Towards a conceptual framework:

Trauma, Family Violence and Health

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Trauma, Family Violence, and Health

Introduction

Family violence is a public health issue with pervasive consequences, including experiences of trauma. Trauma has been linked to a variety of short- and long-term physical and mental health outcomes, including sleep problems, weakened immune system functioning, diabetes, hypertension, cardiovascular disease, post-traumatic stress disorder (PTSD), anxiety, and depression (Lind et al., 2016; Petrov et al., 2016; Lagdon, Armour, & Stringer, 2014; Mason et al., 2013; Out et al., 2012; Irish et al., 2010; Dutton et al, 2006; Seng et al., 2005; Woods et al., 2005; Reiche, Nunes & Morimoto, 2004; Shaw & Krause, 2002; Clum et al., 2001). From a public health perspective, increased attention has been directed to trauma resulting from family violence and its effects on well-being. Continued efforts to bring the field of public health and trauma-informed responses to survivors of family violence is integral to advancing prevention and intervention across the life course, as well as improving services and health for survivors of violence.

Broadly, family violence encompasses all forms of abuse or neglect experienced by a child or adult from a family member or person with "whom they have an intimate relationship" (Public Health Agency of Canada, 2014). Examples of family violence identified by the Public Health Agency of Canada (2014) include: elder abuse/neglect, early and forced marriage, violence directed toward women and girls in the name of "honour", female genital mutilation, intimate partner violence, and child maltreatment (including abuse, neglect and exposure to IPV). This paper focuses on intimate partner violence (IPV) and child maltreatment. Both IPV and child maltreatment are highly prevalent forms of family violence worldwide and represent serious public health concerns, with a range of negative impacts on well-being across the life course.

We begin by reviewing the health outcomes of trauma within the context of IPV and child maltreatment. Next, three theoretical models and their relevance to trauma-informed health promotion for child and adult survivors are presented. Finally, incorporating the model of SAMHSA (SAMHSA, 2014a), we describe a trauma-informed health framework that in future Backgrounders of this series, will provide the foundation for the development of principles, competencies, and outcome indicators for trauma-informed health promotion.

Defining Trauma in the Context of IPV and Child Maltreatment

Research indicates that approximately 76% of adults in Canada report having been exposed to at least some form of trauma in their lifetime, with about 9% meeting the criteria for post-traumatic stress disorder (PTSD) (Van Ameringen, 2008). Trauma can result from a single event, series of events, or set of circumstances which threaten(s) a person's physical or psychological well-being and overwhelm(s) their capacity to cope (BC Provincial Mental Health

and Substance Use Planning Council, 2013). Experiences of trauma vary in magnitude, frequency, duration, complexity, and source. Along these dimensions, there are five types of trauma, summarized in the chart below.

Table 1. Types of Trauma

Type	Description	Examples
Single incident trauma	Trauma related to an unexpected and overwhelming event	Car accident, natural disasters, sudden loss, community violence (e.g. school shooting), single episode of abuse or assault, witnessing violence
Complex or repetitive trauma	Trauma related to ongoing traumatic experiences	War, immigrant/refugee experiences (e.g. forced displacement), ongoing abuse, intimate partner violence
Developmental trauma	Trauma related to early ongoing or repetitive trauma, often within a child's caregiving system and interfering with healthy attachment and development	Neglect, abandonment, physical abuse or assault, sexual abuse or assault, emotional abuse, witnessing violence or death, coercion or betrayal
Intergenerational trauma	Psychological or emotional effects that can be experienced from people who live with trauma survivors	Children living with a parent or caregiver who experienced abuse, children of survivors of residential schools
Historical trauma	Cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma, inflicted by a subjugating, dominant population; intergenerational trauma is an aspect of historical trauma	Genocide, colonialism, slavery, war

Source: BC Provincial Mental Health and Substance Use Planning Council, 2013.

