Module 10

Trauma-Informed Care

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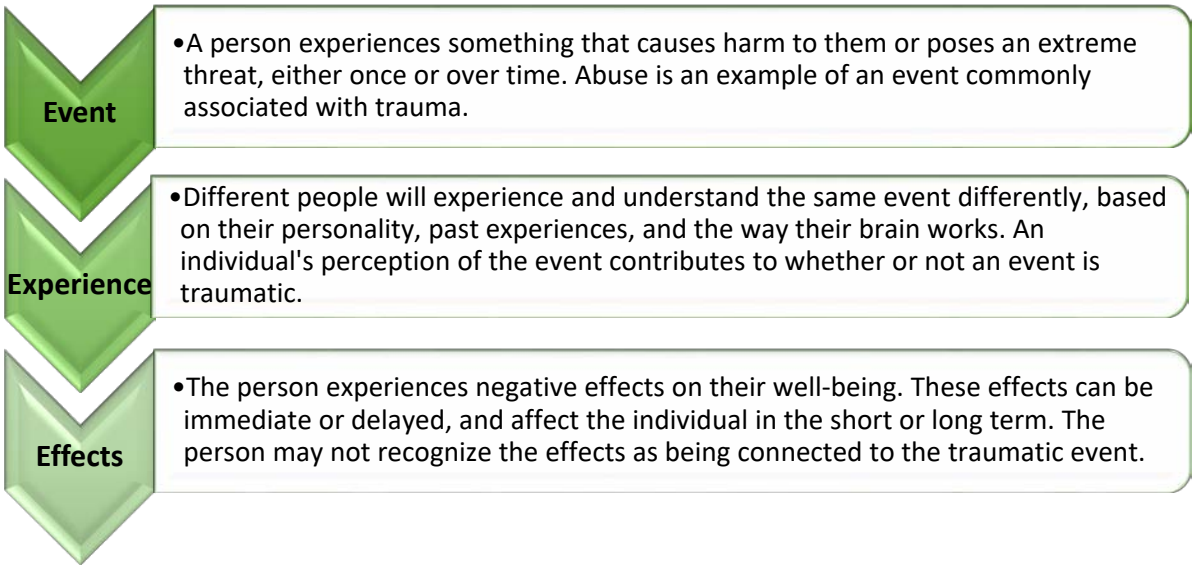
Trauma and FASD

Trauma is an important concept to understand in both the prevention of FASD and the support of children with FASD and their families. This module will discuss what trauma is and how it impacts us, as well as how trauma intersects with FASD prevention and support.

Defining Trauma

Trauma refers to the lasting adverse impacts that result from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening" (Substance Abuse and Mental Health Services Administration [SAMSHA], 2014, p. 7). Trauma can impact a person in many ways such as their feelings of safety, self-concept, relationships, ability to achieve developmental milestones, and mental and physical health.

There are three components of trauma, called the three Es (SAMHSA, 2014):



People can experience trauma at any age. There are many types of potentially traumatic events that people may experience, including experiencing or witnessing community violence; physical, psychological, or sexual abuse; life-threatening injuries; serious, frightening, or painful medical procedures; natural or man-made disasters; being a refugee; discrimination; participation in armed combat; and the sudden unexpected death of a loved one (Ameringen et al., 2008). Children might also experience events like abuse; serious and untreated parental mental illness; living with someone who misuses substances; and separation from a parent/loved one (Bartlett & Steber, 2019; Dong et al., 2004).

Trauma is common:
A cross-Canada survey found that **76.1%** of adults have experienced at least one potentially traumatic event.

Trauma can also be experienced collectively by members of groups who have experienced colonization or genocide, as was the case in Indigenous communities across Canada. Historical or transgenerational trauma is complex, involves multiple traumatic events that occur over time, can lead to psychological, physical, and social consequences, and can affect multiple generations (Gone, 2013).

Trauma is common. In a survey of Canadian adults, Ameringen et al. (2008) found that 73.4% of women and 78.5% of men had experienced an event that might be traumatic. Although individuals can experience negative effects from one traumatic event, the effects of trauma can be cumulative for those who have experienced multiple events.

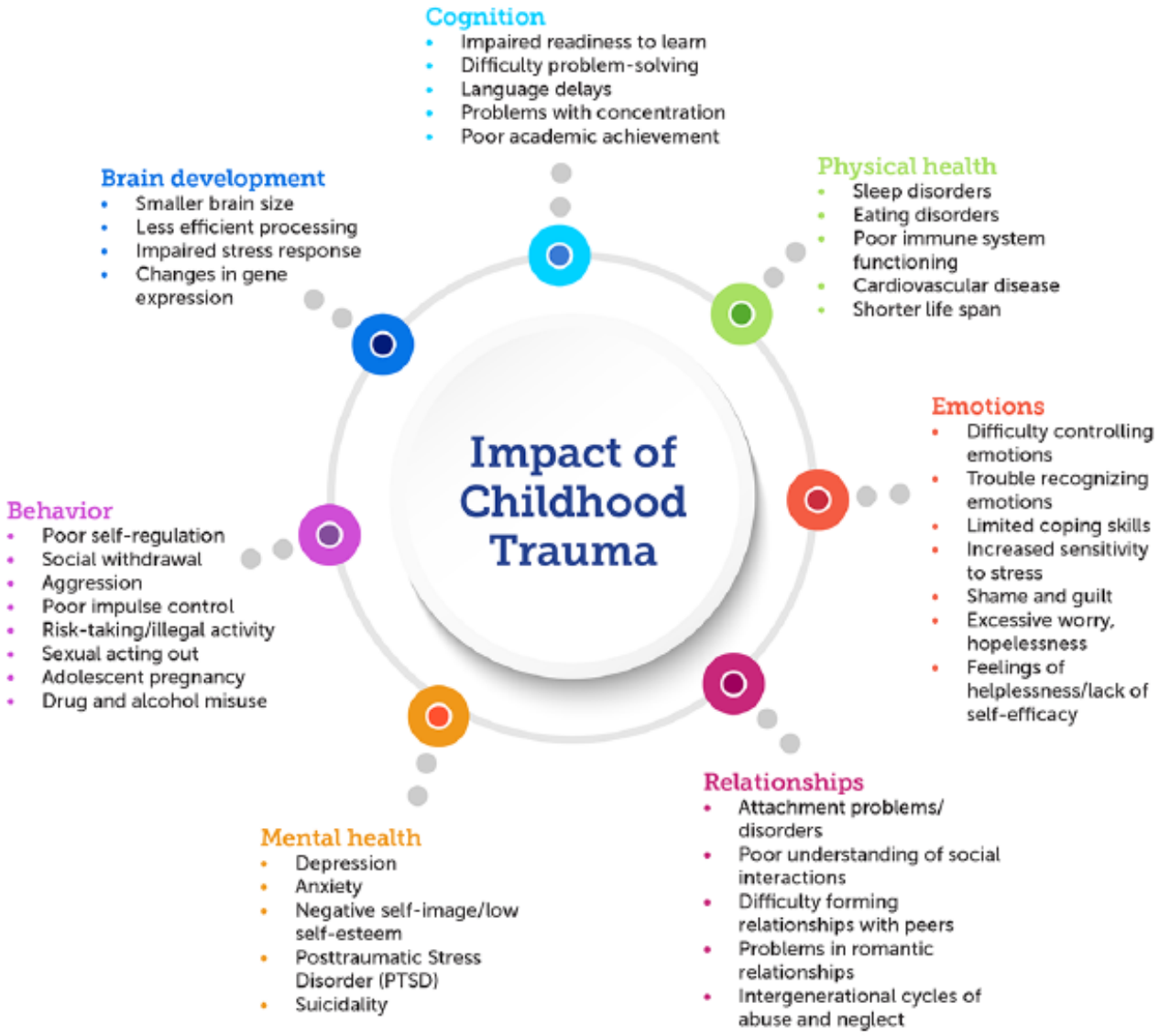
Short- and Long-term Effects of Childhood Trauma

