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Challenges with Trauma-Informed Care

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Introduction

Trauma has no limitations regarding age, gender, or any demographic which makes it a problematic and costly health problem (SAMHSA, 2014). Trauma can occur as a result of emotionally harmful experiences such as disaster, loss, neglect, abuse, and violence (SAMHSA, 2014). There is a growing necessity to address trauma as a crucial component of effective behavioral health. However, addressing trauma to treat its survivors poses many challenges and requires a multi-faceted, multi-agency public health approach that is inclusive in education and awareness, prevention and identification, and trauma-specific assessment and treatment.

Trauma-Informed Care (TIC) is an approach presuming an individual has a history of trauma and recognizes the presence of its symptoms (Buffalo Center for Social Research, n.d.). The TIC approach asks, “What has happened to this person?” instead of, “What is wrong with this person?” The goal is to provide support services that are accessible to those in need because without them the possibility of exacerbating symptoms and retraumatization increases. Additionally, TIC seeks to support healing, development, and enable the regulation of emotions throughout a victim's life (Phung, 2022). However, to reach these goals it is imperative to make changes in organizational and clinical practices in the healthcare system (Menschner & Maul, 2016). Once systematic changes occur to accommodate TIC, healthcare providers can recognize the complexities trauma has on patients and understand the key elements of trauma and TIC.

Key Principles

Trauma is conceptualized using the “3 Es”: Event(s), Experience of Event(s), and Effect(s) (Lathan et al., 2021; SAMHSA, 2014). *Events* are the perception of a physical and/or psychological threat to an individual’s well-being. Traumatic events can be physical or psychological abuse, natural disasters, community or intimate partner violence, sudden or unexpected loss of a loved one, and more. However, events being traumatic are dependent on how the individual perceives them. The events can be a single occurrence or repeatedly happen over time. How the individual *experiences* the events determines if the event is traumatic, specifically how they interpret it and how they are impacted by it psychologically and physically. A particular event may be considered traumatic for one but not another. Lastly, the adverse effect of the event is the critical component of trauma. *Effects* can be immediate or delayed with varying duration (SAMHSA, 2014). Traumatic effects can range from hyper-vigilance, numbing, avoidance, and more. All can wear a person down physically, mentally, and emotionally. Once there is a clear understanding of trauma with a patient using the "3 Es", the groundwork for initiating the essential components of a trauma-informed approach can begin.

The four key elements of the trauma-informed approach are known as the “4 Rs”: *Realize*, *Recognize*, *Respond*, and *Resist* (Phung, 2022; SAMHSA, 2014). All levels of the organization should have a basic *realization* about trauma and be consciously aware of how it can affect families, groups, organizations, communities, and individuals (Lathan et al., 2021; SAMHSA, 2014). Furthermore, the trauma-informed approach *requires* the signs of trauma to be recognized. These signs can vary by gender, age, or setting-specific and can be

associated with the effects of trauma, numbing, avoidance, vigilance and much more (SAMHSA, 2014). Additionally, the organization can *respond* by applying the principles into policies and procedures to ensure the program can actively resist retraumatization (Lathan et al., 2021). *Responding* can also include training staff on evidence-based trauma practices, incorporating trauma in mission statements and staff handbooks to promote a healing approach to trauma (SAMHSA, 2014). To achieve being trauma-informed, there is a required system-wide understanding of the relationships between the "3 Es" of trauma and how they can manifest with patients.

Barriers

The gap for mental health treatment is a global issue and TIC faces barriers to implementation into health services (Lathan et al., 2021). Many facilities have systematically failed at inquiring about patients' trauma. Survivors can experience stigmatization and a lack of acknowledgement. Trauma screening is the most fundamental aspect for a trauma-informed approach, but experts can be conflicted on when or how to screen (Evaldas, 2017; Menschner, 2016). Providers express issues with limited time to screen patients and lack of confidence in their ability to diagnose and treat trauma-related ailments. Without screening, providers will remain uninformed and not incorporate the *event*- and *experience*-related factors for therapeutic objectives (Lathan et al., 2021). Patients can subsequently feel hopelessness, betrayal, and ultimately future avoidance of the healthcare system.

