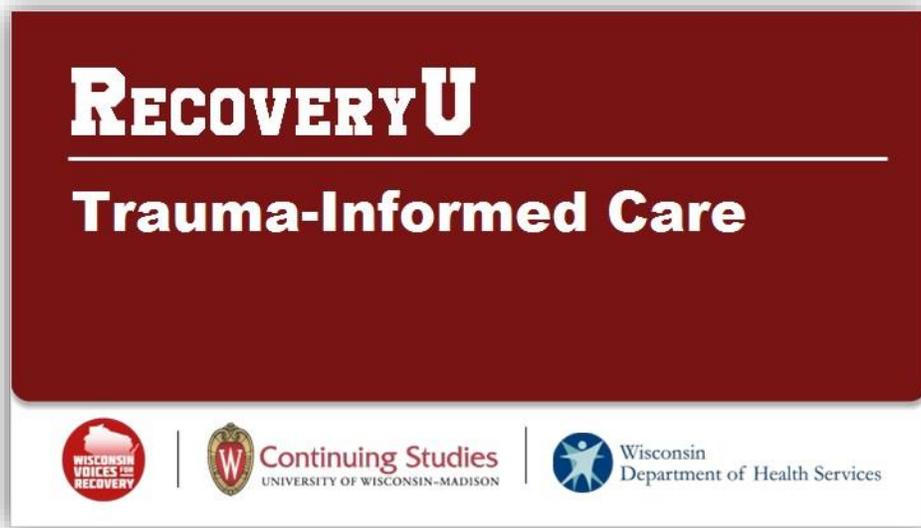


## RecoveryU: Trauma-Informed Care



Welcome to the Recovery U module on trauma-informed care.

### Module Goals

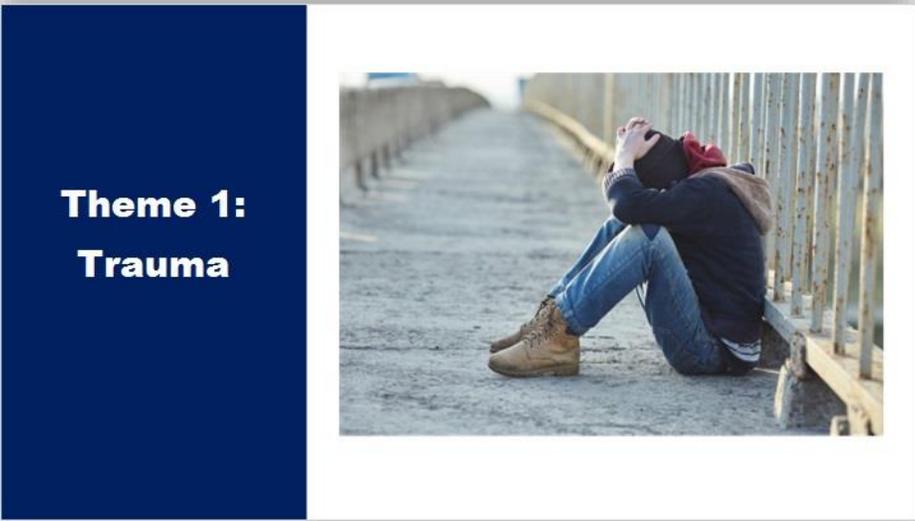
**By the end of this learning module, you will be able to:**

1. Define and be able to identify the types of trauma.
2. Explain the significance of the Adverse Childhood Experiences (ACEs) study and its impact in the advent of trauma-informed care (TIC).
3. Explain resilience and resilience concepts.
4. Define trauma-informed care.
5. Recognize the five principles of TIC culture.
6. Differentiate between traditional substance use disorder recovery practices and trauma-informed recovery practices.



All resources and references are located in the Resources tab of this presentation.

By the end of this learning module, you will be able to: define and be able to identify the types of trauma, explain the significance of the Adverse Childhood Experiences study and its impact in the advent of trauma-informed care (or TIC), explain resilience and resilience concepts, define trauma-informed care, recognize the five principles of TIC culture, and differentiate between traditional substance use disorder recovery practices and trauma-informed recovery practices.



We hear the word trauma used a lot in many different places. But what does it mean?

