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Practicing What We Teach: Trauma-Informed Educational Practice

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This article presents the starting case for applying the elements of trauma-informed care (TIC) to education and outlines the authors' initial efforts to develop guidelines for what they call trauma-informed educational practice. To this end, the article starts with a literature review related to the potential for vicarious traumatization and retraumatization among students in clinical training, followed by a discussion of the TIC framework and past efforts to be trauma sensitive in social work education. The authors then describe what drew them to this perspective and inspired them to apply it to educational practice. They then present guidelines for implementing the trauma-informed principle of safety in the classroom in several domains.

KEYWORDS trauma, higher education, clinical training, classroom safety, vicarious traumatization, retraumatization

> "Trauma confronts schools with a serious dilemma: how to balance their primary mission of education with the reality that many students need help in dealing with traumatic stress to attend regularly and engage in the learning process." — Ko et al. (2008, p. 398)

In hindsight, it is perhaps not surprising that Courtois's (2002) call more than a decade ago to integrate trauma in the clinical training curriculum has been followed by petitions to include instruction on vicarious trauma and self-care in order to ameliorate the risks associated both with engaging in trauma work and with exposure during clinical training (Courtois & Gold, 2009; Dane, 2002; Newell & MacNeil, 2010; Newell & Nelson-Gardell,

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2014; O'Halloran & O'Halloran, 2001). In the past two decades, clinical observations and empirical reports have established that indirect exposure to traumatic material is associated with high rates of posttraumatic stress disorder symptoms among social workers (Bride, 2007) and those working with child maltreatment (Bride, Jones, & MacMaster, 2007), and that listening to trauma narratives also can increase the risk of vicarious traumatization (Figley, 2002; Pearlman & MacIan, 1995). The terms *secondary traumatic stress* or *secondary traumatization* (Bride, Robinson, Yegidis, & Figley, 2003) and *vicarious traumatization* (Pearlman & MacIan, 1995) are often used synonymously in the literature to refer to the condition wherein exposure to information about the victimization of others results in emotional, cognitive, and other symptoms for the clinician that echo aspects of the victim's experience. Because *vicarious trauma* has been used more frequently, we adopt it here to avoid the confusion of using more than one term.

There is also preliminary evidence that indirect exposure to trauma during training can contribute to vicarious trauma in students, faculty, and field educators (Bussey, 2008; Butler & Carello, 2014; Knight, 2010), particularly in those with less trauma training and experience (Adams & Riggs, 2008; Knight, 2010; Michalopoulos & Aparicio, 2012). Recent studies suggest that interactions with field instructors can serve as both a protective and a risk factor for vicarious trauma (Didham, Dromgole, Csiernik, Karley, & Hurley, 2011; Litvack, Mishna, & Bogo, 2010) and that qualified field instructors and supervisors are not always available (Bussey, 2008).

In addition, given that 66%–94% of college students report exposure to one or more traumatic event (Frazier et al., 2009; J. M. Smyth, Hockemeyer, Heron, Wonderlich, & Pennebaker, 2008), approximately 9%–12% of freshman meet criteria for posttraumatic stress disorder (Bernat, Ronfeldt, Calhoun, & Arias, 1998; Read, Ouimette, White, Colder, & Farrow, 2011), and many more may suffer subsyndromal symptoms (Borsari, Read, & Campbell, 2008; J. M. Smyth et al., 2008), it also follows that many, if not most, students enrolled in clinical training programs report trauma histories (Adams & Riggs, 2008; Butler & Carello, 2014; Didham et al., 2011; Elliot & Guy, 1993; Shannon, Simmelink, Im, Becher, & Crook-Lyon, 2014). Because students are exposed to traumatic material in their coursework and field placements and report that both are highly stressful (Carello & Butler, 2014), both aspects of clinical training therefore have the potential not only to vicariously traumatize but also to retraumatize students (i.e., reactivate trauma-related symptoms that may be signaled by exposure to material reminiscent of an earlier traumatic event). This is worrisome because, as we have argued elsewhere (Carello & Butler, 2014), retraumatization can impact learning and educational achievement.

