Trauma-informed

The Trauma Toolkit

a resource for service organizations
and providers to deliver services
that are trauma-informed

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Every summer a UN Food Bank worker comes home for a few weeks. He sticks close to home, going almost nowhere. One day he enters a shopping mall and begins to shake. He calls a friend to come and get him. The friend is confused and tries to comfort him. "Buddy, you're home. Relax. Enjoy. Give yourself a break." The aid worker replies, "It's all too much. Everything in there – the food, the noise, the store after store of stuff … it's all too much. Doesn't anyone get it?"

An aboriginal man is attending a planning meeting for health care. As they read over material that has been presented, someone points out to him that he has made a mistake in some of his wording. The man goes silent and appears to be visibly shaken. For some time he does not speak. Others in the group sense his silence. Finally another committee member asks, "Is something wrong?" The older aboriginal man replies softly, "I can never hear that word 'mistake' the way you say it. I know you said I made a mistake. But all I ever hear is what they told me in that school. I am a mistake."

A sexual abuse survivor is involuntarily hospitalized in a psychiatric ward for suicidal behaviour. She writes in her journal: "I feel like I am being raped over and over again. I feel like I have to tell things to people I don't know who scare me with their presence, people who play tricks on me, who use their power to control me. These people ask question after question with no emotion, with no care for me. I am merely an object for analysis. Look at the poor freak."

1 in 10 people

in Canada suffers from

Post-Traumatic Stress Disorder.

Introduction

Traumatic events happen to all people at all ages and across all socio-economic strata in our society. These events cause terror, intense fear, horror, helplessness, and physical stress reactions. The impact of these events does not simply go away when they are over. Instead, traumatic events are profound experiences that change the way children, adolescents and adults see themselves and their world.

From the time the trauma occurred, people with post-traumatic stress experience it in all stages of their life and in their day-to-day activities – parenting, working, socializing, attending appointments, and interpersonal relationships.

Trauma survivors are at risk of being re-traumatized in every social service and health care setting. This is due to a lack of knowledge about the effects of traumatic events and a limited understanding of how to work effectively with survivors. When re-traumatization happens, the system has failed survivors and leaves trauma survivors feeling misunderstood and unsupported, which perpetuates a damaging cycle that prevents healing and growth. This can be prevented with basic knowledge and by considering trauma-informed language and practices.

This handbook aims to provide this knowledge for service providers who work with trauma survivors.

Traumatic events impact everyone differently, but inevitably there will be some impact in some way. People experience trauma and the subsequent healing process subjectively.

> **"In a trauma-informed system, trauma is viewed not as a single, discrete event, but rather as a defining and organizing experience that forms the core of an individual's identity. The far-reaching impact, and the attempts to cope with the aftermath of the traumatic experience, come to define who the trauma survivor is."** (Harris & Fallot, 2001)

In a trauma-informed system, practitioners assume that when a trauma has occurred, it changes the rules of the game. An individual constructs a sense of self, a sense of others and a belief about the world that incorporates, and is in many cases based on, the horrific event or events. This then informs other life choices and guides the development of particular coping strategies. The impact of trauma is thus felt throughout an individual's life in areas of functioning that may seem quite far removed from the trauma, as well as in areas that are more obviously connected to the trauma (Harris & Fallot, 2001).

Purpose of this toolkit:

1 **This Toolkit provides recommended practices that will assist service providers and/or organizations to increase their capacity in delivering trauma-informed services.**

Trauma survivors and service providers have indicated the need for services and communities to be trauma informed through the implementation of more trauma-informed practices.

The experience of trauma is so prevalent in our society that service providers can assume that a percentage of the people they work with have survived a trauma of some sort. This means that not only do we have the responsibility to understand the impact of trauma, but we also require a basic understanding of recovery and how to help in a way that neither causes harm (re-traumatization) nor completely ignores the impact and meaning that the trauma has to the person.

The more that organizations and service providers are trauma informed in Manitoba, the more that communities are able to deal with crises and emergencies. When crises or emergencies happen, traumatized individuals and families need effective support to deal with the impact immediately. This will reduce negative impacts or threats of re-traumatization that can occur when situations are not handled with the best interests of the survivor in mind. When potentially traumatizing incidents are managed effectively, communities are strengthened and resilience is enhanced.

Trauma-informed services are knowledgeable of and sensitive to trauma-related issues present in survivors.

A trauma-informed system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking health and addiction services. A trauma-informed system uses that information to design service systems that accommodate the vulnerabilities of trauma survivors, and allows services to be delivered in a way that will avoid inadvertent re-traumatization and facilitate consumer participation in treatment (Harris & Fallot, 2001).

When potentially traumatizing incidents are managed effectively, communities are strengthened and resilience is enhanced.

2 **The benefits of providing trauma informed care, regardless of the setting, are many.**

While the benefits to the client/patient are primary and may be obvious we should stop to consider for a moment the resulting benefits to the individual service provider and the organization at large. It is not unusual for people affected by trauma to exhibit a variety of behaviours when taken out of their context are subject to misinterpretation and can result in a communication breakdown and frustration on the part of the care/service provider. People can be unfairly judged and perhaps even labeled.

Some people's behaviour might be incorrectly and unfairly described as resistant, uncooperative, controlling, or manipulative. It is not unusual for a service provider to become angry with the client/patient who may be trauma affected, question their own ability and doubt the person's motivation to change thus creating a potentially toxic situation both. If however the service provider works from the vantage point of being trauma informed the understanding that comes from this awareness can reduce frustration, improve communication, enhance the quality of the relationship and increase work satisfaction. Investing in integrating a trauma informed perspective does not create more work but can instead make the work easier, and more satisfying.

3 **This Toolkit outlines the importance of acknowledging traumatic experiences in the lives of clients, residents, patients, etc., that services are provided to, and identifying appropriate responses that lead to healing and recovery of the whole person – mind, body and spirit.**

A trauma-informed approach emphasizes understanding the whole individual and appreciating the context in which that person is living their life. Rather than asking, *"How do I understand this problem or this symptom?"*, the service provider now asks, *"How do I understand this person?"* This approach shifts the focus to the individual and away from some particular and limited aspect of their functioning. It also gives the message that their life is understandable and that behaviours make sense when they are understood as part of a whole picture (Harris & Fallot, 2001).

4 **This Toolkit is centered on the trauma survivor, and how service providers can keep the needs of survivors at the center of their work.**

When trauma survivors seek help, they often face a hierarchy of expertise that includes many medical and mental health specialists. The survivor usually ends up at the bottom of this hierarchy with little voice or choice in what happens in their treatment process. Keeping the survivors part of the process ensures they are part of their own recovery.

In summary, this Toolkit provides information on all aspects of trauma including what it is, its impacts, effective approaches to working with survivors, trauma recovery, the impact on service providers of working with trauma survivors, and information on resources and training.

what this toolkit is NOT:

This Toolkit is not intended to teach service providers to be counsellors, or to encourage them to step outside their scope of practice and develop skills in the realm of psychotherapy.

who this toolkit is intended for:

Since trauma survivors exist in every human service, **this Toolkit is intended for use by all service providers working with persons, families and/or communities who may be affected by trauma.** This includes all health services, mental health services, counselling and therapy services, law enforcement services, Corrections services, dental services, members of the Clergy, administrative staff, volunteers, and paid staff.

how to use this toolkit:

This Toolkit is a user-friendly information handbook intended to help service providers and organizations become trauma informed. It provides information on all aspects of trauma, including recovery and resources. Getting a basic understanding of trauma, its impacts on clients, and how we can better serve their needs is accomplished by reading the various sections of this Toolkit.

The sections are short and each is focused on a particular aspect of trauma, making it both easy to reference and more accessible in your workspace. Whether or not you consult the Toolkit repeatedly in your work, it is recommended that you review it from time to time to help you stay trauma informed.

No matter how you use this Toolkit, it will help you contribute to the healing and recovery of trauma survivors, families and communities.

contents:

contents (cont.)

What is Trauma?

> **"Trauma refers to experiences or events that by definition are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful – they are also shocking, terrifying, and devastating to the victim, resulting in profoundly upsetting feelings of terror, shame, helplessness, and powerlessness."** (Courtois, 1999)

A traumatic event involves a single experience, or enduring or repeated events, that completely overwhelm the individual's ability to cope or integrate the ideas and emotions involved in that experience.

Recent research has revealed that emotional trauma can result from such common occurrences as an auto accident, sudden job loss, relationship loss, a humiliating or deeply disappointing circumstance, the discovery of a life-threatening illness or disabling condition, or other similar situations.

Traumatizing events can take a serious emotional toll on those involved, even if the event did not cause physical damage.

When the traumatic experience involves another person inflicting pain for their own pleasure or selfish reasons, the survivor's beliefs about humanity and the goodness in people is destroyed. This profoundly affects their identity, resulting in negative effects in mind, body, soul and spirit.

Regardless of its source, an emotional trauma contains three common elements:
- **It was unexpected.**
- **The person was unprepared.**
- **There was nothing the person could do to stop it from happening.**

It is not the *event* that determines whether something is traumatic, but the individual's experience of the event.

Simply put, traumatic events are beyond a person's control. It is not the *event* that determines whether something is traumatic to someone, but the individual's experience of the event.

Those who have good coping skills, who feel supported after the event, and who had a chance to talk about and process the traumatic event, often go on to integrate the experience into their lives, like any other experience. Survivors who do not have this experience and do not express the associated feelings are not able to integrate the traumatic event, and it becomes something to be greatly feared and avoided. It is at this point that negative coping behaviours start and may continue until a survivor decides to face the difficult emotions that surround the traumatic experience.

The impact of these events does not simply go away when they are over. Instead, traumatic events are profound experiences that shape the way a person sees themselves, others, and the world.

Because the traumatic experience was so terrible, it is normal for people to block the experience from their memory, or try to avoid any reminders of the trauma; this is how they survive. However, the consequences of these survival mechanisms are a lack of integration of the traumatic experience, such that it becomes the experience in a person's life rather than one of many. This lack of processing of the trauma means that it is ever-present for the survivor, and they feel as if the trauma happened yesterday when it could have been months or many years since.

Who Can Be Traumatized?

Anyone can be traumatized. No one is immune. It is widespread throughout the world and affects every part of the population.

