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## Challenging Deficit Discourses: Human Services and Trauma-Informed Practice

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**Challenging Deficit Discourses:  
Human Services and Trauma-Informed Practice**

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Honors Program Capstone Project

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**Abstract**

The Adverse Childhood Experiences (ACEs) study by Kaiser-Permanente has significantly influenced trauma practice in many contexts. As a medicalized model, ACEs was intended to collect population information about traumatic experiences. However, many of its current applications are harmful in practice and in need of critique. More specifically, school systems must reconsider how ACEs is used in curriculum since providing screenings or “trauma-informed” models off of this study often portrays trauma as a deficit. By carefully examining my own education on ACEs and trauma theories at Western Washington University, alongside the experiences of other students and several professors, this deficit discourse remains consistent in their responses. It is time for trauma studies to shift to an “asset” approach, which sees trauma as a part of one’s identity instead of something needing to be fixed.

*Keywords:* adverse childhood experiences, trauma-informed practice, deficit, education

Since the 1990s, the Adverse Childhood Experiences (ACEs) study (CDC, 2020) and Trauma-Informed Practice (TIP) have been in the spotlight, influencing many fields, including K-12 education and community-based organizations. While there have been many positive outcomes from the emergence of trauma studies, there have also been research applications which have been potentially harmful, specifically toward youth who are marginalized (i.e. racialized, children from domestic violence [Pyscher & Lozenski, 2014]). This discrepancy also continues to be seen throughout literature (Winninghoff, 2020), as ACEs are often used in ways which label youth and weaponize their trauma (Khasnabis & Goldin, 2020, p. 54), pointing to what is “wrong with them” and the health outcomes they might experience later in life. The ACEs study has had a heavy influence on TIP and, while these are monumental advances in expanding the conversation of trauma, care needs to be taken with how those experiencing trauma are impacted.

Education – both how trauma-informed practices are applied in the classroom and what is taught about trauma – controls much of the narrative. As a Human Services student at Western Washington University, teachings on trauma-informed practice have impacted my professional lens and current work with foster care youth. Before taking a course through the WWU Honors Program with Tracey Pyscher, titled, “Rethinking Trauma,” the language and practices I was taught in Human Services centered around deficit discourses. By truly rethinking trauma and what I *thought* I knew about it, I have been able to unravel and critique many of the ways applications of the ACEs study are harmful to the children I work with every day. Through a critical evaluation of Human Services courses at Western Washington University, alongside survey responses from students and professors about their experience, the ongoing use of ACEs and TIP can be examined more closely. By examining current viewpoints on trauma studies, we

can begin to challenge practices and move toward a more equitable education system as well as better preparation for future social services professionals.

### **Adverse Childhood Experiences Study**

Between 1995 and 1997, Kaiser-Permanente conducted “one of the largest investigations of childhood abuse and neglect” through the Adverse Childhood Experiences (ACEs) study (CDC, 2020). ACEs “refer to the prolonged exposure of children to potentially traumatic events” (Blodgett & Lanigan, 2018, p. 137) and are now considered a public health problem (Verbitsky-Savitz, et.al., 2016, p. 2). With a sample of over 17,000, the ACEs study had individuals complete a confidential survey on the experiences of their childhood (ages 0-17) alongside a physical evaluation of their current health (CDC, 2020). The survey questions ranged (See Appendix A for an ACEs screening example), gathering information on “child abuse and neglect, household challenges and other socio-behavioral factors” (CDC, 2020) and reporting an “ACE score” between 0 and 10, after adding up the number of questions an individual checked (Winninghoff, 2020, p. 33). In reality, most individuals, “61% surveyed across 25 states,” have experienced at least one type of ACE and many report 4+ ACEs (CDC, 2020). Research has linked ACEs, the result of toxic stress in one’s childhood environment, to physiological and psychological issues later in life, including health problems, mental health struggles, and substance abuse (CDC, 2020). Additionally, there has been extensive research done about the consequences, physical and financial, of ACEs and how they disproportionately affect low-income and minority communities (Starecheski, 2015), with “the highest incidence of multiple ACEs and childhood trauma... [occurring] in high-poverty neighborhoods where families and communities may have less access to support” (Koplow, Dean & Blachly, 2020, p. 98). According to Centers for Disease Control and Prevention, ACEs’ effects on individuals and

communities are costly, so many prevention strategies have been proposed (CDC, 2020). The most common recommendation for building resilience from ACEs is the presence of a positive, safe relationship (CDC, 2020), which “gives any child a much better shot at growing up healthy” (Starecheski, 2015).