**Theme 1** **Trauma Defined**

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

SAMHSA, 2014  
[https://www.samhsa.gov/samhsaNewsletter/Volume\\_22\\_Number\\_2/trauma\\_tip/key\\_terms.html](https://www.samhsa.gov/samhsaNewsletter/Volume_22_Number_2/trauma_tip/key_terms.html)

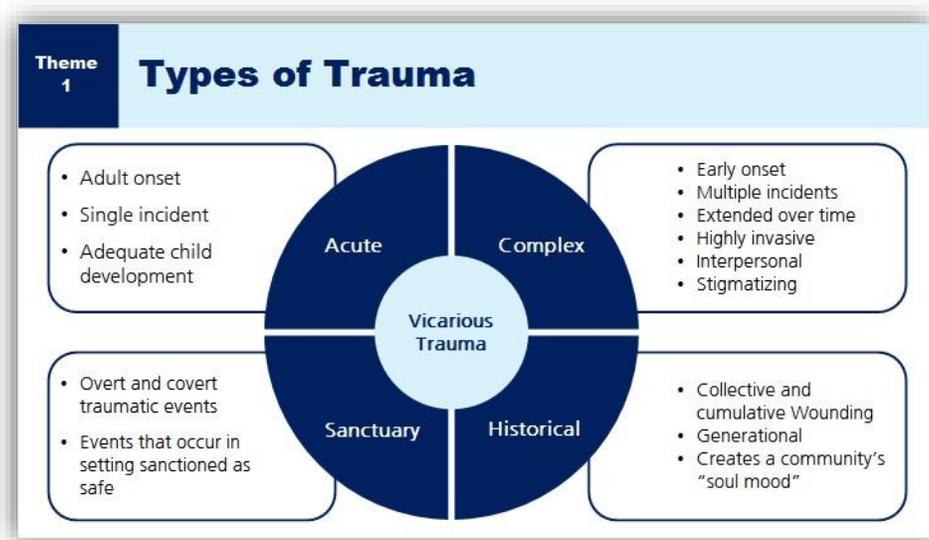
SAMHSA defines individual trauma as resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

It's important to note that trauma is very subjective. For instance, consider a woman in her 60's who was involved in a serious car accident at age 15. She and three of her friends were in the car that rolled over several times. No one was seriously hurt. This woman, as a result of that accident, never got her

driver's license—ever! She was dependent on others to take her places. Her three friends were largely unaffected by the accident and all obtained their driver's license and lived seemingly normal lives.

Trauma leaves people feeling vulnerable and helpless. Fear is a predominant emotion in trauma.

One consequence of trauma is how it can interfere with significant relationships in one's life and the beliefs that person has for themselves and their place in the world.



It's important to know the types of trauma that exist. The type of trauma or traumas that a person experiences may determine how they recover.

Acute trauma is generally experienced in adulthood and tends to be an isolated incident with a definite beginning, middle and end. It's not uncommon to recover rather quickly from acute trauma if the right care is delivered at the right time. Psychological First Aid is considered a best practice for treating acute trauma.

Complex trauma is an emotional state experienced by people, usually the very young, who are exposed to repeated and prolonged trauma. This kind of trauma usually occurs in situations where the victim is unable to flee and is under the control of the perpetrator. Often the victim has a close relationship with the perpetrator. Survivors of domestic violence and child sexual abuse are groups at particular risk of developing complex trauma.

One type of trauma that is not always talked about but is extremely important to discuss is sanctuary trauma. Sanctuary trauma is actions of systems or providers that bring up feelings of vulnerability, helplessness, fear, shame, and other similar feelings. These traumas occur in places we have socially

sanctioned as safe, like medical systems, mental health and substance use disorders treatment, corrections, foster care, home, schools, and places of worship. This type of trauma is very damaging to one's feelings of safety. If I don't feel safe at home, where in the world will I ever feel safe?

You will note that Corrections is listed as an example of a place where sanctuary trauma can occur. Corrections can be heavily debated as an expected place of "sanctuary." However, some people who have been in the correctional system may experience comfort in the routine, the schedule, and the knowledge of what to expect, that they may not have when released back into society. This may be the first time in their life they are not living in chaos.

In the middle of the circle you will see vicarious trauma. This type of trauma is the "elephant in the room" that many in the helping professions either don't notice, or don't want to talk about. However, this is very real and leads to an inordinate amount of people suffering from compassion fatigue or burnout. Many leave the helping profession due to compassion fatigue or burnout. This is serious! Vicarious trauma also has system-level impacts. That is why trauma informed care is for everyone within a system.

One wonders how many helping professionals are squeamish at the sight of emotional blood—even their own!

**Theme 1**

## Prevalence of Trauma

- 56%** of the general population report at least one traumatic event in their life. (Kessler, 1996)
- 90%** of behavioral health consumers have been exposed to a traumatic event; most have multiple exposures. (Muesar, 1998)
- 60%** of adults report experiencing abuse or other difficult family circumstances during childhood.
- 26%** of children in the United States will witness or experience a traumatic event before they turn four (National Center for Mental Health Promotion and Youth Violence Prevention, 2012).

