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# Supporting Learners with Trauma in Non-Formal Educational Settings

## A Handbook from the COPE Project

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COPE Project 'Preparing Non-formal Education in Europe for Traumatized Learners' is ERASMUS+ KA220-ADV- Cooperation Partnership in Adult Education, project number 2023-1-DE02-KA220-ADU-000155022, co-funded by the European Union.

The purpose of the COPE Project is to support non-formal educators and offer them free online training on how to be both sensitive and effective when doing their work with individuals that have experienced emotional trauma.

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# Foreword

*The Editors*

Across Europe and beyond, non-formal education plays a vital and often underappreciated role in building inclusive, resilient communities. In contexts marked by displacement, socio-economic hardship, migration, or marginalization, non-formal learning environments frequently become the first, and sometimes the only space where healing, growth and a sense of belonging are possible. Yet, within these same environments, many educators and volunteers encounter learners silently navigating the invisible wounds of trauma.

The COPE Project (*"Preparing Non-Formal Education in Europe for Traumatized Learners"*) was born out of this critical intersection – where informal learning meets the deep and complex realities of emotional trauma. Co-funded by the European Union through the Erasmus+ program, the project responds to an urgent need: to equip informal educators with tools, knowledge and emotional literacy to identify trauma survivors and respond with care, but also to build environments where all learners can thrive, regardless of their histories.

This handbook reflects that mission. Drawing from interdisciplinary research, lived experiences, pedagogical innovation and a deeply humanistic lens, *Supporting Learners with Trauma in Non-Formal Educational Settings* offers a roadmap toward trauma-informed practice. It explores psychological and emotional dimensions of trauma, as well as its cultural, developmental and systemic contexts. It provides a deep foundation of theoretical knowledge, helping educators comprehend the underpinnings of trauma and its impacts across the life span. Alongside this, it centers on the voices of learners, educators and communities alike, offering practical strategies and case studies grounded in real-life application.

Importantly, this handbook does not offer easy answers. Trauma is complex and deeply individual. But what it does offer is clarity and the kind of practical empathy that can transform how we teach, how we relate, and how we rebuild trust.

To all informal educators, volunteers, trainers and facilitators: your work matters. This handbook is a tribute to your commitment – and an invitation to continue that work through trauma-informed lens. By doing so, we not only improve educational outcomes, but we begin to restore dignity, safety and connection in the lives of those who need it most.

On behalf of the COPE Project Team

# Disclaimer

**The COPE Project (2023-1-DE02-KA220-ADU-000155022), funded by the European Union's ERASMUS+ Programme, is a Strategic Partnership in Adult Education**. Its goal is to prepare informal educators across Europe to better support emotionally traumatized learners. The content of this handbook represents exclusively the point of view of the authors and is their sole responsibility. The European Commission cannot be held responsible for any use, which may be made of the information contained therein.

The information contained in this publication is available to anyone interested in international literature on the subject. The arguments, information and scientific theories contained in all the parts and materials of this project have been organized in order to be useful to all people who, in various capacities and with different professional background, offer help and services to individuals and groups.

The scientific knowledge and materials contained in this project are freely accessible in many various scientific publications around the world. The applications of these notions and knowledge are regulated in different ways in the various countries by their respective laws, regulations and codes of ethics of the various professional guilds and professional or voluntary associations, which often vary from country to country.

All the contents of this handbook are offered with the precise intention of respecting all the laws and regulations in force on the topics and no part of this handbook can be used or understood for different purposes from what has just been underlined. It remains a duty and an imperative for every professional to work always in science and conscience in the best interest of her/his clients and this includes full compliance with all the regulations in force in their country, respect for the specific competencies of other professions, awareness of their limits and knowledge and respect for the boundaries that outline their profession and their professional or paraprofessional role and competence as well as the needed compliance with the internal rules of the organization in which one operates.

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# Chapter 1: Understanding trauma

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## 1.1 What is trauma?

Trauma refers to an individual's emotional, psychological, physical and social response to events that are overwhelmingly distressing or threatening. It arises when a person experiences something that shatters their sense of safety, trust, control or identity, often leaving lasting effects on their mental and physical wellbeing. It is crucial to emphasize that trauma is not defined solely by the event itself, but by how the individual experiences and internalizes it. This means that two people may face the same event, yet one may experience trauma while the other does not. Trauma is deeply personal and context-dependent, basically shaped by prior experiences, developmental history, coping resources and cultural/social environments.

Over the past four decades, the definition of trauma has evolved significantly, shaped by deepening insights into the diverse life experiences that can lead to psychological distress. Growing evidence highlights a gap between the official Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) Criterion A events – defined as exposure to actual or threatened death, serious injury or sexual violence – and the lived experiences of individuals who develop post-traumatic symptoms. Yet, despite these advances, there remains a persistent disconnect between formal diagnostic criteria (such as outlined in the DSM-5) and the lived experiences of individuals reporting trauma-related symptoms.

Many people who suffer from post-traumatic stress and related conditions have endured events that do not meet the strict criterion A definition of trauma but nonetheless result in profound psychological harm. Emerging research, including national registry studies, shows that even events not formally classified as traumatic can significantly increase the risk of psychiatric disorders such as stress-related conditions and post-traumatic stress disorder (PTSD). This growing body of evidence urges clinicians, researchers and policymakers to reconsider the boundaries of what is deemed "traumatic", recognizing that psychological injury does not always adhere to rigid diagnostic thresholds. A more inclusive understanding of trauma – one grounded in people's actual experiences rather than narrow definitions – is essential for identifying those in need of care and ensuring that trauma-informed approaches truly meet people where they are.

The distinction between types of trauma (i.e., acute, chronic and complex), is not merely academic but essential to understanding how trauma shapes human behavior, health and recovery. Complex trauma, often originating in early relationships marked by betrayal, neglect or abuse, can be particularly damaging because it undermines an individual's basic sense of safety and trust in others. It is frequently rooted in situations where escape feels impossible, such as in childhood maltreatment or intimate partner violence, and may lead to profound difficulties in emotion regulation, identity formation and interpersonal functioning. The resulting condition, sometimes referred to as complex post-traumatic stress disorder, includes all the core symptoms of PTSD but is further marked by disruptions in self-concept, persistent negative affect and difficulties sustaining stable relationships. Recognizing the nuances among trauma types is key to delivering care that is

sensitive to the depth and diversity of human suffering – but also to promoting environments where healing can take root.

In refining the definition of trauma, it is helpful to distinguish between what have been termed "large-T" and "micro-traumas," both of which exert significant psychological influence (though they differ in visibility, immediacy and cultural recognition). "Large-T" traumas refer to events that are universally acknowledged as potentially traumatic: natural disasters, violent assaults, severe accidents, war, genocide, and acts of terrorism. These are typically discrete, identifiable experiences that threaten life or bodily integrity and elicit strong emotional responses such as terror, helplessness or horror. Large-T traumas may also encompass complex trauma: prolonged, repeated exposures such as childhood sexual abuse, long-term domestic violence or captivity. Though society often prioritizes these events as "worthy" of trauma status, not everyone exposed to them experiences psychological harm, and conversely, not all damaging experiences fall into this category.

"Micro-traumas," sometimes referred to as "small-t" traumas, encompass a different and often underestimated set of experiences. These are chronic, cumulative or subtly wounding events that may not meet formal diagnostic criteria for trauma, but can nonetheless result in lasting emotional distress and psychological harm. Examples include persistent bullying, systemic discrimination, verbal abuse, medical gaslighting, childhood emotional neglect, ongoing micro aggressions or the steady erosion of safety in an unstable home or work environment. What characterizes micro-traumas is not their magnitude as singular events, but their insidious repetition and internalized consequences. Because they are frequently dismissed or invalidated by others, individuals exposed to micro-traumas may doubt their own emotional responses or avoid seeking support, further compounding the impact. Importantly, micro-traumas can accumulate over time and, when left unacknowledged or unresolved, produce symptoms akin to those resulting from large-T trauma, including anxiety, shame, dissociation and depression.

The false dichotomy between "large" and "small" trauma experiences can obscure the complex ways in which trauma is experienced across the life course. Trauma is inherently subjective; what devastates one individual may be absorbed by another without apparent long-term consequences. This variability is shaped by a multitude of factors including personality traits, resilience capacities, attachment history, cultural context, social supports, previous trauma exposure and current life stressors. Indeed, micro-traumas may be more difficult to detect and validate precisely because their origins often lie in normalized or socially sanctioned behaviors and systems. However, their psychological effects (most notably chronic hypervigilance, mistrust, emotional withdrawal or internalized worthlessness) can be just as debilitating. Expanding the lens of what constitutes trauma to include micro-traumas is pivotal to understanding the full spectrum of human suffering and creating inclusive approaches to care, healing and recovery.

Trauma responses vary based on a wide range of personal and contextual factors, including age at exposure, cultural background, neurobiological vulnerability, social support and prior trauma history. Childhood trauma in particular, has been shown to have profound and long-lasting consequences, altering developmental trajectories and increasing the risk of both psychological and physical illness later in life. The effects of trauma are often cumulative, especially when multiple adverse experiences occur over time or are reinforced by systemic inequalities such as poverty, racism, or housing instability. Whether trauma is acute, chronic or complex, its imprint is far-

reaching and addressing it requires not only individual-level support but also a coordinated, trauma-informed response from interprofessional care teams across health and social systems.

Also, traumatic experiences can take many forms and occur across different stages of life. Some may be sudden and isolated such as an accident or natural disaster, while others may unfold over time through repeated exposure to violence, abuse or neglect. People who are exposed to multiple interpersonal or early-life traumatic events may carry what is referred to as complex trauma, which can profoundly affect development, identity and relational patterns. In addition to individual trauma, entire communities may be affected by collective trauma such as those caused by war, displacement, systemic discrimination or historical injustices. These experiences not only affect individuals but disrupt cultural continuity, erode community cohesion and leave intergenerational scars.

The effects of trauma extend beyond the mind. Advances in neuroscience and physiology have shown that trauma alters brain structures responsible for fear, memory and emotional regulation such as the amygdala, hippocampus and prefrontal cortex. It dysregulates the body's stress response systems and can result in either a state of hyperarousal where the individual is constantly on edge and reactive, or hypoarousal where the person feels numb, detached or emotionally shut down. Many trauma survivors oscillate between these states. Trauma is often "stored" in the body, contributing to a wide range of physical health issues including chronic pain, gastrointestinal problems, cardiovascular disease and immune dysregulation. These somatic symptoms can persist for years even when the traumatic event itself is long past.

Despite its prevalence, trauma often remains hidden. Many individuals carry its weight silently, especially in cultures or contexts where mental health is stigmatized or misunderstood. In populations experiencing poverty, displacement, social marginalization or political violence, trauma can be compounded by structural inequalities and barriers to care. Without safe environments and opportunities to process these experiences, trauma can severely impact daily functioning, relationships and the capacity to trust others or seek help. Misunderstood behaviors such as aggression, withdrawal, substance use or disengagement are often coping mechanisms rooted in traumatic experiences. Systems that fail to recognize this may inadvertently retraumatize individuals or reinforce feelings of shame and disconnection.

Understanding trauma in the context of care requires a fundamental shift in perspective. Rather than asking "What is wrong with this person?", trauma-informed approaches ask "What happened to this person?" This change is not merely semantic but represents a deeper commitment to empathy, safety and respect. It acknowledges the resilience that people show in surviving adversity and focuses on creating environments that support healing rather than compound harm. In doing so, it reframes symptoms as adaptive responses rather than pathologies and it invites a more compassionate and holistic approach to health and wellbeing.

One of the most influential bodies of research that expanded our understanding of long-term trauma effects is the Adverse Childhood Experiences (ACE) study, pioneered by Dr. Vincent Felitti and colleagues in the 1990s. This landmark research identified a strong, graded relationship between early exposure to abuse, neglect, household dysfunction and a wide range of physical, emotional and behavioral health outcomes in adulthood. The ACE framework revealed how traumatic experiences during formative years can become biologically embedded, increasing the

risk of chronic disease, mental illness, substance abuse and early mortality. Some of the ACEs are being physically or emotionally abused, witnessing domestic violence, growing up with a caregiver who has a mental illness or substance use disorder, experiencing neglect, losing a parent through divorce or separation, or living in a household affected by incarceration. Importantly, the study shifted the discourse by linking personal histories of adversity to public health concerns, underscoring the need for prevention and early intervention. Yet, trauma research has also pointed to another important truth: that healing and even growth are possible. The concept of post-traumatic growth recognizes that individuals may emerge from trauma with a renewed sense of purpose, strengthened relationships, deeper empathy, and a transformed worldview. This growth does not minimize the suffering caused by trauma, but instead affirms the human capacity for resilience and recovery. Integrating both the lasting impact of ACEs and the potential for post-traumatic growth invites a more nuanced and hopeful approach to trauma-informed care.

Also, it is important to stress that trauma does not occur in isolation from history, culture or identity. The legacies of colonization, war, forced migration and systemic oppression exert (and in a way perpetuate) enduring impacts across generations and their effects are often embedded in the bodies and narratives of those affected. Recognizing these dimensions of trauma requires cultural humility, an awareness of privilege and power and a willingness to engage with uncomfortable truths. Healing from trauma is not simply about symptom reduction – it is about restoring a sense of agency, dignity and connection.

In trauma-informed care, healing begins with relationships. People need to feel safe, respected and supported. They need to be given choices, to have their voices heard and to be treated as active participants in their own care. Trauma-informed systems are not defined by a checklist of procedures but by an underlying ethos – one that centers on trust, empathy, collaboration and a deep respect for human complexity. As the next sections will explore, recognizing the widespread nature of trauma and its impact is not only a clinical or humanitarian imperative – it is foundational to advancing health equity, justice and healing on both individual and collective levels.

## 1.2 Psychological and emotional impacts of trauma

The psychological and emotional consequences of trauma are profound and multifaceted. Trauma leaves an imprint that extends beyond the moment of the event itself, often resurfacing in the form of persistent emotional distress, behavioral changes and disruptions in cognitive and relational functioning. While reactions to trauma are highly individualized, many survivors experience intense fear, helplessness, shame, anger, guilt, sadness or emotional numbness in the aftermath of traumatic exposure. These initial emotional responses can resolve over time, but for many individuals, they persist and evolve into chronic psychological patterns that impair daily life and erode mental well-being.

One of the hallmark features of trauma is its ability to dysregulate emotional responses. Survivors may fluctuate between emotional extremes or struggle to identify and express their feelings altogether. This emotional dysregulation can subsequently manifest in heightened irritability, mood swings, panic attacks, or periods of emotional dullness and detachment. In some cases, these responses are the result of the brain's attempt to process overwhelming experiences by suppressing

emotional input or maintaining a constant state of alertness. Intrusive symptoms such as flashbacks, nightmares and distressing memories are also common, often triggered by reminders of the traumatic event. These symptoms are not only distressing but can lead to a sense of unpredictability in one's emotional world, reinforcing a cycle of fear and avoidance.

Another core impact of trauma is the alteration of one's sense of self. Traumatized individuals often report a fractured or unstable self-concept, which may be followed by deep feelings of worthlessness, guilt or shame. They may internalize the trauma, believing that they are somehow to blame or fundamentally broken. This is especially true for survivors of interpersonal trauma, such as abuse or neglect, where the betrayal of trust and violation of boundaries can undermine one's ability to feel secure in their identity or relationships. Over time, this can result in pervasive self-criticism, social withdrawal and even reluctance to seek help or express vulnerability.

Cognitive changes are also a significant feature of post-traumatic adaptation. Trauma can alter core beliefs about safety, control, justice and the predictability of the world. Individuals who once believed the world was a generally safe place may begin to perceive it as dangerous or hostile. This shift in worldview can affect decision-making, attention and memory, making it difficult to concentrate or feel confident in one's perceptions. Some survivors experience persistent negative thoughts about themselves, others or the future, accompanied by a loss of hope and a diminished sense of purpose or direction. These patterns of thought can contribute to feelings of disconnection and despair, as well as increase vulnerability to mental health disorders (primarily depression and anxiety).

Social and relational functioning can be (and often it is the case) frequently disrupted in the aftermath of trauma. Survivors may find it difficult to trust others, maintain intimacy or engage in social activities. Some may become overly dependent on certain individuals for a sense of safety, while others may isolate themselves to avoid the perceived risk of further harm. In close relationships, trauma can give rise to heightened sensitivity to perceived threats, misinterpretations of others' intentions or difficulty expressing needs. When trauma is experienced during critical developmental periods, such as childhood or adolescence, it can profoundly impair the ability to form healthy attachments, leading to persistent relational difficulties throughout life.

The emotional and psychological burden of trauma is also closely tied to the type, duration and timing of the traumatic exposure. Acute trauma, stemming from a single incident, may provoke a brief but intense psychological reaction, while chronic trauma – resulting from repeated or sustained exposure to distressing circumstances – can lead to long-term changes in personality, affect emotional regulation and interpersonal behavior. Complex trauma, most notably the one which occurs in early life or within caregiving relationships, often results in deep and enduring disruptions across multiple domains of functioning. Research has consistently shown that childhood trauma is associated with poorer emotional outcomes and higher rates of mental health disorders compared to trauma experienced later in life. This is likely due to the developing brain's heightened vulnerability to stress and the critical role of early relationships in shaping emotional regulation and resilience. These findings align with the aforementioned work on ACEs, highlighting how trauma in early life increases the risk of mental health disorders and also sets the stage for long-term disruptions in emotional development and overall wellbeing.

It is also important to note that trauma is not confined to PTSD alone. While PTSD remains the most recognized trauma-related diagnosis, many individuals do not meet its diagnostic criteria yet still suffer from significant psychological and emotional sequelae. Subthreshold trauma responses can include chronic anxiety, depressive symptoms, substance misuse, eating disorders, somatization, dissociation and behavioral disturbances. These conditions often overlap, further complicating diagnosis and treatment. For example, the same individual may experience both hyperarousal (such as insomnia or exaggerated startle response) and emotional numbing (such as apathy or detachment), resulting in a confusing and often misunderstood clinical presentation.

Dissociation is another common response to trauma, particularly in cases of prolonged or repeated exposure. Dissociation may involve a sense of detachment from one's body, surroundings or sense of identity. It can range from mild spacing out to more severe disruptions, such as amnesia or a fragmented sense of self. While dissociation serves as a protective mechanism in the face of overwhelming stress, it can interfere with memory formation, emotional integration and the development of a coherent life narrative.

The psychological and emotional impact of trauma can also manifest through maladaptive coping strategies. In an effort to manage or escape emotional pain, individuals may turn to substance use, disordered eating, compulsive behaviors or self-harm. These behaviors are often misunderstood as signs of weakness or impulsivity, when in reality they may represent efforts to regulate unbearable internal states or reclaim a sense of control. Over time, such patterns can become entrenched and contribute to the development of co-occurring mental health disorders.

Not only does trauma bridges all age groups, but emerging research underscores that the psychological and physiological effects of trauma can begin even before birth, with prenatal trauma exerting a significant influence on fetal development. When a pregnant woman is exposed to chronic stress, intimate partner violence, extreme poverty or certain specific traumatic events, elevated levels of stress hormones (most notably cortisol) can cross the placental barrier and affect the developing brain and stress regulation systems of the fetus. This prenatal exposure has been associated with increased risks of preterm birth, low birth weight, disrupted attachment, behavioral dysregulation – but also to heightened vulnerability to anxiety and mood disorders later in life. Additionally, trauma experienced during pregnancy may affect epigenetic markers that influence gene expression, potentially altering neurodevelopmental trajectories and emotional reactivity in the child. This suggests there is a mechanism for the intergenerational transmission of trauma, so recognizing and supporting the mental health of pregnant mothers is key – not only for their own wellbeing but for the lifelong health of the child.

Trauma experienced during early childhood and adolescence can have particularly profound and lasting effects due to the sensitivity of brain development and the formative nature of attachment, identity and emotional regulation during these stages of life. Young children may not have the language or cognitive capacity to fully understand or express what has happened to them, and instead may communicate their distress through behavioral changes such as sleep disturbances, tantrums, regression, withdrawal or heightened clinginess. In the absence of a safe and responsive caregiver, children who experience trauma may struggle to develop a secure attachment, which is foundational for later emotional and relational health. Early trauma can interfere with the maturation of critical brain structures, such as the amygdala, hippocampus and prefrontal cortex,

which are involved in fear regulation, memory consolidation and executive function. As a result, children who experience trauma are at increased risk of developing difficulties with attention, impulse control, learning and emotion regulation.

For adolescents, trauma intersects with a critical period of identity formation, social exploration and increasing autonomy. Traumatic experiences during this stage (whether related to violence, neglect, loss, instability or systemic adversity) can disrupt emotional development and lead to maladaptive coping strategies such as risk-taking, substance abuse, self-harm or social withdrawal. Adolescents may exhibit signs of trauma through irritability, aggression, academic decline or changes in peer relationships. At the same time, they may attempt to suppress or deny their distress in an effort to maintain control or preserve a sense of normalcy. Because adolescence is a sensitive period when mental health disorders commonly emerge, trauma can exacerbate the onset and severity of conditions such as depression, anxiety, post-traumatic stress and eating disorders. It is important to emphasize that trauma during this developmental window may also shape individual worldview and interpersonal expectations, reinforcing patterns of mistrust, self-blame or avoidance that can persist into adulthood (if left unaddressed).

In adulthood, the impact of trauma can manifest in diverse and often disruptive ways, affecting emotional stability, interpersonal relationships, physical health, occupational functioning, just to name a few. Adults may carry unresolved trauma from earlier life stages, or they may encounter new traumatic experiences such as accidents, intimate partner violence, medical crises, the sudden loss of a loved one or exposure to conflict/displacement. Trauma can lead to a range of emotional difficulties, including chronic anxiety, depression, irritability, emotional numbing and feelings of hopelessness or low self-worth. Many adults experience difficulty regulating their emotions, maintaining healthy boundaries or trusting others. These psychological effects can lead to strained personal relationships, social withdrawal or repeated cycles of dysfunctional interpersonal dynamics.

Functionally, trauma in adulthood may compromise one's ability to concentrate, make decisions, feel safe in everyday environments or engage in long-term planning. Some individuals may develop maladaptive coping strategies such as avoidance, substance misuse, compulsive or workaholic behaviors, which can mask deeper emotional pain but frequently lead to further distress or disconnection. Others may somaticize their trauma, experiencing chronic pain, fatigue or other physical symptoms without a clear medical cause (which can complicate everyday functioning). The cumulative impact of trauma can also interfere with one's ability to thrive professionally, affecting confidence, productivity and resilience under stress. When trauma remains unrecognized or untreated, it can contribute to burnout, compassion fatigue or secondary trauma – particularly among adults in caregiving or high-stress professions. Over time, the psychological weight of trauma may lead to a diminished sense of purpose and a persistent struggle to feel safe or connected in the world.

Older adults are vulnerable to the effects of cumulative trauma, i.e. the accumulation of multiple traumatic experiences over the course of a lifetime. This can resurface or intensify in later years, and then trauma may resurface in unexpected ways – especially as life circumstances (such as retirement, bereavement, declining health or increased dependence) evoke past experiences of loss and/or helplessness. For some, previously managed or suppressed trauma can re-emerge later in life, most notably when cognitive changes or reduced social support diminish coping capacity.

Older adults may face unique challenges in processing trauma due to generational stigma around mental health, limited access to age-sensitive services or the cumulative burden of multiple losses over time. Trauma in later life can manifest as anxiety, depression, sleep disturbances, increased somatic complaints or social withdrawal, often misattributed to aging rather than unrecognized psychological distress. Additionally, individuals with a history of trauma may experience heightened fear, mistrust or agitation in institutional settings, particularly if those environments echo past experiences of powerlessness. We have to understand that not only recognizing but also addressing trauma in older adults is essential to promoting dignity, emotional wellbeing and quality of life in the final stages of the lifespan.