Avoidance is an additional challenge that TIC can face and is a core symptom of trauma seen with post-traumatic stress disorder (PTSD) (Chadwick & Billings, 2022; Evaldas, 2017).

Victims of trauma will be reluctant to disclose traumatic experiences and reminders of the event due to stigma or shame associated with their experiences. Additionally, providers perceive avoidance in their patients due to a fear of exacerbating distress further and possibly retraumatization (Evaldas, 2017). When victims who experience doubt and reluctance are then faced with providers who do not acknowledge potential trauma, patients may avoid healthcare services even when evidence-based treatments are available.

Another challenge for implementing TIC is the lack of resources (Evaldas, 2017). Training on evidence-based methods that are effective for trauma survivors is not widely available. Only qualified medical doctors or psychologists that complete trauma-focused trainings are allowed to use a TIC approach. Hoysted (2018), found that the overwhelming majority of medical professionals and organizations do not receive training or education for TIC even though most reported having interest. Additionally, the most frequently reported barrier for many medical professionals was the lack of training which inhibited their ability to apply TIC to patients. The lack of training fosters uncertainty of how and when providers can use trauma-informed approaches (Finch et al., 2020). Subsequently, concerns are raised regarding handling the emotional responses of individuals that experienced trauma (Finch et al., 2020). It is imperative that the barriers be addressed to mitigate retraumatization of patients.

Guidance for a Trauma-Informed Approach

A trauma-informed approach should reflect fundamental principles that can be generalized across different settings (SAMHSA, 2014). Staff and patients should all feel physically and

psychologically safe. Operations and decisions made by staff must be conducted with transparency in order to build and maintain trust between everyone. Establishing clear peer support is important to build safety, trust, and enhance collaboration between all parties. Collaboration places importance on balancing power differences between both staff and clients; everyone plays their own role in TIC and each one is crucial for healing. Empowerment strengthens an individual's experience and cultivates self-advocacy. Finally, trauma-informed approaches should recognize and be adaptable to cultural, historical, and/or gender issues. An organization with a strong TIC approach can move past cultural stereotypes and biases to leverage the healing value when addressing trauma.

Developing a trauma-informed approach requires multiple levels of organizational change that are in alignment with the key principles (SAMHSA, 2014). Health care providers can train staff, but broad organizational changes must be implemented to be successfully trauma-informed. Leadership can communicate strategies for changes to both staff and patients (Menschner & Maul, 2016). Engaging patients with planning is useful as they provide first-hand perspectives to inform the changes. Training all staff, clinical and non-clinical, is important to create a skilled, trusting, and non-threatening environment. Non-clinical staff interact with patients frequently and play important roles in trauma-informed settings. Additionally, risk of secondary trauma to staff must be acknowledged. Secondary trauma is when emotional duress occurs when learning of firsthand trauma of another. Training on awareness of secondary trauma, allowing staff to explore traumas, supporting reflective supervision, and mental health days for staff are all possible solutions to secondary trauma.

Conclusion

Trauma is a pervasive and costly health problem affecting individuals, regardless of demographics. The prevalence of traumatic events highlights the urgency in addressing trauma as a component of effective behavioral health. Trauma-informed care recognizes the presence of trauma symptoms and aims to provide appropriate services. The key principles of a trauma-informed approach, including realizing the impact of trauma, recognizing the trauma signs, responding effectively, and resisting retraumatization, form the foundation for implementing TIC. However, barriers such as a lack of provider competence, avoidance from patients, and limited resources can inhibit progress. Overcoming these barriers requires organizational and clinical changes. After adopting a trauma-informed approach, healthcare organizations can better support trauma survivors and contribute to their healing and well-being.

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