Childhood trauma may have negative and long-lasting impacts on development, including the development of the brain, as well as cognitive, physical, and social-emotional development, loss of developmental milestones, learning, attachment relationships, and physical and mental health.

The effects of trauma can be lifelong. Those who have experienced trauma as children may have (Bartlett & Steber, 2019; Dye, 2018; SAMHSA, 2014):

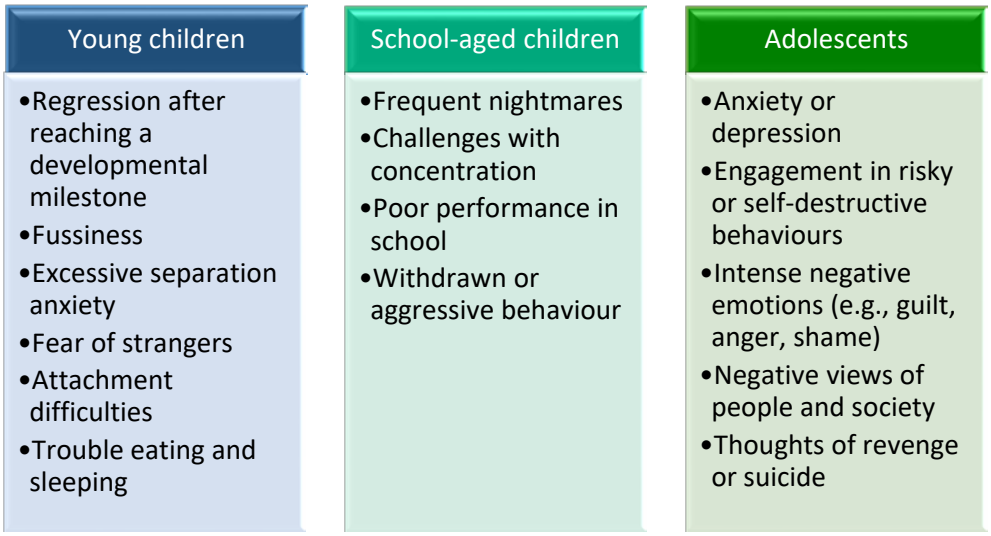
- an increased activation of the stress response system
- difficulty with cognitive processes like attention, memory, and thinking
- challenges regulating emotions and behaviours, setting boundaries, and controlling the expression of emotions
- interpersonal challenges, including difficulty trusting and benefitting from relationships

The graphic on the next page illustrates the many short- and long-term impacts that childhood trauma can have on cognition, physical health, emotions, relationships, mental health, behaviour, and brain development.



Source: Bartlett & Steber, 2019

Common Developmental Short-term Effects of Trauma in Children (Bartlett & Steber, 2019)



Developmental stage at the time of the traumatic event can impact the short- and long-term effects of trauma (Bartlett & Steber, 2019). There is no "typical" trauma reaction. Effects may vary widely between individuals based on genetic, epigenetic, biological, psychological, social, familial, community, societal, and historical factors (Bartlett & Steber, 2019; Kimburg & Wheeler, 2019). For example, females may be at higher risk of post-trauma anxiety and depression, dissociation, and post-traumatic stress disorder (PTSD) than males (Carmassi et al., 2020; Garza & Jovanovic, 2017; Tolin & Foa, 2006; Wamser-Nanney & Cherry, 2018). This difference may be influenced by a variety of factors such as the fact that females are more likely to seek health care and that there are brain differences between males and females (Garza & Jovanovic, 2017; Kimerling et al., 2018; Wamser-Nanney & Cherry, 2018).

Impact of Trauma on the Stress Response System

Trauma is associated with long-term activation of the stress response system, especially if traumatic events are ongoing. The purpose of the stress response system is to help a person survive a traumatic event. When the stress response system is activated, various bodily systems are 'ramped up' and others are 'slowed down'. When the stress response system is chronically activated, the person's body does not have an opportunity to regulate itself. This dysregulation can affect brain development, structure, and processes as well as long-term physical and psychological health (Dye, 2018; Heim et al., 2008; Ho et al., 2021). This over-activation includes the sensitization of the autonomic nervous system and the hypothalamic-pituitary-adrenal (HPA) axis. When the HPA axis is not properly regulating stress responses, individuals may be at risk for negative physiological and psychological outcomes (Heim et al., 2008; Ho et al., 2021; Kuhlman et al., 2015; Kuhlman et al., 2018). Negative physiological outcomes in adults that are associated with childhood trauma include sleep disorders, metabolic syndrome, obesity, hypertension, and diabetes (Dye, 2018). Negative psychological outcomes associated with trauma include depression, anxiety, mania, psychosis, and schizophrenia (Huh et al., 2017; Humphreys et al., 2020; Mandelli et al., 2015; Matheson et al., 2013; Negele et al., 2015; van Nierop et al., 2015; Varese et al., 2012).

