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Trauma Informed Care and Social Work Education: A Case Study

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ABSTRACT

This paper provides a brief description and history of trauma in the social sciences alongside an introduction to trauma informed care in social work education. This paper promotes the understanding that trauma assessment and treatment are a key component to the future of social work education and practice. As a result of a recent teaching experience, a framework for conceptualizing, treating, and supervising trauma related disorders within an educational context was developed. This paper utilizes that unique teaching experience where a graduate course on trauma informed care proved challenging yet profound to the existing methods typically sanctioned for university and college settings. These challenges and the corresponding opportunities associated with trauma work are discussed. Practical and ethical implications of a social work model of trauma-focused are outlined. A case example, employing several students' experiences, is presented. Suggestions for additional study are outlined.

Keywords: trauma; trauma informed care; supervision; social work education.

INTRODUCTION: A THEMATIC CASE EXAMPLE

Sandy, a 30 year old female, while learning about trauma and trauma informed care in her class, came to the awareness that she cannot stand her body and she thinks she is "disgusting." Sandy thinks that this "utter disgust" comes from a childhood history of sexual abuse and that, as an adult she copes by shopping, spending money compulsively, drinking too much alcohol, and using "pills" to help her sleep. After coming to this realization during class, she became very upset and had to leave early. Later in an email to her instructor, she apologized and reported that she called her mother after class for assistance. Her mother was of no help: she denied Sandy's memories of childhood abuse and stated that Sandy "did not have problems with money or alcohol" and could sleep "just fine." Feeling like she had "nowhere else to turn", Sandy went to her instructors' office hours "just to talk".

She sat, obviously uncomfortable as she twitched and fidgeted, and seemed reluctant to describe what she was feeling. She stated that she was "majorly messed up" and that she did not want to be "judged" or "thought of differently." Sandy, a masters of social work student, was aware of mandated reporting laws, and was worried that her "secrets would get out" and that she would be "forced to go to treatment if anyone found out."

Her instructor, trained within a trauma informed care paradigm, first explained that Sandy's mental health was primary and clarified that as long as she was not a danger to herself or others, no mandated reporting or "forced treatment" would occur. Her instructor then listened to Sandy as she tearfully explained her past experiences and current behaviors. Employing trauma informed care as a framework for teaching, her instructor was able to utilize empathy and reflexive feedback while Sandy's talked. Her instructor noticed that Sandy was reduced to a childlike state when she spoke of her childhood. Her emotions intensified yet with continued

empathy from her instructor, she was eventually able to calm herself. Her instructor sat with her for over an hour as they looked over her personal journal and discussed the chance that she had clinically significant trauma symptoms. Of her own accord, Sandy returned to talk with her instructor two more times as she re-told her trauma narrative each time becoming calmer and more stable. On the third visit, Sandy thanked her instructor stating that "getting professional help would be good." Sandy continued to state that she was grateful for this class, as she was unaware that these "issues" upset her to this degree. This case example, while brief, demonstrates the potential for students to have their own trauma memories triggered while in the process of social work coursework. Most importantly, this example showcases the utility of trauma informed care principles in social work education.

TRAUMA AS A MENTAL ILLNESS

Sigmund Freud, the father of modern psychiatry, initially posited that mental illness stemmed from discord in one's external environment, the stressors associated with that environment and the outcomes that the combination of the two had on an individual [5, 20, 24, 31]. Rather quickly however, he changed his views about external stressors and shifted to citing the internal environment of the individual as the cause for mental illness [24, 31]. It is suspected that this philosophical shift may have been due to pressure from Freud's contemporaries as well as the reluctance for culture, at that time, to accept that the external had an impact on the internal [15, 24]. Regardless, Freud's work had a large impact on the modern conceptualization of mental illness and his work is considered to be the basis for the diagnostic criteria found in the Diagnostic Services Manual [DSM] today [1, 17].