Let's take look at these numbers. Fifty-six percent of the general population has reported at least one traumatic event in their life. Ninety percent of mental health clients have been exposed to a traumatic event and most have multiple exposures. Sixty percent of adults report experiencing abuse or other difficult family circumstances during childhood. And twenty-six percent of children in the United States will witness or experience a traumatic event before they turn four.

Most alarming to those of us in the helping professions is that trauma is much more prevalent than we ever thought. If we accept these numbers, we can perhaps conclude that trauma is a main driver of what is making us sick as a society. And yet, how many helping professionals are aware of these statistics and more importantly, shape their work because of this revelation? How many of us screen and assess for trauma?

**Theme 1**

## Trauma Facts

People who experience trauma are:

- Fifteen times more likely to attempt suicide.
- Four times more likely to become alcoholic.
- Four times more likely to develop a sexually transmitted disease.
- Four times more likely to inject drugs.



SAMHSA, 2014

To summarize this section on trauma, we look to SAMHSA which reports that those who experience trauma are fifteen times more likely to attempt suicide and four times more likely to become alcohol dependent, develop a sexually transmitted disease, or inject drugs. This is one of the many reasons we need to screen and assess for trauma.

**Theme 2:**

**Adverse  
Childhood  
Experiences  
(ACE) Study**



Adverse Childhood Experiences are negative experiences, like abuse and neglect, that occur in childhood before the age of 18.

**Theme  
2**

**ACEs Defined**

Negative experiences (abuse and neglect) that occur in childhood before the age of 18.

Adverse Childhood Experiences have been linked to:

- Risky health behaviors
- Chronic health conditions
- Low life potential
- Early death



Adverse Childhood Experiences, or ACEs, have been linked to risky health behaviors, chronic health conditions, low life potential, and early death.

As the number of ACEs increase, so does the risk for these negative health outcomes.

## ACE Study

The ACE study is a 10 question questionnaire created by Co-Principals Dr. Vincent Felitti, and Dr. Robert Anda.

Involved over 17,000 participants from a Health Maintenance Organization in Southern California. It was conducted from 1995 to 1997 with two waves of data collection.

The ACE Study has been replicated all over the world with consistent findings.

The Wisconsin ACE Study conducted in 2011 showed similar results as the national ACE study.

The ACE study came from a questionnaire created by Co-Principals Dr. Vincent Felitti, and Dr. Robert Anda. It is one of the largest investigations of childhood abuse and neglect and how those events affect people's overall health in later life. This research involved 17,000 plus participants who had Kaiser Permanente health insurance in Southern California.

The questionnaire was a simple yes or no response to 10 questions. The highest ACE score an individual could have is a ten. The lowest, a zero. The original questionnaire was made part of the HMO participant's health screen questionnaire.

The ACE study has been replicated all over the world with consistent findings. The study has demonstrated that the higher the ACE score, the more likely the person is to experience negative physical issues such as heart disease, HIV, and cancer, and psychological issues such as depression, anxiety, and suicidality.

Wisconsin conducted its own ACE study starting in 2011 as part of the Behavioral Risk Factor Survey. 4,000 Wisconsin residents with a landline telephone were randomly picked to be a part of the ACE study. As was predicted, the results of the study were consistent with the results of the original national ACE Study.

Theme  
2

## ACE and Health Risks

- Severe obesity (1.6x)
- Alcoholism (7.4x)
- COPD (3.9x)
- Stroke (2.4x)
- Depression (4.6x)
- Heart disease (2.2x)
- Any cancer (1.9x)
- Diabetes (1.6x)
- Individuals who record four or more ACEs are at increased risk for long-term health complications. (Felitti, et. al., 1998)



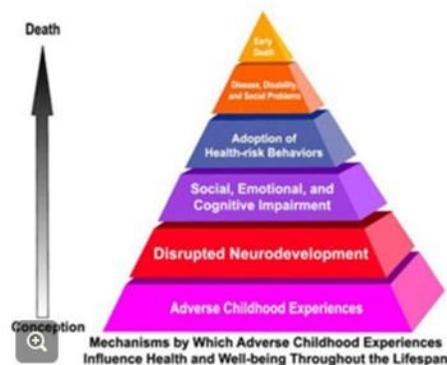
You can see from this slide that ACEs can significantly affect our health and well-being. As was stated earlier, ACEs are what are ailing us as a society. Yet very few even know about the study, much less about asking the proper questions of those we serve. Imagine the impact if we screened for ACEs and were able to move further upstream to design systems and interventions that would interrupt this dangerous life course? Study findings repeatedly reveal a graded dose-response relationship between ACEs and negative health and well-being outcomes across the lifespan. As the number of ACEs increases, so does the risk for these and other types of conditions.

