HOW CAN TRAUMA INFORMED CARE BE USED TO SUPPORT HIGH SCHOOL STUDENTS WITH INTERGENERATIONAL TRAUMA AND POSTTRAUMATIC STRESS DISORDER

by

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APPROVED BY _____

Dedication

I would like to express a thank you to my family for supporting me during my academic journey:

my husband, Nathan Jongenburger, for your “go for it” attitude and unwavering support,

my mom, Kimberly Jones, for your constructive edit suggestions and hugs,

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“The days are long, but the years are short.”

- Kim Jones

Abstract

Approximately 60% of Canadians will have experienced at least one traumatic event as a child (Joshi et al., 2021). A high prevalence of trauma among youth, combined with a large number of children with undiagnosed trauma symptoms (Scheeringa et al., 2011), indicates a need for a theoretical framework within the education system to support the health and well-being of students who have experienced a traumatic event. Trauma informed care utilizes a trauma-informed and strength-based approach which is beneficial to all students and staff within the education system. This paper reviews trauma informed care, intergenerational trauma, and posttraumatic stress disorder, and discusses the benefits of adopting trauma informed care within educational policies, procedures, and practices. Recommendations are provided to educators for support of youth with intergenerational trauma and posttraumatic stress disorder.

Keywords: TRAUMA; TRAUMA INFORMED CARE; POSTTRAUMATIC STRESS DISORDER; INTERGENERATIONAL TRAUMA; TRAUMA INFORMED; STRENGTH-BASED; SECONDARY SCHOOL; EDUCATION SYSTEM

Table of Contents

HOW CAN TRAUMA INFORMED CARE BE USED TO SUPPORT HIGH SCHOOL STUDENTS WITH INTERGENERATIONAL TRAUMA AND POSTTRAUMATIC STRESS DISORDER

Chapter 1: Introduction

"Allowing a student with a hidden disability to struggle academically or socially when all they need for success are appropriate accommodations, is no different than failing to provide a ramp for a person in a wheelchair"

- Joe Becigneul

Introduction

Approximately 60% of Canadians will experience at least one traumatic event as a child (Joshi et al., 2021). A high prevalence of trauma among youth combined with a large number of children that remain undiagnosed with trauma symptoms (Scheeringa et al., 2011), indicates a need for a theoretical framework in the education system that supports the health and well-being of students who have experienced a traumatic event. Trauma informed care utilizes a trauma-informed and strength-based approach which is beneficial to all students and staff regardless of a trauma experience. This paper includes a literature review of posttraumatic stress disorder (PTSD), intergenerational trauma, and trauma informed care, and provides recommendations for implementation of trauma informed care within a school system to support high school students with PTSD and intergenerational trauma.

Background Information

When a person has experienced a traumatic event, they may exhibit behavioural or psychological symptoms that effect their everyday life (Zerach, 2018). In some cases, these symptoms may lead to a diagnosis of intergenerational trauma or posttraumatic stress disorder. Posttraumatic stress disorder (PTSD) is defined by negative symptoms that persist following exposure to a traumatic event or multiple events (American Psychiatric Association, 2013). Symptoms of PTSD include intrusion symptoms, avoidance behaviour, cognitions and mood, and alterations in arousal and reactivity (American Psychiatric Association, 2013). These symptoms impact everyday functioning and an individual's ability to partake in activities performed prior to exposure of a traumatic event (American Psychiatric Association, 2013). Intergenerational trauma is used to define trauma symptoms extending from one generation to the next (Zerach, 2018). An individual with intergenerational trauma may exhibit multiple symptoms such as depressive symptoms, PTSD symptoms, anxiety attention deficiency, mood disorders, lower general positive mood, lower self-esteem, greater anxiety (Sangalang & Vang, 2016), difficulty managing emotions (Barron et al., 2016), cognitive effects, mental illness, and vulnerability to further traumas (Bentall et al., 2014). However, many children and adolescents remain undiagnosed (Scheeringa et al., 2011). Students presenting negative trauma symptoms within a school system may receive discipline instead of support. The trauma informed care framework ensures that services to clients are delivered in a trauma context such that trauma-sensitive practices are being used (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). Literature on trauma informed care identifies five common themes for effective implementation within a service system: trauma, accessible service, safety, client focused, and collaboration (Guarino et al., 2009; Harris & Fallot, 2001; Hopper et al., 2010;

Manitoba Trauma Information and Education Centre, 2013; Morgan et al., 2020; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a, 2014b). Studies have found the implementation of trauma informed care within an organization increases choice, collaboration, empowerment, support, self-care, educational opportunities (Hales et al., 2019), client engagement in service, a removal of barriers to service access (Ghafoori et al., 2019), and lowered psychological stress (Schmid et al., 2020) which are all positive factors when supporting people with PTSD or intergenerational trauma. A trauma informed care framework is applied to a system to create policies and procedures that support client and service providers using trauma-informed practice and strength-based approaches. The question remains, how can trauma informed care be implemented to support high school students with intergenerational trauma and posttraumatic stress disorder?

Statement of the Problem

Current literature explains how to apply a trauma informed care framework to an educational system and indicates positive effects of the implementation of trauma informed care on service providers and their clients (Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013; Margolius et al., 2020; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). However, there lacks information on the effects from implementing trauma informed care within a school system on high school students who have posttraumatic stress disorder (PTSD) and intergenerational trauma. An estimated 32% of Canadian children have experienced or will experience at least one traumatic event in their life (Afifi et al., 2014). It can then be assumed a similar percentage of students have already experienced or will experience trauma during their high school years, and everyone in an

education system are either directly or indirectly affected by trauma (Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013). Research also indicates data of individuals diagnosed with PTSD may not accurately reflect the inclusion of children and adolescents who meet the criteria for PTSD but remain undiagnosed (Scheeringa et al., 2011). As well, there is no formal diagnoses for intergenerational trauma in the DSM-5 manual (American Psychiatric Association, 2013). Thus, there may remain a number of students with PTSD or intergenerational trauma struggling in school due to lack of support. Literature provides information on how implementation of trauma informed care positively impacts a service provider's ability to support clients exposed to trauma (Ghafoori et al., 2019; Hales et al., 2019; Schmid et al., 2020). Can trauma informed care be used to support high school students with intergenerational trauma and posttraumatic stress disorder?

Purpose of the Paper

This paper provides recommendations for teachers, counsellors, and administrators to implement trauma informed care to support students who have posttraumatic stress disorder or intergenerational trauma. A system that follows a trauma informed care framework emphasizes an accessible and safe service for people who have experienced trauma (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). This paper aims to create awareness of trauma, specifically within the context of posttraumatic stress disorder and intergenerational trauma, and provide information on the strengths in incorporating trauma-informed care into the education system. It should be noted that this information is not limited to teachers, counsellors, and administrators. All individuals within an education system, including

office staff, custodians, helping teachers, as well as all students and their respective families, contribute to a school community and can benefit from trauma informed care.

Research Question

How can trauma informed care be used to support high school students with intergenerational trauma and posttraumatic stress disorder?

Significance of the Study

Recommendations in this paper are explicitly relevant to teachers, counsellors, and administrators. These recommendations expand on current literature for applying a trauma informed care framework to a school system to include supporting high school students who have posttraumatic stress disorder or intergenerational trauma. It can be assumed that many youths entering the school system have or will experience some form of trauma, thus the trauma informed care framework becomes a necessary addition to the school system for supporting youth effectively. Teachers, counsellors, and administrators are integral within a school community and interact with students frequently. Arguably, students who have experienced trauma and who have posttraumatic stress disorder or intergenerational trauma will require additional support from these three groups of individuals. Thus, it is recommended teachers, counsellors, and administrators adopt trauma informed care into their practice. Students attending secondary school may exhibit negative behaviours caused by either PTSD or intergenerational trauma, and as they remain undiagnosed, may not receive appropriate and effective interventions. Trauma informed care, when implemented into a service system, has been identified as an effective framework for supporting all individuals (Schmid et al., 2020,

Morrisey et al., 2005, as cited in Hales et al., 2019). Individuals that interact closely with youth within an educational setting have the ability to provide trauma-informed support for students who may otherwise be overlooked.