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Individuals of all ages, walks of life, and sexual orientations (including lesbian, gay, bisexual, transgender and two spirit*) can be profoundly affected. [The term "two-spirit" is an Aboriginal term referring to those who have both male and female spirits.]

Families can be traumatized by an event happening to one or more of its members. Even people who did not directly experience the trauma can be impacted by it, especially if they have a close relationship to the trauma survivor.

Communities can be traumatized when events affect any of its members.

Cultures can be traumatized when repeated denigration, attempts at assimilation, and genocide occur.

Service providers can be traumatized after hearing the stories and witnessing the suffering of trauma survivors. This is called "vicarious trauma" and happens when the provider is regularly confronted with traumatic content.

Who Perpetrates Abuse?

In the case of sexual abuse, physical abuse and neglect, we most often hear about girls being abused by men. And while this is highly prevalent in our society, we also need to be aware of other victims of child sexual abuse and their perpetrators:

- Women can be offenders, perpetrating abuse on their male and female children and other children in their lives.
- Men can be victims of sexual abuse at the hands of any caregiver or older person.
- Teens and older children can perpetrate abuse against young children.
- Very old people can perpetrate abuse, and be victims themselves of sexual abuse and assault.
- Those in positions of authority, such as members of the Clergy, teachers, coaches, therapists, doctors and caregivers, can also be perpetrators.

A trauma-informed service provider acknowledges and understands the effects of violence and trauma on those with whom they work. This is evidenced by the fact that they:

- integrate an understanding of trauma throughout their program,

- review policies and procedures to ensure prevention of re-traumatization,

- involve trauma survivors in designing and evaluating services, and

- place priority on trauma survivors' safety, choice and control.

Is your work Trauma-informed?

When a human-service program becomes trauma-informed, every part of its organization, management and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual who is seeking services. Trauma-informed organizations are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that their services and programs can be more supportive and avoid re-traumatization (National Mental Health Information Centre, 2008).

In the checklists below, answer **yes** or **no** to the questions to help you decide whether your practices and those of your agencies are trauma informed.

Service Provider Checklist

Knowledge:
- ☐**Y** ☐**N** Can you explain to a client what trauma is, including effects?
- ☐**Y** ☐**N** Do you recognize the signs and symptoms of trauma, even if a person does not verbally tell you?
- ☐**Y** ☐**N** Do you know what PTSD is? Can you explain it?

Assessment:
- ☐**Y** ☐**N** Do you routinely ask about previous trauma and how it is impacting trauma survivors?
- ☐**Y** ☐**N** Do you ask them if they have used or currently use drugs or alcohol?
- ☐**Y** ☐**N** Do you routinely ask about mental health issues related to the trauma?

Comfort level:
- ☐**Y** ☐**N** Are you comfortable asking about traumatic experiences and hearing the responses?

■**Y** ■**N** Are you willing to actively listen to difficult feelings and emotions that may arise?

■**Y** ■**N** Are you comfortable talking about traumatic experiences?

Relationship building:

■**Y** ■**N** Is establishing trust and safety a priority in your work with people?

■**Y** ■**N** Do you make sure clients are comfortable with the questions you ask on assessments?

■**Y** ■**N** Do you try to establish a genuine, caring connection with clients?

Responding to disclosure:

■**Y** ■**N** Do you acknowledge to the client the difficulty and courage involved in talking about trauma?

■**Y** ■**N** Do you respond to disclosure with belief and validation?

■**Y** ■**N** Do you encourage the client to disclose only what they are comfortable with sharing?

Coping:

■**Y** ■**N** Do you ask clients how they cope with the difficult feelings surrounding the trauma?

■**Y** ■**N** Do you ask how they cope with difficult behaviours that may result from the trauma experience, i.e., substance abuse?

■**Y** ■**N** Do you acknowledge the link between trauma, mental health, and addiction?

Personal attitudes and beliefs:

■**Y** ■**N** Do you believe that trauma survivors are resilient and able to recover?

■**Y** ■**N** Do you believe that you can affect positive change for clients?

■**Y** ■**N** Do you dispel the many myths surrounding trauma in your work with people?

Resources:

☐**Y** ☐**N** Are you familiar with community resources for trauma survivors?

☐**Y** ☐**N** Do you refer clients to trauma-recovery services?

☐**Y** ☐**N** Do you advocate on behalf of clients who need assistance in accessing resources?

Strengths-based:

☐**Y** ☐**N** Do you focus on clients' strengths and resources?

☐**Y** ☐**N** Do you try to instill a sense of hope and change for clients?

☐**Y** ☐**N** Do you work as a team with the client, letting them make decisions about their care?

Cultural awareness:

☐**Y** ☐**N** Do you consider clients' cultural backgrounds when making referrals and discussing community resources?

☐**Y** ☐**N** Do you get an understanding of their issues from their cultural perspective?

☐**Y** ☐**N** Do you make efforts to provide culturally appropriate services when requested?

Organizational Checklist

Philosophy:

☐**Y** ☐**N** Does your organization include trauma recovery as part of its mandate and/or programming?

☐**Y** ☐**N** Does your organization subscribe to the evidence-based, best-practice, trauma-informed treatment model?

☐**Y** ☐**N** Does your organization support efforts to minimize the possibility of re-traumatization?

Staff training:

☐**Y** ☐**N** Do you train staff on the dynamics and impact of trauma?

■ **Y** ■ **N** Do you encourage your staff to attend information sessions and workshops on trauma?

■ **Y** ■ **N** Do you train staff in communication and relationship-building skills?

Administration:

■ **Y** ■ **N** Do you have trauma survivors on your board of directors?

■ **Y** ■ **N** Does your mission statement address trauma survivor input and participation?

■ **Y** ■ **N** Are there trauma survivors on your administrative team?

Suicide prevention:

■ **Y** ■ **N** Are all of your staff members trained in suicide intervention/prevention?

■ **Y** ■ **N** Are suicide assessments included in the assessment and intake process?

■ **Y** ■ **N** Does your organization acknowledge the impact of suicide on clients and staff, and include supports around suicide grief?

Cultural awareness:

■ **Y** ■ **N** Do you provide training for staff in cultural competency?

■ **Y** ■ **N** Does your organization strive to include ethnic and minority groups in staffing and client programs?

■ **Y** ■ **N** Does your organization stay current on issues facing immigrants, refugees, and Aboriginal people?

Hiring practices:

■ **Y** ■ **N** Does your organization include experience in working with trauma survivors in job descriptions?

■ **Y** ■ **N** Does your organization hire trauma survivors?

■ **Y** ■ **N** Does your organization hire Elders or those involved in traditional/spiritual healing practices?

Policies and protocols:

- ■**Y** ■**N** Does your organization include universal screening for trauma for all clients?
- ■**Y** ■**N** Has your organization ensured that current policies and protocols are not hurtful or harmful to trauma survivors?
- ■**Y** ■**N** Does your organization involve trauma survivors in the creation of policy and protocols?

Survivor involvement:

- ■**Y** ■**N** Does your organization include trauma survivors in program development and evaluation?
- ■**Y** ■**N** Does your organization include trauma survivors in service provision in paid or voluntary roles?
- ■**Y** ■**N** Does your organization get assistance from trauma survivors when developing procedures that are potentially invasive?

Link between trauma, mental health and addiction:

- ■**Y** ■**N** Does your organization acknowledge the links between trauma, mental health issues, and addiction in its policies and procedures?
- ■**Y** ■**N** Does your organization provide training and knowledge to staff on co-occurring disorders?
- ■**Y** ■**N** Does your organization's screening procedure include mandatory trauma assessment where addiction issues are present?

Support and supervision for providers:

- ■**Y** ■**N** Does your organization have mandatory supervision for staff working with trauma survivors?
- ■**Y** ■**N** Does your organization acknowledge the impact on those who work with trauma survivors through vicarious trauma workshop opportunities?
- ■**Y** ■**N** Does your organization foster a climate of sharing feelings and experiences related to clients in a safe and confidential setting?

■**Y** ■**N**

Total Y: _____
Total N: _____
Date: _____
How did your workplace score? Revisit this survey after putting the Trauma-informed Toolkit into practice and re-evaluate.

Total Y: _____
Total N: _____
Date: _____

"Those at highest risk for permanent damage are people who have been directly exposed to traumatic events: who were physically immobile and helpless while trying to escape from disaster; who have first-hand experiences of its sounds, smells, images; who directly witnessed traumatic events; and whose lives have been permanently altered by the death or injury of a loved one." (Van der Kolk, p. 34, 2002)

Post-Traumatic Stress Disorder (PTSD): The Aftermath of Trauma

People respond to traumatic events in their own way and according to their individual coping skills and available support systems. Research on the impact of trauma on various populations indicates that the great majority of those not immediately and personally affected by a terrible tragedy sustain no lasting damage. Most of those involved in witnessing or being a part of devastating events are able, in the long term, to find ways of going on with their lives with little change in their capacity to love, trust, and hope for their future.

People can develop PTSD when, instead of facing and dealing with the situation, they react to traumatic events by emotionally blocking them during and after the trauma. This allows the experience to dominate how they organize their lives and causes them to perceive most subsequent stressful life events in the light of their prior trauma. Focusing on the past in this way gradually robs their lives of meaning and pleasure.

The description and symptoms of PTSD go all the way back to Ancient Greece. However, it was not until 1980 that the cluster of symptoms classified as a mental illness after the suffering of Vietnam War veterans was incorporated into the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.

Impact depends on the age and development of the person and the source of the trauma i.e. whether the trauma was relational and perpetrated by a close other, a natural disaster, war, or by a person outside of the family.

The diagnosis of PTSD usually focuses on three elements:

1 The **repeated reliving of memories of the traumatic experience** in images, smells, sounds, and physical sensations. These are usually accompanied by extreme physiological states, as well as psychological stress that may include trembling, crying, fear, rage, confusion, or paralysis – all which lead to self-blame.

2 **Avoidance of reminders of the trauma,** as well as emotional numbing or detachment. This is associated with an inability to experience pleasure and with a general withdrawal from engagement with life.

3 **A pattern of increased arousal,** as expressed by hyper vigilance, irritability, memory and concentration problems, sleep disturbances, and an exaggerated startle response. Hyper arousal causes traumatized people to become easily distressed by minor irritations. Their perceptions confuse the present and traumatic past, such that traumatized people react to many ordinary frustrations as if they were traumatic events.

