



Ten Guidelines for Trauma-Informed Research in Clinical and Community Psychology: Application to a Community-Agency-University Domestic Violence Research Collaborative

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Introduction

Nearly a decade ago, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a guidebook delineating the concept of trauma and recommending the provision of Trauma-informed Care (TIC) across behavioral health organizations [1]. Since that time, Langhinrichsen-Rohling and colleagues, in concert with many other scholars and clinicians, have argued for the necessity and effectiveness of providing trauma-informed healthcare, creating trauma-informed schools and classrooms, and promoting trauma-informed policing in response to sexual assault [2-6]. Langhinrichsen-Rohling and colleagues have also argued for the importance of adopting SAMHSA's operational definition of trauma, rather than the narrower conceptualization that is formally offered by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders [7]. Specifically, SAMHSA defines trauma broadly via the 3 E's (event(s), experienced, with effects) stating "trauma results from 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 [1]. In contrast, the DSM-5 requires exposure to "actual or threatened death, serious injury, or sexual violence". This narrower conceptualization constitutes the language underlying Criterion A for the diagnosis of post-traumatic stress disorder, despite the reality that other events can be experienced in ways that are emotionally harmful and generate long-lasting adverse effects that mirror those seen in PTSD [8].

This opinion piece will review the key features of TIC, before advancing our argument for the importance of conducting Trau-

ma-informed Research (TIR), particularly when working in the community and when studying emotionally laden topics such as sexual assault, domestic violence, or community gun events. Our argument, in support of TIR, is predicated on a more inclusive definition of trauma and is in alignment with an adapted version of SAMHSA's key features of trauma-informed care. Specifically, we offer a ten-principle framework for applying the SAMHSA TIC guidelines to research with vulnerable populations or when researching sensitive topics. We assert the ethicality of becoming a trauma-informed researcher and show how the researcher's role has to be expanded in this effort. Last, we offer a brief example of the application of our TIR principles to the study of a Domestic Violence Research Collaborative. The DVRC constitutes a research-focused partnership among survivors, service providers, and scientists. Per this opinion piece, both clinical and community research psychologists, related professionals and partners, and other community-engaged scholars, are encouraged to become trauma-informed scientists who conduct Trauma-Informed Research (TIR).

SAMHSA's TIP 57 [1], published in 2014, lays out the key features of trauma-informed care within behavioral health services. The original SAMHSA 16 principles of TIC have been succinctly condensed by the Centers for Disease Control and Prevention (CDC) into six core concepts. Namely, TIC has to promote safety (1), be conducted with trustworthiness and transparency (2), involve collaboration and mutuality between patients and providers (3), provide patients with choice and pathways to empowerment (4), and be aware of and sensitive to cultural, historical and gender issues manifesting across time (5). Finally, TIC actively calls for facilitating

peer support among providers (6), in order to address and reduce secondary trauma, ensure adherence to the TIC model, and promote provider self-care in ways designed to protect against patient depersonalization and employee burn-out. Importantly, providing TIC requires adopting a sociocultural lens as well as the utilization of a multi-level, organization-wide, systemic, and environmental approach (Guideline 15, SAMHSA, TIP 57). The TIC healthcare provider is explicitly instructed that it is necessary to understand the community, the family, and the patient's cultural background when considering how trauma is interpreted and responded to. Providers are also to keep in mind that cultural factors operating at each level (individual, family, & community) affect both the perceived acceptability and expression of symptoms and the likelihood of seeking help [1].

Unfortunately, the CDC's truncated summary of the TIC guidelines neglects at least one important theme clearly embedded in the original SAMHSA guidelines: the importance of a strength-oriented approach. This theme is reflected in Guideline 2: Recognize that Trauma-Related Symptoms and Behaviors Originate from Adapting to Traumatic Experiences; Guideline 12: Use a Strengths-Focused Perspective to Promote Resilience; Guideline 13: Foster Trauma-Resistance Skills (e.g., What behaviors have helped you survive during and after your traumatic experiences? What coping tools have you learned from ____?); and the final Guideline, #16, Provide Hope – Recovery is Possible. We assert that the failure of mainstream psychology to consistently embody a strength-based approach has

violated our profession-wide ethics to do no harm. Thus, a truncated version of this guideline must be re-inserted into our enactment of TIC. We further argue that promoting patient choice and encouraging patient empowerment require inter-related but at times distinct processes.