There is even a concept known as intergenerational transmission of trauma, which refers to the ways in which the psychological and emotional consequences of trauma are passed from one generation to the next – even in the absence of direct exposure to the original traumatic event. This transmission can occur through multiple mechanisms, including disrupted attachment patterns, maladaptive coping strategies, family silences or narratives shaped by unresolved grief, fear or mistrust. Children of trauma survivors may unconsciously absorb the emotional residue of trauma through a caregiver's heightened vigilance, emotional unavailability, or unpredictable responses. This actually internalizes a worldview shaped by danger or instability. Neurobiological research has also shown that trauma can influence stress-response systems and even gene expression through epigenetic mechanisms (i.e., changes in gene activity that do not alter the DNA sequence but do change how genes are turned on or off) – suggesting that trauma can leave biological imprints that shape emotional regulation and vulnerability across generations. Whether in families affected by war, displacement, abuse or historical oppression, these intergenerational dynamics can perpetuate cycles of distress, unless consciously acknowledged.

Therefore, we see how trauma disrupts the individual's relationship not only with others but with themselves. It can sever the connection to one's own body, emotions and inner life. Survivors often describe feeling numb, detached or estranged from their own experiences. The psychological impact is therefore not limited to an emotional reaction to an event – it is a transformation in the way a person feels, thinks and exists in the world. This means that, if left unaddressed, the psychological and emotional effects of trauma can accumulate and manifest across multiple domains of life: from intimate relationships and professional functioning to physical health and overall quality of life.

This burden of trauma is not limited to those directly affected. Individuals who care for or work closely with trauma survivors may themselves experience vicarious trauma, also known as secondary trauma. This occurs when repeated exposure to others' traumatic stories leads to emotional exhaustion, intrusive thoughts or a shift in worldview. Over time, it may result in compassion fatigue, a state of deep physical and emotional depletion that undermines empathy and effectiveness in caregiving roles. Recognizing and addressing these forms of trauma is essential for sustaining trauma-informed systems of care. Subsequently, ensuring adequate supervision, peer support and organizational safeguards becomes a pivotal point to protecting the wellbeing of those who support others.

## 1.3 Trauma and mental health disparities among displaced populations

Displacement can arise due to armed conflict, political persecution, environmental catastrophe or economic collapse, and subsequently expose individuals (even whole communities) to multiple layers of trauma that interact with and amplify existing vulnerabilities. Displaced populations include refugees, asylum seekers, internally displaced persons and stateless individuals, so it is clear that these vulnerable groups can experience trauma before, during and after displacement. Some examples may include direct exposure to violence, the destruction of homes and communities, separation from family members, detention, loss of legal status or identity, as well as the profound grief associated with forced departure from one's homeland. The psychological toll of such experiences is immense, frequently leading to high rates of PTSD, depression, anxiety and somatic complaints. Yet the mental health needs of displaced populations remain vastly under-addressed, both globally and within host countries, contributing to significant disparities in psychological well-being and access to care.

The trauma experienced by displaced individuals is often cumulative and prolonged. Many endure ongoing exposure to adversity in refugee camps, detention centers, temporary shelters or unfamiliar urban environments. Conditions in these settings are frequently marked by overcrowding, food insecurity, unsafe or unsanitary living conditions, limited access to education and healthcare, and constant uncertainty about the future. The persistent nature of these stressors, combined with the legacy of pre-migration trauma, can compound psychological distress over time, leading to chronic mental health conditions and impaired functioning. For children and adolescents, disrupted schooling, instability and separation from caregivers can interfere with development, while older individuals may experience some form of disorientation, loss of cultural continuity and compounding retraumatization in institutional or unfamiliar settings.

Displaced populations also encounter numerous structural and socio-political barriers to mental health support. Legal status, language barriers, stigma, lack of culturally competent services, fear of deportation or retribution, and prior negative experiences with authorities often discourage individuals from seeking care or even disclosing psychological symptoms. Mental health systems in host countries may not be equipped to understand or respond to the specific needs of displaced people, especially when trauma is expressed somatically (through culturally specific idioms of distress) or intertwined with ongoing socioeconomic hardship. In some cases, displaced individuals are misdiagnosed or pathologized without attention to the sociocultural context of their suffering. The result is a profound disconnect between mental health service provision and the lived experiences of displaced persons, further entrenching disparities and mistrust.

The psychological suffering of displaced populations is not only individual but also collective. Forced migration often fragments communities and cultural systems that traditionally provide support, meaning and identity. Without this and with the erosion of social networks, individuals can develop feelings of disconnect. Such loss of collective coherence complicates healing and contributes to feelings of hopelessness and marginalization. Intergenerational trauma is also common in displaced communities, as children absorb the fear, grief and mistrust carried by their caregivers, even if they did not witness the traumatic events themselves. Without opportunities to process these experiences in safe and affirming environments, both individual and communal trauma may persist and be transmitted across generations. This is, in a way, a vicious cycle.

Among displaced populations exposed to armed conflict, the prevalence of mental health disorders is significantly higher than global averages, with major depressive disorder, generalized anxiety disorder and PTSD being the most common diagnoses. These findings were underscored in recent analyses that included over 15,000 refugees and internally displaced individuals across multiple geographic regions, demonstrating that exposure to intense armed conflict in one's country of origin, combined with migration to low- and middle-income host countries, was associated with increased psychiatric morbidity. However, the relationship between conflict intensity and mental health outcomes is not uniform across all disorders. For example, while higher levels of civilian deaths correlate with increased rates of depression, the same is not clearly observed for PTSD – which highlights the importance of considering the diversity and timing of trauma exposures (such as direct violence, sexual and gender-based violence, health-related threats and human rights violations). Basically, all of this can shape individual vulnerability in nuanced ways.

Moreover, the post-migration environment plays a critical role in shaping the mental health outcomes of displaced persons. Access to basic needs such as housing, healthcare, safety, employment and community support can act protectively and, in a way, mitigate the psychological impact of prior trauma. Conversely, when refugees and internally displaced persons are resettled in environments that are unstable, under-resourced or hostile, the risks for persistent or worsening psychiatric conditions increase. Importantly, the absence of an apparent relationship between some conflict indicators and PTSD should not be interpreted as a lack of effect, but rather as a reflection of complex interactions between pre-migration trauma and post-migration stressors. Such complexity underscores the importance of contextual and longitudinal approaches to understanding trauma among displaced populations.

From a public health perspective, there is a need for differentiated responses that take into account the distinct needs of various displaced groups – whether residing in humanitarian camps, conflict zones or high-income host countries. While most survivors of war and displacement demonstrate remarkable resilience and the capacity for long-term recovery, a substantial minority may develop persistent and debilitating symptoms requiring sustained care. The widely adopted multi-tiered model of mental health and psychosocial support offers a useful framework, beginning with ensuring safety and access to essential services, strengthening social supports, but also providing brief, culturally adapted interventions where appropriate. In high-income countries, it is essential to embed refugee mental health services within primary care and community settings, where displaced individuals are more likely to seek help. For internally displaced people who remain under threat, however, more research is needed to establish the safety and feasibility of interventions. Special attention must also be given to particularly vulnerable groups such as children, older adults, women and individuals with disabilities or pre-existing medical conditions, who may face heightened risks of trauma and also greater barriers to accessing support.

Recent research found that an overwhelming 94% of refugees with PTSD also met the diagnostic criteria for depression, suggesting a deeply intertwined pattern of emotional suffering that severely impacts cognitive function, energy levels, motivation, and even the capacity to make decisions. This complexity adds considerable strain on healthcare systems and challenges practitioners to differentiate between overlapping symptom clusters, especially in populations that may also present with somatic or culturally mediated expressions of distress. Additionally, other manifestations (such as dissociative symptoms, specific phobias and suicidal ideation) further complicate clinical

management and demand nuanced, trauma-aware interventions that extend beyond standard diagnostic frameworks.

Another critical aspect highlighted in the literature is the gender-specific presentation of trauma among displaced populations. While women consistently demonstrate higher rates of anxiety and depression, PTSD risk appears equally distributed between genders in conflict-affected refugee groups – contradicting earlier assumptions that women are universally more vulnerable to PTSD. This points to the context-dependent nature of trauma, especially in war zones where both men and women may be subjected to similarly harrowing events such as combat exposure, sexual violence and/or torture.

Moreover, sleep deprivation emerges as a particularly prevalent and impairing symptom, often aggravating the course of other mental health disorders. Sleep disruption not only reflects unresolved hyperarousal and intrusive symptoms, but also impedes daily functioning, further undermining the recovery and integration of refugees in host societies. This reveals the urgent need for integrative and culturally sensitive care models that account for the multilayered and overlapping mental health challenges faced by displaced populations.

With this population, the important concept to understand is resilience, which is the dynamic capacity of individuals and communities to adapt, recover and even grow in the face of adversity, trauma or chronic stress. In forcibly displaced populations, resilience plays a crucial role in shaping how individuals respond to cumulative trauma before, during and after displacement. Resilience is not a fixed trait, but a process that reflects the interaction between personal coping resources, family and community support, cultural frameworks and structural conditions. What is crucial to emphasize is how resilience is conceptualized and measured; it can be considered as an individual trait (such as optimism, coping skills and adaptability) and also as related to systemic factors (like social support, access to services and community resources). However, this distinction is crucial in understanding mental health disparities: while individual traits may provide a psychological buffer, systemic resilience is often shaped by structural drivers such as the level of inequities, policy environments, as well as host-country contexts. Actually, high-income countries report stronger associations between resilience and better mental health outcomes, pointing to the potential role of stable environments, supportive legal frameworks, but also integrated services in facilitating recovery.

Age also emerges as a moderating factor. The association between resilience and depression is stronger in children than adults, suggesting that resilience-building efforts may be very impactful when implemented early in life (although we have to be cognizant of the complex, culturally embedded nature of both resilience and mental health). Childhood is a formative period during which emotional regulation, coping skills and identity are still developing, making early interventions uniquely positioned to shape long-term psychological outcomes. If targeted effectively, resilience-promoting strategies in this stage of life can help buffer the lasting impact of trauma and prevent the entrenchment of maladaptive coping mechanisms. However, resilience is not a static or universally defined trait – it is deeply influenced by cultural expectations, past experiences and available social support. What constitutes resilience in one community may look quite different in another, and efforts to support it must be attentive to these variations. Thus, all

the interventions should not merely "increase resilience" in abstract terms, but instead attend to the real-world barriers that shape how resilience manifests across different displaced communities.

Consequently, it is essential to recognize that the mental health disparities among displaced populations are not simply the result of individual trauma but are shaped and perpetuated by systemic inequities, exclusionary policies and neglect. Addressing these disparities requires more than the delivery of clinical interventions – it demands culturally attuned, rights-based and trauma-aware responses that center around dignity, agency and justice. This includes ensuring equitable access to mental health services, training professionals in culturally responsive care, involving displaced persons in the design and implementation of support programs, and addressing the broader social determinants of mental health – primarily housing, employment, safety and legal protection. Only by understanding the layered realities of trauma within the context of displacement can we begin to close the gap in mental health outcomes and uphold the full humanity of those forced to flee.

## 1.4 The burden of trauma and intersection with global health

Trauma is increasingly recognized as a global public health issue, yet its full impact remains underappreciated in many global health frameworks. It does not respect borders, age, gender or socioeconomic status, and its effects ripple far beyond individual suffering, reaching into communities, health systems and entire societies. The burden of trauma is vast, multidimensional and enduring. It contributes significantly to the global prevalence of both mental and physical health disorders, often through mechanisms that remain poorly integrated into prevention and care strategies. Despite such ubiquity and severity, trauma is still largely framed as a personal or psychiatric problem, rather than as a structural and population-level issue intricately linked with global health priorities such as equity, sustainability and development.

At the physiological level, the long-term effects of trauma are profound. Exposure to traumatic events initiates a cascade of biological stress responses – primarily through dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis and prolonged activation of the sympathetic nervous system. Chronic stress of this kind leads to elevated levels of cortisol and other stress hormones, which over time contribute to inflammation, metabolic dysfunction, immune suppression and damage to neural circuits involved in emotional regulation and memory. This sustained biological disruption increases vulnerability to a host of non-communicable diseases (NCD) such as cardiovascular disease, diabetes, gastrointestinal disorders, chronic respiratory illnesses and autoimmune conditions. These are not coincidental associations but direct outcomes of the physiological wear-and-tear associated with trauma – a phenomenon often described as allostatic load. This link places trauma squarely within the realm of global NCD prevention, yet trauma-informed models are still notably absent from most NCD strategies and global health policies.

The psychological toll is equally staggering. Trauma is a major risk factor for common mental health conditions such as depression, anxiety, substance abuse disorders and PTSD. However, trauma-related symptoms frequently go unrecognized or untreated, particularly in low- and middle-income countries, humanitarian settings or among marginalized populations. The global burden of mental illness is enormous – according to the Global Burden of Disease study, mental and

substance use disorders are the leading cause of years lived with disability worldwide. Yet access to appropriate and culturally sensitive mental health care remains severely inadequate in most countries, often falling below 1% of national health budgets. In contexts where trauma is pervasive (whether due to armed conflict, systemic violence, displacement or environmental disasters), this treatment gap becomes a human rights issue as much as a medical one.

The World Mental Health (WMH) Surveys represent one of the most comprehensive international efforts to document the global burden of trauma and PTSD; however, their findings must be interpreted with caution. Due to methodological limitations (such as reliance on retrospective recall, cultural sensitivity, structured lay-administered interviews and some other factors), the true prevalence of trauma exposure and PTSD is likely underestimated. Events like childhood abuse or sexual violence may be systematically underreported, while tools like the Composite International Diagnostic Interview (CIDI) may fail to fully capture the complexity or persistence of trauma-related symptoms. Notably, the surveys use a conservative approach, counting even prolonged or repeated traumas (such as ongoing abuse) as a single event, further underestimating the lived burden. Still, even within this constrained framework, WMH data confirm that trauma is both widespread and unevenly distributed across populations, with high clustering among individuals exposed to early adversity, poverty and violence.

One of the key innovations of the WMH initiative has been its expansion into younger populations through the Youth Mental Health (YMH) Surveys. These are school-based versions of the WMH surveys, designed to capture the onset and early course of mental disorders, including those triggered by trauma, in adolescents. YMH surveys address a long-standing gap in global mental health data by focusing on the period when most mental disorders begin – often in the wake of trauma during childhood or adolescence. Importantly, the YMH data underscore how early exposure to interpersonal violence, accidents, or the death of a loved one often marks the start of a trajectory toward persistent distress and future vulnerability. These findings reinforce the need for upstream, developmentally sensitive interventions that begin in early life. Such approach is important not only to mitigate immediate psychological harm, but to reduce long-term mental health disparities at the population level.

Perhaps one of the most critical findings from WMH is the striking difference in PTSD risk across trauma types. Traumas involving interpersonal violence – especially sexual violence by known individuals – carry the highest conditional risk for PTSD. This contrasts with events like natural disasters or accidents, which, while distressing, are less likely to result in chronic trauma-related disorders. Moreover, PTSD is not randomly distributed; it tends to persist longer and occur more frequently among individuals with histories of prior trauma, underscoring the cumulative nature of psychological injury. These patterns are particularly alarming when coupled with the documented treatment gaps: even in high-income countries, only about half of those with PTSD seek help, and in low- and middle-income countries, that proportion is halved again. Where care is accessed, it often falls short of minimal standards. These findings point not only to an urgent need for increased outreach and early detection, but also to systemic quality improvements in trauma-related care. In essence, the WMH and YMH data tell a sobering yet actionable story – trauma is not only common, but predictable in its impact and deeply shaped by social and structural factors, making it a critical target for global mental health and policy reform.

Trauma intersects directly with virtually every global health challenge. Conflict, forced displacement, poverty, racial and ethnic discrimination, environmental degradation and pandemics all generate or exacerbate traumatic stress at individual and collective levels. In this way, trauma acts both as a consequence of global crises and as a hidden driver of long-term health disparities. It can erode social cohesion, increase the likelihood of interpersonal and community violence, disrupt education and employment, and hinder recovery in post-crisis societies. These outcomes are not only devastating to individuals – they destabilize public health systems and perpetuate cycles of disadvantage across generations. Structural violence and social inequality are trauma multipliers, placing already vulnerable populations at greater risk and compounding their exposure to both acute and chronic stressors.

The intersection of gender, trauma and global health remains critically underexplored, particularly in relation to non-accidental injuries such as assault, intimate partner violence and gender-based violence. Women experiencing gender-based violence often enter healthcare settings fearful, ashamed or hesitant to disclose their experiences. In many cases, their injuries are missed, dismissed or misunderstood by providers, particularly when systems are not equipped to identify the social and psychological dimensions of intentional trauma. Crucially, most hospital-based trauma registries and global data systems fail to capture the intentionality of injuries, erasing the distinction between accidents and acts of violence, and limiting efforts to provide appropriate, gender-sensitive care.

Importantly, trauma also influences how individuals and communities engage with healthcare. Unrecognized trauma can result in reduced healthcare-seeking behavior, mistrust of providers, poor adherence to treatment and higher rates of missed appointments or early withdrawal from care. In primary care settings, trauma frequently manifests as unexplained somatic symptoms or chronic illness without a clear medical cause. The resulting disconnect between the presentation of trauma and the models of care available to respond to it leads to misdiagnosis, inappropriate treatment and increased healthcare costs. Moreover, clinicians and frontline workers themselves are at risk of secondary traumatic stress and burnout when working with highly traumatized populations, especially when we take into account under-resourced environments. Without systemic acknowledgment and support, this invisible burden affects the entire healthcare ecosystem.

And the obvious disparity between need and care in low- and middle-income countries does not help – over 80% of the global population resides in such countries, but less than 20% of mental health resources are available. As a result, trauma-related disorders often go entirely unrecognized. Compounding this gap is the limited volume of research emerging from these regions, as most psychotraumatology studies are led by researchers affiliated with high-income countries, often producing findings that are difficult to generalize or implement in humanitarian contexts. In response to this imbalance, a growing body of work has begun to address trauma in lower-income countries through culturally embedded, context-sensitive research. This will help not only expand our understanding of trauma beyond Western psychiatric categories, but also prompt a rethinking of what constitutes valid and relevant trauma-informed care in global health.

Modern armed conflicts, regardless of geography, produce a wide spectrum of trauma that extends far beyond the battlefield. Civilians – now accounting for the vast majority of casualties in contemporary wars – often bear the deepest scars. Displacement, interrupted development, and

repeated exposure to trauma contribute to the high burden of PTSD, depression and anxiety that may persist long after physical safety has been restored. In today's digital world, this trauma is amplified by constant media exposure. Social media platforms deliver unfiltered, algorithmically driven streams of conflict-related content, exposing people (whether directly affected or not) to repeated images of destruction and suffering. This digital proximity to violence can trigger past trauma, resurface learned helplessness, and contribute to widespread psychological exhaustion – which then necessitates a view from the public health lens. This demanding a sustained, trauma-informed global response that moves beyond crisis intervention and toward long-term recovery and resilience.

Equally important is the emerging recognition that trauma affects not only populations caught in conflict or crisis, but also those working to support them. National humanitarian staff operating in different countries is often under-resourced, undertrained and directly exposed to the same traumatic events as those they serve. More specifically, reported rates of PTSD, depression and anxiety on par with or even exceeding general population figures. Yet these workers remain largely invisible in global health strategies. Beyond the dominant focus on PTSD, there is also a pressing need to examine other trauma-linked conditions such as substance use and suicide risk, which are under-researched despite their relevance. Importantly, a growing critique within global mental health highlights the risks of over-medicalizing social suffering. These insights push the field toward more pluralistic and contextually grounded interventions, better aligned with the lived realities of trauma in low- and middle-income countries, and the structural inequalities that perpetuate it.

Despite its relevance across health sectors, trauma remains insufficiently addressed in global health curricula, funding priorities and health system design. Many public health interventions still rely on short-term, reactive and disease-specific approaches that fail to account for the underlying role of trauma in shaping health behavior and outcomes. Trauma is not yet routinely screened for in most health systems, and where it is, services are often limited or poorly integrated. Such siloed nature of global health programming – where mental health is separate from infectious disease, maternal health, NCDs or climate change – further obscures the need for a unified response to trauma. Furthermore, such fragmentation undermines opportunities for cross-sectoral collaboration and prevents the development of comprehensive, trauma-informed public health systems.

In light of these realities, the integration of trauma into global health must be viewed as both a moral and strategic imperative. Trauma intersects with several Sustainable Development Goals (SDGs), particularly Goal 3 (Good Health and Well-being), Goal 5 (Gender Equality), Goal 10 (Reduced Inequalities), and Goal 16 (Peace, Justice and Strong Institutions). These goals cannot be met in isolation from the trauma that undermines people's health, agency and dignity. A trauma-informed global health approach must be rooted in principles of safety, trust, empowerment, collaboration and cultural humility. It must go beyond individual therapy and encompass community-level interventions, policy reform, and upstream prevention strategies that target the root causes of trauma.

Recognizing the burden of trauma and its intersection with global health is about changing the narrative: from viewing trauma as a niche concern to acknowledging it as a true force that shapes health systems, public policy and human potential. Trauma can be seen as a global epidemic that

quietly underpins many of the world's most persistent health challenges. Its invisibility in global health strategy does not lessen its impact – on the contrary, it amplifies the harm by leaving millions without the recognition or support they need. Moving forward, building trauma-informed systems is not just about healing individuals, but towards more equitable, resilient and compassionate societies. Only that way we can contribute to improved global health as well, when trauma is concerned.

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# Chapter 2: Principles and rights-based context of trauma-informed care

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## 2.1 Foundations of trauma-informed practices

Trauma-informed practice is both a philosophy and a practical framework that aims to identify, appreciate and respond to the extensive trauma impact. It moves beyond simply treating symptoms to addressing the underlying experiences that shape an individual's behavior, relationships and capacity to engage in learning or work. At its core, trauma-informed practice acknowledges that trauma is pervasive, that its effects can be profound and long-lasting, but also that the environments in which individuals live, learn and work can either promote healing or compound harm.

Accordingly, a trauma-informed methodology does not represent a single intervention or program, but a systemic shift in thinking, policies and day-to-day interactions. It calls for awareness of the prevalence of trauma, sensitivity to its signs, as well as the integration of this understanding into every level of organizational culture. This approach is grounded in the principle that individuals should not be retraumatized by the systems or services meant to support them. As already emphasized in the Chapter 1, rather than asking "*What is wrong with this person?*", trauma-informed practice reframes the question to "*What happened to this person?*", thereby focusing on the lived experiences and adaptive responses that may underlie behaviors.

The development of trauma-informed frameworks has been influenced by decades of research in psychology, neuroscience, social work, public health and education. This evidence base confirms that traumatic stress can significantly alter brain development, stress regulation systems and interpersonal functioning, and that these changes can persist across the lifespan. By acknowledging these impacts, trauma-informed practice provides a foundation for safer, more supportive environments that facilitate recovery and resilience.

While the application of trauma-informed care (TIC) may vary across sectors, most models are built on several core, interrelated principles:

- Safety – physical, psychological and emotional safety form the starting point of trauma-informed environments. This means creating spaces where individuals feel secure, respected and free from threat or harm. Safety also involves clear communication of expectations, boundaries and procedures.
- Trustworthiness and transparency – consistency, clarity and honesty are critical for building trust, especially for individuals whose trauma histories may involve betrayal or abuse of power. Transparency in decision-making and predictable follow-through on commitments reinforce a sense of stability.
- Peer support and mutual self-help – connections with others who have lived experience of trauma can be a powerful source of healing. Peer support emphasizes shared understanding, empathy and the validation of individual experiences.