Psychiatry specifically places heavy emphasis on the individual's internal environment in mental diagnosis and treatment whereas [5] social work finds that examining only one facet of being is not enough to understand emotional or mental health [14]. Since social work finds that to understand a problem one must examine the internal as well as the external environments, a markedly different approach to mental health assessment, treatment, and supervision results [14]. Despite social work's expanded model of problem assessment and treatment, the impacts of early psychiatry still remain dominant; one area where this is still true is that of trauma and trauma informed care.

For social workers trained in mental health assessment, it is likely that becoming familiar with the etiology, assessment, and treatment of trauma will be an important part of best practice [18, 29- 30-31]: as it is estimated that trauma will become a pressing health concern in the near future [26]. It is important that universities and colleges understand how to best train and support their instructors who work with students who may have traumatic event histories in order to provide the most appropriate and most ethical treatment possible. Thus, this paper will outline trauma is, common coping mechanisms associated with traumatic exposure, and ways to instruct from a trauma informed lens. This exploration specifically utilizes the experiences from teaching a graduate social work class on trauma assessment and treatment. Through this experience, the instructor was placed into multiple roles as students learned course concepts, dealt with their own trauma as well as the trauma of their peers and clients. Necessary for the future of social work, it is hoped that this paper serves as a guide for instructors in the classroom who wish to operate with an enhanced understanding of trauma.

Trauma Defined

Due to recent advances in neuroscience and brain chemistry, researchers have started documenting the connections between the biological and social environments along with epigenetic interactions between genes, DNA, and traumatic experiences [11, 23, 25, 29-30]. As

a result there has been an increased impetus towards integrating contrasting disciplines in assessment, diagnosis, and intervention of trauma symptomology [11, 15, 22-23]. It is likely that, social work will be a part of this multidisciplinary approach to trauma practice.

Traumatic events are those that result in intense bio-psychological reactions and often include experiences such as participating in, witnessing or being the victim of violence, child abuse or neglect, natural disasters, war, poverty, and famine [11; [15]). Since social workers, by virtue, work in impoverished and depressed areas [14], it is common to interact with individuals who have histories of domestic violence, community violence, poverty, and childhood histories of abuse and neglect. By definition, events become traumatic when the individual's functioning and quality of life are compromised [11]. Prevalence rates of trauma vary based on the specific population yet it is estimated that anywhere from 20% to 80% of adults have experienced at least one type of trauma throughout their life [2, 7, 11]. Further, it has been found that those with the highest rates of trauma exposure include homeless individuals, individuals with histories of inpatient mental health treatment, military veterans, inner city youth, as well as those who live in extreme poverty [3, 11]. Experiences of trauma and the trauma symptomology that results are projected to increase rapidly in the coming decades, making the study of trauma in social work pedagogy crucial [11, 26].

Traumatic events can have differential impacts based on an individual's age, gender, and developmental capacity [11, 15]. Additionally, the intensity, chronicity, and frequency of the event itself will determine the impact to the individual [11, 15]. For example, the earlier that a traumatic event occurs, chances that neurological development are impacted increase [6, 13]. Traumatic events that occur at young ages are also associated with the disruption of important biochemical neurotransmitters responsible for communication within the brain [6, 12-13]. Additionally, due to hormonal differences among men and women, traumatic events have differential impacts based on gender [11]: men with trauma symptoms tend to become externally aggressive whereas females with trauma symptoms tend to become internally withdrawn [11]. Overall, the lifetime trauma exposure for women is twice that of men [16] and it is thought that trauma exposure is one of the largest health problems facing women worldwide today [26].