Theme  
2

## ACE Impact Over the Lifespan

Effects of cumulative adverse childhood experiences:

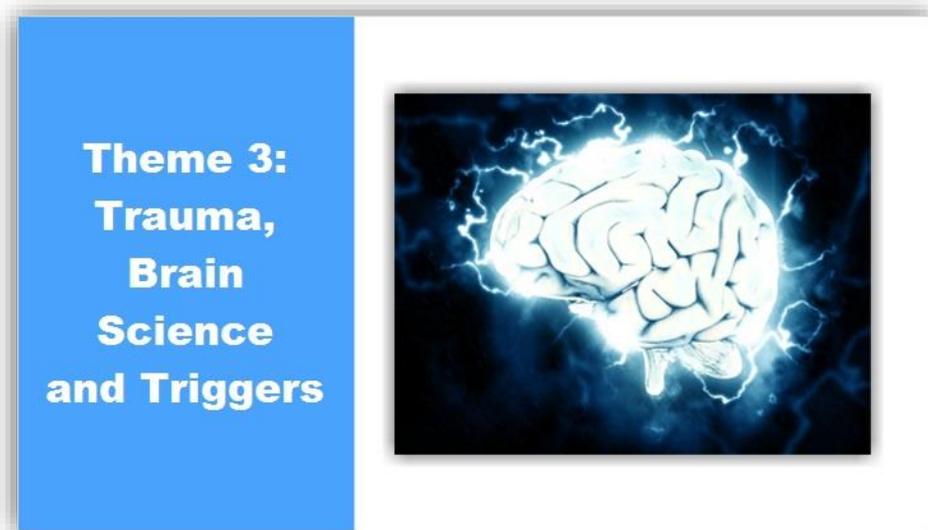
- Neurological
- Biological
- Psychological
- Social
- Mortality



This pyramid is found in most ACE publications. We tend to know a lot about the top part of the pyramid. For instance, we know that disease, disability and social problems can result in early death.

Just think about someone addicted to drugs. Not only is the drug dangerous, but the lifestyle associated with that drug use can be dangerous, traumatic, and deadly.

We know as a society very little about the base of the pyramid. Not many of us realize that at conception, adversity in childhood can lead to disrupted neurodevelopment, which can lead to social, emotional, and cognitive impairment, which leads to the adoption of health-risk behaviors, substance use as one example, and so on up the pyramid.



What we have learned about trauma is that it shakes the nervous system to froth. Trauma lives in the body. It significantly affects the way the brain is wired.

## Fight, Flight, or Freeze

Fight: Resist

Flight: Run Away

Freeze: Stay Still

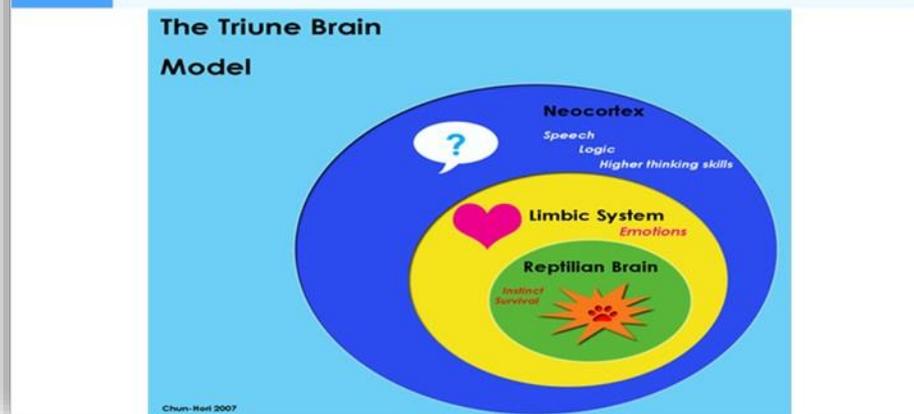


It is estimated that there are over 1,400 physiological changes that happen in the body when we go into reactive brain, otherwise known as fight or flight. Our muscles tense, our breathing gets fast and shallow, blood flow slows to major organs and the executive brain, blood flow speeds to muscles and limbs in order to "react," strength, energy and aggression increase, digestion slows or ceases, cortisol is released depressing the immune system, blood pressure rises, adrenaline is released, insulin is released, hearing may shut down, tunnel vision occurs, and pain sensation is dulled with endorphins, the body's natural morphine.

All of these changes affect how we experience the situation. The traumatic event is recorded in "high definition." Memory loss from parts of the event are common, and time slows down or speeds up.

The human body is designed to be in fight or flight mode for only 20 minutes—the time needed to fight the threat or flee from the threat. But what happens when a child is going through this process multiple times a day, every day? What happens to their brain and nervous system? Like a car engine that is forced to run consistently at 7,000 RPM, our bodies will wear out. The stress hormones that flood our bodies when in flight, fight, or freeze are very powerful and will exact a toll on our health.