The core issue of PTSD is that certain sensations or emotions related to traumatic experiences are dissociated, keep returning, and do not fade with time. People with PTSD seem unable to put an event behind them and minimize its impact. They may not realize that their present intense feelings are related to the past, so they may blame their present surroundings for the way they feel.

PTSD can be placed on a continuum from minimal traumatic impact to moderate effects, to high or complex PTSD that includes additional symptoms associated with severe long-term childhood trauma, i.e., sexual and physical abuse, residential school experience.

The more prolonged the trauma and the more interpersonal in nature, the more severe the impact will be.

PTSD Continuum

trauma trauma **trauma Trauma TRAUMA**

minimal impact   moderate effects   high or complex PTSD

Those who have fewer traumatic experiences and were able to address the impact of the event either at the time it occurred or sometime later, will be closer to the lower end of the continuum. As the frequency and duration of traumatic events increase, so do the negative impacts and symptoms. When children experience trauma and their caregivers address it shortly after it occurred, the likelihood of developing PTSD is lower.

Complex PTSD is at the far end of the continuum and is characterized by a history of severe, long-term trauma that usually includes exposure to caregivers who were cruel, inconsistent, exploitive, unresponsive or violent. Survivors struggle with more chronic self-destructive behaviours like self-harm, substance abuse, and suicidal behaviours.

Many thousands of Aboriginal children were taken from their families and enrolled in the residential school system during its existence. (...) Aboriginal people across the country have paid a high price, both individually and collectively for the government's misguided experiment in cultural assimilation.

(Aboriginal Healing Foundation, 2003)

Examples of Trauma

Interpersonal Trauma

- **Childhood abuse:** sexual, physical, neglect, witnessing domestic violence
- **Sexual assault:** any unwanted sexual contact
- **Historical trauma:** colonialization and the residential school experience of forcible removal from the family home, destruction of culture and language
- **Domestic abuse:** physical, sexual, financial, spiritual, cultural, psychological
- **Loss due to homicide**
- **Torture and forcible confinement**
- **Elder abuse:** physical, sexual, financial, spiritual, cultural, psychological

External Trauma

- **War:** combat, killing, fear of being killed, witnessing death and extreme suffering, dismemberment
- **Being a victim of crime**
- **Sudden death of a loved one**
- **Suicidal loss**
- **Loss of a loved one to homicide**
- **Sudden and unexpected loss:** of a job, housing, relationship
- **Living in extreme poverty**
- **Natural disasters**
- **Accidents:** vehicle, plane, etc.

Developmental Trauma: Child Abuse

Developmental trauma includes sexual, physical and psychological abuse, neglect, and witnessing violence in the home. These experiences happen during the developing years of infancy, childhood and adolescence, and are perpetrated by trusted adults and/or older figures in the person's life.

Given that children are completely dependent on the adults in their lives for survival, trauma that occurs at this stage of life deeply impacts identity and shapes beliefs about self and the world. Development is severely negatively affected, resulting in many problems in most areas of life that continue through all the stages of development into adulthood.

The experience of many Aboriginal people in Canada due to forced attendance at residential school encompasses all types of developmental traumas.

Historic Trauma: The Legacy of Residential Schools

> *"Our dignity was taken away... and a lot of people don't realize that. They don't really understand about how our dignity was taken away from us, how we were taught to be ashamed to be Natives. Then our self-respect was gone. Once you lose your self-respect, how can you respect someone else? Then you take your frustrations out on other people."*
> (Elder, 1998)

Colonialization

Given the high population of Aboriginal people living in Manitoba, it is crucial that service providers have an understanding of the profound effects of colonialization in Aboriginal people. Colonialization itself is a collectively experienced trauma. There are important historical factors that surround the experience of being Aboriginal in Canada.

The term "Aboriginal" includes Métis, Inuit and First Nations, regardless of where they live in Canada and regardless of whether they are "registered" under the Indian Act of Canada.

Many thousands of Aboriginal children were taken from their families and enrolled in the residential school system during its existence. While the majority of these children were status Indians, attendance also included many Inuit, Métis and non-status Indians. Regardless of the precise number of people involved, Aboriginal people across the country have paid a high price, both individually and collectively for the government's misguided experiment in cultural assimilation (Aboriginal Healing Foundation, 2003).

In 1867, Canada instituted a policy of Aboriginal assimilation designed to transform communities from "savage" to "civilized". Canadian law forced Aboriginal parents under threat of prosecution to send their children to the schools. The residential schools prohibited the use of Aboriginal languages, as well as the observance of their traditions and customs. Children did not see their family members for months and even years at a time.

From the mid-19th to mid-20th centuries, residential school was the norm for Aboriginal people. They were operated by religious orders in the earlier years and then moved to total governmental control in later years.

Atrocities that occurred in schools are numerous, including physical abuse, neglect, torture, murder, and sexual abuse at the hands of the staff. Despite the fact that abuses were directed toward specific individuals, they were part of a larger project to suppress Aboriginal culture and identity in its entirety. Although this effort was not successful, Aboriginal communities continue to feel the impact of what some call attempted "cultural genocide".

Impacts

The impacts of the residential school experience are intergenerational – passed on from generation to generation. Parents who were forced to send their children to the schools had to deal with the devastating effects of separation and total lack of input in the care and welfare of their children. Many of the children suffered atrocities from the staff, but also sustained further abuse as a consequence of the curriculum that stripped them of their native languages and culture. This caused additional feelings of alienation, shame and anger that were passed down to their children and grandchildren.

The effects of trauma tend to ripple outward from the victims to those who surround them, and among residential school survivors, the consequences of emotional, physical and sexual abuse continue to be felt in each subsequent generation. Deep, traumatic wounds exist in the lives of many Aboriginal people who were taught to be ashamed just because they were Aboriginal.

The impacts are felt at individual, family and community levels:

Individual
- isolation/alienation
- shame
- anger toward school and parents
- self-hatred
- internalized racism
- fear of authority
- low self-esteem
- self-destructive behaviours (substance abuse, gambling, alcoholism)
- acting aggressively

Family
- unresolved grief
- difficulty with parenting effectively
- family violence
- loss of stories
- loss of traditions
- loss of identity

Community
- loss of connectedness with languages and traditions
- loss of togetherness and collective support
- loss of support from Elders
- lack of control over land and resources
- increased suicide rate
- lack of communal raising of children
- lack of initiative
- dependency on others
- communal violence

Because the impacts of residential schools are intergenerational, many Aboriginal people were born into families and communities that had been struggling with the effects of trauma for many years. These are reinforced by the racist attitudes that continue to permeate Canadian society.

Hope and resilience

Despite the legacy of residential schools, there are many reasons to be hopeful. The experience of residential schools for some Aboriginal people has strengthened their identity and caused communities to come together to implement healing initiatives that address aspects of the residential school legacy. Resilience is evident in the steps Aboriginal people have taken to counteract negative outcomes. Many former students have found support in Elders and healing circles. They have also opted to share memories and stories with other former students, pursue further education, relearn Aboriginal languages, and follow spiritual paths to reinforce Aboriginal identity (Aboriginal Healing Foundation, 2003).

The cycle of trauma is being broken as the stories of trauma are being told and the many strengths of Aboriginal cultures are being used to heal.

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The Experience of Immigrants and Refugees

> *"I came to Canada to find peace. I've climbed the ladder of peace and I thought that would be all. I ran from flames, but now I'm faced with hidden flames. Integration is like that."*
> (Somali refugee, 2006)

Given that immigrants and refugees are a significant and growing part of our Canadian population, it is crucial that service providers and service systems acknowledge trauma in these groups by being knowledgeable about their experiences in their home country and their experience of migration and settling in Canada.

An immigrant is a person who has been granted the right to live in Canada permanently by Canadian immigration authorities. There are many different classes of immigrants depending on the circumstances under which the immigrant has come to Canada.

Citizenship and Immigration Canada's definition of a Convention Refugee is based on the United Nation's definition: A person who, by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is (a) outside their country of nationality and unable, or by reason of that fear, unwilling to avail themselves of the protection of that country; or (b) not having a country of nationality, is outside the country of their former habitual residence and unable, or by reason of that fear, unwilling to return to that country.

Immigrants and refugees face similar experiences in their home countries and in the process of settling in the new country. However, because refugees are fleeing extremely traumatic conditions, almost all of them have experienced losses and may have suffered multiple traumatic experiences, including torture. Their vulnerability to isolation is exacerbated by poverty, grief, and the lack of education, literacy and skills in the language of the receiving country (Robertson et al., 2006).

Immigrants (non-refugee status) may have faced the same issues as refugees, and the two groups share the same experience of having to settle in a foreign country. Issues related to trauma that they have already experienced can be compounded by the following circumstances and challenges faced in the integration process:

- not understanding Canadian cultural norms
- feeling that the host country doesn't understand their culture, or make any efforts to do so
- facing constant racism that is deeply rooted in Canadian society
- feeling unwelcome in Canada
- finding adequate employment
- learning English or French
- lack of recognition of education
- finding adequate housing
- few family supports
- dealing with bureaucracy
- feeling isolated
- inadequate childcare

- difficulties enrolling children in school
- grief of missing family in their home country and not seeing family for years at a time
- finding themselves living in lower living standards due to low income
- lack of societal acceptance of religious beliefs and practices
- facing continued family violence
- dealing with negative comments by politicians, the media, or in private conversations that reflect negative public opinions about immigrants and refugees

For those who faced discrimination, punishment and torture in their home country, some additional issues may include:

- continued discrimination in Canada
- distrust of the Canadian government because it could have been responsible for their maltreatment in the home country
- feelings of shame
- feeling guilty for having survived when other family and community members may have been killed
- feeling they need to prove how bad the situation was at home to stay in Canada and the associated fear of deportation
- living with the physical, psychological and emotional consequences of trauma while trying to negotiate settlement and integration (Canadian Council for Refugees, 2002)
- living with little or no information about the welfare of family members in life-threatening situations
- constantly wondering when they will be reunited with their families
- being stuck for years without permanent status in Canada

All of these issues contribute to a difficult transition into Canadian society. For trauma survivors, their traumatic issues may not be addressed at all due to all the other issues that refugees and immigrants face on a daily basis. Additionally, survivors may not feel comfortable asking for help due to the lack of understanding of their culture by service providers and/or the image of weakness that this may invoke in their own culture.

