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Journal:	Professional Development: The International Journal of Continuing Social Work Education
Article Title:	*Becoming Trauma-Informed: Suggestions for Incorporating Research Findings into Practice*
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Volume and Issue Number:	*Vol. 16 No. 1*
Manuscript ID:	*161030*
Page Number:	*30*
Year:	*2013*

Professional Development: The International Journal of Continuing Social Work Education is a refereed journal concerned with publishing scholarly and relevant articles on continuing education, professional development, and training in the field of social welfare. The aims of the journal are to advance the science of professional development and continuing social work education, to foster understanding among educators, practitioners, and researchers, and to promote discussion that represents a broad spectrum of interests in the field. The opinions expressed in this journal are solely those of the contributors and do not necessarily reflect the policy positions of The University of Texas at Austin's School of Social Work or its Center for Social and Behavioral Research.

Professional Development: The International Journal of Continuing Social Work Education is published two times a year (Spring and Winter) by the Center for Social and Behavioral Research at 1 University Station, D3500 Austin, TX 78712. Journal subscriptions are $110. Our website at www.profdevjournal.org contains additional information regarding submission of publications and subscriptions.

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ISSN: 1097-4911

URL: www.profdevjournal.org **Email: www.profdevjournal.org/contact**

Becoming Trauma-Informed: Suggestions for Incorporating Research Findings into Practice

Kerry L. Beldin and Karen A. Rolf

The burden of behavioral health disabilities in the United States is staggering. While it is estimated that one in four Americans will meet diagnostic criteria for a behavioral health condition in their lifetime (Kessler, Chui, Demler, & Walters, 2005; National Institute of Mental Health, 2009), the impact extends beyond the individual and the family. It is estimated that behavioral health conditions cost Americans almost $200 billion annually due to both direct costs related to treatment and indirect costs resulting from issues such as loss of productivity (Kessler et al., 2008). Worldwide, individuals with behavioral health conditions are at increased risk of disability and/or premature death (World Health Organization, 2010).

Social workers have long recognized the importance of the effect of the environment on the individual. It seems that, in regard to the exploration of the etiology of behavioral health conditions, the current state of the research literature is becoming more congruent with this line of thinking. Perhaps this is best reflected in the current emphasis on “trauma-informed care,” a concept that might be dismissed as simply a buzzword without consideration of how it might actually transform practice.

Social workers providing services in a variety of settings will be increasingly involved in prevention efforts and service efforts that involve trauma-informed care. This paper provides a brief overview of some of the research on trauma and highlights how it is specifically relevant to social work education, work with children in schools, work with individuals in outpatient settings, and provides implications for the future of social work practice with individuals.

Research on Trauma-Informed Care

From 1995-1997, the Centers for Disease Control and Kaiser-Permanente collected data for the first phase of their Adverse Childhood Experiences Study (ACE), exploring the relationship between early childhood adversities and their connections to well-being, health, and functioning in adulthood. Almost two-thirds of the study’s respondents indicated they experienced at least one adverse childhood experience. The negative outcomes associated with these experiences were both short-term and long-term and were related to a variety of health and behavioral health conditions (Felitti et al., 1998). Reports from the U.S. Department of Health and Human Services indicate that somewhere between 85% and 95% of women who seek services in mental health settings indicate they have experienced some type of trauma. For most of these women, that trauma was experienced during their childhood (Rosenberg, 2011). This increased awareness of the profound effects of trauma upon mental health led to the establishment of the National Center for Trauma-Informed Care (NCTIC) in 2005. Housed under the umbrella of the Substance Abuse and Mental Health Services Administration (SAMSHA), the NCTIC primarily offers technical assistance to foster the development and implementation of this type of care among publicly-funded programs (SAMSHA, n.d.).

Since exposure to trauma or adverse experiences in childhood is thought to be so pervasive and not everyone is affected in the same manner, those interested in the impact of traumatic experiences upon children are often also concerned with factors that may be associated with worse (or bet-

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ter) outcomes. For example, while it is well known that childhood trauma is associated with the development of later life behavioral health conditions, there can be mitigating factors that have been identified through research. For example, intimate partner violence in which one parent assaults another can be traumatic for a child to witness, however, the effects of the abusive parent may be diminished by the presence of a loving, caring parent (Edwards, Holden, Felitti, & Anda, 2003).