## The Triune Brain Model



This is the Triune Brain Model developed by Dr. Paul MacLean in 1990. In the Triune Brain Model, there are three distinct brains working together as one.

First, the reptilian brain: The base of brain directly connects with the spinal cord and is called the basal ganglia. It includes the brainstem and cerebellum. This part of the brain is equated with animal instincts. It controls reflex behaviors, muscle control, balance, et cetera. The reptilian brain is very reactive to direct stimulation. Have you ever seen the series *The Walking Dead*? Those zombies are basically human beings walking around with only the reptilian brain working—in other words, no humanity.

Second, the limbic system is the midbrain, the center of emotion and learning which is unique to mammals. Everything in the limbic system is agreeable (pleasure) or disagreeable (pain or distress). The limbic brain has no clock. Survival is based upon avoidance of pain and reoccurrence of pleasure.

And third, the neocortex is unique to primates. The more highly evolved version is unique to humans. This part of the brain includes the pre-frontal lobes of the brain. This brain regulates so much of what makes us human: executive functioning, higher-order thinking skills, reason, speech, meaning-making, will power, and wisdom.

The limbic brain is activated during original trauma to help the person "flight, fight or freeze". When the limbic brain is activated, the prefrontal lobes go offline.

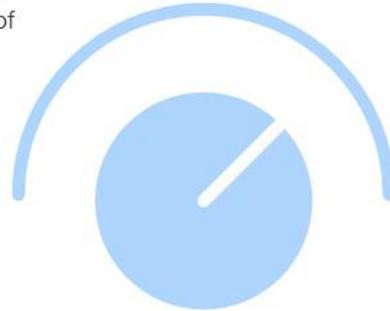
Traumatic material gets stored in the limbic brain, which was never designed to hold anything long-term. The goal of treatment is to move the traumatic material out of the limbic system and into the neocortex. To remove the "charge" and turn that highly-charged traumatic memory into just a bad memory.

## Triggers Defined

A trigger is anything that elicits feelings of vulnerability, helplessness, fear, or loss of control.

Examples include:

- Lack of control
- Isolation
- Lack of information
- Being told what to do
- Being touched



Now we begin to understand trauma, its prevalence and its negative effects on our health and our life. Knowing all of this, we see we have a responsibility to do what we can to protect trauma survivors from re-experiencing their original trauma. To do this we need to be mindful of potential triggers or reminders of that trauma. The list here on this slide is not an exhaustive list. But we can all agree that these triggers have the potential to create a limbic reaction—reactive brain—in a person who has experienced trauma in their life. Again, anything that elicits feelings of vulnerability, helplessness, fear, or loss of control can be a trigger. Like trauma, triggers are very subjective. This list is not exhaustive, but it gives you an idea that a trigger can be a person, place, thing, event, time, date, smell, or even texture. It is very important to teach trauma survivors how to ground themselves using all five senses, as stimuli to any and all of our senses can be a trigger.

## Triggers and Re-Traumatization

Re-traumatization can be a situation, attitude, interaction, or environment that **replicates the events or dynamics of the original trauma** that triggers overwhelming feelings.

Re-traumatization can be obvious or not so obvious.

It is usually unintentional.

It is always hurtful.



We now understand that when we trigger someone, or activate their limbic brain, that can lead to re-traumatization. If we do not have our trauma lenses on, we can easily and innocently move a person farther away from recovery. If we are not trauma-aware and trauma-informed, we end up looking and feeling like every other non-trauma-informed system that the traumatized person interacts with. So in a Trauma Informed Care approach, we want to be mindful of all the ways we as helpers, both the practitioner and the system, inadvertently re-traumatize a consumer seeking services. This slide lists some of the important points to remember about re-traumatization: It can be a situation, attitude, interaction or environment that replicates the events or dynamics of the original trauma and triggers the overwhelming feelings and reactions associated with them. Re-traumatization can be obvious, or not so obvious. It is usually unintentional. It is always hurtful, exacerbating the very symptoms that brought the person into services. This can result in pushing the consumer farther way from where they need to be to begin to heal and recover.

## Theme 4: Resilience



Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress. It means “bouncing back” from difficult experiences. Research has shown us that resilience is ordinary, not extraordinary.

Theme  
4

### Resilience Defined

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress. It means “bouncing back” from difficult experiences.

<http://www.apa.org/helpcenter/road-resilience.aspx>



Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered adversity.

Theme  
4

## Resilience Research Results

Some are born with resilience.

Resilience does not decline with age.

It is a reflection of both protective and risk factors.

It is a skill that can be learned and honed like any other skill, regardless of our histories of adversity, challenges, or trauma.