As service providers, we can be helpful even though we do not understand the specifics of every culture represented in Manitoba. If we understand survivors' issues from their perspective and make a concerted effort to understand their cultural interpretations of the traumatic events, then that will guide our work with them. It is the survivors' interpretation of the trauma that is important and helps us understand both the impact of the trauma now and how we can be helpful.

In summary, service providers working with trauma survivors have a responsibility to be aware of the many challenges that immigrant and refugees face as they try to integrate into Canadian society. Displaying this knowledge and willingness to learn will help form a solid helping relationship essential to trauma recovery.

The Far-Reaching Effects of Trauma: Prevalence

Many statistics are available in Canada on sources of trauma such as war and family violence. Incidences of violence and abuse are generally under-reported, especially in the areas of sexual abuse and sexual assault. It has been well established that because of the stigma and shame associated with trauma, current statistics only reflect reported data and not necessarily the actual number of cases.

The following statistics are primarily drawn from national and provincial sources and are intended to provide a general understanding of trends only.

PTSD:

- According to the Canadian Mental Health Association, about 1 in 10 people in Canada have PTSD.
- Some people can experience symptoms without developing the full-blown disorder.
- About 5 to 10 percent of people may have some symptoms without developing high levels of the disorder.
- Women are twice as likely as men to develop PTSD (CBC News, 2006).

Canadian Forces:

- More Canadian soldiers than ever are presenting with psychiatric disabilities such as PTSD. More than 8,500 pensions have been awarded, representing an increase of 2,100 since 2001. Veterans' Affairs say 30 percent of pensions go to veterans from World War II and the Korean War, but Canada's mission in Afghanistan is also boosting the numbers. According to the Military Ombudsman's Office in Canada, the rate of PTSD among Canada's peacekeepers is as high as 20 percent.
- There is no centralized Canadian Forces (CF)-wide process in place to collect up-to-date statistics on the number of current and former CF members who have been diagnosed with PTSD or other stress-induced

Incidences of violence and abuse are generally underreported, especially in the areas of sexual abuse and sexual assault.

injuries. However, in 2002, CF was surveyed by Statistics Canada to determine the prevalence of PTSD and other conditions. The survey found that in 2001, 2.8 percent of the regular force and 1.2 percent of the reservists had symptoms of PTSD. The more missions soldiers had embarked on, the more likely they were to develop PTSD (Canadian Community Health Survey, 2002).

Refugees:

- According to trends and statistics regularly released by the UN High Commissioner for Refugees, the number of refugees around the world had increased by the end of 2006 to almost 10 million, the highest in five years.
- Canada generally accepts more than 25,000 refugees a year, and over the past five years has granted permanent residence to more than 147,000 refugees (Citizenship and Immigration Canada, 2007).
- Refugees come to Canada primarily from Africa, the Middle East, and South America.
- In 2006, 1,208 refugees came to Manitoba (Province of Manitoba, 2007)

Immigrants:

- In 2006, Manitoba received 9,989 immigrants, an increase of 23.4 percent over the previous year.
- Manitoba also received 50 percent of all provincial nominees who came to Canada.
- Manitoba's top immigrant source countries were the Philippines, Germany, India, China and Korea.

Sexual assault:

- The General Social Survey of 2004 suggests that only 8 percent of sexual assault incidents in that year were reported to police.
- Rates of reported sexual assault have declined since 1993.

Family violence:

Partner Violence (Statistics Canada, 2004, 2005, 2007)

- According to the 2004 General Social Survey, it is estimated that 7 percent of Canadians 15 years of age and over in a current, previous or common-law union experienced spousal violence in the previous 5 years, unchanged from 1999.
- In 1999, it was found that 4 percent of both men and women in current marital or common-law relationships experienced either physical or sexual violence from their partner. In 2004, there was no significant change in rates for either women or men in current relationships.
- Survey data from 2004 show that rates of spousal violence are highest among those who are common-law and who have a previous partner/spouse.
- Aboriginal people were three times more likely to be victims of spousal violence than were those who were non-Aboriginal (21 percent versus 7 percent).
- In 2004, 36 percent of Aboriginal people experienced emotional or financial abuse, which is much higher than that of non-Aboriginal people, visible minorities, and immigrant populations.
- Emotional abuse and/or controlling behaviour are often pre-cursors to violence in a relationship.
- Emotional or financial abuse was 2.5 times more common between partners than physical violence. Both women and men reported emotional and financial abuse.
- Being called names or being put down is one of the strongest predictors of family violence.

Child Abuse (Statistics Canada, 2007; The Canadian Incidence Study of Reported Child Abuse and Neglect, 2003)

- Rates of sexual assault and sexual abuse are more than 5 times higher for children and youth than for adults.
- Rates of physical abuse are slightly lower than for adults.
- Perpetrators of violence are part of the immediate environment of children and youth.

Prevalence

- Parents are the most common perpetrators of violence.
- In 2005, male family members were identified as the accused in 97 percent of all family-related sexual assaults and 71 percent of physical assaults; female family members were accused in 3 percent of family-related sexual assaults and 29 percent of physical assaults.
- Research estimates that 1 in 6 boys is sexually abused (Klinic Community Health Centre, 2005).
- According to the Canadian Incidence Study of Reported Child Abuse and Neglect 2003, which consisted of reports from Child Welfare workers, substantiated cases of child abuse broke down in the following percentages:
  - **neglect:** 30 percent
  - **exposure to domestic abuse:** 28 percent
  - **physical abuse:** 24 percent
  - **emotional abuse:** 15 percent
  - **sexual abuse:** 3 percent

Older Adults (Statistics Canada, 2004, 2007)
- Male seniors experience higher levels of violence.
- The only violent offence for which senior females experienced higher rates than males was for sexual assault.
- Senior women experience higher rates of family-inflicted abuse.
- Most senior victims know their perpetrator.
- An adult child commits most family violence against seniors.

Residential School:
- The last federally run residential school closed in 1996.
- There are 80,000 people alive today who attended residential schools (Indian Residential Schools Resolution, 2006).
- Of the 19,220 Indian Residential School Claims filed against the Government of Canada by former students, 7,257 have been resolved (Indian Residential Schools Resolution, 2006).
- The average age of claimants is 57 years old (Assembly of First Nations).

The Effects of Trauma

The effects of being traumatized are very individual, and survivors are impacted physically, emotionally, behaviourally, cognitively and spiritually.

Physical

- eating disturbances (more or less than usual)
- sleep disturbances (more or less than usual)
- pain in areas on the body that may have been involved in the traumatic experience
- low energy
- chronic unexplained pain
- headaches
- anxiety/panic

Emotional

- depression, spontaneous crying, despair and hopelessness
- anxiety
- extreme vulnerability
- panic attacks
- fearfulness
- compulsive and obsessive behaviours
- feeling out of control
- irritability, anger and resentment
- emotional numbness
- frightening thoughts
- difficulties in relationships

Behavioural

- self-harm such as cutting
- substance abuse
- alcohol abuse
- gambling
- self-destructive behaviours
- isolation
- choosing friends that may be unhealthy
- suicide attempts

Cognitive

- memory lapses, especially about the trauma
- loss of time
- being flooded and overwhelmed with recollections of the trauma
- difficulty making decisions
- decreased ability to concentrate
- feeling distracted
- withdrawal from normal routine
- thoughts of suicide

Spiritual

- guilt
- shame
- self-blame
- self-hatred
- feeling damaged
- feeling like a "bad" person
- questioning the presence of God
- questioning one's purpose
- thoughts of being evil, especially when abuse is perpetrated by Clergy
- turning away from the faith or obsessively attending services and praying
- feeling that as well as the individual, the whole race or culture is bad

The experience of Sexualized Trauma

"My uncle sexually abused me from age 8 to 23. I spent those years living in constant fear, and there was no one to talk to because I was afraid my family wouldn't believe me and blame me like he did. He's dead, and it was a long time ago, but I still feel like I'm back there sometimes. I feel like a damaged, used-up person. I just want to feel whole instead of all over the place."
(Trauma survivor, 2008)

Sexual abuse survivors experience additional effects due the sexual nature of their experiences – additional shame, self-blame, and self-hatred. Survivors have to contend with feeling dirty and damaged, a direct result of the messages the perpetrator instilled in them. The abuse usually occurs over a period of time in secret, is perpetrated by a trusted adult, and is a deep, dark secret the survivor will have hidden for a very long time.

To be "informed about trauma" when working with abuse survivors means to know the history of past and current abuse in the life of a person with whom you are working. This information allows for more holistic and integrated services. Being trauma-informed also means understanding the role that violence and victimization plays in the lives of survivors (Harris & Fallot, 2001).

Perpetrators of violence and abuse often make recurring statements to their victims that blame them and place them at the centre of the responsibility for the abuse. They say things like, "You deserve this", "I know you want this", and "You asked for this". Children cannot ask to be sexually abused, nor can they say "no" to an adult or older person who has total control over them. Victims live in fear of their perpetrators who make terrifying threats against them to ensure that their victims do not disclose the abuse to anyone. In a young person's world, this is all that they know. They obey the perpetrator because, in their mind, their very survival depends on it. In reality, their dependency is often used against them.

These feelings and fears are carried into adult life, as are the behaviours the victims used to survive. Many child abuse survivors define themselves

Being trauma-informed also means understanding the role that violence and victimization plays in the lives of survivors.

by these abusive experiences, and still live from day to day as if they are just surviving and living in fear of further victimization.

Self-destructive behaviours are common survival mechanisms. Self-harming, for example, is a coping mechanism developed to manage intense emotional pain resulting from the experience of being abused by those who were the most important people in the child's life. For those who do not have the emotional capacity to work through their difficult emotions and experiences, self-harming activities such as cutting, burning and bruising parts of the body provide immediate help in the short term.

The horrific memories of the abuse accompany child abuse survivors daily, and are often manifested in nightmares and flashbacks that make them feel as if the abuse is happening again. This is the brain's way of dealing with overwhelming experiences and feelings that must be processed, but survivors often avoid dealing with these feelings out of fear of losing control.

Child abuse survivors often feel and behave in a way that makes them seem "unstable" because they have great difficulty regulating their emotional states, which swing from one extreme to another.

