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The Continuum of Victim to Survivor: Trauma-Informed Principles and the Impact of Language

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Abstract

As knowledge regarding trauma has evolved, debates around language have also emerged among healthcare professionals. These debates include the meaning of terms such as victim and survivor. As a result, professionals across the medical and behavioral healthcare fields must attend to the language of trauma and the unique ways in which individuals express their traumatic experiences. In this article, we provide a perspective on how Substance Abuse and Mental Health Services Administration's (SAMHSA) trauma-informed care (TIC) principles (i.e., safety, trust, choices, collaboration, and empowerment) can be implemented as an approach to the language of trauma used by healthcare providers. We discuss the nuances of trauma-informed language and consider the influence of sociocultural factors, diversity, and neurodiversity.

Keywords: Trauma Recovery, Trauma-Informed Care, Trauma-Informed Principles, Survivor Language, Victim Language.

Introduction

The exploration and understanding of trauma has evolved since its first appearance in the *Diagnostic and Statistical Manual of Mental Disorders* in 1980, when it was introduced as a means of better understanding the psychological challenges of Vietnam veterans.[1,2] This article presents a perspective on how the Substance Abuse and Mental Health Services Administration's (SAMHSA) trauma-informed care (TIC) principles (i.e., safety, trust, choices, collaboration, and empowerment) can be implemented as an approach to the language of trauma used by healthcare (medical, behavioral and mental health) professionals.[3] Specifically, it addresses important nuances in the use of the terms, *victim* and *survivor,* and it examines the influence of sociocultural factors, diversity, and neurodiversity on terms used to describe traumatic experiences.

According to Gergen, knowledge is language-based, and people internalize their thoughts and actions within their cultural, political, and social contexts.[4] As knowledge regarding trauma has evolved, debates around language have also emerged among healthcare professionals. For the purpose of this paper, healthcare refers to the range of professions in medical, behavioral and mental healthcare settings. These debates include the meaning of terms such as *victim* and *survivor*. As a result, professionals across the medical and behavioral health fields must attend to the language of trauma and the unique ways in which individuals express their traumatic experiences.

When seeking any form of healthcare (medical, behavioral or mental health), individuals with complex trauma histories bring a lifetime of diverse experiences. Findings from research show the relationship between adverse childhood experiences and the development of serious medical conditions or mental health/substance use greater utilization of medical services, and a higher cancellation and no-show rate, all of which can hinder recovery.[5-8] Given that healthcare professionals will be

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working with people who have experienced trauma, and that professionals themselves may experience their own trauma activation, they must be knowledgeable about trauma-informed practices and the unique ways in which individuals express trauma, to avoid causing iatrogenic effects for healthcare service users.

Nuances of Language Associated with Trauma: Victim, Survivor, and Beyond

In response to the need for a widely applicable approach to trauma-informed care, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed a set of principles to guide professionals in their work.[3] This guidance offers professionals a way to consider how they use language in a way that is sensitive to clients' individual experiences of trauma, enabling them to regain a sense of control as they begin the journey from victim to survivor. Despite SAMHSA's guidance, terminology related to trauma and trauma-informed approaches remains a source of contention across healthcare sectors. Some professionals feel that a lack of language standardization across disciplines has been problematic for collaboration, while others highlight service access concerns for people whose experiences do not fit easily with accepted definitions of trauma.[9]