### **Trauma-Informed Practice**

Kaiser-Permanente’s study jumpstarted “the ACEs movement” (Turner, 2019) and their research findings have led to an emphasis on “trauma-informed” practices, or TIP, in almost all care settings, including K-12 education, foster care, prisons, shelter housing, and health care. The emergence of trauma-informed, or trauma-sensitive, practices within the school system stems from “a proven link between healthy socioemotional development and academic success” (Perry & Daniels, 2016, p. 177). Most students entering the classroom have experienced toxic stress at home. For instance, in Washington, 43% of students have reported three or more traumatic experiences (Perry & Daniels, 2016, p. 177) and “nearly half of children [is] experiencing one or more ACEs” within the general elementary school population (Blodgett & Lanigan, 2018, p. 145). With direct effects on “learning, cognition, and behavior” (Winninghoff, 2020, p. 36), the education system acknowledges ACEs as a problem in need of addressing, as they cause additional “developmental challenges” teachers should be prepared to support in their classrooms (Verbitsky-Savitz, et.al., 2016, p. 2). Trauma-informed models have been introduced in many schools across the country, with Lincoln Alternative High School in Walla Walla, Washington (Redford, 2014) being one of the most notable. But, as ACEs screening and research has begun to be applied in more recent years, there have been unintended consequences on the wellbeing of students.

## **Labeling and Discipline**

In the past decade, schools adopting trauma-informed practice have undergone a complete “‘paradigm shift’ in school approach and culture” (Winninghoff, 2020, p. 33). However, the impacts of these curriculum overhauls have only recently been brought into question, as researchers and psychologists examine the help *and* harm of such approaches (Pyscher & Crampton, 2020). It has been argued in ACEs research and in TIP school professional development practices that students with ACEs have endured trauma and are exposed to stress within their home life, which activates a stress response in their brain, diminishing their “capacities of memory consolidation, concentration, sustained attention, and retaining or recalling information” (Perry & Daniels, 2016, p. 177). Instead of addressing the root causes of trauma and working to reduce a student’s at-home stress, the school system has often labeled these children (Pyscher & Lozenski, 2014) as “‘unruly’ or ‘unmotivated,’” which is often followed by diagnoses of learning disabilities, ADHD, or Oppositional Defiant Disorder (Perry & Daniels, 2016, p. 178). The labels themselves pathologize students but, if their behavior is determined “unmanageable” by a teacher, students might be removed from the classroom, isolating them from community, and their peers, and communicating to them that *they* are the problem (Pyscher & Lozenski, 2014). This micro-level focus on student behavior minimizes the responsibility of *systems*, which are out of student control, and “blames children and families for challenges they did not cause” (Khasnabis & Goldin, 2020, p. 46). Educators must ask themselves broader questions when managing student behavior: what are they holding students accountable for? Are they fixating on the students’ assets or their deficits (Khasnabis & Goldin, 2020, p. 44)? Is a student truly “disruptive” or are they communicating a need (Pyscher, 2016)? As students work to process and understand their trauma, traditional disciplinary responses to

“acting out” at school can vaporize what is potentially one of the few “safe” environments in a student’s life.

### **ACEs Screenings**

As the concept of ACEs has grown in popularity, universal ACEs screenings have been advocated for and used by a variety of professions who see the service as essential to understanding trauma and helping individuals. Like Winninghoff (2020) writes, the National Child Traumatic Stress Network (NCTSN), wants “healthcare, schools, home visiting programs, and domestic violence shelters” to be administering the ACEs screening (2020, p. 38). In practice, the Behavioral Risk Factor Surveillance System (BRFSS), a yearly, randomized phone survey, has administered the ACE screening on a statewide level; it has been used by 48 states since 2009 “to collect information on child abuse and neglect and household challenges” (CDC, 2020). However, others urge that trauma screenings, unless used within therapeutic contexts, run the risk of causing significant harm to those who have or are currently experiencing trauma (Winninghoff, 2020, p. 38).

