Trauma and Diversity: Justice, Equity, Diversity and Inclusion (JEDI) Principles Operationalized through the Trauma- Informed Care (TIC) Framework

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The past year has been one of loss and upheaval for millions of people, particularly for people who are Black, Indigenous and people of color (BIPOC). The syndemics of racism and COVID-19, one chronic and the other acute, have left a trail of trauma, grief and stress that will likely have long-term mental and physical health effects across generations.

Prejudice, discrimination and systemic or structural inequities such as policies, practices and behaviors that perpetuate disparities in wealth, housing, education, employment, health care and opportunities can be traumatic themselves.[1] Moreover, they create conditions that increase the likelihood that BIPOC individuals will be exposed to other traumas, such as violence and death.[2,3] This vicious cycle has played out in stark terms over the course of the pandemic.

Following the declaration of the COVID-19 pandemic in March 2020, we experienced the abrupt end to "normal life" and a shift into survival mode in self-isolating spaces. The response to the COVID-19 pandemic disrupted every aspect of life for many in the world. In the U.S., the brunt of the COVID-19 pandemic was disproportionately borne by BIPOC communities. BIPOC individuals coped with the greatest losses in employment and financial security, were more likely to have front-line essential jobs putting them and their families at greater risk for viral exposure, pre-existing health conditions that put them at greater risk for medical complications, and also the least likely to have assets or resources to improve coping and health outcomes in the pandemic (e.g., reliable internet necessary for remote education, employment or social support; green and blue spaces for fresh air, exercise and recreation, insurance and access to health care.[4,9] As a result, these communities shouldered the greatest burden of death and disability from COVID-19 infection.[4,10]

We were barely grappling with the acute pandemic-induced restrictions and losses—big and small—when George Floyd was killed by police officers on May 25, 2020. Mr. Floyd's death became a catalyst for nationwide protests that grew out of the existing Black Lives Matter protest movement against racial injustice generally and racist police brutality specifically. The anti-racism protests following Mr. Floyd's murder shifted much of the nation's collective focus to the legacy of pervasive ongoing racism and systemic inequality in our society. This shift in attention may have been particularly acute for non-Black individuals, as members of the Black community have been coping with the personal and collective trauma and grief due to institutionalized racism for generations.[9,11,12]

Since late spring 2020, the increased public focus on racial injustice has resulted in a deluge of statements of support from many organizations and efforts to provide workshops and listening sessions. While these are positive steps, racial injustice is a systemic problem, embedded in the fabric of policy, practice and society. Therefore, increasing justice, equity, diversity and inclusion (JEDI) requires systemic change. It also requires acknowledging trauma, loss and suffering that has occurred as a result of systemic inequity and enacting JEDI policies and practices that prevent future trauma. Indeed, we assert that the structural conditions that prevent trauma also promote justice.

In the U.S., prior to the COVID-19 pandemic, adverse childhood events (ACEs; e.g., physical, emotional or sexual abuse, parental separation/ divorce or incarceration, household mental illness and substance abuse, domestic violence)[13-15] were highly prevalent with approximately two-thirds of adults experiencing at least one ACE and nearly 25% reporting three or more.[13,14] ACEs are associated with adult mental and physical health, including morbidity and mortality,[13,14,16] risky health behaviors,[16] reduced engagement with preventive health care,[17,18]

and revictimization,[19,20] and can also have negative intergenerational effects on offspring development through multiple biobehavioral pathways.[15,21,22] Emerging data suggests increased rates of ACEs during the pandemic with a disproportionate impact on underserved and racial minority communities.[5,26] Of note, ACEs and traumas are at least partially downstream outcomes of structural inequities. Indeed, structural inequities arise from exploitative power dynamics,[5,27] as do most types of trauma.

Trauma-informed care (TIC),[28,29] is a systemic approach that arose in response to pervasive adversities. It acknowledges the ubiquitous prevalence of trauma and adversity, recognizes its broad-spectrum impact on mental and physical health across the life course and intergenerationally, and refers to approaches that include policy, procedures and practices that integrate knowledge about trauma and its effects in ways that actively seek to resist re-traumatization. SAMHSA's six principles of TIC—safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender Issues—are briefly described in Table 1 below.[28,30]

We suggest that TIC may be one approach to reduce systemic inequities in power and control generally, and therefore may be leveraged to increase JEDI. In Table 1 we briefly describe the six TIC principles, provide examples to operationalize TIC in health care, and how this intersects with JEDI efforts.