While there are many experiences which can result in trauma, we focus on IPV and child maltreatment – which are examples of, or strongly related to, each of the aforementioned types. It is important to note that IPV and child maltreatment do not always lead to trauma. Although many violent experiences are inherently considered to be traumatic, the event itself is not the determining factor of whether someone experiences trauma or not; rather, "it is the

individual's experience of the event and the meaning they assign to it" (Klinic Community Health Centre, 2013, p.9.). That is, two individuals may be exposed to the same event, yet differ on what is interpreted as traumatic (SAMHSAa, 2014). Protective factors (e.g. self-esteem, social support, self-regulation) following a potentially traumatic event can negate the preceding trauma; however, not all individuals have the capacity for or are able to access these protective factors. As a result, some individuals may have a greater risk of experiencing consequences to health and well-being following trauma (Klinic Community Health Centre, 2013; Pearlin, 2010). This paper centers on instances where IPV and child maltreatment results in trauma, resulting in both direct and indirect effects on health. We also recognize that survivors of IPV and child maltreatment may have previously experienced or may continue to experience other forms of trauma beyond family violence (e.g. a survivor of intimate partner violence may also be affected by intergenerational trauma related to residential schools).

> "Individual trauma results from an event, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."
>
> SAMHSA, 2014b, p.7.

Intimate partner violence refers to a range of abusive behaviours perpetrated by a current or former partner, including but not limited to: physical, sexual, and psychological or emotional harm (Sinha, 2013). These dimensions of IPV are defined in Table 2.

Table 2. Forms of IPV and definitions.

Physical Violence	Physical injury or death resulting from the intentional use of physical force (e.g. pushing, shoving, throwing, biting, hair-pulling, choking, slapping, punching, burning, use of a weapon, use of one's body, size or strength against another person)
Sexual Violence	Sexual acts committed against an intimate partner without freely given consent (e.g. physical force or alcohol/drug induced sexual acts, "non-physical" pressure to engage in sexual acts—through fear, verbal pressure, intimidation, forcing a partner to engage in unsafe or humiliating sexual acts, and non-contact acts of a sexual nature—sexual comments, voyeurism, exhibitionism)
Psychological or Emotional Violence	The use of words or action is to control or frighten an intimate partner, or destroy their self-respect (e.g. insults, humiliation in front of others, use of intimidation, coercive control, hurting pets, destroying belongings, threats of physical or sexual violence, control of reproductive or sexual health—hiding birth control pills, exploitation)

Source: Adapted from Sinha, 2013 & PHAC, 2014.

IPV has particular impacts on the formation of trauma. Specifically, IPV is typically chronic in nature. It is often ongoing yet unpredictable, leading to more powerful, negative consequences (Katerndahl et al., 2010; Engnes, Liden & Lundgren, 2012; Herman, 1992a,b). Such violence is also perpetrated by a loved one, leading to a violation of trust and disruption of attachment, which can be highly traumatic itself (Scott & Babcock, 2010).

IPV can occur in all types of relationships, regardless of the gender of the individuals involved in the relationship, which may or may not include sexual intimacy. Police-reported Canadian data indicate that there were 341 victims per 100,000 population of intimate partner violence in 2011, with 80% of victims being women (Sinha, 2013). Rates are particularly high for young women (age 15 to 24 and 25 to 34) and marginalized women (e.g. Indigenous women). At a global level, approximately 30% of women have been subjected to physical and/or sexual violence by an intimate partner (WHO, 2013). Though IPV is most commonly experienced by women and perpetrated by men, men can also be survivors of violence. Police-reported data indicates that 147 men per 100,000 have experienced intimate partner violence in Canada, compared to the rate for women at 574 per 100,000 (Sinha, 2012). Rates for men may be underestimated, however, given US findings that men are less likely than women to report experiences of violence (Black et al., 2011).

Child maltreatment includes all forms of physical, sexual, and psychological abuse directed toward a child as well as neglect and exposure to IPV (Public Health Agency of Canada, 2010). Specific forms of child maltreatment are further defined with examples in Table 3.