Dr. Mark Seligmann

People are born with varying amounts of resilience. The good news is resilience does not decline with age, like many of our other abilities, and we can learn how to become more resilient despite our histories.

Theme  
4

## Trauma Mitigating and Exacerbating Factors

### Person

- Age or developmental stage
- Past experiences
- Inherent strengths and coping skills

### Environment

- Supportive responses from significant others
- Access to safety and resources

### Event

- Severity and chronicity
- Interpersonal as opposed to an act of nature
- Intentional or accidental

Why is it that some people seem to deal with trauma and tragedy pretty well while others struggle? It depends on many different factors which can be broken out by the person, the environment they live in, or the event itself. But, as was mentioned earlier, being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered adversity. For instance, a trauma survivor may experience a devastating heart attack, survive it, and respond to the trauma by losing a lot of weight and exercising every day. Even though that person looks

to be handling the traumatic medical event well, they may still experience fear, depression and sadness. They are still showing resilience.



Let's continue our discussion of Trauma-informed Care.

**Theme 5** **Trauma World View**

No place is safe.

Other people are unsafe and cannot be trusted.

My own actions, thoughts, and feelings are unsafe.

I expect crisis, danger, and loss.

I have no worth and no abilities.

In working with those with trauma histories, we need to address the trauma worldview as it is their reality, it's their truth.

The question to you is, how well will these people engage in services if this is their reality? Probably not very well.

Within recovery we talk about responsibility or accountability. Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. They must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness. In a safe trauma-informed treatment environment, this takes priority. Placing newly-recovering people into cookie cutter types of treatment does not work well. The trauma world view must be taken into account.

**Theme 5** **Trauma-Informed Care Defined**

What it is:	What it is not:
<ul style="list-style-type: none"><li>• A principal-based culture change process</li><li>• It focuses how trauma may affect an individual's life and their response to behavioral health services</li></ul>	<ul style="list-style-type: none"><li>• An intervention to address PTSD</li><li>• A "flavor of the day" approach to delivering care</li></ul>

Trauma-informed Care, or TIC, is not a practice or type of therapy. There are many out there who think they know what TIC is and still operate under the notion that this is a type of therapy. TIC is an approach, a process of culture change that takes several years to set in place. TIC includes program policies, procedures, and practices to protect the vulnerabilities of those who seek and provide trauma-related services. TIC includes everyone: all staff in an organization and the consumers and their families and support systems. TIC levels the playing field.

Despite what some may believe, TIC is not a fad, or a "flavor of the day." Consider this: If treating people with care, compassion, and empathy is a flavor of the day, what does that say about the state of our helping professions? The TIC approach should be standard operating procedure. But sadly, it is not. Rules and regulations by payers, insurance companies, even State systems, have removed the humanity from human services. Trauma-informed Care seeks to instill humanity back into human services.

“What’s  
wrong with  
you?”

“What  
happened to  
you?”

“What’s  
right with  
you?”

The key distinguishing feature of TIC is to move from "What’s wrong with you?" to "What happened to you?" to "What’s right with you?"

The whole notion of "What’s wrong with you?" is part of the medical model, which is deeply engrained into our culture. The medical model assumes that the helper is the expert, they gather data, symptoms, and the like, and come up with a diagnosis which leads to a creation of a treatment plan which the consumer agrees to. It’s assumed that the practitioner is the expert, the consumer is not. Therefore, the conversation tends to be one-way, expert to consumer. The consumer has little to no voice.

In a TIC culture, we encourage the consumer to tell their story. The goal is to create enough safety, compassion and respect that the person feels, for perhaps the first time in their life, that they can talk about what happened to them.

No matter how traumatized or broken some people may appear, there is a lot more right with them than wrong. Always look for their strengths and bring those to their realization. We need to celebrate that.

“The oldest medicine in the world is love and compassion”

VADM Vivek Murthy, M.D.