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TIC Principle	Definition	Health Care	JEDI
Safety	*Policies, procedures and interactions that ensure the physical and psychological safety of client/ patient and all health care workers*	**Challenge:** Past trauma can influence a person's sense of safety. **TIC approach:** Ask the client/ patient what might help them feel comfortable during the visit, their fears and what might help (e.g., during a medical exam).	**Challenge:** School disciplining practices influence children's senses of safety and may impact BIPOC students disproportionately. **TIC approach:** - Minimizing the use of security officers, instead engaging school counselors and mental health supports, and collaborating with parents - Balancing accountability with an understanding of how trauma may impact peer relationships and school engagement - Modeling and/or promoting respectful interactions and trust among school staff; between teachers, parents and students; and between students
Trustworthiness and Transparency	*Transparency in procedures to build and maintain trust among all involved (clients/patients, family members, medical and nonmedical staff)*	**Challenge:** The legacy of medical abuse and lack of informed consent for medical procedures and research has bred mistrust in the medical system. **TIC approach:** - Discuss what is written in their client/patient medical chart. - Share the computer screen or visit summary31 - Participate in the OpenNotes Initiative promoting transparency in health care communications by having health care clinicians and teams provide access to visit notes and medical records to clients/patients on a routine basis.	**Challenge:** Organizational interactions that lack transparency, such as negotiations for jobs or raises, may be particularly harmful for BIPOC individuals, since interactions that lack transparency and trustworthiness exploit systemic power dynamics. **TIC approach:** Ensure that the same information is available to all parties in an interaction and increase the transparency of interactions—not just between those directly involved, but also between others in the organization to create a culture of trust and transparency. Actively review hiring and wage increases to identify and correct bias.

Peer Support

Mutual self-help to promote support, particularly including individuals with lived experiences whose narratives encourage healing and recovery

Challenge: Trauma and abuse survivors commonly experience stigma and shame.

TIC approach:
- Share resources such as survivor groups or patient community resources to reduce isolation and stigma.
- Closed-loop referral systems (where the referring provider receives a report from the receiving provider after completion of the visit and key stakeholders in the referring and receiving health care teams maintain contact and information flow to facilitate follow-up and health care engagement).

Challenge: A lack of peer support can increase isolation, reduce morale and contribute to burnout. Individuals who are from BIPOC communities may be at particularly high risk of isolation, especially in the context of ongoing bias or discrimination.

TIC approach: Create official structures for peer support such as assigned mentors, affinity groups and "safe spaces" for dialogue and support. Encourage unofficial peer support through activities and a culture of cooperation rather than competition.

Collaboration and Mutuality

Acknowledging and leveling power differences between medical teams and clients/patients, within the team, and within the health care setting as a whole

Challenge: Existing power dynamics and hierarchies, which are implicit in every setting including health care and inherent in the idea of who is the "expert" and whose perspective is valued.

TIC approach:
- Collaboratively setting agenda for visit
  Identifying patient-centered health outcomes and goals
  Including patient inputs while creating a patient care plan
- Team huddles
- Including inputs from all team members and recognizing the role and potential impact of changes and policies on all team members (e.g., front desk or housekeeping staff)

Challenge: Large organizational power differences such as between employers, customers, and employees, and between teachers and students can exacerbate inequitable and discriminatory behavior and norms.

TIC approach: Acknowledge the existing power differentials and enact practices and policies that explicitly reduce these differences and promote mutual decision making.