Association Between Trauma and Risk-Taking

People who have experienced trauma may have a higher likelihood to engage in risk-taking behaviour. This behaviour can lead to negative consequences as well as positive consequences (Ben-Zur & Ziedner, 2009; Laceulle et al., 2019; Maepa & Ntshalintshali, 2020; Norman et al., 2012). Most of the research on the intersections of trauma and risky behaviours has focused on substance use/misuse or risky sexual behaviours such as unprotected sex. Both of these are important when discussing FASD.

The relationship between trauma and risk-taking can be explained by *impaired decision making, increased emotion-focused coping, and changes to neurocognition* such as HPA axis functioning (Ben-Zur & Ziedner, 2009). Symptoms of PTSD may also be connected to impulsivity and a bias towards immediate rewards, which can also explain risk-taking (Morris et al., 2020).

Five Reasons Trauma may be Associated with Risk-Taking (Ben-Zur & Ziedner, 2009)	
Avoidance coping	When people consider doing something, they avoid thinking about negative information or the possible consequences.
Self-esteem enhancement	People might pay more attention to what they might get from the risky behaviour that restores a positive self-concept, increases their resources, or increases their sense of control.
Emotion regulation	Some risky behaviours may help people to feel positive emotions or might help them cope with or diminish negative emotions.
Simplified information processing	People consider less information and are more likely to discount risks that are not related to the trauma they experienced.
Suppression of higher cortical processes	People are less likely to reason through decisions, because of trauma-related activation of the amygdala and increased emotional processing. This dampens or turns down their ability to think rationally and problem-solve.

Interconnections Between Trauma and FASD Prevention and Support

There is a strong relationship between trauma and alcohol/substance misuse and dependence (Berenz et al., 2016; Dye et al., 2018; Edalati, 2020; Lotzin et al., 2016; Moustafa et al., 2021; Patock-Peckham et al., 2020). This relationship likely exists because of the many different effects trauma can have on the brain, psychological well-being, and social relationships (Edalati, 2020). Successful treatment of substance use disorders may also be more challenging for people who have a trauma history, possibly because they are at higher risk for experiencing new or reoccurring traumatic events than those without a trauma history (Edalati, 2020; Gil-Rivas et al., 2009).

The relationship between trauma and alcohol/substance misuse and dependence means that people with a trauma history may be more likely to be dependent on alcohol or other substances when they get pregnant. In fact, research with women during the prenatal period has shown that those with a history

Effects of trauma related to substance misuse/dependence:

Impaired social relationships
Increased sensation-seeking
Increased "negative" emotions (sadness, anger, shame, fear)
Trauma-related mental health disorders
Feelings of hopelessness
Impaired activation of the stress response system
Impaired cognition (memory, attention)
Impaired ability to control behavioural inhibition

of trauma, especially childhood trauma, are more likely to use alcohol or other substances during the pregnancy (Olsen, 2018; Osofsky et al., 2021; Waddell & Thanos, 2019). People with a trauma history may experience greater difficulties if they try to stop drinking or using substances during their pregnancy.

Past trauma may interfere with the pregnant person's ability to form an attachment to the fetus, and experiences related to the pregnancy can trigger new/recurring trauma symptoms (Hugh-Bocks et al., 2013; Millar et al., 2021; Osofsky et al., 2021). Trauma symptoms can be triggered by the experience of being pregnant itself, interactions with healthcare providers (e.g., cervical exams, abdominal touch, height and weight measurement), labour, and the birth of the baby (Chamberlain et al., 2019; Kuzma et al., 2020; Millar et al., 2021; Sobel et al., 2018). Experiencing trauma symptoms during pregnancy may make it more difficult for some pregnant people to abstain from the use of alcohol/substances, especially if they use substances to cope and/or are experiencing substance dependence.

Trauma-Informed Approaches

Because of how common trauma is, and the links between trauma, alcohol misuse/dependence, and use of alcohol and other substances during pregnancy, it is very important to apply a trauma-informed approach to FASD prevention and support. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) worked with practitioners with experience in trauma, policymakers, and trauma survivors to develop a white paper on trauma-informed care. In this white paper, trauma-informed care is defined by the following:

> ***"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."***
>
> ***(SAMHSA, 2014, p. 9)***

The **4 Rs**, described further below, make it clear that trauma-informed care is NOT just about offering trauma-specific services. Implementing a trauma-informed approach affects all aspects of an organization, including the provision of all services (Kimburg & Wheeler, 2019). A trauma-informed approach means understanding trauma and its effects on individuals and interacting with people involved with the organization (patients/clients and staff) in ways that are aware, sensitive, and person-centered.

4 Rs of a Trauma-Informed Approach

Realization:
People at all levels of the organization have knowledge about trauma and its potential effects. People's experiences and behaviours are seen through a trauma lens.

Realization involves people at all levels of the organization or system having knowledge about trauma and its potential effects on individuals, families, groups, organizations, and communities. People's experiences and behaviours are viewed through a **trauma lens**. This means that they are understood in the context of coping strategies that help people survive adversity, even if the coping strategies are no longer helpful or are causing harm to the person. Experiences and behaviours should be considered through a trauma lens even if the trauma happened a long time ago, or involved exposure to someone else's trauma (SAMHSA, 2014).