Theoretical Framework

The literature review of posttraumatic stress disorder, intergenerational trauma, and trauma informed care, and the recommendations for applying a trauma informed care framework to an education system when supporting youth with posttraumatic stress disorder and intergenerational trauma, is done through a client-centered theory lens. Client-centered theory, or Rogerian theory, was first introduced by Carl Rogers in 1959 (Rogers, 1959). Rogers maintained that the therapist-client relationship is more important than any technique, which he outlines as three essential qualities for client-centered theory: congruence (or genuineness), unconditional positive regard, and empathetic understanding (Rogers, 1959, as cited in Thorne & Sanders, 2013). In client-centered theory, congruence refers to a therapist's self-awareness and ability to be transparent when communicating with a client (Rogers, 1959, as cited in Thorne & Sanders, 2013). Unconditional positive regard refers to the basic human need to be accepted (Rogers, 1959, as cited in Thorne & Sanders, 2013). Following client-centered theory, a therapist will display care for a client devoid of judgement or evaluations (Rogers, 1959, as cited in Thorne & Sanders, 2013). Empathy within client-centered theory refers to a therapist's willingness and ability to enter into the life of their client without fear, and with a secure enough grasp of their own identity to return to their own existence (Rogers, 1959, as cited in Thorne & Sanders, 2013).

Definition of Terms

Education System

Also referred to as school system or educational system, the education system comprises of law, policies, and regulations; funding, resource allocations, and procedures; administrative offices, school facilities, and transportation vehicles; human resources and staffing; and other contributing elements to the public-school sector (Great Schools Partnership, 2013).

Intergenerational Trauma

After an individual experiences a traumatic event and displays trauma symptoms, their dependants are defined as experiencing intergenerational trauma if the dependants display similar symptoms despite having not experienced a traumatic event themselves (Bezo & Maggi, 2015).

Posttraumatic Stress Disorder

Posttraumatic stress disorder is defined as negative psychological and physical symptoms that persist following exposure to one traumatic event or multiple events (American Psychiatric Association, 2013).

Strength Based Approach

A strength-based approach involves the belief that every individual has a unique set of strengths that will allow the individual to overcome problems. Emphasis is on an individual's abilities rather than their shortcomings, symptoms, or difficulties (Xie, 2013).

Trauma Informed Approach

A trauma informed approach follows six key principles which are related to positive views around client resilience and recovery: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender issues (MentalHealth, 2015).

Trauma Informed Care

Trauma informed care is a framework applied to an organization with staff trained in trauma informed care; policies and procedures are designed within a trauma context to ensure trauma sensitive practices are provided to customers; and it is acknowledged that all individuals within the system may have experienced trauma (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a, U.S. Department of Health & Human Services, 2021).

Trauma Sensitive Schools

A trauma sensitive school is one where trauma sensitivity is adopted by all school staff for supporting students by educating staff to recognize students who need more intensive services; addressing negative effects of trauma on family and students; reducing trauma-related triggers in the school environment and eliminating potentially retraumatizing practices; considering trauma in all assessment and behaviour school plans and policies; ensuring children and family have voice, choice, and empowerment; and addressing the secondary effects on educators when working with trauma survivors (National Center on Safe Supportive Learning Evironments, 2018).

Outline of the Remainder of the Paper

This paper reviews existing literature on trauma informed care, posttraumatic stress disorder, and intergenerational trauma. Trauma informed care, as a theoretical framework, is introduced with consideration to its history, benefits, and limitations. Posttraumatic stress disorder (PTSD) and intergenerational trauma are defined with extensions to children and young adults. Key recommendations for teachers, administrators, and counsellors are then addressed for supporting traumatized students using trauma-informed practices and strength-based approaches within trauma informed care.

Chapter 2: Literature Review

Introduction

A person diagnosed with posttraumatic stress disorder (PTSD) will experience negative psychological and physical symptoms that effect their everyday life following exposure to a traumatic event (American Psychiatric Association, 2013). A person experiencing intergenerational trauma may exhibit symptoms similar to those of PTSD (Sangalang & Vang, 2016). However, an individual with intergenerational trauma may not have directly experienced a traumatic event but instead be a dependant of an adult who had experienced a traumatic event and display trauma exposed symptoms (Sangalang & Vang, 2016). Unfortunately, many youths and adolescents remain undiagnosed for PTSD (Scheeringa et al., 2011), and there is currently no official diagnosis for intergenerational trauma (American Psychiatric Association, 2013). Thus, systems that provide service to people who may have been exposed to trauma require a framework to ensure service is trauma-sensitive. Trauma informed care is a framework applied to a system to ensure trauma-sensitive practices are implemented by service providers (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a).

Posttraumatic Stress Disorder (PTSD)

Introduction to PTSD

Posttraumatic stress disorder (PTSD) is defined by negative symptoms that persist following exposure to a traumatic event or multiple events (American Psychiatric Association, 2013). Individuals diagnosed with PTSD experience psychological and physical symptoms that affect everyday activities (American Psychiatric Association, 2013). This section outlines

possible causes and symptoms, procedure for diagnosis, known neurology, treatment options, and the limitations of current research on PTSD.

Posttraumatic Stress Disorder (PTSD)

The Diagnostic and Statistical Manual of Mental Disorders edition 5 (DSM-5) defines posttraumatic stress disorder (PTSD) as lingering negative symptoms following exposure to a traumatic event (American Psychiatric Association, 2013). These symptoms impact everyday functioning and an individual's ability to partake in activities performed prior to exposure of a traumatic event (American Psychiatric Association, 2013). Symptoms are frequent, persistent and may include a combination of fear-based emotional and behavioural symptoms, changes in mood states, decline in cognition, and dissociative symptoms (American Psychiatric Association, 2013). In Canada, the lifetime prevalence of PTSD is estimated to be 9.2% (Katzman et al., 2014). However, research indicates this data may not accurately reflect the inclusion of children and adolescents who meet the criteria for PTSD but remain undiagnosed (Scheeringa et al., 2011). Although the DSM-5 for posttraumatic stress disorder includes criteria for children and adolescents ages 6 to 18, with specific criteria for children under the age of six, research suggests there are many barriers that affect diagnoses of PTSD in children and adolescents (Scheeringa et al., 2011). Barriers include ability to disclose trauma, effective communication of needs, and the understanding of symptoms (Scheeringa et al., 2011). As well, young children and adolescents exhibit symptoms of trauma differently than adults and may have difficulty understanding and expressing their experiences (Scheeringa et al., 2011).

Causes of PTSD

As described in the DSM-5, criteria for PTSD includes an exposure to one or more traumatic events (American Psychiatric Association, 2013). An individual may directly or indirectly experience the traumatic event(s) (American Psychiatric Association, 2013). This can include experiencing the traumatic event(s) firsthand, witnessing others experiencing the traumatic event(s), learning of close family or friends experiencing the traumatic event(s), or having exposure to details of the traumatic event(s) (American Psychiatric Association, 2013). Repeat or extreme exposure to the traumatic event(s) does not apply to exposures in media, movies, or pictures unless work related (American Psychiatric Association, 2013).