Empowerment, Voice and Choice	*Organizational policies and practices that value individual experiences, needs and strengths; promote shared decision-making, particularly acknowledging and supporting those historically excluded, minimized or treated coercively; and support self-advocacy efforts*	**Challenge:** Lack of representation and inclusion of a range of voices and perspectives. **TIC approach:** Proactively including patients in their care planning; asking about and including self-management choices as much as possible; including team members inputs and choices whenever possible.	**Challenge:** Lack of representation and inclusion of a range of voices and perspectives. **TIC approach:** Assess who is at the table when decisions are made and who has decision making power. Enact practices that increase representation and give feasible and true choices to stakeholders who are underrepresented.
Cultural, Historical and Gender Issues	*Organization recognizes historical trauma and loss; actively addresses bias and stereotyping; uses policies, protocols and processes that are responsive to unique cultural needs; invites, integrates and promotes cultural connections, supports and resources into the care/treatment plan*	**Challenges:** Some groups and communities have been marginalized and abused by the health care system. Some policies and practices have been developed based on data from nonrepresentative samples. **TIC approach:** • Acknowledge the historical context • Ask patients about their experiences with health care systems • Inquire about and discuss differences in cultural views of health • Implement self- and team-education processes that help the health care team to have the understanding, language and comfort to discuss cultural differences and their role in health care Promote ways to work on unconscious biases (e.g., peer consultation, implicit bias assessments) • Gender-responsive and intersectional approaches (e.g., asking about gender identity, using preferred pronouns) Making intentional and active choices to include the voices of historically underrepresented individuals	**Challenge:** Practices within the organization and with the broader community that disproportionately impact certain cultural, religious, or racial/ethnic groups or genders. **TIC approach:** Actively collect and analyze data from an equity perspective (e.g., whom does your organization serve? Is it representative of your catchment area? Is there a selection bias or another systematic pattern in the pipeline?) Review protocols and procedures to address bias, taking into account perspectives of diverse stakeholders. Be active in responding to concerns about bias, prejudice and discrimination.

As we consider the "next normal" in the COVID-19 pandemic era, responsive organizations and institutions must recognize that justice and equity are inherently complex and affected by individual, social and historical factors, including trauma and its sequelae. An intergenerational, life course, systemic and multilayered lens rather than a primary focus on downstream injuries or outcomes is imperative. The TIC framework might be one approach to further justice, equity, diversity and inclusion. Hence, acknowledging trauma, resisting re-traumatization, and preventing trauma are necessary but also insufficient goals. Addressing the multidimensional effects of racism, prejudice and discrimination that are embedded in the fabric of our society, institutions and cultures due to hundreds of years of systemic racism requires an equally robust, systemic, multilevel and intentional approach to inculcate justice and equity into these same structures. Our individual and collective health and wellbeing and that of the future generations depend on it.

About the Authors

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References

1.   Mikhail JN, Nemeth LS, Mueller M, Pope C, NeSmith EG. The Social Determinants of Trauma: A Trauma Disparities Scoping Review and Framework. *J Trauma Nurs.* 2018;25(5):266-281.

2.   Wilkins NJ, Zhang X, Mack KA, et al. Societal determinants of violent death: The extent to which social, economic, and structural characteristics explain differences in violence across Australia, Canada, and the United States. *SSM Popul Health.* 2019;8:100431.

3.   Knopov A, Rothman EF, Cronin SW, et al. The Role of Racial Residential Segregation in Black-White Disparities in Firearm Homicide at the State Level in the United States, 1991-2015. *J Natl Med Assoc.* 2019;111(1):62-75.

4.   Centers for Disease Control and Prevention. *Health equity considerations and racial and ethnic minority groups.* https://www.cdc.gov/coronavirus/2019-ncov/community/healthequity/race-ethnicity.html2020.

5.   Hamel L, Lopes L, Muñana C, Artiga S, Brodie M, KFF. *Race, Health, and COVID-19: The Views and Experiences of Black Americans Key Findings from the KFF/Undefeated Survey on Race and Health.* http://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf: Kaiser Family Foundation; October 2020.

6.   Laster Pirtle WN. Racial Capitalism: A Fundamental Cause of Novel Coronavirus (COVID-19) Pandemic Inequities in the United States.*Health Educ Behav.* 2020;47(4):504-508.

7.   Falk G, Nyhof E, Carter J, Romero P, Nicchitta I. *Unemployment Rates During the COVID-19 Pandemic: In Brief.* https://fas.org/sgp/crs/misc/R46554.pdf January 12, 2021.

8.   Khazanchi R, Evans CT, Marcelin JR. Racism, Not Race, Drives Inequity Across the COVID-19 Continuum. *JAMA Netw Open.*2020;3(9):e2019933.