These findings, along with our own teaching experiences, have prompted us to examine the content of our courses and our practices of

instruction to ensure that each minimizes the potential for student retraumatization and maximizes student emotional safety. However, despite apparent movement toward a trauma-informed (TI) approach to service delivery in human service programs (Jennings, 2008) and even in some K-12 schools (Massachusetts Advocates for Children, 2005), this shift has yet to occur in higher education, including programs that train professionals for clinical practice. As instructors who teach classes on both trauma and trauma-informed care (TIC), we have been struck by a growing realization that our process of teaching should be informed by and consistent with the implications of the content we teach. In short, we should be practicing what we teach.

To this end, we endeavor in this article to make a beginning case for applying the essential elements of TIC to education and outline our initial efforts to develop guidelines for what we call trauma-informed educational practice (TIEP). Starting with a discussion of a TIC framework (and previous scholarship related to making instruction more responsive to possible effects of traumatic material), we then describe personal experiences that drew each of us to the TI perspective and inspired us to apply it to educational practice. We conclude with some general principles and specific guidelines for applying the core TI principle of safety in the classroom.

WHAT IT MEANS TO BE TRAUMA-INFORMED

TIC is an approach developed by Harris and Fallot (2001) to improve clinical practice and service delivery. To be *trauma-informed*, in any context, is to understand the ways in which violence, victimization, and other traumatic experiences may have impacted the lives of the individuals involved and to apply that understanding to the design of systems and provision of services so they accommodate trauma survivors' needs and are consonant with healing and recovery (Butler, Critelli, & Rinfrette, 2011; Harris & Fallot, 2001; N. J. Smyth, 2008).

Fallot and Harris (2009) also identified five principles that are fundamental to creating and sustaining TI settings. Each is vital to accommodating the vulnerabilities and needs of trauma survivors and to facilitating their participation in treatment. These principles are ensuring safety, establishing trustworthiness, maximizing choice, maximizing collaboration, and prioritizing empowerment. Each of these principles arguably may be important to all good clinical practice; however, in the context of working with those who have (or likely have) trauma histories, they are all essential.

Although we have sought to implement all five TI principles in our teaching, we believe that the first principle—ensuring emotional and physical safety—is the most fundamental. Safety is a necessary precondition to a learning-conducive environment, and this is especially true when teaching content that includes trauma. Simply put, in the clinical domain, establishing

safety is a necessary precondition to successful work with trauma survivors (Herman, 1997). In the provision of TIC (Harris & Fallot, 2001), however, it is essential because it addresses a fundamental TIC tenet: to make every effort to minimize the risk of inadvertent retraumatization, vicarious traumatization, or wholly new traumatization, each a risk for students when teaching about trauma. Making a commitment to reduce the risk of such experiences for students and to ensure their emotional safety captures the directive: *primum non nocere* (first, do no harm).

MOVING TOWARD TRAUMA-INFORMED EDUCATIONAL PRACTICE

Education has been influenced by the same paradigm shift that has led to the disability-informed and TI movements. This shift is detailed by Kalantzis and Cope (2008) in their book *New Learning: Elements of a Science of Education*, which presents a vision for the future of instruction that promotes the role of education in creating a more socially just and egalitarian society. Their suggested paradigm shift is consistent with the current move in education toward learner-centered approaches that promote a shift in power from teacher as expert to teacher as facilitator, allowing students to be experts on their own learning and their own lives (see Presidential Task Force on Psychology in Education, 1993, for discussion of learner-centered principles).

Getzel (2008) pointed out the importance of "increasing the awareness of instructional faculty on students with disabilities and incorporating concepts of universal design into faculty instruction and curriculum that benefit all students in their learning process" (p. 209). Harris and Fallot (2001) drew the analogy between TI versus trauma-specific services and disability-informed versus disability-specific services: Disability-informed organizations make their services accessible to all individuals, including those with disabilities; these organizations do not, however, provide specific services to treat persons with disabilities. In this way, TI and universal design theories share some similar principles: They are strengths-based, person-centered, and solution-focused approaches. As Harrison (2006) pointed out, "Disability in and of itself is not a problem, but the environment in which we ask people with disabilities to function often is" (p. 152). Similarly, a TI approach recognizes that the environment in which we ask trauma survivors to function is often a problem. The goal of TIEP is to remove possible barriers to learning, not to remove traumatic, sensitive, or difficult material from the curriculum.