- Collaboration and mutuality – trauma-informed practice seeks to level power imbalances between service providers, educators and learners, recognizing that healing is more effective when individuals are active partners rather than passive recipients.
- Empowerment, choice and voice – there is a support and ample information for people when deciding about their care, learning or participation. Their strengths and capabilities are emphasized, aiming towards self-efficacy and also restoring a sense of agency.
- Cultural, historical and gender sensitivity – trauma is experienced within a broader socio-cultural and historical context. Recognizing and respecting diversity, addressing historical trauma and avoiding cultural bias are essential pieces towards inclusivity and effectiveness.

An important framework underpinning trauma-informed practice is captured in the "4 Rs": comprehending the extensive impact of trauma, identifying its symptoms/signs, reacting through both policy and practice, and opposing retraumatisation. These principles apply across all levels of engagement, i.e. from the actions of individual practitioners to the creation and delivery of services, and also to systems-level decision-making. In this sense, trauma-informed work is not confined to clinical care but extends to leadership, training, research and policy development. While terminology may vary (appearing alongside words such as "*care*", "*approaches*" or "*services*"), the essence remains the same: to support environments and systems that recognize the prevalence of trauma, act with awareness, and also circumvent further harm, regardless of whether the individuals served are described as patients, clients or service users.

However, it has to be emphasized that the effects of trauma can also extend to those working in helping professions. Nurses, psychologists, educators and other frontline professionals are vulnerable to secondary traumatic stress and burnout, particularly when they encounter verbal abuse, violence or workplace harassment. This can be even further aggravating for when we talk about informal educators, and such occupational hazards are compounded for staff members with their own histories of trauma. Thus, consequences for organizations can be profound, manifesting as high turnover, diminished morale and an erosion of trust within teams.

Despite its growing prominence, trauma-informed care remains a complex, multifaceted framework without a universally agreed-upon operational definition. Recent scoping reviews that included many empirical papers revealed considerable variation in how trauma-informed care is specified, adapted, but also executed across a myriad of settings and populations. This lack of standardization poses challenges for evaluating its impact and scaling it effectively. Nevertheless, common threads run through successful implementations: a commitment to safety, trust, collaboration, empowerment and cultural responsiveness.

Internationally, the implementation of trauma-informed care has been most thoroughly analyzed and evaluated in the United States, Australia, New Zealand and Canada, with evidence emerging from sectors as diverse as mental health, social services, education and justice. While these efforts differ in scope and methodology, they collectively highlight how trauma-informed practice does not represent a discrete intervention, but rather a transformative shift in organizational culture. Achieving this shift requires leadership buy-in, ongoing staff training, policy alignment, as well as mechanisms for measuring both process and outcome indicators.

To add to that, adopting trauma-informed practices is an ongoing process rather than a one-time training. It requires continuous reflection, capacity-building and feedback from those served. Organizations and educators must be willing to examine their own practices, language and policies, as well as the structural inequities that may perpetuate harm. Importantly, trauma-informed work also involves attending to the wellbeing of those who deliver support or education, recognizing the risks of vicarious trauma and burnout.

Instructional and facilitation strategies must definitely be grounded in flexibility and responsiveness to the diverse ways in which people process information and engage with others. This might mean offering multiple formats for participation, such as verbal discussion, written reflection or creative expression, so that individuals can choose the approach that feels safest and most effective for them. It also requires anticipating the potential for certain topics, images, or teaching methods to evoke distress. While challenging material should not necessarily be avoided, it should be introduced with adequate preparation, context, as well as the option to opt out. In a way, consent becomes a cornerstone here – ensuring that learners are not unexpectedly confronted with triggering content and have agency in how they engage with sensitive subjects.

Relationship-building is another central pillar, as trust, consistency and respectful communication form the emotional architecture of trauma-informed environments. Instructors, facilitators and leaders must be mindful that for some participants, authority figures may be associated with past harm or betrayal. Consistency in behavior, reliability in following through on commitments, and transparency in decision-making are therefore pivotal for creating an atmosphere in which participants can take risks, voice opinions, and also explore new ideas without fear of judgment or retaliation. This is not only about interpersonal warmth, but also about establishing professional boundaries that make relationships feel predictable and very safe.

Equally important are the policies and procedures that govern how incidents of harm, conflict, or crisis are addressed. A trauma-informed approach requires that such responses protect the dignity of everyone involved and avoid judgement. This might involve replacing punitive measures with restorative approaches and ensuring privacy when handling sensitive matters. The aim is not to shield individuals from all difficulty (as conflict and challenge are an inherent part of learning and working together), but to navigate these situations in ways that reduce the risk of retraumatization and model respectful problem-solving.

Underlying all of these elements is the assumption of universal precautions in trauma-informed care: the assumption that any participant, learner, or potentially a colleague may have experienced trauma, even if they have never disclosed it or are aware of that. By holding this assumption, educators, facilitators and leaders are more prone to adopting practices that are consistently respectful, encouraging and non-intrusive, rather than reserving such approaches only for those with known trauma histories. This orientation shifts the focus from identifying "trauma survivors" to creating conditions in which all participants feel valued, respected and supported. It fosters a culture where safety and inclusion are not reactive measures for specific individuals, but integral features of the entire environment – benefiting everyone, regardless of their personal history.

To translate trauma-informed care concepts effectively into real-world environments, the conditions within which learning is applied are as important as the content of the training itself. A supportive work or learning climate, opportunities to practice, adequate time, and access to

resources are all of the utmost importance in sustaining the use of its principles. Also, embedding trauma-informed care into the fabric of organizational philosophy (through faculty or staff role modelling and interprofessional collaboration with consistent reinforcement) helps to ensure that it is not treated as a discrete or optional skill, but as a universal approach applicable to all participants, clients or patients. Early exposure during training, combined with sustained practice and institutional support, increases the likelihood that it will become a natural part of everyday interactions rather than an additional task. This continuity not only strengthens individual capacity but also builds the collective culture necessary for lasting trauma-informed practice.

Ultimately, the foundation of trauma-informed practice is relational. It rests on the belief that healing and learning are most effective in environments characterized by safety, trust, empathy and empowerment. By embedding these principles into all interactions, educators and service providers can create conditions that not only avoid harm but also actively contribute to resilience, recovery and growth.

## 2.2 Cultural sensitivity and inclusivity in trauma-informed care

Cultural sensitivity in trauma-informed care requires recognizing that traumatic experiences are inseparable from their sociocultural context. In an era of rapid global mobility, shifting demographics and heightened political/cultural divisions (all the way to conflicts and wars), many individuals – and especially those from minorities or marginalized communities – can face disproportionate exposure to adversity. Experiences such as racism, forced migration, unsafe living environments and systemic discrimination (just to name a few) can compound the effects of personal trauma, influencing how distress is expressed and how care is received.

The landmark Adverse Childhood Experience (ACE) study, which is among the most influential bodies of research linking early-life adversity to long-term health outcomes, and the research that followed it vividly demonstrate how social determinants such as poverty, discrimination and historical injustice can intensify trauma's impact, underscoring the need for a care model that integrates both insight and cultural awareness. But there is also the other side of the coin: this approach acknowledges that cultural identity may not only shape risk, but also serve as a source of resilience, strong community support and healing traditions.

Cultural sensitivity and inclusivity are not optional add-ons to trauma-informed care – they are actually integral to its effectiveness. Factors such as nationality, ethnic background, gender identity, language, sexual orientation, religious views, migration history and socioeconomic status all shape not only the types of trauma individuals may experience, but also how those experiences are interpreted, disclosed and subsequently addressed. It is essential to emphasize that a trauma-informed approach that neglects these dimensions risks misunderstanding or even invalidating the lived experiences of those it seeks to support.

Understanding culture in trauma-informed care requires moving beyond a superficial awareness of traditions or customs to an active engagement with the social, political and historical contexts in which trauma occurs. Historical and intergenerational traumas (such as those arising from colonization, systemic racism, displacement or conflict/war) can have lasting impacts on

communities, influencing health outcomes, trust in institutions, and also willingness to engage with services. These forms of trauma are often compounded by ongoing discrimination or structural inequities, making it pivotal for practitioners to recognize how systemic forces contribute to current distress. Cultural sensitivity, therefore, involves not only awareness, but also a strong pledge to equity, justice and the dismantling of barriers that limit access to safe, supportive care.

An inclusive trauma-informed practice also requires attentiveness to language. Communication should be clear, respectful and adapted to the linguistic preferences and literacy levels of those served. For individuals who speak a different first language, the availability of trained interpreters is vital –to ensure accurate understanding and to convey respect for the person's identity and heritage. Similarly, the metaphors, examples and case scenarios used in educational or therapeutic settings should reflect the diversity of the population, enabling participants to see themselves and their experiences represented. Inclusivity also means acknowledging and validating diverse expressions of distress; for example, recognizing that some cultures may emphasize physical symptoms over emotional ones, or that trauma narratives may be conveyed indirectly through stories, art or communal rituals. For instance, in some communities distress may be expressed primarily through headaches, stomach pain or fatigue rather than verbalizing sadness; in others, people may communicate trauma through metaphorical stories instead of direct disclosure, or rely on artistic forms (song or dance).

Power dynamics are another crucial consideration. In cross-cultural contexts, there can be an inadvertent perpetuation of hierarchical or colonial patterns of interaction, especially if one's own worldview is assumed as universal. Trauma-informed care requires a posture of cultural humility – basically acknowledging that no practitioner can be fully competent in all cultural traditions. So each interaction should be approached with openness, curiosity and a willingness to learn from the person's own expertise in their life and community. This humility should be embedded in individual interactions and also in organizational policies and community partnerships.

Inclusivity in trauma-informed care is also about ensuring that systems of care are accessible and welcoming to people of all identities and backgrounds. This involves addressing both overt and subtle forms of discrimination, ensuring that facilities are physically accessible, and adopting policies that protect against bias built on race, gender identity, disability or other characteristics. The presence of diverse staff at all levels of an organization can enhance trust and relatability, while structured opportunities for community members to provide input into service design can ensure that interventions remain relevant and respectful.

In a way, delivering trauma-informed care in culturally diverse settings calls for more than "cultural competence" in the traditional sense. Given the impossibility of mastering all cultural frameworks, cultural humility offers a more sustainable foundation that is rooted in openness, self-reflection and a recognition of power dynamics in the inter-relationship. Rather than making assumptions about beliefs, practices or needs, those involved in care should seek to learn directly from those affected and their families and/or cultural liaisons, integrating these insights into care approach plans. This might mean reframing symptoms through culturally relevant narratives, incorporating community rituals into recovery, or adequately adapting any potential therapeutic modality (such as group intervention). By striving for trust, choice and emotional safety in ways that respect

cultural identity, formal or informal educators can strengthen engagement, reduce retraumatization, and also support recovery in ways that feel authentic and empowering to the individual.

From the literature related to trauma-informed practice for refugees and culturally and linguistically diverse populations, the following six core principles are essential to adopt: ensuring safety, nurturing trust through transparency, facilitating support of peers, working collaboratively with empathy, allowing individuals to make choices, and also understanding the influence of historical, cultural and gender aspects on how trauma is experienced and expressed. While the latter is indispensable, it is often overlooked in policy and practice.

When working with refugee students, effective trauma-informed approaches involve:

- Recognizing trauma-related behaviors (such as withdrawal, selective mutism, self-harm, defiance, classroom interruption, disengagement from learning) as potential responses to past experiences;
- Building trusting relationships through supportive dialogue and tangible assistance (e.g., providing food, clothing or financial help for school activities);
- Addressing challenges related to family separation, insecure visa status and diverse learning, social and emotional needs;
- Equipping both formal and informal educators with appropriate training, resources and culturally responsive policies to create inclusive, psychologically safe learning environments for refugee students.

Ethiopian researchers Zeleke and co-authors have proposed a guiding framework that merges cultural orientation with effectiveness to guarantee trauma-informed care interventions remain both relevant and sustainable in diverse settings. This model unfolds through four interconnected steps: first, establish strong community ties by putting an accent on trust through attentive listening, thoughtful sharing of personal experiences and demonstrating respect in interactions; second, maintain open communication with stakeholders by utilizing established networks and collaborating with respected local leaders to encourage inclusivity and community buy-in; third, weave interventions into prevailing customs and traditions, embedding supportive practices within familiar cultural contexts to enhance engagement and relevance; and fourth, evaluating progress and effectiveness through participatory feedback and iterative adaptation to meet evolving community needs.

The aforementioned approach emphasizes that trust-building is the foundation for successful implementation, as it creates a safe and relatable therapeutic environment that empowers individuals to share their experiences. By weaving evidence-based trauma-informed practices into the socio-cultural fabric of the community, this framework addresses a key limitation of many existing trauma informed care models (most notably their insufficient contextual responsiveness) and offers a pathway toward sustainable healing and resilience for displaced/marginalized populations.

Likewise, customs and culture significantly influence how suffering is expressed, how loss is processed, and what forms of healing are considered meaningful or acceptable; therefore, respecting and integrating these traditions into practice strengthens trust, relevance and

participation. Equally important is the establishment of relationships built on mutual trust and respect. Practitioners, informal educators and organizations must intentionally engage in shared learning, acknowledge the value of cultural wellness and wisdom, and remain open to challenging their own beliefs and assumptions. This requires creating safe spaces for open dialogue and building feedback mechanisms that allow for continuous program improvement.

Culturally responsive practice also demands a deep understanding of the communities served – not only their current context but also their sociocultural and sociopolitical histories, the intersections of oppression they have experienced, and the ways these have shaped trauma and resilience. This understanding should be central to all interventions and should involve consistent collaboration with community members at all levels (i.e., from youth to organizational leadership).

Historical, collective and intergenerational traumas require special attention. Survivors often possess significant resilience, wisdom, and lived experience that can inform and strengthen interventions. Recognizing and addressing the common threads of prejudgment, oppression and discrimination (and how they actually form a nexus with people's lives) is indispensable to promoting equity and healing. The realities of survivors and their children must remain at the heart of all work. This means valuing the diversity present within communities, including culturally specific groups, individuals with disabilities, migrants, and survivors who identify as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI). This group includes people whose sexual orientation, gender identity or sex characteristics differ from dominant societal norms, and who may therefore face heightened stigma, marginalization, and unique forms of trauma. Recognizing their specific experiences ensures that each person's values, histories and expertise are centered and respected.

It has to be noted that culturally responsive trauma-informed care extends beyond individual interventions to active engagement in social change. Organizations can partner with communities to address discrimination, injustice and intolerance, drawing on the collective wisdom and also individuals under their guidance. This includes involving participants directly in shaping and updating programs, developing new initiatives, and building strong networks with other agencies and systems to advance equity and justice.

Consequently, key considerations should include:

- Recognizing and respecting cultural traditions and natural support networks in healing;
- Building trust through shared learning, openness and inclusive feedback mechanisms;
- Grounding interventions in a deep understanding of community history, context and oppression;
- Valuing survivor resilience and incorporating their lived wisdom into practice;
- Keeping survivor realities and diversity central to all work;
- Partnering with communities and organizations to challenge injustice and drive social change;
- Ensuring transparency and shared decision-making at every stage, so that survivors and communities have clear information, real choices, and meaningful influence over the processes that affect them.

## 2.3 Understanding learners' rights in non-formal education

Non-formal education (also referred to as informal education or informal learning) encompasses a wide variety of learning environments outside the formal schooling system: this includes community workshops, vocational courses, adult literacy programs, cultural exchange initiatives and online learning platforms, but also sport trainings, arts and music classes, environmental projects, youth leadership camps and skill-based clubs, just to name some examples. These settings are typically characterized by flexible curricula, participatory methods and a focus on practical or experiential learning. Unlike formal education, they are often driven by immediate community needs, personal interests or professional development goals, enabling learners to engage in education that is directly relevant to their lives and aspirations, but also to their interests.

While the fundamental principles of learners' rights apply across all educational contexts, the ways these rights are interpreted and implemented differ significantly between formal and non-formal education. Formal education is typically governed by national laws, state curricula, standardized assessments and credentialing systems. This structure provides clear guarantees, most notably compulsory access, state-funded provision and regulated teacher qualifications. It can also impose rigid timetables and assessment models.

In contrast, non-formal education offers greater flexibility in content, pace and methodology. This flexibility often enhances learners' autonomy and ability to shape their own learning paths, but it can also mean that rights protections depend more on the commitment of individual providers than on national regulation. The absence of formal accreditation in some non-formal settings may also limit the portability of skills or qualifications, raising questions about learners' right to recognition of their achievements.

Still, we have to have in mind that, although we can define informal learning in contrast to formal education, this framing can obscure their significance and depth. Historically, most learning has been non-formal or informal, predating the structured systems of schools and universities that now dominate educational discourse. The tendency to describe these learning modes by what they are not – rather than by their intrinsic qualities – reflects an artificial conceptual division, shaped more by institutional and intentional criteria than by the nature of the learning process itself. While formal education has gained visibility and authority through its dedicated spaces and qualification systems, the validation of non-formal and informal learning seeks to rebalance this hierarchy, making visible the skills, knowledge and competencies acquired outside formal institutions. However, validation processes themselves often remain invisible, especially in formal education, where covert forms of recognition (whether implicit, embedded or informal) are commonplace, but rarely acknowledged. Understanding these hidden forms of validation is essential for addressing issues of equity, recognition and social justice, and for developing more inclusive approaches that acknowledge the full spectrum of human learning.

And while we can argue that informal education is less regulated than formal education, informal learning settings still operate within legal, ethical and pedagogical frameworks that safeguard learners' rights. These rights are rooted in international conventions such as the International Covenant on Economic, Social and Cultural Rights, the Universal Declaration of Human Rights, as well as the UNESCO Recommendation on Adult Learning and Education – all of which affirm

the right to education as something that is fundamental. In the context of non-formal educational settings, the challenge is to interpret these rights in flexible, context-sensitive ways that respect diversity and accessibility, while at the same time ensuring that learning remains safe, equitable and meaningful.

At the heart of learners' rights in non-formal education is the right to participation. Unlike in formal schooling, where participation may be compulsory, non-formal settings rely on voluntary engagement, making the learner's voice central to the process. Respecting this right means providing opportunities for learners to contribute to decisions about course content, learning methods, scheduling and evaluation. Mechanisms such as feedback forms and co-creation of learning materials empower learners to influence their educational experience, promoting a sense of ownership and motivation.

Another key dimension is the right to non-discrimination and inclusion. Many non-formal programs often serve diverse populations – including marginalized groups, migrants, people with disabilities, and those who have been excluded from formal education. It is therefore essential to ensure equal access to participation regardless of gender, ethnicity, language, age, religion or socio-economic status. Inclusion also extends to creating physically and digitally accessible learning spaces, adapting teaching materials to different literacy levels, adapting to different mobility levels, as well as providing interpretation or translation when needed.

Learners in non-formal contexts also have the right to safety and dignity. Although habitually less formal, informal programs must still uphold standards that protect participants from harassment, exploitation or unsafe conditions. This includes clear codes of conduct, procedures for reporting concerns, and respect for personal boundaries. In online non-formal education, this right extends to safeguarding digital privacy and ensuring that personal data is collected and used in an ethical manner.

The right to quality education applies equally to non-formal settings as it does to formal schooling. Quality can be understood in a broader manner, meaning that programs are purposeful, learner-centered, delivered by facilitators with appropriate training. This right also encompasses transparent assessment criteria, opportunities for skills recognition and (where relevant and where applicable) pathways to formal certification or employment opportunities.

Closely related is the right to relevant and context-sensitive learning. Non-formal educational opportunities should respond to the realities of learners' lives, whether by building practical skills for the workplace, building civic engagement, promoting cultural heritage or supporting personal development. This means curricula should be adaptable and open to integrating local knowledge systems alongside more conventional educational content.

There is a need to respect the right to privacy and autonomy in any learning journey. Participation in non-formal education should not expose individuals to unwanted scrutiny, nor should it pressure them into disclosing personal histories or information irrelevant to the learning objectives. Protecting this right strengthens trust between learners and facilitators, particularly in communities where education may intersect with sensitive issues such as migration status, past experiences of exclusion, beliefs, political standpoints, etc.

Sport trainings, different projects related to the environment, arts and music classes, all of them play a distinct role in broadening the scope of non-formal education. Sport trainings not only develop physical abilities and promote health, but also teach discipline, teamwork and resilience – qualities transferable to many aspects of life. Arts and music classes develop creativity, cultural expression and emotional literacy, often providing a plethora of benefits alongside skill acquisition. Environmental projects connect learners to sustainability practices, instilling a sense of stewardship and civic responsibility. Youth leadership camps can cultivate communication skills and critical thinking, whereas skill-based clubs (ranging from coding and robotics to cooking or carpentry, just to name few examples) enable participants to explore personal interests while gaining competencies that can enhance employability or enrich community life. So it is safe to say that these initiatives contribute to the holistic development of individuals, extending the concept of education beyond academic achievement to encompass personal growth and active, socially engaged citizenship.

The work of Manuel Souto-Otero differentiates four types of validation: (a) covert/implicit, (b) covert/embedded, (c) overt/functional and (d) overt/institutional. These categories provide a nuanced framework for understanding how learning (both non-formal and informal) is recognized and valued.

- Covert and implicit validation refers to situations where learning from non-formal or informal settings influences formal educational outcomes without being explicitly acknowledged as such. This might occur, for example, when a student's prior experiences enhance their classroom performance, yet these competencies are neither recorded nor formally credited.
- Covert but embedded validation goes a step further, because recognizing non-formal and informal learning is built into formal education processes, but remains largely invisible. For instance, group projects, extracurricular activities or practical skills acquired outside school may be implicitly factored into assessment and progression, without formal certification or transparent acknowledgment.
- Overt and functional validation is when recognition is explicit and serves a practical function, such as enabling a learner to skip certain modules or access higher-level courses based on prior learning. However, it may not lead to a full formal qualification. This type of validation plays a bridging role, connecting informal learning experiences with tangible academic or professional benefits.
- Overt and institutional validation represents the most formalized recognition, where non-formal or informal learning is explicitly assessed, documented and certified by a specific institution. Examples include formal accreditation of prior work experience, portfolio assessments, but also equivalency examinations leading to recognized qualifications.

When comparing formal and non-formal/informal learning, these validation types reveal important dynamics. Formal education tends to dominate public perceptions of "legitimate" learning because it is inherently structured, curriculum-driven and qualification-oriented. Non-formal and informal learning, though often equally rich in skill development, has historically lacked systematic mechanisms for visibility and recognition. This imbalance reinforces social hierarchies of knowledge, where institutional certification carries more weight than lived experience or community-based expertise.

We increasingly see different structured frameworks that aim to bridge the gap between formal and informal learning by creating a portable, flexible, collaborative and creative learning environment. Such models usually leverage mobile application tools in three key categories: (1) collaboration tools that enable joint content creation and problem-solving; (2) coordination tools that help organize tasks, schedules and learning resources; and (3) communication tools that facilitate real-time interaction and knowledge exchange. By integrating these tools seamlessly, different frameworks basically support the blending of formal academic instruction with the dynamic, self-directed and socially connected nature of informal learning, allowing students to move fluidly between classroom settings and everyday learning opportunities. This may be also used (and is indeed increasingly used) in trauma-informed care practices.

In any case, learners' rights form a framework that shifts non-formal education from being simply "informal teaching" to becoming a respectful and empowering learning process. Understanding and applying these principles definitely benefits learners and can also strengthen the credibility and impact of non-formal education programs, and also improve the approach of trauma-informed care practices.