Table 3. Forms of child maltreatment and definitions.	
Physical abuse	Any act of physical aggression directed toward a child (e.g. shaking, pushing, hitting with object, biting, choking).
Sexual abuse	Sexual molestation or exploitation of a child by an adult or older child within or outside the family (e.g. penetration, fondling, pornography).
Emotional/psychological abuse	Terrorizing or threat of violence (e.g. threats against child's cherished objects), verbal abuse or belittling (e.g. name-calling), isolation or confinement (e.g. purposely cutting child off from other children), inadequate nurturing or affection (e.g. lack of parental interaction), exploiting or corrupting behaviour (e.g. encouraging involvement in criminal behaviour).
Neglect	Failure to provide for child's basic needs, adequate protection, and adequate supervision (e.g. inadequate nutrition, failure to provide medical treatment).
Exposure to intimate partner violence	Child is present during physical or verbal violence between intimate partners and can see and/or hear the violence (direct); child not present during violence but suffers consequences, hears about it, or experiences changes in his/her life as a result (indirect); child is exposed to emotional violence between intimate partners.
Source: Public Health Agency of Canada, 2010.	

Cases of child maltreatment are difficult to identify and rates of child maltreatment can vary depending on the methods used to gather data (Hambrick et al., 2014). The Canadian Incidence Study of Child Maltreatment (CIS) is one of the few nationwide studies to investigate the prevalence of child maltreatment cases (Tonmyr, Ouimet, & Ugnat, 2012). This study utilized direct reports from child welfare workers to uncover maltreatment rates for the four categories of maltreatment. Of the 6,163 substantiated investigations of maltreatment among children of all ages, the primary category of maltreatment was physical abuse in 20% of cases, sexual abuse in 3% of cases, emotional abuse in 9% of cases, neglect in 34% of cases, and exposure to IPV in 34% of cases (PHAC, 2010).). Further analysis of the data from this study focusing on First Nations children found that of the substantiated cases of maltreatment, the primary category of maltreatment was neglect in 46% of cases, exposure to intimate partner violence in 36% of cases, physical abuse in 23% of cases, emotional maltreatment in 9% of cases, and sexual abuse in 3% of cases (Sinha, Trocme, Fallon, MacLaurin, Fast, Prokop et al, 2011).

The consequences of child maltreatment have direct impacts on healthy development as well as achievement, which can increase the likelihood of disease in adulthood (WHO, 2016). In

fact, the World Health Organization identifies child maltreatment as a contributing factor to slowed economic and social development at the nation-level. Furthermore, the poor health outcomes resulting from child maltreatment form a significant portion of the global burden of disease (WHO, 2016). It is also likely to occur in the context of IPV, with prevalence estimates for co-occurrence ranging from 30 to 60% (Edleson, 1999; Jouriles et al., 2008; Hamby et al., 2010) and can be a risk factor for the future perpetration of IPV (see Etherington & Baker, 2016a, for a review). Child maltreatment can be particularly traumatic because it is perpetrated by a caregiver - a person whom the child depends on for their basic needs and protection in addition to love, warmth, and support. This type of family violence can also be chronic in nature, often involving multiple forms of abuse, which can further exacerbate experiences of trauma.

Considering the Health Impacts of Trauma

Substantial research has documented the impacts of trauma and family violence on health and well-being (e.g. Lum et al., 2016; Lopez-Martinez et al., 2016; Ely et al., 2004; Lagdon et al., 2014; Macy et el., 2009; Wong & Mellor, 2014; WHO, 2013; Blasco-Ros, Herbert & Martinez, 2014; Herrenkohl et al., 2013; Dillon et al., 2013). This section summarizes the physical, psychological, behavioural and interpersonal health consequences found to be specifically related to trauma that occurs in the context of IPV and child maltreatment (see Table 4). In general, the health consequences of trauma are more severe with multiple or chronic exposures and can be long-lasting, particularly with regard to mental health (for a review, see D'Andrea et al., 2011). Trauma emerging from IPV or child maltreatment can have a variety of direct and indirect health consequences, as well as the potential to lead to further co-occurring disorders and/or concerns, such as substance use.