In short, our framework for TIR, as adapted from the SAMHSA framework for Trauma-Informed Care, consists of the 10 guidelines shown in Table 1. These guidelines also draw from principles of community-based participatory research such as research should be participatory, involve co-learning, and be an empowering process [9]. Moreover, as is apparent in Table 1, in our TIR model, the traditional enactment of the lead researcher as a sole agent with important expertise to share has been discarded. Instead, the TIR researcher is expected to work collaboratively with partners, be open to learning and growing, and to behave in ways that recognize trauma, repair traumatic harm, and resist re-traumatization of all stakeholders. To accomplish this, the TIR researcher might be expected to enact a variety of roles, both simultaneously and contiguously. These roles run the gamut from: System Interrogator; Risk Analyst; Safety Manager; Transparent Communicator; Active Listener; Humble Team Member; Co-Participant; Ally; Anti-Racist; Process Facilitator; Active Learner; Social Justice Advocate; Inter-disciplinarian; Systems Thinker; Sustainability Planner; to Agent of Change. At the heart of all of these roles is the requirement that the TIR researcher embody the full spirit of collaboration with all stakeholders while employing personal and interpersonal reflexivity.

Table 1: Ten Guidelines for Trauma-Informed Research.

S.No	TIR: Guideline	Principle	Researcher role, position, and/or responsibility	Example Considerations	APA Ethical Principle
1	The safety of stakeholders is paramount; Stakeholder safety takes precedence over research objectives.	Safety	System Interrogator; Risk Analyst; Data and Safety Manager	When, where, how, and who is collecting the data and under what conditions? Are there appropriate data protection and data sharing mechanisms in place? What are all the potential risks and how can harm be prevented?	Principle A: Beneficence and Non-Maleficence
2	The research purpose should be clear to all involved. All aspects of the research process (why, what measures, what data, what conclusions) should be transparent to all stakeholders.	Trustworthiness & Transparency	Communicator and Listener	Informed consent processes should be clear and concise; Closing the loop is also paramount. Participants should be part of interpreting the findings and shaping conclusions	Principle B: Fidelity and Responsibility Principle C: Integrity
3	The research focus and approach are co-chosen; all participation is voluntary; researchers consider who is and isn't in the room	Choice	Team Member, Facilitator, and Ethical Ally	All (research) activities are a point of choice, as is every question on every survey, interview, agenda, or report; processes that elicit explicit choices (voting, dissent, consensus) are encouraged	Principle D: Justice. Principle E: Respect for People's Rights and Dignity.
4	The research is co-designed; This collaboration occurs before the project is started and through all aspects of the scientific method	Collaboration	Collaborator, Facilitator, and Co-Participant (as warranted)	Researchers need to attend to and reduce uneven power dynamics. Divides among researchers, community partners/leaders, and participants are often more arbitrary than anticipated	Principle D: Justice. Principle E: Respect for People's Rights and Dignity.

5	The researcher learns about and enacts structures and processes that support participants and community stakeholders as partners throughout	Empowerment	Advocate and Systems Interrogator; Life-long Learner	Researchers need to find ways to pay participants and community members for their time, effort, and expertise; successful learning is a bi-directional and humbling process	Principle E: Respect for People's Rights and Dignity.
6	Individuals, their actions, and the research process and outcomes are contextualized within current and historical social, racial, and economic contexts	Bio-psycho-social-cultural model, historical lenses, and anti-racist approaches are utilized	Social Justice Advocate, Inter-disciplinarian, and Systems Thinker	Understand that the individual is nested in family, organization, community, policies, culture, and history. Subsequently societal problems cannot solely be addressed at the individual level, nor can the individual be held responsible nor blamed for hardships created by policies and programming	Principle D: Justice
7	The researcher(s), participant(s), and partner(s) understand one another as people with unique strengths and expertise, as well as the capacity for growth	Strength-based	Agent of Change; Positive Psychologist	The researcher recognizes and looks to uplift the power and expertise of each participant and of the group; The research focuses on strengths and growth following trauma, not solely on deficits. The researcher recognizes their own limitations and adopts a growth-oriented self-frame	Principle A: Beneficence and Non-Maleficence
8	The researcher is part of a team; research no longer occurs in silos, nor is it conducted in a vacuum.	Peer Learning and Peer Support; Openness to Feedback	Open Co-learner; Consults with others	Communication can go sideways; researchers can do too much or over-relate; feedback to course correct is essential; difficult problems require different types of expertise; be prepared to error and repair	Principle B: Fidelity and Responsibility Principle C: Integrity.
9	The researcher focuses on sustainability, how the work can be supported and survive beyond the researcher's involvement	Sustainable	Planner; System interrogator and advocate	Brainstorm with participants and community partners about (1) whether they want to continue the project and if so (2) what existing or new funds could be acquired to support continuation; sustainability planning should be discussed from the beginning of the project	Principle A: Beneficence and Non-Maleficence
10	The researcher is responsible for this specific research experience. The researcher is also responsible for representing scientific processes, the importance of knowledge, and TIR	Responsibility	Role Model and Institutional Trauma Healer	Did participants drop out of the project? Why? Did participation in this project make it more or less likely for future participation in research to occur? Did this project facilitate greater trust in, participation with, and use of scientific knowledge?	Principle A: Beneficence and Non-Maleficence Principle B: Fidelity and Responsibility Principle C: Integrity.