Several clinical educators have documented their experiences teaching trauma courses and have provided valuable recommendations for maximizing student resilience and reducing student risk (Black, 2006; Cunningham, 2004; Graziano, 2001; Mattar, 2011; McCammon, 1999; Miller, 2001). Most, if not all, stressed the importance of teaching self-care, titrating exposure, eliciting and responding both emotionally and intellectually to student feedback,

creating networks of support both in and out of the classroom, being mindful of power imbalances, and maintaining effective boundaries. In addition to anecdotal evidence, some educators also have documented the effectiveness of their methods in reducing risk and promoting resilience by way of individual and group student feedback, course evaluations, and qualitative survey assessment (Agllias, 2012; Black, 2008; Breckenridge & James, 2010; Bussey, 2008; Shannon et al., 2014; Zosky, 2013).

Creating a structured and predictable learning environment that fosters a sense of safety is challenging for any educator working with adults who are experiencing high stress levels or are traumatized (Perry, 2006). Striking an effective balance between student safety and effective clinical training is also difficult (Agllias, 2012). Like Zurbriggen (2011), we do not wish to erode or to minimize the concept of traumatization by including low levels of distress within its scope; at the same time, we believe it is necessary for educators to recognize that any student may be (or become) vulnerable, and we therefore have a responsibility to prevent possible harm.

Lafrance, Gray, and Herbert (2004) raised the question of gate-keeping, which also is relevant to this discussion. Occasionally there will be students who cannot tolerate, for example, exposure to materials on child abuse or who are unable to complete coursework due to retraumatization. How might we respond from a TI perspective without changing the expectation that students complete all course and program requirements? In such cases, we might advocate to make an accommodation, similar to one described by Newman (2011), who gave a student extra time so that student could complete an assignment after the stressor had ended.

Nonetheless, there may be a few students for whom temporary accommodations are not sufficient. Some students with serious trauma histories may enter clinical programs having completed little (or inadequate) personal psychotherapy to work through their trauma histories, and consequently they may have limited insight into how those experiences may still actively affect them. (Indeed, it is possible that some seek clinical training in an effort to engage their histories.) It behooves educators and program administration to recognize that such students may not (yet) be able to work with specific clients, or be ready to review course materials that relate to or directly recapitulate their histories. This is one reason we strongly believe that *all* students in clinical training should undergo their own psychotherapy prior to or during their training. In addition, all students, with or without a trauma history, may become vulnerable to vicarious trauma during the course of training and, as previously indicated, adequate supervision may not be available (Didham et al., 2011; Litvack et al., 2010). It is also incumbent upon students who plan to engage in clinical social work to have firsthand experience of what a therapeutic relationship is like.

However, some students simply may find that they are more comfortable and effective if they focus their training and professional work with a

population or in an area of practice that is not so personally significant and activating. In addition, we believe that it is appropriate to acknowledge that there may be students who, due to their histories, simply may not be ready for clinical training at the time they seek it.

OUR BACKSTORY

Before we enumerate the principles and guidelines that we have developed to facilitate the application of the TI principle of safety in the classroom, we thought it might be of interest to briefly describe some of the personal experiences that drew each of us to the TI perspective and inspired us to apply it to educational practice.

Janice Carello: In 2010, I was a Master of Social Work (MSW) student at the University at Buffalo (SUNY) as the School of Social Work began to implement a new curricular focus: a TI, human rights perspective. Like for many, social work was my second profession: Prior to my completing my MSW, I earned a master's degree in English and taught composition, creative writing, literature, and academic support courses for many years at area colleges.

It is not uncommon for students to write about their trauma histories in writing courses. A staple in many 1st-year composition courses (and many undergraduate creative writing seminars) is the personal essay. Journals also are common expectations, as are assignments based on books and films about individual and cultural trauma such as rape, the events of 9/11, and genocide. Even when personal writing is not assigned, students often choose to research and write about topics related to their personal trauma (Carello & Butler, 2014). In addition, because of typically small class sizes and formats, writing instructors often interact more with students than do instructors in other classes, and this type of involvement also may enable self-disclosure, both in and out of the classroom.

As Berman and Schiff (2000) pointed out, most educators are not trained to respond to students who disclose personal crises or to effectively manage emotions that get triggered when such disclosures occur in the classroom. This was true of me: I was totally unprepared when, in one of my first semesters of teaching, a student submitted a narrative in which she disclosed childhood sexual abuse. I had not required or expected such disclosure, and I now purposefully design course assignments in ways that prevent it. Nevertheless, every semester a few students choose, whether via writing assignments or class discussions, to disclose their child's cancer, their mother's murder, their father's alcoholism, their brother's fatal car accident, their best friend's suicide, or their own child abuse or chronic health problems.