An important way to achieve realization as part of a trauma-informed approach is workforce and professional development training on trauma and its effects (Bartlett & Steber, 2019; Champine et al., 2019; Hanson & Lang, 2016; SAMHSA, 2014). The format of training and the exact topics covered might depend on the organization and people they are serving (Berger & Quiros, 2016; Jackson & Jewell, 2021). Some important things for professionals to know include:

- the prevalence of trauma, and its effects on people
- how to apply a trauma lens to the provision of services and work with individuals and families
- the role that trauma plays in mental health and substance use disorders
- how trauma can be a barrier to positive outcomes in many areas, including the justice system, health care, and education

(SAMHSA, 2014)

The need for education/training around trauma might seem more obvious for professionals/staff who are working closely with individuals or families. However, it is important for staff at all levels of the organization to be supported in gaining knowledge about trauma. For example, in a healthcare context, not only clinical staff but anyone who has contact with patients and families (e.g., front desk staff, security guards) should receive education about trauma (Berger & Quiros, 2016; Menschner & Maul, 2016). It might be helpful to provide training at multiple levels, with more basic education on trauma and a trauma-informed approach for all roles within an organization, and more specialized or in-depth education to meet the needs of specific roles like clinicians and program providers (Choi & Seng, 2015).

Realization also means understanding that staff or care providers working with individuals who have experienced trauma can experience secondary or vicarious trauma because of this work and, therefore, need to be supported as part of a trauma-informed approach (Hanson & Lang, 2016; Menschner & Maul, 2016; SAMHSA, 2014). Finally, because the incidence of trauma is high in the general population, staff may also experience short- or long-term impacts of trauma that can impact their functioning within the workplace or interactions with an individual.

Recognizing:
People within the organization recognize the effects of trauma in people and understand that trauma symptoms and effects may differ between individuals.

Recognizing involves being able to recognize the signs of trauma in individuals. Workforce training/development is necessary to help staff/professionals working with people who may have experienced trauma recognize the symptoms, which may vary by age, gender, type of trauma, and the setting in which interactions are taking place (Bartlett & Steber, 2013; SAMHSA, 2014). It is also important to recognize if trauma is influencing the ways a person engages (or does not engage) with activities and services, interacts with others in the program/service/clinical space, and the degree to which they engage with rules and guidelines (Bartlett & Steber, 2019). During interpersonal interactions, some signs of emotional dysregulation in clients/patients that could be related to trauma or triggered trauma symptoms include:

- increasing and visible anxiety
- speaking more quickly or loudly
- suddenly ceasing to talk
- appearing to be "zoning out" or dissociating from the present moment

(Kimburg & Wheeler, 2019)

Depending on the type of organization/system and the services being provided, **trauma screening and assessment** may be an important tool to help recognize trauma among those accessing services or programming (SAMHSA, 2014). Universal screening with a standardized tool or question can be done upfront with all individuals accessing the program/services; this might be an effective approach for many clinical settings (Menscher & Maul, 2016). An example of universal screening is screening persons who are pregnant at their first prenatal appointment. Screening can also be done later, or on an as-needed basis (for example, if organization staff notice a person behaving in a way that might be indicative of trauma).

Screening should only be done if providers are able to have appropriate follow-up discussions, offer appropriate care options (e.g., modifications to service provision/care or trauma-specific services), and/or refer to trauma-specific services (Menschner & Maul, 2016).

For some settings/programs, an approach called **Universal Education** may be helpful instead of using a screening tool. In a healthcare setting, universal education would involve a healthcare provider talking about how trauma might be related to the presenting issue, specifying the type(s) of trauma that might be related, then offering resources to the patient for them to use or distribute to others. This approach does not require the person to disclose any personal trauma details (Kimburg & Wheeler, 2019).

Employee assistance and supervision are helpful for staff to be able to recognize trauma in people they are working with, as well as their own secondary trauma (Berger & Quiros, 2016; Menschner & Maul,

2016; SAMHSA, 2014). Some of the ways that supervisors might facilitate the recognition of trauma include:

- emphasizing training/ongoing professional development related to trauma
- doing regular check-ins with staff instead of waiting for them to bring up vicarious/secondary trauma
- frequent staff/supervisor meetings to talk about specific client issues
- advocating and modeling self-care
- exploring staff's own trauma reactions with them, and modeling strategies for addressing them which can then be applied with clients

(Berger & Quiros, 2016)

Re-traumatization:
People in the organization understand how interactions, practices, and settings can trigger symptoms of trauma, and structure settings and practices to avoid re-traumatization.

In order to resist **re-traumatization** of clients and staff, the people within the organization need to be taught how particular practices, settings, and interactions can trigger painful memories and re-traumatize those with trauma histories (SAMHSA, 2014). This learning can occur through training, mentorship, and supervision, within organizational environments that support a trauma-informed approach.

Re-traumatization refers to the re-emergence of trauma symptoms when individuals have exposures to events, interactions, relationships, or stimuli that elicit memories and emotions connected to past trauma, whether the new exposure is inherently traumatic or not (Alexander, 2012).

Trauma survivors can be especially vulnerable to re-traumatization in healthcare settings because of things like feelings of being restrained, the use of physical restraints, the need to remove clothing, procedures that are uncomfortable or invasive, intimate contact with healthcare providers, waiting in rooms that have closed doors, seeing blood, the power imbalance between the patient and care provider, the impacts of colonization, and paternalistic approaches within healthcare systems (Chamberlain et al., 2019; Bradbury-Jones & Taylor, 2017; Kimburg & Wheeler, 2019; Kuzma et al., 2020; Purkey et al., 2018).

Re-traumatization can be minimized or avoided through organizational changes, and changes to staff practices. These might include:

- making changes to environments that avoid common triggers and enhance feelings of safety, like monitoring access to buildings, making sure there is clear access to exits and people can leave when they want to, and structuring the environment so there is not a lot of noise and chaos
- avoiding screening individuals for trauma multiple times, limiting the degree to which the details of individuals' trauma history are asked about or discussed, or addressing potential trauma in ways that do not require individuals to disclose

- ensuring that collaborations and referrals involve other organizations, providers, or services that are trauma-informed
- consistent and enforced avoidance of any organizational practices that staff identify as potentially retraumatizing for the people they serve

(Bartlett & Steber, 2019; Kimburg & Wheeler, 2019; Menschner & Maul, 2016; SAMHSA, 2014).