Social Determinants of Health

The following factors have been shown to strongly effect the health of Canadians:

- Aboriginal Status
- Disability
- Early life
- Education
- Employment and working conditions
- Food insecurity
- Health services
- Gender
- Housing
- Income and income distribution
- Race
- Social exclusion
- Social safety net
- Unemployment and job security

Raphael (2009)

The health impacts of trauma should be considered in the context of pre-existing health inequalities or differences in health among Canadians based on the structural circumstances, or social and economic conditions, in which individuals live. Research demonstrates that factors such as gender, income, education, ethnicity/culture, Aboriginal status, and immigrant status are key factors in shaping health outcomes (Health Disparities Task

Group, 2005; Canadian Population Health Initiative, 2004; Government of Canada, 2008; Canadian Population Health Initiative, 2008). These and other factors, commonly referred to as the social determinants of health (see PHAC, 2016) are associated with inequalities in such outcomes as mortality, early childhood development, health behaviours (e.g. smoking, exercising), and health care utilization (e.g. visits to the doctor), mental illness, morbidity, and disability (Pan-Canadian Public Health Network, 2010). Thus, some individuals may have an increased vulnerability to health problems, which can subsequently affect or be affected by their trauma experience.

Due to the prolonged, re-occurring trauma associated with IPV, there is an increasing likelihood of developing severe health consequences (e.g., Lum et al., 2016; Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Ely, Dulmus, & Wodarski, 2004; Haskell, 2001; Jones, Hughes, & Unterstaller, 2001; Lagdon et al., 2014; Macy, Ferron, & Crosby, 2009; Wathen, 2012; Wong & Mellor, 2014; WHO, 2013). The most prevalent health impacts of IPV are PTSD and depression. Rates of PTSD in women who have experienced IPV have been shown to range in magnitude, from 14% to 92% of women exhibiting at least some symptoms (Dillon et al., 2012). PTSD has also been found to be a long-lasting effect of IPV, with some women experiencing high rates of PTSD symptoms as many as nine years after an abusive relationship has ended (Wong & Mellor, 2014). With regard to depression, women who have experienced IPV victimization appear to experience rates two to five times higher than women without such an experience (Beydoun et al., 2012; Wathen, 2012). While the type of IPV victimization has not been found to play a large role in the development of depression, it has been suggested that psychological abuse alone may lead to even higher rates of depressive symptoms (Lagdon et al., 2014). In addition, repeated victimization greatly increases the risk of developing major depression (Lagdon et al., 2014).

The physical health impacts of IPV are far-ranging, from short-term injuries to death. Such consequences of violence have been divided into three distinct categories: immediate and direct impacts (i.e., death and injury); long-term and direct impacts (i.e., disability and chronic illness); and indirect impacts (i.e., health behaviours, such as smoking, diet, and physical activity) (Wong & Mellor, 2014). Although some consequences are more serious than others, all physical health impacts resulting from IPV can be life altering. Table 4 contains a summary of the effects of IPV on the health and well-being of survivors.

Table 4. Effects of IPV on health and well-being.			
Physical	**Psychological/Emotional**	**Behavioural**	**Interpersonal**
Physical injuries (e.g. cuts, bruises, sprains, broken or fractured bones) Brain injury Cardiovascular disease Hypertension Arthritis Irritable bowel syndrome Chronic pain Reproductive and gynecological health problems Somatoform symptoms Poor self-reported physical health and quality of life Sleep problems Digestive problems Disability Death	Post-traumatic stress disorder Anger management Anxiety Depressive symptoms Major depressive disorder Suicidality Obsessive-compulsive disorder Poor self-rated mental wellness Poor emotional regulation	Eating disorders Substance abuse High medication use Self-harm High-risk sexual behaviours	Frequent relationship conflict Experiences of re-victimization Perpetration of violence Difficulty establishing and maintaining relationships
Adapted from: Lum et al., 2016; Wong & Mellor, 2014; WHO, 2013.			