Not all traumatic events lead to PTSD. Traumatic events that cause feelings of fear, helplessness, or horror are more likely to result in a PTSD diagnosis (J. W. Barnhill, 2020). Women are two times more likely than men to experience PTSD symptoms (Hetzel-Riggin & Roby, 2013). Other risks that correlate with developing PTSD symptoms following a traumatic event include prior mental disorders, lower social economic status, lower education, exposure to prior trauma, cultural characteristics, self-blaming coping strategies, lower cognitive ability, minority racial or ethnic status, social support, age, severity and magnitude of trauma, and subsequent adverse life events (American Psychiatric Association, 2013).

Symptoms of PTSD

The DSM-5 criteria for PTSD symptoms is divided into four sections which are intrusion symptoms, avoidance behaviour, cognitions and mood, and alterations in arousal and reactivity (American Psychiatric Association, 2013). Following a traumatic event or exposure, a person may feel any combination of symptoms, however symptoms from each section must be met for a diagnosis of PTSD (American Psychiatric Association, 2013).

Intrusion Symptoms (Criterion B). Intrusion symptoms may include distressing memories or dreams, dissociation (may be described as flashbacks), and psychological distress when exposed to internal or external reminders of the traumatic event(s).

Avoidance Behaviour (Criterion C). Avoidance behaviour may include avoiding memories, thoughts, or feelings of the traumatic event(s); or avoiding external reminders associated with the traumatic event(s).

Cognitions and Mood (Criterion D). A change in cognitions and mood may include memory loss when recalling the traumatic event(s), negative thoughts and/or expectations about self, self-blaming, negative emotional state, lowered interest in participation of activities, feelings of detachment, and inability to experience positive emotions. In children under six symptoms may also include socially withdrawn behaviour and reduced positive emotions.

Alterations in Arousal and Reactivity (Criterion E). Alterations in arousal and reactivity may include a negative change in behaviour, maladaptive behaviour, hypervigilance, increase in startle response, new difficulties in concentrating, and sleep disturbances. Maladaptive behaviours are more common among young men as a possible symptom of PTSD (Carmassi et al., 2014).

Diagnosing PTSD

PTSD is diagnosed by a psychologist or psychiatrist often at the referral of a counsellor or family doctor (Katzman et al., 2014). Clinicians determine a client's PTSD scale using assessments based on the DSM-5 criterion completed through one or more interviews (Katzman et al., 2014). One assessment for PTSD used in Canada and the United States is the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), which includes an adapted version for

assessing children and adolescents (CAPS-CA-5) (*Clinical-Administered PTSD Scale for DSM-5 - Child/Adolescent Version (CAPS-CA-5)*, 2020). A patient's trauma history, use of substances, and prior mental health are reviewed in concurrence with the 30-item measured assessment (*Clinical-Administered PTSD Scale for DSM-5 - Child/Adolescent Version (CAPS-CA-5)*, 2020). A patient must be experiencing symptoms in all four DSM-5 symptom criteria for a period longer than one month and the symptoms must significantly affect social, occupational, or daily functioning (American Psychiatric Association, 2013). The CAPS-5 and CAPS-CA-5 provides a single severity rating based on the frequency and intensity of each symptom (*Clinical-Administered PTSD Scale for DSM-5 - Child/Adolescent Version (CAPS-CA-5)*, 2020). One study in Canada and the United States revealed PTSD criteria was reliable when diagnosing adults using the DSM-5 (Regier et al., 2013). However, these field tests did not include PTSD diagnoses in children and adolescents. There are many similarities when considering symptoms of PTSD and other mental health disorders (Katzman et al., 2014). An estimated 75% of patients diagnosed with PTSD are also diagnosed with additional anxiety related disorders (Katzman et al., 2014). Thus, clinicians will consider comorbidities when assessing for PTSD (Katzman et al., 2014). Individuals who do not meet the full criterion for a PTSD diagnosis may instead meet the diagnosis for acute stress disorder (ASD) (American Psychiatric Association, 2013).

Neurology of PTSD

There is limited research as to how trauma alters the brain and why PTSD symptoms may linger following a traumatic event (Quinones et al., 2020). Research has attributed inflammation within the brain and other neurological factors as possible identifiers of PTSD (Quinones et al., 2020). Fear is an emotional response which can develop from persistent memories of trauma

exposure (Gonzalez & Martinez, 2014). Excessive fear can be pathological and may be diagnosed as PTSD (Gonzalez & Martinez, 2014). Severe symptoms of PTSD are related to a decrease in fear inhibition and an increase in conditioning fear responses (Gonzalez & Martinez, 2014).

Amygdala. The amygdala is crucial in processing environmental stimuli and contributes in determining human behaviours (Janak & Tye, 2015). The amygdala is located within the temporal lobe which is essential for emotional processing (Janak & Tye, 2015). For the body to react to a potential external threat, the amygdala signals danger to the body (Toyoda et al., 2011). Neuroimaging research on individuals diagnosed with PTSD identified increased activity in the amygdala during trauma recall and non-trauma emotional stimuli (King et al., 2016).

Anterior Cingulate Cortex. The anterior cingulate cortex (ACC) is located within the limbic lobe of the brain (Toyoda et al., 2011). Whereas the amygdala processes danger and emotional fear, the ACC contributes to maintaining attention to a threat, and the storing and recalling of fear memory (Toyoda et al., 2011). Evidence suggests the ACC can recall conditioning fear memories that have been stored for longer than a month (Toyoda et al., 2011).

Prefrontal Cortex. The prefrontal cortex (PFC) is located in the frontal lobe and controls cognitive and executive functioning (Thomaes et al., 2013). Adults diagnosed with PTSD were found to have a decreased activity in their medial PFC and increased activity in the left ventrolateral PFC (Thomaes et al., 2013). The medial PFC is associated with fear extinction and diverting attention from trauma-related stimuli (Thomaes et al., 2013). The left ventrolateral PFC affects sematic memory (Thomaes et al., 2013).

Hippocampus. The hippocampus is part of the limbic system and is located in the temporal lobe of the brain (Thomaes et al., 2013). Studies show an increase in activity of the

hippocampus in adults diagnosed with PTSD compared to control groups (Thomaes et al., 2013). The hippocampus is associated with explicit memory and fear responses (Thomaes et al., 2013). Increased activity of the hippocampus is thought to reflect impaired and over-generalization of fear responses (Thomaes et al., 2013). The increase in activity could also relate to dissociation symptoms or the hippocampus having less efficient function (Thomaes et al., 2013). Symptom severity of PTSD has been correlated to decreased medial PFC and increased hippocampus activity (Thomaes et al., 2013).

Treatment of PTSD

PTSD symptoms may be treated with medication, therapy, or a combination of both. Paroxetine and sertraline are approved medications for treating PTSD (Katzman et al., 2014). Cognitive behavioural theory (CBT) and trauma-focused cognitive behavioural theory (TF-CBT) have been shown to decrease client PTSD symptoms and distress (Katzman et al., 2014). In small case studies, it has been found that eye-movement desensitization and reprocessing (EMDR) can reduce PTSD symptoms in individuals similarly to TF-CBT, but an EMDR approach required less clinical time (Katzman et al., 2014). For individuals who exhibit self-harm, dialectical behaviour theory (DBT) as a pre-treatment to PTSD treatment has been effective (Katzman et al., 2014). Cognitive processing therapy (CPT) is an effective practice for reducing PTSD symptoms from sexual trauma (Surís et al., 2013). Prolonged exposure therapy (PE) has proven effective for reducing PTSD symptoms and distress when considering comorbidity with other mental health disorders (Van Minnen et al., 2012). Exposure therapy is used to guide patients through confronting fears developed from trauma and has proven to reduce anxiety and effectively treat PTSD symptoms (J. Barnhill, 2020).