**Within schools.** When ACEs screenings are requested within an educational context, students are placed in a compromising position of being asked to disclose their trauma. In an environment where power dynamics are already at play, many students might not feel as though they can refuse an ACEs screening and those who complete the screening may feel at a disadvantage once their teachers, who hold a position of power, have access to such personal information. Since teachers are mandated reporters, there is the possibility of them having to report certain traumas reported on the student’s ACEs screening.

**Shortcomings of ACEs screenings.** Though ACEs screening results might provide teachers with a better understanding of their students and the ability to “offer more tailored



support” (Turner, 2019), the intent of an ACE score was to inform “population-level epidemiological research” (Turner, 2019) rather than practices for an individual student. Additionally, the original ACEs study was conducted with “primarily white, middle-class, and highly educated individuals” (Merritt, et. al.), making applications to other populations and identities beyond its intent. In addition, the current ACEs screening falls short by failing to “recognize all adversities. Important factors such as cultural, structural, and systemic forms of oppressions are not explicitly recognized as ACEs” (Winninghoff, 2020, p. 39), meaning many students’ experiences are not even represented in the questions provided in a screening. Even the CDC (2020) website has been updated to note, “the examples above are not meant to be a complete list of adverse experiences. There are many other traumatic experiences that could impact health and wellbeing.”

Because the educational infrastructure has not been designed to provide individualized support to every student, providing this information to teachers can do more harm than good. The information provided by an ACEs screening “directs attention to the wrong target” (Khasnabis & Goldin, 2020, p. 44) and teachers utilizing a student’s results can cause re-traumatization, as well as stigmatize those who are more likely to have ACE scores (ex. low-income and minority students). Since ACEs screenings were intended as a tool to demonstrate an association between ACEs and poor outcomes, being “ACE-aware” communicates to students that “having ACEs is bad” and tells them intervention is required to mitigate the health outcomes their childhood adversities might cause. Instead of asking students to do an ACEs screening and singling out those with high ACE scores, schools should be looking for ways to shift educational culture from the stigmatization of students and toward and/or TIP practices spaces where students know they will be heard and understood by their teachers, no matter how many

traumatic experiences they have endured. ACEs is a medicalized model that is now being widely used in spaces it was not created for and placed on communities and identities who were not a part of the original study. Applying ACEs screenings within schools strays from the initial purpose of ACEs – to find relationships between childhood trauma and negative adult health – and opens the door for stigmatization and further trauma.

### **ACEs and TIP in Practice**

#### **Lincoln Alternative High School**

On a national level, Washington state led the charge on implementing TIP into school curriculum. As mentioned earlier, Lincoln Alternative High School (LAHS) in Walla Walla, Washington has received tremendous attention for their implementation of trauma-informed practice, primarily due to their documentary *Paper Tigers* (Redford, 2014), which shadows students attending LAHS. On the film’s website, they refer to LAHS’s curriculum as an “unlikely success story” (About, KPJR, n.d.), which, in 2010, was inspired by the findings of Kaiser-Permanente’s ACEs study (Redford, 2014). After learning about chronic and severe stress from the ACEs study, Jim Sporleder, who was then the principal of LAHS, realized he had “been doing ‘everything wrong’” with his disciplinary practices (Stevens, 2015). Instead of asking “what is wrong with you?,” the question needed to shift to, “what happened to you?” through minor alterations to their approach. Teachers worked on early behavior interventions with students exhibiting stress symptoms, talking one-on-one with students or offering extended time with the counselor and at the Health Center (Stevens, 2015). For non-compliant students, teachers sent them to the principal’s office, where they talked through their “decision-making ability: green, yellow, or red,” with red being “unable to think clearly” about how they would change their behavior next time a similar situation arose (Stevens, 2015). As a staff, LAHS re-

focused their attentions from discipline to supporting students and their families (Stevens, 2015), which led to them constructing a Health Center adjacent to the high school in an effort to remove barriers for students in need of medical or mental health care (Redford, 2014).