Consistent with trauma-informed principles that emphasize safety, empowerment, choice, collaboration, and the identities of individuals, it is important also that service and care providers are person-centred in their approach. Person-centred approaches involve being attuned to individuals' safety needs and discussing with them how their trauma triggers can be avoided or managed in the provision of care or services.

Responding:
Principles of a trauma-informed approach are applied throughout the organization. Staff consider the impacts of trauma, are committed to a culture of safety, and avoid processes that replicate trauma.

Responding involves applying principles of a trauma-informed approach to all aspects of the organization or system (SAMHSA, 2014). These principles include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. These are described below.

Responding involves applying the principles of a trauma-informed approach, but the exact ways that principles are applied will depend on the organization and the target population that is being served. They should be applied throughout the organization, not just at the level of frontline services (Hanson et al., 2016; Menschner & Maul, 2016). Through training, leadership, and implementation of policies, staff at all levels of the organization should be able to respond to trauma by considering the impact of trauma among the people served as well as their own workforce, committing to providing a culture of safety, and using evidence-based trauma practices including processes to avoid replicating trauma (SAMHSA, 2014).

Six Principles of Trauma-Informed Approaches

SAMHSA (2014) describes six principles of a trauma-informed approach.

Safety: Both clients/patients and staff feel physically and psychologically safe in both the physical setting and interpersonal interactions. Understanding what people served by the organization need to feel safe is a priority.

Trustworthiness and transparency: The organization prioritizes transparency in decision-making and how its services operate. They work to build and maintain trust with clients and families, staff, and others involved with the organization.

Peer support: Peer support refers to support provided between people who have experiences of trauma or are family members of individuals who have experienced trauma. Peer support is an important way to establish safety, build trust, enhance collaboration, and help recovery and healing.

Collaboration and mutuality: The organization recognizes that everyone is part of a trauma-informed approach. Power and decision-making are shared in a way that is meaningful and prioritizes relationships.

Empowerment, voice, and choice: Individuals' experiences and strengths are recognized. Clients are supported in shared decision-making, choices, goal setting, and self-advocacy. Clients' resiliency and agency are valued. Staff are also supported and empowered to do their work.

***Cultural, historical, and gender issues*:** The organization recognizes and addresses historical trauma and is sensitive to how trauma might intersect with aspects of gender and culture. The organization does not incorporate stereotypes and biases into its practices. Its policies, protocols, and practices are responsive to individuals' ethnic, gender, cultural, and other needs (Elliot et al., 2005; Harris & Fallot, 2001; SAMHSA, 2014).

SAHMA's principles are very broad and can be applied to different types of organizations or systems. Others have described principles of trauma-informed care specific to working with clients, and ways they can be applied. The box on the next page shows how five principles of trauma-informed care can be applied to the practice of medicine (Purkey et al., 2018), although these examples could be applied to interactions with clients/patients in other contexts as well.

Applying the 5 Trauma-Informed Principles (Adapted from Purkey et al., 2018)	
Trauma awareness and acknowledgement	• Asking about past trauma experiences, in general. Let the person choose what to tell instead of asking probing questions. • Listening compassionately. • Acknowledging the ongoing effects of trauma. • Identifying and helping patients understand links between past traumatic experiences and current health and coping strategies.
Safety and trustworthiness	• Recognizing clients' need for physical and emotional safety. Promote a safe space. • Understanding how other factors (e.g., financial instability, involvement with child protective services) may impact safety. • Being consistent and predictable in interactions and care procedures. • Being careful not to be rushed, stressed, or patronizing with patients. • Scheduling appointments at times when the waiting area is less busy.
Choice, control, and collaboration	• Emphasizing the importance of informed choices. • Presenting both positive and negative choices (including the option to not engage in care). • Developing collaborative relationships that help the patient actively engage, rather than fostering passivity or dependence. • Using a collaborative approach to understand barriers to change or engagement.
Strengths-based and skills-building care	• Viewing clients through a lens of strength and resilience, instead of as a victim with deficits and pathologies. • Highlighting the person's strength and helping them see progress. • Avoiding paternalistic or disempowering interactions. • Encouraging growth, even when the process is slow or there are setbacks.
Cultural, historical, and gender issues	• Incorporating processes into care that are sensitive to a person's culture, ethnicity, and personal/social identities. • Being sensitive to group marginalization and recognizing the challenges and trauma many individuals and many groups face. • Recognizing the intergenerational transmission of trauma.

4 Cs Paradigm: Calm, Contain, Care, Cope

Kimburg and Wheeler (2019) described the **4 Cs paradigm** (Calm, Contain, Care, Cope), which is intended to help providers enact trauma-informed care. Many of the same practices from the box above are reflected in this paradigm. Some additional suggestions for applying trauma-informed principles in practice include the following:

- Pay attention to your own feelings during interactions, and model calming strategies.
- Practice calming exercises (deep breathing, grounding) with patients/clients while they are already calm.
- Redesign physical environments, policies, and practices to reduce chaos (e.g., minimizing noise, harsh lighting, cramped or uncomfortable spaces).
- Limit detailed accounts of trauma history to promote safety.
- Provide trauma-specific education, resources, and referrals without requiring disclosure.
- Monitor individual's emotional and physical responses to discussions/education around trauma and help them navigate distress if it occurs.
- Invite suggestions from the client on changes that would make their engagement with care, programming, or interactions with providers more tolerable, positive, and healing.
- Normalize and destigmatize trauma symptoms and harmful coping behaviours.
- Practice cultural humility (reflecting on one's own cultural biases and assumptions, while learning about the cultures of others).
- Practice self-care and self-compassion while caring for others.
- Inquire about practices (including cultural) that help the individual feel better and promote hope.
- Document positive coping strategies along with problems.
- Minimize and mitigate power differentials in behaviours, practices, and policies.
- Ask about and emphasize ways to build resilience, including coping skills, positive relationships, and interventions.
- Connect individuals and families with other helpful, trauma-informed resources and supports.