Research has also consistently linked child maltreatment to numerous health outcomes that can span across the life course (e.g. Briere & Jordan, 2009; Fry et al., 2012; Hébert et al., 2016). One examination of substantiated cases of maltreatment found that 28% of children experienced health problems other than immediate physical injury, such as asthma or non-organic failure to thrive (Health Canada, 2005). Emotional harm appears to be more common than physical harm, with 34% of children experiencing emotional harm, and 21% requiring treatment. This outcome was particularly prevalent for children who experienced sexual abuse (Health Canada, 2005).

Recent Canadian research indicates that these negative health outcomes often continue into adulthood for children who have experienced maltreatment. Specifically, findings indicate increased odds of physical conditions (e.g. back problems, cancer, chronic fatigue, stroke), poor self-perceived health, and mental health issues (e.g. anxiety, depression, and post-traumatic stress disorder) (Afifi et al., 2016; Afifi et al., 2014). In many instances, the odds of experiencing a physical condition in adulthood were approximately 1.5 to 3 times greater compared to

individuals who had not experienced child abuse (Afifi et al., 2016). Notably, odds ranged from 1.4 to 7.9 for mental health issues (Afifi et al., 2014). In other words, victims of childhood abuse are approximately 1.5 to 8 times more likely to experience psychological or emotional consequences in adulthood, depending on the outcome examined. Suicidality is of particular concern given findings that experiences of sexual abuse result in an increased likelihood of attempting suicide 8 times that of individuals without such an experience. The effects of child maltreatment on the health and well-being of children are summarized in Table 5.

Table 5. Effects of child maltreatment on health and well-being

Physical	Psychological/Emotional	Behavioural	Interpersonal
Pain Increased number of surgeries Increased rates of hospitalization Somatic symptoms Obesity Chronic illness/disease in adulthood/later life	Anxiety Major depressive disorder Oppositional-defiant disorder Conduct disorder Post-traumatic stress disorder Psychological distress Low self-esteem Suicidality Psychiatric symptoms Antisocial behaviour & personality disorders Emotion regulation difficulties Cognitive disturbances	High-risk sexual behaviours Early initiation of smoking Substance use and abuse (drugs and alcohol) Eating disorders Self-harm Educational impacts (poor academic achievement)	Vulnerable to later re-victimization Difficulty forming relationships Dating violence/IPV perpetration Bullying

Briere & Jordan, 2009; Fry et al., 2012; Rodgers et al., 2004; Zimmerman & Mercy, 2010; Rogosch et al., 2011; Herrenkohl et al., 2008; Romano, Babchishin, Marquis, & Fréchette, 2015.

Toward a Framework for Understanding Violence, Trauma and Health

The application of the social-ecological model to trauma and its effects as well as to public health prevention can be complemented by other existing health frameworks, such as the life course perspective (see Elder, Johnson & Crosnoe, 2003) and intersectionality theory (see Hankivsky, 2011).

Socio-ecological Model

The socio-ecological model has been fundamental to public health's approach to violence prevention (for examples see, CDC, 2015; Miszkurka, Steensma, & Phillips, 2016). This model views violence as a complex behaviour that is best explained by the interactions of

multiple factors related to individuals and the contexts within which they live, learn, play, and work. Specifically, four contexts are identified as levels of influence contributing to violence and as sites to stop violence, to respond to those affected or at risk of being affected by violence, and to prevent violence from beginning: individual, relationship, community, and societal. Table 6 summarizes the factors associated with each level of the model.

Risk and protective factors at each of the levels are targeted through prevention and intervention initiatives. There are thus numerous opportunities for implementing a multifaceted, multi-level prevention strategy. For example, health promotion for trauma survivors at the individual level may include educating high school students about health risk behaviours associated with trauma/family violence (e.g. smoking, drinking, drugs) and include programming for alternative health-promoting coping strategies (e.g. yoga, sports). At the interpersonal level, students might participate in healthy relationships programming that teaches about negotiating safe-sex practices with a partner. Community-level prevention might include a youth health drop-in centre offering confidential assessment, STI-testing, and counselling services. Finally, societal initiatives might include polices to provide funding for low-income adolescents to participate in team sports.