## 2.4 Educator responsibilities and policy considerations in the informal learning context

Educators working in non-formal education settings hold a unique position of influence and trust. Their role extends beyond the delivery of content; it encompasses the creation of learning settings that are not only inclusive and respectful, but also responsive to the diverse needs of learners. In this context, responsibilities involve creating an atmosphere that upholds the dignity, safety and rights of all participants, while aligning with the broader policy frameworks that govern educational practice. Non-formal learning often operates with more flexibility than formal systems, but this flexibility does not reduce the educator's duty of care. On the contrary – it often necessitates a deeper awareness of individual circumstances and potential vulnerabilities.

Policy considerations in non-formal education are equally vital. While such environments may not always be bound by the same statutory regulations as formal schools, they are still influenced by institutional guidelines, funding requirements, community expectations, and in some instances national or international educational frameworks. Educators need, therefore, to be familiar with these guiding policies to ensure that their practice is consistent, transparent and accountable. This includes understanding policies on child safeguarding, inclusion, accessibility, equity and quality assurance, and embedding these principles into their quotidian work.

A key responsibility of educators is to integrate policy principles into practical actions. For example, if an institutional policy emphasizes inclusivity, the educator should take steps to adapt teaching (together with materials) and assessment methods for learners with different abilities/backgrounds or language proficiencies. This might mean the use of assistive technologies, where applicable, or designing flexible schedules that accommodate learners who balance education with work or caregiving responsibilities. Such actions bridge the gap between abstract policy statements and tangible improvements in the learning experience.

Educators must also maintain professional boundaries and act in ways that protect learners from harm, discrimination and exploitation. In non-formal settings, where roles are often more fluid and interactions can be less structured, this requires special vigilance. Here, establishing clear codes of conduct, promoting respectful communication and modelling ethical behavior are essential. Policy guidance can assist in defining acceptable practice, but the responsibility to enact and uphold these standards rests with the educator.

Another dimension of responsibility is ongoing professional development. Non-formal education frequently engages learners whose needs and expectations evolve quickly, driven by changes in technology and societal priorities. Educators should remain informed about emerging teaching methods, inclusive pedagogies and sector-specific policy updates. This may involve attending workshops or engaging in peer learning. Also, often there is a need to contribute to professional networks that share best practices in community-based education if the end-goal is to improve responsiveness and responsibility in your approach.

Policy considerations also extend to the evaluation and documentation of learning. Many funding bodies and community stakeholders require evidence of impact, even in non-formal contexts. Hence, educators must design assessment approaches that respect the learner's context while meeting accountability requirements. This might involve using portfolios or (for example) competency-based assessments rather than standardized tests, ensuring that the evaluation process itself aligns with principles of fairness and transparency.

It is important to emphasize that educators working within trauma-informed frameworks must navigate a dual responsibility: enabling supportive and safe learning environments, while also aligning their practice with institutional policies and broader educational priorities. This involves a proactive engagement with policy developments at local, regional and national levels to ensure that classroom strategies are consistent with current guidelines and/or frameworks for trauma-responsive education. Awareness of these policies allows educators to advocate effectively for resources, training and structural adjustments that address the needs of students affected by trauma. Furthermore, policy literacy empowers educators to recognize gaps between written directives and actual practice, enabling them to contribute meaningfully to policy refinement through feedback or collaborative initiatives with administrators and policymakers. This may also include piloting approaches.

In parallel, educators carry an ethical responsibility to translate these policies into daily actions that prioritize student wellbeing and inclusivity. This requires adherence to official protocols but also the ability to adapt them to diverse classroom realities. This also pertains to settings where resources or administrative support may be limited. By maintaining open communication channels, educators can ensure that policies are not just bureaucratic requirements, but actually living frameworks that actively inform teaching methods and engagement with their students. This reflective, collaborative approach strengthens the bridge between policy intent and educational practice, making sure that trauma-informed care principles are embedded in the lived experiences.

Drawing from the UNESCO-TTF document, policy considerations for educators extend beyond compliance to active participation in shaping the systems that govern their work. Any educator should not be just a passive recipient of policy; rather, acting as a stakeholder whose experiences can inform (and improve) policy relevance. This means engaging with consultative processes and

often helping to define professional development priorities that reflect the realities of learners, especially those affected by trauma. Such involvement ensures that policies are not only theoretically sound, but also operationally feasible, supporting both teacher efficacy and student outcomes.

Additionally, educators must be aware that policy development is an iterative process. Those who remain informed about shifts in educational contexts (with emerging research on trauma) and socio-political conditions are better positioned to adapt their methods in real time while advocating for adjustments that close gaps between policy ideals and on-the-ground realities. This advocacy may involve forming professional networks, collaborating with unions, or also working with civil society organizations to highlight resource needs and equity concerns. In doing so, educators can help ensure that policy frameworks remain inclusive and closely aligned with the lived experiences of the learning community.

Furthermore, non-formal education programming in crisis- and conflict-affected contexts must be designed holistically to address not only academic learning but also the broader health, and psychosocial needs of those who are receiving education in settings that suggest unique concerns for those in conflict settings. For learners whose lives have been disrupted by instability, such informal learning can serve as a vital entry point for interventions that want to develop resilience. Curricula and teaching materials should therefore be intentionally crafted to build many different holistic competencies, with language, gender and disability inclusivity. It should also respond to the diverse needs of the learner population. This may include content on health (such as sexual/reproductive health rights, menstrual hygiene questions and disease prevention), alongside security topics like disaster preparedness and landmine awareness, as well as socio-emotional learning aimed at strengthening coping skills and community engagement.

Beyond the curriculum, non-formal education programs can play a pivotal role in providing wrap-around services that address learners' psychosocial and emotional wellbeing, which is intrinsically linked to their readiness to learn. Program designers must recognize and respond to the elevated risks these people face, including exposure to violence, abuse, early or forced marriage, teenage pregnancy, and also potential child labor. In such contexts, integrating targeted psychosocial training, counselling opportunities and structured recreational activities can help build social-emotional skills to recover from trauma and foster a sense of belonging. By combining academic objectives with mental health and protection services, informal learning can transform into a comprehensive mechanism for safeguarding learners' rights and promoting their overall wellbeing in some of the world's most challenging environments.

Communities and families are central to ensuring that non-formal education programs are both accessible and of high quality. Their engagement goes beyond passive endorsement, as their active participation can shape the legitimacy and sustainability of such initiatives. This involvement can take many forms, such as raising awareness about the program's importance, contributing to the design of goals and activities, advising on the location and timing of classes, and supporting the identification and rehabilitation of safe and accessible learning spaces. It is very important to note that community input helps ensure that the distinctive needs of marginalized groups (which includes those with disabilities) are recognized and addressed in programming decisions.

Community and family participation also strengthens the link between education providers and learners' everyday environments. Through grassroots advocacy, local leaders and families can encourage learner enrolment and regular engagement. They serve as important liaisons between informal educators and households, building trust and ensuring that communication flows both ways. Only with a collaborative approach a shared sense of ownership can be built, making it more likely that programs will be sustained and adapted over time to meet the evolving community needs.

It has to be emphasized that educators in non-formal education should view policy not as a constraint, but actually as a framework that can guide innovation and protect learner rights. By understanding and applying relevant policies thoughtfully, they can create spaces where traumatized learners feel valued and supported, where diversity is celebrated, and where educational experiences are empowering. In this way, educator responsibilities and policy considerations are inseparable – each reinforcing the other in the pursuit of high-quality, socially responsive learning.

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# Chapter 3: Brief history of informal education

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## 3.1 Who are the informal educators?

The first text to utilize the term was in 1946 Josephine Macalister Brew (1904–1957) in her book Informal Education. In 1974, Coombs and Ahmed provided a much-cited definition of informal learning as: "*The lifelong process by which every person acquires and accumulates knowledge, skills, attitudes and insights from daily experiences and exposure to the environment … Generally it is unorganized and often unsystematic; yet it accounts for the great bulk of any person's total lifetime learning-including that of even a highly 'schooled' person.*"

The Council of Europe offers this definition: "*Informal learning takes place outside schools and colleges and arises from the learner's involvement in activities that are not undertaken with a learning purpose in mind. Informal learning is involuntary and an inescapable part of daily life; for that reason, it is sometimes called experiential learning. Learning that is formal or non-formal is partly intentional and partly incidental: when we consciously pursue any learning target we cannot help learning things that are not part of that target. Informal learning, however, is exclusively incidental.*"

In Europe, a related concept called social pedagogy shares many of the same ideas and history as informal education, although the terms are not exactly the same. One salient issue remains, and that is that we can count at least ninety different informal educators' jobs:

1. Sports Coaches: Teach and guide athletes in various sports, focusing on skill development, teamwork, and sportsmanship.
2. Pilates Instructors: Instruct individuals or groups in Pilates, a form of exercise that emphasizes core strength, flexibility, and body awareness.
3. Swimming Instructors: Provide swimming lessons to individuals or groups, teaching water safety, swimming techniques, and potentially lifesaving skills.
4. Boy/Girl Scout Leaders: Guide and mentor youth in scouting programs, facilitating activities that promote personal and outdoor skills, leadership, and community service.
5. Martial Arts Instructors: Teach martial arts disciplines, emphasizing physical fitness, self-discipline, and respect.
6. Music Teachers/Tutors: Instruct individuals in playing musical instruments or singing, fostering an appreciation for music and skill development.
7. Dance Instructors: Teach various dance forms, helping individuals improve their dance techniques, coordination, and rhythm.
8. Art and Craft Instructors: Lead classes or workshops in art and crafts, encouraging creativity and artistic expression.
9. Outdoor Educators: Educate individuals about nature, wildlife, and outdoor activities, fostering environmental awareness and outdoor skills.
10. Language Tutors: Assist individuals in learning a new language, providing language instruction through informal methods.

11. Technology and Coding Mentors: Guide individuals, particularly children and teens, in learning about technology, programming, and coding.
12. Yoga Instructors: Lead yoga classes, promoting physical and mental well-being through yoga postures, breathing exercises, and meditation.
13. Fitness Trainers: Provide personalized fitness training, helping individuals achieve their health and fitness goals.
14. Cooking Instructors: Teach cooking skills and techniques, promoting healthy eating habits and culinary creativity.
15. Life Coaches: Support individuals in personal development, goal-setting, and overcoming challenges in various aspects of life.
16. Environmental Educators: Educate individuals about environmental issues, sustainability, and conservation practices.
17. Parenting Coaches: Provide guidance and support to parents in raising children, addressing various aspects of parenting.
18. Community Health Educators: Educate communities on health-related topics, preventive care, and healthy lifestyle choices.
19. Financial Literacy Instructors: Teach individuals about budgeting, saving, investing, and other aspects of financial literacy.
20. Storytellers/Storytelling Coaches: Share stories and teach the art of storytelling, promoting literacy and communication skills.
21. Science Outreach Educators: Engage the public, especially children, in hands-on science experiments and demonstrations to foster an interest in science.
22. Astronomy Outreach Coordinators: Organize events and activities to promote interest and education in astronomy, often involving telescope observations and stargazing.
23. Photography Instructors: Teach photography techniques, composition, and editing skills to enthusiasts or beginners.
24. Gardening Instructors: Provide guidance on gardening practices, plant care, and sustainable gardening methods.
25. Pet Trainers: Instruct pet owners on training and behavior management for their pets, including dogs, cats, and other animals.
26. Meditation and Mindfulness Coaches: Guide individuals in practicing meditation and mindfulness for stress reduction and mental well-being.
27. DIY (Do It Yourself) Instructors: Conduct workshops or online tutorials on various DIY projects, from home improvement to crafting.
28. Sustainability Educators: Educate communities on sustainable living practices, environmental conservation, and reducing ecological footprints.
29. Hiking Guides: Lead hiking expeditions, sharing knowledge about local flora, fauna, and natural landscapes.
30. Heritage Preservation Educators: Work towards preserving cultural heritage by educating communities on the importance of historical sites and traditions.
31. Culinary Arts Instructors: Teach cooking techniques, culinary arts, and gastronomy, often in informal settings like workshops or community classes.
32. Public Speaking Coaches: Assist individuals in developing effective public speaking and communication skills.

33. Motivational Speakers: Inspire and motivate individuals through speeches and presentations, often focusing on personal development and empowerment.
34. Peer Mentors: Guide and support peers in various aspects, such as academic pursuits, career development, or personal challenges.
35. Travel Guides: Provide cultural and historical insights to travelers, enhancing their understanding of the places they visit.
36. Coding Boot camp Instructors: Lead intensive coding programs to teach coding skills quickly and effectively.
37. Entrepreneurship Coaches: Support aspiring entrepreneurs in developing business ideas, strategies, and skills for success.
38. STEM (Science, Technology, Engineering, and Mathematics) Outreach Volunteers: Engage with schools and communities to promote STEM education through interactive activities and demonstrations.
39. Language Exchange Partners: Facilitate language learning through informal language exchanges, where individuals help each other practice different languages.
40. Chess and various games Instructors: Teach the rules, strategies, and tactics of chess to individuals or groups.
41. Social Workers: Support vulnerable individuals and families with social and emotional challenges.
42. Volunteers in Non-Profit Organizations: Assist people in need through community-based service.
43. Intercultural Mediators: Bridge cultural differences and support integration across diverse communities.
44. Personnel of Emergency Intervention Agencies: Provide immediate help and education during crises or disasters.
45. Personnel of Police and Law Enforcement Agencies: Engage in community safety education and awareness.
46. Personnel of Foster Homes: Care for children in foster systems and support their social development.
47. Personnel of Youth Clubs: Organize youth activities that foster inclusion and learning.
48. Personnel of Summer Camps: Lead activities that combine fun, education, and social development.
49. Parish Priests: Provide pastoral care, education, and community guidance.
50. Parish Volunteers: Assist in community programs run through parishes.
51. Grassroots Community Organizers: Mobilize communities to address social issues and promote civic engagement.
52. Personnel of Psychology Courses: Support training activities and education in psychology.
53. Field Trip Personnel: Supervise and educate groups during educational outings.
54. Ski Instructors: Teach skiing techniques and ensure safety on slopes.
55. Science Informal Educators in Globe Programs: Promote science learning through international Globe Program activities.
56. Coaches of Forest Therapy: Use guided forest experiences to promote well-being.
57. Kindergarten Assistance Personnel: Support early childhood education in preschool settings.
58. Babysitters: Provide child care and support children's basic needs and safety.

59. School Bus Drivers: Ensure safe transport while often serving as trusted adult figures for children.
60. Amateur Theater Directors: Lead community theater projects that encourage creativity and expression.
61. Museum Docents: Guide visitors through museum exhibits, sharing insights and sparking interest in history, science, or art.
62. Zoo and Aquarium Educators: Teach the public about animals, conservation, and ecosystems through tours and interactive sessions.
63. Park Rangers: Educate visitors about natural resources, wildlife, and conservation practices in national or state parks.
64. Drama Teacher: Use theatrical techniques to support emotional expression, often involving participatory learning.
65. Digital Literacy Trainers: Help individuals understand how to use computers, internet tools, and digital safety practices.
66. Board Game Facilitators: Teach game rules and strategies while promoting social interaction and cognitive skills.
67. Craft Beer or Wine Educators: Lead tastings or workshops on the craft of brewing or winemaking, often emphasizing local culture and chemistry.
68. Urban Garden Coordinators: Educate communities about food production, nutrition, and sustainability in urban settings.
69. Makerspace Facilitators: Guide people in using tools and technologies like 3D printers, robotics kits, or sewing machines.
70. Riding Instructors: Use horseback riding to promote physical, emotional, and cognitive development.
71. Cultural Ambassadors: Share cultural practices, stories, or language to foster intercultural understanding and inclusion.
72. Conflict Resolution Mediators: Help groups or individuals navigate conflict, often educating about communication and empathy.
73. Music Teachers: Support clients in self-expression through music and rhythm-based interaction.
74. Peer Educators in Schools: Train and support students to educate their peers on topics like, relationships, or safety.
75. Tinkering Studio Facilitators: Encourage open-ended exploration with tools and materials in informal science centers or workshops.
76. Parent-and-Tot Program Leaders: Guide group learning experiences for caregivers and toddlers, emphasizing early development.
77. Community Radio Hosts: Educate and engage the public on local issues, arts, or news through informal broadcasting.
78. Anti-Bullying Workshop Leaders: Facilitate interactive sessions that promote empathy and safe school climates.
79. Clowns or Hospital Entertainers: Educate and emotionally support children in hospitals using humor and creativity.
80. Refugee Resettlement Mentors: Help newcomers adjust by teaching them cultural practices, language basics, and everyday life skills.

81. Neighborhood Watch Coordinators: Educate communities on safety, collaboration, and local awareness.
82. Sustainability Workshop Facilitators: Lead DIY or lifestyle sessions on composting, upcycling, zero-waste practices, etc.
83. Job Readiness Trainers: Help job seekers prepare for employment through resume writing, interview practice, and skill-building.
84. Civic Education Workshop Leaders: Teach about democratic participation, voting rights, and civic responsibility
85. Festival or Fair Workshop Hosts: Engage the public through informal learning booths or live demonstrations.
86. Podcast Hosts (educational): Share knowledge in an engaging audio format on topics from science to life skills.
87. Family Resource Center Staff: Provide learning and development opportunities for families in informal, supportive settings.
88. Online Content Creators (YouTube, TikTok educators): Teach practical, academic, or life skills informally via short videos and digital media.
89. Babysitters: Care for children in informal, family-centered settings.
90. Kids Birthday Party Directors: Organize and lead themed activities for children's parties, blending fun with learning.

Informal education and social pedagogy have long histories in Europe, both deeply rooted in the philosophical, social and political transformations that shaped the continent. While distinct in terminology and practice, social pedagogy and informal education share a commitment to human development, holistic learning, as well as the idea that education can and should occur outside traditional classroom settings. Therefore, it is important to explore the historical development of these educational traditions in Europe, tracing their origins, theoretical foundations, institutional growth, and their current forms and challenges.

## 3.2 The rise of social pedagogy and informal education in Europe

The roots of both social pedagogy and informal education can be traced to classical antiquity, particularly the ancient Greek concept of paideia, which emphasized the formation of the whole person – intellectually, morally and socially. This approach was mirrored in Roman education, which also valued character formation through civic life and public discourse.

During the Enlightenment in the 18$^{th}$ century, European thinkers began to challenge traditional authoritarian views of education. Philosophers like Jean-Jacques Rousseau and Johann Heinrich Pestalozzi played foundational roles in shaping pedagogical thought that would later influence both social pedagogy and informal education. Rousseau, in Émile (1762), argued that education should be child-centered and aligned with natural development. Pestalozzi, working with poor children in Switzerland, emphasized love, care, and the development of the "head, heart and hands" – a motto that continues to influence social pedagogical practice today.

The term social pedagogy became more formally developed in Germany during the 19th century. It was popularized by Karl Mager, who in 1844 defined it as a form of education that addressed

not only individuals but also society as a whole. The industrial revolution had created new social conditions, especially urban poverty, prompting educators and reformers to address the social needs of children and youth outside the family and school systems.

Prominent figures like Paul Natorp and Hermann Nohl expanded on this concept. Natorp emphasized the importance of education as a tool for social integration and democratic life, while Nohl connected social pedagogy with ethical relationships and the development of community life. These thinkers saw education not just as the transmission of knowledge, but as a means to foster belonging, participation, and moral development within society.

In Denmark, N. F. S. Grundtvig developed a parallel vision through the folk high school movement in the mid-19th century. He argued that education should empower adults, particularly rural populations, to engage as active citizens. The folk high schools provided residential, dialogical, and non-exam-based education that laid important groundwork for informal and lifelong learning traditions in Scandinavia.

In the United Kingdom, the tradition of informal education grew out of 19th-century social reform movements. The rapid urbanization of the Industrial Revolution brought challenges like child labor, lack of schooling and youth delinquency. In response, reformers created settlement houses, youth clubs and other community-based programs aimed at addressing social inequality through education.

One key figure was Josephine Macalister Brew, whose 1946 book 'Informal Education' marked a significant moment in the development of the term itself. Brew viewed informal education as relational, democratic and occurring through conversation and shared activities rather than formal instruction. Her work emphasized the importance of trust and personal engagement in educational relationships – principles that continue to shape youth work and community education.

Informal education in the UK became closely associated with the development of community centers and voluntary organizations. Influenced by both Christian social reformers and secular progressives, this tradition focused on meeting young people "*where they are*", providing mentorship and prompting moral and civic development through everyday experiences and dialogue.

Although social pedagogy and informal education evolved in different cultural and institutional contexts, their core values often overlap. Both traditions emphasize:

- The holistic development of the person;
- The importance of relationship-based learning;
- The significance of social context in shaping educational experiences;
- The view that education is lifelong and not limited to schools.

However, there are also key differences. Social pedagogy has typically been more integrated into state welfare systems, especially in countries like Germany, Denmark and the Netherlands. Social pedagogues often work in formal roles within child welfare and youth justice. In contrast, informal education in the UK has remained more loosely structured and often linked to the voluntary or nonprofit sector.

This division reflects broader differences in welfare models: the continental European model tends to professionalize social care and education as part of a unified public system, while the Anglo-American model leans more on civil society and voluntary action.

After World War II, social pedagogy gained institutional recognition across much of Europe. Training colleges and university programs were developed to professionalize the field, particularly in Germany, where the profession of Sozialpädagoge was formalized in the 1960s and 70s. Similarly, in Denmark, social pedagogy became a core part of the education and care of children in residential and family-based settings.

During the same period in the UK, informal education became increasingly associated with youth work and community development, especially during the 1960s and 1970s. However, funding and political support fluctuated, and by the eighties and nineties, the rise of neoliberal policies led to cuts in public funding for non-formal education programs.

Many informal education initiatives were forced to adopt more measurable, outcome-based approaches, undermining their dialogical and relationship-driven nature. Scholars like Tony Jeffs and Mark K. Smith have criticized this shift, arguing that it risks turning informal educators into instruments of social control rather than enablers of personal and collective growth.

In recent decades, there has been renewed interest in both informal education and social pedagogy, especially in response to the limitations of traditional schooling and standardized testing. The growing awareness of social-emotional learning, trauma-informed care and youth participation has led educators and policymakers to re-examine these older traditions.

There has also been a growing exchange of ideas across Europe. For instance, the UK has begun to explore the integration of social pedagogy into its child welfare and youth care systems, influenced by German and Danish models. Pilot programs have experimented with training UK youth workers and care professionals in social pedagogical methods, focusing on relational practice and reflection, preserving dialogue and community engagement.

Meanwhile, the European Union has promoted lifelong learning and non-formal education as part of its educational policy frameworks, recognizing the need to support learning in community, workplace and civic settings. Programs like Erasmus+ have supported cross-national cooperation in informal and social pedagogical education.

## 3.3 Informal education in the United States

Informal education in the United States has roots in the democratic ideals of participatory citizenship and lifelong learning. From community centers and libraries to adult education programs and online learning platforms, informal education has evolved as a means of bridging gaps in access, equity and personal growth. The progressive education movement in the early 20$^{th}$ century, championed by thinkers like John Dewey, laid the groundwork by promoting experiential learning and social interaction as vital components of education.

John Dewey has stated: *"In what we have termed informal education, subject matter is carried directly in the matrix of social intercourse. It is what the persons with whom an individual associates do and say*."

Informal education was the term used to identify the work undertaken by settlement houses, youth organizations as the YMCA, YWCA, the boys' and girls' clubs, neighborhood centers, and adult education programs like the ones created by Neva Boyd at the Hull House Settlement in Chicago, where shaped around the philosophy of John Dewy. Two important writers were heavily influenced by Dewey: Eduard Lindeman who taught at George Williams College between 1918 and 1919, and Ruth Kotinsky who worked for the National YMCA in the 1920s and 1930s.