Current research has assessed the effectiveness of EMDR and CBT through an online delivery model (Lenferink et al., 2020). Though the study found PTSD symptoms were reduced, small sample size and the absence of a control group indicate the need for further research (Lenferink et al., 2020). Online tools will provide treatment for secluded or otherwise inaccessible populations. Pandemic protocols have shown the need for treatments to be accessible by means other than just face-to-face.

Limitations of Knowledge of PTSD

The severity of PTSD varies across different cultural groups (Hinton & Lewis-Fernandez, 2011). There are concerns PTSD criteria has been developed within a Western culture framework which decreases validity for PTSD diagnoses across different cultures (Hinton & Lewis-Fernandez, 2011). This may be due to the different types of trauma exposure non-western cultures may experience (e.g., genocide).

Summary of PTSD

The DSM-5 has defined PTSD as lingering negative symptoms following exposure to one or more traumatic events (American Psychiatric Association, 2013). Symptoms of PTSD may include intrusion symptoms, avoidance behaviour, cognitions and mood, and alterations in arousal and reactivity (American Psychiatric Association, 2013). PTSD symptoms may be treated with medication, therapy, or a combination of both.

Intergenerational Trauma

Introduction to Intergenerational Trauma

The term intergenerational trauma is used to define trauma symptoms an individual exhibits when they have not necessarily experienced trauma themselves, but are the dependent of an individual who is exhibiting trauma symptoms from exposure to a traumatic event (Bezo & Maggi, 2015). An individual with intergenerational trauma may exhibit multiple symptoms such as depressive symptoms, PTSD symptoms, anxiety attention deficiency, mood disorders, lower general positive mood, lower self-esteem, greater anxiety (Sangalang & Vang, 2016), difficulty managing emotions (Barron et al., 2016), cognitive effects, mental illness, and vulnerability to further traumas (Bentall et al., 2014). This section outlines the causes, symptoms, treatments, and limitations of intergenerational trauma.

Intergenerational Trauma

Intergenerational trauma, also referred to as generational trauma or secondary trauma, is trauma symptoms extending from one generation to the next (Zerach, 2018). Intergenerational trauma may also be referred to as transgenerational trauma (Braga et al., 2012). Historical trauma is used to describe the impact of colonization, cultural suppression, and historical oppression on the current generation specific to Indigenous and Aboriginal peoples in North America (Kirmayer et al., 2014). The term intergenerational trauma, first noted in 1966 (Sangalang & Vang, 2016), defines trauma symptoms a person exhibits when they have not experienced trauma themselves, but are a dependent of a trauma survivor (Bezo & Maggi, 2015). In relation to intergenerational trauma, types of trauma may include slavery, racism (Graff, 2014), oppression, marginalization, humiliation, discrimination (Barron et al., 2016), or the negative historical and cultural experiences of a population over an extended period of time (Menzies, 2013). Similarly,

literature defines intergenerational transmission of trauma as the symptoms exhibited in offspring as a result of trauma experienced by a caregiver (Bowers & Yehuda, 2016).

Causes of Intergenerational Trauma

Not all survivors of trauma will pass trauma symptoms to following generations as transmission of trauma is linked to risk and resiliency factors (Sangalang & Vang, 2016). In a study of refugee parents who had experienced similar types of traumas, it was found that children in some families did not exhibit PTSD symptoms (Sangalang & Vang, 2016). Children without PTSD symptoms were found to be more resilient than children of non-traumatized parents in the control group (Sangalang & Vang, 2016). This was similarly found in a study with Brazilian offspring of Holocaust survivors where both traumatic experiences and resiliency patterns were transmitted to following generations (Braga et al., 2012). Children of traumatized parents are at risk of developing intergenerational trauma and reoccurring factors are present when trauma symptoms are transmitted intergenerationally (Braga et al., 2012). Parent-child attachment was an indicator of the emotional and behavioural health of the child (Sangalang & Vang, 2016). Also, the family's communication style impacted a child's sense of belonging (Sangalang & Vang, 2016). It was found that if the parent did not communicate their trauma experience, and their thoughts and feelings of that trauma to their child, there was a continual generational pattern of silence and avoidance that followed (Sangalang & Vang, 2016). The parent's ability to provide a sense of safety to their children also affected the vulnerability of generations to psychological stress (Sangalang & Vang, 2016). As well, a study of children of Holocaust survivors reported that a family's use of communication between parent and child affected the psychological well-being of future generations (Bezo & Maggi, 2015). Another study of

Holocaust survivors found that the degree of trauma symptoms passed onto offspring was due to the child's feeling of safety in their environment and the strength of parent-child attachment (Barron et al., 2016). Offspring resiliency and the transmission of the survivor's trauma was linked to parental depression, dissociation, and emotional availability (Barron et al., 2016). Further, poor parent-child attachment and family separation led to an increase in trauma symptoms found evident in following generations (Barron et al., 2016). Another study found that offspring behavioural and psychological symptoms were dependant on a parent's emotional regulation (Zerach, 2018). A parent's use of coping strategies to manage challenging events or circumstances was related to the transmission of posttraumatic stress symptoms to offspring (Zerach, 2018). This was similarly seen in a study that found that children react to their environment in a mimicked fashion to their parent's behaviours which is explained as intergenerational trauma (Bowers & Yehuda, 2016). A study by Solomon and Zerach identified parent and offspring gender as having a role in the transmission of trauma symptoms (Solomon & Zerach, 2020). A parent's posttraumatic stress symptoms were more likely to be passed onto offspring of a similar gender (Solomon & Zerach, 2020). A study on intergenerational trauma of Aboriginal men in North America provides an Intergenerational Trauma Model to interpret the cause of generational trauma (Menzies, 2006). The Intergenerational Trauma Model defines a person as four systems: the individual, their family, the community they belong to, and their Nation (Menzies, 2006). In absence of trauma the four systems support the individual, whereas intergenerational trauma pushes the four systems away (Menzies, 2006). With intergenerational trauma, an individual may not have the skills necessary to deal with their own trauma, the community and Nation may be vulnerable due to systemic exploitation, and the family may endure lateral abuse, racism, and/or poverty (Menzies, 2013). When a system is suffering from

intergenerational trauma, instead of a system of support for the individual, it becomes a system in need of support (Menzies, 2013).

Symptoms of Intergenerational Trauma

In a study of offspring of traumatized parents, observed symptoms included depressive symptoms, posttraumatic stress symptoms, anxiety attention deficiency, psychological stress, mood disorders, lower general positive mood, lower self-esteem, and greater anxiety (Sangalang & Vang, 2016). In relation to a surviving parents' trauma, children were seen to take responsibility for parental pain and burden (Sangalang & Vang, 2016). Additional symptoms of generations have also included feeling unsafe, loss of identity, dissociation, difficulty managing emotions, educational difficulties, relationship problems, substance abuse, victimizing behaviour, and suicide (Barron et al., 2016). Intergenerational trauma also effects neurobiological changes in the brain and is known to lead to poor parenting skills (Isobel et al., 2021). Trauma and mental illness are intertwined as trauma has behavioural and cognitive effects and mental illness causes vulnerability to further traumas (Bentall et al., 2014).