Men and women have many common effects, but there are differences in how they experience and interpret the abuse, and how they and others see themselves in the world.

Complex Post-Traumatic Stress Disorder can occur:
- the earlier the abuse,
- the more prolonged it was,
- the closer the relationship with the perpetrator, and
- the more severe the violence.
- Chronic suicidal behaviours, self-harming behaviours, relationship problems, addictions and depression are commonly associated with this disorder.

Issues for Male Survivors of Childhood Sexual Abuse

It is difficult to know how widespread male sexual abuse is because it often goes unreported. In our society, men are portrayed as strong, unemotional, tough, and heroic, and there is great pressure on them to maintain this image, even at the risk of neglecting their own emotional needs. For male survivors of sexual abuse, getting help is difficult and often avoided for fear of appearing weak.

It is important to differentiate the effects of sexual abuse on men because they are more likely to be overlooked. Men also tend to bottle emotions, which leads to high-risk behaviours including more completed suicides and violent behaviour.

There are many myths in our society about men being victims of abuse. If service providers believe in these myths, this will prevent them from providing knowledgeable and sensitive services to male survivors of sexual abuse. These myths hold a lot of power and may create obstacles for men to talk about their experiences.

Common myths about men as victims of abuse

> **Myth:** Men who have been sexually abused will eventually sexually offend against others.
> **Fact:** Most people who have been sexually abused do not abuse children as adults. It is a small minority of men who eventually go on to perpetrate sexual abuse.

> **Myth:** Most sexual abuse is perpetrated by "dirty old men".
> **Fact:** Sexual abuse is perpetrated against boys by anyone in a position of power in relation to them.

> **Myth:** Men who have experienced sexual abuse are, or will become, gay or bisexual.
> **Fact:** Sexual abuse is an act of violence where sexual acts are the weapon. The abuse itself is not about sex, but power. Therefore, there is no impact on sexual orientation.

Myth: Childhood sexual abuse rarely happens to boys.
Fact: Research estimates that 1 in 6 boys is sexually abused (Klinic, 2005).

Myth: Boys sexually abused by an adult female enjoyed it.
Fact: Sexual abuse is never enjoyable. Abuse is nonconsensual and violating, but because the body is designed to respond to stimulations, physical reactions such as ejaculation can occur. This is not under the survivor's control and contributes to shame and self-blame.

The impact of these myths on boys and men

It is impossible to effectively work toward trust and safety with a trauma survivor if service providers believe the myths about abused men and boys that are prevalent in our society. These beliefs cause harm to trauma survivors. As long as these myths continue to be believed and replicated, male survivors of sexual abuse will be less likely to get the recognition and help they need, and the cycle of guilt, shame, anger and silence will continue.

For any male survivor who has been sexually abused, overcoming these myths is an essential part of recovery. This can only happen, however, with providers who are willing to educate and support male survivors in their healing process.

Effects of Sexual Abuse

Physical

- pain in the genital areas or anywhere on the body where abuse occurred
- extreme discomfort in medical exams
- chronic pain
- unexplained medical problems
- no sexual pleasure
- shakiness
- nervousness

Emotional

- depression
- suicidal thoughts
- anger
- helpless and ineffective
- worthlessness
- guilt
- shame/self-blame
- feel like a "bad" person
- feel unworthy of love and respect of others
- feel like an outsider/misfit
- self-hatred
- fear of authority
- loss of faith/spiritual self

Behavioural

- avoidance of intimate relationships/pursuing many relationships
- isolation
- substance abuse
- over-engaging in relationships/refusal to connect to friends and family
- self-destructive behaviours
- suicide attempts
- aggression and hostility
- breaking the law
- missing appointments

Cognitive

- thoughts of suicide
- dissociation
- lack of concentration
- over thinking
- see "Effects of Trauma" section (page 43)

Spiritual

- feeling permanently damaged
- lacking a sense of identity outside the abuse context
- doubting the existence of God
- feeling soulless
- feeling evil
- stops practising faith

The effects of traumatic exposure depend on both the developmental level of the individual when the trauma occurred, and who the perpetrator was. Some people may have been abused as far back as they can remember, while others will remember times before the abuse started. If a person had some support and understanding from significant people in their lives at the time the trauma occurred, the impact will most likely be less than a survivor who had no support or understanding when the abuse was disclosed to the family and community. In our role as service providers we do not want to continue with the denial of trauma. When we acknowledge its presence, we can make a difference for someone in pain.

Co-occurring Disorders: Substance Abuse and Trauma

"I started using drugs and alcohol, or anything I could get my hands on, when I was 13. I found it was the only way that I could deal with my Mom's temper, and it took the edge off of the anger and sadness, but now I'm really messed up, and find that the memories are still there and so are the feelings I had when I was 13, but I'm 42. I've never felt so stuck...."
(Trauma survivor, 2003)

The term "co-occurring disorder" refers to the abuse/dependence of substance use and mental disorders.

> **Co-occurring disorders are so common with trauma survivors that they should be considered expected rather than an exception.** They are associated with a variety of negative outcomes, including high relapse rates, hospitalization, violence, incarceration, homelessness, and serious infectious diseases (CODI, 2004).

Currently it is estimated that 4 million people in the United States have a co-occurring disorder, but this number could be as high as 10 million (SAMHSA).

Persons diagnosed with co-occurring disorders have one or more mental disorders, as well as one or more disorders relating to alcohol or substance abuse.

People with a lifetime history of PTSD have elevated rates of co-occurring disorders. Among men with PTSD, rates of co-occurring alcohol abuse or dependence are the highest. Research also shows that PTSD is a risk factor for substance abuse and addiction.

Substance abuse is very common amongst trauma survivors because it is a quick way to numb feelings and avoid the profound emotional pain and suffering. When an addiction is present, assessment should consider any existing traumatic impacts.

Substance abuse is very common amongst trauma survivors because it is a quick way to numb feelings and avoid the profound emotional pain and suffering.

In mental health programs, it is estimated that 25 to 50 percent of people have a substance use disorder. This is mirrored in drug treatment facilities where it is estimated that 50 to 75 percent of people have a mental disorder.

The two issues cannot be separated because they are so closely interwoven: If the person were not dealing with trauma, they would not feel the need to use substances to cope.

One issue triggers the other. For example, sobriety often reveals unresolved memories and emotional pain. These flood the addicted individual who then uses substances, alcohol, and addicting behaviours to regulate and numb their emotions.

Many mental illnesses are born out of unresolved trauma from childhood. For many people, disorders such as depression, personality disorders, and anxiety disorders are directly related to a history of unresolved trauma. It is here where treatment addresses only the current symptoms and not the root cause. According to Judith Herman, "Survivors of childhood abuse, like other traumatized people, are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete." (Herman, 1992 p.123)

This demonstrates the strong link between trauma, mental illness, and substance abuse. Because the root cause is not addressed, people use substances to manage the pain and push down the memories and negative feelings associated with the trauma. This becomes a negative circle that keeps the person stuck until both the trauma and the substance abuse issues are treated.

These issues can and should be treated at the same time so that the survivor doesn't work on one issue while the other is being neglected. The source of the psychological pain must be addressed to positively impact reduction of substance use. When this doesn't happen, survivors often fall through the cracks of the social service and health systems and receive poor care. The attitude of "You must get clean before you can work on your trauma issues" keeps survivors stuck.

It is important to let survivors know that it's normal to use substances to cope with the overwhelming emotions, and that help exists for reducing or stopping substance use and for addressing the traumatic issues.

CODI

The Co-occurring Mental Health and Substance Use Disorders Initiative of Manitoba (CODI) was undertaken as a partnership project of the Winnipeg Regional Health Authority, The Addictions Foundation of Manitoba, and Manitoba Health. This is a systems change model that is committed to the Comprehensive, Continuous and Integrated System of Care, an integrated mental health and substance abuse philosophy that aims to efficiently use existing resources and utilize best practices. Part of this process is a comprehensive training program for service providers in mental health and addictions services. There are eight best practice principles and accompanying clinical training guidelines. This training is offered regularly in the City of Winnipeg. Please see the Training area of this Toolkit for more information (page 82).

"It's like I can live without fear of being harmed again. Sometimes I still feel scared, but I know that I am stronger now and I'm a better person for having gone through it. I feel like my recovery is well on its way now." (Trauma survivor, 2008)

Trauma Recovery

Recovery is the core goal for trauma survivors, their families, and their treatment providers. Recovery does not necessarily mean complete freedom from post-traumatic issues. However, it does mean regaining the understanding, support, and practical assistance so that trauma survivors can find within themselves a genuine basis for hope, as well as personal, relational and spiritual renewal (Connecticut Department of Mental Health and Addictions Services).

Important Aspects of Trauma Recovery

Herman (1992) conceives trauma recovery to proceed in three stages:
- Safety and Stabilization
- Remembrance and Mourning
- Reconnection

Safety and Stabilization

The central task of recovery is safety. Clients may feel they lack control over their emotions and other issues that stem from the unresolved trauma. Helping clients to realize what areas of their life need to be stabilized and how that will be accomplished will help the client move toward recovery. For example:

- a trauma survivor struggles with containing difficult emotions in everyday life that stem from the trauma
- a service provider helps the survivor contain these emotions
- they work together as a team to stabilize the emotions so the survivor can move on with the recovery process. This process takes time and varies from person to person.
- Some people who experienced trauma, particularly complex trauma, find that speaking about their experience or the impact of their experience emotionally overwhelming. Recently, both therapists and researchers have been exploring nonverbal ways to foster emotional regulation. Several studies have suggested that Mindfulness Based Stress Reduction (MBSR) groups and the use of acupuncture for clients with PTSD reduce negative emotions and promote a more calm appraisal of life situations (Hollifield, 2007 and Davidson et. al., 2003). These practices work well with

more traditional talk therapies allowing greater stability throughout recovery. Auricular acupuncture has the added advantage of reducing cravings for alcohol and drugs as well as promoting better sleep and clearer thinking among clients who receive it regularly (Stuyt, 2005). It is also well suited for supporting work with refugees and immigrants in that it is nonverbal and closer to the methods of traditional medicine found in their own cultures.

Remembrance and Mourning

When clients feel stable, the task shifts to recounting the trauma, putting words and emotions to it, and making meaning of it. This process is usually undertaken with a counsellor or therapist in individual and/or group counselling.