The field of developmental psychopathology was established as a result of recognition of the need to explore how factors in childhood development might lead to behavioral health conditions in adulthood. These factors have commonly been given the descriptors "risk" factors and "protective" factors, with risk factors typically associated with worsening outcomes and protective factors with better outcomes. Finally, the concept of "resilience," generally used to describe the process through which someone endures, overcomes, or thrives despite adversity, has been embraced by those who seek to promote positive outcomes among those (especially children) who have experienced adversity, specifically trauma. Conceptualizing critical and sensitive periods for risk and resiliency over the life course presents an ongoing challenge for researchers (Ben-Shlomo & Kuh, 2002) and promises to have important implications for practitioners. Social work practitioners are in a key position to help guide the research as they know specifically what risk and protective factors may interact to produce the most positive outcomes for individuals. While the logic of the research in this area is fairly easy for practicing social workers to embrace, the challenge here, as it often is, is to find concrete ways to incorporate research findings into everyday practice. The following recommendations are not meant to be exhaustive, but rather a starting point for a discussion of how to inform social work practice based on some of the research around exposure to trauma in childhood and its potential to contribute to behavioral health conditions in adulthood.

Considerations for Social Work Education

Social work educators are charged with the responsibility of educating professionals who are able to work competently, often around issues of health and mental health, as well as provide services within the framework of social work values and ethics. Some researchers have expressed concern that within education, we simply have not been effective at conveying current knowledge to our students, specifically where trauma is concerned. It has been suggested that graduate programs training mental health professionals do not sufficiently incorporate information on trauma generally and treatment specifically. The result of this oversight can be seen in the endorsement of myths and misinformation regarding trauma by mental health professionals and a lack of resources available to meet the needs of individuals needing trauma-specific interventions (see Courtois & Gold, 2009 for further discussion).

The concept of resilience is one that often is used when discussing the differential effects of trauma on individuals. It seems, at least according to one interesting study on child welfare workers, that the profession of social work is outpacing other disciplines in educating students about the concept of resilience. Of a sample of 102 child welfare workers, Thomas and Reifel (2010) found that 96% of those with a social work degree were familiar with the concept of resilience, while only 45% of those workers without a social work degree were. However, it appears there is room for improvement in helping social work students understand the concept of resilience more fully, since the evidence indicates that these social workers had difficulty discerning "resilience" from the general strengths perspective that is often taught as a dominant model in social work education programs (Thomas & Reifel, 2010). As social work educators, we can help clarify these concepts and provide basic information about trauma, its impact, and efforts regarding prevention and intervention. This requires that educators themselves make the effort to consume research that focuses not simply on trauma, but also resilience and risk factors.

Considerations for Social Work Practice in School, Child Welfare and Outpatient Settings

Unfortunately, it is tacitly recognized in social service provision that many times individuals who experience trauma in childhood, especially childhood sexual abuse, do not receive supportive and therapeutic services until adulthood. While intervention is often still beneficial, many practitioners lament the fact that perhaps outcomes might have been better for the individual had someone: known the trauma occurred, promoted protective factors, fostered the child's natural resilience, or recognized the potential detrimental effects and secured help sooner. There is certainly a need to think about how to better identify those who experience and are adversely affected by trauma so that they may be linked with services early, perhaps minimizing the resultant long term effects.

In addition to being watchful for the signs of trauma and making early referral for intervention, social workers can examine and promote protective factors in families. For example, childhood sexual abuse is often considered the most detrimental of traumatic childhood experiences and is linked with most types of behavioral health disorders in childhood as well as adulthood. These effects are similar for male and female victims (Spataro, Mullen, Burgess, Wells & Moss, 2004). However, research has also shown that, in cases in which the abuser was not a family member, if the child has a loving home environment, this can decrease the likelihood of long-term negative effects resulting from childhood sexual abuse (Edwards et al., 2003).

Another reality of social service provision is one that is exclusively recognized among work with children, and that is the prevalence of behavioral disorders in mental health settings. As the general public often suggests that disorders like AD/HD are concocted to placate parents lacking appropriate discipline skills or to line the pockets of physician and pharmaceutical companies alike, those working directly with these children whose behaviors are disruptive and bothersome at best and dangerous and disturbing at worst often suspect that there may be more complicated factors contributing to acting out. Even in less disruptive cases, research supports that trauma can affect children in a variety of ways: hyper-vigilant and aggressive behaviors, memory difficulties and attention problems, a sense of powerlessness (Steele, 2002).

Children who are misdiagnosed with disruptive behavior disorders after a trauma experience can experience aggravated symptoms, more trauma, and delayed care through the use of behavior management strategies for disruptive behaviors. It is essential for practitioners to assess and treat for trauma when a child in the child welfare system is displaying aggressive behaviors as well.

Certainly, it is worth educating our social work practitioners, especially those in child welfare, school settings, and mental health settings, about the profound and complicated ways in which trauma may present. The more aware these social workers are of this reality, the more likely they will be to consider the need to intervene, educate, and/or refer to more extensive services for the child and/or his/her family.

In conclusion, this issue of trauma is one that has far-reaching effects on the individuals who are exposed to it. It is our responsibility, if we are to provide the most effective care possible, to be proactive about our education regarding trauma. Fortunately, it is a topic that is being embraced broadly, and therefore quality resources and information should be increasingly easy to access.

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