Trauma-informed approaches in community engaged research and programming

Trauma-informed approaches in community engaged research (CEnR) and programming for public health and health inequities.

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Key Findings

- Trauma-informed approaches (TIAs) can support community engaged public health work to minimize unintended consequences, avoid re-traumatization and maximize benefits for communities heavily burdened by collective traumatic events and health inequities
- Trauma-informed principles can be used as guidance to enhance the community engagement process for both community-engaged research (CEnR) and practice
- Community partners and community engaged research teams are often informally implementing TIAs
- Building capacity to use TIAs intentionally is an opportunity for all partners in community engaged public health teams, including community partners and researchers.

Abstract

In communities heavily impacted by trauma, trauma-informed approaches (TIAs) are essential practices to minimize unintended consequences and harm associated with receiving clinical, social, and other support services. The incidence and visibility of individual and community traumatic events continues to increase. In turn, it is necessary for public health teams to build capacity and integrate TIAs into public health research and practice, particularly for communities managing multiple health inequities. Community engaged approaches have become increasingly common in public health to address health inequity. Community engaged research (CEnR) is a TIA used by public health researchers to meaningfully and respectfully serve traumatized individuals and communities. CEnR is often intended to address health disparities and inequities, and similar engagement strategies can be used for public health program development. Community engaged public health teams usually include partners from community, research, and other disciplines, and they often work in minoritized and vulnerable communities. In community engaged research (CEnR) and program design, the team can use principles of TIAs to guide the development and decision-making processes; they can also use feedback during the process to enhance the community benefit of the research and programs being offered. The team can benefit from training to understand and use TIAs to support their work. Finally, CEnR can be enhanced by building upon the scientific literature about TIAs to extract strategies and practices to exert more positive impact on the people served by their work and their organizations.

In communities heavily impacted by trauma, trauma-informed approaches (TIAs) are essential practices to minimize unintended consequences and harm associated with receiving clinical, social, and other support services. TIAs have gained traction in clinical and social systems to promote psychological wellbeing and minimize unintended consequences for individuals receiving services within these systems[1]. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization"[2]. The prevalence and visibility of individual and collective traumatic events is increasing, and public health efforts are often paired with clinical and human services activities to respond to traumatic events. In response, public health professionals and researchers can integrate TIAs into public health efforts as they more frequently engage with trauma-impacted populations.

SAMHSA highlights six key principles of a TIA to include: (1) safety, (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice and choice; and (6) cultural, historical, and gender issues[2]. TIAs adhere to these principles through the processes, design, implementation, and evaluation for any trauma-informed program, organization, or system. TIAs have a significant value because they can be used with a range of programs, organizations, and systems intended to address social, community, clinical, and environmental factors that define community environments and impact multiple dimensions of lifestyle and behavior among community members.

Public health efforts often take a community or population level approach to address recognized health and safety concerns, and are often designed to complement individualized clinical and social/human services[3,4]. Trauma is a recognized public health issue[5] that has largely been addressed through the study of traumatic stress and other individual health responses to trauma such as post-traumatic stress disorder (PTSD). Traumatic events usurp resources in minoritized and socioeconomically disadvantaged settings. They also have individual and community-wide effects on social[6], health[7-10], and wellbeing outcomes that affect residents across the life course.

Exposure to multiple traumatic events has a strong association with symptoms of depression, anxiety, and PTSD[11]. Exposure to continuous chronic trauma with community violence, cumulative stress, and secondary trauma is positively associated with PTSD, depression, and anxiety[12]. Individualized and tailored services may be necessary to manage the health and social consequences associated with traumatic experiences. Unfortunately, community traumas can amplify the mental health concerns of people managing their individual trauma. Community trauma, also referred to as collective trauma, has been defined as "an aggregate of trauma experienced by community members or an event that impacts a few people but has structural and social traumatic consequences"[13]. Other definitions describe collective trauma as "a shared feeling of being subjected to horrendous events that leave negative marks on group consciousness"[14,15]. There remains a need for collective, population-level supports for mental and behavioral health that strengthen the community environments in which individuals with traumatic and other lived experiences reside.