The Life Course Perspective

A life course approach to health emphasizes the temporal and social dimensions of health. Within this perspective, health is viewed as a dynamic process extending from the prenatal period through to old age. This process is influenced by social, economic, and cultural contexts and occurs not only across individuals' lives, but also, across generations. Further, health and the factors that shape it are not static. In other words, health and its determinants can change over time. For example, an individual may be unemployed for several years and then employed again, and in turn, experience benefits to health that they formerly did not possess.

In its recognition of dynamic processes, the life course perspective emphasizes the link between early life events and later life outcomes, and the cumulative impact of these events. This is an important tenet to consider given the often cumulative nature of violence, trauma, and its related stressors. For example, a survivor may have had experiences of physical abuse during childhood by a parent, sexual abuse during adolescence by a peer, and emotional abuse during a marital relationship. Apart from re-victimization, violence can have a cumulative effect within one relationship as it is often a process rather than an event (Williams, 2003). IPV, for example, is often chronic and enduring, with each episode of violence building on previous episodes.

Table 6. Socio-ecological Model Levels and Factors.	
Levels:	**Factors:**
Individual	Identifies biological and personal history factors; such as age, education, income, substance use, or history of abuse, that increase the likelihood of becoming a victim or perpetrator of violence
Relationship	Examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle-peers, partners and family members-influences their behavior and contributes to their range of experience.
Community	Explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence.
Societal	Looks at the broad societal factors, such as health, economic, educational and social policies, that help create a climate in which violence is encouraged or inhibited and help to maintain economic or social inequalities between groups in society.
Source: CDC., (2015) The Social-Ecological Model	

Intersectionality: Bringing context to the center

Intimate partner and sexual violence scholarship and activism are grounded in an intersectional understanding of survivors' vulnerabilities to and experiences with violence, in addition to the systems and services with which they become involved (e.g. Sokoloff, 2005; Crenshaw, 1991). Intersectionality draws attention to the ways in which lived experiences and life changes are shaped by interconnected dimensions of stratification (e.g. ability, indigeneity, gender, age) as well as the broader social context (e.g. social disadvantage, historical and current oppressions). Accordingly, not all survivors of family violence experience IPV or child maltreatment in the same way, and their experiences of trauma and health occur in – and are impacted by – different contexts.

When research examines violence, trauma, and health among various groups, it often fragments individuals into single or dyadic categories. In reality, individuals may identify as belonging to several different groups and can be impacted by the multiple oppressions facing

each group. In addition, no single axes of inequality is more important than any other as these axes are interconnected and work simultaneously to shape individuals' experiences.

It is important to note that while occupying multiple disadvantage statuses can have implications for individual outcomes, these implications are not additive in nature (Dill & Zambrana, 2009). That is, "the impact of intersecting identities is *qualitatively* different from the impact of any single identity or the addition of them" (Etherington & Baker, 2016b, p. 3, emphasis added). Survivors of violence navigate multiple social statuses and experiences of oppression simultaneously, and have unique experiences of trauma and health as a result. It is not a question of whether one person experiences "greater" or "worse" effects than another; rather, it is a matter of understanding the context in which these experiences occur. Further, when interpreting available research on violence, trauma, and health among diverse groups, it is important to avoid conflating experiences of violence with stereotypical accounts of particular groups as this may overlook the complexities of lived experience and reinforce oppressive discourses (e.g. racism, ableism, homophobia, transphobia).

From a trauma-informed lens, it is critical that services avoid re-traumatizing individuals and the risk of re-traumatization is greater for those experiencing multiple forms of oppression (Miller et al., 2016). There has also been increasing recognition of the need for trauma researchers and practitioners to consider the diverse experiences of survivors (see Bryant-Davies, 2010). Intersectionality is therefore a key element of trauma-informed approaches to improve the health and well-being of survivors of violence given the importance of context for these outcomes.