Traumatic events can have deleterious consequences to all systems: biological, social, psychological, and spiritual. In the days and weeks after a traumatic event, it is common to experience several side effects which fall into three main categories: arousal, intrusion, and avoidance [11, 15]. Common arousal related symptoms include hypervigilance, being easily startled, inability to sleep, inability to concentrate, irritability as well as anger [11, 15]. Those who experience intrusion related symptomology may have flashbacks and vivid dreams as the traumatic event is re-experienced in great detail [15]. This re-playing of the traumatic experience may leave the individual in a consistent state of upset, distress or anxiety that may impact ability to work, communicate, and care for children [9]. Avoidance symptoms occur when an individual loses interest in pleasurable activities and often leads to feeling emotionally numb and possibly depressed [9, 15]. In an attempt to get rid of trauma memories, individuals with avoidance symptoms may completely ignore the people, places, and things associated with said traumatic event [9, 15].

Realistically, those with trauma symptoms may shun family and friends, workplace/school performance may suffer, and mental/physical health may decline [9, 15]. As a result, the quality of life of those with untreated trauma symptoms is likely to decrease [9, 15]. Since the effects of trauma vary from person to person, those with traumatic exposure may be

misdiagnosed; it is not uncommon for those with trauma symptoms to have diagnoses of depressive, addictive, personality, behavior and/or schizoaffective disorders [9, 15, 22]. Individuals with misdiagnoses, despite seeking out treatment, are unlikely to receive long term relief from their trauma symptoms. Individuals may become distrustful, feeling completely alone, with a lack of hope for the future [9, 15]. Frequently, intimate relationships suffer as sex drive decreases and individuals may appear to their partners as cold, aggravated, and/or angry [15, 22]. Socially, it is not uncommon for individuals to completely withdraw from the external world as smells, sounds or places can act as trauma triggers [22].

As trauma memories are triggered, the body responds by releasing large amounts of stress related hormones into the bloodstream preparing the person to "fight, flight, or freeze" [11] These "fight, flight, or freeze" chemicals are powerful and can affect the body in debilitating ways; past studies have documented that triggering trauma can cause individuals to black out, faint, or lose consciousness temporarily [11, 22]. All of this stress on the body has concrete physical outcomes like high blood pressure, digestive upset, headaches, and sexual dysfunction [8, 11]. Long-term chronic stress can also effect blood sugar regulation and immune function, making those with trauma histories more vulnerable to illness, diabetes, and premature death [8, 11].

Coping with Trauma

Considering the effects that traumatic event exposure and traumatic symptomology can have on functioning and quality of life, it is natural for individuals to find ways to cope. Substance use, alcoholism, and smoking are common ways of coping with trauma symptoms [11, 22]. Such coping mechanisms are thought to increase the risk of engaging in additional harmful acts like criminal and unsafe sexual activity [11, 22]. Socially, traumatized individuals may associate with other people who also engage in risky behaviors and subsequently may form peer groups linked by traumatic events [8]. Specifically, individuals that experience extreme arousal may appear aggressive, angry or emotional while those experiencing extreme withdrawal may neglect their homes, jobs, and even children [8, 11, 22]. Some may avoid professional help and try to deal with the trauma alone as the fear of remembering the traumatic event is too great to confront [9]. As a result, cyclical patterns of repeated behavior related to trauma, namely domestic violence and drug/alcohol use, are replete within the academic literature [11, 22].

DEVELOPMENTS IN SYNTHESIZING TRAUMA AND SOCIAL WORK EDUCATION

Trauma informed care has been slowly permeating the fields of mental health and substance use for the past decade, however it remains a fairly new subject in most fields [4]. Recently, schools of social work have begun to integrate coursework and trauma informed principles with the National Center for Social Work Trauma Education and Workforce Development [National Center] and the University of Buffalo as examples [21, 28]. The National Center, finding that there is a "shortage of social workers [that are] prepared to deliver culturally competent, evidence-based trauma treatment" has implemented trauma informed principles into the curricula of U.S. schools of social work since 2009 [21, para 1]. Similarly, the University of Buffalo (UB) publically adopted Trauma Informed Care as its "guiding principal" and founded an institute on Trauma and Trauma Informed Care (ITTIC) in 2012 [28]. Together, the UB and the National Center work with social work faculty, students, and community agencies to provide multidisciplinary training on trauma assessment and treatment [21, 28]. Collaborative work such as this demonstrates that the future of social work best practice is directly related to understanding trauma informed care.