As noted previously, the need to attend to each of these guidelines and/or enact the described roles often overlaps and plays out over time. In the case example we provide below, we, the researchers, were often enacting two or three of these roles at any given time. We believe that our commitment to TIR was particularly important as most of the participants in the room had a personal trauma history with interpersonal violence. Many also had a history of betrayal by institutions theoretically designed to protect or care for them (e.g., the police, health care, the legal system). Marginalized and intersecting identities were commonly held by participants (Black, female, domestic violence survivor) but not necessarily shared by the researchers who were predominantly white, female,

and highly educated. Thus, conducting TIR had to be intentional.

Case

The Mecklenburg County North Carolina Domestic Violence Research Collaborative (DVRC) is a coalition of domestic violence survivors, advocates, researchers, and practitioners, which was convened to co-develop trauma-informed guidelines for conducting research, collecting, managing, and using sensitive domestic violence data. The DVRC was also tasked with designing trauma-sensitive processes for future researchers and agency-based stakeholders to collaborate with domestic violence survivors. As researchers on the project, we provided evaluation and technical assistance

to the DVRC. Throughout the one-year DVRC project, we used the above-stated TIR guidelines as we completed our evaluation.

First, the topic (trauma-informed research guidelines), approach (a participatory multi-stakeholder research collaborative), and weekly foci (for group meetings 1-10) were co-designed with Mecklenburg County Community Support Services (CSS) staff. Mecklenburg County Community Support Services is both a domestic violence survivor service provider and a coordinator of the Domestic Violence Speakers Bureau, which consists of a largely survivor-based and voluntary group of individuals who have self-identified their desire to participate in domestic-violence-related advocacy. Through the Speakers Bureau, CSS connected with survivors who wished to participate in this research project. Once the collaborative was officially convened, these decisions were re-visited and re-considered by all DVRC members.

Collaboration and Choice:

Specifically, the DVRC was initiated in response to observations shared by a number of local practitioners. They noted that prevention, reduction, and intervention efforts against Domestic Violence (DV) remained largely at the periphery of local efforts to address gun and community violence. Additionally, although survivor-focused policies and regulations have been enacted to protect DV data, community stakeholders noted that these same policies often had the unintended consequence of domestic violence data underutilization and invisibility. Furthermore, many of the existing domestic violence data sharing and utilization policies were designed without survivor input or voice. Finally, many noted that existing data collection approaches can be disempowering, confusing, and even retraumatizing to survivors, making the establishment of survivor-oriented processes vital. The DVRC sought to address these concerns via a collaborative, choice-driven collective that unfolded across a 12-month time period.

Safety, Trustworthiness, and Transparency:

At the first DVRC meeting, we, as researchers, explained the purpose of simultaneously establishing a DVRC and conducting an evaluation of our process. We articulated how the evaluation (i.e., the research component) related to and yet was distinct from the functioning and development of the DVRC. For example, we discussed that doing an evaluation of the DVRC was part of our contract with our funders. This funding allowed us to compensate DVRC members for each meeting, which we believed was an important enactment of the TIC principles of empowerment and collaboration. Additionally, we shared our belief that the resulting evaluation could inform both local organizations seeking to prevent domestic violence and those seeking to understand the relationship between domestic violence and gun violence in our community. We also shared our hope that our evaluation and documentation effort might aid others hoping to engage in a similar initiative. Finally, we articulated our hope that conducting this evaluation would allow us (as researchers in an academic setting) to participate in the DVRC, learn from survivors and providers, and support the project

through accessing human and material resources from the university.

Various TIR guidelines came up again during our data collection and consent processes. We used meeting time to thoroughly review the DVRC evaluation informed consent document, answer questions, and clearly communicate how DVRC members could choose to participate in the evaluation or not. For example, we let them know that they could sign up for the interview, show up to the interview, answer some, one, or no interview questions, and still receive the \$25 compensation. By providing full transparency, we were able to build greater trust with DVRC members (the research participants) and demonstrate that we cared about them as people more than we cared about data collection.