Community traumas disproportionately impacts minoritized communities, as they have more likely been impacted by violence, historical discrimination, oppression, and poverty[16]. While causes of community trauma vary, research suggests that it is typically rooted in social inequities such as racism, poverty, oppression, and erasure of culture/communities[17]. These conditions tend to exacerbate known health inequities and problems related to injury[18], interpersonal violence[19], morbidity[20], and mortality[21]. Residents in these communities often have a need for multiple public health, clinical, social, and community services to navigate these community conditions. The subset of collective traumas that are identified as public health disasters, like the Flint Water Crisis[22-24], may receive such a designation because they have obvious effects on physical health. In this case, the link between lead exposure and cognitive impairment[25] was the alarming concern that precipitated public health responses[26]. However, shared experiences of worry[27], fear[28], and distrust[29] across communities can also increase the risk of psychological distress and other mental and behavioral health problems, consistent with experiences of Flint residents[30-32]. Traumatic psychological stress responses may also occur more frequently[33], with negative mental and physical health implications[34].

Public health activities (research and programs) are often (necessarily) structured to focus on a particular disease or health concern, and thus requires alignment with other public health activities and community priorities when serving in the same population or community. For

public health practitioners and researchers that center health equity in their work, this alignment is essential to ensure that the benefits of the multiple programs are realized within the intended community. For those who also use community-engaged strategies to conduct their work, this message resounds from community partners as necessary to minimize unintended consequences, especially if there are similar but different messages (as in recent crises[35,36]) and see actual health improvements. Without alignment in under-resourced and minoritized communities, there is greater potential for misunderstanding, missed opportunities for collaboration, loss of synergy, and low awareness of key facilitators and barriers to effective programming and research. The integration of TIAs into public health work, including prevention and intervention work[13], can enhance the intended benefits and limit unintended consequences in service of supporting the community.

Knowledge About TIAs among Public Health Partners

       CEnR Partners are Expert Drivers of TIAs. Community engaged research (CEnR) is a TIA often used in public health to meaningfully and respectfully serve traumatized individuals and communities[37,38]. We can bring the body of literature around TIAs to CEnR and practice work in vulnerable communities by building on the principles associated with TIAs. CEnR is usually structured to build trust[39], operate with transparency[40], and foster collaboration[41] and mutuality[42,43] Various community-engaged projects and studies also acknowledge cultural[44,45], historical[46], and gender[47,48] issues, empower community voices[45,49], and engage community partners in decision-making[50,51] processes (selecting choices) for public health action.

       The benefits of CEnR and community partnerships extend from the professional and personal expertise of the individuals involved. These benefits center on the ability of CEnR teams (inclusive of community, academic, and other institutionally affiliated partners) to collaboratively identify barriers and nuances of the community that have been overlooked, minimized or unaddressed in previous efforts[52]. Partners that work to promote public health often implicitly or anecdotally acknowledge the worst-case scenarios that they or their clients/consumers have faced and use these encounters to inform their recommendations for best health promotion practice. Within the work of community-engaged public health research, non-academic partners come from multiple settings, including school, justice, clinical, and community organizations, and together create a multidisciplinary team to address some of the most critical health issues facing vulnerable communities. The team serves to address the

problem using their expertise from working within their respective professions and based on their individual experiences in their community setting. Successful CEnR in the United States has been in collaboration with several academic institutions. Example studies include the use citizen science to examine physical activity patterns on greenways at Wake Forest School of Medicine/Wake Forest Baptist Health[53-54] and the Mind Your Heart Intervention for American Indian Women at the University of North Carolina at Chapel Hill[55]. Community-partnered research centers have also developed in collaboration with academic institutions. Examples include the Detroit Community-Academic Urban Research Center at the University of Michigan[56] and the Flint Center for Health Equity Solutions at Michigan State University[57] among many others.

Knowledge about TIAs among Community Partners. Community members, leaders, and other partners have long recognized, perhaps informally, the need for their programs to address the principles of TIAs. Community partners often carry a significant amount of institutional knowledge about policies and practices that function as social determinants of health. Partners also have (some) power to integrate language that supports TIAs throughout their institutions. Partners may have an implicit understanding of the ways in which those communities have been shaped by complex and systemic factors that have created various forms of community trauma, chronic stress, and health inequities for the residents.

