an individual's experience of an event or enduring condition that is an actual threat or perceived as a threat to his or her life and personal integrity, or that of a carer or family member. The nature of the experience is so overwhelming for the individual that he or she is unable to successfully integrate his or her emotional response to the event or condition with previous experiences and cognitions (Saakvitne, Gamble, Pearlman, & Tabor Lev, 2000). Furthermore, the impact of trauma is often enduring, manifesting in biological, psychological, and social sequelae, and becoming a persistent influencing factor in a person's current presentation and perspective (Brown, Baker, & Wilcox, 2011; Harris & Fallot, 2001).

Adverse life events are often associated with trauma responses and have been described in the literature for both the general population (Edwards, Holden, Felitti, & Anda, 2003) and individuals with I/DD (Wigham et al., 2011a). While experiencing physical, sexual, and emotional abuse, as well as witnessing abuse within the family environment are most commonly identified as adverse life events, other experiences such as illness, injury, accidents, hospitalizations, loss of employment, and bereavement may also be included (Hastings, Hatton, Taylor, & Maddison, 2004; Hulbert-Williams et al. 2014, as cited in Wigham, Hatton, & Taylor, 2011a). Although exposure to adverse life events is relatively common in the general population (Felitti et al., 1998), it is believed to be more so among individuals with I/DD given their increased vulnerability—reasons for which are discussed later in this article (Hastings et al., 2004; Wigham et al., 2011a). However, because there has been a lack of standardized instruments for inquiry into adverse life events, there is an absence of reliable prevalence rates within the I/DD population (Wigham et al., 2011a).

In the general population it has been found that many people exhibit resilience to adverse life events and never develop trauma

responses; however, numerous others experience a wide range of psychiatric symptoms—from mild depression and anxiety to the debilitating effects of posttraumatic stress disorder—in response to adverse life events (Bensimon, 2012). As there are no definitive boundaries between the stress associated with adverse events and trauma, it remains important to emphasize that the experience of trauma is subjective based upon the person's perception (Weathers & Keane, 2007). What may be perceived as traumatic to one person may not be traumatic to another; this, thus, presents the challenge to defining the full spectrum of potentially traumatic events (Black, Woodworth, Tremblay, & Carpenter, 2012). Yet, regardless of response, the impact of adverse events especially those in childhood, can be far-reaching; they have been associated with compromised health in later life, as well as premature mortality in the general population (Brown et al., 2009; Edwards et al., 2003; Felitti et al., 1998). However, when considering factors such as resilience, perception, and the association between adverse life events and compromised health, it is important to note that they have not yet been fully explored in the I/DD population.

PAVING THE WAY FOR TIC WITHIN I/DD SERVICES

Prevalence

Although there is a dearth of research investigating actual prevalence rates of adverse life events across the lifespan for individuals with I/DD, there is some literature that has evaluated prevalence of abuse among children with I/DD. Spencer et al. (2005) found that children with moderate to severe intellectual disabilities were 2.9 times as likely to have been emotionally abused, 3.4 times as likely to have been physically abused, 5.3 times as likely to have been neglected, and 6.4 times as likely to have been sexually abused than children without disabilities. In addition, Sullivan and Knutson (2000) found that 31% of children with disabilities experienced maltreatment, 25% of whom were diagnosed with intellectual disability, compared with 9% of nondisabled children. Children with disabilities were significantly more likely to experience multiple forms and multiple episodes of maltreatment than nondisabled peers. Furthermore, those with intellectual disabilities had four times the risk for enduring physical, emotional, and sexual abuse, as well as neglect, than those without disabilities. While many individuals with I/DD have known histories of abuse (with some researchers suggesting nearly 30%), the rate may be attenuated by underreporting or lack of recognition (Sullivan & Knutson, 2000).

Influencing Factors

The likelihood and impact of life adverse events among individuals with I/DD can be influenced by vulnerability in light of population-specific characteristics such as a tendency toward being manipulated (Ryan, Salbenblatt, Schiappacasse, & Maly, 2001); the relative exposure to perpetrators, desirability of acceptance, fear of rejection, dependence on others (Petersilia,

2000); difficulty processing information and other cognitive limitations (Mitchell & Clegg, 2005); and previous trauma exposures or victimization (Nettelbeck & Wilson, 2002). In addition, their experiences may be further complicated by the impact of deprivation due to poverty and lack of resources, lack of social relationships and supports, insufficient coping skills, as well as any other comorbid conditions related to their medical, physical, or psychiatric status.