**Classroom practices.** While this all seems innovative and ‘healing,’ *Paper Tigers* offers several scenes from a LAHS classroom which allows viewers to see some of the damaging oversteps trauma-informed practice is capable of. Near the beginning of the documentary, a teacher is shown instructing on the ACEs study, showing seventeen high schoolers two PET scan images: one a “healthy brain” and the other an “abused brain” (Winninghoff, 2020, p. 36-7). After this, the teacher asks students to anonymously submit their answers to the ten ACEs questions (See Appendix A) and the results show that more than half of the students in the classroom reported 5+ ACEs (Winninghoff, 2020, p. 37). The teacher asks the students, “How are you going to be different?” and proceeds to tell them, “twenty years ago, those adults [from the PET scans] would have been sitting here in this room saying I’m so different. There’s no way I’m going to create a life of stress for my kids. The cycle’s going to stop with me. So how do you sit here now and say the same thing they said and have it actually turn out differently?” (Redford, 2014, 5:13-9:42). Through this “trauma-informed lesson,” the teacher communicated that 1) students with ACEs have abused, damaged brains and 2) “breaking the cycle” of toxic stress is the personal responsibility of each student (Winninghoff, 2020, p. 37-8). Instead of being empowered by their experiences, stories, and unique identities, students are left to view their upbringings as deficiencies, which will only cause irreparable damage. Though this is only one case study of trauma-informed practices in the school system, LAHS demonstrates “how the ACEs framework can lead a teacher toward negative assumptions and presuppositions, and how students can be led to accept messages of their likely deficiencies and negative life outcomes”

(Winninghoff, 2020, p. 38). Furthermore, LAHS offers an example of how literary response initially provided accolades where there should have been critical reflection on what trauma practices might be communicating to students.

**Critique.** Before taking the Honors seminar on “Rethinking Trauma,” *Paper Tigers* and Lincoln High School’s approaches were presented in courses as an exemplar implementation of trauma-informed practice. As I watched the opening scenes of *Paper Tigers* – described earlier with the two PET scans – in 2019, my professors offered this high school teacher’s approach as a progressive presentation of how ACEs affect students and how education on ACEs can interrupt them intergenerationally and the stress they cause. The resilience factor promoted time and again in Human Services courses and referenced in the above quotation – “the presence of a stable, caring adult in a child’s life” (Redford, 2014) – was taught as the golden ticket to avoiding the predicted health outcomes of ACEs, reaching a place of healing, and what we, as Human Services professionals, should strive to be for individuals with high ACE scores. This continues to be seen throughout the literature, even though the CDC website states it as a short-sighted solution: “safe, stable, nurturing relationships... [and] can prevent ACEs and help all children reach their full health and life potential” (CDC, 2020).

### **WWU Human Services Curriculum Evaluation**

From a program perspective, the Human Services major does not have a standardized stance or approach to trauma education or TIPs. The topic of trauma was woven into multiple Human Services courses I took, which are taught by a variety of professors, however TIP and ACEs were presented as irrefutably useful tools in all of these settings. As an individual who works with foster care youth and who is preparing to graduate from this program, it is now evident how the lack of critical evaluation of TIP led to many assumptions in the field, working

from the one-sided standpoint of what trauma research *thinks* individuals with ACEs or toxic stress need. In nearly every Human Services course I completed, professors covered an informal base understanding of trauma and trauma-informed care, as students take on larger topics such as how to work with clients experiencing trauma, best practice for language surrounding trauma, and what fields trauma studies have been applied to. Through the data I gathered in interviews and surveys, one professor provided the definition of trauma-informed care as: “care involving intentionally and consistently looking through the lens of trauma.” Though vague, this powerfully paints the limited foundation given to students about what trauma really means and how it should be approached in the world of social work. I recall being taught to approach care as “trauma-informed” and approach one’s clients/field of interest with sensitivity to “how many ACEs they might have.” Yet, no Human Services course I took – between fall of 2018 and the spring of 2021 – held a discussion which delved into the harmful features of the ACEs framework, the longitudinal studies on the impact of trauma-informed practice, or the possible sociocultural dimensions of traumatic experience. Even though I did not have the language to describe it yet, as I began to intern and work in foster care services, I felt a tension between what I had been taught and how it was affecting the young lives I had relationships with.