In community engaged public health work, community champions bring this recognition to the work. However, their knowledge does not always become foundational knowledge for public health work in their communities. This represents an opportunity to extend practice-based evidence in promoting health and wellbeing in vulnerable communities. It also has the potential to generate new evidence-based practices that can be applied and disseminated for use by public health professionals in various communities.

Knowledge about TIAs among Researchers. Public health researchers and practitioners (our team included) have used multilevel framing, including the socioecological model[58] and Social Determinants of Health models[59] to identify and act upon the upstream and downstream factors that contribute to public health. Using community engaged approaches, we examine community-based and evidence-based practices and interventions that are designed to improve health and social outcomes influenced by social factors. We center our work in the communities where we seek to achieve the greatest impact through our research. We turn to community

partners as experts to understand the cultural, historical, and social contexts that can limit the potential benefits of public health interventions and programs. We also turn to community experts to share in the decision-making process about the appropriateness of potential interventions and programs in various community contexts. Traumatic events define the community landscape within which public health interventions for other health concerns are offered. Integrating research on TIA into public health research design enables traditional academic researchers to consider unintended consequences of their well-intended work (both with organizational partners and residents)[60].

Taking Action

Using Trauma-Informed Principles to Inform Priority Program and Research Areas. Interests from institutional and academic practitioners and researchers can vary substantially, even within a single community. While some professionals may focus on narrow but high need populations, others may address more prevalent conditions. Community partners may have different experiences with different research teams, and they may share their experiences across teams in finding ways to best support their community. In sharing perspectives, the priorities for community partners, programs, and research teams can create tension that warrants management using an agreed upon framework to navigate the process. In this context, the trauma-informed principles help to form a framework to be used and minimize unintended consequences or re-traumatization in the process of service, program, and intervention development and delivery. Potential benefits of using trauma-informed principles include that they may strengthen community interest in various forms of public health research, including disease surveillance, vaccine uptake, school health, community violence, behavioral health, mental health, and others that are often influenced by social factors.

Incorporating TIAs to Address Barriers to Public Health Intervention Activities (including research and program development processes). An opportunity for strengthening CEnR is centering attention on limiting unintended consequences and managing conflicting priorities between researchers, providers, and intended users of public health activities. As an example, managing obesity generally includes a significant dietary change and increased physical activity. The language used to describe the need, emotions attached to the behavioral changes, and ideal activities embedded in the related intervention for weight change may be significantly different for community members and partners in contrast to clinicians, researchers,

and programming teams. The CEnR team could use the principles of TIAs to navigate their discussions to arrive at a well-received obesity management intervention. In addition, for communities burden by trauma, the principles of TIA can also be used to identify potential intervention activities that elicit trauma-related mental health concerns. This balance of priorities between providers and individuals must be managed to determine what interventions, if any, are appropriate[61]. This requires researchers and practitioners (academic, community, and otherwise) to become more knowledgeable about TIAs both conceptually and practically.

Training on TIAs for Community Partners. There is significant value in equipping partners from the community and other organizations to use TIAs. Existing programs and resources are available[62-72] to support providers from multiple backgrounds to build their capacity around TIAs. TIAs carry important value in the community. In the same ways that clinical and social services systems use these practices to motivate systemic change and promote empathy in responding to individuals that may have experienced traumatic events, it would be equally as important to use similar practices within community organizations that also serve large numbers of community members. Building the TIA knowledge would heighten their capacity to acknowledge the socially constructed aspects of mental health and wellness that may vary across societies and cultures[73].

The expertise required to implement TIAs is significantly less attributable to professional discipline and more aligned with the amount of required interpersonal communication and interactions with people managing traumatizing experiences. Using CEnR practices, public health professionals can use health communications strategies to translate language around TIAs from clinical to community spaces.