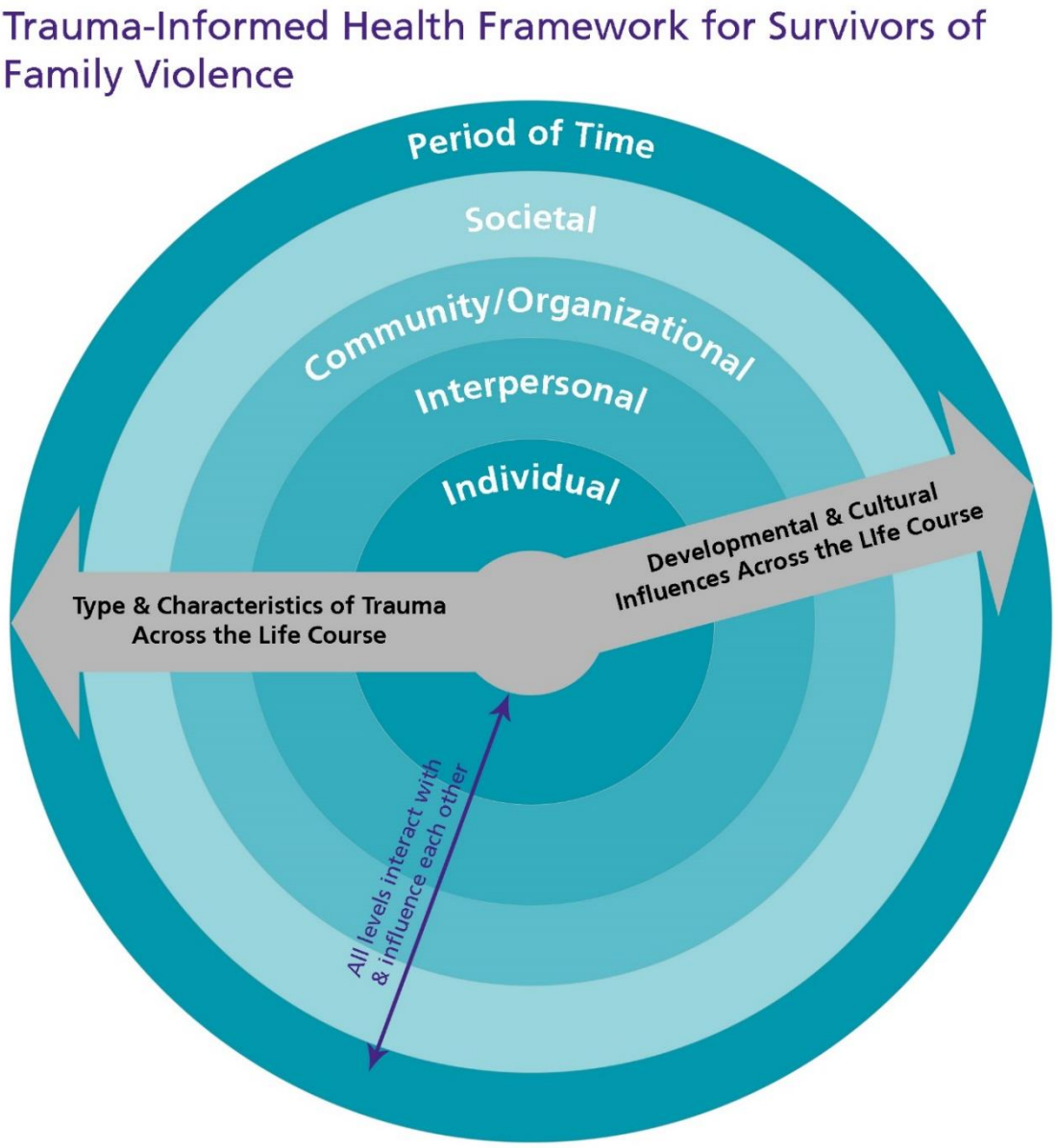
A Trauma-Informed Health Framework

A social-ecological model (SEM) informed by the life course perspective and intersectionality can be applied to both trauma and health, as it involves many of the same elements in each instance while recognizing the reciprocity of each level (i.e. individual, interpersonal, community, societal) in shaping relevant outcomes. Accordingly, it makes sense to integrate approaches to trauma and health through the social-ecological model, which has also been fundamental to intervention strategies (see, for example, CDC, 2015; Magruder et al., 2016). Such a model has been developed by SAMHSA (2014a) and is presented in Figure 1.

The SEM model provides a strong conceptual base for trauma-informed health promotion. Specifically, trauma is viewed through a broad lens that incorporates individual, interpersonal, community, and societal level factors, all of which are present before, during and after the trauma. It recognizes that environmental factors, including our access to resources, greatly influence all aspects of our well-being (see Social Determinants of Health, on p.8). The framework supports primary, secondary and tertiary prevention initiatives that work through inter-related factors at each of the social-ecological levels while acknowledging the link between early and later experiences and how this may be shaped by intersecting social

inequalities (see Table 7). When applied to health promotion, this model brings trauma to the forefront of developmentally sensitive intervention efforts and health outcomes.

Figure 1. A Social-Ecological Model for Understanding Trauma and Its Effects



Source: SAMSHA, 2014, Page 36

Table 7. Examples of factors operating at each level within the social-ecological model of trauma and its effects.

Individual Factors	Interpersonal Factors	Community and Organizational Factors	Societal Factors	Cultural and Developmental Factors	Period of Time in History
Age Biophysical state Mental health status Personality traits (e.g. temperament) Education Gender Coping styles Socioeconomic status	Family Peer and significant other interaction patterns Parent/family mental health Parents' history of trauma Social network	Neighbourhood quality School system and/or work environment Social services, family violence services, and health services quality and accessibility Faith-based settings Transportation availability Community socioeconomic status Community