**Research.** Through a limited case study, anonymously surveying 10 past and current HSP students and 4 HSP professors (See Appendix B for survey questions), the data confirmed a similar deficit narrative to what I took away from my time in Human Services, along with some responses I was not expecting. In my email to professors, I offered a personal interview space, if anyone had a vested interest in the topic and wanted to talk with me directly. Out of the 16 professors who were contacted, one of the survey responders agreed to also be interviewed, stating it was an “area of interest” and presenting their perspective as “the only one who has

taught the trauma class” for Human Services students. All in all, there was a 17.5% survey response rate from students contacted and 25% survey response rate from HSP professors.

**Findings.** In reflecting on student and professor responses, I did my best to keep an open mind and lean on my previous research when evaluating language and curriculum takeaways. Though I was hoping to find something different when I surveyed other Human Services students, much of the language taught to me was consistent throughout the survey responses. I found the same medicalized terminology in student, and professor, responses, defining trauma as having “long-term negative effects” or being “at risk for mental illness, death, drug abuse, suicide, etc.” The majority of students, like myself, have graduated from the Human Services program with a narrow view of trauma.

**Student.** When HSP students were asked to define trauma and “trauma-informed care,” their descriptions included phrases like: “abnormal and detrimental experience,” “disturbing experience,” and “adverse physiological effect caused by a distressing event.” These words reflect deficit thinking and negative connotations of trauma and this language was consistent throughout the majority of student responses (70%). Most students mentioned having an overview of trauma or watching a video on ACEs during their coursework, however 30% of students shared their trauma education had missed the mark. Students said, “it is something I felt was lacking,” “none of the core classes I took directly touched on trauma,” and “I don’t remember a course specifically teaching about ‘trauma-informed care’ by name.”

Students were asked if they had heard of the ACEs study and what their general knowledge consisted of. Many students mentioned the adult health outcomes reflected by someone’s ACE score. One student wrote, “the number of ACEs in childhood correlates to adverse outcomes later in life.” Another mentioned, “people with more ACEs are more at risk for

mental illness, death, drug abuse, suicide, etc.” Some students (20%) were able to name the limitations of the ACEs screening (ACEs “is not limited to those events”) and mentioned learning about generational trauma or racial trauma in courses, which are experiences missing from the ACEs study. One student, who mentioned their current work in foster care, shared “ACEs are a common tool used in training programs” but also recognized, “this can be a good tool, but it puts people in boxes which can be detrimental to their outlook on life.”

There was minimal asset language and sociocultural dimensions in student responses. Only one student mentioned HSP teaching “helped me learn about my own trauma and positionality and taught me that others deserve care that is strengths-based and personalized. Every person responds to support differently.” This reflection provides a glimpse of hope and leans toward the type of educational takeaway the HS program should strive for and possibly a wholly different approach for TIP in general.

**Professors.** Similar to students, professors were asked to define trauma and trauma-informed care. Words like, “emotional response,” “violent,” “distressing,” “long-term negative effects,” and “dangerous” were seen throughout their responses. One professor referred to trauma as, “systemic experiences that create pain and get in the way of full living as each person defines it.” Part of the professor’s survey asked specific questions about their curriculum choices and what types of trauma frameworks were included. One of the professors who responded stated their courses were “not related” to trauma-informed care and another shared they did not use ACEs in any of their courses. 75% of professors said they examine the ACEs framework, including its limitations, original intent, and the types of trauma overlooked by this questionnaire. When asked to categorize the ACEs study as asset or deficit (or in between), 75% of professors stated the ACEs framework is a deficit model while 25% sees it neither one nor the

other. This respondent emphasized it is “important that [students] have the ability to critically evaluate it.” While 50% of professors do not plan to add more trauma-related curriculum, 50% shared they are always updating their classes. One respondent is “interested in adding more... about survival, resilience, and healing.”

