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Trauma-Informed Approaches and Community Engagement: Community Engaged Research (CEnR) and Programming for Public Health and Health Inequities

Vicki Johnson-Lawrence, Rodlescia Sneed, Kenyetta Dotson, Margaret Njoroge, and Pamela Pugh

Cover photo: Community partner meeting in Flint, Michigan, to discuss trauma-informed approaches. Photo courtesy of Vicki Johnson-Lawrence.

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 CEnR 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.

Introduction

In communities heavily affected by trauma, trauma-informed approaches (TIAs) are essential 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 visibility of traumatic events (e.g., mass shootings) is increasing,[3,4] 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 these professionals engage with trauma-impacted populations more frequently.

SAMHSA highlights six key principles of a TIA: (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 affect multiple dimensions of community members' lifestyle and behavior.

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.[5,6] Trauma is a recognized public health issue[7] 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 drain resources in minoritized and socioeconomically disadvantaged settings. They also have individual and community-wide effects on social,[8] health,[9–12] and well-being outcomes that affect residents across the life course.

Exposure to multiple traumatic events has a strong association with symptoms of depression, anxiety, and PTSD.[13] Exposure to continuous chronic trauma with community violence, cumulative stress, and secondary trauma is positively associated with PTSD, depression, and anxiety.[14] 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 caused by 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."[15] Other definitions include "a shared feeling of being subjected to horrendous events that leave negative marks on group consciousness."[16,17] A need remains for collective, population-level supports for mental and behavioral health that strengthen the environments where individuals with traumatic and other lived experiences reside.

Community traumas disproportionately affect minoritized communities, as violence, historical discrimination, oppression, and poverty are more likely to affect these communities.[18] Although 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.[19] These conditions tend to exacerbate known health inequities and problems related to injury,[20] interpersonal violence,[21] morbidity,[22] and mortality.[23] Residents in these communities often need multiple public health, clinical, social, and community services to navigate these community conditions. Public health disasters, like the Flint Water Crisis,[24–26] may receive the designation of collective trauma because they have obvious effects on physical health. In this case, the link between lead exposure and cognitive impairment[27] was the alarming concern that precipitated public health responses.[28] However, shared experiences of worry,[3] fear,[29] and distrust[30] across communities can also increase the risk of psychological distress and other mental and behavioral health problems, as Flint residents did.[31–33] Traumatic psychological stress responses may also occur more frequently in communities with collective traumas,[34] with negative mental and physical health implications.[35]

Public health activities (research and programs) are often (necessarily) structured to focus on a particular disease or health concern, and thus require alignment with other public health activities and community priorities serving 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 intended community benefits from all programs. 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[36,37]) 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. Integrating TIAs into public health work, including prevention and intervention work,[15] can enhance the intended benefits and limit unintended consequences 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 serve traumatized individuals and communities meaningfully and respectfully.[38,39] 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,[40] operate with transparency,[41] and foster collaboration[42] and mutuality.[43,44] Various community-engaged projects and studies also acknowledge cultural,[45,46] historical,[47] and gender[48,49] issues, empower community voices,[46,50] and engage community partners in decision-making processes[51,52] for public health action.

2

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 (including community, academic, and other institutionally affiliated partners) to collaboratively identify barriers and nuances of the community that previous efforts have overlooked, minimized, or not addressed.[53] Partners that work to promote public health often implicitly or anecdotally acknowledge the worst-case scenarios that they or their clients and consumers have faced and use these encounters to inform their recommendations for best health promotion practice. Within 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 addresses the problem using their expertise from their respective professions and 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 of citizen science to examine physical activity patterns on greenways at Wake Forest School of Medicine/Wake Forest Baptist Health[54, 55] and the Mind Your Heart Intervention for American Indian Women at the University of North Carolina at Chapel Hill.[56] 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[57] and the Flint Center for Health Equity Solutions at Michigan State University,[58] 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 complex and systemic factors have shaped these communities and created various forms of community trauma, chronic stress, and health inequities for the residents.

In community-engaged public health work, community champions recognize the need for TIAs in their work. However, their knowledge does not always become foundational knowledge for public health work in their communities. This gap in use of knowledge represents an opportunity to extend practice-based evidence in promoting health and wellbeing in vulnerable communities. It also could generate new evidence-based practices that public health professionals can apply and disseminated for use in various communities.