My desire to learn how to more effectively respond to students, both making and witnessing disclosures, is one of the reasons I enrolled in a graduate social work program. A second reason was my concern that the students who were most likely to struggle or drop out of my own and my colleague's courses were those who had recently experienced a personal crisis or those who had experienced adverse events in childhood.

My teaching experiences led me to begin thinking about whether and how to apply the TI principles I was learning about in my social work program to the domain of education. Applying a TI approach to teaching made sense to me, particularly because it distinguishes itself from trauma-specific approaches which seek to treat specific trauma symptoms (Harris & Fallot, 2001). My goal was not to learn how to provide therapy to students but, instead, to ensure their—and my own—emotional safety, especially when discussing traumatic material.

My initial thinking resulted in an assessment that I conducted (as a class assignment) to determine the extent to which the writing program in which I worked was trauma informed. I was so inspired upon completing the assessment that I also developed a set of surveys, started writing a research proposal, and applied to the School of Social Work's doctoral program in order to acquire the knowledge and research skills necessary to develop and promote TI teaching across the curriculum. This is how I came to meet and collaborate with Lisa D. Butler.

Lisa D. Butler: I am a faculty member at the School of Social Work and have been a trauma researcher for 20 years. I served as a member of the team that implemented the school's new curricular framework, spearheaded the development of a series of self-care web pages as part of that effort, and subsequently conducted research on self-care and trauma exposure in clinical training.

The germ of my thinking about the potential deleterious effects of trauma material on audiences began after the terrorist attacks of 9/11—an event that my colleagues and I studied for several years (Butler et al., 2005; Butler et al., 2009; Butler et al., 2002). In the moments before I was to give an invited presentation on psychological trauma to a professional group of family physicians, who were concerned about the effects of the attacks on their patients, an audience member approached me to introduce himself. He described how he had been at Ground Zero on that dreadful day 5 months before and had witnessed truly horrific things—he was clearly still severely traumatized. The physician was keen to learn about the posttraumatic stress condition from which he apparently was suffering, but he was apprehensive about whether he could handle the content of the talk or the images on the slides (some of which were, indeed, pictures from that event).

As it happened, I had tried to exercise care in my choice of slides, eliminating the obviously disturbing ones, because of my concern that some audience members were likely to be survivors of the events being presented

and could be unduly disturbed by such content. Nonetheless, I suggested to the physician that, in his present condition, *any* slide related to the attacks had the potential to be triggering and that he should seriously consider whether he was ready to hear and see such material. With that warning in mind, he chose to sit out that part of the talk but was able to attend the rest of the presentation.

Of interest, the specific experiences and images he *very briefly* shared that day actually haunted me for many months thereafter, intruding into my own thoughts and reactions. The emotional toxicity of some experiences, even simply in their description, cannot be overstated, nor can the minimal exposure conditions under which vicarious trauma can develop. Although these experiences went some distance in sensitizing me to the need to take into account the possible vulnerabilities of audiences, including those of students, it was not until Janice Carello arrived in my office and proposed a doctoral research project based on the application of a TIC framework to education that our present line of inquiry began in earnest.

PRINCIPLES AND PRACTICES TO ENHANCE CLASSROOM SAFETY

There are a number of domains in which awareness of issues of safety in the classroom need consideration. These include the individual characteristics of students, the content and context of what is taught, the requirements of assignments, aspects of both instructor and student behavior and interaction, characteristics of the classroom setting, and the instruction on and practice of self-care. In what follows we have summarized some of the principles we have identified and practices we have implemented in each of these domains to adapt our educational pedagogy to address safety, first and foremost. This is not meant to represent an exhaustive summary of what we have done (or could or should be done) to address the principle of safety in the classroom. Rather, we hope that the discussion provides a snapshot of general principles and specific practices that may be useful to others.

Student Characteristics

Students bring to their educational pursuits a range of individual strengths that they employ to meet the trials of training along with a life's history of challenging, and in some cases traumatic, experiences and present stressors. Consequently, instructors should assume that in virtually every classroom some unknown subset of students will be at heightened risk for retraumatization or vicarious traumatization as a result of personal trauma histories, mental illness experiences, and current challenges or difficult life transitions. This working assumption then obliges instructors to become familiar with

the implications of trauma for learning, as well as the signs and symptoms of trauma, retraumatization, and vicarious traumatization.