Treatment of Intergenerational Trauma

Intergenerational trauma requires a holistic approach when considering treatment options (Menzies, 2013). Trauma informed care has been seen to effectively treat trauma and mental illness concurrently (Isobel et al., 2021). Common themes emerge when considering a mental health treatment framework for providing treatment for someone with intergenerational trauma. When providing treatment, it is essential to be knowledgeable of trauma cycles occurring within families (Isobel et al., 2021). It is also important to recognize intergenerational trauma as an

individual and cultural experience (Isobel et al., 2021). A safe environment is necessary for individuals to learn about and process the effects intergenerational trauma has had on their life (Isobel et al., 2021). Treatment to parents needs to extended to their children to proactively disrupt the effects of intergenerational trauma on future generations (Isobel et al., 2021). A study of third generation children of Holocaust survivors identified resistance to receiving treatment as some individuals felt healing within their generation implied forgetting the trauma experienced by past generations (Barron et al., 2016).

Intergenerational Trauma and Education

The Final Report of the Truth and Reconciliation Commission of Canada (National Centre for Truth and Reconciliation, 2015) includes six recommendations for reconciliation within Canada's education system. This report was used to guide research on the effects that intergenerational trauma may have on Aboriginal student university success as Aboriginal students with appropriate academic skills to succeed were instead not completing their classes (Gaywsh & Mordoch, 2018). All students interviewed in the study were identified as having intergenerational trauma and were struggling with the impact it had on their educational journey (Gaywsh & Mordoch, 2018). Situating intergenerational trauma in the educational journey Gaywash and Mordoch's 2018 study, "Situating Intergenerational Trauma in the Educational Journey", divides the effects of intergenerational trauma in relation to education into three categories: family, self, and the school system:

Family. The effects of intergenerational trauma are deeply integrated within the family system. It is estimated that residential school survivors received on average a grade three education (Gaywsh & Mordoch, 2018). Similarly, second generation children of residential

school survivors completed a grade six to eight education (Gaywsh & Mordoch, 2018). Families with low education may not have learned appropriate study skills to pass onto their children, may be unable to assist in higher academic homework, and may discourage the pursuit for further education (Gaywsh & Mordoch, 2018). Aboriginal students perceive a resentment from their family and community for continuing their education journey (Gaywsh & Mordoch, 2018). Students believe their parents feel they are following a colonized path which pulls them away from the Indigenous culture (Gaywsh & Mordoch, 2018). It is also noted that low education contributes to unemployment, deeper levels of poverty, increased violence, and high prevalence of addictions among Aboriginal people (Gaywsh & Mordoch, 2018). Students may be struggling with difficult family dynamics, may be receiving inconsistent support in navigating poor family relations, or be receiving lateral violence from their family (Gaywsh & Mordoch, 2018).

Self. Students with intergenerational trauma may struggle with self doubt, low self-esteem, feelings of incompetence, alcohol, and addictions (Gaywsh & Mordoch, 2018). Students may lack coping strategies for dealing with the stressors and challenges of being a student (Gaywsh & Mordoch, 2018). This may be further complicated by disorganization, negative disposition, and low confidence in a learning environment (Gaywsh & Mordoch, 2018). Aboriginal students fear being stigmatized and viewed differently by other students (Gaywsh & Mordoch, 2018). Some students are forced to move from their home residence to receive education which may remove them from family and community supports (Gaywsh & Mordoch, 2018).

School System. Aboriginal students may first learn about their history including colonialism, historical trauma, current systemic struggles, and their own intergenerational trauma in an educational environment (Gaywsh & Mordoch, 2018). However, the school system is

arguably not prepared to provide appropriate supports for students to grieve and heal from their personal, family, and community experiences (Gaywsh & Mordoch, 2018). Students may feel mistrust towards non-Aboriginal people which contributes to an uncomfortable feeling in a classroom setting (Gaywsh & Mordoch, 2018).

A trauma-informed approach to education is critical for minimizing the effects of intergenerational trauma. Students with intergenerational trauma require appropriate supports to maximize their strengths in their educational journey and possibly begin their healing process (Gaywsh & Mordoch, 2018). Educators must acknowledge the effects intergenerational trauma has had on their students, see students as survivors instead of victims, address personal sensitive experiences, and understand the historical and current inequalities that exist in society for Aboriginal peoples (Gaywsh & Mordoch, 2018). To build safety within a classroom setting, educators can connect students to academic and counselling supports, help build self-esteem, understand that students may be trauma survivors, acknowledge the reality of intergenerational trauma, recognize the stigma related to access and Aboriginal-focused programs, acknowledge resentment toward Aboriginal student funding by both Aboriginal and non-Aboriginal students, realize that students want accessible resources but not special treatment, and realize not all students will be able to afford resources and supports (Gaywsh & Mordoch, 2018).

Limitations of Knowledge of Intergenerational Trauma

As intergenerational trauma is a relatively new concept, current studies do not consider the unique ways a population may express distress (Sangalang & Vang, 2016). Though literature identifies the theoretical effects of genocide and mass traumas on survivor parents and offspring,

there are few studies that research current impacts of trauma on following generations (Bezo & Maggi, 2015). There are limited studies investigating the neurological effects of intergenerational trauma. One study identifies an increase in DRD2 receptor genes in parents having a genetic influence on intergenerational trauma (Graff, 2014); however, this study did not assess the neurological changes in surviving parent offspring.

Summary of Intergenerational Trauma

Intergenerational trauma is used to define trauma symptoms extending from one generation to the next (Zerach, 2018). A holistic approach is required when considering treatment options for intergenerational trauma (Menzies, 2013). It has found that when a system is suffering from intergenerational trauma, instead of a system of support for the individual, it becomes a system in need of support (Menzies, 2013).

Trauma Informed Care

Introduction to Trauma Informed Care

Trauma informed care is a framework applied to an organization such that staff are trained in trauma informed care, policies and procedures are designed within a trauma context to ensure trauma sensitive practices are provided to customers, and it is acknowledged that all individuals within the system may have experienced trauma (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a, U.S. Department of Health & Human Services, 2021). The implementation of trauma informed care on a system minimizes possible re-traumatization (Substance Abuse and Mental Health Services Administration (SAMHSA),

2014a). This section outlines the trauma informed care theoretical framework, the history of trauma informed care, and the benefits and limitations of implementing trauma informed care.

Trauma Informed Care

In the past, systems that provided services to people were often unaware of the traumas individuals had experienced (Harris & Fallot, 2001). Without consideration of prior trauma, systems risk re-traumatizing or miss appropriate referrals for individuals (Harris & Fallot, 2001). It is currently estimated that 75% of the population has experienced at least one traumatic event (U.S. Department of Health & Human Services, 2021). Thus, there maintains a need for systems to be trauma-informed to better provide services to their clients. Trauma informed care is a theory applied to an organization (U.S. Department of Health & Human Services, 2021). Staff are trained in trauma informed care, and policies and procedures are designed within a trauma context to ensure trauma sensitive practices are provided to customers (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). While implementing this framework, it is acknowledged that all individuals may have experienced trauma and the use of trauma informed care minimizes possible re-traumatization (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). Service providers are educated about the prevalence of trauma, symptoms individuals may exhibit following exposure to trauma, and then provided further educational opportunities about trauma informed care (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). It is recognized that trauma impacts not only the individual who experienced the initial traumatic event, but also the systems and service providers an individual engages with (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). Further, service providers actively integrate this knowledge

into their practice. Incorporating trauma informed care involves utilizing a strength-based framework and emphasizes physical, psychological, and emotional safety for both the customer and service providers (Hopper et al., 2010). Trauma informed care also promotes the building of resiliency, empowerment, and autonomy skills (Hopper et al., 2010). Trauma-specific services are used to decrease symptoms and facilitate recovery by providing individual treatments for mental disorders developed from trauma exposure (Hopper et al., 2010). Where trauma-specific services are used to treat individuals, trauma informed care is a framework that acknowledges the impact of trauma, provides interventions at a system level, and may include trauma-specific services (Hopper et al., 2010). Within trauma informed care, it is recommended that various service systems collaborate to provide a more universal care for trauma exposed clients (Hopper et al., 2010). Trauma informed care also includes trauma-informed practices (TIP) (Hopper et al., 2010). When service providers use TIP, they recognize that trauma symptoms may present differently within the unique experiences of individuals, families, and communities (The Royal Australian & New Zealand College of Psychiatrists, 2020).