Trauma Informed Care

Trauma Informed Care [TIC] is an approach to understanding and examining client needs and problems that typically occur in the domains of social work, psychology, and counseling [9, 26-27]. TIC adopts a longitudinal and contextual approach to understanding an individual, with assessment ideally starting at childhood [9 26]. By taking an early and detailed assessment approach, the social worker allows for the inclusion of multiple data points and past diagnoses to paint a picture of "why" specific behaviors and habits occur throughout the lifecourse [9, 22]. Additionally, when a deeper appreciation of the underlying problem is understood, it is thought that better suggestions on "how" to treat problems can result [22]. TIC, a person-centered approach, focuses ultimately on improving quality of life and functioning for the client and their family [9]. Since TIC does not view people as being "broken" or in need of fixing, this approach may naturally reveal unhealthy behaviors, relationships, and systems contributing to the clients' problem [9, 22]. A main tenant of TIC is that individuals have the ability to heal from trauma if sufficient time and support are provided [15]. Traumatic events are cumulative and when events build up the impacts can be drastic [22].

Garnering an understanding of trauma requires the social worker to gain an appreciation and recognition that treatment is a very vulnerable time hallmarked by an increased sense of exposure as one tells their trauma narrative (personal recollection) of events [9, 15, 22]. A client will, over time, become more comfortable telling their "story" to others and it is theorized that in doing so the vivid emotion surrounding the traumatic events will lessen, leading to an increased tolerance for trauma triggers [11, 22]. This method of increasing vulnerability to promote strength may be seen as risky since clients telling their story may feel more exposed than ever before [15). The telling of one's story and the accompanying feelings of exposure can actually cause a latent trauma memory to be "triggered"; it is not uncommon for the client to feel worse before they feel better [9, 11]. This is also, in part, why TIC is a longitudinal technique: if treatment is cut short, trauma symptoms may be left open and raw [9, 11]. Practitioners and instructors alike must understand the vulnerability associated with the trauma narrative and be keenly aware of a client's individual's trauma triggers. The quality of the relationship between practitioner and the client or the instructor and the student are critical to successful trauma work.

Trauma Informed vs. Non- trauma informed

Those that are new to the trauma informed paradigm may find that they align well with the tenants and values of the approach. This is not surprising given that trauma informed methods match social work values like, respect, dignity, self-worth, strengths based approaches, and adherence to strict professional boundaries and ethics. With that said, it may be beneficial to the reader to further discuss the differences between the two perspectives (trauma informed and non-trauma informed), as they are indeed quite different.

Trauma informed systems understand that trauma exposure is not a rarity and that in specific populations (inpatient mental health, prison, foster care, military, etc.) the estimated prevalence of traumatic exposure is high [15, 22]. Trauma informed systems recognize that coping mechanisms may be venues for dealing with traumatic history and instead of blaming a client for their situation, safety, connection, and stabilization are the main goals [10, 26-27]. Collaboration between the clinician and the client are stressed at all times and relationships are seen as the primary treatment method promoting long-term health and stability [15]. Knowledge and learning about one's trauma are important ways to empower the client: when clients understand what is going on in their own body and mind, they may be more apt to trust the treatment process [22]. On a micro level, TIC notes of the language that is used in

assessment and treatment with neutral, culturally appropriate language, preferred at all times [15]. Compassion and empathy are stressed as well: instead of asking "What did you do?", trauma informed clinicians ask "What happened to you?" [26]. In this manner, it is thought that the chances of re-traumatization from the treatment process are minimized as the client is integrated into the work and trusted at all times [10].