**Interview.** In my single interview with a professor, I was encouraged by the language used and overall awareness of current trauma studies critique. When asked about trauma-informed care, this professor stated, “something problematic about that term is the word ‘care’. It says that professionals have something to help, save, or fix the person in a harmed role... we need to be careful about assuming a knowledgeable role and that people need something from us.” In their curriculum and teaching, the professor aims to “show what is out there” and teach students to be “critical of what they have to offer us as well as aware of their limitations.” The healing centered engagement model, by Dr. Shawn Ginwright (2018), is something this professor has begun to incorporate, and they will continue to add to their Human Services courses as trauma studies evolve.

The language this professor utilized surprised me because of my experience in their course, which was a year prior to the interview. When I took their course, students were required to take the ACEs screening test and submit a 5-7 minute audio clip, reflecting on how it felt to take the test and their reaction to their answers. While the class did not require direct disclosure of one’s answers, this assignment was point-heavy and, rather than an optional self-exploration opportunity, was required for completion of the course. Additionally, this course was where I originally watched the documentary, *Paper Tigers*. Lincoln High School’s approaches were presented in courses as an exemplar implementation of trauma-informed practice. As I watched the opening scenes of *Paper Tigers* – described earlier with the two PET scans – in 2019, my



professor offered this high school teacher's approach as a progressive presentation of how ACEs affect students and how education on ACEs can interrupt them intergenerationally and the stress they cause. Because of this, I was taken aback to hear this professor use such updated verbiage and class content. As I advocate for asset orientation, this dramatic shift is refreshing, and I sincerely hope this professor's awareness of trauma studies will begin to influence other instructors in the HS program.

### **Implications**

The professor and student responses provide a stark contrast; while many of the professors shared a critical lens of ACEs and recognized a need for resilience and healing, most students did not leave the program with this perspective. There seems to be a disconnect between what the professors know and understand about ACEs and trauma studies and what is being communicated to students during their time at Western. A current student stated that HSP courses taught, "mostly just that [trauma] exists and is important. Nothing really about how to do it." This vague conclusion points to a need for more direct education on trauma as well as field TIP applications. These students, preparing to become professionals, should leave the program equipped to consider how survivors' personal identities and cultural knowledges affect their lens and everyday life. If the social workers and counselors of tomorrow are unsure of how to support those who have experienced trauma, this could have serious ramifications on the quality of services available and set all parties up for potential failure.

### **Suggestions**

ACEs has and continues to be a model presented in academia with medicalized, deficit language which presents those who have experienced trauma as needing to be "fixed" (Pyscher, 2016, p. 8). Instead of being objectified, trauma should be taught as an asset and a valuable part

of one's identity. As trauma studies continue to evolve, there is a significant need for the Human Services program – and others like it – to increase access to varying literature, requiring multiple perspectives to be examined in class, rather than hand-picking what suits the professor. In addition, the Human Services program teaches from a place of privilege, utilizing texts and sources like *Paper Tigers* which were developed from medicalized research (ACEs). This gatekeeping of trauma literature is another barrier needing to be explored, since those who have experienced trauma are not given agency to choose what they want or need in their road to healing.

Both professors and students used language grounded in deficit thinking, with no mention of how trauma becomes engrained in one's identity and can be framed as an asset. As course curriculum continues to evolve, professors should reflect on what words are used to describe trauma and how that might affect students in their classroom who have experienced trauma. Are they being told their experiences are “detrimental” and “damaging”? It is important that professors are continuing to update their course content as more scholars (e.g. Dr. Shawn Ginwright, Tracey Pyscher, Alex Winninghoff) are engaging in critical trauma work. As scholars begin to challenge trauma studies, Human Services students should be equipped with the tools to critically analyze them as well.

From my personal perspective as a student, Western Washington University's Human Services program (HSP) needs to review what type of trauma education undergraduates are receiving. Several professors mentioned incorporating resilience and healing, which seems like an important next step to improving the HSP curriculum. It might be helpful to take a standardized approach, bolstered by a critical analysis of ACEs and focus on healing-centered

engagement (Ginwright, 2018), to ensure all students walk away with the same understanding and the ability to critically analyze the shortcomings of trauma studies.