Comorbidity and Diagnostic Overshadowing

The identification and treatment of trauma for individuals with I/DD may be compounded by high rates of psychiatric comorbidity and other factors. Mental health professionals may fail to consider the possibility of trauma as the root cause of an individual's distress, especially when presenting symptoms have endured for a prolonged period of time (Mitchell & Clegg, 2005). Additionally, although direct care staff often raise concerns regarding individuals' behavior and mental health, they may be inaccurate in their appraisal of individuals' mental health needs despite their ongoing contact with them. Individuals' behavioral manifestations may be solely attributed to their having an I/DD—a concern referred to as “diagnostic overshadowing” (Mevisen & de Jongh, 2010). In addition, common treatment modalities such as behavior management and psychiatric medications are often minimally effective in treating the complexity of trauma (Barol & Seubert, 2010).

Direct Care Staff, Organizations, and Quality of Service Delivery

Direct care staff are the foundation of service provision and are often the most prominent people in the lives of individuals with I/DD (Hall & Hall, 2002; Skirrow & Hatton, 2007). As such, they have the ability to significantly impact individuals' behavior and well-being (Disley, Hatton, & Dagnan, 2009). In fact, the emotional well-being and security of individuals are likely dependent upon their relationships with direct care staff (Schuengel, Kef, Damen, & Worm, 2010). Therefore, the quality of relationships with the staff is salient for individuals' quality of life (Schuengel et al., 2010).

Over time, however, with the shift from institutional to community-based care, the responsibilities of direct care staff have grown exponentially. In addition to meeting individuals' basic health, safety, and care needs, they are required to support the development and achievement of individuals' goals, balance risk with choices, promote relationships, and to support active participation in the community (Larson, Hewitt, & Anderson, 1999; Skirrow & Hatton, 2007). Yet, despite expanding responsibilities, the minimum educational and experiential requirements for direct care staff have largely remained unchanged (Hewitt & Larson, 2007).

The stability and competence of direct care staff are integral to the quality of care individuals receive; however, this dyadic relationship is influenced by a dynamic interplay with the environment. Factors such as low pay, inadequate training, and minimal requirements have been associated with increased staff stress and burnout, both of which are implicated with staff atti-

tudes, behaviors, and practices (Chung & Harding, 2009; Kormann & Petronko, 2004; Rose & Rose, 2005; Skirrow & Hatton, 2007). As organizations and direct care staff are challenged to do more with declining resources (Braddock et al. 2011), the interactions between staff and individuals can become increasingly strained. Amid such an environment, stress (Devereux, Hastings, & Noone, 2009), emotional exhaustion (Willems, Embregts, Stams, & Moonen, 2010), burnout (Chung & Harding, 2009), sense of low personal accomplishment (Disley et al., 2009), and perceived lack of reciprocity in working with the individuals (Buunk & Schaufeli, 1993, as cited in Rose & Rose, 2005) can be exacerbated. With increased staff dissatisfaction and turnover, individuals may experience discontinuity in care, receive poorer quality of care, and experience increased vulnerability (Hamilton, Sutherland, & Iacono, 2005; Larson, Hewitt, & Lakin, 2004; Murphy, O'Callaghan, & Clare, 2007).

Although the role of direct care staff is significant, other organizational factors also impact individuals' quality of life. For example, individuals may be exposed to victimization by other individuals receiving services (Hamilton et al., 2005). Additionally, organizational practices may result in repeated changes in placement for individuals which can result in the loss of relationships with peers and staff (Igelman, Conradi, & Ryan, 2007; Murphy et al., 2007). Furthermore, individuals may be encouraged to remain compliant with authority, lack opportunities for skills and/or sexuality trainings, and may be perceived as lacking credibility especially with regard to allegations of abuse (Charlton, Kliethermes, Tallant, Taverne, & Tishelman, 2004).

Although organizations are critical in advancing the quality of life for many individuals with I/DD, this is juxtaposed by the previous considerations that are recognized as a potential causeway for organizations to also be associated with harm (Charlton et al., 2004; Mevisen & de Jongh, 2010). It had been suggested that individuals living with paid carer support were likely to be exposed to significantly more adverse events than those living with families (Hamilton et al., 2005). For example, Strand, Benzein, and Saveman (2004) noted that, over the course of a year, 14% of direct care staff admitted to acts of violence against individuals while 35% said they had witnessed violence against individuals.

