Promises to Keep

Interview with Ann Jennings, PhD, Founder and Executive Director , Anna Institute
Interview by Linda Ligenza for National Council Magazine
Ann Jennings is a pioneer in the field of trauma-informed care. She is the founder and executive director of the Anna Institute, named after her daughter, which provides guidance, resources, and information to support trauma-informed care. She also manages the national "SPSCOT" listserve and has worked in the trauma field as an educator, administrator, advocate, consultant, and author for over 30 years.

How did you get involved in the field of trauma-informed care?

It was through personal experience that I became aware that traumatic events, particularly in childhood, play a causal role in the development of emotional disorders. I was working in the field of mental health when I learned about my daughter Anna's history of early childhood sexual abuse. This was in 1979. She was 19 years old and had been in mental health facilities for 4 years when in a group session she heard other patients' stories and realized she was not the only person in the world to have been sexually abused as a child. It was then that she was able to disclose to me and others what had happened to her. Her disclosure made sense of so many of her behaviors and feelings that I hoped I might finally find her the kind of help she needed. Hope was quickly informed by reality, however, in this quest for help.
For the 17 years that Anna was in mental health services and psychiatric hospitals, she was never assessed or helped with the impacts of what happened to her — even though she herself asked for such help. No one had trauma training. The focus was on identifying what was wrong with her, counting symptoms, diagnosing her, and then medicating her. For 17 years no psychiatric treatments, mental health services, or medications helped her. In fact, many such treatments retraumatized her. As many sexual abuse survivors do, she felt defective, deficient, unworthy, bad, different from others — yet was never given the opportunity to share this burden, or to be understood and responded to. She finally lost hope and in 1992 at the age of 32, took her life.
Her story is similar to the stories of many others in our service systems. We must give all children and adults in our services the opportunity to share their stories and to be listened to and believed, understood, and helped. Needless suffering is caused by lack of knowledge of trauma and its centrality to mental health, addictions, and health problems. We need to understand this connection and ask about the person's life experiences, rather than assuming their problems to be solely genetic or biological.

How would you describe trauma-informed care?

I think Roger Fallot has described this best so in part I'll quote from his recent

work: “A trauma-informed service system or organization is one that thoroughly incorporates, in all aspects of service delivery and in all staff, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to put “safety first” and to avoid retraumatizing those who come seeking assistance.”
The culture of a trauma-informed organization is built on core values of safety, trustworthiness, choice, collaboration, and empowerment. When a program can say that its culture reflects each of these values in every contact, physical setting, relationship, and activity, and *that this culture is evident in the experiences of staff as well as consumers,* then the program’s culture is trauma-informed. This kind of environment is capable of supporting and sustaining the positive effects of “trauma-specific” services, which are designed to directly address sequelae
of trauma.

What advances have you witnessed in the field of trauma informed care?

Thinking about the advances made in this field over the past 25-30 years, in the public sector where I have been most involved, a few things stand out for me: advances in scientific research reflecting a paradigm shift in how we think about mental illness and addictions; growth in public and professional awareness of the prevalence and impacts of trauma over the lifespan; development of trauma-specific treatment models and trauma-informed approaches; focus on creating trauma-informed cultures in service settings and communities; increase in personal disclosures of traumatic experiences and the impact, and multiple paths to healing.

Advances in scientific research. Recognition of the impact of trauma on the development of mental illness and addiction was rare in the early 1980s. Now in 2011, 30 years later, science is catching up with what we know from many consumers; that trauma from overwhelmingly stressful childhood and/or adult experiences is a core causal factor—and that mental illness and substance abuse are not rooted exclusively in biology or genetics. Two examples of such research follow.

A 2008 comprehensive review of research literature on schizophrenia and psychosis — *Child Maltreatment and Psychosis: A Return to a Genuinely Integrated Bio-Psycho-Social Model* —illustrates, and I quote, “for several decades the conceptualization and treatment of mental health problems, including psychosis, have been dominated by a rather narrow focus on genes and brain functions. Psychosocial factors have been relegated to mere triggers or exacerbators of a supposed genetic predisposition. This paper advocates a return to the original stress vulnerability model proposed by Joseph Zubin and Bonnie Spring in 1977, in which heightened vulnerability to stress is not, as often wrongly assumed, necessarily genetically inherited, but can be acquired via adverse life events. There is now a large body of research demonstrating that child abuse and neglect are significant

causal factors for psychosis."

The Adverse Childhood Experiences, or ACE Study, is another critical body of knowledge challenging long held models of thinking in the fields of health and behavioral health. Conducted by the Centers for Disease Control and Kaiser Permanente's Department of Preventive Medicine, the study involved over 17,000 Kaiser patients.Its findings provide irrefutable evidence of
A high prevalence of childhood adverse experiences in a middle class population, and A strongly proportionate and significant relationship between traumatic stress in childhood and leading causes of morbidity, mortality, and disability in the U.S.
Study participants received an "ACE Score" between 0 and 10 based on their responses to yes or no questions on 10 categories of adverse childhood experiences (age birth to 18). Each participant's ACE score was then compared with his/her comprehensive health records. The findings were stunning. Repeatedly, in every analysis, the data revealed the higher an individual's ACE score, the greater the likelihood in adulthood of Behavioral health and health risk problems such as alcoholism, smoking, obesity, depression, IV drug abuse, suicide attempts, and hallucinations Social problems such as revictimization by rape or domestic violence, homelessness, prostitution, teen and unwanted pregnancy, and inability to sustain employment, and Health problems including liver disease, COPD, autoimmune disease, and coronary artery disease — even after controlling for risk factors such as smoking. Early death is also associated with childhood trauma, as the study found persons with an ACE score of 6 or higher die almost 20 years sooner than those with an ACE score of 0.