Many individuals with healthcare needs have intersectional identities, various socio-cultural and socio-political locations, and multiple forms of oppression that affect them. However, studies on language use have demonstrated inconsistent terminology related to trauma care. Messamore and Paxton studied language use among several thousand organizations that served women or offered health and disaster recovery services between 1998 and 2016.[10] They found that both the terms *victim* and *survivor* were used but that their use varied by time and situation. They noted that in criminal investigations, the term victim was used more often than survivor. Victim language can honor and emphasize the harm and violence perpetuated by oppressive systems by holding the perpetrator accountable.[11] Conversely, survivor language positions individuals as the focus of their experiences, connoting ownership of an empowering narrative.[12] Sweeney and Taggart shared the example of grassroots survivor organizations that point to concerns about over-emphasizing the term victim, which limits "access to other, less vulnerable identities" stressing that service users should develop their own trauma narratives.[13(p.385)] While claiming one's own experiences can be empowering, the choice of labels may become limiting and/or oppressive. For example, Williamson and Serna studied the effects of self-labeling (victim or survivor) on attitudes of 85 persons who had experienced sexual assault. They determined that labeling even in the context of encouraging people to determine the label that best describes their individual experiences (self-labeling) can "potentially force individuals to incorporate their experiences with assault into their identity, which may not be something some individuals want."[14(p.681)]

Furthermore, scholars of radical feminist, critical, and postcolonial theories have seen post-traumatic stress disorder (PTSD) symptoms "as coping or survival skills that allow individuals to survive unbearable situations" not aspects of a disorder.[15(p.146)] Burstow saw trauma as a personal reaction to a specific event within a particular socio-political context.[16] This *survivor* view centered on how people may regain power by naming their own experiences and includes approaches that account for narratives within non-Western and collectivist cultures.

Language Considerations from a Decolonized Approach

Recent discussion of trauma language and theory emphasize the importance of diversity and inclusivity including consideration of non-Western terms. The movement toward a broader understanding of trauma theory is based in criticisms of the trauma theory developed in the 1990's as being Eurocentric in its conceptualization.[17] Specifically, Visser states, "Part of the original theory's Eurocentrism is its exclusive focus on the event-based model of trauma, which does not account for the sustained and long processes of the trauma of colonialism".[17(p.252)] Thus, efforts to decolonize trauma theory underscore traumatic experiences as cultural trauma unrelated to single events, such as racism as well as cultural, religious, and spiritual aspects of healing.[17, 18] While historians attribute the definition of decolonization to the political and economic shift away from imperialism following World War II, the term as applied here refers to the process where "postmodernist thought, in which the commanding position of Western culture is questioned and the term 'Eurocentric' qualifies as an unsustainable conceit has joined with postcolonialism in changing the

way the world is understood and seen."[19(p.33)] Applied to trauma specific language, decolonization includes consideration of how trauma experiences are discussed in various cultures. For example, Suarez surveyed the use of alternative terms to refer to trauma in non-Western and post-war contexts.[15] They found references to "suffering" or "hurt" in Cambodia, "difficult times" or "times of big sorrow and grief" used by indigenous people in Peru, and "anger of the spirits" in Mozambique and Angola.[15(p.144)] In their narrative study, Mckenzie-Mohr and Lafrance used "living well" instead of "survivorship," "recovery," "post-traumatic growth," "thriving," and "resilience" to help women who experienced rape share their stories.[20(p.385)] Thus, decolonization adds another dimension to our perspective that TIC principles guide the development of language to communicate about and with those who have experienced trauma.

Language Considerations for Neurodevelopmental Conditions

Another nuance to be considered in the discussion of trauma language is neurodiversity. Neurodiversity is defined as both a biological term that refers to the diversity of the human brain signifying multiple possibilities of cognitive functioning and a social movement that emphasizes acceptance of this diversity rather than cure or prevention.[21] Given the neurodiversity of service users, examinations of the language of trauma for individuals with intellectual and developmental disabilities (IDD) have looked at ways to adapt assessment and treatment based on different cognitive and verbal abilities.[22] For example, Carrigan and Allez modified the abstract signifiers of PTSD through metaphor to be more responsive to a person with an autism spectrum condition.[23] They likened the brain "as a kitchen cupboard where the tins (trauma memories) have not been stacked properly and keep falling out."[23(p.331)] Honoring the importance of trauma language for people with IDD involves understanding treatment, identifying internal states and symptoms, and focusing on temporal aspects of experience (e.g., those who are present-focused). However, implementing these considerations can challenge clinicians.[24]

Due to the diversity within and across populations, De La Rue and Ortega warned health and social service systems against using a "one-size-fits-all" approach to trauma.[25] They noted that "trauma-informed interventions and programs must transform to explicitly acknowledge how systems of privilege and oppression interact."[25(p.510)] The key to a trauma-informed approach is attending to gender-based and culture- and context-specific trauma presentations while remaining sensitive to the language used to share those experiences. Without these lenses through which to offer help, service providers may cause harm despite their good intentions, especially in contexts where people are already at-risk.