Non-trauma informed systems, on the other hand, do not provide the client with the knowledge or tools to understand their trauma and instead try to treat the presenting problem without addressing the underlying cause [15]. Clients may blindly trust their social worker without knowledge on the type of treatment used, its effectiveness or even its applicability to their life [22]. History of traumatic events may be ignored and may lead to misdiagnoses of Bipolar Disorder or Schizophrenia [11, 22]. Clients may be prescribed the wrong medications and may engage in treatments that are not relevant to the actual root problem [15, 22]. Additionally, non-trauma informed systems stress compliance with the case plan even if the client feels uncomfortable. Instead of exploring the source of resistance and tension, the social worker may impose strict time frames when the client must show progress and stability; completion of case plans is a priority and even if services are not working, clients are told to 'trust in the process' [11, 15]. Some scholars go so far as to say that systems that are not trauma informed may actually be "trauma inducing" [10]. Clients may be perceived as "weak", "needy", or "manipulative" and clinicians may appear inflexible and overly stern. One of the largest hallmarks of a non-trauma informed system appears to be the time with which clients are allowed to access services [15, 22]. Since TIC understands that both trauma and healing are cumulative, clients need time to unravel their past and move towards stability. Non-trauma informed systems may provide a set number of sessions and then simply refuse to pay for any more. Triaging mental health care, the opposite of trauma informed, may do more harm than good.

As an analogy of trauma informed care, consider an iceberg. The tip of the iceberg, which is the only thing visible from the surface, represents the client's presenting problems (like drug use or criminal activity) that are often the target of traditional assessment and treatment. While the social worker may have good intentions, the real mass of the iceberg lies below the surface. This mass represents the trauma (childhood abuse for example) that is thought to be the true cause of the problems experienced. When operating out of a non-trauma informed system, clinicians are likely to only address the tip with the real root of the problems left untouched.

TRAUMA INFORMED SOCIAL WORK EDUCATION

Much like trauma informed care, trauma informed education acknowledges the individual's experience as truth; instruction and supervision must include the building of rapport, trust, and communication. In alignment with TIC, students are not seen as weak or broken but rather their humanity and self-care are made explicit. The supervision trauma narrative can effectively promote discussion with students by focusing on emotions and feelings related to painful events. As students navigate through their own trauma, alternative working styles (such as working from home) may result; if the student finds his/herself with extreme trauma symptoms, it may be necessary to seek additional mental health help.

One of the main challenges associated with instituting trauma informed practice is the potential for students to become traumatized themselves [15]. A main tenant in TIC is the ability for the practitioner to remain open, honest, and unbiased [9]. Since TIC asks that individuals explore the deeper reasons for their presenting problems, social workers need to learn a different (and possibly more refined) set of assessment and engagement techniques not

normally taught in social work [19]. While teaching a masters level social work class on trauma assessment and treatment, this author covered these refined skills and asked that students provide their viewpoint on the real-world utility of such methods. To emphasize this approach, students were provided with over 25trauma assessments and were asked to conduct a role-play with a classmate while using these assessments as a guide. Students wrote weekly reflective essays regarding the effectiveness and appropriateness of the instruments in social work practice. While not necessarily intentional, these assignments allowed the students to explore deep-seated issues underlying their psyche from their pasts; although students were not required to role play as themselves, many of them chose to do so.

Child maltreatment, manipulative and coercive relationships, emotional abuse with intimate partners, domestic violence, drug and alcohol use, as well as mental health concerns like anxiety, depression, and eating disorders were some of the traumas that students reported experiencing. This proved difficult as students were placed in a dual role position: within one class period they would have played both a client as well as a social worker. The instructor was also placed into a role duality as deescalating students' trauma symptoms became more important than teaching the course concepts: the mental health of the students had to come first. This unique position required a new way of teaching and supervising that focused on empathy, the impact of trauma on social workers, and the development of trauma informed professional boundaries and ethics.