UNDERSTANDING THE IMPLICATIONS OF TRAUMA HISTORIES

Regardless of the population served, many organizations unknowingly serve persons with trauma histories, in part due to insufficient screening or assessment processes. As such, individuals may not receive appropriate referrals for trauma treatment and may be inadvertently re-traumatized by “treatment as usual” and day-to-day practices (Butler, Critelli, & Rinfrette, 2011; Jennings, 2008). This has been complicated in the I/DD field given that, until relatively recently, the awareness of trauma was limited by a lack of research, the absence of validated trauma measures (Wigham et al., 2011b), as well as the historic lag between research and practice (Morris, Wooding, & Grant, 2011).

Nevertheless, trauma has considerable implications for trust and safety, especially when it is of an interpersonal nature. In the

general population, interpersonal trauma has been found to affect the way individuals approach potentially helpful relationships as they become a source of distrust and threat rather than comfort (Brown et al., 2011; Cook et al., 2005). Among adults with I/DD, Mitchell, Clegg, and Furniss (2006) found that those individuals who had been abused by carers had more difficulty knowing who to trust. As such, they often did not talk about their experience because they were concerned about not being believed, being afraid to tell, or wondering what others might think. They subsequently continued to experience the world as unsafe. However, those who spoke about their experiences often realized relief.

It has been found in the general trauma literature that through the validation and recognition of trauma experiences, individuals are afforded the opportunity to develop a sense of safety and hope, to reduce shame and guilt, and to be empowered and engaged (Elliott, Bjelajac, FalLOT, Markoff, & Reed, 2005). As such, relationships become the primary agent of growth and renewal (Brown et al., 2011) especially through their predictability and continuity (Brown et al., 2011; Focht-New, Clements, Barol, Faulkner, & Service, 2008). Past trauma cannot be undone, yet its impact can be modified through self-regulation skills and a sense of security (Bath, 2008; Elliott et al., 2005; Streeck-Fischer & van der Kolk, 2000). While trauma histories can yield complex needs, they are often undergirded by more basic components, such as sense of safety and coping skills, that can be addressed by carers without requiring extensive training (Bath, 2008; Elliott et al., 2005). While there is need for further research, given what is currently known about trauma in the I/DD field, there is reason to believe that the same considerations can be extended to individuals with I/DD.

TRAUMA-INFORMED CARE

Trauma-informed care is a systems-focused framework for service delivery that emerged in the general population and acknowledges the pervasiveness of trauma in the lives of all persons—service recipients and providers alike. Recognizing the enduring impact of trauma as an influencing factor in a person's current presentation and perspective, TIC identifies traumatic experiences not as past events but as defining and organizing experiences that form the core of one's identity (Brown et al., 2011; Harris & FalLOT, 2001). As such, TIC is sensitive to the potential for trauma-related issues to manifest, whether or not historic experiences are directly linked to the person's present needs (Bloom, 2006; Butler et al., 2011). Although it is not specifically designed to treat trauma sequelae, TIC fosters a common language within an organization and supports an environment that minimizes the likelihood of re-traumatization (Bath, 2008; Brown et al., 2011; Butler et al., 2011; Jennings, 2008).

PRINCIPLES OF TRAUMA-INFORMED CARE

According to FalLOT and Harris (2009), TIC involves the establishment of a culture that emphasizes safety, trustworthiness, choice, collaboration, and empowerment among service providers

and service recipients. In some aspects, how these values are integrated into an organization is influenced by the needs and characteristics of the population; this is particularly true with respect to individuals with I/DD. As such, descriptions of the five tenets of TIC follow with specific considerations extended for I/DD services (e.g., day programs, residential alternatives).

Safety

Safety is fundamental to human existence, promoting emotional and physical well-being. As such, it is an integral component to any environment within which individuals work, live, or receive services (Butler et al., 2011). Within TIC, safety is emphasized within the context of the physical environment as well as with respect to interpersonal dynamics. Within I/DD organizations, safety can be fostered through training direct care staff in crisis prevention and intervention; providing staff with debriefing following crises or behavioral interventions; providing facilities that are functional in design (e.g., clear walkways, identified exits) and well-maintained; ensuring adequate staffing patterns to sufficiently address the needs of individuals, especially those who may present with challenging behaviors; developing mechanisms within organizations for oversight and support of both direct care staff and individuals; proactively providing individuals with I/DD education in social skills, self-advocacy, and sexuality; conducting risk assessments and implementing well-developed support plans sensitive to the individuals' needs and history. An example toward ensuring safety might be in proactively ensuring staff are well-trained in the needs of the individuals with whom they are assigned prior to working with them rather than encouraging staff to read supporting documentation when they have time. Another example is to consider an individual's prior history of victimization when identifying an appropriate residence, being mindful of other residents' sex or histories of perpetration.