Implementing SAMHSA's Trauma-Informed Principles Using Client-Centered Language

As defined by McNamara and colleagues "Trauma-informed care (TIC) refers to a set of practices that foster not only physical, but also psychological and emotional healing."[26(para5)] SAMHSA's trauma-informed care principles (i.e., safety, trust, choices, collaboration, and empowerment) attend to cultural, historical, and gender issues that extend beyond a medicalized focus on individuals' internal processes and pathologies.[3] These trauma principles expand upon definitions of healing and recovery and related terms. Although some individuals may be helped by using a mainstream medical narrative, such as the symptoms and diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth*, it is essential to note that medicalization can "individualize, decontextualize and depoliticize experiences." [20(p.53)]

Implementing trauma-informed care principles through a person-centered approach to the language and terminology of trauma aligns with therapeutic practices involving service users' voices and choices throughout the treatment process, including using culturally sensitive language.[9,28] The question that clinicians should be asking, "What happened to you?" instead of "What's wrong with you?" highlights this perspective.[3] While interconnected, we describe each of the principles with a focus on language to clarify our position:

- *Safety* connotes a non-hierarchical approach to the application of language, one that relies on service users' own versions of their traumatic experiences such that oppressive dynamics from their relational histories do not become replicated.
- *Trust* emerges from the "safety, respect, and acceptance" engendered by the clinician through terms that arise from genuinely

listening and responding to service users in ways that meet their needs.[28]

- *Choice* may be seen as helping service users gain control over the language used to guide their treatment and recovery.
- *Collaboration* signifies an equal partnership/alliance that draws on service users' expertise in determining the language used to describe their experiences and coping strategies based on their history and cultural backgrounds.[28]
- *Empowerment* reflects an overall shift in the clinical language of all fields from pathology to strength and resilience. By respecting each service user's right to determine their own way of describing traumatic experiences, they can regain a sense of power both in treatment and in their daily lives.

Conclusion

In this article, we highlighted the importance of attending to the complexities surrounding the language of trauma. We addressed elements of language in trauma theory to explore the nuanced use of terms such as victim or survivor when working with clients who have experienced trauma. We also addressed the importance of understanding the impact of culture, diversity and neurodevelopmental differences in the use of trauma language. Finally, we proposed a perspective of using SAMHSA's trauma-informed care principles (i.e., safety, trust, choices, collaboration, and empowerment) to guide the development of an approach to language of trauma within healthcare professions.[3] Providers working in medical, behavioral and mental health care settings must consider how language has been historically, culturally, and politically embedded in our society so they can effectively meet people where they are along the continuum of recovery. Using trauma-informed care principles offers a model for professionals to find a shared language to talk about trauma and clear guidelines to assist them in a way that is not "one size fits all." SAMHSA's trauma-informed care principles offer guidelines that underscore the need to remain sensitive to the uniqueness of each service user's way of sharing their traumatic experiences.[3] This sensitivity includes being attuned to service users' choices and needs when they speak of themselves in ways that connote victimization versus survivorship. This collaborative process seeks to build safety and trust in the relationship between service users and healthcare professionals by respecting the service user's choice of descriptive language to help them move toward a sense of empowerment that supports their recovery both in the sheltered spaces of healthcare professionals' offices and in their home environments.

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The authors report there are no competing interests to declare.

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Authors' Contributions

J.A.C., E.S.S. and R.V. conceptualized the study and led the research and writing processes. All authors (J.A.C., E.S.S., and R.V.) contributed to and approved the final article before submission. This article has been submitted only to this journal and is not published elsewhere.

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