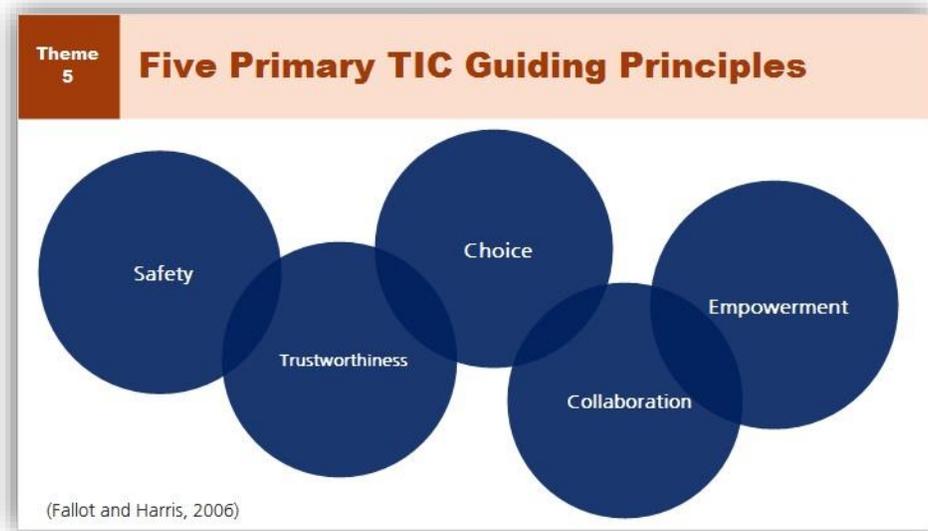
Former United States Surgeon General



In 2009, the Wisconsin Trauma-Informed Care Advisory Committee came up with their TIC Guiding Principles. You will note that this was created in 2009, 3 years before SAMHSA came up with their guiding principles.

Please note that all of the principles listed in this slide touch the main principle: Healing happens in relationships. In fact, it's not the type of therapy that helps trauma survivors heal, it's the quality of the relationship that makes the most difference! Former US Surgeon General Dr. Vivek Murthy expressed this beautifully during a Seattle conference in 2017: "The oldest medicine in the world is love and compassion." How true.

In a trauma-informed program or organization, the first priority of every person who interacts with a consumer is to form, maintain, and strengthen their relationship with the consumer. It's the quality of the relationship, not the type of therapy used, that leads to healing.



Roger Fallot and Maxine Harris are researchers who have boiled down the TIC approach into five key principles or values. They have also created a TIC culture fidelity tool that's built around these five values.

First is safety: Physical and emotional safety. Both the setting and interactions are physically and psychologically safe which includes where and when services are delivered, as well as an awareness of an individual's discomfort or unease. Question for you: What other things would you consider for safety?

The second principal is trustworthiness and transparency. Meaningful sharing of power and decision-making. Transparent operations and decisions maintain trust. Make sure you do what you say you will do. If your organization has a 24-hour helpline that is live answer, you want to make certain that's the case. Ensure trustworthiness through clarity and consistency. Question: What other areas would you consider important regarding trustworthiness?

Third is choice. Voice and choice. The aim here is to strengthen staff's, participants', and families' experience of choice. Trauma survivors are used to having people talk down to them, or at them, rather than with them. There is recognition of the need for an individualized approach. There is active participation in decision-making regarding services. It's understood that offering built-in small choices can make a real difference. Question: What kind of choice is relevant to providing services?

Fourth is collaboration and mutuality. Partnership and leveling of power differences. Recognition that healing happens in relationships and meaningful sharing of power. The consumer is seen as an expert in their own lives. There is active collaboration going on between the consumer, their family, if the

consumer is willing, and the helper to develop a comprehensive recovery plan. Question: What does collaboration look like in your day-to-day work?

And fifth is empowerment. An individual's strengths are recognized, built on and validated. Question: How would you go about empowering your clients?

**Theme 6:  
Trauma-  
Informed  
Care and  
SUD  
Recovery**



Next, we will discuss Trauma-informed Care and Substance Use Disorder Recovery.

**Theme 6**      **Trauma-Informed Care and Substance Use Disorders**

Adults who experience trauma may self-medicate; self-medication may also increase risk for further abuse and traumatic experiences.



Review of possible order effects by Simpson & Miller, 2002

An area often overlooked is trauma and substance abuse. Adults who experience trauma may self-medicate, and self-medication may increase risk for further abuse and traumatic experiences. These

people can live very dangerous lives. Not only is the drug dangerous—think opiates as one example—, but the drug-seeking lifestyle can also be traumatic and deadly.

**Theme 6**

## Creating Safety in the Recovery Process

**Best practices:**

- Avoid re-traumatization
- Consider the role of shame in both addiction and trauma
- Avoid judgments
- Be genuine as you build rapport
- Ask open-ended questions
- Convey experience, strength and hope
- Have closure strategies ready



It's crucial to create an environment of safety for change to take place. Recall that safety is one of the core TIC principles. In fact, it could be said that safety is the core principle. If a person feels unsafe, the other TIC principles (trustworthiness, choice, collaboration, and empowerment) will mean little to the person in early recovery. What are some safety best practices?