Trustworthiness

Trust is a critical component for a person's healing and sense of safety, especially when he or she has experienced adversity within the context of a relationship (Butler et al., 2011). For individuals with I/DD, trust is established through sensitive, consistent, and reliable interactions and approaches as well as clearly identified expectations, responsibilities, and boundaries. Similarly, direct care staff also benefit from a sense of trust, not only from management but also from their peers, which can be fostered through the development of transparent organizational policies and procedure that are consistently implemented, forthcoming information about individuals' behaviors and needs, open dialogue with management, and team-building exercises. A fundamental example of trustworthiness is staff ensuring consistency between their communication and action when engaging with individuals (e.g., if an individual has a scheduled appointment and staff arrive to take them as they were told they would). Additionally, management could exemplify trust with staff by supporting them in making decisions regarding approaches and interactions with individuals.

Choice

Choice refers to the ability of a person to advocate for his or her preferences. In the I/DD field, choice has been highlighted in person-centered planning for some time as integral to one's quality of life, yet it has remained a topic of concern and discussion (e.g., Shaw, Cartwright, & Craig, 2011; Stancliffe et al., 2011). Person-centered planning is a "well-known and often used approach to individual program planning in the [I/DD] field" that emphasizes choice, dignity, and respect (Claes, Van Hove, Candevelde, van Loon, & Schalock, 2010, p. 432).

In part, choice requires that individuals have an awareness of options and what is available to them. However, for those with I/DD this is often hindered by cognitive impairments or lack of prior experiences. This might be exacerbated by staff's assumptions that compromised levels of functioning equate with individuals' inability to make choices (Bigby, Clement, Mansell, & Beadle-Brown, 2009). Furthermore, staff's well-intentioned efforts to safeguard individuals might inadvertently result in a limitation of individuals' choices.

Through education and training, direct care staff can develop competency regarding reasonable risks, support individuals in better understanding available options, provide individuals with opportunities to explore novel experiences, and ultimately help individuals to become better able to make informed choices. For example, helping an individual to identify different ways to express his or her anger in healthier ways (e.g., exercise, hit a pillow, talk with staff) rather than becoming aggressive toward their peer.

From a staff perspective, administration can foster choice through allowing staff input into work schedules and assigned tasks, the development of policies and procedures, and the types of benefits to be received or how benefits are utilized. Furthermore, staff can be included in creating opportunities for individuals and personal growth, as well as organizational change.

Collaboration

Collaboration involves the sharing of power and influence between management, direct care staff, and individuals. In TIC, like person-centered planning, treatment plans and goal-setting are the product of collaboration between staff and individuals, with individuals' preferences incorporated whenever practical. Similarly, agency policies and departmental procedures engage staff and individuals and integrate their perspectives and concerns. Collaboration is manifested when individuals are encouraged to interact with one another as appropriate, and when staff provide support to one another. It is fostered when staff perceive individuals as similar to themselves, and when management is willing to relinquish power in favor of providing support and guidance to the staff rather than establishing traditional top-down dynamics. An example of collaboration can be seen in staff affording one another a break rather than only allowing one staff to work consistently with an individual who may be aggressive or perhaps encouraging individuals to work together on a task rather than one individual relying on staff.

Empowerment

Like choice and collaboration, empowerment of individuals is not new in the I/DD field as can be seen in the self-direction afforded through person-centered planning. However, under the philosophy of TIC, it is extended to direct care staff as well. Individuals and staff alike are empowered through the identification and acknowledgment of their skills and abilities. From a strengths-based perspective, individuals can be supported by focusing on abilities rather than disabilities. This becomes powerfully critical for those with mild impairments who may feel disconnected from those who are more severely impaired as well as the general population. Recognizing strengths and skills can be integral to helping individuals and staff overcome obstacles as they may already possess the resources necessary to strategize a solution. Similarly, skills and abilities can be an essential contribution to current circumstances and future successes in the lives of individuals and direct care staff, as well as the organization as a whole. For example, when staff is frustrated by an individual who is slow to learn, they can be encouraged to think of alternative ways of working with the individual, afforded opportunities to attend additional trainings, or simply praised for their perseverance.