The traditional model of supervision where reflection and processing accompany case based problem solving [15, 19] was not appropriate in this situation. Students, instead of evaluating cases as objective outsiders, were actually peering into their own traumatic memories. Likewise, the instructor was not merely grading students on quality of completed work but was forced into a new trauma informed method of teaching and supervision. As such, the student's immediate concerns and emotions were central to their mental health; it was essential to target their responses to trauma before providing any instruction. As demonstrated by Sandy, this trauma can be debilitating and can impact functioning both in and out of work. Supervisory duties in this case are not to be taken lightly – the de-escalation and processing of one's own trauma must be done within a context of safety and learning. In this manner, professional relationships and the importance of student-teacher/worker-supervisor dynamic is worth considering [19].

A challenge for even veteran instructors, working with students with actively triggered trauma symptoms, can be an ethical challenge. Students must understand that they have the confidence of their instructors. Should a student disclose their past traumatic memories, the instructor must help in the creation of a self-care plan while also working to make sure that course grade or performance evaluation is not impacted disproportionately. It was learned that students in this class, who were trauma triggered, were fearful of judgment from others especially their superiors. It is important in this context that the instructors makes confidentiality and respect a top priority while letting their students know that their own trauma will not change the way they are treated. As well, students may benefit from trauma-related psychoeducational materials to learn more about their experiences. When using trauma informed instruction, educators have the opportunity to build upon existing supervision techniques as a foundation to help support, educate, and develop future workers in a manner that does not aggravate or re-trigger their trauma symptoms. The case narrative at the introduction of this paper, which is a conglomerate of multiple students, illustrates the typical situation that this instructor was in while teaching that course. Students shared similar trauma symptoms as well as similar concerns over getting professional help. Likewise, the

techniques that this instructor used (reflexivity, the trauma narrative, extra time, and empathy) were consistent among the multiple trauma-triggered students who sought help throughout the semester.

In reading this aforementioned narrative and understanding the etiology and effects of trauma, the instructor's actions may be a bit clearer. By staying calm and helping Sandy to process, the healing process that naturally comes from trauma work was able to occur on its own. Sandy was able to reach a new level of self-awareness and was able to tell her "story" without fear of triggering additional unwanted memories while also learning about trauma coping techniques at the same time. Sandy's trauma was not fully resolved before the course ended yet she felt stable enough to proceed in obtaining long-term psychotherapy apart from her instructor. While this may seem like typical instruction or supervision, it was in fact not. These actions were guided with the understanding that trauma work can actually be a trauma trigger: Sandy's instructor was abundantly available to students and chose to put their health and well-being before academic work. Working from a TIC perspective, while challenging, provides social work specific opportunities and challenges, which are discussed below.

IMPLICATIONS OF A TRAUMA INFORMED MODEL OF SOCIAL WORK EDUCATION

One of the main barriers to operating from a TIC model is the apparent contradiction with some case management principles. Trauma work may actually cause the presenting problem to become worse before it gets better. The individual may attempt to cope and self-soothe with the habits that he/she knows best. When the individual realizes or is told by their social worker that their coping mechanisms (like drug use or social isolation) may be harmful, he/she may feel judged or stigmatized. Individuals may appear to be resistant, fearful, angry, or generally non-communicative. Appropriate trauma work allows the affected individual time to learn about their traumatic history and then to engage in services necessary for healing. Time limited therapeutic services may not afford the chance to attain that long-term stability and may possibly cause more trauma if services are prematurely stopped.

Similar situations can occur with social work students as their coursework changes each semester: they may not have the ability to process their trauma symptoms and triggers before the course ends. In this vein, there are strong advocacy and policy implications for the trauma informed instructor. Students may need more time for coursework, which may require an adaptation or change of policies all together. Instructors may need to refer students to services outside of the university in order to comply with mandated reporting, but more importantly to promote mental health stability. Agencies and colleges alike may need to be more flexible with the amount of time given to individuals who are trauma triggered. Likewise, instructors must to pay attention to their own self-care since utilizing trauma informed principals carries a risk of secondary trauma itself. It is important for instructors to institute their own self-care plans to ensure that they remain healthy, balanced, and happy both in work and at home. In short, social work must return to its roots of individualized treatment, empathy, and concern for long-term wellbeing when operating out of a trauma informed model.