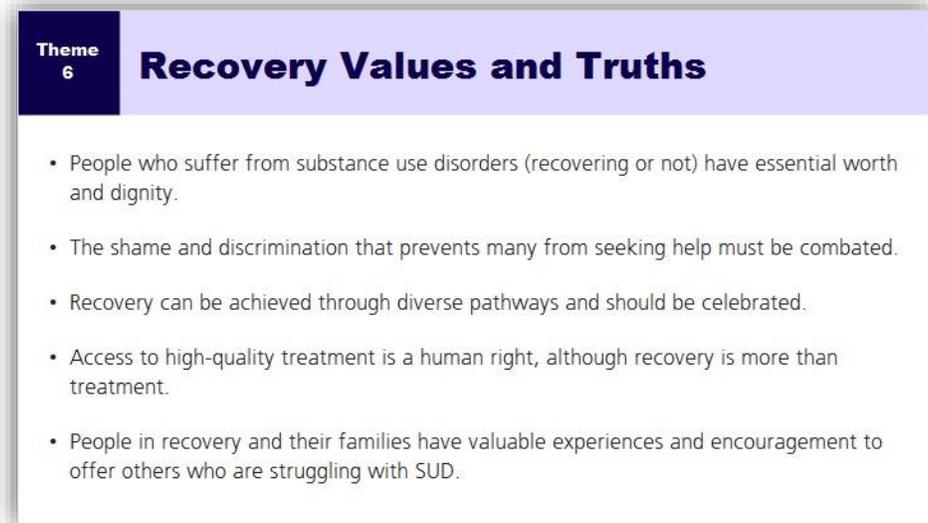
We want to avoid re-traumatization. Well intentioned professionals, recovery coaches and sponsors re-traumatize without realizing it. For example, pushing too fast for trauma detail before the consumer is ready. Or perhaps a trauma survivor who is new to recovery is sent to a 12 step meeting that is highly confrontational. It's so important to consider the role of shame in both addiction and trauma. We need to be mindful of the synergy that exists between the trauma, mental health issues and addiction.

Be nonjudgmental. Conveying acceptance of the consumer and their story is powerful and can be a welcome departure from the consumer's interaction with others. Nonjudgmental does not mean endorsing negative behaviors. Refrain from name calling or other hot seat techniques.

Be genuine as you build rapport. Ask open-ended questions. Ask questions that invite the consumer to share their experience, their story. However, in a trauma-informed culture, it's not imperative that the consumer share their story. We only want to create the environment that would allow the story to come forth if they so choose.

Convey experience, strength, and hope, and have closure strategies ready. Teaching consumers how to ground and reinforcing that throughout treatment is so important and well worth the time. Trauma

survivors need additional coping tools in their toolbox besides alcohol, other drugs or other destructive behaviors in their effort to deal with the pain of the past.



**Theme 6**

## **Recovery Values and Truths**

- People who suffer from substance use disorders (recovering or not) have essential worth and dignity.
- The shame and discrimination that prevents many from seeking help must be combated.
- Recovery can be achieved through diverse pathways and should be celebrated.
- Access to high-quality treatment is a human right, although recovery is more than treatment.
- People in recovery and their families have valuable experiences and encouragement to offer others who are struggling with SUD.

When you look over the items in this slide, we hope you can see a TIC approach throughout. Too often our treatment programs become rote. A cookie-cutter approach that fails to take in the uniqueness of each individual. Every person has their own story, their own experience and their own path to recovery. Do we allow these people new to recovery the safety, time and space to explore what has happened to them in their lives and how what they have gone through is affecting the way they interact with the world? Is our treatment designed to fulfill a regulatory requirement or to help fulfill a person's potential?

## Module Goals

In this learning module you learned how to:

1. Define and be able to identify the types of trauma.
2. Explain the significance of the Adverse Childhood Experiences study and its impact in the advent of trauma-informed care.
3. Explain resilience and resilience concepts.
4. Define trauma-informed care.
5. Recognize the five principles of TIC culture.
6. Differentiate between traditional substance use disorder recovery practices and trauma-informed recovery practices.



All resources and references are located in the Resources tab of this presentation.

We hope that as you review these themes, you'll be able to define and identify the types of trauma, explain the significance of the Adverse Childhood Experiences study and its impact in the advent of trauma-informed care, explain resilience and resilience concepts, define trauma-informed care, recognize the five principles of TIC culture, and differentiate between traditional substance use disorder recovery practices and trauma-informed recovery practices.

If we begin to screen and assess for trauma in people's lives, if we begin to create workplace cultures that are trauma-informed and trauma responsive, perhaps we can create recovery experiences that are safe, empowering and unique to each person.

For far too long we have treated people with mental health issues and substance use disorders with a one size fits all treatment that either ignored or minimized the impact that trauma has played in their life.

As we inadvertently triggered and re-traumatized our clients, we have moved them farther away from where they need to be. We have created more head wind for ourselves and our clients. With adopting and implementing Trauma-Informed Care, we can change that.



Continuing Studies  
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Department of Health Services