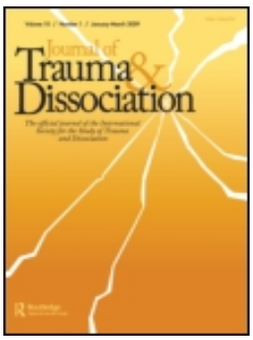

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EDITORIAL

Advancing a national cradle-to-grave-to-cradle public health agenda

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In 1881, President James A. Garfield was shot by an assassin—one bullet to his arm and another to his back. Physicians rushed to care for him, believing that he had survivable injuries. The discovery of microbes as the origin of infectious processes was still new, and although Joseph Lister's pioneering work in antisepsis was known to American doctors, and Lister himself had visited America in 1876, few doctors had confidence in it, and none of the advocates of germ theory were among Garfield's treating physicians. As a result, no sterile procedures were used to treat his wounds. No hands were washed, no instruments were boiled in probing his wound. He died 2 months later after a grueling decline as a result of massive infection (Millard, 2011). The recognition—finally—that microbes were the etiological agents behind the major killing diseases of earlier centuries brought about a radical change in the way health care is delivered and gave birth to the whole field of public health prevention, from antibiotics and vaccines to clean water, healthy food, and decreased poverty. Germ theory was the paradigm shift in knowledge and understanding that provided the basis for individual, local, national, and global changes in practice *and* policy and initiated the modern era of public health intervention and prevention.

Almost exactly 100 years later, in 1980, the American Psychiatric Association defined posttraumatic stress disorder, and shortly thereafter, in 1985, the field of traumatic stress studies was propelled forward by the formation of the International Society for the Study of Traumatic Stress with an initial focus on combat veterans, disaster victims, and other survivors of adult trauma (Bloom, 2000). Not long thereafter, the organization that is now known as the International Society for the Study of Trauma and Dissociation was formed with a focus on dissociative disorders and the treatment of what are now considered the complex disorders that follow on the heels of childhood exposure to overwhelming stress. In 1998, the Adverse Childhood Experiences Study was published, clearly demonstrating that there is a strong positive association between the amount of exposure to toxic

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stress that children experience and a wide variety of health, social, mental health, and substance abuse problems that unfold interactively across the life span (Felitti et al., 1998). Epigenetic research is demonstrating that these effects may be transmitted to subsequent generations (National Scientific Council on the Developing Child, 2010). These recent advances in knowledge—each of which highlights a broader and deeper knowledge base that has accumulated across two centuries—represent the consolidating of a massive paradigm shift in how we understand human health, human pathology, and human nature.

Paradigm shift: The relativity of time and place

A paradigm shift is a change in the underlying principles on which belief, understanding, attitude, practice, and policy are built (Kuhn, 1970; Senge, 1990). In the understanding of the human body that spans centuries of scientific endeavor, advances in care were built on the gradual accumulation of knowledge about basic anatomy and physiology, giving rise to the ability to trace cause and effect across space, especially the space of the body. Edema —or *dropsy*, as it was once called—was discovered to be an outcome, not a cause (MedicineNet.com, 2016). The cause could be as spatially near as an ankle injury or an insect bite or more remote, caused by heart disease or malnutrition. This gave rise to the notion of differential diagnosis, which resulted in far more effective interventions. The accumulating knowledge base about exposure to adversity and trauma produces a similar pattern of cause and effect when we look at symptoms that are now treated largely as separate, unconnected entities—substance abuse, depression, learning problems, anxiety, phobias, personality disorders, criminal behavior, autoimmune disease, heart disease, pulmonary disease, cancer, stroke, and much, much more. All can be viewed as the complex and often interactive outcomes of childhood trauma. This shift requires a willingness to trace cause and effect not only across the space of the body but across the dimension of time, requiring an Einsteinian recognition of the relativity of space *and* time or, as William Wordsworth (1994) put it, the idea that "the child is father to the man" (p. 91). It is impossible to fully comprehend adult behavior without understanding how the patterned trajectories of childhood have played a determining role in the unfolding of adult lives as well as in the intergenerational transmission of both vulnerabilities and strengths (Bradfield, 2013) .

