

An Extension Educator Perspective on Trauma-Informed Care

WHAT WORKS, WISCONSIN - RESEARCH TO PRACTICE SERIES

ISSUE #13, June 2017

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Interest in Adverse Childhood Experiences (ACEs) and Trauma-Informed Care (TIC) among child and family-serving professionals in Wisconsin and across the nation has grown over the past several years. More recently, attention to trauma-informed care has been promoted by Wisconsin first lady Tonette Walker through her work with the [Fostering Futures](#) initiative. In response, we have published a [companion brief](#) on adverse childhood experiences (i.e., ACEs) that explores how the ACEs findings might be applied to extension educators, family professionals and others who serve children and families. In this brief we discuss trauma-informed care, provide a critical overview of its principles and assumptions, and consider implications for Extension and other community educators.

Defining Trauma

Interest in the topic of trauma, more generally, has been growing over the past two decades, especially as new research and brain imaging methods have been able to examine the long-term effects of trauma on the brain. [According to SAMHSA](#) (Substance Abuse and Mental Health Services Administration), trauma is the result of

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.

The kinds of experiences that can cause trauma include physical and emotional abuse, child neglect, sexual assault, the loss of a loved one, exposure to violence, disaster, war, and other emotionally harmful experiences. The findings from the [ACEs study](#) have raised our awareness of the frequency and scope of adverse childhood experiences and their contribution to trauma and future adult physical and mental health. This underscores the important distinction between trauma and adverse childhood experiences; they are not synonymous. Some adverse experiences may result in trauma, others may not. It depends on a host of factors such as the history of the individual, the duration, severity and timing of the adverse event, and the protective factors surrounding the individual. However, because of the potentially traumatic nature of many of the events identified in the ACEs study, trauma-informed care has gained popularity as an approach for responding to them.

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Defining Trauma-Informed Care

SAMHSA's [National Center for Trauma-Informed Care](#) defines *trauma-informed care* as an approach for engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. It can be implemented in nearly any type of service or educational setting, organization or system. A trauma-informed care approach to professional practice emphasizes the need for practitioners and their organizations to be aware of the possible prevalence and impact of trauma in the lives of the people with whom they work and to utilize practices that are trauma-sensitive and services that are trauma-responsive.

A trauma-informed approach is not limited to organizations and professionals who primarily work with high-risk populations or individuals who are known to have experienced trauma in their lives. It is considered appropriate in most settings including education, health care, law enforcement and recreation. This is because, as the ACEs study showed, many people have experienced adverse events during childhood that may lead to trauma. Consequently, using practices that are sensitive to these potentially traumatic experiences, regardless of whether clients or practitioners are aware them or their consequences, can reduce potential distress for individuals, help them feel safe, reduce the chances that they will be re-traumatized, and contribute to the quality of the program or service being provided.

A trauma-informed care approach typically involves a number of essential practices. These include creating an environment where those being served feel physically and psychologically safe, recognizing and building on the strengths of clients, using practices that do not re-traumatize individuals with a history of trauma, working with clients in a compassionate, collaborative and respectful manner, and encouraging the use of trauma-informed principles by all staff within an organization. A trauma-informed approach

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also involves acknowledging the widespread occurrence of adverse childhood experiences and possible resulting trauma, recognizing the signs and symptoms of trauma in individuals and families, and knowing about the resources and practices that can help people on their path to recovery.

Clarifying Terms

As interest in trauma-informed care has grown, the term *trauma-informed* has increasingly been used in a variety of different ways. A perusal of online resources related to the topic of "trauma-informed" yields such related terms as trauma-informed culture, trauma-informed practice, trauma-informed systems, trauma-informed policy, trauma-informed parenting, trauma-informed principles, trauma-informed perspectives, and trauma-informed services. Many of the terms are used interchangeably although sometimes they refer to different concepts. Such imprecision is common in a new area of work,

especially if interest is growing rapidly and terms are being incorporated into existing models of delivery and practice. Unfortunately, at this time the current language surrounding trauma-informed work does lack some precision and can lead to confusion.

One distinction that has been made involves the difference between *trauma-informed care* and *trauma-specific services*. Though they have sometimes been used interchangeably, trauma-specific services are particular clinical interventions or treatments designed to address the consequences of trauma. In contrast, trauma-informed care is the more general, strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" ([Hopper, Bassuk, & Olivet, 2010, p. 82](#)).

Another distinction has been made by SAMHSA regarding what they refer to as [trauma-informed principles](#). These are a set of guiding assumptions, operating philosophies, and value orientations

that are intended to guide organizations and their staff who wish to take a trauma-informed care approach in their work. These principles may be generalizable across many different types of settings, although how they are specifically applied may differ by the situation.

Trauma-Informed Principles

1. **Safety** - Throughout the organization, staff and the people they serve feel physically and psychologically safe.
2. **Trustworthiness and transparency** - Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust among staff, clients, and family members of those receiving services.
3. **Peer support and mutual self-help** - These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
4. **Collaboration and mutuality** - There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
5. **Empowerment, voice, and choice** - Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary. The organization aims to strengthen the choices of staff, clients, and family members and recognize that every person's experience is unique and requires an individualized approach.

6. **Sensitivity to cultural, historical, and gender issues** - The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

From: [Guiding Principles of Trauma-Informed Care, SAMHSA 2 News, Spring 2014, Volume 22, Number 2.](#)

Implications for Extension Educators

Given our role as educators, it seems appropriate to provide education about trauma-informed care and how it might guide programmatic, organizational, policy, and community responses. Educators who choose to provide this information should have foundational understanding of the field and the many nuances inherent in the concept. In addition, adopting and promoting a positive, strengths-based trauma-informed approach in our interactions with learners is well aligned with our best practices and organizational core values. Being sensitive to the needs of our learners and partners through whatever means is vital to our educational role.