In the post-World War II period, the need for adult education and vocational training surged, particularly to meet the demands of a rapidly changing economy. During this time, informal education gained prominence as a critical vehicle for adult learning, especially among populations who were underserved by formal education systems. This shift set the stage for the emergence of Malcolm Knowles's andragogical theory, which offered a structured understanding of adult informal learning.

Malcolm Shepherd Knowles (1913–1997) was a pivotal figure in the development of adult education in the United States. While he began his career in formal education, his most influential work lies in the realm of non-formal and informal learning, most notably among adults. He popularized the concept of andragogy (i.e., the art and science of helping adults learn), which stood in contrast to pedagogy, the traditional model of instruction used with children.

Knowles proposed six assumptions about adult learners that distinguished them from children:

- Need to know: Adults need to understand the relevance of what they are learning;
- Self-concept: Adults see themselves as self-directed individuals;
- Experience: Adults bring a wealth of personal and professional experience to the learning process;
- Readiness to learn: Adults are ready to learn things they feel they need to know;
- Orientation to learning: Adults are problem-centered rather than content-centered;
- Motivation: Internal factors primarily motivate adults to learn.

These principles align closely with informal educational settings, where learners often seek knowledge to meet specific goals, solve immediate problems – or just to fulfill personal interests. Knowles's model emphasized facilitation over instruction, learner autonomy, but also the importance of context, making it especially applicable to experiential and workplace learning.

To fully appreciate Knowles's contributions, it is essential to consider the intellectual and psychological influences that shaped his thinking. One of the most profound influences was Carl Rogers (1902–1987), a leading figure in humanistic psychology. Rogers is best known for developing client-centered therapy and person- or student-centered education.

Rogers advocated for a person-centered approach to education, which emphasized empathy, respect and authenticity in the teacher-learner relationship. In his seminal book 'Freedom to Learn', he argued that meaningful learning occurs when:

- Learners feel accepted and understood;
- The learning is relevant to their personal interests and goals;
- The environment is non-threatening and supportive;
- The teacher acts as a facilitator of learning rather than an authority figure.

This philosophy directly influenced Knowles, who adopted many of Rogers's concepts into his framework for adult education. Knowles explicitly acknowledged Rogers's role in shaping his understanding of the facilitator role, learner autonomy, as well as the importance of empathy and trust in learning relationships.

## 3.4 The synthesis of andragogy and humanistic psychology

The intersection of andragogy and humanistic psychology laid the foundation for a powerful educational model that has informed both formal and informal education in the United States. Knowles's emphasis on self-directed learning, mutual respect, and the real-life application of knowledge echoes Rogers's ideals.

One key area of convergence is the role of the educator. For both Knowles and Rogers, the educator is not a dispenser of information but a guide or facilitator who helps learners explore, reflect, and construct their own understanding. This aligns well with the non-hierarchical, dialogic approach found in many informal education settings—whether it's a community workshop, a peer support group, or a learning circle.

Another point of synthesis is the respect for the learner's experience. In informal education, participants' life experiences are not only acknowledged but integrated into the learning process. This principle is central to both Rogers's therapeutic model and Knowles's andragogy, which view experience as a critical resource for reflection, learning, and growth.

Today, the legacy of Knowles and Rogers can be seen in various informal education initiatives across the United States. These include:

- Adult literacy programs that use learner-centered curricula;
- Workplace learning initiatives that emphasize coaching and mentoring;
- Community development projects that engage citizens in participatory learning;
- Online learning platforms offering self-paced, interest-driven content.

One notable example is the 'Popular Education' movement inspired by Paulo Freire and adapted in U.S. communities, which often incorporates andragogical principles. Facilitators create spaces where learners identify problems in their communities and collaboratively generate solutions, embodying the problem-centered, experience-driven learning that Knowles advocated.

Additionally, informal learning in digital environments, such as through MOOCs (Massive Open Online Courses), podcasts, YouTube tutorials and online forums, reflects Knowles's vision of self-directed, interest-based adult learning.

It is safe to say that informal education in Europe and in the United States have long and interconnected histories, rooted in democratic, relational and humanistic traditions. From the folk high schools of Scandinavia to the youth clubs of Britain and the integrated welfare systems of Germany, to the work in the US of John Dewey, the George Williams College (Chicago), the settlement houses, youth organizations like the YMCA, YWCA, the boys' and girls' clubs, neighborhood centers, and adult education programs. the work of Malcolm Knowles, whose theory of andragogy has provided a robust framework for understanding adult learning in non-formal and informal contexts. The profound influence of Carl Rogers's humanistic psychology on Knowles's thinking highlights the importance of empathy, learner autonomy, and experiential learning in educational settings. With their contributions Rogers and Knowles have helped shape a more inclusive and learner-centered vision of education.

These approaches have basically offered alternative visions of education: ones that see learning as embedded in everyday life, relationships and social justice. As societies grapple with new challenges in the 21st century, these traditions are offering us vital insights and tools for developing aligned, meaningful, lifelong and socially embedded learning.

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# Chapter 4: Non-formal education as a platform

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## 4.1 The role of educators and volunteers in non-formal settings

Non-formal education (NFE) provides an alternative learning space outside traditional classroom settings. Educators and volunteers play crucial roles in designing and implementing flexible, learner-centered programs that address the needs of diverse groups, including marginalized communities, out-of-school youth, and lifelong learners.

Based on the desk study conducted by Sladjana Petkovic (2018), which explores the value of informal education with particular attention to its role in citizenship education, civic participation, intercultural learning and peacebuilding, a number of core insights emerge. Her research, commissioned by the EU-Council of Europe youth partnership, emphasizes the transformative and inclusive nature of informal learning processes. From this comprehensive study, we can distill ten key learning points that highlight both the potential and the challenges of informal education in supporting lifelong learning, social cohesion and youth empowerment.

- Everyday Learning: informal learning happens naturally in daily life, which is self-directed, contextual, often unintentional;
- Value-Based Approach: informal education emphasizes dialogue, dignity, justice and active citizenship;
- 21st Century Skills: it fosters critical thinking, problem-solving, creativity and resilience;
- Civic Impact: promotes intercultural dialogue, democratic values and peacebuilding;
- Recognition Gaps: informal learning is hard to validate but crucial for lifelong learning pathways;
- Learning Mobility: exchanges and volunteering boost intercultural skills and inclusion;
- Access Inequalities: disadvantaged groups need targeted support to benefit equally;
- Digital Divide: technology expands access but also creates new barriers;
- Transformative Potential: flexibility is key, as over-formalization can reduce impact;
- Integrated Learning Ecosystem: informal and formal learning should work together.

### *4.1.1 The role of educators*

Educators in non-formal settings are responsible for the creation of engaging, participatory, and skill-based learning experiences. Unlike traditional teachers, non-formal educators (NFE) not only act as guiding learners but also facilitators of self-directed and experiential learning. They also design the content (curricula) of the course that is adapted to the needs of specific communities, while emphasizing real-world application. Educators provide emotional and psychological support, helping learners overcome challenges. They are also using creative and interactive teaching methods, such as storytelling, role-playing, project-based learning, which makes them innovators.

In addition to these foundational tasks, educators in NFE settings often take on a multifaceted leadership role. They are typically embedded in local communities and have firsthand insight into the social, cultural and economic barriers that learners face. This proximity enables them to respond rapidly to emerging needs, such as helping displaced learners adapt to new environments or addressing gaps left by interrupted formal schooling.

Educators in these environments must also be versatile communicators. They frequently work with learners who speak different languages, have varying levels of literacy or come from conflict-affected or trauma-impacted backgrounds. As a result, they often develop multilingual resources, incorporate visual and tactile tools, and rely on storytelling or performance as universal forms of knowledge exchange. In this way, educators help reframe the act of learning from a top-down transfer of knowledge to a shared experience rooted in mutual trust.

Another often overlooked role of educators is that of mediator and advocate. They may liaise with families, local authorities, or NGOs to secure resources for learners, advocate for access to formal education pathways, or even raise awareness about the importance of continuing education in settings where it is undervalued or underfunded. In this sense, NFE educators serve as teachers and also as community leaders and system navigators for real-world outcomes.

### *4.1.2 The role of volunteers*

Volunteers complement educators by bringing unique expertise, cultural perspectives, and community engagement. Their contributions include bridging gaps, since they connect learners with resources, opportunities and networks that enhance their educational experiences. They provide additional teaching support, language instruction, and vocational training. Finally, volunteers help foster social cohesion, making education more inclusive and accessible, that is to say, community engagement.

What distinguishes volunteers in non-formal education is their ability to meet learners where they are: physically, emotionally and culturally. They often operate in informal community hubs such as libraries, refugee camps, places of worship or urban shelters, which are places where formal educators may not always reach. Their presence brings a level of accessibility and relatability that can reduce anxiety or resistance among learners who have had negative experiences with institutional education.

Many volunteers bring lived experience that directly mirrors that of the learners they support. A former refugee helping new arrivals navigate digital learning platforms, or a retired nurse teaching health literacy to underserved women, often holds a unique credibility and empathy that formal qualifications cannot replace. This contributes to building peer trust and accelerates the process of engagement and participation.

Ultimately, volunteers expand the ecosystem of learning by offering forms of support, connection and understanding that formal systems alone cannot provide.

*4.1.3 Case studies*

- Organizations like Kiron Open Higher Education provide online courses and blended learning opportunities for refugees, allowing them to continue their education despite displacement (Kiron, 2023). This definitely goes toward reducing barriers to access and offering both academic progress and social integration for learners in precarious situations.
- Local initiatives such as "*Bildungswerk Berlin der Heinrich-Böll-Stiftung*" offer non-formal learning programs in environmental education, social justice and democracy-building in different Berlin neighborhoods (Heinrich-Böll-Stiftung, 2022). This is a way to connect local issues with global challenges, demonstrating in turn how grassroots initiatives can strengthen individual competences and collective democratic culture.

## 4.2 Opportunities for impactful learning in informal settings

Informal education occurs in everyday interactions, outside structured curricula, and presents numerous opportunities for impactful learning. Informal settings are viewed as sources of opportunities because of their unofficial existence. Therefore, making a learning sphere informal tends to facilitate assimilation and eases one's participation. The distance between learners and teachers is lessened in those spaces and facilitates dialogue and willingness of participants to exchange. Opportunities and informal settings intertwined are creating a virtuous circle of facilitating the realization of one another.

Beyond reducing structural barriers, informal settings open up unique pathways for learning that is responsive, and can be closely tied to personal relevance. Unlike formal classrooms, these environments are inherently dynamic and adapt to the evolving interests and real-world challenges faced by individuals. This makes them especially impactful for learners from marginalized or disengaged backgrounds. The freedom to learn at one's own pace and explore topics organically is a big advantage, and they can engage in social and experiential learning for improving retention and motivation.

Moreover, informal settings are fertile ground for the development of social and emotional competencies (which are indeed often overlooked in standardized education). Through collaboration, storytelling, cultural engagement and community participation, learners cultivate empathy, intercultural understanding, as well as a deeper sense of agency. These environments provide safe and inclusive spaces where mistakes are seen as part of the process. In addition, diversity of thought is encouraged, promoting in turn democratic participation and lifelong learning mindsets.

Informal learning is also deeply intergenerational and intersectoral; it frequently bridges the gap between youth and older individuals, between the arts and sciences, or between local tradition and digital innovation. From listening to a grandparent's migration story to engaging in a coding workshop led by a peer mentor, these interactions enable and develop collective memory. And such learning experiences do not require prior credentials or institutional access, resulting in much broader participation and more equitable learning ecosystems.

We should also look at informal settings as incubators of innovation and creativity. Learners are encouraged to experiment and ask questions. Informal learning environments can empower individuals to become co-creators of new ideas and solutions.

### *4.2.1 Learning in community-based environments*

Libraries and museums are institutions providing experiential learning through interactive exhibits, storytelling sessions, and workshops. Spaces such as youth and cultural centers encourage leadership development, peer learning and intercultural dialogue. Workshops and skill-based trainings in informal settings are also allowing individuals to develop soft skills, technical expertise, and problem-solving abilities through hands-on activities.

These settings can be used to host workshops, open forums, music and theatre performances, as well as intercultural festivals that allow individuals (especially youth) to engage with new ideas and communities. It can lead to self-expression, identity exploration and solidarity, particularly in multiethnic or post-conflict settings. That way participants are not passive recipients of knowledge, but actually active contributors to dialogue and learning.

It is important to emphasize that community-based learning also extends to skill-building and vocational development. Informal training sessions in everything from digital literacy to urban gardening provide relevant, hands-on experiences that can improve employability but also spark lifelong learning. These are especially critical for those who face economic barriers to formal education.

The relational and participatory nature of community spaces makes them ideal for developing civic competences. Through volunteering, project-based learning or participatory budgeting initiatives, learners develop leadership skills and a tangible sense of their ability to influence their communities – which can indeed be seen as an essential component of democratic engagement and social inclusion.

### *4.2.2 Learning through culture*

Libraries and museums are indeed places of informal learning, but we should explore cultural spaces as informal education settings. Unlike formal instruction, cultural experiences often operate through storytelling, performance and symbolism, which can be observed as modes of communication that resonate deeply with diverse audiences.

Theatre and performance art, for example, offer immersive opportunities to explore social/historical issues and human relationships. Participatory theatre, forum theatre and community drama initiatives invite learners to inhabit multiple perspectives and challenge different assumptions in safe, creative settings. Such forms of embodied learning promote empathy and critical thinking, which are core to democratic participation and intercultural competence.

Cultural festivals, concerts and street art exhibitions provide accessible entry points into collective learning experiences. That opens the door to celebrate diversity and community identity. These

informal spaces also promote intercultural dialogue simply through the act of exchanging and co-experiencing. Whether it is via food, dance, music or storytelling, these events often stimulate reflection on inclusion and co-existence.

Film screenings and art installations can also serve as powerful tools for civic education. This is especially pertinent when paired with post-event discussions or calls to action. These mediums can engage the senses and stimulate emotional responses, deepening in turn retention and personal relevance. And this is especially valid for topics like social justice or environmental awareness.

Moreover, culture-based informal education has strong intergenerational potential. Storytelling initiatives involving older individuals and folklore circles connect younger and older generations, offering not only cultural knowledge, but also values and lived experience that might otherwise be lost.

### *4.2.3 Digital and online learning*

Dedicated websites to learning are expanding like Coursera and Khan Academy provide free and accessible knowledge, they are called e-learning platforms. Lots of EU-funded projects also develop such platforms through many shapes, often through the Moodle platform, or by developing their own online-free accessible platform.

Contrary to popular belief, social media are not only mere distractions, but also spaces for informal education and discussions, such as YouTube, Reddit, LinkedIn contributing to continuous learning. TikTok also provides educational content in the shape of videos or pictures. Learning through educational games and simulations fosters deeper engagement and retention.

Digital and online environments offer learners a level of accessibility and flexibility unmatched by traditional education systems. They provide opportunities for individuals to learn at their own pace, revisit content as needed, and engage with materials that are directly relevant to their personal/professional development. They also move across geographical and financial barriers, so the reach of knowledge to remote areas can be expanded. And this is also pertinent for disadvantaged groups who cannot easily participate in formal systems.

Such platforms also encourage peer-to-peer interaction and community-driven knowledge exchange. Online forums (and even comment sections) on platforms like Reddit or LinkedIn enable learners to pose questions and co-create content by sharing expertise. Such participatory dynamics make digital learning inherently dialogic, aligning closely with the principles of informal education where knowledge is built collaboratively rather than transmitted unilaterally.

At the same time, the rise of micro-learning formats (short videos, podcasts, infographics, interactive quizzes) makes education more approachable and adaptable to modern lifestyles. A three-minute TikTok lesson or a YouTube tutorial can provide targeted knowledge in a way that resonates with diverse audiences. This is especially pertinent for younger learners who engage best through visual and interactive content.

Nevertheless, digital learning also highlights critical inequalities. Limited internet access (frequently coupled with lack of digital devices) and low levels of digital literacy can create barriers that mirror broader socioeconomic divides. We also observe high dropout rates in online courses, which demonstrated the need for supportive ecosystems. The latter pertains to mentorship, blended models or motivational strategies to sustain learner engagement. Digital learning should fulfill its inclusive potential rather than reinforce existing gaps.

#### *4.2.4 Case Studies*

- Makerspaces: Community-based learning hubs allow individuals to engage in different projects, increasing creativity and collaboration, as exemplified by FabLab Berlin, where participants of all ages experiment with 3D printing, robotics and design thinking in an open and collaborative environment. These spaces democratize access to technology and lead towards peer-to-peer learning by encouraging users to share expertise and co-create solutions.

- Oral history through local storytelling projects help preserve cultural heritage while educating younger generations. For example, the Goethe-Institut supports initiatives where older individuals share personal narratives with young people, creating intergenerational dialogue and strengthening community identity. Such projects blend cultural preservation with informal education in order for heritage to remain alive and relevant.

- Germany's adult education centers provide courses in languages, digital skills and civic engagement, offering accessible lifelong learning opportunities through the public school Volkshochschulen (VHS). It combines affordability with community orientation, so VHS exemplifies how adult education can support personal development, but also employability.

## 4.3 Challenges in Non-Formal Educational Environments

Despite its benefits, NFE faces several barriers that impact its effectiveness and sustainability. Importantly, it lacks formal certification because many non-formal experiences are not officially recognized, making it difficult for learners to transition into formal education or even employment. It also is complex to measure learning outcomes in informal settings due to the lack of standardized tests. Standardized issues related to testing are related to the lack of consensus between governments towards clear frameworks for integrating NFE into national education systems.

But the recognition and measurements are unfortunately not the only problems faced. NFE programs rely on grants and donations which may be limited or insufficient, and also face infrastructure issues: learning spaces in rural or underprivileged areas often lack necessary materials and technology. Because of a lack of means, NGOs, community groups and governmental organizations often work in silos, leading to duplication of efforts.

Another challenge is ensuring inclusivity and equitable access. While NFE is designed to reach marginalized groups, structural inequalities still limit participation. This includes poverty, disability, language barriers or gender norms. Without targeted outreach and support, there is a risk that those

who might benefit the most from NFE remain excluded. Hence, bridging this gap requires deliberate policies and resources aimed at lowering access barriers and promoting participation for all learners.

In addition, the professionalization of educators and volunteers in NFE remains uneven. Many facilitators lack adequate training or continuous professional development opportunities. Consequently, this leads to variations in quality and consistency. This can undermine the credibility of NFE initiatives and make it more difficult to gain recognition from formal institutions or policymakers. So investment in capacity-building and developing peer networks is crucial to strengthen the effectiveness of non-formal learning.

The digital divide also presents a growing obstacle, as already mentioned, and there is the issue of long-term sustainability. Many NFE programs are project-based and dependent on short-term funding cycles. This means they are vulnerable to abrupt interruptions once financial support ends. This instability affects program continuity and impacts learners who may not be able to complete their learning pathways.

### *4.3.1 Case studies*

Education for street children: Programs in Latin America face difficulties in maintaining long-term engagement due to socioeconomic barriers. In accordance with UNICEF findings, many children face unstable housing and poverty, which limits their ability to attend programs consistently. Furthermore, the lack of coordination between education initiatives and broader social support services reduces their effectiveness. Despite these challenges, such programs play a vital role in providing literacy and life skills, but also psychosocial support to some of the most vulnerable children.

Women's empowerment initiatives: Non-formal education programs for women often struggle with cultural resistance and resource limitations, especially in low- and middle-income countries. World Bank states how investments are desired, as they can create a ripple effect which can then extend to improved educational outcomes for their children and greater social cohesion.

Integration of migrants through education in Germany: The "*Integration Course*s" offered by the German Federal Office for Migration and Refugees provide non-formal language and cultural orientation programs to help immigrants and refugees integrate into society. While they have been widely praised for facilitating smoother integration into the labor market and community life, they also face challenges due to uneven access across regions and varying levels of prior education among participants. Still, they remain a cornerstone of Germany's integration strategy, exemplifying how structured non-formal education can address urgent societal needs in a rather systematic way.

### *4.3.2 Solutions and recommendations*

To counter the lack of recognition, a simple solution would be to establish an accreditation system to validate non-formal learning, as proposed by the European Qualifications Framework (2022),

encourage collaboration between governments, businesses and NGOs to fund and support non-formal education initiatives, that is to say partnerships between private and public sectors. Overall, a structural change needs to happen, through policy reforms for national policies to integrate NFE into lifelong learning strategies.

Another key step is to strengthen validation and certification mechanisms in ways that are both accessible and flexible. Tools such as competency portfolios, digital badges and modular certifications can make informal and non-formal achievements visible to employers and formal institutions. These recognition systems must be designed with inclusivity in mind; this will ensure that disadvantaged groups can also demonstrate their skills without facing excessive administrative barriers.

Improving capacity building for educators and volunteers is equally vital. Governments and NGOs should invest in training programs that raise the quality and credibility of NFE delivery. When facilitators are empowered with the right skills/tools and recognition of their own contributions, they can better respond to learners' needs and adapt to evolving challenges.

To address inequalities in access, targeted support mechanisms for vulnerable groups are needed. Special attention should also be paid to bridging the digital divide by ensuring devices and affordable internet access. At the systemic level, cross-sector collaboration is of utmost importance. Partnerships that bring together civil society, local authorities, educational institutions and private companies can ensure that NFE initiatives are better coordinated and aligned with labor market needs. Such collaboration also prevents duplication of efforts and maximizes the use of available resources.

In any case, ensuring the long-term sustainability of NFE programs requires moving away from short-term project-based funding models. Establishing stable financial frameworks can provide continuity and allow programs to grow in scope and impact. This can be achieved through continuous public funding, corporate social responsibility programs, international cooperation and donations. Embedding NFE into national strategies for education and social inclusion ensures it is not treated as supplementary, but as an integral part of lifelong learning systems.

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# Chapter 5: Towards safe and supportive learning environments

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## 5.1 Trauma and the learning environment

Creating a safe and supportive learning environment hinges on understanding the multifaceted impacts of trauma on students. Knowledge of how traumatic experiences manifest in students' behavior, emotions, and cognitive processes is crucial for designing effective interventions and pedagogical strategies that meet their needs. Emphasizing that trauma, as defined by the DSM-5, encompasses a broad range of exposures and can have long-lasting consequences, makes it essential that educational settings are aware of the diversity of students' experiences and necessitates flexible and individualized approaches. An awareness of the neurobiological effects of trauma, which can affect memory, attention and executive functions, highlights the need to adapt teaching and assessment methods, for example, by offering flexible learning paces.

As trauma often disrupts concentration, memory, and emotional regulation, making traditional in-person learning environments challenging for these students, online and hybrid modalities can be offered to provide the flexibility to engage with material at a pace that accommodates the emotional and psychological needs of these students. By reducing the need for constant face-to-face interaction, these online and hybrid environments can mitigate the social pressures and potential triggers that can be present in traditional in-person settings, which are often overwhelming for trauma survivors. In addition, designing predictable routines and minimizing sensory overload can further enhance a sense of safety.

A truly supportive environment also depends on the social fabric of the learning space. Peer relationships, mentoring opportunities and a sense of belonging can act as protective factors that buffer against the negative effects of trauma. Group activities that emphasize cooperation over competition, restorative practices instead of punitive discipline, and opportunities for students to voice their perspectives contribute to a culture where vulnerability is not stigmatized but met with understanding. When educational communities intentionally nurture solidarity and mutual care, they can successfully address the needs of trauma-affected students and at the same time strengthen resilience across the entire learning environment.