A personal journey

As I learned about all this, the implications became staggeringly important and drew me away from helping individual survivors and into public health. After being involved in the treatment of thousands of adults who had been exposed to overwhelming adversity as children, and through them

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developing an understanding of the complex nature of their adaptations to this adversity over time, I became increasingly angry, frustrated—and hopeful (Bloom, 2013). Almost all of the problems that plagued the suffering people I had been treating for decades had been—at some point in time—preventable. These diseases that we were supposed to treat effectively based on a system of discrete categories were not separate disease entities at all. Like dropsy a century before, these were all symptoms of a wide variety of conditions that had caused so much stress during critical developmental periods that the wide array of developmental adaptations—both positive and negative—could only be fully comprehended by understanding each person's life story, the multiple contexts of his or her individual, social, and cultural life experiences.

Somehow, in the course of grappling with and realizing the far-reaching implications of this knowledge, something had shifted inside my colleagues and myself, something deeper than simply knowing something new. We had experienced a deep change in attitude. We came to understand, as my colleague Joe Foderaro perceptively noted in a team meeting in 1991, that "we have stopped asking people 'What's wrong with you?" and instead are asking people 'What happened to you?'" (Bloom, 1994, p. 476). Over the course of two decades, we discovered that such an upstream question leads to completely different downstream solutions.

As a result, I began an intensive and ongoing reeducation process, moving hierarchically upward in my research from individual to small group, to organizations, to systems, and now to communities, widening my scope of understanding using the notion of parallel process. I came to understand each higher level of our social organization as having emergent properties related to, although not identical to, the lower level from which each had issued. Every individual staff person and client brought to the organization his or her own adaptation to the stresses, adversities, and traumas of his or her own life. These then interacted, across time, with the experiences of the organization as a whole. Organizations formed systems, and systems coalesced into local, statewide, and even national interactive dynamic entities, always bringing along the adaptations and changes in social norms that are so typical of exposure to toxic stress, relentless stress, and traumatic stress—namely, conditions that frequently result in even more stress (Bloom & Farragher, 2010).

Over time it became clear to me that we need to view the problem of stress as the major public health challenge of the 21st century (Bloom & Reichert, 1998; Sorenson, 2002). I believe that the most fundamental question of our time is whether we can effectively create cultures that address and prevent the relentless stresses of poverty and discrimination; the toxic stress of childhood adversity; and the traumatic stress resulting from all forms of interpersonal violence, including warfare. We cannot prevent natural disasters, and we are likely now not able to prevent the manmade disasters that climate change

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and pollution will continue to bring to us. But there is so much suffering that is within our power to prevent.

Stress and public health: Changing culture

Changing paradigms is no small feat and demands a new integration of mind, heart, and spirit to which many readers of this journal can attest. Shifting paradigms is what every trauma survivor encounters—the internal earthquake that occurs when there is no more normal. Many of the institutions that are intended to address the needs of our population, such as health care, child welfare, mental health, and education, are developing an awareness of the need to educate staff members about the complex effects of trauma and adversity on children, adults, families, and in many cases communities. But substantial, universal, deeply rooted change is unlikely to occur unless the components of the human services delivery system become aligned with one another. Currently these components exist within relatively unconnected silos. Such change will not happen without significant shifts in policy at all levels of government.

To bring about such change perhaps we would be best served by launching a tripartite strategy that has been of some use in grappling with the complexity of widespread public health prevention: primary, secondary, and tertiary interventions. Addressing any kind of public health problem requires intervening at all three fundamental levels, although defining where one leaves off and another begins can be difficult because of the complex and interactive nature of human experience. Primary intervention refers to universal strategies that apply to everyone in a designated population—like washing your hands, prohibiting smoking in public spaces, or not exposing children to maltreatment of any sort (Skeffington, Rees, & Kane, 2013). Secondary interventions are applied to all those in a population who are at risk for developing a problem, such as children in foster care. Tertiary interventions are measures applied to those who already have a problem in order to minimize damage and prevent further deterioration. This applies to those who already have the symptoms of posttraumatic stress disorder, dissociative disorders, and all of the related and complex problems associated with exposure to trauma and adversity. Although making fine-line distinctions between these three levels may be difficult for research purposes, using them as a way of organizing thought can be strategically helpful. Aiming policy changes at all three levels would constitute a social movement.