Theoretical Framework

The trauma informed care framework ensures that service practice is delivered within the context that individuals are more likely than not to have been exposed to trauma (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Literature about trauma informed care identifies five common themes on the structure of a trauma-informed system, a trauma-informed approach to providing care, and the challenges in providing care to individuals exposed to trauma. These five common themes are trauma, accessible service, safety, client focused, and collaboration.

Trauma. An understanding of trauma and implementing this knowledge into practice is a critical part of trauma informed care and involves all members within an organization. Without the consideration of how trauma effects individuals, the system risks re-traumatization which can prevent healing and cause continuation of trauma (Manitoba Trauma Information and Education Centre, 2013; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). An understanding of trauma starts with trauma awareness. Individuals, families, communities, and cultures may be exposed and influenced by trauma (Manitoba Trauma Information and Education Centre, 2013), and in some situations, groups of people are affected by historical trauma (Morgan et al., 2020). Trauma-informed practice includes recognizing that traumatic events are beyond a person's control (Manitoba Trauma Information and Education Centre, 2013) and may impact an individual's mental health and behaviour (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Unhealthy and ineffective behaviours are understood to be an individual's coping strategies that were developed to survive a traumatic event (Guarino et al., 2009). In trauma informed care, service providers are educated to recognize the symptoms resulting from trauma and actively resist re-traumatizing (Guarino et al., 2009). As an individual may communicate with multiple people within an organization, it is important that all individuals within a system commit to using trauma-informed practice (Harris & Fallot, 2001). It is significant to note that trauma-informed services do not treat trauma symptoms directly (Manitoba Trauma Information and Education Centre, 2013). Trauma-informed service providers understand the limitations of their education and do not work beyond their training (Manitoba Trauma Information and Education Centre, 2013). This includes recognizing when further supports are necessary for an individual and being aware of which referrals are appropriate (Harris & Fallot, 2001). Trauma-specific services may be included

within trauma informed care; however, this is only when appropriate training is in place (Harris & Fallot, 2001). For children who have experienced trauma, it is essential for service providers to be aware of assessment tools and supports available (Manitoba Trauma Information and Education Centre, 2013). Service providers are also at risk of experiencing trauma symptoms (Manitoba Trauma Information and Education Centre, 2013). A system built within a trauma informed care context recognizes an individual's responsibility to partake in self-care. However, organizations are tasked to create an environment where self-care and wellness is accessible and expected (Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013). Within a trauma informed care framework, service providers have an understanding of their own trauma history, and are aware how this may affects their own bias when working with clients (Manitoba Trauma Information and Education Centre, 2013).

Accessible service. A system following trauma informed care addresses accessibility to services. There are many barriers which may restrict individuals from accessing services (Morgan et al., 2020). Creating systems within a trauma informed care framework includes understanding these barriers and working to remove them for all individuals (Morgan et al., 2020). Many individuals experience financial constraints and may have difficulty accessing transportation (Morgan et al., 2020). By offering free or supplemented services and assisting with access to transportation, the system becomes accessible to more individuals. Trauma-informed systems include inclusive policies and procedures that respect cultural differences and diversity (Hopper et al., 2010; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Individuals may not access services due to stigma around mental health (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Stigma may come from family, friends, community members, or even the individual themselves (Substance

Abuse and Mental Health Services Administration (SAMHSA), 2014b). A universal screening process for all service programs to identify trauma history creates an inclusive environment that promotes individuals to think about trauma and consider how trauma has affected their life (Harris & Fallot, 2001). This process institutionalizes trauma awareness and reduces stigma.

Safety. Physical, emotional (Fallot & Harris, 2009; Guarino et al., 2009), and psychological safety (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b) are important considerations when working with traumatized people. Safety is created when service providers are predictable, respectful, and transparent in their interactions with clients and others (Fallot & Harris, 2009; Morgan et al., 2020; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Trauma-informed service providers develop strong connections to the people around them which can play a significant role in client recovery from trauma (Fallot & Harris, 2009; Morgan et al., 2020). Many individuals who have experienced trauma, do so within a power dynamic known as intrapersonal trauma (Morgan et al., 2020). Historically, traumatized clients suffer from power differentials where their voice and choices are diminished (Manitoba Trauma Information and Education Centre, 2013; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Thus, it is important service providers bring humility to service delivery. Privacy and confidentiality are also critical to ensure emotional safety (Hopper et al., 2010).

Client focused. In trauma-informed care, client input is included when designing and evaluating systems that provide services (Guarino et al., 2009; Hopper et al., 2010). Within a trauma-informed approach, service providers believe that recovery is possible for every individual (Guarino et al., 2009; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Clients are perceived as resilient and are guided to create personal future-

oriented goals (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Trauma informed care also includes a strength-based approach where service providers focus on client strengths rather than their deficits (Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). An individual's strengths, resiliency, and experiences are recognized, and then further developed (Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013). Individual voice, choice, skill-building, and autonomy are supported and valued to prioritize empowering the client and regaining control (Fallot & Harris, 2009; Guarino et al., 2009; Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b).

Collaboration. Individuals who are affected by trauma are often in need of multiple support services (Morgan et al., 2020). A system follows trauma informed care when collaboration with members within and around services are provided to clients (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). Initial collaboration is between the service provider and client (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Through a meaningful sharing of power and decision-making, an individual can begin their healing (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Service providers are considered experts in their position, but clients are recognized as experts of their own lives and are given autonomy for decision making (Manitoba Trauma Information and Education Centre, 2013). Service providers who use a trauma-informed approach treat clients as equal collaborators and acknowledge their strengths (Manitoba Trauma Information and Education Centre, 2013). Within trauma informed care, service providers connect with community members to provide a context for understanding the individual's

behaviour and coping skills due to trauma (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Further, the effectiveness of a community's response to an individual accessing services who has experienced a traumatic event may facilitate recovery or alternately adversely interfere with an individual's rehabilitation (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Another important collaboration of trauma informed care is the establishment of peer support (Guarino et al., 2009). Peer collaboration builds safety and promotes recovery and healing within an organization (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b).

The theoretical framework for trauma-informed care within an educational setting follows a pyramid structure (Margolius et al., 2020). The foundation of the pyramid, called Tier 1, includes universal interventions appropriate for all students (Margolius et al., 2020). In Tier 1, the emphasis is to build resiliency skills and provide a relevant general understanding of trauma (Margolius et al., 2020). Interventions at this level are provided by all staff within an education system (Margolius et al., 2020). Tier 2 interventions target students exposed to trauma or who are at risk of being exposed to trauma (Margolius et al., 2020). Students in Tier 2 require appropriate interventions which may include individual or small group therapy (Margolius et al., 2020). Tier 2 level supports are provided by educational staff, such as counsellors, who have additional training on trauma-informed care (Margolius et al., 2020). Tier 3 supports include trauma-specific services for individuals (Margolius et al., 2020). In most education systems, students requiring trauma-specific services are referred to community agencies (Margolius et al., 2020).