employment rates	Laws Provincial and Federal economic and social policies Media Societal norms Judicial system	Collective or individualistic cultural norms Ethnicity Cultural subsystem norms Cognitive and maturational development	Societal attitudes related to family violence Changes in diagnostic understanding between editions of the Diagnostic and Statistical Manual of Mental Disorders

*List not exhaustive. Adapted from SAMHSA, 2014a, p. 16.

Conclusion

The burden of victimization is evident in the emerging body of evidence linking experiences of family violence as children and/or as adults to trauma, and in turn, to poor health outcomes. While not all experiences of violence lead to trauma and not all trauma results in poor health, a substantial number of survivors experiencing trauma face resulting physical, psychological/emotional, behavioural, and social hardships (Lum et al., 2016; WHO, 2013; Wong & Mellor, 2014). The fields of public health and trauma-informed approaches are foundational to supporting survivors of IPV and child maltreatment.

Socio-ecological, life course, and intersectional approaches contribute explanatory value to a trauma-informed health framework. The integration of these frameworks recognizes the social-ecological influences on trauma, and in turn, on health, while at the same time recognizing temporal patterns and intersectional experiences. Key to such a framework are the following premises: there is a link between and cumulative impacts of events in early life and later life outcomes; risks and protectors linked to violence are associated with individual factors (e.g. biological factors) and contextual factors (e.g. relationship, community, societal factors); experience and life changes—including experiences of violence, trauma and help seeking—are shaped by interconnected dimensions of stratification (e.g. ability, indigeneity, gender, age) as well as the broader social context (e.g. social disadvantage, historical and current oppressions); and, survivors of family violence experience IPV or child maltreatment in different ways.

The elements of the framework described above are represented in the social-ecological model for understanding trauma and its effects developed by SAMHSA (2014a). This heuristic framework provides the foundation for developing values, principles and competencies for trauma-informed and developmentally sensitive health promotion.

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