As outlined by the Robert Wood Johnson Foundation's (2016) work on creating a culture of health, a true public health approach will need to be based on explicit values, more equity, cross-sector collaboration, and the integration of systems of care. In service of such comprehensive change, those of us who understand the complexities involved in individual and

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group adaptations to trauma and adversity may be required to increase the precision of our definitions. For the past several decades, attention to individual biology and psychopathology has dominated the mental health system and all related social services. In practice, it has been as if the context of human experience has been deleted. The word *trauma-informed* points to a very different set of causal notions, updating and adding significantly to an older knowledge base in which environment and the individual were seen as deeply interconnected, and each person could only be fully understood within the context of his or her experience.

Is trauma informed enough?

According to the Substance Abuse and Mental Health Services Administration's (2015) concept of trauma informed, a program, organization, or system that is trauma-informed: 1) *Realizes* the widespread impact of trauma and understands potential paths for recovery; 2) *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3) *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and 4) Seeks to actively resist *re-traumatization*.

This description is all embracing and requires extensive change in any organization or system dedicated to becoming trauma informed. Such far-reaching organizational change requires change in the organizational culture, and this necessitates an extensive commitment of resources in terms of people, time, and money. According to the organizational development literature, this kind of change in organizations and in systems is known to take years and must be embraced throughout the organizational hierarchy and modeled by leadership commitment (Bloom & Farragher, 2010, 2013; Goldsmith, Martin, & Smith, 2014). Too often, however, there appears to exist within some people, organizations, and systems a belief that simply expecting staff to attend a training about trauma or about adverse childhood experiences means that programs are now trauma informed.

Certainly, a training can be the beginning of change, but actually changing paradigms that underlie the way we act toward one another, what and whom we value, and how we change our social norms requires far more extensive, uncomfortable, and consistent realignment over time and will only happen if leaders at all levels embrace and model change in their own attitudes and behavior. Meaningful shifts in attitude and behavior from the board of directors or government regulators down the chain of command to all of the stakeholders within an organization—including the indirect and support staff—require an extensive investment of time and resources.

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Similarly, in other places there exists a notion that a program is trauma informed because a few clinicians were sent away for specialized training in a specific treatment approach, and that is all that is required to make sure that trauma survivors get the attention they require. Well, in a way that is true—everyone who attends the training does know more. And it is important to have appropriate trauma treatment available. But guaranteeing that healing and recovery from the complexities of childhood exposure to adversity become central to the treatment environment requires much more than therapists who are trained in one specific technique.

As I go around the country I find that many places, such as shelters, schools, and juvenile justice programs, that are struggling to become trauma informed are facing great challenges at the interface with their communities, namely, at finding support for the significant system changes that need to occur and at finding adequate treatment resources. At the same time, mental health, health, and substance abuse treatment programs are struggling with actually treating traumatized people—in part because of a lack of resources, in part because people are not trained in trauma-specific interventions, and in large part because this kind of change for the mental health system demands a change in very basic assumptions. Just as taking on board the concept of trauma-informed systems necessitates a change in mental models, so too does understanding exactly what it is we are to treat, who to treat when, and what recovery from trauma and adversity actually looks like.

As a result of these and other factors, there remain large gaps between what is meant by *trauma-informed care* and what actually happens, and this means that there is a need for more clarification. Better defining what we are talking about may be a key to advocating for more resources for addressing these problems and clarifying exactly what changes in research, resource, and policy measures will be needed. In service of an increase in precision I suggest that we consider a continuum of designations that reflect the three levels of public health intervention and that we call these trauma- informed (primary), trauma-responsive (secondary), and trauma-specific (tertiary). We may be able then to push for and evaluate different policies based on the level of intervention the policy is designed to affect.