History of Trauma Informed Care

A clinical definition of trauma was first identified in the Diagnostic and Statistical Manual of Mental Disorders, edition 3 (DSM-3) (American Psychiatric Association, 1980, as cited in North et al., 2016). The DSM-3 describes trauma as a stressor that causes symptoms of distress (American Psychiatric Association, 1980, as cited in North et al., 2016). Through studies, the definition of trauma and the framework for supporting individuals who had experienced trauma was reviewed. In 1992 within the United States, The Substance Abuse and Mental Health Services Administration (SAMHSA) was developed to reduce the impact of mental illness on communities (Substance Abuse and Mental Health Services Administration, 2021). In 1994, SAMHSA held a conference for survivors of trauma to speak about how standard practices in health care caused re-traumatization (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). At this time the Diagnostic and Statistical Manual of Mental Health Disorders, edition 4 (DSM-lV) was also published (American Psychiatric Association, 1994, as cited in North et al., 2016). The definition of trauma was then described as a traumatic event invoking fear, helplessness, or horror through actual or threatened death (American Psychiatric Association, 1980, as cited in North et al., 2016). In 2001, the United States launched an initiative aimed to increase the understanding of child trauma (Harris & Fallot, 2001). This same year, Maxine Harris and Roger Fallot published Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift (Harris & Fallot, 2001). Harris and Fallot developed requirements for creating a trauma-informed system of care for effectively serving individuals without the need to be aware of prior trauma (Harris & Fallot, 2001). This paper would become the foundation for creating a framework for trauma informed care. In 2013, the Diagnostic and Statistical Manual of Mental Health Disorders edition 5 (DSM-5) was published

(American Psychiatric Association, 2013). In the DSM-5, trauma- and stressor-related disorders were given their own identification and trauma was further defined to include sexual violence (American Psychiatric Association, 2013). Various informative reports were published to assist organizations in integrating trauma informed care into practice (Fallot & Harris, 2009; Guarino et al., 2009; Manitoba Trauma Information and Education Centre, 2013; Margolius et al., 2020; Ravi & Little, 2017; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). In 2018, the Government of Canada provided information and resources on supporting trauma and violence-informed approaches for policy and practice (Government of Canada, 2018).

Benefits of Trauma Informed Care

In one study on implementation of trauma informed care within an organization, staff reported an increase in perceived safety, trustworthiness, choice, collaboration, and empowerment (Hales et al., 2019). The study found there was also significant increase in supervision, support, self-care, and educational opportunities (Hales et al., 2019). Another study noted trauma informed care interventions removed barriers to service access and increased client engagement with service (Ghafoori et al., 2019). Another study had results suggesting trauma informed care reduces psychological stress and aggression among traumatized youth and adolescents (Schmid et al., 2020). Staff also exhibited lowered psychological stress and an increase in self-care practices (Schmid et al., 2020). Implementing trauma informed care has been found to positively impact mental health, substance abuse, and frequency of trauma symptoms (Morrisey et al., 2005, as cited in Hales et al., 2019). Counsellors who integrate the trauma informed care framework into their practice recognize trauma-related behaviours, avoid

re-traumatizing, and make appropriate treatment referrals for supporting traumatized clients (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). trauma informed care has also been found to positively impact an organization. Evidence suggests implementing the trauma informed care framework into a system will lower operational costs, increase client retention, and reduce staff turnover by increasing staff satisfaction (Hales et al., 2019).

Limitations of Trauma-Informed Care

Currently there are limited opportunities for people to engage in educational opportunities related to trauma informed care (Isobel, 2021). Also, although many systems organically adopt elements of trauma-informed practices, few have developed policies and procedures within a trauma context of trauma informed care. Thus, there is limited influence of trauma informed care on current human service systems. It has also been noted individuals within a system require appropriate time, resources, and support to properly implement trauma informed care (Hall et al., 2016).

Summary of Trauma-Informed Care

The trauma informed care framework ensures that services to clients are delivered in a trauma context such that trauma-sensitive practices are being used (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). Literature about trauma informed care identifies five common themes: trauma, accessible service, safety, client focused, and collaboration. Studies have found the implementation of trauma informed care within an organization has increased choice, collaboration, empowerment, support, self-care, educational

opportunities (Hales et al., 2019), client engagement in service, a removal of barriers to service access (Ghafoori et al., 2019), and lowered psychological stress (Schmid et al., 2020).

Summary

Posttraumatic stress disorder (PTSD) is defined by negative symptoms that persist following exposure to a traumatic event or multiple events (American Psychiatric Association, 2013). Symptoms of PTSD may include intrusion symptoms, avoidance behaviour, cognitions and mood, and alterations in arousal and reactivity (American Psychiatric Association, 2013). PTSD symptoms may be treated with medication, therapy, or a combination of both. Intergenerational trauma is used to define trauma symptoms extending from one generation to the next (Zerach, 2018). Intergenerational trauma is recognized as an individual and cultural experience (Isobel et al., 2021). A holistic approach is required when considering treatment options for intergenerational trauma (Menzies, 2013). The trauma informed care framework ensures that services to clients are delivered in a trauma context such that trauma-sensitive practices are being used (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). Literature about trauma informed care identifies five common themes: trauma, accessible service, safety, client focused, and collaboration. Studies have found the implementation of trauma informed care within an organization has increased choice, collaboration, empowerment, support, self-care, educational opportunities (Hales et al., 2019), client engagement in service, a removal of barriers to service access (Ghafoori et al., 2019), and lowered psychological stress (Schmid et al., 2020) which are all positive factors when supporting people with PTSD or intergenerational trauma.

Chapter 3: Summary, Recommendations and Conclusions

Summary

Although the number of people diagnosed with posttraumatic stress disorder (PTSD) continues to increase (Institute of Medicine, 2014), and the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders edition 5 (DSM-5) provides a PTSD diagnoses section specific to children, many youth and adolescents still remain undiagnosed (Scheeringa et al., 2011). Also, there is still no formal diagnoses for intergenerational trauma in the DSM-5 manual (American Psychiatric Association, 2013). Since an estimated 32% of Canadian children have experienced or will experience at least one traumatic event in their life (Afifi et al., 2014), it can be assumed a similar percentage of students have already experienced or will experience trauma during their high school years. Further, it can be extrapolated that this percentage may also mirror the number of trauma-exposed individuals within a school community. This would include staff, students' immediate and extended families, and community members. Everyone in an education system are either directly or indirectly affected by trauma (Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013).

An individual with PTSD may experience dissociation, avoidance behaviour, change in cognitive abilities, negative emotional states, self-blaming, negative thoughts about self, lowered interest in activity participation, socially withdrawn behaviour, reduced positive emotions, maladaptive behaviour, hypervigilance, difficulties concentrating, and is at risk of re-traumatization (American Psychiatric Association, 2013). An individual with intergenerational trauma may experience depressive symptoms, PTSD symptoms, anxiety attention deficiency, mood disorders, lower general positive mood, lower self-esteem, greater anxiety (Sangalang & Vang, 2016), difficulty managing emotions (Barron et al., 2016), cognitive effects, mental

illness, and vulnerability to further traumas (Bentall et al., 2014). Students attending secondary school may exhibit negative behaviours caused by either PTSD or intergenerational trauma, and may not receive proper intervention as they remain undiagnosed. Trauma informed care has been identified as an effective framework for supporting all individuals, including both clients and staff, when implemented into a service system (Schmid et al., 2020, Morrisey et al., 2005, as cited in Hales et al., 2019). It can be assumed that many youths entering the school system have or will experience some form of trauma, thus the trauma informed care framework becomes a necessary addition to the school system for supporting youth effectively. It is recommended that in order to support all students entering a secondary school, the education system implements the five themes of trauma informed care: trauma, accessible service, safety, client focused, and collaboration.