Applying a Trauma-Informed Approach to FASD Prevention and Support

FASD Awareness and Prevention Efforts

It is important to take a trauma-informed approach to FASD awareness and prevention efforts and initiatives, because of the associations between trauma history and substance misuse and dependence including substance use during pregnancy. A trauma-informed approach can be applied to all four levels of FASD awareness and prevention described by Nancy Poole (2008):

1. Broad FASD-awareness building and health promotion at the community level
2. Discussion of alcohol use and its risks with all people who can become pregnant in their childbearing years, as well as their support networks
3. Specialized and holistic support of people with identified alcohol, health, and social problems
4. Postpartum support, including support for child assessment and development

For example, at the first stage of Poole's framework (broad community awareness), a trauma-informed approach might include increasing awareness among service/care providers and broader communities about how trauma may affect people's use of alcohol and other substances. It might also include an emphasis on FASD prevention campaign messaging and images that are not stigmatizing, do not present abstinence as the only goal, and are relational and strengths-based (e.g., emphasize choice, agency, and available supports) (Poole et al., 2016; Schwartz et al., 2017).

A good example of such messaging comes from the Piruqatigiit Resource Centre in Nunavut, whose goal is to provide FASD-informed services and community support. Their recent campaign is centred around the idea that all of us are connected, emphasizing that people who are pregnant are part of a community. Their FASD awareness and prevention Circle of Support poster (presented to the right) avoids stigmatizing images or language and situating abstinence as the only goal. It also communicates the message that it is never too late to reach out and directs viewers to further information and support.

Piruqatigiit Resource Centre, TAMATTA FASD Awareness Visuals, 2019 & 2020

A trauma-informed approach can also be applied in FASD prevention efforts through the incorporation of trauma-informed principles, and trauma-related content, into interventions for populations who may be at risk of alcohol/substance use during pregnancy (stage 3 of Poole's 2008 framework). An example of this is an intervention developed by Myers et al. (2018).

The Trauma-Informed Women's Health Co-operative intervention was a trauma-informed substance use and sexual risk reduction intervention, for young women with past trauma and current substance use who were at risk of unintended pregnancy and other negative sexual health outcomes. In line with other research, the young women who took part in the intervention reported using substances to cope with intrusive memories and negative emotions related to past trauma, as well as current stressors. This intervention involved:

- engaging people from the target population in the development of the intervention, to make sure it would meet their needs; the content requested by women was included in the intervention
- seeking feedback on the intervention after it was developed, to make sure it was a safe and helpful intervention and to identify areas for improvement

- intervention content that was approached from a trauma-informed perspective, which included information on substance use and its intersection with violence and sexual health risks, violence prevention strategies, nutrition, exercise, budgeting, and parenting
- trauma-specific information, which included common coping responses to trauma, how to manage these in relation to sexual health risks, and cognitive-behavioural-therapy techniques on identifying and managing trauma-related triggers for substance use using emotional regulation and coping strategies
- a group-based format, to facilitate peer support

Across all levels of FASD prevention efforts, a trauma-informed approach emphasizes the need to understand the prevalence of trauma and its potential effects on individuals' lives. Interactions with people who are pregnant, their families, and their support people should be viewed through a trauma-informed lens.

As described by the British Columbia Centre of Excellence for Women's Health (2014), a trauma-informed approach entails "changing the conversation" of how we think and talk about alcohol use during pregnancy to one that is non-judgmental, supportive, situates alcohol use during pregnancy in the context of people's broader lives, acknowledges that alcohol use is often a coping mechanism, and emphasizes people's strengths.

Recognizing Trauma via Screening During the Perinatal Period

Screening for trauma can be an important part of recognizing trauma during the prenatal period. Trauma screening might be very important for FASD prevention if the person is at risk for, or currently using, alcohol during their pregnancy. Identifying that a patient or client has a trauma history can then spark conversations about how past or current trauma may be affecting their behaviours, emotions, or engagement in services/programming. It can also lead to discussions about whether services need to be modified to increase feelings of safety and avoid re-traumatization.

Screening is also important for connecting patients to appropriate resources (Flanagan et al., 2018). Universal screening may be effective in many clinical settings (Menschner & Maul, 2016), whereas Universal Education (Kimburg & Wheeler, 2019) or including information about trauma and its effects into programming and/or service provision may be most effective if there are no clear benefits from individual disclosure of trauma.

Health or service providers can screen for trauma using a screening tool, or by asking people a single question about past or current (e.g., intimate partner violence) trauma that is intended to open a conversation. The quotations in this section offer several examples of recommended screening questions for trauma during the perinatal period.

"Are there any experiences now or in your past that were traumatic that could affect your pregnancy, birthing, or parenting experiences?" *(Mosley & Lanning, 2020)*

"We know that some stressful experiences can have an effect on pregnancy, even if they happened a long time ago. I ask everyone questions about past stress because sometimes there are things we can do to help with those effects on you and the baby. Have you had a severe trauma or stress in which you thought you or another person might die or experience serious harm? Examples include: physical attack, mugging, rape, severe car accidents, natural disasters, being diagnosed with a life-threatening illness, or sexual abuse." *(White et al., 2016)*

Screening can be difficult to do, because of factors such as limited time with patients/clients, lack of protocols for screening within the organization, lack of privacy, staff/professional discomfort with asking screening questions or receiving potentially negative responses, and lack of resources to adequately respond to someone's disclosure of trauma (Flanagan et al., 2018; Long et al., 2019).

"Traumatic events are very common and can have direct effects on physical and mental health. For these reasons, I've begun asking all of my patients about any prior difficult experiences they've had and whether or not they feel comfortable sharing them." *(American College of Obstetricians and Gynecologists, 2021)*

Although screening may be very beneficial to a trauma-informed approach, it needs to be done with care. Research with adults and adolescents suggests some optimal practices for trauma screening during the prenatal period (Flanagan et al., 2018; Millar et al., 2021; Sobel et al., 2018; White et al., 2016), including the following:

- Avoid asking about trauma history until a relationship and trust between the patient/client and professional have been developed.
- Frame the screening by explaining the prevalence of trauma and why it is important to ask about it.
- Make it clear that inquiry is routine, and disclosure is confidential.
- Clarify the concept of trauma/what is being asked about, as individuals may have different conceptions of what trauma is.
- Ensure there is adequate time to discuss.
- Ensure that disclosure of trauma is documented in patient records, so individuals do not have to disclose repeatedly to multiple care providers.
- Be attentive to physical and emotional safety when asking about trauma (e.g., should be in a private space, the person should be fully clothed, the asker should be attentive and not appear rushed, a comfortable surrounding is ideal).
- Respond with empathy, compassion, and/or emphasize courage in talking about the trauma.
- Let the person lead the conversation. You do not need to know details of the trauma.
- Accompany screening with a discussion of (and offering of/referral to, where appropriate) available resources and interventions, even if an individual does not disclose a trauma history.