The concept of trauma informed has been extremely important in raising awareness of what needs to happen universally. All systems, all organizations, and all *people* need to become trauma informed. Basic knowledge about the short-term and long-term impact of trauma, adversity, and allostatic load need to become so well known that consideration of these impacts is brought into every practice and policy decision, not just in the health, mental health, and social service delivery sectors but in all spheres of human activity, including governmental bodies and businesses. Such universal application could then legitimately lead to policies that are designed to reduce exposure

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to trauma, such as policies that prevent gun violence, or motor vehicle accidents, or child abuse as well as policies that promote better health care, more equity, and income security for everyone. This could constitute *primary prevention*.

But the attainment of knowledge is not always enough. Everyone knows about the dangers of smoking or the importance of using safety belts in cars, but the depth and scope of knowledge that is required depends on what we are doing. People doing smoking prevention programs for teenagers require a different knowledge base than a doctor treating lung problems related to smoking. Agencies assigned to enforce seatbelt laws need a different level of knowledge than people installing safety belts in new cars. But these and other policy changes have rested on the basic identification of the problem and the potential means of resolving the problem. The notion of trauma informed encompasses that basic identification of the problem and leads to an array of opportunities to resolve the problems related to exposure to adversity and trauma.

In order to truly meet the needs of people who have experienced trauma and adversity, it is necessary, once a greater knowledge has been achieved, to achieve a more significant level of responsiveness to those needs that derives from the increased knowledge. For example, a domestic violence shelter offers the opportunity to do primary and secondary prevention. Everyone who comes to such a shelter has by definition experienced trauma or he or she would not be in a domestic violence shelter. That means that everyone connected to the shelter—clients, staff, management, providers of other services, consultants, and board members—needs to become trauma informed. Therefore, everyone in a domestic violence shelter needs to be trauma informed as a primary preventive measure.

In addition, all of the clients—adults and children—in a shelter are *at risk* for further problems, so the shelter will have to decide on and implement secondary prevention strategies. In such a setting, there are great opportunities to respond to the trauma that adults and children in a shelter have already experienced by organizing the environment around responding to the issue of trauma, thereby becoming trauma responsive. To do this, the staff will need ongoing opportunities to design, implement, and evaluate innovative interventions and strategies. In this case, this will mean equipping the women and children with basic useful skills and tools to help them to identify and positively deal with the impacts of exposure to trauma in the present while preparing them for diminishing risk and improving outcomes for the future.

Some of the clients will require trauma-specific treatment for symptoms that already exist. Others will need it, but their present circumstances make such a treatment focus inadvisable, or they refuse to engage in treatment. A trauma-

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responsive shelter would probably not be providing actual treatment—tertiary prevention—but would have performed a basic screening and assessment to discover which individuals or families might benefit from or desperately need further treatment. Such a facility would also have made sufficient connections to resources in the community that appropriate referrals could be made and have found ways to expedite such referrals.

The degree of responsiveness that is necessary will depend on the goals and mission of the organization. At-risk children populate all child welfare organizations. At-risk children are in many school settings where we know already there are likely to be high levels of exposure to adverse childhood experiences among the children as well as their parents. Hospital-based violence intervention programs and criminal justice settings of all kinds are filled with people who are at risk for many other problems. It is not sufficient for such organizations and systems to be trauma informed. They need the resource base that enables them to become trauma responsive to the people they serve and to the staff who provide the service.

A trauma-responsive environment, then, would do more than educate everyone to make sure that they were trauma informed. It would also design specific practices and policies within the organization to ensure that secondary prevention were an integral part of the environment. A trauma-responsive environment would deliberately set about to minimize the risk of making things worse for individuals or families who have experienced trauma and maximize the possibility of improvement. Leadership training and development, skills for teamwork, cross-collaboration, and system integration all require time and sufficient freedom from immediate stress for the brains of participants to engage in innovative and strategic change. Some of the greatest challenges to organizational change are the ethical problems and moral dilemmas that are rarely addressed in social service and health care environments when demands for productivity clash with patient care (Bloom & Farragher, 2010; Pope, 2015). A trauma-responsive environment would also create a dense network of connections with community resources who could provide actual trauma-specific treatment.