Growth of public and professional awareness of trauma. What was anomalous is becoming expected. This is one of the signs of a paradigm shift. When I first entered the field, childhood traumas such as physical or sexual abuse were considered rare, if considered at all. Now, both the general public and human service systems from federal to local levels are significantly more aware of the prevalence and impacts of violence and trauma in childhood.

Development of trauma-specific treatment models and trauma-informed approaches. Whereas in the early 1990s there were few if any models for traumaspecific treatments and trauma-informed care, now there is a plethora of such approaches available.

Focus on creating trauma-informed organizational cultures and communities. Numerous federal and state systems and behavioral health organizations are exploring and implementing ways of becoming trauma-informed. A model trauma-informed community, *Peace4Tarpon*, is evolving in Tarpon Springs, Florida. Its stated mission is "to provide everyone in our community with information on the causes and consequences of trauma" and to support "public and provider education, resource assistance, and advocacy for appropriate prevention and

intervention services." *Peace4Tarpon* includes virtually every group and civic organization in the city — the mayor's office and city council, the city manager's office, the police and fire departments, the housing authority, the school system, health and human services, the business community, the faith-based community, and the local college, art museum and library. These disparate groups are working together with a common mission — to make Tarpon Springs a safe, healthy, healing, and productive community.

Increase in personal disclosures and advocacy. Consumers are increasingly speaking out about their histories of childhood trauma and advocating for services that facilitate healing and do not retraumatize, adding trauma on top of trauma. Prior to this, people understood consumers as ill or having a disease. This perception can be extremely stigmatizing and ignores the context of an individual's life. As one consumer responded when asked what was different for her now that the mental health agency she went to for services had become trauma-informed, she said, "Well before, I brought a part of myself through the [agency] door. Now I bring my whole self through the door."

What direction would you like to see the field go?

Basically, we have an epidemic of trauma in our society. The prevalence and impacts of childhood trauma and violence in this country represent a public health crisis of enormous proportions. Like AIDs—this epidemic has continued to grow and spread, in large part because it has been denied, ignored, or minimized for so long — or simply because we lack the will to do anything about it.
My hope is that we will soon come to recognize childhood trauma as the major public health crisis it is, underlying many of our most pressing and costly problems, and that the necessary fiscal and policy structures will be put in place to support programs that teach parents about trauma and its impacts, and help us learn how to heal ourselves, and how to protect and nurture our children and build their natural resilience.

One important issue that needs addressing is the imbalance of research, in the U.S. especially, with research into biological causes outweighing social causes by about fifteen to one. For example, of 1,284 publications about childhood schizophrenia only five relate to child abuse and eight to poverty.
Finally, I agree with John Briere that "If child abuse and neglect were to disappear today — the Diagnostic and Statistical Manual would shrink to the size of a pamphlet in 2 generations, and the prisons would empty."

What direction is your work going?

I love much of the work I am already engaged in and will continue it. My interest at this time, however, increasingly centers on primary prevention of childhood trauma. I probably focus on this because of my experience as a mother — wishing I had known more about how to raise my children, watching how my

daughters, mothers themselves, and my sons, too, learn their parenting not just from their experience as children with me and their dad, but also from parenting programs and peer self-help. Because of this, they are breaking the intergenerational cycle of trauma in our family system.

I am also keeping a promise to my daughter Anna to finish and publish a book she and I wrote together, telling the story of her childhood and titled *A Child's Path to Mental Illness.* A second book will be about her years in institutions and will include much of her artwork — which is hauntingly beautiful. Then, I want to tell the story of my own life as honestly as I can, and leave that legacy behind for my children, grandchildren, and great grandchildren who might be curious about me and perhaps learn something of use from my story.

What can child and adult serving organizations do to help?

Short term, this depends on what they are charged with doing now, and what funding exists. What they can do, now and in the long term, is to continually work on becoming trauma-informed — so that everything they are presently doing and everything that is realistically possible for them to do, and is infused with the values of trauma-informed care.

Management can set the tone. Organizational leadership and involvement is key to achieving this kind of transformative change. Advocates for trauma-informed care working as staff or as clients within organizations can make a significant difference by continually bringing up the issue of trauma in multiple settings within the organization, and using a variety of strategies to educate and raise awareness of other staff.

What can clinicians do to help?

Clinicians can also work as trauma advocates within their organizations and in the community as well. They can apply trauma-informed principles to their own practice and influence others in numerous ways: shifting from a "we/they" approach and from seeing people as "well/ill" to understanding the whole person within the context of their lived experience; deepening their knowledge and understanding of trauma and multiple paths to healing, and sharing what they know with others. They can refuse to adopt an authoritarian "expert" stance, conveying they know more about a person seeking help than that person knows about him or herself. They can become more transparent in recognizing and revealing the impact on their lives of their own traumatic childhood experiences and how much they share in common with the people they are committed to helping.

As Dan Gottlieb says in *Nobody Gets to See the Wizard,* "We are all part of the human family; each of our lives travels along the continuum of human experience, facing the same basic existential issues as we go. We have the capacity to really hear and understand each other, and on common ground, we can learn from each other and help each other to heal."