Content Presentation and Processing

Some course content may have the potential to retraumatize or vicariously traumatize students. To address this reality, we have found it helpful to preview material for appropriateness and eliminate content that is likely to shock or disturb. For difficult material that needs to be retained, we recommend developing warnings so that students know what to expect in terms of content, severity, and duration. In our experience, students handle difficult material better if there is an effort to warn (i.e., inoculate) them ahead of time. This may include verbal warnings prior to viewing, discussing material during class, and online warnings prior to viewing electronic postings.

In addition, conducting regular verbal check-ins with students during the class can help determine how students are doing emotionally and whether adjustments are needed. Brief written check-ins at the beginning and end of each class that invite (but not require) students to share emotional responses to course content and process also can be helpful. It is important, as well, to follow up in person, by e-mail, or by phone with students who express concerns and to use student feedback to inform/revise present and future class material.

Discussing difficult content that has been presented allows students to process, reorient, and regain emotional distance. One way to facilitate such a discussion is to ask students what they found to be the most difficult material to discuss, and start the conversation there.

Allowing students to *not* participate demonstrates respect for limits and teaches students to take responsibility for their own well-being. It also may help circumvent the activation of feelings of powerlessness that may accompany some trauma survivors' histories. As instructors, we sometimes need to remind ourselves that a student's reluctance to participate in a given discussion of difficult material, in fact, may be an instance of self-protection rather than of resistance, or evidence of lack of preparation. In our educational practice and modeling, we endeavor to remind students that it is okay to tune out or leave the room briefly to attend to emotional needs when necessary.

It also is tremendously important to acknowledge, normalize, and discuss the difficult feelings that can arise when learning about trauma and its victims—including feelings of helplessness, being overwhelmed, despair, hopelessness, anger, disapproval, shame, guilt, vengefulness, disgust, and the desire to rescue—and how experiencing such feelings can help us understand the victim's experience. In the classroom, we also explicitly acknowledge that these feelings may be triggering for some students.

Assignment Requirements and Policies

Just as it is wise to preview materials presented in class, assignments should be scrutinized as well for their potential to disturb or trigger students. If any assignments require personal disclosure by students, we suggest that instructors critically examine their rationales and objectives and whether the requirements of the assignment could be adjusted to respect personal and appropriate boundaries. Students may push their own emotional limits in an effort to please the instructor or to excel in the assignment. For those who decide to retain assignments that require personal disclosure, we suggest allowing students to pursue alternate assignments. Students will sometimes disclose, bidden or not, and so all instructors should become familiar with the potential risks associated with classroom disclosure (Carello & Butler, 2014).

Implementing policies and practices that can help students avoid shame and feel safe while preparing assignments is another protocol that may reduce risk. One recommendation is to initiate a late-day policy that gives all students extra days over the course of the semester to turn in work without having to provide an excuse and without penalty. Another is to require drafts of papers in order to provide ungraded feedback and to catch problems before they result in failure of an assignment.

Instructor Behavior

Some instructor behavior (even if inadvertent) may be activating for students. One way to diminish this risk is to avoid engaging in minimizing or being dismissive of student concerns, or permitting threats, ridicule, or displays of power, impatience, or even disappointment. Using neutral language and a strengths-based perspective in communication, including in all aspects of feedback and grading, can also address this risk.

We have also learned to be mindful of the concepts of transference and countertransference and how they can underpin reactions and overreactions in the classroom. When possible, we teach these invaluable concepts to students as well, and refer to this learning, when appropriate, to explicate our own and our students' reactions in the classroom. The discussion of one's own strong reactions can model self-reflection and understanding without being invasive. Consulting with colleagues may also provide a means for checking emotional involvement and boundary issues with one's students (in particular, the impulse to assume a counseling role), especially for those in crisis.

It also helps to be prepared to provide appropriate and timely referrals. This means having on hand *specific* information for referrals to the college counseling center, disability services program, student support services, and/or crisis intervention program. Including contact information for

these services in the syllabus can also be helpful, especially for students who may not readily seek out such referrals directly. Finally, we have found it helpful to inform students that we are employing a TI approach and to both solicit and integrate their feedback regarding creating and maintaining a safe classroom environment.