Expanded definitions may also help us address the current dilemma of defining what constitutes adequate treatment (Johnson & Lubin, 2015). The appropriate theoretical and research base is still evolving. Nonetheless, leaving traumatic fragmentation untreated, when we know resolution and integration are possible, is unconscionable. We all know that if you get a splinter in your arm it must be removed because if it is not you are likely to develop an abscess, which can become the site of a chronic and progressively debilitating infection. You learn to live with it, you adjust to it, but it is still there. If you have a splinter in your foot, you walk differently than you would if your foot were healthy. If you have a splinter in your finger, you adjust your behavior to avoid constantly causing pain in that finger.

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Unintegrated posttraumatic fragments of memory and experience are splinters in the psyche. If healing is to occur, these splinters must come out. Trauma-specific treatment is about taking out the splinters. Next steps are designed to help the person adapt to a life no longer defined by the presence of the psychic splinters that have determined self-perception and the nature of relationships. As difficult as it may be, and as much as trauma-specific treatment may challenge the existing status quo in treatment environments, it is vital that as agents of change we advocate for trauma-specific treatment approaches. At the same time we must insist that all mental health educational and training programs provide the knowledge base and skills necessary to integrate trauma-specific treatment with all its complexities into existing treatment approaches (Dalenberg, 2014; Danylchuk, 2015; Turkus, 2013). In the wider sphere of activity, outside of our specialized and trauma-based services, dissociation, dissociative disorders, and even the recognition that another person is in an altered state of awareness secondary to stress remain poorly understood and rarely addressed (Floris & McPherson, 2015; Ross, 2013; Sar, Middleton, & Dorahy, 2013).

Underfunding, successful failure, and the social will

An emphasis on making sure that what we do in mental health, social service, juvenile justice, and other human service delivery systems actually works—meaning that clients truly recover or at least get on a road to recovery so that we can see measurable positive change—is long overdue. Ensuring that the treatment measures we use are evidence based certainly serves that emphasis on seeing positive change. At the same time, innovation may be held back by the sometimes premature demand for evidence-based practices when there are actually relatively few practices that are applicable to every problem posed by people suffering from complex posttraumatic and dissociative problems (Brand, 2012; Courtois, 2008; Courtois & Ford, 2013; Kinsler, 2014). In a new field of discovery and innovation, holding everyone in the treatment arena accountable to a standard that is applicable to the pharmaceutical industry discourages the creativity that is necessary if we are to change the paradigm for individuals, organizations, systems, and whole communities. Drug companies have enormous reservoirs of money to fund their research, and the often extraordinary profits made from one drug can then be applied to research and development of another. Because they are profit-making companies, they can draw investment from many different sources and attract people willing to buy stock. Years and years of investment go into the development and then testing of every single drug. Randomized controlled studies that are necessary for a drug (or a treatment protocol) to become evidence based are extraordinarily expensive, but when profits are likely to be substantial, the return on investment can be significant.

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But where does the profit come from in healing wounded people that would then be available to invest in research and development? All we know of adversity and trauma tells us that we are spending our national wealth on preventable problems—billions of dollars every year. But investments in education, mental health care, job development, and the multiplicity of resources it will take to eliminate poverty, hunger, adversity, and interpersonal violence are long-term investments—in some cases investments that will take generations to make manifest. This kind of investment does not happen in the world to which the readers of this journal belong. When did you last see a well-funded Department of Research and Development in a psychiatric program? We are currently in the midst of trying to help one traumatized urban community to become trauma informed. We were able to get a grant to work on this with a research component—but the grant is only for 1 year! It has taken several hundred years to create the compounded problems of racism, poverty, and unemployment, and they will not be remedied in a year.

I suspect that every single person reading this has his or her own personal experience with this kind of dilemma. Is it that we do not have the solutions to our problems or that the problems are impossible to solve? Or is it that our society is not willing to do what it takes to solve these problems? A German researcher, Dr. Wolfgang Seibel, has touched on this issue in his own society. He has said that the human service delivery system gets delegated by the larger society to fix the problems it does not *really* want to fix. So society funds that sector just enough to survive, but never enough to thrive. He calls this "successful failure." It comes down to the social will (Seibel, 1996).

