Framework for Categorizing Trauma Response Programing

	Development	Peace		Health	
	Community Building	**Community Healing**	**Rights-Based**	**Public Health**	**Clinical Health**
Framing of Problem	Violence, conflict, and trauma are the result of, and a major contributor towards, social divisions and inequality	Violence creates trauma at the individual and community levels; unaddressed, this trauma leads to recurring cycles of violence against self and others	Traumatic exposure results from a violation of people's rights, and the inability/unwillingness of those in power to protect vulnerable populations and uphold their rights	Traumatic exposure, without appropriate interventions, serves as a driver of population-level ill health and suffering particularly among vulnerable populations	Traumatic exposure can contribute to many illnesses, including contributing to specific clinical diagnoses (PTSD, addictions, depression, anxiety, hypertension, etc.)
Framing of Response	Prevention and response are simultaneously addressed by reducing inequality, division, and bringing different, previously separated groups together in shared spaces and for shared work	Trauma can be healed, violence prevented, and communities reconciled with mutual sharing, awareness, and skills for trauma healing, reconciliation, resilience & restorative justice	Change through awareness, giving voice, and mobilizing people to demand and uphold human rights, and advocate for change to laws, policies, and practices of groups in power	Response through targeted evidence-based prevention efforts of traumatic exposure and/or downstream health effects among at-risk populations	Trauma-linked clinical diagnoses should be addressed through specific evidence-based clinical interventions at the individual level
Examples of Interventions	• Youth clubs/activities bringing participants from different sides of a conflict together • Economic development initiatives with marginalized groups • Creation of shared safe spaces for relationship building/interaction	• Healing the Wounds of Trauma (ABS/THI) • Strategies for Trauma Awareness and Resilience (STAR) • Healing and Rebuilding our Communities (HROC) • Singing to the Lions (CRS) • Alternatives to Violence Project (AVP)	• Advocacy efforts to change policy/law • Education and empowerment of survivors to stop future violations and demand justice from perpetrators • Legal efforts to secure protections or compensation	• Developing treatment for trauma-linked conditions • Early intervention (psychological and medical) for most at-risk sub-populations • Targeted violence reduction programs for populations at risk of perpetrating violence	• Provision of evidence-based clinical treatments for trauma-linked conditions (PTSD, addictions, depression, anxiety, hypertension, heart disease, metabolic disorders, autoimmune disorders, physical injuries, etc.)
Types of Impact Indicators	• # of people across boundaries participating in relationship building • % of participants altering negative views about themselves or others • % growth in income among participants • % growth in social contacts across boundaries	• % of participants altering negative views about themselves or others • % of participants using self-calming techniques • % change in violent or conflict incidents • % change in measures of anxiety, stress, and coping • % change in willingness to seek support/care	• Change in laws/policies • % of target population reached with education and mobilization • # of cases with legal aid • % of survivors finding legal justice in the courts • % of population with awareness of relevant human rights and or legal rights	• % change in at-risk populations experiencing traumatic exposure • % change in "adverse childhood events" scores • % of at-risk population with access to evidence-based treatments for trauma-linked conditions • % change in incidence trauma-linked conditions	• % change in condition-specific indicators (blood pressure in hypertension, PCL scores for PTSD, etc.) • % of people in remission (or equivalent category) for target conditions • % change in participation in activities of daily living • % of people treated with target conditions

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Factors in Assessing Context Appropriateness	• Possibly the most broadly applicable, flexible, and least technical of the approaches outlined. • Potentially counter-indicated if creation of shared spaces puts participants at risk for further violence or marginalization • Potentially counter-indicated if economic empowerment initiatives put participants at risk for further violence or marginalization • Potentially counter-indicated if economic assistance provides incentives that discourage healing and recovery	• Most often used in community-level experiences of mass trauma • Potentially counter-indicated in situations where conflict reduction techniques are seen as a way to pacify targeted populations or de-politicize a conflict in order to maintain an unjust status quo • Potentially counter-indicated in situations of ongoing conflict/trauma, where immediate safety and security are the top priorities	• Most effective in contexts where there are strong rights-based legal, cultural, or institutional frameworks in place to draw upon and call to account • Potentially counter-indicated when, due to the political, cultural, or religious context, the use of a 'rights-based' approach is seen as a foreign or politically dangerous and puts survivors or partners at higher risk	• A flexible approach that can be appropriate in most contexts. Best with information on exposure rates, prevalence of risk/mitigating factors, and where an assessment of the relative importance of this issue can be made versus other public health priorities. • Potentially counter-productive when other public health issues have been widely identified as a higher priority (even by survivors), which could create resistance to efforts and undermine effectiveness	• Contexts with institutional capacity to competently and ethically reach most at-risk populations for screening, diagnosis, and treatment using evidence-based interventions • Clinical PTSD treatment is generally counter-indicated for people in situations of continuing traumatic exposure (hypervigilance may be protective) • Many clinical interventions can be counter-productive or harmful if diagnosis and treatment are non-evidence based, not culturally adapted, or not well implemented
Resources To Learn More	• MCC Peace Club materials • Aldrich (2012) Building Resilience: Social Capital in Post-Disaster Recovery • Rylko-Bauer & Farmer (2016). Structural Violence, Poverty, and Social Suffering • Varshney (2003) Ethnic Conflict and Civic Life: Hindus & Muslims in India • Kalyvas (2006) The Logic of Violence in Civil War	• Strategies for Trauma Awareness and Resilience - STAR (EMU/CJP) • Singing to the Lions (CRS) • Trauma Healing Institute (American Bible Society) • Yoder & Zehr (2005) The Little Book of Trauma Healing • Tomlinson (2007) A review of the literature concerning the Alternatives to Violence Project (AVP)	• Haugen & Boutros (2014) The Locust Effect: Why the End of Poverty Requires the End of Violence • Bowen & Murshid (2016) Trauma-Informed Social Policy • UN Practitioner's Portal on Human Rights Based Approaches • Lawrence et al (2019) Lancet Commission Legal Determinants of Health	• Horwitz (2018) PTSD: A Short History • CDC (2019) Adverse Childhood Experiences (ACEs) • Magruder et al (2017) Trauma is a public health issue • Harris (2018) *The Deepest Well* • De Jong (2010) A public health framework to translate risk factors into interventions	• National Center for PTSD • Resick et al (2016) Cognitive Processing Therapy for PTSD: A Comprehensive Manual • Foa et al (2007) Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences • Hughes et al (2017) The effect of multiple adverse childhood experiences on health: systematic review