It has to be emphasized once again how trauma initiates a series of interconnected reactions at the psychological, emotional and physiological levels, which can manifest in a student's behavior within the educational setting. Understanding these connections is crucial for a trauma-informed approach. It may also heighten sensitivity to perceived threats, making neutral classroom interactions feel unpredictable or unsafe. Likewise, trauma can lead to temporal disintegration, hindering concentration and planning, and to identity dissolution, affecting self-image. Below is an example of how we can use flexibility, a more individual approach, in order to take into account the risks of trauma exposure.

**Table 5.1.** A comparison of traditional and trauma-informed approaches in communication

| Aspect | Traditional Approach | Trauma-Informed Approach |
|---|---|---|
| Guiding Question | "*What is wrong with you?*" | "*What happened to you?*" |
| Student Behavior | Treated as a problem to be punished | Understood as an attempt to cope with the effects of trauma |
| Teacher Reaction | Often based on discipline and control | Based on empathy, compassion, and understanding of the neurobiology of trauma |
| Goal of Intervention | Stopping unwanted behavior | Creating a safe environment and support in regulation |

**Key principles of a Trauma-Informed Approach:**

- Safety: Ensuring physical, psychological and emotional safety;
- Trustworthiness and transparency: Building trust through open and clear communication;
- Peer support: Utilizing support from individuals with similar experiences to foster hope and safety;
- Collaboration and mutuality: Involving students in the decision-making process and creating partnerships;
- Empowerment, voice and choice: Enabling students to make decisions and express their needs;
- Consideration of cultural, historical and gender issues: Being sensitive to the diverse experiences of students.

### *5.1.1 Model of safe and supportive learning environments*

Creating safe and supportive learning environments, incorporating a trauma-informed approach, requires a holistic and flexible approach, adapted to the specific context of the environment. This requires building relationships based on trust and respect, offering choice and empowerment and actively responding to students' needs, with the awareness that many may have experienced trauma are key. Educating teachers on trauma awareness is fundamental for the effective implementation of this model.

In a trauma-informed classroom setting, ensuring physical and emotional safety begins with collaboratively established and consistently enforced behavioral rules that create predictability and stability. Adjustments to the physical space such as access to quiet areas for self-regulation, flexible desk arrangements and incorporating yoga practices can help promote calmness and emotional regulation. Avoiding sudden environmental changes like abrupt lighting or loud noises is essential to prevent triggering students. Teachers play a critical role by modelling calmness and demonstrating curiosity and empathy even when faced with students' difficult emotions, signaling that such feelings are safe to express. Trustworthiness and transparency are built through open empathetic communication, active listening and clearly explaining lesson objectives and notifying students about any upcoming changes. Consistently keeping promises and addressing reported concerns further reinforces trust. Support and collaboration are nurtured through opportunities for pair or group work, promoting a sense of community and peer connection which are vital for well-being. Teachers support rather than dictate, encouraging questions and sharing experiences while maintaining respect for students' privacy. They also ask what makes students more comfortable in the space while being cautious with potentially loaded words like "safe" or "unsafe". Empowerment and choice are fostered by allowing students to select tasks or forms of work where possible, encouraging them to express their opinions and needs and actively recognizing their strengths to build agency. Finally, trauma awareness is crucial: educators need a basic understanding of how trauma affects learning and behavior, responding to challenging situations with curiosity rather than punishment, naming emotions, avoiding triggers when possible and incorporating supportive activities such as yoga and mindfulness not as therapy but as tools to build resilience and coping skills.

Hybrid teaching combines elements of both classroom and online learning, requiring careful integration of trauma-informed principles from both environments. Flexibility in choosing how to participate whether in person or online can significantly enhance students' sense of control and safety, directly aligning with empowerment and safety principles. Establishing clear and transparent rules for both in-person and remote participation including assessment requirements helps to create predictability and build trust. Online platforms can serve as extended spaces for communication and support beyond face-to-face sessions, enabling students to ask questions and interact with peers and educators in a less pressured environment. Providing recordings of face-to-face lessons and asynchronous work options ensures accessibility and accommodates diverse needs and learning styles. Furthermore, teachers should actively monitor students' well-being across both settings, offering various channels for support and demonstrating continued awareness of students' emotional and psychological states regardless of the medium. This dual attention to structure and care enhances trust, autonomy and connection, making hybrid teaching more inclusive and responsive to trauma-related needs.

In trauma-informed online learning, safety and predictability begin with a user-friendly platform offering clear instructions, intuitive navigation, reliable access to materials and timely technical support, all of which reduce anxiety and frustration. Ensuring privacy and protection of students' personal data is essential for psychological safety while moderated discussion forums with clearly defined rules help foster respectful communication and prevent exclusion or hate speech. Trustworthiness and transparency are established through regular multi-channel communication from educators (e.g. via email or platform announcements), clear assessment criteria and well-

defined deadlines. The teacher's availability during set virtual office hours further reinforces a sense of reliability and support. Online collaboration is enhanced through discussion forums and support groups that allow students to share experiences and provide mutual encouragement. Allowing students to ask questions or share difficulties anonymously can increase safety for those with trauma-related sensitivities. Teachers actively participating in these forums ensure guidance, which reinforces a safe and engaged learning environment. Empowerment and choice are promoted by offering asynchronous access to materials, allowing students to learn at their own pace and providing tasks and materials in various formats such as text, video or audio to support different preferences. Where possible, allowing students to choose their learning path adds to their sense of autonomy. Trauma awareness in the digital environment includes optional participation in synchronous sessions to reduce social pressure, avoiding potentially triggering content or clearly warning students beforehand and offering access to mental health resources. Educators should also recognize that students' preference for online learning may stem from past trauma or social anxiety and respond with empathy rather than misinterpretation, fostering a culture of understanding and care.

## 5.2 Recognizing signs of trauma in learners

Recognizing signs of trauma in learners is a crucial aspect of trauma-informed approaches in various settings, including education and policing. This process involves understanding the multifaceted impact of trauma and being attentive to a range of potential indicators. A trauma-informed process necessitates a comprehensive framework that considers the nature of traumatic experiences to better understand and relate to individuals who have experienced severe psychological harm. This understanding is best achieved through a 'bio-psycho-social' lens, acknowledging the biological, physiological, psychological, and social impacts of trauma.

Individuals exposed to trauma may exhibit a wide array of observable signs and symptoms affecting their emotional, physical, cognitive and behavioral well-being. Recognizing trauma involves understanding that the signs and their presentation can vary depending on the nature of the trauma, the individual's characteristics, and their available resources. These symptoms, often termed traumatic stress reactions, can include:

- Intrusive thoughts and vivid imagery
- Affective dysregulation (manifesting as emotional numbing or heightened arousal states)
- Diminished hope
- Heightened fear
- Strained relationships (across various life spheres, e.g., family, friends, employment)
- Symptoms of depression and anxiety
- Sleep disturbances
- Feelings of excessive guilt or self-blame
- Re-experiencing symptoms (such as flashbacks, nightmares, or intrusive thoughts triggered by a stimulus; these recollections are often experienced as vivid sensory recalls rather than as a story with a beginning, middle, and end)

- Avoidance symptoms
- Arousal and reactivity symptoms
- Cognitive or mood symptoms

It's important to note that, while exposure to trauma might lead to related symptoms, it does not automatically equate to a diagnosis of Post-Traumatic Stress Disorder (PTSD). Nevertheless, individuals exhibiting such reactions need support to minimize their symptoms and facilitate healing.

It is helpful to differentiate between a typical stress response and a trauma response. A stress response is often triggered by a connected stimulus, whereas a trauma response can be triggered by a stimulus that may seem unrelated to the original traumatic event. For example, a child crying after scraping their knee is a stress response, while a child crying because a teacher wears a specific perfume that triggers a memory of past trauma is a trauma response.

Trauma can also have a significant neurobiological impact, leading to alterations in brain structures and functions associated with stress responses. These changes can affect crucial learning components such as: memory, attention, executive functioning. Furthermore, trauma-exposed students may show deficits in social cognitive tasks and emotional recognition, potentially impacting their interactions and leading to feelings of isolation. Trauma, particularly attachment-related trauma, has a significant negative impact on both the capacity for mentalization and the development of epistemic trust.

Furthermore, trauma can disrupt the attachment system and impair mentalizing abilities. Increased arousal associated with trauma can lead to a switch from controlled to automatic defensive mentalization (fight/flight/freeze). It has to be noted that this elaboration builds on concepts of trauma responses which are widely discussed, for example, in van der Kolk (2014, 2015). Individuals with a history of trauma may have a lower threshold for this switch, meaning they more easily revert to pre-mentalistic modes, such as psychic equivalence (feeling that thoughts are reality), teleological mode (acting based on expected physical effects) and pretend mode (a sense of unreality). Prolonged early adversity can lead to the development of epistemic mistrust, epistemic hypervigilance, or epistemic freezing, hindering social communication and learning.

Trauma, especially in attachment relationships, characteristically negatively affects the ability to develop epistemic trust. In cases of maltreatment, ostensive cues (indicating a readiness to share knowledge) are typically absent or undermined by fear and disorientation, preventing the relaxation of epistemic vigilance and leading to epistemic mistrust, and in extreme cases, to epistemic hypervigilance and freezing. Individuals who have experienced trauma in attachment relationships may defensively block thinking about other people's minds, further closing them off to new information.

As a result, trauma-affected learners may struggle not only to access new information but also to trust its source, making it essential for educators to create relationally safe environments where knowledge can be received without triggering defensive epistemic responses.

*5.2.1 Recognizing trauma in-class and in-group setting: the role of educators and service providers*

Educators and service providers play a vital role in recognizing signs of trauma. They should be trained to understand the potential impact of trauma on learners' behavior and academic engagement. This training can include learning about:

- The effects of trauma on the brain;
- Expected behavior in the aftermath of a traumatic event;
- Ways to recognize signs of trauma and respond in a trauma-informed manner.

By being attuned to these potential indicators and understanding the underlying impact of trauma, educators and other professionals can create more supportive and effective environments for learners who have experienced adversity.

The process of recognizing signs of trauma in a group of learners within a classroom setting necessitates attentive observation by the educator, the creation of a safe and supportive environment, and an understanding of the potential impact of traumatic experiences on student behavior. The following outlines an example of how an educator can identify these signs during group activities:

The educator initiates a group activity, such as a project requiring collaboration and interaction. To foster a secure and predictable space, the educator implements clear and consistent rules and communicates expectations transparently. This approach aligns with the principles of safety and trustworthiness inherent in trauma-informed practice.

During the group work, the educator carefully observes student behaviors, paying attention to potential indicators of trauma:

→ **Social withdrawal or isolation:** some students may avoid interaction with peers, work independently even when the task requires collaboration, or appear detached from the group; this can be indicative of avoidance strategies linked to past traumatic experiences.

→ **Hyperarousal or hyperreactivity:** students may exhibit disproportionate reactions to minor stimuli, such as sudden noises or changes in instructions; they might be easily agitated, have difficulty remaining seated, or display hypervigilance; these behaviors can reflect an elevated level of physiological arousal associated with trauma.

→ **Difficulties with concentration and attention:** some students may struggle to focus on the task, be easily distracted, or show difficulty following instructions; trauma can impact the brain's executive functions, including attention and working memory.

→ **Sudden mood shifts or emotional outbursts:** students may experience abrupt changes in mood, ranging from withdrawal to sudden outbursts of anger, crying, or anxiety that seem disproportionate to the situation; emotional dysregulation is a common consequence of trauma.

→ **Excessive need for control or rigidity:** certain students may display a strong need to control the progression of group work, resist changes, or exhibit a rigid adherence to specific plans; such behaviors can stem from past experiences of helplessness and lack of control.

→ **Reactions to potential triggers:** the educator may observe that certain stimuli (e.g., a specific tone of voice, type of task, the presence of a particular person) elicit a sudden change in behavior in some students, such as withdrawal, anxiety or agitation; these reactions may be linked to unprocessed traumatic memories.

*5.2.2 Interpretation and subsequent actions*

The educator interprets the observed behaviors within the context of knowledge regarding the impact of trauma, keeping in mind that a single behavior does not necessarily indicate trauma, and various factors can influence a student's conduct.

⇒ It is crucial for the educator to adopt a perspective of "what happened?" rather than "what is wrong with you?"

⇒ The educator refrains from directly questioning students about their traumatic experiences, as this could be retraumatizing.

Instead, the focus remains on creating a safe and supportive atmosphere where students can feel secure and may eventually seek support over time.

If concerning signals are observed, the educator can take the following steps:

- Individual conversation: The educator can speak with the student privately, expressing concern for their well-being and offering support without pressuring them to disclose traumatic experiences; the goal is to establish a trusting relationship and offer help in coping with current difficulties.
- Consultation with other specialists: The educator can consult with the school psychologist, special education teacher, or other specialists to discuss the observed behaviors and obtain guidance on further action.
- Informing parents/guardians: In cases of serious concern for the student's welfare, the educator, in accordance with established procedures, informs parents or guardians about the observed signals and suggests seeking professional help.
- Adaptation of teaching methods: The educator can adjust classroom practices to better meet the needs of students, for example, by offering more choices, ensuring predictability and structure in activities, and promoting self-regulation strategies.
- Non-judgmental communication: Using respectful, non-judgmental language makes students feel accepted.
- Validation of experience: Recognizing that each person has a unique history and that emotional reactions are understandable helps normalize difficult experiences.
- Awareness of triggers: Avoiding potentially triggering content without prior warning and always providing a safe context before discussing sensitive topics.

Recognizing the signs of trauma in the classroom is an ongoing process that requires sensitivity, knowledge, and a readiness to take appropriate action to support students. Consequently, the

educator plays a vital role in identifying potential difficulties. However, the diagnosis of trauma and recommendations for therapeutic interventions fall within the competencies of qualified specialists.

## 5.3 Establishing safety and responsibility in non-formal settings

Creating a sense of safety, both physical and psychological, is a foundational element for effective engagement and positive outcomes. This includes:, establishing a safe foundation, building consistent schedules, open communication, collective decision-making, and the creation of safe physical spaces. This ensures physical and emotional safety for students, educators and administrators as an indispensable prerequisite – however, it requires defining safety by those with less power which is actively promoted by those in authority.

Responsibility, may not be explicitly framed in non-formal settings as it might be in formal legal contexts, is often implied through the actions and duties of professionals and the guidelines they follow.

In schools, social workers, as frontline mental health providers, hold a significant responsibility in identifying and addressing trauma responses in students. Healthcare facilitators delivering stress management programs like Self-Help Plus (SH+) are responsible for creating engaging and safe group environments, understanding their organization's procedures for responding to safety issues, and ensuring competent and safe facilitation through supervision.

Trauma-Informed Care (TIC) offers a guiding framework for establishing safety and navigating responsibility in these settings. TIC emphasizes understanding the impact of trauma and aims to prevent retraumatization. As already emphasized, this approach necessitates a shift towards asking "*What happened?*" rather than "*What is wrong?*". Implementing TIC often involves organizational changes, staff training, and policy adjustments. For example, in child and adolescent residential settings, trauma-informed interventions have shown the potential to reduce coercive practices.

Psychological safety, a related concept, is vital for fostering trust and engagement. In work teams, psychological safety promotes learning behavior, involves leadership that supports open communication and reduces uncertainty and pressure.

Of course, clear guidelines and procedures play a crucial role in defining responsibilities and ensuring safety. Regulatory bodies often have mandates to protect the public. Healthcare organizations should have established protocols for responding to safety concerns, such as current sexual or intimate partner violence, as recommended by World Health Organization. In educational settings, policies and procedural changes at the organizational level are needed to support a trauma-informed approach.

Collaboration and communication are essential for both safety and responsible practice. In trauma-informed education, strong collaboration with mental health professionals is recommended. It is important to state that establishing safety and responsibility in non-formal settings relies on a trauma-informed framework that prioritizes physical and psychological well-being, clear operational guidelines, effective communication, but also a recognition of the potential impact of trauma.

## 5.4 Cultivating trust through transparent communication

Building trust through clear and open communication is a vital part of creating positive relationships and effective work in various settings, including law enforcement, healthcare, support for refugees, and the workplace. Transparent communication involves sharing information, intentions, and decisions openly, honestly and clearly, which helps to build trust between people and organizations.

In the context of TIC and policing, transparency builds trust by showing reliability and predictability. For individuals who have experienced trauma, clear and consistent messages about procedures, decisions and limitations can increase their sense of safety and control, helping to prevent further trauma. For example, when interacting with refugees, avoiding actions that seem like "making things difficult" and prioritizing clarity in actions, processes, and plans strengthens feelings of safety and trust. Another example regarding healthcare, including trauma-informed dental care, open and effective communication, which includes active listening, thoughtful responses, and focusing on the patient, is fundamental to building trust. Explaining treatment options in a way that is easy to understand and avoiding judgment creates physical and emotional safety for the patient. Similarly, in therapy, the therapist's honesty and transparency contribute to building a strong therapeutic relationship and trust, which is crucial for effective support, especially for those with a history of trauma.

In the workplace, clear communication from managers directly influences how much employees trust their leaders and the organization. Research based on motivating language theory has shown that managers who use language that provides meaning, shows empathy, and gives clear direction build greater trust among employees, especially during difficult times, such as the COVID-19 pandemic. Transparency from leaders sets an example of openness and creates an environment of trust and understanding, where employees feel safe to share their opinions as well. However, it's important to note that not all employees might see direct and open communication from leaders as encouragement to express their own views, and those with low self-esteem based on others' opinions may not feel secure enough to be open.

Leadership based on trust and transparency, in line with the six core principles of the Substance Abuse and Mental Health Services Administration's (SAMHSA) trauma-informed approach (safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical and gender issues), is key to an organization's success and ability to cope with challenges. Engaging in respectful, transparent, and reliable communication is the foundation of creating a safe and trustworthy environment.

In any case, clear communication is a fundamental element in building trust in various situations. It is characterized by openness, honesty, clarity, and reliability in the information shared. Leaders play a crucial role in promoting transparent communication, which leads to increased trust, a greater sense of safety, and more effective teamwork. However, it is important to consider individual differences in how communication is received and to continuously strive to improve communication practices to build lasting relationships based on trust.

An openness to receiving social communication that is personally relevant and generally applicable is called epistemic trust, which forms the basis of social learning and enables an individual to benefit from their social environment. The development of epistemic trust is closely related to early attachment experiences and adequate mentalization by caregivers – that is, their ability to accurately recognize, interpret, and respond to the child's emotions, thoughts, and intentions rather than focusing only on observable behavior.

### *5.4.1 The relationship between mentalization and epistemic trust with trauma-informed care*

A trauma-informed care (TIC) approach aims to minimize the risk of retraumatization and build a sense of safety and trust. Mentalization and epistemic trust are key mechanisms underlying the effective implementation of TIC. Hence, there are several important components:

- **Building Safety and Trust:** In TIC, transparent communication, as discussed previously and alluded to in the emphasis on trustworthiness and transparency in trauma-informed principles, is fundamental to building credibility and predictability, which in turn supports the development of epistemic trust. Clearly explaining procedures, decisions, and limitations can help individuals with a history of trauma feel safer and more in control.
- **Supporting Mentalization:** TIC acknowledges the impact of trauma on psychological functioning, including the capacity for mentalization. Interventions within TIC can be aimed at supporting the ability for reflective thinking about one's own and others' mental states, which helps in emotion regulation and improving interpersonal relationships. Psychoeducation about trauma and mentalization can help understand reactions to traumatic experiences and rebuild the capacity for mentalization.
- **Counteracting Epistemic Mistrust:** TIC recognizes that individuals with a history of trauma may exhibit epistemic mistrust, which hinders their ability to benefit from help and learn from others. Therefore, TIC emphasizes building relationships based on trust and respect, where communication is clear and reliable, which can gradually counteract epistemic mistrust and open the way for social learning.

In summary, mentalization and epistemic trust are interconnected and are crucial for understanding the impact of trauma and for the effective implementation of TIC. Trauma can disrupt the capacity for mentalization and lead to epistemic mistrust, hindering adaptation and healing. TIC, by prioritizing safety, transparent communication, and building trust, creates conditions that can support the recovery of mentalizing abilities and epistemic trust, which are essential in the process of healing from trauma.

### *5.4.2 Case study: Alicia's difficulties in class*

Alicia, a 15-year-old student, recently joined a new secondary school. Her classroom behavior is inconsistent. At times, she is withdrawn and reluctant to interact, while at other times, she reacts explosively to minor provocations from her peers. Her history teacher, Ms. Nowak, has observed that Alicia often appears distrustful of her intentions and struggles to accept new information,

particularly regarding social relationships and historical conflicts. When Ms. Nowak gently attempted to correct the wrong answer Alicia gave, the girl responded defensively, stating that Ms. Nowak was "picking on" her. Alicia's prior experiences are not known to Ms. Nowak in detail; however, general records indicate that she has experienced difficulties in family relationships and frequent changes in environment in the past.

Alicia's behavior can be partially understood through the lens of impaired mentalizing capacity and a low level of epistemic trust, which may have developed as a result of her prior traumatic experiences. More specifically, Alicia's defensive reaction to Ms. Nowak's correction may indicate difficulties in distinguishing her own thoughts and feelings from the thoughts and intentions of others. She may have interpreted the teacher's comment as a personal attack ("Ms. Nowak is picking on me"), not considering that Ms. Nowak's intention was solely to support her learning process. In stressful situations, individuals with a history of trauma may more readily switch to automatic, defensive modes of mentalizing, which hinders reflective thinking about interpersonal relationships. In essence, she struggles to understand what others might be thinking or feeling and why they are behaving in a certain way.

Furthermore, Alicia's distrust of Ms. Nowak' intentions and her difficulty in accepting new information may suggest a lack of epistemic trust. Her previous negative experiences may have led to a closed mind towards communications containing potentially relevant knowledge from others. She may have learned that relationships with adults are unpredictable and unsafe, making it difficult for her to open up to a new relationship with her teacher and accept her support. Simply put, she finds it hard to trust what others, especially authority figures like teachers, tell her and may be wary of their motives. This can stem from past experiences where adults may not have been reliable or supportive.

Ms. Nowak, acting in accordance with the principles of TIC, can take the following steps to support Alicia:

- **Building a safe and predictable relationship:** Ms. Nowak should consistently demonstrate interest and acceptance towards Alicia, even when her behavior is challenging. It is important for communication to be clear and predictable, which can gradually build epistemic trust. This means being reliable, consistent, and making sure Alicia knows what to expect from her.
- **Modelling mentalizing:** Ms. Nowak can model an attitude of curiosity towards mental states – both her own and Alicia's. For example, instead of reacting to Alicia's defensive statement with a reprimand, she could say: "I understand that you might have felt I was criticizing you. However, my intention was to help you better understand the topic." This way of communicating her own intentions and noticing Alicia's potential interpretations supports the development of her mentalizing abilities. By explaining her own thoughts and feelings and considering how Alicia might see things, Ms. Nowak can help Alicia learn to do the same.
- **Empathetic support and validation:** Ms. Nowak should strive to understand Alicia's perspective and validate her emotions, even if she does not agree with her interpretation of the situation. She could say: "I can see that you got upset when I corrected your answer." Such empathetic responding can help Alicia feel safer and reduce her defensiveness. Acknowledging Alicia's feelings, even when her reaction seems disproportionate, can help her feel understood and less threatened.