Recommendations

For clarity, the education system will be defined as the individuals who are included within a school community. This is not to be confused with the term 'school community' often used to describe a school culture or sense of feeling within the school. School community is defined as the various individuals and groups involved in the school and surrounding area (Merriam-Webster, 2022b). School community then includes, but is not limited to, school teachers, administrators, staff members within the school and district, students who attend the school, their respective families, school-board members, and other local residents or organizations linked to the school. Trauma informed care applied to the education system benefits those in the school community who have experienced trauma which extends to high school students with PTSD or intergenerational trauma. A review of the education system

through the lens of the trauma informed care framework is organized below in five themes: trauma, accessible service, safety, client focused, and collaboration.

Trauma

An understanding of trauma begins with trauma awareness. When students exhibit negative behaviours, it is important for service providers to recognize that a student's actions may be the result of a traumatic event (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Service providers in the education system is defined as all individuals a student is in contact with once entering the school system. Service providers recognize that a student's unhealthy or ineffective behaviours may be coping strategies developed during a traumatic event (Guarino et al., 2009). This encourages a shift in perspective when working with students and an aim to reduce possible re-traumatization. Service providers recognize the symptoms students with PTSD and intergenerational trauma may demonstrate and understand these may present as negative behaviours within an education system. By identifying negative behaviours as a need for support, service providers can refer the student to the appropriate resources (Harris & Fallot, 2001). Service providers educated about trauma informed care will understand to operate within the limitations of their own education and not work beyond their training (Manitoba Trauma Information and Education Centre, 2013). This includes recognizing when further supports are necessary and being aware of which referrals are appropriate (Harris & Fallot, 2001). Beyond a care team meeting, which is further discussed under *collaboration*, referrals within a school system can be made to learning support services and school counsellors. In some cases, students may need trauma-specific services which require specialized training (Harris & Fallot, 2001). In these cases, community referrals may be

appropriate. Within a trauma informed care framework, service providers have a knowledge of their own trauma history and understanding that they are also at risk of experiencing trauma symptoms (Manitoba Trauma Information and Education Centre, 2013). Organizations are advised to create an environment where self-care and wellness are accessible and expected (Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013). Though service providers within the education system have access to benefits which include counselling, benefits can be limited and viewed as difficult to access. Support benefits are generally accessed outside of the work hours which may lead to a gap for accessing assistance when needed. Within a trauma informed care framework, service providers would understand supports available to students, as well as supports available to themselves during a working day.

Accessible Service

The Merriam-Webster dictionary defines accessible as "easily used or accessed by people with disabilities" (Merriam-Webster, 2022a). Many barriers can restrict trauma-affected individuals from accessing services. Service providers that apply a trauma informed care framework aim to understand these barriers and work to remove them for all individuals (Morgan et al., 2020). For example, a trauma informed care framework ensures clients have access to transportation so that the service system and its supports are accessible to all individuals (Morgan et al., 2020). In 2016, fees for public school bus transportation in British Columbia were increased, and in some areas, busing services were removed altogether (McElroy, 2016). Not only were fees for public school busing increased, but limitations as to who could apply for busing services meant restricted access for many individuals. To be eligible for busing services, students must live in the school catchment area and not within a certain

distance to their school. Another barrier to accessible services is the use of an online platform for application of busing services. Families registering for school may find this process confusing or not have access to the online portal. The online access as well as possible financial constraints may affect accessibility to services.

It has been reported that individuals may not access service due to stigmas around mental health (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Mental health stigmas within the education system can be decreased by service providers in a number of ways. Applying a universal screening process when students first register for school would not only assist in identifying if there was trauma history (Harris & Fallot, 2001), but also would create an inclusive environment that promotes individuals to think about trauma and how it may have affected their life. This institutionalizes trauma awareness and reduces stigma. Mental health literacy should also be included in the British Columbia curriculum. Educating staff and students about mental health and trauma has a positive affect on stigma and inclusion within the education system (Simkiss et al., 2020).

Safety

Within a trauma informed care framework, service providers are predictable, respectful, and transparent in their interactions with clients and others (Fallot & Harris, 2009; Morgan et al., 2020; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Service providers use strategies for developing strong connections with clients which plays a significant role in an individual's recovery from trauma (Fallot & Harris, 2009; Morgan et al., 2020). Historically, traumatized clients have suffered from power differentials where their voice and choices were diminished (Manitoba Trauma Information and Education Centre, 2013; Substance

Abuse and Mental Health Services Administration (SAMHSA), 2014b). Interpersonal trauma, which presents as a power dynamic, is a common form of trauma experienced by many individuals (Morgan et al., 2020). There are a number of power dynamics within the education system between students and staff. It is necessary then for staff to be predictable, respectful, and transparent in their interactions with students to create a feeling of security and safety within the education system. Following a trauma informed care framework within a high school setting, students are involved in decision making for their course selection, individualized education plan (for those who have them), and support access. Students are aware of supports available and have a right to access them.

Client Focused

Within a trauma informed care framework and trauma-informed approach, service providers perceive individuals as resilient and believe every client is possible of recovery (Guarino et al., 2009; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Service providers also use a strength-based approach with a focus on client strengths rather than their deficits (Hopper et al., 2010; Manitoba Trauma Information and Education Centre, 2013; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Service providers in the education system value individual voice, choice, skill-building, and autonomy. Students are empowered and given control over their learning through project-based learning in the classroom (Ellis & Ed, 2021). Secondary students are provided education on future career options and course choices to fit their aspirations and abilities. Following a trauma informed care framework, students and families are provided the opportunity to provide

feedback about the education system. Their feedback is valued and can influence changes to the current education system.

Collaboration

Individuals who experience trauma are often in need of multiple support services (Morgan et al., 2020). A system follows trauma informed care when collaboration with members within and around services are provided to clients (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a). There are many contributors that provide support within an education system. When a student expresses the need for support directly, they are able to access support from school counsellors or community organizations. A student may indirectly express a need for support. In this situation, a student's needs may be discussed at a school Care Team Meeting, which is comprised of teachers, school counsellors, administrators, family members, learning support service teachers, and individuals from outside agencies when appropriate. At the secondary level, the student may participate in this meeting as clients are recognized as experts of their own lives and should be allowed autonomy for decision making (Manitoba Trauma Information and Education Centre, 2013). Secondary school counsellors may refer to supports from outside agencies; however, it is the student's decision to access and participate. Peer support is recognized as an important support in trauma informed care as peer collaboration can build a feeling of safety and promote recovery and healing (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Peer support, such as a program that pairs senior secondary students with junior students, should be implemented in the education system. Students receive peer collaboration but also are given guidance from a teacher-in-charge who monitors peer support and provides appropriate further mentorship education.

Conclusions

Many youth and adolescents remain undiagnosed for PTSD (Scheeringa et al., 2011) and there is no formal diagnoses for intergenerational trauma (American Psychiatric Association, 2013). Trauma informed care applied to the education system benefits those in the school community who have experienced trauma which extends to high school students with PTSD or intergenerational trauma. It is recommended that in order to support all students entering a secondary school, including those who have experienced trauma, the education system implements the five themes of trauma informed care: trauma, accessible service, safety, client focused, and collaboration. Within a trauma informed care framework, service providers understand supports available to students, as well as supports available to themselves during a working day. Staff and students are educated about mental health and trauma as it has a positive affect on stigma and inclusion within the education system (Simkiss et al., 2020). Service providers apply a trauma informed care framework to understand possible barriers and work to remove them for all individuals. Staff are predictable, respectful, and transparent in their interactions with students to create a feeling of security and safety within the education system. Students are aware of supports available and have a right to access them. Service providers perceive individuals as resilient and believe every client is possible of recovery. When a student expresses the need for support, they are able to access support from school counsellors or community organizations. Peer supports, such as a program that pairs senior secondary students with junior students, are implemented in the education system.

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