Suggestions and Opportunities

Trauma informed social work may take more time, funding, and energy than non-trauma informed social work and people may feel as though it is not worth the investment. While that is understandable, the benefits and opportunities afforded by trauma informed social work and the corresponding trauma informed education certainly seem to outweigh the drawbacks. Trauma informed social work may lead to increased stability as well as increased motivation in completing case plan goals. Likewise, when providing instruction from a trauma informed

manner, students may be more aware and more likely to utilize their teachers for consultation and debriefing. Students and their teachers have the distinctive opportunity to communicate about self-care and can brainstorm strategies and techniques together. It is hoped that in doing so, teachers will be able to help their students avoid future "burn out" in the field.

It is proposed here that trauma informed education is sensible as the methods used to engage clients can also be used to engage students. The supervision trauma narrative is the first practice point to consider: it is important that teachers make a regularly scheduled habit of speaking with their students, who are trauma triggered, while paying attention to both verbal and non-verbal communications. Listening to students, more than talking to them, is vital in conveying messages of support, value, and respect. Secondly, when a student discloses trauma or pain, the trauma informed instructor must respond with empathy and compassion. The trauma informed instructor, one who is educated on trauma symptoms and coping mechanisms, is able to document mental health and productivity changes in their students over time. Trauma informed educators can, thirdly, work creatively and collaboratively with students to develop grounded self-care plans and work management techniques aimed at best practice, professional ethics and work-life balance. Creating a self-care plan involves crafting healthy coping mechanisms complete with socio-emotional supports apart from work/school. Trauma informed educators may choose to provide instruction to students on trauma, trauma triggers, and trauma symptoms as a precautionary measure. The trauma informed instructor does not want to enable their student or engage in a co-dependent relationship with them but rather seeks to support them in attaining health and balance. Likewise, the trauma informed instructor makes their self-care a priority attending to their own mental and physical health regularly. Fourth, if a student is experiencing extreme trauma symptoms, the instructor has the duty to uphold mandated reporting; if there is a concern over harm to self or others, the proper authorities should be contacted without delay. Fifth, if the student is unable to function, the instructor must realize this and respond with kindness rather than frustration. The student may be allowed to take medical leave in order to heal without poor grade reports. Formal trauma treatment or formal support groups can provide needed relief if a student is having extreme difficulty. Finally, teachers have a role that is important and should not be downplayed; appreciating this importance means never underestimating the power of caring. Sometimes merely showing compassion and concern may be enough to change someone's life and is a practice point that all social workers can embody.

FUTURE DIRECTIONS AND CONCLUDING REMARKS

When working from a TIC paradigm, instructors must realize that simply learning about trauma can actually constitute a trauma trigger. As a result, the health of the student must be a priority. While this may be frustrating for instructors, continuing to work without addressing said trauma may prove to be even more damaging. A student who has been triggered may unintentionally harm the clients he/she is working with. Teachers must display care and concern while also renegotiating the boundaries of their working relationship. What is an instructor to do if a student discloses that she/he is a threat to herself or others? How should an instructor treat their students while also evaluating their trauma at the same time? How does the instructor remain objective when such deep disclosure inevitably causes an empathic response? Personal experiences have dictated that these situations are best handled on a case-by case basis however that common techniques discussed can be used.

In the future, it is foreseeable that, all schools of social work may be teaching about trauma, the effects of trauma as well as trauma informed models of care. Those learning about trauma as well as those already operating from a trauma informed paradigm are going to need

instructors who are knowledgeable and prepared. Trauma informed social work is certainly fodder for additional study as traditional best practice, self-care, and ethical norms are challenged in the process. Clinicians, supervisors, administrators and policy makers can all work together to help realize the future of social work that uncovers the whole iceberg, not just the tip

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