Both the ACEs research and trauma-informed care call attention to the fact that early experiences in the lives of children can have long-term consequences. This presents an opportunity to raise awareness about early adverse experiences. Raising awareness through education is important, but it is not enough. We also need to increase understanding of and support for the importance of childhood experiences that promote well-being and development and protect against harm. This is highly consistent with a focus on prevention, early intervention and promotion. Extension educators can be helpful framing issues, identifying common language and definitions, and sharing current research findings on child development, family strengthening and community support for families. Moreover, working on initiatives and programs that involve prenatal and childhood intervention and education, the prevention of child abuse and neglect, and the

promotion of parenting and family well-being are in line with an educational approach that focuses on early intervention and prevention. Parenting education and support efforts share an intended long-term outcome related to reducing the risk of child abuse and neglect and other adverse childhood experiences. These preventative investments tend to have the highest payoffs and cost effectiveness and we should not be reticent about communicating this.

Working with coalitions that adopt ACEs and/or trauma-informed frameworks and are directed at reducing the incidence of trauma and adverse experiences (e.g., child abuse and neglect, domestic violence, drug abuse, etc.) seems appropriate and consistent with our work as educators. Our contributions might include developing system level logic models based on sound theories of change, sharing research and recommendations about effective interventions and practices (see [Child Trends](#), [Promising Practices Network](#), [What Works Wisconsin](#)), leadership and guidance on developing and facilitating effective coalitions, as well as assistance on evaluating such activities. It is also appropriate for extension educators to communicate to partners and stakeholders how our current youth and family-focused efforts, whether direct education or via coalitions, support the work of preventing ACEs and reducing trauma.

Trauma-informed care can be an important area of focus for Extension educators but it is not without its risks. When working in this area, we need to be aware of the boundaries of our organizational mandate and the limits of our expertise and professional training.

Direct involvement in programs and interventions targeted at high-risk audiences who have been affected by traumatic events or who are currently coping with them moves us into a grayer area. Whether or not to become involved should probably be considered on a case-by-case basis depending on one's professional training, experience, organizational support, and the expertise of one's professional partners. For example, providing parent training to foster parents who are caring for children with a history of traumatic events

may be appropriate for educators with training and experience in marriage and family therapy, counseling, social work and/or who are co-teaching with a licensed therapist or counselor.

When it comes to intervention, TIC often follows an individualized approach and emphasizes the uniqueness of each person's experience. Most Extension educators have not traditionally been in the position to provide individualized education or counseling. Rather, our mainstay has been group-based education, coalition engagement, policy education, professional development, and consultation with professionals who work more directly with individuals who need clinical intervention.

When working in this area we should be careful that we do not inadvertently cause harm. For individuals who are suffering from trauma, educational programs may not be sufficient to address their problems. We need to be cautious that our efforts are not substituted in lieu of needed therapy or treatment. We should also avoid administering clinical screening tools that assess possible traumatic or adverse events. Without proper interpretation and follow-up, individuals may draw inappropriate conclusions that can lead to unnecessary distress.

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Similarly, presentations of ACEs findings may lead some people who have experienced one or more adverse events

but who are not themselves traumatized, to think otherwise. On the other hand, when providing presentations about ACEs or TIC, we have a responsibility to make available information on resources and referrals to qualified professionals to increase the chances that individuals and families will get the support or treatment they might need.

Although many of the organizations and groups we work with support the trauma-informed framework, there are others that may not. Careful use of the words *trauma* and *survivor* can help prevent others from interpreting this approach as promoting a victim mentality that could undermine support for interventions to negate trauma and associated conditions. There is a real concern that using the word *trauma* as a catch-all term may actually have negative repercussions. We know that even within the same adverse event

such as parental separation or the incarceration of a family member, there are those who may not experience substantive negative effects or if they do, they are short term. For other individuals who experienced parental incarceration or separation as a child, their situations may have resulted in real adversity that continues to affect them negatively as adults. If we use the term too generally, it becomes impossible to truly distinguish full trauma from other less challenging experiences. Assuming that individuals who have experienced ACEs have also been traumatized is a slippery slope and may undermine the support that is vital to those who have experienced pervasive, recurring and severe adversity. Recent discussions in the field have begun to use the term *complex trauma* to describe situations of pervasive, severe and unrelenting adversity.

As is common when other new initiatives or issues emerge, Extension educators are likely to be drawn in to efforts related to trauma-informed care. Whether or not one becomes involved should be based on a variety of factors such as how it advances one's major program efforts, the value you can bring to this issue, organizational priorities and support, opportunity costs, and your comfort working in this area. If involved, appropriate roles for us to play include educating professionals and policy makers about TIC and its implications, working with coalitions that are developing initiatives to prevent adverse experiences, and implementing effective interventions that can reduce the incidence of adverse childhood events or protect against their consequences. However, working in the area of trauma-informed care is not without its risks. We need to be vigilant that we cause no harm while remaining cognizant of the boundaries of our organizational mandate and the limits of our expertise and professional training.

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This Research to Practice brief was prepared by the What Works, Wisconsin team at the University of Wisconsin-Madison, School of Human Ecology, and Cooperative Extension, University of Wisconsin-Extension. All of the briefs in the series can be downloaded from: <http://fyi.uwex.edu/whatworkswisconsin/>

The authors would like to thank Lori Zierl, Cailin O'Connor and members of the UW-Extension ACEs/TIC workgroup for their helpful insights and feedback.

This publication may be cited without permission provided the source is identified as: Small, Stephen & Huser, Mary. (2017). An Extension Educator Perspective on Trauma-Informed Care. What Works; Wisconsin Research to Practice Series, 13. Madison, WI: University of Wisconsin-Madison/Extension.