Empowerment approach:

At the first official DVRC meeting, we (the research and evaluation team) emphasized to DVRC members that we were hoping this group could be a member-led, collaborative, and survivor-centered space. One way we did this was by ensuring that decision-making power rested with DVRC members. Often, this required us to sufficiently prepare for meetings, so that members had the information they needed to make decisions. For example, members asked for a list of the monthly meeting topics so that they could provide feedback. We compiled the list and spent the subsequent meeting reviewing each topic and making changes to the proposed meeting topics. We revisited the list of meeting topics at every meeting, sometimes taking up to 45 minutes of our 90-minute meeting to align the upcoming meetings with what members deemed critical. We also used multiple explicit strategies to amplify participants' voices and reduce researcher voices including our group guideline "you plus two" (at least two, if not many more than two, different participants need to make substantive comments before any one person can offer a second thought). DVRC members also created a set of group guidelines to foster a safe, equitable, shared space.

At the meeting following mid-year data collection, we presented our preliminary findings back to DVRC members as both a member check and a way to share power over the data. During this presentation, we discussed opportunities for implementing changes to improve the DVRC that emerged from the evaluation. We discussed what was feasible and collectively set expectations for what could be implemented in our remaining time together.

An important part of sharing power with others is to name and disrupt power dynamics. In one meeting, we talked about how four of the five facilitators and administrative support personnel were white. While we contextualized this within the larger context of advanced degrees and advanced employment opportunities, in which white people are often overrepresented, we also spoke about our anti-racist and trauma-informed orientation towards the work. We also explicitly discussed with DVRC members what we could do to ensure that the group facilitators reflect the group's diversity (racial and otherwise). For example, moving forward, the county department may contract with a consultant to facilitate the DVRC. This

would be one way to diversify DVRC leadership. We also discussed the absence of men in the work. While this mirrors that fact that domestic violence survivors are predominantly female, the absence of male survivors and male facilitators influenced the dynamics and functioning of the DVRC.

Strengths-Based Approach:

We used a strengths-based approach as part of the research process. As one example, when DVRC members expressed that they wanted to share their products with local policy makers, we used policy connections that DVRC members had (e.g., several members worked in local government) to share our products with a local audience. In this arena, the participants, rather than the researchers/facilitators led the presentation and walked the audience through the project and the findings.

Bio-Psycho-Social-Cultural and Historical Lens and Anti-Racist Approach:

On multiple occasions during the DVRC, survivors shared the stigma associated with being a known victim of domestic violence. This stigma was differentially experienced by race. Furthermore, police-related interactions had to be considered in their full social-cultural-and historical context. The work of DVRC was to consider policies related to informed consent and data sharing. Survivor data sharing is much more fraught in the absence of trust in external systems and in the presence of systemic racism. As a result of these conversations, presenting findings to the police department emerged as a key outcome for the group.

Sustainability

Ensuring sustainability is an important consideration for researchers conducting TIR. For decades researchers have exploited communities, particularly communities already marginalized by the systems we represent. Often, researchers enter a community, gain trust, run a limited time grant program, and exit when the grant is over. To combat this historical trauma and exploitation, researchers conducting TIR should, from the beginning, speak with community partners and members about how any new program or research will be sustained over time, and beyond the researcher's involvement. For the current project, we spoke with partners about who could continue the DVRC, what funds could be used, and what funding could be acquired, well in advance of the project ending. This allowed our community partners to prepare for the end of our grant funding. On-going sustainability planning led Mecklenburg County Community Support Services to decide to allocate internal funding to the project in the upcoming year.

The final guideline we propose requires the TIR researcher to accept responsibility – not just for ethically conducting the project at hand – but for managing the project in a way that recognizes the likelihood of trauma responses occurring, responds to those trauma reactions in a helpful manner, and, most importantly, resists re-traumatization of all stakeholders (participants, community partners, and researchers). Historically, many marginalized communities have been harmed by scientists (e.g., the Tuskegee syphilis project). In the wake of institutional betrayal, and personal and cultural harm, our ability to fully understand our world, with the robust and voluntary inclusion of participants in all aspects of the process, has been lost. We hope, with the adoption of these trauma-informed research guidelines, that researchers can go beyond their own scientific agenda, and take responsibility for restoring the public's faith in the pursuit of knowledge through research.

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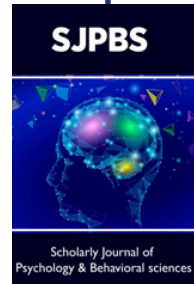
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