An overview of Trauma-Informed Approaches (TIA)

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Key points

- Trauma is diverse and varied and can have lasting impacts on how a person interacts socially and builds healthy relationships well into adulthood.
- Trauma-informed approaches aim to educate individuals, organisations, and communities about the effects of trauma on a person.
- Numerous models of trauma-informed approaches have been developed, however, the three most prominent are the Sanctuary Model, the ARC Model, and the CARE Model.
- These models have in common a top-down approach to educating systems about trauma, from the community and organisational levels through to the individual practitioner and front-line staff.
- There is limited empirical evidence on these models and none on the use of these models in a domestic abuse setting.

What is trauma?

Trauma refers to single or multiple events that are experienced as harmful or life-threatening and that have lasting impacts on mental, physical, emotional, and/or social well-being well into adulthood (SAMHSA, 2014; Terr, 1991).

Trauma can be done to oneself or witnessed as something being done to someone else.

Common examples include domestic abuse, neglect or family separation. Less common examples are community violence, such as bullying, gang culture, sexual assault, homicide and war. It can also include social trauma, such as inequality, marginalisation, racism and poverty, and historical trauma, which is the legacy of violence having been committed against entire groups, for example slavery, genocide, and the Holocaust (Sweeney et al, 2015).

Trauma can overwhelm a person's ability to cope in normal situations and affect their sense of safety, self-regulation, and approach to developing relationships.

People who experience trauma often struggle with social responsibility and building healthy relationships. The effects can be demonstrated through their behaviour, rather than verbal explanation of their emotions. Making sense of their emotions is difficult and can lead to reliving events and re-traumatisation.

Psychological symptoms often fall into three basic categories:

1. Hyperarousal - The person is in a permanent state of alert mode as if the danger could return at any minute. In this state a person is easily startled, reacts irritably to small provocations, and sleeps poorly.
2. Intrusion - The person relives the event as though it continues to recur in the present and even small reminders can bring about memories.
3. Constriction - The person escapes their situation by a demonstrating indifference, detachment, or passivity.

What is a Trauma-informed Approach?

A trauma-informed approach was first introduced in the United States as a response to growing awareness that health services were not designed to recognise the impact of trauma in children, young people and adults. It was recommended that services to focus on returning *"a sense of control and autonomy to the [trauma] survivor"* (Harris and Fallot, 2001).

Trauma-informed approaches have built on the Adverse Childhood Experiences (ACEs) research and the link between childhood trauma and behaviours in adulthood. There is no universal definition of what a trauma-informed approach is, but it has been described as:

"a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development" (Paterson, 2014).

Approaches encourage services to become informed about trauma at an organisational level, community level and individual level by understanding how trauma shapes individual behaviour. They encourage relational and strength-based practice and language, for example by asking *What has happened to you?* rather than *What is wrong with you?*

Adult services have developed clear practice principles which include recognising trauma, resisting re-traumatisation, trustworthiness, and transparency. However, trauma-informed practice focuses mainly on the relationships that are established between organisations, workers and individuals rather than a list of prescribed interventions.

As the idea of trauma-informed approaches have gained support in the USA, in 2014, the United States Federal Substance Abuse and Mental Health Services Administration (SAMHSA) introduced trauma-informed practice guidelines which comprise:

1. Establishing a safe environment,
2. Developing trustworthiness and transparency,
3. Offering systems of peer support,
4. Promoting collaboration and mutuality between staff and participants,
5. Supporting the empowerment, voice, and choice of survivors, and
6. Attending to cultural, gender, and historical issues.

Trauma-informed Models

Due to the varied nature of trauma-informed approaches, a number of frameworks have been developed. These include the Addictions and Trauma Recovery Integration Model (ATRIUM) for survivors of sexual and physical abuse who exhibit substance abuse and other addictive behaviours. The Seeking Safety Model is designed to attend to both PTSD and substance use disorders. Furthermore, there is the Trauma Recovery and Empowerment Model (TREM) that supports women trauma survivors. This list is by no means exhaustive and many models have been developed to address specific needs.

This section outlines three primary frameworks of trauma-informed practice that are more general.

Sanctuary Model

The Sanctuary Model was developed by Sandra Bloom in the late 90s. The focus of this model is to create organisational cultural change and is structured on universal training of all staff in the organisation to define problems in a trauma-informed way, understand toxic stress, working together and creating non-violent, therapeutic communities. Its primary outcome aims are to reduce the number of critical incidents, reductions in child and staff injuries, improved staff morale and reduced staff turnover.