A different vision and policy research

A true public health approach to the prevention of adversity and trauma requires a vision of an altogether different kind of society than presently exists. An explicit policy can achieve several things: It defines a vision for the future, it outlines priorities and the expected roles of different groups, and it builds consensus and informs people. Many of us in the fields of traumatic stress and dissociation have seen the power of shared knowledge and how that knowledge can assist us in crossing great divides of experience, education, class, ethnicity, age, and gender. Likewise, we all acknowledge that research on traumatic stress, toxic stress, and dissociation needs to translate into policy, but we are only beginning to understand how the translation from practice to policy occurs.

As public health professional Dr. Jonathan Purtle has pointed out, there is very little guidance on how to translate traumatic stress research into policy and even less trauma policy research. As he has demonstrated in his research, at the Congressional level most attention, where it exists at all, has been directed

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toward combat veterans and relatively little has been directed toward civilian survivors (Purtle, 2014, 2016). A policy typology that differentially defines trauma informed, trauma responsive, and trauma specific may help to define a typology of trauma policies as well. Trauma-informed polices could provide momentum for the primary prevention measures that always appear to be left out of meaningful discourse at a policy level, as if such change is impossible to achieve. Trauma-responsive policies could then be explicitly designed to minimize damage and maximize opportunities for healthy growth and development in populations at risk. Trauma-specific policymaking could be directed toward the creation and maintenance of effective interventions that mitigate the effects of trauma exposure and promote healing.

Not a new institution, a new campaign

The task is a daunting one, but as knowledge spreads, increasing numbers of people are available for recruitment into the sea change embodied in this knowledge. In December 2015, the first organizing meeting of a national policy organization was held in Washington, DC, at the offices of Van Ness Feldman, a law firm whose members are well acquainted with policymakers and the need to provide them with accurate, evidence-supported knowledge about important policy changes. Those attending represented different disciplines, experience with a wide variety of populations, and different geographic areas, but they shared a recognition of the need for a big tent national organization focused on changing national policy around trauma and adversity. The proposal for a National Institute on Sexual Violence made recently by Dr. Jennifer J. Freyd is a good example of how we need to elevate these issues to the level of national importance and commitment to change (Freyd, 2015)

As of this writing, a board has formed, as has an executive committee of the board; operating committees have been developed; and Dan Press, a partner in the aforementioned law firm, has donated pro bono legal services to set up the organization as a nonprofit company. The working name for the organization is Campaign for Trauma-Informed Policy and Practice (www.CTIPP.org). Its mission is to create a resilient, trauma-informed society in which every individual has the opportunity and the supports necessary to flourish. Our fundamental goal is to advocate for public policies and programs at the federal, state, local, and tribal levels that incorporate recent scientific findings regarding the relationship between complex trauma and many social, health, and mental health problems. Like anything else, we need funding to support the work, and we depend on donations to do that. We hope you will join us.

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Conclusion

We live in an era of mass social denial. On the one hand, there is an expectation that somehow all of the preventable problems that unnecessarily plague our culture—poverty, educational failure, child abuse, elder abuse, homelessness, violence, mass incarceration, drug epidemics, infrastructure breakdowns, expensive and inadequate health care—must all be solved and it should be someone's responsibility to do so. On the other hand, these problems are somehow supposed to be solved without requiring any further investment from the public. When listening to the political discourse, such as it is, a mental health professional can easily walk away with an eerie feeling of familiarity, of being sane in insane places.

If, as a culture, we would just learn that fixing things after they are broken is *always* more expensive than not breaking them in the first place, we could all live in a land of plenty. But as things exist now, our culture and a large proportion of our people are broken in body, mind, and spirit. Our house is badly in need of repair. Repair, as it always is, will be expensive, especially when the deterioration has gone on for so many years and there have been so many patches applied that are also now breaking down. We need the money and the investment to do proper research on all of our interventions if we are to use the standard of evidence that presently exists. That will require an enormous shift at the policy level in local, state, and national politics. More important, it will require a shift in the ground on which our country is built, a system in which short-term profitability is what counts and the only value that matters in the end is money.

As a society, we have a moral responsibility to do something with the knowledge we now have that most of the suffering brought about in the world today is *preventable*. In the past century, during World War II, we launched the Manhattan Project to create and detonate the first atomic bombs. Surely we have the ability, though not yet the will, to launch a similar project, only this time not about creating weapons of mass destruction but instead about creating a future worth surviving.

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