Student Behavior

Some student behavior may be activating for other students. For example, angry, aggressive, combative, and disrespectful student behavior directed at the instructor (or other students) understandably may be upsetting and require immediate intervention and processing with the class. Such incidents, of course, also can provide important opportunities to model appropriate conflict resolution behavior in the classroom.

Classroom Characteristics

Features of the classroom or of classroom behavior may be triggering for some students. For example, abrupt changes in the physical characteristics of the classroom (such as in lighting and sound levels) may be startling for those living with some degree of hyperarousal symptoms. Similarly, instructors who walk through classrooms may inadvertently loom behind students, which may be disturbing for those with an assault history. In addition, some students may have special trauma-related needs. Veterans may want their back to the wall or other special conditions to enhance their sense of security. Soliciting student feedback and suggestions for improving the safety and comfort of the classroom may help identify and address such specific needs and accommodations.

Self-Care

As instructors and professionals, we believe in teaching, modeling, and practicing self-care at all opportunities. In fact, we typically teach a brief self-care module in our classes. We also recommend, at minimum, including a self-care statement on course syllabi that emphasizes the importance of and the instructor's expectations with respect to student self-care, as well as providing links to resources, such as our school's own self-care website: http://www.socialwork.buffalo.edu/students/self-care/

It is also worthwhile to discuss barriers to self-care and have students brainstorm responses. One small-group activity we have used to promote this discussion is to ask students to anticipate the types of reasons that clients might offer (or have offered) for not practicing self-care and then come up with a list of solutions to address each of them. Discussing the

reasons as a class and then asking students whether their proposed solutions could equally apply to themselves can stimulate a particularly useful discussion. Stressing the professional and ethical rationale for self-care may also be valuable.

PRELIMINARY RESPONSES AND CONCLUSIONS

Students have been very receptive to our efforts to bring TI principles into the classroom, though our evidence to support this claim is thus far only anecdotal. When asked to informally evaluate the extent to which a class on trauma and human rights (taught by Janice Carello) this past semester was trauma informed, the students reported that they found the class to be highly trauma informed and cited as evidence many of the practices that we have described. Perhaps because graduate social work students both expect and are used to engaging with traumatic course content, they did not focus as much on practices (such as content warnings) as one might expect. In fact, some stated that they fully expected difficult content: It was a trauma and human rights class, after all. However, they also pointed out that they have been triggered in other classes by course elements that did not merely involve content.

The three practices students noted as most valuable were the self-care plan, the late-days policy (even if they did not personally take advantage of late days), and the nonjudgmental feedback on drafts (even though some students voiced their preference that drafts be optional). Students also provided suggestions for improvement, though many of these related to changing content or assignments more than improving TIEP. One particularly helpful suggestion, however, was to avoid offering too many choices, as doing so can feel overwhelming to some students.

Because students are just learning about these trauma principles, it may be possible that they are simply having a hard time differentiating and applying them. However, when prompted to specifically link their examples to the five principles, students linked most back to safety or trustworthiness, even when they thought their example also related to choice, collaboration, or empowerment. This response provides support for what we have long suspected: It is not just pictures of airplanes crashing into buildings or material about child abuse that can trigger trauma symptoms; when students, particularly those with complex trauma histories, feel belittled, ashamed, overwhelmed, confused, or powerless, they do not feel safe. And if they do not trust the instructor, they do not feel safe.

A TI approach obliges us to take students and their comments seriously and to assume that they know what helps them feel secure. The students' feedback also points to the need for further study, especially exploration of

students' perspectives on educational practices that reduce risk and increase resilience.

Generally, faculty members are eager for guidelines for teaching trauma, but they do not yet exist. The material presented here (and elsewhere, e.g., Carello & Butler, 2012, 2014) represents our effort to date to address this need, and we are committed to developing TIEP further in the future. In particular, we are working to identify ways to adapt and implement all five TI principles in the classroom, and we hope to develop an assessment tool for use by instructors. Ideally, these efforts will establish some of the groundwork for the generalization of TIEP to educational systems more broadly.

For now, it can be hard to heed the old adage: Don't let the perfect be the enemy of the good. As instructors we sometimes get annoyed with ourselves for not being more trauma informed in our practice. Sometimes we still focus on what's wrong with us (or what we may have done wrong) rather than on what has happened to prevent us from using a TI lens. Like our students, we are still learning.

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