Reconnection

The final stage of recovery involves redefining oneself in the context of meaningful relationships. Trauma survivors gain closure on their experiences when they are able to see the things that happened to them with the knowledge that these events do not determine who they are. They are liberated by the belief that, regardless of what happened to them, they always have themselves.

In many instances, survivors find a mission through which they can continue to heal and grow, such as talking to youth, or peer mentoring. Successful resolution of the effects of trauma is a powerful testament to the resiliency of the human spirit.

Other aspects of trauma recovery

- Assist the client in connecting with services that are central to recovery: health and mental health services, addictions services, therapeutic services, crisis services, culturally appropriate/relevant services, traditional healing services.
- Partner with the client as they define what recovery means to them.
- Consider the client's cultural context and include social supports that help them connect to the community.
- Encourage and assist the client in connecting with themselves, safe family members, friends, culture and community in a meaningful way.

Successful resolution of the effects of trauma is a powerful testament to the resiliency of the human spirit.

Trauma-informed

The Resilience of Trauma Survivors

"Being a trauma survivor means that I have remarkable coping skills, intuition, and resiliency. Contrary to what many (including other survivors) may think, trauma survivors can be, and often are, highly functioning individuals. Even though we sometimes have an inability to care for ourselves and make safe choices, this does not mean we are strangers to ourselves and do not know our needs."
(Trauma survivor, Provincial Trauma Forum, 2007)

Too often, programs focus so intently on the problems that they miss the strengths and resilience people bring to the human service setting. Just as we spend time and energy on focusing on the impact of trauma, we must spend equal time on how people survived the experience, the strengths they have developed from having survived it, and how that resiliency has, or will help, in their recovery.

Traditional helping approaches highlight pathology or illness, and inadvertently give the impression that there is something wrong with a person rather than that something wrong was done to the person (Elliot, et al., 2005). When working with survivors of trauma, it is crucially important to make the distinction between who they are as human beings and what was done to them. Survivors tend to blur these lines and it is our task to make this distinction clear in our work with them.

Trauma-informed practice recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important even when past coping behaviours are now causing problems. Understanding a symptom as an adaptation reduces a survivor's guilt and shame, increases their self-esteem, and provides a guideline for developing new skills and resources to allow new and better adaptations to the current situation (Elliot, et al., 2005).

The language we use when speaking with trauma survivors should also reflect resilience. The term "survivor" was coined to counteract the sense of powerlessness that "victim" implies.

Common traumatic experiences in communities can be a uniting force that builds collective resiliency and is viewed as strength- and capacity-building.

Working from a resilience-minded perspective helps trauma survivors realize that they have the skills they need to heal and recover. However, many survivors do not see these and need their coping behaviours and knowledge reframed from weakness to strength. This is a chief part of trauma-informed practice.

Service Providers: qualities and characteristics essential to working with trauma survivors

"A big part of my recovery and decision to start dealing with my past was talking to my Minister. He helped me to feel comfortable, like I was normal, and I was accepted by him unconditionally, even though I talked about doing drugs and crime. He seemed to really listen and I never felt bad or stupid around him. This was a new experience for me. I still keep in contact with him and do talks at the AA meetings at the Church." (Trauma survivor, 2001)

Working with trauma survivors is tough work, and can be emotionally draining. The stories and situations that they may describe can make a provider feel many emotions, including sadness, pity, frustration, hopelessness, anger and disbelief. The skills and characteristics outlined below are essential in building strong relationships with trauma survivors. Strong provider/survivor relationships are the foundation of helping and recovery.

Empathic:

Survivors need to feel supported and understood, not pitied. So rather than being sympathetic, providers need to demonstrate empathy by communicating an understanding of feelings to the individual. For example, "I get the sense that you are feeling sad and hurt by what happened". This statement does not imply judgement, but rather that you are trying to understand where they are coming from.

Able to talk openly:

In order to be helpful to trauma survivors, providers need to be able to talk openly about issues, feelings and experiences related to the trauma. It is up to the trauma survivor to disclose these things, and there is no right way to do this. The amount or nature of the information is not relevant. If you come across as uncomfortable or unable to say certain words, it communicates to the survivor that you don't want to hear it; survivors will feel bad and this can be harmful.

Strong provider/survivor relationships are the foundation of helping and recovery.

Self-aware:

Providers who are self-aware of their feelings, thoughts, and how they come across are more likely to invite trauma survivors to discuss their feelings more openly. Survivors will sense this, leading to a stronger helping relationship.

Flexible:

Providers must be flexible when working with trauma survivors in order to demonstrate care and concern. This can include a willingness to change normal routines or procedures to accommodate some trauma survivor's difficulties with, for example, medical exams or office space.

Comfortable with the unknown:

Someone else's experience of trauma may not be something with which the provider can directly relate. This can provoke feelings of discomfort and a need to provide familiarity. Staying open to different possibilities and trusting the survivor's needs will allow you to be more effective in keeping the survivor feel more grounded.

Willingness to learn from survivors:

Providers are often considered experts. However, when providers position themselves as experts in relation to their clients, it makes clients feel less than. You are not the expert of your clients' lives; they are the experts, and you must be willing to learn from them. Letting them teach us about their world is the best way to become knowledgeable.

Willingness to connect emotionally with the trauma survivor's experience of trauma:

In order to make a strong connection with trauma survivors, providers must make a connection beyond only facts and symptoms. Feelings and emotions play a central role in your work with survivors. This type of connection allows survivors to feel accepted and genuinely cared for.

Willingness to step into the world of the survivor:

Providers must be willing to step into the shoes of the trauma survivor for the time they share together. This will make a strong connection and create a solid understanding of what it is like for that person to live with the trauma.

Able to regulate own emotions:

Given the intense emotions that can result from discussions with survivors, providers need to be able to regulate these emotions and stay grounded during and after work with survivors. Survivors themselves may present as unable to regulate their emotions, so it is your job to stay calm and demonstrate emotional regulation.

Able to treat the survivor as an equal:

In order not to pathologize trauma survivors, providers need to treat survivors as equals and not act on a belief system that survivors are weaker and less resourceful. When trauma survivors are treated as equals, their strengths and resources are highlighted.

Good listener:

Providers must be willing to actively listen to trauma survivors by focusing solely on what they are saying and showing genuine interest. This will encourage the survivor to open up and share information and feelings that will help in healing and recovery.

Willingness to debrief:

If the provider is to be successful in processing the experience, it is important that they be able to debrief with co-workers about their contacts with trauma survivors. It is normal to be left with difficult feelings after conversations about trauma, or its impact. You are more helpful when you can share with others your feelings and thoughts about the experience.

Trauma-informed services do not need to be focused on treating symptoms or syndromes related to trauma. Rather, regardless of their primary mission – to deliver primary care, mental health, addictions services, housing, for example – their commitment is to provide services in a manner that is welcoming and appropriate to the special needs of trauma survivors (Harris & Fallot, 2001).

Guidelines for Working with Trauma Survivors

Strengths-based Perspective

Focusing on strengths instead of weaknesses is a basic tenant of work with all people, but especially with trauma survivors who may see themselves as inherently weak due to their experiences. Working from a strengths-based perspective is part of a process of relationship and trust building.

> Focusing on their strengths engages clients in their own process of change by instilling hope about the ultimate possibility of changing and creating a better life for themselves and their family (ARC Community Services, Madison, WI).

Conversations with trauma survivors should be nonjudgemental and occur within a context of compassion, empathy and humanity. The primary focus is on rapport and relationship building, as well as the client's own capacity for survival and healing.

This non-authoritarian approach views the client as the expert in their own life, and as a whole person rather than just an illness or mental health label. As a result, the treatment of their trauma symptoms encompasses their mind, body, soul and spirit.

How We Talk to Trauma Survivors

In any verbal message, the part of language that has the most impact is how we say it. We need to be cognizant of the words we choose, the tone we use, and how our statements and questions are phrased.

Conversations with trauma survivors should be nonjudgemental and occur within a context of compassion, empathy and humanity.

Important points to consider

Some important points on language and what we need to consider when working with trauma survivors are:

- Since English is often a second language, make sure that people who do not speak English as a first language understand the process.
- Use appropriate language at the client's level of understanding.
- Don't use jargon.
- Acknowledge non-verbal communication as verbal communication. Some people communicate more through behaviour than with words.
- Acknowledge silence as a way of communicating. Some people can't speak about it, or need time to feel comfortable.
- Clarify anything you do not understand or are confused by. Some people will speak indirectly about trauma. For example, *"He was bothering me"* could mean *"He was abusing me"*.
- Use language that does not denote assumptions or judgements. Your inner assumptions should never be reflected in your language.
- Don't always refer to perpetrators as *"he"*, and victims as *"she"*, or vice versa. We know that victims and perpetrators of violence can be both sexes.
- Be careful about the label *"offender"* or *"perpetrator"* as it could describe a beloved parent or family member that abused them.

Language and assumptions

If we want trauma survivors to hear us and be open to sharing their feelings and needs, then it is important to watch the language we use and assumptions we make. If we approach survivors with a belief system based on negative assumptions, we will perpetuate the cycle and add to the problem. Below is a list of commonly held assumptions that service providers may unwittingly promote, as well as suggestions for turning

these unhelpful responses into helpful belief systems that will assist the person with their recovery.

UNHELPFUL ASSUMPTION	HELPFUL RESPONSE
■ "This person is sick."	■ "This person is a survivor of trauma."
■ "They are weak."	■ "They are stronger for having gone through the trauma."
■ "They should be over it already."	■ "Recovery from trauma is a process and takes time."
■ "They are making it up."	■ "This is hard to hear, and harder to talk about."
■ "They want attention."	■ "They are crying out for help."
■ "Don't ask them about it or they will get upset."	■ "Talking about the trauma gives people permission to heal."
■ "They have poor coping methods."	■ "They have survival skills that have got them to where they are now."
■ "They'll never get over it."	■ "People can recover from trauma."
■ "They are permanently damaged."	■ "They can change, learn and recover."

Asking About Traumatic Experiences

Having knowledge about the experience of trauma survival is important. Equally important is knowing how to ask about it and acknowledge it in a way that feels comfortable and genuine, and is appropriate in the current circumstances. There are times when asking about trauma is not appropriate, and/or the provider must be cognizant of guiding the conversation in a way that doesn't lead the trauma survivor to feel overwhelmed. A series of scenarios below outlines how to appropriately ask about trauma and respond in different circumstances.