### **Conclusion**

In presenting the Human Services curriculum and Lincoln High School's approaches to trauma-informed education, it is evident that ACEs research can and has been used in damaging ways. While the Human Services program was a limited critique of trauma education, it is representative of where current gaps are and a need for larger scale reforms. Though this study from the 1990s has provided a framework for beginning the conversation of trauma, "it is founded in understandings of trauma that were born in the medical field as doctors searched for explanations for differential health outcomes" (Khasnabis & Goldin, 2020, p. 45) and has since been applied and taught in extraneous ways. As Winninghoff (2020) points out, there is no current "best standard of practice" (p. 38) in traditional public school systems or otherwise "as the literature contains very few controlled evaluation studies" (Blodgett & Lanigan, 2018, p. 144). The concept of trauma-informed schooling is not inherently bad "but the underlying logic and practices of ACE frameworks and scores contribute to a continuation of social narratives that tell students there is something wrong with them because something happened to them" (Winninghoff, 2020, p. 40). Additionally, implementation in schools has failed to examine what these practices might mean for children and youth from trauma and the unique cultural perspectives they bring because from their traumatic experiences (Pyscher, 2016). As an educational community, a shift needs to occur toward creating "healing-centered" spaces, like Dr. Shawn Ginwright (2018) suggests, rather than "trauma-informed" practices. Instead of feeling stuck in a place of deficiency, like Lincoln High School's approaches, healing-centered engagement "views those exposed to trauma as agents in the creation of their own well-being

rather than victims of traumatic events” (Ginwright, 2018, p. 4). There is no “remedy” for trauma however, healing-centered engagement presents an opportunity to holistically approach communities and individuals affected by trauma, focusing on student well-being instead of the “symptoms we want to suppress” (Ginwright, 2018, p. 3) and providing a collective sense of responsibility. Instead of trying to change the student or child who has experienced trauma, we need to be looking at the systems affecting them and asking ourselves how to change the *causes*.

Whether or not all of the literature reflects it, the ACEs study has had a profound effect on trauma-informed practice. Systemic-level changes are necessary to construct new teaching practices and curriculum, which are reflective of the current dysfunctions that create and amplify trauma for students and their families. While Kaiser-Permanente’s study contributed to more discussion and education around trauma, it seems time to retire this medicalized model and find more humane ways to work with people who have experienced trauma. As the effects of ACEs and TIP continue to be seen, current practice must be challenged as we reach toward a future of care that is more than just “trauma-informed.”

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## Appendix A

### Sample ACEs Screening Questionnaire

From *ACEs Aware* website (<https://www.acesaware.org/wp-content/uploads/2020/02/ACE-Questionnaire-for-Adults-Identified-English.pdf>)

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?
2. Did you lose a parent through divorce, abandonment, death, or other reason?
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?
5. Did your parents in your home ever hit, punch, beat, or threaten to harm each other?
6. Did you live with anyone who went to jail or prison?
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?
9. Did you feel that no one in your family loved you or thought you were special?
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?

\_\_\_\_\_ **Your ACE score is the total number of checked responses**



## Appendix B

### Student and Professor Evaluations

#### **Student** Survey: Human Services Education on Trauma Discourses

1. How do you define trauma?
2. What does “trauma-informed care” mean to you?
3. What Human Services course(s) have you taken that addressed trauma? Please choose as many as apply.
4. What did these course(s) teach you about trauma? Please specify if you received different messages from different courses.
5. Have you heard of the Adverse Childhood Experiences (ACEs) study? If so, what do you know about it?

#### **Professor** Survey: Human Services Education on Trauma Discourses

1. Course(s) Taught in Human Services Program (past and present)
2. How do you define trauma?
3. What does “trauma-informed care” mean to you?
4. Have you included trauma education in any of your courses? If so, which courses and what theories and frameworks related to trauma did you use?
5. Have you heard of the Adverse Childhood Experiences (ACEs) study? Have you taught about it in any of your courses? If so, how did you teach the ACEs framework?
6. To what extent do you believe the ACEs framework is DEFICIT-based and/or ASSET-based (or somewhere in between)? Please explain.
7. Did you teach anything related to trauma beyond the ACEs framework? If so, what other frameworks did you use?

8. What do you consider to be the positive and/or negatives with the emergence of trauma studies?
9. Do you plan to add more to your teaching/curriculum related to trauma studies?