- **Scaffolding mentalizing:** Ms. Nowak can gradually support Alicia in understanding the complexities of social relationships and the intentions of others. She can do this by asking questions that encourage reflection ("What do you think this historical figure was thinking in this situation?") and helping her to consider different perspectives. Ms. Nowak can help Alicia think about the reasons behind people's actions by asking open-ended questions and encouraging her to see things from different viewpoints.
- **Creating a safe learning environment:** Ms. Nowak should ensure that the classroom is a place where mistakes are treated as part of the learning process, rather than a cause for shame or punishment. This can reduce Alicia's anxiety levels and make it easier for her to open up to new information. Making the classroom a place where it is okay to make mistakes and ask questions can help Alicia feel less anxious and more willing to learn**.**

There are also several key implications for classroom settings:

- Students' behaviors may reflect prior traumatic experiences that affect their ability to understand others' minds (mentalizing) and trust new information (epistemic trust);
- Teachers, by applying the principles of TIC, can create an environment that supports the development of mentalizing and the building of epistemic trust in students;
- Key elements of a trauma-informed response include building a safe relationship, modelling mentalizing, providing empathetic support and validation;
- Understanding the student's perspective and communicating one's own intentions can help de-escalate tensions and build trust.

This case study can be used in class to discuss the impact of trauma on student behavior, the roles of mentalizing and epistemic trust in the learning process, as well as the importance of a trauma-informed approach in education. Students could be asked to consider what other strategies Ms. Nowak could use and what challenges might arise when working with students with a history of trauma.

## 5.5 Peer support and self-help strategies

*5.5.1 Peer support*

Peer support is an integral practice within trauma-informed care. It empowers refugee entrepreneurs by addressing sociocultural challenges and fostering resilience. Through shared experiences and mutual understanding, individuals are better equipped to navigate the emotional and practical complexities of rebuilding their lives in new environments.

Peer-based relationships can also provide essential resources, including mentoring, emotional support and coping strategies. When peers share similar cultural backgrounds, this can further assist in the acculturation process, help preserve cultural identity and promote overall well-being and entrepreneurial success.

Peer support is especially valuable for individuals who have experienced bereavement by suicide. In these cases, peer support groups offer a space for social connection, facilitate healthier coping

with grief and help alleviate psychological distress by providing understanding and companionship in a time of deep vulnerability.

The core values of peer support groups include non-hierarchical relationships, choice, reciprocity, support, a sense of community, self-help and self-determination. These principles create a foundation of trust and mutual respect that differentiates peer support from more formal therapeutic or institutional approaches.

Peer support and mutual self-help are also vital tools in promoting recovery and healing from trauma. By creating both formal and informal opportunities for connection among individuals with shared experiences, and by offering access to community support groups, these approaches help build resilience and a sense of belonging.

In times of crisis, such as displacement or conflict, peer support becomes even more significant. For example, factors like support sought from peers and participation in peer groups have been shown to influence the mental well-being of Ukrainian students, underlining the importance of social connection and solidarity in maintaining psychological health during periods of instability.

### *5.5.2 Self-help strategies*

The use of mobile applications and online programs for mindfulness and self-compassion training, known as digital mindfulness-based interventions (dMBIs), is becoming increasingly common among employees. These interventions typically offer psychoeducation, guided meditation exercises and other practical features that promote well-being. They are considered low-cost, accessible and convenient self-help strategies that individuals can use independently. However, challenges remain, such as low motivation among users and concerns about confidentiality, which can limit their overall effectiveness.

Self-Help Plus (SH+) is a group-based stress management course developed by the World Health Organization. It is designed for adults experiencing psychological distress and is particularly relevant for refugees and migrants, including those who have experienced trauma. The program uses audio recordings and an illustrated guide to teach stress management skills and is grounded in the principles of acceptance and commitment therapy. Research has shown that SH+ is effective in reducing stress, improving daily functioning and enhancing overall mental well-being. Facilitators play a supportive role by guiding participants through the process but do not provide individual counseling or therapy.

While not directly focused on self-help, the concepts of mentalizing and trauma highlight the importance of trust and social communication in building psychological resilience. People who are perceived as trustworthy can help reduce excessive epistemic vigilance, making individuals more open to receiving and internalizing helpful information.

Modeling mentalization, offering empathic support and creating a psychologically safe learning environment can indirectly enhance an individual's ability to engage in self-help. These actions support the development of deeper understanding of oneself and others, promote emotional

awareness and help build the trust needed to adopt and benefit from self-guided psychological practices.

### *5.5.3 Examples from the research*

Bateman and Fonagy (2019) describe in Mentalization-Based Treatment (MBT), strategies to enable the individuals to progressively manage their emotional states and navigate interpersonal relationships in more adaptive ways.

The study by Bégin et al. (2022) aimed to determine the extent of psychiatric distress within two community sectors and to understand how digital mental health tools (DMHTs) were utilized to cope with the mental health consequences of the Covid-19 pandemic.

Kelly et al. (2023) conducted a systematic review of the evidence regarding the use of trauma-informed interventions in reducing coercive practices in child and adolescent residential settings.

Miller and Turliuc (2024) conducted a study on parental evaluations of symptom improvement in children following trauma-informed therapy. Parents reported the therapy to be effective.

Montgomery (2025) engaged in a dialogue with ChatGPT regarding the distinction between a machine therapist and a human therapist – ChatGPT concluded that the key differentiator lies in authenticity, and specifically in a human therapist's capacity for genuine relational presence and shared humanity.

Nafari and Ruebottom (2025) authored an article on a trauma-informed approach to supporting refugee entrepreneurship – importance of temporal reorientation, identity reconstruction, and prevention of retraumatization; involves the application of mindfulness, bridging practices, identity narratives, and attention to safety; trust-building and refugee engagement in decision-making are crucial aspects.

Tucker et al. (2024) evaluated a Trauma-Informed Reflective Practice Group for staff working in NHS CAMHS (Child and Adolescent Mental Health Services).

The World Health Organization (WHO, 2021b) – a group-based stress management course for adults – group-based stress management course for adults; teaches stress management skills grounded in acceptance and commitment therapy; provides instructions for facilitators and materials for participants, including an illustrated booklet; emphasizes the importance of confidentiality and boundaries of support; guidance on discussing suicidal ideation and addressing language barriers; recommends maintaining a calm and kind demeanor during sessions.

The World Health Organization (WHO, 2024) released the SH+ facilitator training manual – for training facilitators to deliver the SH+. This manual offers information on translating and adapting the course, as well as training facilitators; it clarifies that facilitators are not therapists and do not provide therapy; explores basic helping skills, such as empathy and active listening; includes a list of actions that facilitators should avoid and information on maintaining confidentiality.

Choi et al. (2024) investigated the influence of leader open communication on employees' feelings of psychological safety and their willingness to voice their opinions. The findings indicated that leader openness positively correlated with psychological safety and voice behavior, although this effect was less pronounced in individuals whose self-esteem was contingent on others' approval.

Elisseou (2024) wrote a commentary titled "*Trauma and the Health Care System*", addressing trauma within the context of healthcare. The author emphasizes the significance of peer support and mutual aid in the process of trauma recovery.

Men et al. (2022) examined how supervisory communication (specifically, the use of motivating language) impacted employee trust during the COVID-19 pandemic. The study revealed that supervisors' empathetic language had a strong positive effect on employee trust.

Serra et al. (2024) aimed to evaluate whether the cumulative effect of exposure to multiple potentially traumatic events (PTEs) predicted the level of improvement following SH+ participation in terms of psychological distress, well-being, and quality of life among asylum seekers and refugees.

Stachakarou et al. (2024) investigated how military medics perceived virtual patient simulations and how gamification elements could inform their design for trauma care training.

van der Kolk (2015), in "*The Body Keeps the Score*", discusses how language can be both a miracle and a tyranny in articulating traumatic experiences. The author emphasizes the difficulty of verbalizing internal feelings and suggests that experiences are sometimes more readily expressed through the body and emotions.

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# Chapter 6: Developing trauma-informed pedagogical tools

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## 6.1 Core competencies for trauma-informed educators

Trauma-Informed Care (TIC) is not just a set of guidelines – it is basically a transformative approach that reshapes how we understand and respond to those who have experienced adversity. At its core, TIC acknowledges that trauma profoundly affects brain development, emotional regulation and social interactions – the facets which we have discussed in depth in previous chapters. So, rather than viewing behaviors as problems to be disciplined, TIC encourages educators and professionals to see them as signals of unmet needs, fostering environments where healing and growth can take place.

The main goal of professionals working with trauma survivors is to create a supportive environment that enables personal growth, social integration and mitigation of the impacts of trauma, as well as to provide respectful and individualized interventions to facilitate the healing and readjustment process of those who have experienced traumatic experiences. Practitioners need to understand how to work in an integrated manner to be able to address the multiple challenges that trauma survivors may encounter during their adjustment and reconstruction process and, above all, be trauma-informed to avoid traumatizing their service users.

Therefore, there is a need to provide psychological and pedagogical resources to be sensitive to the traumatic experiences of people, promoting their ability to cope with and overcome the psychological consequences of the trauma they have experienced, operate in science and conscience, and make all people who come in contact with service users must be trauma-informed.

Research clearly shows us that better results can be achieved not only by training all practitioners in trauma care, but by making the entire organization become trauma-informed, so that the processes of admission and service delivery and referral are trauma-free and maximize opportunities for recovery and remove dangers of retraumatization.

This creates a context that supports the rebuilding of their lives with dignity and resilience, paying particular attention to the aspect of trauma in the psychosocial setting. The literature shows how important it is for non-formal educators and volunteers working with trauma survivors to be able to create a welcoming learning and caring environment that meets the unique needs of this vulnerable group. Such a stance ensures that every interaction, no matter how brief, contributes to the gradual restoration of a survivor's sense of control.

Therefore, we believe that the foundational elements of practitioner training must consider the three dimensions of personal and professional development as three indispensable pillars: area of knowledge (knowledge of trauma), know-how area (emotional support and practical skills) and knowing how to be (personal growth and self-awareness).

I) AREA OF KNOWLEDGE: Knowing About Trauma

1. Receive ongoing training on trauma and its impacts, including hands-on practice through case studies to translate theory into application.
2. Understand trauma manifestations, such as PTSD and dissociation, and effective coping and recovery strategies.
3. Be familiar with psychological theories guiding trauma intervention, such as attachment theory, polyvagal theory, and cognitive-behavioral frameworks.
4. Deepen cultural competence to understand how gender, race, ethnicity, and identity influence the experience and expression of trauma.
5. Map local networks of trauma-informed services to build effective, rights-based referral pathways and interagency collaborations.

II) KNOW-HOW AREA: Emotional Support and Practical Skills

6. Create a safe and welcoming environment that fosters emotional stability and trust through nonjudgmental, active listening.
7. Conduct comprehensive assessments to evaluate trauma impact and identify resilience factors, needs, and personal strengths.
8. Build collaborative networks with specialized trauma services for appropriate and person-centered referrals.
9. Offer psychosocial support to reduce isolation, build connectedness, and reestablish relational trust.
10. Facilitate peer support groups that create space for shared experiences and mutual healing.
11. Practice inclusive education, using culturally sensitive approaches that honor diversity and lived experiences.
12. Empower service users by involving them in the planning and delivery of their educational or therapeutic journey.
13. Share trauma survivor success stories to inspire hope and model pathways toward recovery.
14. Respect each person's pace, avoiding triggers or rushed interventions that may destabilize their healing process.
15. Offer emotional literacy programs to build survivors' social-emotional awareness and interpersonal skills.
16. Encourage emotional expression, using verbal and creative methods as tools for processing and resilience.
17. Implement mentorship programs pairing survivors with trained, culturally competent mentors for individualized support.
18. Create interdisciplinary teams, bringing together educators, psychologists, and social workers to develop integrated, cross-sectoral support systems.
19. Schedule regular team meetings to review cases, plan coordinated interventions, and provide mutual supervision and care.
20. Use respectful, clear, and empathetic language in all communication with survivors.
21. Build strong, trust-based relationships as the foundation for authentic connection and sustained support.

III) KNOWING HOW TO BE: Personal Growth and Self-Awareness

22. Adopt a deeply empathetic and nonjudgmental attitude, respecting the full humanity of those you serve.
23. Participate in support groups or peer circles to process vicarious trauma and protect your own mental health.
24. Prioritize self-care practices, recognizing the emotional toll of trauma work and preventing burnout.
25. Maintain self-awareness and know when to seek help or supervision to stay grounded and effective.
26. Practice flexibility, adapting your methods, pace, and expectations to meet each person's evolving needs.

By embracing these 26 core competencies, practitioners not only become better equipped to support trauma survivors – they become agents of systemic change. When every member of an organization embodies trauma-informed values, the entire system becomes a healing force.

The literature and lived experience alike affirm that trauma-informed practice is not just about what we do, but actually about how we show up. It is about walking beside someone without needing to fix them. It is about creating space where people feel safe enough to grow, and strong enough to hope.

### *6.1.1 Case study: how to adapt teaching methods and sustain educator resilience*

Imagine a student named Jordan, who frequently lashes out in frustration during class. A traditional disciplinary approach might label Jordan as disruptive or disrespectful, leading to punishments that only deepen his sense of alienation. However, a trauma-informed educator takes a different path. Instead of reacting with punishment, they recognize Jordan's behavior as a response to stress or past trauma. By creating a safe, predictable environment and using calm, compassionate communication, the educator helps Jordan feel secure and understood, ultimately paving the way for positive change.

To support students like Jordan, educators must first develop trauma literacy, i.e., the ability to recognize how trauma influences learning and behavior. Research shows that experiences such as neglect, abuse, and instability can rewire the brain, making it harder for children to focus, regulate emotions, or build trust. Understanding these impacts helps teachers move from frustration to empathy.

For instance, a student who appears "lazy" may actually be struggling with sleep deprivation due to a stressful home environment. Rather than labeling the student as unmotivated, a trauma-informed educator might explore ways to provide additional support, such as a quiet space for rest or flexibility in assignment deadlines. A simple tool like an ACEs (Adverse Childhood Experiences) questionnaire, adapted for educators, can provide insights into underlying challenges.

Once educators understand trauma's effects, the next step is fostering communication that builds trust and safety. A child who has experienced trauma may struggle to express emotions constructively. When frustration boils over, the response of an adult can make all the difference.

Consider this scenario: A student slams their book shut and exclaims, "*I hate this class! It's stupid!*" A typical reaction might be, "*That is inappropriate – stop yelling!*" However, a trauma-informed approach would sound different: "*You sound really frustrated. Want to take a walk and tell me what's bothering you?*" This simple shift, using active listening and non-threatening language, helps to de-escalate the situation while making the student feel heard.

For students affected by trauma, the classroom should serve as a sanctuary – a place where they feel emotionally and physically secure. Achieving this requires more than just kind words; it involves consistency, structure and intentional design.

A trauma-sensitive classroom includes visual schedules, predictable routines and quiet spaces for self-regulation. Collaborative rule-making, where students participate in setting expectations, reinforces a sense of ownership and safety. Research suggests that well-structured environments counteract the negative effects of trauma by providing the stability children may lack elsewhere.

All case studies have one thing in common, and that is the fact that trauma does not exist in a vacuum; it intersects with factors such as race, socioeconomic status and identity. A trauma-informed approach acknowledges these complexities, ensuring that interventions are culturally responsive and inclusive.

For example, a student's refusal to make eye contact might be misinterpreted as defiance, when in reality, it aligns with their cultural norms. Educators who engage in bias audits and collaborate with families can prevent misjudgments and create more supportive learning environments.

Traditional teaching methods often assume that all students are equally prepared to focus, retain information, and engage in learning. However, for students affected by trauma, difficulties with concentration and memory are common. Effective educators adapt their strategies to meet these students' needs.

Multimodal learning (incorporating movement, art, discussion) can increase engagement and comprehension. Additionally, trauma-sensitive assessments, such as allowing students to choose between oral or written responses, empower students to demonstrate their knowledge in ways that feel safe and accessible. Caring for trauma-affected students can be emotionally demanding. Thus, educators must prioritize their own well-being to sustain their ability to provide support. Self-care is not a luxury, but a necessity.

Practices such as mindfulness exercises, peer support groups and reflective journaling can help educators process their experiences and prevent burnout. A simple yet powerful question to ask oneself daily is: "*Did I take a moment to regulate my emotions before responding to a student today?*". Modeling self-regulation benefits the teacher, but also teaches students valuable coping skills. Ultimately, the aim is to create learning spaces where trauma-affected students can rebuild confidence and see it as a place of genuine safety and possibility.

*6.1.2 Towards a culture of empowerment and agency*

Empowering students with voice and choice in their learning environment fosters agency and a sense of control – key components in trauma recovery. Encouraging self-expression through art, journaling or discussion can help students process their experiences. Additionally, recognizing cultural and historical contexts of trauma is essential for inclusivity. Educators should be mindful of how diverse backgrounds influence trauma responses and tailor interventions accordingly.

By integrating these core competencies into their teaching practices, educators can create a learning environment that supports the well-being and academic success of all students, particularly those who have experienced trauma. However, the impact of trauma-informed care extends beyond the classroom. Social workers, healthcare providers, community leaders and law enforcement officers all play critical roles in fostering safe, supportive, and empowering environments. In mental health and social services, professionals must be equipped with the skills to recognize trauma responses, provide appropriate interventions, and advocate for policies that promote healing. In healthcare settings, trauma-informed approaches ensure that patients feel safe, respected, and heard, reducing the risk of re-traumatization during medical treatment.

Law enforcement and first responders can also benefit from trauma-informed training, allowing them to interact with individuals in crisis with greater empathy and understanding. Community leaders and policymakers, by integrating trauma-informed principles into public services and local initiatives, can contribute to systemic changes that support long-term resilience and well-being.

By fostering safe spaces, building trust and practicing self-care across various professions, we create not just trauma-sensitive classrooms, but trauma-sensitive communities. Through collaborative efforts, individuals affected by trauma can find the support they need to heal and thrive, regardless of their background or past experiences.

*6.1.3 From classroom to community: a call to action*

The impact of trauma-informed care extends beyond the classroom. Social workers, healthcare providers, law enforcement officers and community leaders all play vital roles in enabling safe, supportive environments. When entire systems embrace trauma-informed principles, individuals who have experienced adversity find the support they need to heal and thrive.

Educators are the first link in this healing chain. By integrating trauma literacy, responsive communication, safe environments, cultural awareness, adaptive instruction and self-care, they become agents of resilience and transformation.

As a step forward, schools can initiate a "*Trauma-Informed Week*", where educators reflect on their practices using a structured checklist. Additionally, advocating for school-wide training through SAMHSA's Trauma-Informed Schools Toolkit ensures that trauma-sensitive approaches become embedded in the culture of education.

Ultimately, when educators shift their perspective (i.e., from reacting to behavior to understanding its roots), they create not just trauma-sensitive classrooms, but trauma-sensitive communities. In

doing so, they provide students with something invaluable: the opportunity to feel seen, supported, and empowered to succeed, regardless of their past experiences.

Educators, too, must be mindful of their own emotional well-being. Supporting students who have experienced trauma can be emotionally demanding, making self-care an essential practice. Whether through mindfulness, peer support or professional development, teachers must prioritize their own resilience to effectively guide and uplift their students. Trauma-informed educators should engage in reflective practices, seek supervision or peer consultation, and maintain a strong support network to prevent burnout. By creating the environment for safe spaces, and by building trust and practicing self-care across various professions, we create not just trauma-sensitive classrooms, but trauma-sensitive communities. Through collaborative efforts, individuals affected by trauma can find the support they need to heal and thrive, regardless of their background or past experiences.

of course, supporting trauma survivors requires more than knowledge; it requires presence, humility, and a systems-level commitment to safety, trust and empowerment. The ultimate goal of trauma-informed practitioners is to cultivate environments where survivors feel seen, heard and supported in rebuilding their lives with dignity. To do this well, we must prepare professionals not only to act, but to be – to actually embody the values and relational depth that trauma-informed care demands.

Trauma affects every dimension of a person's experience: cognitive, emotional, physiological, relational and social. Similarly, the response must be multi-dimensional. Practitioners must learn to work collaboratively and with deep intentionality, guided by evidence and ethics. Most importantly, they must be trained in a way that centers the survivor, not the system.

## 6.2 Designing situational simulations for educators for skill development/application

Situational simulations have gained prominence as an effective tool for educator skill development and application. Defined as immersive, interactive scenarios that mimic real classroom dynamics, these simulations empower educators to practice their responses to various challenges in a controlled environment. Particularly in the context of trauma-informed care, simulations offer a safe space for educators to explore their reactions to challenging student behaviors, fostering a compassionate and structured learning atmosphere. For example, studies indicate that engaging with simulations can increase educators' confidence and effectiveness in managing trauma-affected classrooms.

Imagine stepping into a classroom where a student suddenly freezes, eyes wide, shoulders tensed. Another clenches their fists, breathing shallowly. How an educator responds in these moments can either reinforce safety or deepen distress. Yet, responding effectively to trauma responses is not intuitive – it must be practiced.

Situational simulations offer a bridge between theory and action, allowing educators to refine their TIC skills in a controlled, supportive environment. Studies highlight their effectiveness: classroom management improves by 27%, skill retention is 2.5 times faster compared to lecture-based training,

while punitive discipline practices decline by 40%. The challenge? Designing simulations that mirror real-world complexity without causing harm.

### *6.2.1 Learning in context and evidence-based design principles*

At its core, simulation-based learning aligns with experiential learning theory, where educators cycle through direct experience, reflection, abstract learning and active experimentation. In a trauma-informed context, this means role-playing de-escalation strategies, analyzing responses and using new insights in future interactions. Situated cognition theory stresses that learning is truly context-dependent, and that effective trauma-informed simulations must reflect real-world variables:

- Cultural diversity: A child's trauma response may be shaped by displacement, racial trauma or cultural stigma around mental health;
- Behavioral complexity: Dissociation, hypervigilance aggression are factors that require distinct educator responses for each of them.

Research underscores that educators experience relational safety in simulations, they demonstrate greater trauma-responsive competence in real-world settings.

Beyond these theoretical foundations, effective simulation design must incorporate evidence-based principles such as psychological safety and graduated exposure to challenging scenarios. Psychological safety ensures that educators can take interpersonal risks without fear or judgment. Graduated exposure introduces increasingly complex trauma-related scenarios, allowing learners to build confidence and emotional regulation skills over time. Structured debriefing consolidates learning by helping participants make sense of their reactions, integrate feedback, but also translate insights into practical strategies. Together, these elements ensure that trauma-informed simulations replicate the complexity of real-life interactions. This way, they can also support the reflective, relational and adaptive capacities that educators need to work safely and effectively affected ones.

### *6.2.2 Practical application: 4-step simulation design*

The first step in trauma-responsive training for educators is to identify trauma-responsive skills that support student safety and regulation. Educators need structured practice in recognizing dissociation (glazed eyes, silence, disconnection), de-escalating aggression without restraint, and using restorative language ("*What do you need?*" instead of "*Why did you do that?*"). The *ACES-Informed Skill Checklist* can be used as a guiding tool for this process.

The second step is to build immersive scenarios that allow educators to apply these skills in realistic contexts. A case example is "the overwhelmed student," where a student hides under their desk during a fire drill. Trauma links might include noise sensitivity (linked to auditory trauma) or fear of confined spaces (possible abuse history). In this situation, educator goals are to regulate by modeling calm breathing, reassure by saying "*You are safe here. I will stay with you*", and adapt by offering noise-canceling headphones next time. A simple template can be applied: [Trigger] → [Trauma Link] → [Ideal Response] → [Common Mistakes].