The Sanctuary model is inclusive of a wide range of therapeutic services, such as educational and rehabilitative that are also trauma informed.

It is built upon four pillars:

1. Trauma theory - Provides a scientific underpinning for the model
2. Sanctuary commitments - Provide values and trauma-informed goals
3. SELF conceptual framework – This is a shared language of talking about trauma
4. Sanctuary toolkit - Provides tasks and exercises centred around building community engagement and awareness through regular community meetings, implementing safety and self-care planning, and delivering a psychoeducational curriculum.

According to the model, its success is dependent on the ways in which groups of people implement the methodology and nature and quality of relationships built between staff and service users.

Current research

Limited empirical evidence exists on the Sanctuary Model. In 2005, Rivard et al published preliminary results from a study on the implementation and short-term effects of the model as it was being implemented in residential treatment programs for youth.

In 2003, Wright et al evaluated a 6-week voluntary inpatient treatment programme for treat patients with PTSD. The study examined whether the programme reduced symptoms of PTSD and whether symptom reduction was maintained over a 1-year follow-up period. The study found that both the frequency and the intensity of PTSD symptoms were reduced at discharged, at 3-months and at 1-year post-discharge.

ARC Model

The Attachment, Regulation and Competency (ARC) Model is focused on supporting children, adolescents, and foster caregivers.

Attachment is centred around strengthening the caregiving system surrounding children through enhancing supports, skills, and relational resources for adult caregivers. Regulation emphasizes cultivating youth awareness and skill in identifying, understanding, tolerating, and managing internal experience. Finally, competency addresses key factors associated with resilience in stress-impacted populations.

This model has developed over four areas of study:

1. Normative childhood development
2. Traumatic stress
3. Attachment
4. Risk and resilience.

The framework is both an individual level clinical intervention, to be used in treatment settings for youth and families, and as an organizational framework, to be used in service systems to support trauma-informed care.

Blaustein and Kinniburgh have published a book on the ARC Model titled *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. The ARC curriculum contains 9 sessions developed specifically for child welfare agencies to use to train foster parents to better care for children who have had traumatic experiences. Each of the sessions focuses on a different theme starting with understanding trauma and the behaviours displayed in children and young people who have experienced trauma, through to developing healthy and positive relationships and developing an understanding of identity and self. The ARC model encourages organisation employees to participate in the training in order to develop a shared language and communication plan.

Each organisation may choose to use ARC differently depending on the context they are working.

Current research

More research has been conducted on the ARC model, such as Gabowitz et al (2007), Arvidson et al (2011), and Hodgdon et al (2016; 2013).

Most notably, in 2015, Boel-Studt (2015) conducted the first quasi-experimental examination of the effectiveness of the ARC model in psychiatric residential treatment (PRT) facilities serving trauma-affected children and adolescents. The results showed that youth who received the model experienced greater improvements in functional impairment and had fewer seclusion room incidents.

Recent research by Hickle (2020) drew upon focus group data from an evaluation of a trauma-informed approach (TIA) implemented by an organisation in Southeast England. The study highlighted that choice and control is linked to feelings of physical, emotional and relational safety and that feeling safe is a key component to trauma recovery.

CARE Model

The Children and Residential Experiences (CARE) model takes a full systems approach to organisational cultural change when creating a trauma-informed environment. However, it has been developed to work with traumatised children, and includes the family in the care, treatment and planning as a core principle.

It is focused on providing training to staff at every level of the organisation, supported by the following six guiding principles:

1. Developmentally focused
2. Family involved
3. Relationship based
4. Competence centred
5. Trauma informed
6. Ecologically oriented.

Current research

There has been very little empirical research on the CARE Model. In 2010, a survey study collected data from 41 staff members at four agencies in South Carolina where the model had been implemented since 2006 (Holden et al, 2010). This study examined staff knowledge of the core concepts of CARE before and after training, their reactions to the training and their intention to modify their practice according to the CARE principles. Staff demonstrated increased knowledge of the CARE concepts once completing the training, however, it was hypothesised that staff application of the knowledge they had learned depended on how relevant they perceived it and the amount of support the agency gave the model. There are currently no studies on the effectiveness of the CARE model.

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