In vulnerable communities, access to community resources is not governed by use of individual use of clinical and mental health services. For staff of organizations that provide community resources to many community members, TIA training designed for direct service providers may be beneficial to learn how to interact with persons managing (potentially unaddressed) trauma. It is essential to ensure the staff that works directly with clients (which could be congregants in faith organizations, children in youth programs or on sports teams, and adults in various community spaces as well) realize the potential for recovery, recognize the symptoms, and avoid re-traumatizing their clients. Such TIA training may emphasize working

with empathy and awareness to (1) encourage staff to monitor their reactions to reactive clients and (2) minimize the likelihood of unintended re-traumatization.

Other relevant training content would provide an opportunity for community partners to understand effective and appropriate strategies for examine common decision-making practices for their potential unintended consequences on the vulnerability of the individuals and communities served. This type of training content would also review example situations in which similar patient/consumer populations have experienced health (physical and psychological), social, and other unintended consequences seemingly not connected to the program services being offered, or influenced by having traumatic lived experiences.

Community members and leaders with frequent social interactions would also benefit from TIA training designed to create community spaces and conversations that limit the potential for unintentional psychological distress. They may also benefit from training to recognize signs of mental health issues when needed (e.g., mental health first aid[74], community members can be empowered to support each other, and importantly support their peers as they seek the health services they need. For this to happen, we need to ask what resources have been offered to enhance their capacity to meaningfully contribute their expertise without also creating unintended consequences that increase individual vulnerabilities. The systemic use of TIAs can ensure accessibility for individuals using various forms of clinical (e.g., in health systems) and community services/programs for health promotion (e.g., disease management programs or fitness classes) and social connection/well-being (e.g., community clean-ups or celebrations).

Trauma-Informed Training for Research Teams. In action, the additional of the trauma-informed lens to community engaged public health research can have multiple dimensions, but always with diligent monitoring for unintended material, relational, and research-related consequences. Researchers should also seek training and engage in thoughtful consideration about each principle of being trauma-informed within their work. We encourage researchers to explore existing continuing education opportunities about TIAs within their own fields, disciplines[75], and professional organizations. With a CEnR approach, advisory groups representative of intended intervention/program participants are often engaged in intervention or program design. This may be the case when a shared leadership approach is not feasible[41]. Through a trauma-informed lens, such an advisory group can collaborate with or aid the research team to ensure that research activities have been examined and as needed, adapted to integrate

community culture[76,77], historical treatment or experiences that are recognized barriers to trust and partnership with the populations to be served. Such committees can also assess whether research activities seem appropriate, safe, and realistic. When this feedback is used to ensure benefit of the research for the intended communities and demonstrate appreciation to those who gave the feedback, these actions bolster the trauma-informed principle of empowerment, voice, and choice. The research team can promote trustworthiness, transparency, collaboration, and mutuality by seeking partner input in the development of project materials rather than feedback after development; ensuring partners have the language to engage in the research process; by communicating and brainstorming together often about barriers and facilitators to the research process; discussing indicators of equity and fairness upfront, including compensation for their contributions; demonstrating adoption of partner feedback in project materials and activities; and respectfully addressing boundaries in the scope of the project work.

Conclusion

As health equity remains a primary goal of public health programming and research, we can strengthen the integrate existing scientific literature about TIAs to enhance the benefits of CEnR for equitable health outcomes. Partners in health equity work often join such activities with a range of lived experiences that motivated their participation. This motivation leads to the development of well-intended programs and research studies, which should now be augmented by TIAs to deliberately monitor the potential for unintended consequences. Community engaged public health teams, including partners, researchers, and others, can strengthen their capacity to use TIAs by participating in trainings about TIAs and collaborating with clinical and human services professionals to advance public health work. Community engaged programming and research teams can choose to implement activities and benchmark their progress for alignment with trauma-informed principles. As this type of public health work progresses, meaningful research will be necessary to evaluate how CEnR can contribute to understanding the benefits of the systematic and community-wide use of TIA. These evaluation efforts will also need to capture the collective benefit of using TIA to addressing health disparities and inequities, and the ways in which the use of TIA can increase the effectiveness and reach of interventions across communities and populations that have experienced various forms of collective trauma.

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