Being able to provide immediate resources (e.g., educational handouts), referrals to other relevant trauma-informed and/or trauma-specific services, and trauma-specific interventions or modifications to reproductive care are essential if doing screening (Bradbury-Jones & Taylor, 2017; Flanagan et al., 2018;

Mosley & Lanning, 2020). It is also very important that providers working with individuals during the perinatal period understand that not everyone with current or past trauma will choose to disclose (Reeves, 2015, as cited in Kuzma et al., 2020; Sobel et al., 2018). It is, therefore, important for providers working with patients or clients during the perinatal period to be aware of nonverbal indicators of distress such as body tension, restlessness, trouble making eye contact, aggressive behaviours, and rapid breathing, and modify the care being provided to avoid re-traumatization.

A trauma-informed approach involves recognizing the high incidence of traumatic experiences, and that anyone can be a trauma survivor, so in addition to screening it is important to apply the principles of a trauma-informed approach when working with all people.

Responding to Trauma and Resisting Re-traumatization During the Perinatal Period

Knowledge about the implementation of a trauma-informed approach in general applies to responding to trauma during the perinatal period. One trauma-specific response may include providing a referral to obstetric care providers who have become experts in trauma-informed care (Bradbury-Jones & Taylor, 2017). Engagement with a trauma-informed doula, who can offer consistent support from pregnancy into the postpartum period, may be another helpful trauma-specific service (Mosley & Lanning, 2020). If the person has substance abuse/dependence issues and is drinking during their pregnancy, they may be able to get priority placement into an alcohol and drug treatment/harm reduction program (British Columbia Centre of Excellence for Women's Health, 2014).

Care and service providers can also approach interactions with individuals during the perinatal period in ways that **enhance physical and emotional safety**, **support resilience and positive coping strategies**, and **avoid re-traumatization**. Recommendations for how do to this have been developed specifically for the perinatal period (British Columbia Centre of Excellence for Women's Health, 2014; Bradbury-Jones & Taylor, 2017; Millar et al., 2021; Sobel et al.), although suggestions for applying trauma-informed principles in general are also relevant. These recommendations include the following:

- Ensure consistency with providers as much as possible.
- Avoid pressuring individuals to answer questions.
- Fully explain all components of care, how they might feel, and why they might be necessary.
- Encourage people to express discomfort prior to and during procedures, and if they need a break during care procedures or interactions.
- Seek permission before all touch or conducting any physical examinations.
- Allow the client/patient to determine the timing, pace, and termination of examinations.
- Encourage the development of a birth or care plan, identify potential care modifications, and provide a concise overview of this plan in the medical record.
- Allow modifications to procedures where helpful (e.g., a woman inserting the speculum herself for an exam).
- Minimize the number of examinations and the number of people conducting them.

- Consider the potential impact of provider gender as a trauma trigger, and address this in the care plan accordingly (e.g., offering a female care provider or chaperone for persons uncomfortable with a male provider).
- Allow the pregnant person to wear as much clothing as possible during examinations.
- Encourage doula support.
- Communicate trauma history between all relevant providers (with permission).
- Encourage informed decision-making and provide full descriptions of any suggested interventions during labour.
- Validate individuals' emotions and experiences.
- Provide coping strategies (e.g., to deal with triggers) where possible, and support client/patients in the implementation of their preferred coping strategies and healing practices.
- Avoid coercive, threatening, or forceful language, recognizing that language may be a trauma cue.
- Knock, announce oneself, and wait for permission before entering the room.
- Consider elective caesarean section delivery as an appropriate option for some trauma survivors.
- Have a prepared and current list of other trauma-informed and trauma-specific resources and services that individuals can be referred to.
- Highlight the potential for breastfeeding to help establish positive bodily connections but be sensitive and supportive of the decision not to breastfeed.
- Notice and measure positive outcomes, such as post-traumatic growth or individuals' efficacy in keeping their other child/ren safe from abuse.
- If applicable, let patients/clients know that people who are pregnant can skip the waiting list and get priority placement into many alcohol and drug treatment/harm reduction programs.
- Emphasize harm reduction and information on healthy pregnancy (e.g., nutrition, prenatal care), with the understanding that people may feel a lot of pressure to immediately change drinking patterns and may not feel able to stop drinking entirely.

These recommendations may be helpful for interactions with all patients/clients as part of a trauma-informed approach, but many of them are especially important when working with people who have an identified trauma history.

To guide efforts in using a trauma-informed approach, The British Columbia Centre of Excellence for Women's Health (2014) provided self-assessment questions organizations can ask themselves that specifically consider the intersections between past and current violence and abuse, pregnancy, and substance use. These questions (presented in the box below, as written by the BC Centre of Excellence) may be especially helpful for working with people who are at risk for/are using alcohol or other substances during pregnancy.