Knowledge About TIAs Among Researchers

Public health researchers and practitioners (our team included) have used multilevel framing, including the socioecological model[59] and Social Determinants of Health models,[60] 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 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. Research teams offer public health interventions for other health concerns in community landscapes defined by traumatic events. 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).[61]

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. Some professionals may focus on narrow but high-need populations, whereas others may address more-prevalent conditions. Community partners may have different experiences with different research teams, and they may share their experiences across teams when finding ways to best support their community. In sharing perspectives, differing priorities for community partners, programs, and research teams can create tension; bringing multiple perspectives to a discussion warrants management using an agreed-upon framework to navigate the process. In this context, the trauma-informed principles help form a framework to minimize unintended consequences or re-traumatization in the process of service, program, and intervention development and delivery. Trauma-informed principles 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 other forms of research 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, clinical management of obesity generally includes significant dietary and physical activity expectations, among other health considerations. Clinicians may focus their language on the clinical outcomes. Research interventionists designing a relevant obesity management intervention may focus their language on the overall health benefits of the dietary and activity changes. The individual (community member), however, may experience the entire situation differently or negatively, regardless of intent from the clinical, research, or program teams. The language used to describe the need, emotions attached to the behavioral changes, and expectations for behavior change may be significantly different and may be attached to traumatic events. CEnR teams can be beneficial here because persons with this lived experience can participate in the development of the intervention and identify the activities that need revision. The CEnR team could use the principles of TIAs to navigate their discussions to arrive at a better, and more accepted, obesity management intervention. In addition, for communities burdened by trauma, the principles of TIA can also be used to identify potential intervention activities that elicit trauma-related mental health concerns, and minimize their potentially negative effects. This balance of priorities between providers, researchers, and individuals must be managed to determine what interventions, if any, are appropriate.[62] 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[63–73] to help providers from multiple backgrounds 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 is equally 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.[74]

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. Public health professionals can apply CEnR practices to health communications strategies to translate language around TIAs from clinical to community spaces.

In vulnerable communities, access to community resources is not governed by individual use of clinical and mental health services. For staff members of organizations that provide community resources to many community members, TIA training designed for direct service providers may help them learn how to interact with people managing (potentially unaddressed) trauma. It is essential to ensure that staff members who work directly with clients (which could be congregants in faith organizations, children in youth programs or on sports teams, and adults in various community spaces) realize the potential for recovery, recognize the symptoms of trauma, and avoid re-traumatizing their clients. Such TIA training may emphasize working with empathy and awareness to (1) encourage staff members to monitor their reactions to reactive clients and (2) minimize the likelihood of unintended re-traumatization.

Other relevant training content would support community partners in understanding effective and appropriate strategies for examining common decision-making practices for their potential unintended consequences on the vulnerability of the individuals and communities they serve. This type of training content would also review example situations in which similar patient and consumer populations have experienced unintended health (physical and psychological), social, and other consequences seemingly not from program services, 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).[75] Training can empower community members 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 (e.g., financial, materials, information) have been offered to enhance community members' capacity to meaningfully contribute their expertise without also

4

creating unintended consequences that increase individual vulnerabilities of the people they are aiming to help. Systemic use of TIAs can ensure accessibility for individuals using various services. This includes use of clinical and health systems, community services/programs for health promotion including disease management programs or fitness classes, and social connection/well-being activities like community clean-ups or celebrations.

Trauma-Informed Training for Research Teams

In action, a trauma-informed lens in community-engaged public health research can have multiple dimensions but must always diligently watch for unintended material, relational, and research-related consequences. Researchers should also seek training and engage in thoughtful consideration about each trauma-informed principle within their work. We encourage researchers to explore existing continuing education opportunities about TIAs within their own fields, disciplines, and professional organizations.[76] 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.[42] Through a trauma-informed lens, such an advisory group can collaborate with or aid the research team to ensure research activities have been examined and, as needed, adapted to integrate community culture,[77,78] 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 researchers use this feedback to ensure the research benefits the intended communities and demonstrate appreciation to those who gave the feedback, they 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; communicating and brainstorming together as a team often about barriers and facilitators to the research process; discussing indicators of equity and fairness up front, 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 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 be augmented by TIAs so research teams can 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 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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5

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About the Authors

Vicki Johnson-Lawrence, MS, PhD, is a senior manager in public health at RTI International. https://orcid.org/0000-0002-8582-3916

Rodlescia Sneed, MPH, PhD, is an assistant professor at the Institute of Gerontology at Wayne State University. https://orcid.org/0000-0001-7732-6197

Kenyetta Dotson, DMIN, MSW, is director of community-based implementation and engagement for Michigan State University, College of Human Medicine, Charles Stewart Mott Department of Public Health.

Margaret Njoroge, PhD, is an assistant professor of psychology at United States International University–Africa in Nairobi, Kenya.

Pamela Pugh, DrPH, is the owner of Urban Regeneration, LLC.

RTI Press Associate Editor

Anne Deutsch

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