ORGANIZATIONAL CONSIDERATIONS FOR INTEGRATING TRAUMA-INFORMED METHODS

Generally speaking, becoming trauma-informed requires a commitment to changing organizational culture, policies, and practices (Harris & Fallot, 2001). More specifically, it requires administrative support for the integration of trauma knowledge, staff-wide basic education in trauma (Bath, 2008; Butler et al., 2011; Harris & Fallot, 2001); prioritized recruitment and hiring of staff with sensitivity to trauma; the establishment of trauma-sensitive policies, procedures, practices, and human resource activities; screening of all individuals seeking and receiving services (Bath, 2008; Jennings, 2008); the development of comforting environments, risk management strategies, and client training in self-care and emotional regulation (Bath, 2008); and the development of a seamless system for individuals with diverse needs (Cooper, Masi, Dababnah, Aratani, & Knitzer, 2007).

Regardless of the type of services provided or the population served, organizations can adopt a philosophy and approach consistent with TIC (Butler et al., 2011). However, perhaps among the most well-known conceptualizations of TIC are the "Sanctuary Model" (e.g., Bloom & Sreedhar, 2008) and "Risking Connections" (e.g., Brown et al., 2011).

Effectiveness of Trauma-Informed Care

Trauma-informed care has not yet emerged as a prevalent topic in the I/DD literature. Yet, while TIC is a growing topic in the general population literature and there remains a dearth of rigorous research investigating its effectiveness, preliminary evidence suggests potential gains. When compared with treatment-

as-usual, TIC has been associated with better subjective physical health and lower prevalence of chronic illness among women in the general population who were diagnosed with co-occurring disorders (Weissbecker & Clark, 2007). Within psychiatric care for children and adolescents, TIC has been associated with a marked reduction in use of restraints and seclusion (Azeem, Aujla, Rammerth, Binsfield, & Jones, 2011; Bloom et al., 2003); increased patient satisfaction, increased staff patience and consistency in approach, increased ability to de-escalate crisis situations, decreased counter-aggressive actions between clients and staff (Bloom et al., 2003); and increased staff awareness of the impact of their communication on safety as well as increased leadership among youth in treatment (Rivard et al., 2004).

Other studies have investigated the impact of TIC training on staff. Giller, Vermilyea, and Steele (2006) found in one situation that more than 85% of care providers reported that the training made them better equipped to help clients with trauma histories, viewed symptoms as adaptations, agreed that a therapeutic relationship was critical to healing, and agreed with identifying client strengths as part of the framework. Similarly, Brown et al. (2011) noted, among direct care staff in children's residential treatment, significant increases in knowledge and self-reported behavior and beliefs favorable toward TIC.

Potential Barriers to the Implementation of TIC

Despite supporting evidence, potential barriers exist for any given organization to adopt a trauma-informed approach, regardless of the population served. A fundamental challenge is staff attrition, as high turnover has the potential to compromise the stability of any organizational environment (Bloom et al., 2003; Rivard et al., 2004). Additionally, given the basic tenets of TIC and an emphasis on flattened organizational hierarchy, management may be disinclined to relinquish some control to staff and individuals in order to create a democratic management style (Bloom et al., 2003). Other barriers may include lack of time to foster communication and team building, as well as interdepartmental differences in treatment approach (Rivard et al., 2004).

In addition, obstacles may be perceived in the parameters set forth by various state and federal policies, as well as the historic and residual influence of paternalism. For example, direct care staff may approach individuals with an expectation of trust and compliance, and the need to safeguard individuals. Although often well-intentioned, these dynamics may inadvertently compromise individuals' choice and disempower them. Staff actions may be overzealous out of fear of an allegation of abuse or neglect, as well as the anticipation of possible disciplinary action for failure to appropriately ensure individuals' safety, which often takes precedence given the subsequent risk to organizations (e.g., lawsuits, penalty from regulatory body).

Implications of Organizational Culture

The culture of any organization can significantly impact its overall performance as culture is implicated in staff productivity and the outcomes of those served (Gillett & Stenfert-Kroese,

2003). Yet, despite its impact, organizational culture is often overlooked as it works indirectly and frequently through nonverbal communication (Bloom, 2006). Nonetheless, the culture can buffer or exacerbate the effects of stressful environmental factors, such as maladaptive behaviors often noted among individuals with I/DD (Broadhurst & Mansell, 2007).