Violence and trauma-informed care is about seeing every aspect of your service from the perspective of a woman who has experienced or is experiencing violence or abuse and making it as safe as possible for her to access the supports she needs, when she is ready. Ask yourself and your colleagues the following questions, trying to put yourself in the shoes of a woman impacted by abuse who is accessing your service:	
Who is the first person she will encounter when she calls or comes into your program?	
Will her interaction make her want to keep coming back?	Or will she feel that no one here will understand what she's going through and that she is more alone than ever?
What if she's late for her appointment because her partner wouldn't let her leave the house (but she doesn't say this is the reason)?	
Will she be respectfully re-scheduled, for the same day if possible?	Or will she be made to feel that she's done something wrong, just as she is often made to feel in her relationship?
What questions will she be asked during her first visit? Will they be open or close-ended?	
Will she feel she has choices in how much personal information she has to share? Will that first conversation form the basis of safe, trustworthy, collaborative, and empowering relationships with staff that maximize her choice?	Or will she feel cornered by intrusive questions and that she has to hide the truth?
What will happen if she discloses abuse or violence?	
Will she be listened to with empathy and respect? Will you try to provide the support and information she says she needs, wherever possible? Will you connect her to resources that can provide the supports you are unable to?	Or will she be told what to do? Worse, will she be placed in a potentially unsafe situation by having someone talk to her partner, or make a report to the police without her permission? Will she leave feeling even more isolated, unsafe, and responsible for her situation?
What will happen if she never discloses abuse or violence?	
Will she still be given access to information about anti-violence services and supports? Will symptoms of trauma (e.g., anger, lack of trust, apprehensiveness, etc.) be recognized as such?	Or will it be assumed that her partner is supportive and she is safe? And that her symptoms of trauma are simply "problem behaviours" or "low self esteem". Or that her continued alcohol use means she doesn't care about her baby?
What will discussions about her substance use or mental health be like?	
Will they take into consideration that abuse or violence often underlies the development of concerns in these areas? Will she be supported in making the links between her experiences?	Or will they be treated as entirely separate issues? Will she be judged for not being able to reduce or quit using substances, especially during pregnancy?
How will her coping strategies and adaptations in the face of violence, abuse, and trauma be viewed?	
Will they be seen as strengths?	Or will they be seen as deficits?

If she is physically examined, what will that be like?	
Will she be informed about how she will be touched and why, and asked if this is okay? Will her choices about physical contact be respected?	Or will she feel she has no control over how and where she is touched, an experience that may also have been part of her abuse?
How will her personal information be used?	
Will it be kept confidential, used to provide her appropriate care, and shared only with her permission? Will she be told this before she is asked any questions?	Or will information be shared with other agencies without her consent or knowledge?
What will the physical space be like?	
Will she feel comfortable? Will posters and other resource information reflect her age, culture, ability, and other aspects of who she is?	Or will she feel like she doesn't belong there? That she is intruding in someone else's space?
Will her culture and ethnicity be taken into consideration?	
Will she be asked how she culturally self-identifies? Will her cultural practices and views be respected? Will she be connected to community agencies and linked to cultural services and programming? Will she be asked what cultural healing practices she may want to be connected to?	Or will assumptions be made about her because of her culture and ethnicity? Will she be referred elsewhere because she appears to be of a "different" cultural background? Will it be assumed she is Caucasian because she looks "white"? Will she feel uncomfortable sharing her cultural identity?
How is violence and trauma-informed practice supported in the work environment?	
Do all staff receive training on the dynamics and impacts of abuse and violence? On the effects of intergenerational trauma on First Nations women? On the intersection of violence and abuse with substance use, trauma, and other mental health concerns? Do staff learn how to ensure safety and avoid re-traumatization? Do they receive ongoing support in providing violence and trauma-informed practice? Do prospective staff interviews include questions about violence and trauma knowledge? Do staff performance reviews include violence and trauma-informed skills? Does the agency collaborate with local anti-violence services to provide integrated services for women?	Or is it up to individual service providers to learn the knowledge and skills required to provide violence and trauma-informed care? Do they have to do it on their own time?

(British Columbia Centre of Excellence for Women's Health, 2014, pp. 8-11)

These questions are intended to help organizations think about their own practices, how trauma-informed they are, and where there is room for improvement.

Secondary Trauma and Staff/Provider Re-traumatization

When using a trauma-informed approach, it is also crucial to recognize secondary trauma and the potential for re-traumatization of health and social care providers and other staff who work with people experiencing current trauma or who have a trauma history (Hanson & Lang, 2016; Menschner & Maul, 2016; SAMHSA, 2014). Trauma-informed organizations build and support provider and staff resilience, and proactively address secondary trauma. This ideally occurs through a multi-pronged approach (Bradbury-Jones & Taylor, 2017; Kimburg & Wheeler, 2019), including:

- reflective supervision, mentoring, and case conferences with experienced colleagues in which vicarious trauma and coping can be discussed
- time and support for individual and group reflection
- staff training on trauma, resilience, and coping/stress reduction techniques
- workplace structures that support self-care (e.g., flexible work schedules, reasonable workloads and hours, small breaks)
- accessible therapeutic/mental health support

It is also important for staff and service providers to be aware of the potential for secondary trauma and to practice self care. The box to the right shows some self-care activities that were suggested for doulas as part of a trauma-informed approach (Fairley, 2016; as cited in Mosley & Lanning, 2020), which could be helpful for others working with people during the prenatal period.

Self-care practices:

Be aware of your emotional, physical, and mental limits

Pursue ongoing education and training

Access helpful community resources

Engage with colleagues and your social support network

Practice grounding and self-care rituals

Process and debrief with colleagues

Follow a general self-care plan with behaviours that promote well-being

Staff/provider training within a trauma-informed approach should address secondary trauma and supports to mitigate it (Jackson & Jewell, 2021). Training on trauma that is related to the perinatal period specifically (e.g., in response to negative fetal or birth outcomes) may also help to support some types of providers who work with families during this period (e.g., Kuhnly et al., 2020).

Conclusions

This module describes what constitutes trauma and its effects, how trauma is relevant to FASD prevention, the key elements of a trauma-informed approach and how they can be applied, and how a trauma-informed approach can be implemented during the prenatal period and as part of FASD prevention. A limitation of the information provided is that it focuses heavily on the person who is pregnant. Although the implementation of a trauma-informed approach in general is of course applicable to partners of pregnant individuals, it would be helpful to think about whether they have specific trauma-related challenges and needs at this time. In addition, the COVID-19 pandemic has adversely affected the well-being of providers and patients/clients/families, and complicated efforts to provide care and services that are in line with trauma-informed care principles (Hall et al., 2021). It is

important to consider how care and services can best be aligned with trauma-informed principles considering the heightened stress, decreased well-being, limited resources, and changes to practice that have resulted due to the pandemic. This module provides guidance and suggestions for implementing a trauma-informed approach with individuals and families during the perinatal period and as part of FASD prevention. The research in this area is new and will continue to evolve. It will be important for service provider individuals and organizations to regularly review emerging evidence and ensure they are using current best practices regarding trauma-informed care.

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