9.   Bailey ZD, Feldman JM, Bassett MT. How Structural Racism Works - Racist Policies as a Root Cause of U.S. Racial Health Inequities. *N Engl J Med.* 2021;384(8):768-773.

10. Andrasfay T, Goldman N. Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations. 2021;118(5 e2014746118).

11. Sotero M. A Conceptual Model of Historical Trauma: Implications for Public Health Practice and Research. *Journal of Health Disparities Research and Practice.* 2006;1(1):93–108.

12. Bor J, Venkataramani AS, Williams DR, Tsai AC. Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study. *The Lancet.* 2018;392(10144):302-310.

13. Merrick MT, Ford DC, Ports KA, Guinn AS. Prevalence of Adverse Childhood Experiences From the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. *JAMA Pediatr.* 2018;172(11):1038-1044.

14. Merrick MT, Ford DC, Ports KA, et al. *Vital Signs: Estimated Proportion of Adult Health Problems Attributable to Adverse Childhood Experiences and Implications for Prevention — 25 States, 2015–2017.* 2019.

15. Bhushan D, Kotz K, McCall J, et al. Office of the California Surgeon General. Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health. California: Office of the California Surgeon General;2020.

16. Felitti VJ, Anda RF. The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders, and Sexual Behavior: Implications for Healthcare. In: Lanius R, Vermetten E, eds. *The Hidden Epidemic: The Impact of Early Life Trauma.* Cambridge University Press; 2009.

17. Duke NN, Borowsky IW. Adverse childhood experiences: Evidence for screening beyond preventive visits. *Child Abuse Negl.* 2018;81:380-388.

18. Koball AM, Domo# SE, Klevan J, Olson-Dor# D, Borgert A, Rasmussen C. The impact of adverse childhood experiences on healthcare utilization in children. *Child Abuse Negl.* 2021;111:104797.

19. Papalia N, Mann E, Oglo# JRP. Child Sexual Abuse and Risk of Revictimization: Impact of Child Demographics, Sexual Abuse Characteristics, and Psychiatric Disorders. *Child Maltreat.* 2021;26(1):74-86.

20. Brassard A, Tourigny M, Dugal C, Lussier Y, Sabourin S, Godbout N. Child Maltreatment and Polyvictimization as Predictors of Intimate Partner Violence in Women From the General Population of Quebec. *Violence Against Women.* 2020;26(11):1305-1323.

21. van Ee E, Kleber RJ, Mooren TTM. War trauma lingers on: Associations between maternal posttraumatic stress disorder, parent-child interaction, and child development. *Infant Ment Health J.* 2012;33(5):459-468.

22. Chamberlain C, Gee G, Har$eld S, et al. Parenting after a history of childhood maltreatment: A scoping review and map of evidence in the perinatal period. *PLoS One.* 2019;14(3):e0213460.

23. Holland KM, Jones C, Vivolo-Kantor AM, et al. Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic. *JAMA Psychiatry.* 2021.

24. Bryant D, Oo M, Damian A. The rise of adverse childhood experiences during

the COVID-19 pandemic *Psychological Trauma: Theory, Research, Practice, and Policy,*. 2020;12(S1):S193–S194.

25. Calvano C, Engelke L, Di Bella J, Kindermann J, Renneberg B, Winter SM. Families in the COVID-19 pandemic: parental stress, parent mental health and the occurrence of adverse childhood experiences-results of a representative survey in Germany. *Eur Child Adolesc Psychiatry.* 2021.

26. Gur RE, White LK, Waller R, et al. The Disproportionate Burden of the COVID-19 Pandemic Among Pregnant Black Women. *Psychiatry Res.* 2020; 293:113475.

27. Prins SJ, McKetta S, Platt J, Muntaner C, Keyes KM, Bates LM. The Serpent of Their Agonies: Exploitation as Structural Determinant of Mental Illness. *Epidemiology.* 2021;32(2):303-309.

28. Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* Rockville, MD2014.

29. Lewis-O'Connor A, Warren A, Lee JV, et al. The state of the science on trauma inquiry. *Womens Health (Lond).* 2019; 15:1745506519861234.

30. Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884.* Rockville, MD2014.

31. Delbanco T, Walker J, Bell SK, et al. Inviting patients to read their doctors' notes: a quasi-experimental study and a look ahead. *Ann Intern Med.* 2012;157(7):461-470.