Although cultural shifts are a challenge for organizations and their staff, a shift toward TIC has the ability to heighten staff awareness that their behavior and communication are integral to individuals' well-being and that trauma may be at the core of individuals' behavior. In turn, these considerations often lend themselves to more appropriate and sensitive responses from direct care staff (Rivard et al., 2004; Walker & Weaver, 2007). In contrast, systems that fail to understand trauma may inadvertently create invalidating and re-traumatizing environments (Bloom, 2006; Elliott et al., 2005). Jennings (2008; p. 9) has noted that becoming trauma-informed is

a profound cultural shift in which . . . behaviors are viewed differently, [direct care staff] respond differently, and the day-to-day delivery of services is conducted differently. The new system will be characterized by safety from physical harm and re-traumatization; an understanding of [individuals] and their symptoms in the context of their life experiences and history, cultures, and society; there will be open genuine collaboration between provider and recipients of services at all phases of the service delivery; an emphasis on skill building and acquisition rather than symptom management; an understanding of symptoms as attempts to cope . . . and by a focus on what has happened to the person rather than with what is wrong with the person.

Current Philosophies within I/DD Services—A Cornerstone for TIC

The nature of organizations serving the I/DD population has gradually evolved and shifted since the commencement of deinstitutionalization nearly four decades ago. As the number of institutions has dramatically declined and given way to community housing alternatives (including group homes), there has been yet another trend—to provide extensive support and services within family and individual homes. Although philosophies have shifted over time, from regarding individuals as passive recipients of services to the focus of person-centered planning (Claes et al., 2010), and from quality of care to quality of life (De Waele, van Loon, Van Hove, & Schalock, 2005), efforts have been increasingly directed at ensuring individuals' well-being. However, for many individuals, staff have consistently remained an integral part of this.

When attention was focused on quality of care, organizations were afforded the opportunity to allocate resources toward management structures and individuals were regarded as "merely 'clients' of a care system" (De Waele et al., 2005, p. 229). However, quality of life—embracing current thought and best practices in the field—has become a catalyst for organizational change, aligning organizational strategies and staffing with individual needs and outcomes (Schalock & Bonham, 2003; Schalock, Verdugo, Bonham, Fantova, & Van Loon, 2008).

Emphasizing the importance of the individual's perspective, quality of life recognizes the impact of factors important to all persons such as relationships. Furthermore, it embraces the importance of self-determination as in person-centered planning where the individual is acknowledged as "an active decision-maker and participant in his/her treatment" (Schalock & Bonham, 2003, p. 230) and he or she is involved in organizational operations through meaningful roles (Schalock et al., 2008).

Indeed, the principles and practices associated with person-centered planning and quality of life are complementary and can be further augmented by TIC. Trauma-informed care in essence fosters the same values and philosophies yet extends them to staff and individuals alike, while acknowledging the potential impact of trauma and demonstrating sensitivity to triggering events and stimuli in the lives of both (Fallot & Harris, 2009).

CONCLUSION

Historically, the recognition of the importance of trauma has not been at the forefront of service delivery for individuals with I/DD (Charlton et al., 2004; Hollins & Sinason, 2000) and has not been identified as a significant part of individuals' lives. Yet, in recent years, there has been a growing awareness of the widespread prevalence and pervasive impact of trauma within both the general and I/DD populations. In the United States, this awareness has reached the national level with the Department of Health and Human Services providing TIC funding initiatives and the Substance Abuse and Mental Health Association and the National Child Traumatic Stress Network calling for local organizations nationwide to adopt a trauma-informed approach.

Because of the nature of their disabilities, individuals with I/DD often require support across the lifespan and encounters with organizations for service delivery are anticipated. Despite a myriad of organizational safeguards and regulations, individuals remain vulnerable. However, TIC challenges organizations "to stretch their vision . . . [to] search for new ways to operationalize the values of empowerment, and co-create cultures that foster sustainable partnerships with those receiving services" (Prescott, L., 2001, p. 83). It is plausible that organizations serving individuals with I/DD can adhere to state and federal mandates, embrace TIC, and, perhaps through a fresh lens appropriately align existing policies and legislation with increased sensitivity and more effective practices.

In 1999, Hatton et al. suggested that a culture that promoted staff well-being might result in increased quality of services for individuals. In 2010, a similar message was echoed by Lernihani and Sweeney who suggested that, to fully support individuals' needs, the emotional needs of staff should be considered as well. Further, Jackson (2011) called for an exploration of "innovative and practical approaches to enhancing the quality of the services offered" and "strategies that develop essential expressive and relational aspects of care practice" (pp. 941–942). Perhaps organizations can heed these challenges set forth by various authors by adopting and integrating TIC, recognizing that it presents an opportunity to create not only a

culture in which individuals might thrive, but also one in which direct care staff may succeed.

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