How do I ask about trauma when a person doesn't come out and say it, but gives other indications that they are having difficulties?

SCENARIO:
You are having a conversation with someone who is talking about feelings, behaviours, and thoughts that indicate they could be dealing with unresolved trauma, but they do not say that this is an issue for them. You are not sure how to address it, but feel it should be addressed.

APPROPRIATE RESPONSE: Ask for clarification or for the individual to help you understand why the feelings, etc., are present. Invite them to talk more in depth about the trauma that may have occurred and is currently affecting them negatively. For example, *"What are your thoughts about what these feelings might be connected to?"* or *"I'm wondering if you could expand a bit on some feelings and thoughts you have mentioned to help me understand how to be helpful."*

INAPPROPRIATE RESPONSE: Not providing a context for why you are asking. *"You must have been abused"* or *"Was it a traumatic experience in your past that you haven't dealt with yet that is causing these feelings?"*

What if I ask about the trauma and say the wrong thing and make it worse?

> **SCENARIO:**
> An individual is describing traumatic experiences at the hands of their mother during their childhood. They are very emotional, and you feel quite moved and saddened by their experiences. You take your time to decide how you would like to address this because you want to help them feel accepted and comfortable.

APPROPRIATE RESPONSE: You will not make the situation worse if your response is validating, nonjudgemental, and accepts the person's feelings and their right to feel that way. For example, *"Sounds like you are going through a hard time and that makes sense given what you've already gone through."*

INAPPROPRIATE RESPONSE: Making discounting statements or ignoring their strong feelings can make the situation worse for the trauma survivor because it reinforces negative belief systems. For example, *"That was a long time ago. Let's move on."*

What if I say something that comes out wrong and what I really meant gets lost?

> **SCENARIO:**
> A woman is describing a painful traumatic experience involving witnessing killings in her village in her home country. You feel empathy and support for her situation, but what you say is...

APPROPRIATE RESPONSE: You see the discomfort on her face, and realize what you said was just phrased improperly. You say, *"I'm sorry. That came out wrong. What I meant to say was, that was a terrible experience, and I'm so glad you were able to find safety."* This response shows the woman that you are human and able to admit when you've made a mistake.

INAPPROPRIATE RESPONSE: *"That's awful. Aren't you glad you live in Canada now?"* This discounts her situation and makes an assumption that things are better now.

What if someone discloses trauma and they want to tell me all about it, but it's not my role or responsibility to be a counsellor?

SCENARIO:
A young woman discloses that she was sexually assaulted a few months ago. She goes on at length about the situation, asking you for advice and stating she feels she needs to work on the impacts that she is just now acknowledging. She says she feels comfortable talking with you.

APPROPRIATE RESPONSE: Acknowledging the feelings and courage it takes to disclose trauma is important, but it is not necessary for you to counsel people if this falls outside the realm of your role. A more appropriate response is to refer them to the service that fits for them and that they are willing to use. For example, *"This is a hard time for you, and I thank you for sharing this with me. Sounds like you have a lot to talk about and I'm wondering if counselling is an option for you right now?"*

INAPPROPRIATE RESPONSE: Shutting a person down by cutting off the contact: *"I'm not a counsellor, so I can't help you, but here's the number for some services."* Or conversely, trying to provide counselling that is outside your role: *"I'm not a counsellor, but I can try and give you the best advice I can."*

How do I ask men about trauma in a way that may help them feel more comfortable in discussing their feelings and experiences?

SCENARIO:
You are speaking with a man in his mid-40s who says his childhood was really hard, and that he lived in fear of his father for most of it. You ask him if his father abused him and his reply is, *"Yeah, he was really mean and he'd let you know with his fists when he was angry. He also knew how to take it to the next level of humiliation in my room at night."* You feel he is referring to sexual abuse.

APPROPRIATE RESPONSE: Acknowledge his reference to sexual abuse and validate the experience. For example, *"You described physical abuse by your Dad, and I know that abuse can often be sexual, too. Is that what you mean by the humiliation in your room?"* The man says, *"Yeah, he did stuff to me and I hated it, and I never told anyone about it because I was afraid they'd think it was my fault and I was gay."* Responding to this appropriately would invite the man to acknowledge the harsh judgements as a societal myth. For example, *"Abuse is never the fault of the child; you were in a situation where you had no choices. Sexual abuse cannot make you gay because it is used as a weapon, but society sure seems to send us that message. It's not easy to talk about this stuff. I appreciate your sharing it with me."*

INAPPROPRIATE RESPONSE: Not acknowledging the sexual abuse reference. For example, *"I know a lot of guys who were beat up as kids; good thing you've moved on from that now."* This response does not acknowledge the sexual abuse, but does assume he's over it. This sends the message that you don't want to hear about the sexual abuse.

Are there times when I shouldn't ask about the trauma?

SCENARIO:
You are speaking with a woman whose emotions of panic, anxiety and hopelessness are very strong. She seems overwhelmed, distracted, and in need of immediate help. She states that she's been bombarded with memories and flashbacks recently, has missed work, is crying a lot, and isn't really feeling she's in reality. She needs help now.

APPROPRIATE RESPONSE: Acknowledge her feelings and fears and assess her current situation as someone who is in crisis and having difficulty containing her emotions and dealing with daily functioning. This individual is not physically or mentally able to function properly, so asking about the trauma may exacerbate the situation by adding to her inability to cope. Instead, you could ask, *"How can I help you now? What needs to happen to help you feel more under control now?"*

INAPPROPRIATE RESPONSE: *"Sounds like you are dealing with trauma. Do you have time to talk about the memories and how they are impacting on*

you now?" This response ignores the immediate needs of safety and stabilization this woman needs, and focuses instead on issues that are longer term.

Do I need to get all the details of the trauma in order to understand where the survivor is coming from and for them to heal?

SCENARIO:
You are speaking with a veteran who states that the war is still with him in his mind and he feels like he just left Germany yesterday. He wonders if the pain will ever go away.

APPROPRIATE RESPONSE: Acknowledge his statement, but do not ask for specific details or the whole story of the trauma unless the survivor indicates that this is an important part of recovery for them. Just asking about the feelings and impacts of the trauma is all that is necessary to encourage healing and recovery. For example, *"Seems that an experience like war can really stay with you. How do you make sense of the experience now?"* This focuses on the impact of the trauma, which is current.

INAPPROPRIATE RESPONSE: Focusing on getting the whole story of the trauma, including details of specific incidents. For example, *"Can you please start from the beginning and tell me in detail about your experiences that are still painful?"* This provides too much information that may not be necessary to recovery and may actually set the individual back because the memories are still too painful.

What if I become frustrated with people because I sense they are trying to be difficult by withholding information?

SCENARIO:
You are speaking with an Aboriginal man in his 50s who suffers from depression. He says very little about his feelings, and does not make eye contact. When you ask him about his depression, he provides little information and seems uncomfortable, like he doesn't want to be there,

even though he came voluntarily. You become frustrated, low on patience, and wonder why he can't just be "normal".

APPROPRIATE RESPONSE: Ask about his discomfort and what you can do differently to accommodate him so he can benefit from the meeting. Understand what his "normal" way of communicating is and place your work with him in that context.

INAPPROPRIATE RESPONSE: Being judgmental, and allowing your emotions to interfere with service. For example, *"I can't help you if you don't give me information."*

Trauma-Informed Practice

Best practices of working with trauma survivors are rooted in the following areas:

- Relationship building based on respect, trust and safety
- Using a strengths-based perspective when working with people.
- Frame questions and statements with empathy, being careful not to be judgmental.
- Frame the client's coping behaviours as ways to survive, and explore alternative ways to cope as part of the recovery process.
- Respond to disclosure with belief and validation that will inform practical issues related to care (Havig, 2008).
- Help the client contain difficult emotions before focusing on recovery.
- Acknowledge that what happened to the client was bad, but that the client is not a bad person.
- Recognize that the client had no control over what happened to them. Let them know that the way they survived during the traumatic experiences was actually their way of resisting what was happening to them and of saying no, even if it did nothing to stop the perpetrator.
- Provide an appropriate and knowledgeable response to the client that includes concerns they may have regard-

ing the services and then using this knowledge to guide service delivery.

■ Watch for triggers and trauma reactions and making efforts to reduce these.

Providing and receiving information

■ Inquire about trauma history and facilitate a supportive discussion with the client while keeping it contained.

■ Make sure the client is comfortable with the conversation.

■ Check in with the client to make sure the discussion of trauma feels safe and not overwhelming.

■ Make time for questions and concerns that the client may have.

■ Write things down for clients who may dissociate during encounters.

■ Provide a suicide risk assessment where indicated and follow up with the client when the risk has passed.

■ Inquire about a possible history of trauma if a client is perpetrating abuse themselves.

Creating a climate of hope and resilience

■ Acknowledge the client's abilities to transcend adversity.

■ Acknowledge the strengths it takes to get to where the client is currently.

■ Make reference to the client as "a survivor", and focus on healing and recovery as "possible".

■ Move beyond just survival to a context of a healing process, and let the client decide what their path to healing consists of.

■ Let the client know that you believe in them and support their efforts to heal.

Providing choices

- Involve the client in the decision-making process re: treatment/service options.
- Inquire about counselling in the past and offer referrals if indicated
- Ensure that the client feels comfortable in invasive assessments and procedures, and make adjustments to these processes where clients request it.
- Inform before performing – continually inform the client of what is happening during health care encounters and assessments (Havig, 2008).
- Give the client choices about referrals where possible.
- Involve other service providers that are currently involved in the client's care.

Culturally appropriate/informed

- Have the knowledge and skills to work within the client's culture by asking them about it, and understand how your own cultural background can influence transactions with the client (Elliot, et al., 2005).
- Understand the meaning the client gives to the trauma from their cultural perspective.
- Understand what healing means within the cultural context.
- Be open to being educated, and ask questions about the culture.
- Be open to referring clients to traditional healing services, and become educated on traditional Aboriginal healing ways.
- Be involved in the cultural community that is served.
- Advocate on behalf of clients who speak English as a second language or are newly negotiating Canadian human services.
- Work through historical distrust – issues may exist from the past that interfere with effective service provision. Understanding that this is normal and not personal will help in building a strong relationship (Brokenleg, 2008).
- Teach Western ways as skills, not identity replacement (Brokenleg, 2008).

"**This huge panic came over me and all I could think was, 'Please let me get to my car, please...'. I started running; all the while visions of me being raped were going through my head. I heard someone call my name, and it was my co-worker running after me with my purse. The fear I felt that day scared me. I was never like that before.**" (Guidance counsellor, 2005)

Effects on Service Providers: Vicarious Trauma

Working with trauma survivors is hard work. As with anything, there are the good aspects – strength and resilience building, personal growth, and being a witness to incredible progress and change – and the difficult aspects – knowing about human cruelty and the devastating impact it has on the people we work with.

Working with trauma survivors puts us at risk of developing vicarious trauma. This term refers to "the cumulative, transformative effect on the provider working with survivors of traumatic life events" (Saakvitne & Pearlman, 1996).

Vicarious trauma is the experience of bearing witness to atrocities that are committed human against human. It is the result of absorbing the sight, smell, sound, touch and feel of the stories told in detail by survivors who are searching for a way to release their own pain (Health Canada, 2001).

Just as being a primary victim of trauma transforms clients' understanding of themselves and the world around them, so, too, does bearing witness to it, sometimes in detail. Providers become secondary victims of trauma when they form relationships with trauma survivors and are privy to the information that caused such terror, shame and sadness for clients. Providers are vulnerable because of their empathic openness, which is a necessary part of the helping process.

Vicarious trauma can be seen as an occupational hazard that is almost unavoidable when hearing about traumatic experiences. Just as PTSD is on a continuum, so is vicarious trauma. The more traumatic material the provider is aware of, the more likely they are to develop vicarious trauma. This is normal and is completely manageable with strong workplace and social supports.

Vicarious trauma disrupts our belief and assumptions about self and the world in seven core areas (Malaviya, 1997):

Frame of reference:
Identifying too closely with clients' situations of helplessness, horror, sadness and cruelty disrupts our frame of reference, our comfort zone, and our basic beliefs that people are good and the world is safe.

Safety:
Loss of safety due to so much knowledge about how others take advantage of vulnerable people.

Trust and Dependency:
We become aware of violations of trust, and that clients become dependent on abusive people.

Power:
We may identify with clients' feelings of helplessness and powerlessness, and take it on to the disadvantage of our client.

Independence:
We may feel that our own freedom of movement is restricted by the awareness/fear for ourselves.

Esteem:
The perception that people are "bad" can develop because we are exposed to the malicious and cruel behaviour of others.

Intimacy:
Trauma-related providers can feel increasingly alienated and estranged from those who don't do the same kind of work.

Providers may have difficulty managing strong feelings and maintaining a positive view of themselves.

Vicarious trauma is different from burnout, which is the psychological strain of working with difficult populations – high stress with low rewards. Burnout doesn't affect you in the same seven areas as vicarious trauma does.

Managing Vicarious Trauma

Vicarious trauma is manageable if the provider realizes it is impacting in a negative way, and then takes immediate steps to address it. It is important that providers have a clear distinction between work and personal life. Although empathy and genuine connection are critical in working with trauma survivors, providers need to be able to make a separation that allows them to nurture their mind, body, soul and spirit. If providers are not connected to themselves, then they will not be as effective in connecting with clients.

Just as providers encourage their clients to find ways to become more centered and grounded, providers themselves need to practice this.

Vicarious trauma is manageable if the provider realizes it is impacting in a negative way, and then takes immediate steps to address it.

The ABCs of Addressing Vicarious Trauma
(from Health Canada, 2001)

Awareness
- being attuned to one's needs, limits, emotions and resources. Heed all levels of awareness and sources of information, cognitive, intuitive and somatic. Practice mindfulness and acceptance.

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

Connection
- connecting with yourself, to others and to something larger. Communication is part of connection and breaks the silence of unacknowledged pain. These connections offset isolation and increase validation and hope.

Local Resources

Community and Provincial Services for Trauma Survivors

On our web site, www.trauma-informed.ca, we will maintain a directory of appropriate international, national and provincial resources with links to their web site. Below is an example of a provincial overview:

Manitoba

CONTACT

is Manitoba's community resource data warehouse. CONTACT community information is one of the most comprehensive listings of community resources in Manitoba.

- To locate counselling services for trauma survivors in your community visit CONTACT at:
  http://cms00asa1.winnipeg.ca/crc/crc
- Click on "**Locating Services**" ; enter the type of service you are looking for. For example, by entering "**Counselling and trauma**" several services within Winnipeg and Manitoba are available with descriptions and links to the service's website if available.

Winnipeg Regional Health Authority:
Mental Health Programs: www.wrha.mb.ca/community/mentalhealth

Regional Health Authorities of Manitoba:
www.rham.mb.ca

TRAUMA SPECIFIC COUNSELLING SERVICES IN WINNIPEG

Fort Garry Women's Resource Centre
Counselling for Women
1150-A Waverly St. Winnipeg, MB
(204) 477-1123
www.fgwrc.ca

Klinic Community Health Centre
Counselling Appointments (Group and Individual Counselling) for adult survivors of trauma
870 Portage Avenue Winnipeg, MB
(204) 784-4059
www.klinic.mb.ca

Immigrant Women's Counselling Services
Provides counselling services to immigrant and refugee women in family violence, adaptation and post-traumatic stress:
200-323 Portage Avenue Winnipeg, MB
(204) 940-2172
http://norwesthealth.ca/immigrant%20women%27s%20counselling.html

The Laurel Centre
Counselling for women with a history sexual abuse and addiction.
104 Roslyn Rd. Winnipeg, MB
(204)783-5460

Men's Resource Centre
Counselling Appointments for adult male survivors of trauma (Group and individual counselling) (204) 956-6562
301-321 McDermot Avenue Winnipeg, MB
www.elizabethhill.ca/mrc

Mount Carmel Clinic
Multicultural Wellness Program: Provides culturally appropriate counselling to immigrants and refugees who have experienced life crises.
886 Main St. Winnipeg, MB
(204) 582-2311
www.mountcarmel.ca

Operational Stress Injury Clinic
A specialized outpatient program that exclusively serves veterans of the Canadian Forces, current Forces members, and eligible members of the RCMP
Deer Lodge Centre, 2109 Portage Avenue Winnipeg, MB
(204) 837-1301
www.deerlodge.mb.ca/osi/whatis.asp

24-HOUR CRISIS LINES:

Klinic Crisis Line: 786-8686

Toll free: 1-888-322-3019

Klinic Sexual Assault Crisis Line: 786-8631

Manitoba Suicide Line: 1-877-435-7071

Domestic Violence Crisis Line: 1-877-977-0007

Training for Service Providers

Addictions Foundation of Manitoba (AFM):
Regularly scheduled courses in Addictions and co-occurring disorders.
www.afm.mb.ca

Applied Suicide Intervention Skills Training (ASIST):
Regularly scheduled workshops in suicide prevention provided in various locations in Manitoba.
www.livingworks.net/AS.php

Co-occurring Disorders Initiative of Manitoba (CODI):
Nine clinical guidelines for clients with co-occurring disorders. These guidelines are intended for use by trainers, clinical supervisors and program administrators to support the training for clinical staff expected to work with persons who have co-occurring mental health and substance use disorders.

Crisis and Trauma Resource Institute Inc. (CTRI):
Provides professional training and consulting services for individuals, schools, communities, and organizations affected or involved in working with issues of crisis and trauma.
www.ctrinstitute.com

Klinic Community Health Centre:
Workshops provided to service providers at Klinic and within the communities of Winnipeg and throughout the province on Suicide Prevention, Family Violence, Women and transgender women working in sex trade, working with adult survivors of sexual abuse, and auricular acupuncture.
www.klinic.mb.ca

Recommended Websites

Canada

Aboriginal Healing Foundation:
http://ahf.ca

Canadian Mental Health Association Manitoba:
www.manitoba.cmha.ca

Center for Mental Health and Addictions Canada (CMAH)
www.camh.net

Center for Suicide Prevention:
www.suicideinfo.ca

CODI No Wrong Door Newsletter:
www.afm.mb.ca/codi.html

Klinic Community Health Centre:
Manitoba Provincial Forum on Trauma Recovery Forum
Final Report: www.klinic.mb.ca

Men Overcoming Sexual Abuse:
www.mosa.ca

Mental Health Resource of Canada:
www.mherc.mb.ca

www.trauma-informed.ca

United States

The National Center for Trauma Informed Mental Health:
http://mentalhealth.samhsa.gov/nctic/default.asp

The National Trauma Consortium (NTC):
www.nationaltraumaconsortium.org/

Substance Abuse Mental Health services administration's National Mental Health Information Centre (SAMHSA) U.S.A.:
www.samhsa.gov

The Trauma Center at JRI:
www.traumacenter.org

Books for service providers and trauma survivors:
The following website contains a comprehensive list of books on trauma in a variety of areas for service providers and survivors of trauma:
www.parentbooks.ca/Abuse_Trauma_Adult_Survivors_&_Therapists.html

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Feedback

We would appreciate your taking a few minutes to help us in the on-going development of this toolkit and other trauma-informed materials. Your comments, observations and contributions will help improve resources for service providers and ultimately the delivery of services to people effected by trauma.

1) Is this Trauma-Informed Toolkit a good resource for your needs?

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2) What parts of the toolkit did you find the most helpful?

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3) What changed in how you understand trauma as a result of reading the toolkit?

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3) What difference might the toolkit make in how you deliver services in the future?

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3) Were there parts of the toolkit that could be improved or information that was missing?

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5) Do you have any relevant website links or written material you can recommend ?

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6) Other comments?

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Thank you for your feedback.

This evaluation can be forwarded to:
Klinic Community Health Centre
Attn. Tim Wall
870 Portage Ave.
Winnipeg, Manitoba, R3G 0P1
Fax: 1-204-772-7998, email: twall@klinic.mb.ca

Trauma-informed

"**Trauma refers to experiences or events that by definition are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful – they are also shocking, terrifying, and devastating to the victim, resulting in profoundly upsetting feelings of terror, shame, helplessness, and powerlessness.**" (Courtois, 1999)

Trauma-informed