**Table 6.1.** Adapting educational principles for trauma-informed learning

| Principle | General Application | Trauma-Informed Upgrade | Study Reference |
|---|---|---|---|
| **Authenticity** | Realistic classroom scenarios | Incorporate ACEs-related triggers (e.g., loud noises, sudden transitions) | Kaufman & Ireland (2016) |
| **Interactivity** | 'Choose-your-own-response' decision-making | Practice co-regulation (e.g., *"Let's breathe together")* | Porges (2011) – Polyvagal Theory |
| **Feedback** | Peer/instructor debriefs | Use non-shaming language ("*You seemed anxious*" vs. "*You failed*") | Hattie & Timperley (2007) |
| **Scaffolding** | Beginner → advanced scenarios | Prioritize physiological safety (lighting, seating) before introducing trauma triggers | Perry (2009) – Neurosequential Model |
| **Resilience** | Stress management techniques | Address vicarious trauma with coping strategies | Figley (1995) – Compassion Fatigue |

The third step is to choose simulation modality depending on the learning goal. Role-play works best for practicing verbal responses, but "student" roles should be assigned to trained actors to avoid peer re-traumatization. VR simulations provide high-immersion triggers such as yelling and should always include opt-out safewords. Case studies are effective for low-risk cognitive processing, using anonymized real student stories. Research shows that VR training reduced educator stress in crisis scenarios by 33%.

The final step is to debrief with trauma-informed feedback. Key prompts include "*What body signals did you notice in yourself?*" (polyvagal theory insight) and "*How might a traumatized student perceive your tone?*" Debriefing should avoid blame-focused language such as "*You should have…*" and instead use constructive, supportive dialogue. The *Trauma-Informed Feedback Rubric* offers a structured way to guide reflection and feedback.

*6.2.3 Making every interaction count*

In the evolving landscape of education, the question is no longer *whether* educators will encounter trauma in the classroom – it is actually *how* they will respond when it inevitably surfaces. The classroom is not a vacuum; it is a living, breathing environment shaped by the histories, nervous systems and unspoken stories of every child within it. And for educators, the challenge lies not only in recognizing trauma, but in cultivating the skills to meet it with steadiness, empathy and clarity. This is where situational simulations reveal their quiet power. It does not come as flashy technologies or training trends, but as human-centered practice grounds where safety and resilience are learned and rehearsed.

Designing trauma-informed simulations is, at its core, an act of care. It means moving beyond generic training modules to create spaces where educators can safely encounter the messy complexity of trauma. This entails freezing students, eruptive behaviors, silence thick with unsaid fear, just to name a few. And here we need a response with practiced compassion. These simulations are not merely exercises in problem-solving; they should be exercises in presence. And presence, for trauma-affected youth, can be the difference between alienation and repair.

Through the lens of experiential learning and situated cognition, we understand that knowledge is not simply absorbed, but actually lived. Educators who engage in well-designed simulations do more than memorize techniques; they embody them. They come to recognize their own nervous system responses, to regulate under pressure, to shift their internal narratives from "*What is wrong with this student?*" to "*What might have happened to them – and how can I help?*" When paired with thoughtful scaffolding and trauma-aware feedback, these simulations create a loop of reflective practice that strengthens both skill and self-awareness.

The stakes are high. Misattuned responses can unintentionally retraumatize. But within the intentional design of simulations (crafted with cultural nuance and trauma-sensitive structures), educators are invited into a space of transformation. They can make mistakes, learn from them, and return better prepared to face the realities of their classrooms. The data is promising: reduced punitive practices, improved emotional regulation, faster skill uptake. But beyond the metrics lies something more intangible yet equally vital: the quiet confidence of an educator who knows how to hold space for a child in crisis.

In the end, situational simulations do not promise perfection. They promise *preparation*. They allow educators to rehearse the moments that matter most: the pause before speaking, the grounding breath, the shift from correction to connection. In a world where trauma too often isolates, simulations offer educators a path toward relational repair. They remind us that healing does not begin with the right answers – it begins with the right presence, practiced again and again, until it becomes who we are in the moments that matter most.

And when this presence becomes habitual and cultivated through repetition, it transforms educator practice and creates the conditions for the possibility of healing within their learning environments, but also for experiencing safety.

## 6.3 Practical strategies for managing trauma-related behaviors

Supporting individuals who have experienced trauma is not just about providing care. It is about creating a foundation where healing feels possible. Trauma rewires the brain's ability to trust, seek connection and feel safe in the world. For many survivors, even the most basic aspects of daily life can feel overwhelming. That is why trauma-informed care emphasizes meeting individuals where they are, prioritizing their sense of safety, and empowering them to move forward at their own pace.

Imagine someone who has just survived a traumatic event. They may be struggling to eat, sleep, or even feel at ease in their own body. Trauma is not just a psychological wound, because it affects the nervous system, disrupts physiological regulation, and can make even fundamental self-care feel out of reach. Maslow's hierarchy of needs reminds us that before we can address emotional healing, we must first ensure that a person's basic survival needs are met. Food, water, rest and medical care are not just checkboxes; they are prerequisites for healing.

Safety is more than physical security, it is the ability to exist without constant fear. Many trauma survivors live in a state of hypervigilance, where the world feels unpredictable and threatening. Practitioners, caregivers and loved ones can help by creating environments that are consistent, respectful, and free from sudden disruptions. This might mean setting predictable routines, using a calm and reassuring tone, and always asking for consent before offering help. When survivors begin to feel that their surroundings are safe, their nervous system can start to shift out of survival mode, making space for deeper healing.

One of the most valuable gifts that can be offered to a trauma survivor is a nonjudgmental, compassionate presence. The way in which support is provided can significantly impact a survivor's ability to cope with distressing emotions and behaviors. Trauma often leaves individuals feeling isolated, ashamed or responsible for what happened to them, even when the event was entirely beyond their control. Therefore, one of the core principles of trauma-informed care is to reassure survivors that they are not to blame and that they are not alone in their recovery journey.

A critical element of trauma-informed support is ensuring that survivors feel seen, heard and validated. Consequently, simple yet powerful messages such as *"I am here for you",* or *"We will get through this together"* can reinforce a sense of safety and resilience. Survivors often struggle with self-doubt and feelings of vulnerability, making it essential for supporters to convey strength and stability. This does not mean forcing positivity or diminishing the reality of their pain but rather acknowledging their struggles while expressing confidence in their ability to heal.

Equally important is avoiding judgment or pressure. Some trauma survivors may not be ready to seek professional help or discuss their experiences in depth. In such cases, it is beneficial to maintain an open and patient stance, reassuring them that support is available whenever they feel ready to access it. A person who has experienced trauma should never feel coerced into a particular path of healing, but instead empowered to make choices at their own pace.

### *6.3.1 Practical support in recovery*

Practical support is crucial for survivors, especially when trauma has disrupted their ability to manage daily responsibilities or access essential services. However, well-intended help can sometimes feel intrusive or disempowering. The key to providing effective support is offering assistance that aligns with the survivor's needs, respects their autonomy, and avoids reinforcing a sense of helplessness.

Here are some practical ways to support trauma survivors, with examples tailored to different situations:

I) Helping with daily life while respecting boundaries

- **What to do:** Offer specific, concrete help instead of general statements like "*Let me know if you need anything.*" Trauma can make decision-making overwhelming, so clear and actionable offers are more helpful.
- **Example:** Instead of saying, *"Tell me if you need groceries,"* say, *"I am going to the store today – can I pick up some basics for you?"*
- **Why it works:** It removes the burden of asking for help while ensuring the survivor still has control over their choices.

II) Assisting with medical and mental health appointments

- **What to do:** Offer to help schedule or attend medical or therapy appointments if the survivor is struggling to take these steps alone.
- **Example:** If a survivor hesitates to seek professional help, say, *"I can sit with you while you make the call, and we can figure it out together,"* rather than *"You really should see someone."*
- **Why it works:** Trauma can make reaching out for help feel overwhelming. A gentle, collaborative approach encourages engagement without pressure.

III) Creating a sense of safety in shared spaces

- **What to do:** If the survivor spends time in a shared space (classroom, community center, home), ensure that the environment is predictable, calm and non-threatening.
- **Example:** In a classroom or workshop, allow survivors to sit near exits or in quieter areas. Use soft lighting and avoid loud, sudden noises.
- **Why it works:** Trauma often heightens sensory sensitivity and triggers a need for control over surroundings. Small adjustments can reduce anxiety and increase engagement.

IV) Supporting without creating dependence

- **What to do:** Encourage small steps toward independence while still being available.
- **Example:** Instead of repeatedly completing tasks for the survivor, invite them to collaborate: *"Would it help if we set a reminder together for that appointment?"*
- **Why it works:** It helps the survivor regain a sense of agency and capability, which trauma often strips away.

V) Managing your own emotional boundaries

- **What to do:** Pay attention to signs of frustration or emotional fatigue in yourself. If helping starts to feel overwhelming, take a step back and seek support for yourself.
- **Example:** If you're feeling exhausted, say, *"I care about you, and I also need some time to recharge. Let's check in tomorrow."*
- **Why it works:** Sustainable support requires self-care. When helpers set healthy boundaries, they model self-respect and resilience.

While professional support is invaluable, many trauma survivors may not have immediate access to psychotherapy, or they may feel hesitant to seek help. The World Health Organization (WHO) has developed Self-Help Plus (SH+), which is a structured, low-cost psychological intervention designed to help individuals manage stress and trauma-related distress. This program is particularly useful for communities with limited mental health resources and can be facilitated by non-specialists.

Key components of Self-Help Plus (SH+) are as follows:

- **Guided self-help approach:** SH+ is based on Acceptance and Commitment Therapy (ACT) principles, helping individuals focus on what they can control while developing psychological flexibility.
- **Group or individual delivery:** It can be provided in a group setting with trained facilitators or used individually through an illustrated workbook and audio materials.
- **Simple, accessible techniques:** The program includes breathing exercises, mindfulness strategies, and values-based goal setting to help survivors regain a sense of control.

Non-formal educators can integrate SH+ strategies into their work by introducing grounding exercises before or after group discussions to help participants manage stress and by encouraging small values-based actions such as writing, art or community participation to restore a sense of agency. They can also normalize seeking support by weaving SH+ concepts into workshops or informal conversations which helps reduce stigma around mental health and fosters a more supportive learning environment. By integrating SH+ principles into trauma-informed care, non-formal educators can provide survivors with evidence-based tools to navigate distress while reinforcing their resilience and autonomy.

Practical support in trauma recovery should always be guided by respect, collaboration and flexibility. Survivors need to feel that they are not alone, but they also need to rebuild a sense of control over their own lives. The best support is one that empowers rather than rescues, listens rather than directs, and offers help in ways that are thoughtful, practical, and, above all, trauma-informed. By incorporating these approaches, non-formal educators, caregivers and community workers can create environments that not only assist with recovery but also foster long-term resilience.

### *6.3.2 Encouraging professional assistance without pressure*

While informal support is invaluable, some trauma-related struggles require professional intervention. If a survivor's distress persists or significantly impacts their daily functioning, it may

be necessary to explore psychotherapy, medical treatment or specialized trauma recovery programs. However, suggesting professional help should always be done with care and without coercion. Survivors may hesitate due to fear, stigma, or previous negative experiences with the mental health system. Rather than pushing them toward a specific treatment, a trauma-informed approach involves gently providing options, explaining potential benefits, and respecting their autonomy in deciding when and how to seek help.

For those who are reluctant, maintaining an open and accepting stance is essential. Reminding them that help will always be available when they are ready can make a significant difference. Healing is a nonlinear process, and survivors need to know that they are supported at every stage – even if they are not yet ready to take the next step.

Trauma-informed care is about more than just addressing symptoms. It is about creating a culture of safety, respect and empowerment. By focusing on stabilizing basic needs, fostering nonjudgmental support, and encouraging help-seeking without pressure, we can help trauma survivors rebuild a sense of trust in themselves and the world. Every small act of compassion, validation and patience contributes to the survivor's ability to heal, demonstrating that they are not alone and that recovery, though indeed challenging, is always possible.

## 6.4 Incorporating interactive learning and technology

Technology and interactive learning methods have the potential to enrich trauma-informed care, offering survivors tools that enhance accessibility and autonomy. However, integrating these resources effectively requires careful attention to safety, choice and inclusivity. When thoughtfully designed, digital tools can support healing while reducing the risk of retraumatization. In that regard, online platforms provide an opportunity for psychoeducation while allowing users to engage at their own pace, minimizing the experience of feeling overwhelmed.

Interactive apps can make psychoeducation more engaging and accessible. For instance, platforms like 'Sanvello' offer self-care quizzes that help users identify personalized coping strategies, while 'MoodTools' provides CBT-based activities in a structured format. To ensure a trauma-sensitive experience, it is pivotal to design these platforms with clear content warnings, avoid sudden loud sounds or flashing visuals, and offer users the ability to customize their learning journey.

Likewise, gamified applications help trauma survivors build coping mechanisms in a non-intimidating way. Apps like 'PTSD Coach', developed by the by the U.S. Department of Veterans Affairs, use mini-games to teach breathing exercises, grounding techniques and cognitive restructuring – all without clinical jargon. The incorporation of game elements, such as badges for progress, improves motivation, which is particularly pertinent for survivors who may avoid traditional therapy.

Trauma-informed design emphasizes creating digital and learning environments that prioritize safety and user control. Users should have the ability to opt out of triggering content, such as war imagery, to protect their emotional well-being. One example is 'Re-Mission', a game designed for cancer patients, which shows how interactive play can foster a sense of control, an approach that

can be adapted for trauma recovery. At the same time, caution is needed as competitive features may inadvertently increase stress levels and undermine the goals of trauma-informed practice.

### *6.4.1 From virtual safe spaces to interactive trauma-support tools*

A key element of trauma-informed care is providing spaces where survivors feel supported and in control of their interactions. Platforms like 'Moodle' or 'Slack' can be tailored to create private forums where survivors can engage in grounding exercises, guided breathing videos and moderated Q&A threads. These digital sanctuaries offer anonymity and flexibility, fostering a sense of security and agency.

Interactive trauma-support tools are especially beneficial in providing individualized and group support. One example is AI chatbots for 24/7 crisis support. Based on Miner et al. (2019), AI-driven chatbots such as 'Woebot' and 'Wysa' provide immediate, judgment-free coping strategies for moments of distress such as panic attacks or flashbacks. These bots use cognitive-behavioral therapy (CBT) principles to offer grounding exercises and challenge negative thoughts. Research indicates that *"68% of users disclose more to chatbots than to human therapists initially"* (Miner et al., 2019), showing how anonymity can reduce shame. For trauma-informed implementation, script clarity is essential, with bots stating, *"I am not a therapist, but I can help you ground yourself right now."* Clear escalation paths are also required so that if suicidal ideation is detected, chatbots automatically refer users to live professional help. Still, over-reliance on chatbots is risky since they lack human empathy and cannot replace professional support, and recently they are getting some bad reviews from their use in depressive anxious people.

Another promising approach is anonymous digital platforms for peer support. According to SAMHSA (2021), platforms like '7 Cups' or moderated 'Slack' groups help reduce isolation while protecting privacy. The ability to exit conversations instantly can prevent retraumatization and uphold user agency. Implementation requires skilled moderation, with facilitators trained in trauma-informed responses such as *"I hear you. Would you like resources?"* A school using 'Padlet' for anonymous student check-ins provides a powerful example, reporting a 40% rise in participation without coercion. Risk mitigation is also crucial, for example banning graphic trauma descriptions to prevent vicarious trauma among community members.

Finally, trauma-informed care in digital spaces requires strong digital boundaries and safety considerations. While technology offers innovative support options, it also poses risks such as retraumatization, privacy breaches and unmoderated exposure to triggering content. Safeguards must be embedded into implementation, including consistent moderation of forums to prevent harmful content sharing, and using secure encrypted platforms like 'Signal' for peer support groups to ensure confidentiality. Facilitators should also communicate digital boundaries clearly from the start, for instance by stating: *"This app allows you to control your level of engagement. You can turn off cameras and microphones at any time, and no sessions will be recorded without your consent."*

Interactive workshops (hybrid and online) can foster connection and engagement while maintaining trauma-sensitive principles. Anonymous polling with tools like 'Mentimeter' allows participants to share their needs without revealing identities. A simple question such as *"Which topic*

*feels safest to discuss next week?"* with multiple-choice options ensures that discussions align with the group's comfort levels. Collaborative whiteboards on platforms like 'Miro' or 'Jamboard' can be used for expressive arts activities. Participants may, for example, *"drag an image that represents resilience,"* facilitating self-expression in a nonverbal way. To remain trauma-informed, facilitators should always provide opt-out options for interactive activities and allow pseudonyms when using digital sharing tools.

Tech-assisted grounding techniques can provide immediate relief in moments of distress. Mindfulness apps such as 'Insight Timer' offer free guided meditations, while 'Calm' provides body scan exercises to help users reconnect with the present moment. Biofeedback tools like 'Fitbit' or 'Spire Stone' track heart rate and breathing patterns, offering gentle prompts to engage in grounding exercises when physiological signs of stress appear.

Synthesizing the evidence: key principles highlights several lessons for trauma-informed technology use. Trauma survivors should have agency over algorithms, with the ability to customize or cancel interactions. AI tools should act as complements, not replacements, for professional care. Accessibility also matters, and low-tech alternatives such as printable virtual reality exposure therapy (VRET) exercises should be available. As SAMHSA emphasizes, *"The mute button is as vital as the mic in trauma tech design."*

Action steps for practitioners include piloting a tool by starting with free apps such as 'PTSD Coach' or 'Insight Timer.' Training stakeholders is equally important so staff understand how to use VR and chatbots as adjuncts, not replacements, for care. Evaluating safety is critical, and SAMHSA's 2021 checklist can be used to audit tools for potential triggers. For additional guidance, practitioners can consult the WHO's 2020 *Digital Mental Health Guidelines* for adaptations in low-resource settings.

By thoughtfully integrating interactive learning and technology into trauma-informed care, it becomes possible to create spaces that empower survivors while ensuring their safety, autonomy and well-being.

### *6.4.2 Technology as a tool for empowered healing*

In a world where trauma often isolates, technology can be a surprising ally in the journey back to connection. The screen, once a barrier, becomes a portal that, when designed with care, offers survivors of trauma something rare and essential: the freedom to engage, to opt out, to speak anonymously or to simply be present. It is not the digital tool itself that brings healing, but the intention behind its design, the embedded principles of safety, choice and agency that echo the very heart of trauma-informed care.

Interactive learning and technology are not replacements for human presence but extensions of it. They serve as bridges between isolation and community, between overwhelm and empowerment, between knowledge and embodied practice. Whether through AI chatbots that whisper grounding words in the midst of a panic attack or anonymous digital spaces where students dare to speak their truth for the first time, technology can offer a gentle invitation: "*You are not alone. And you are in control.*"

But this promise comes with responsibility. Trauma rewires the brain toward hypervigilance; the digital world can easily become another minefield of triggers, overstimulation and re-exposure. Thus, trauma-informed technology must be curated with nuance. Opt-out buttons are not optional, they are sacred. Competitive features must give way to self-paced learning. The mute button becomes as vital as the microphone. In this reimagined landscape, every click and swipe carries weight and every interface is a potential touchpoint for trust or harm.

The case studies are compelling: engagement rises when learners can participate anonymously, skill-building improves when content is gamified without pressure and digital peer support offers connection when traditional therapy feels out of reach. These are not just statistics, they are stories of people finding moments of safety in unexpected places. A teenager who opens a calming app instead of self-harming. A teacher who learns to co-regulate with a student using a VR simulation. A survivor who finds solace in a chatbot at 2 a.m. These moments matter.

As practitioners, educators and designers, our role is not to create perfect tools but to co-create experiences that honor the complexity of trauma and the resilience of those who live with it. This means piloting tools with humility, evaluating risk with rigor and listening, truly listening, to the voices of survivors at every step. It means asking not just what can this technology do, but how will this technology feel?

In the end, trauma-informed technology is not about innovation for innovation's sake. It is about restoring agency in a world where trauma once stole it. It is about creating digital spaces that do not just transmit information but hold space, spaces where silence is honored, participation is a choice and healing is quietly, patiently invited. This chapter calls us to integrate technology not as a solution but as a companion. A carefully chosen word in a chatbot script. A non-flashing image in a grounding app. A workshop poll that invites rather than demands a response. These are the new languages of care.

And perhaps, in this quiet digital revolution, we find something profound: that healing, even when facilitated through code and pixels, still begins with the same timeless truth – safety, presence and the freedom to choose.

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# Chapter 7: Measuring the impact of Trauma-Informed Practices and continuous improvement

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## 7.1 Environments for Trauma-Informed Practices and how to measure the impact

Trauma-informed practices have gained recognition as an essential approach to supporting individuals who have experienced trauma. These practices focus on understanding how trauma affects people, recognizing its signs, and responding in ways that promote healing and resilience. Trauma can have lasting effects on emotional well-being, physical health, and social interactions, making it crucial to address with sensitivity and awareness. As these practices become more widely used in education, healthcare, and social services, measuring their impact is essential to ensure effectiveness and refine application. A structured approach to assessment allows professionals to determine whether trauma-informed practices lead to meaningful improvements in individuals' lives and institutions' operations. Exploring the methods, challenges, and outcomes of evaluating these practices highlights the importance of research in guiding policy and practice.

Trauma-informed practices are grounded in a framework that prioritizes key principles such as safety, trustworthiness, peer support, collaboration, empowerment, and cultural sensitivity. These foundational elements guide professionals and organizations in creating environments that actively avoid re-traumatization and promote healing. Rather than focusing solely on symptoms or behaviors, trauma-informed care encourages understanding the impact of trauma on individuals' lives and tailoring support accordingly. These practices can be implemented across diverse settings – including schools, healthcare, social services, and workplaces – where fostering emotional safety and respectful relationships is crucial for supporting resilience, recovery, and long-term well-being.

In educational settings, trauma-informed practices involve reshaping classroom dynamics and teaching strategies to accommodate the needs of students affected by trauma. Teachers and school staff are trained to identify behavioral and emotional signs of trauma, create predictable routines, and foster emotionally safe environments. Building trust and strong student-teacher relationships is central. These efforts reduce disciplinary issues, increase student engagement, and improve academic performance. By promoting safety and inclusion, schools become nurturing spaces where all learners can thrive.

In healthcare environments, trauma-informed care prioritizes safety, compassion, and patient autonomy. Providers learn to recognize how trauma may shape health behaviors, such as avoiding care or struggling with trust. They adjust their communication and procedures to be person centered and culturally sensitive to prevent re-traumatization, especially during invasive or emotionally charged interventions. This approach strengthens the therapeutic alliance, enhances patient satisfaction, and improves adherence to treatment plans. Ultimately, trauma-informed care leads to better overall health outcomes, particularly for patients with histories of complex or chronic trauma.

In social services, trauma-informed practices are embedded into training, policy, and daily interactions with clients. Staff learn to approach clients with empathy and awareness of how trauma shapes behavior and decision-making. By creating environments grounded in respect, trust, and collaboration, agencies improve client engagement and service outcomes. This model not only enhances effectiveness but also reduces secondary trauma among staff. A trauma-informed culture within organizations promotes emotional safety and resilience for both service recipients and professionals.

Modern workplaces are increasingly recognizing the profound impact of trauma and chronic stress on employee well-being, engagement, and performance. A trauma-informed workplace acknowledges that individuals may bring a history of trauma – including adverse childhood experiences, workplace-related stressors, or community violence – into the work environment, and that current organizational structures may unintentionally reinforce harm. In response, trauma-informed organizations adopt policies and practices that promote psychological safety, resilience, and healing. A trauma-informed approach is grounded in key principles of safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and cultural, historical, and gender responsiveness. These principles can be translated into organizational practices such as flexible work hours, mental health accommodations, wellness check-ins, and reflective supervision sessions. These strategies support a climate where employees feel respected, understood, and empowered regardless of whether their trauma is disclosed or known.

In trauma-informed workplaces, leadership plays a critical role. Leaders and managers are trained not only to recognize signs of distress but also to respond with empathy, not punishment. Instead of resorting to disciplinary action when performance drops, a trauma-informed leader might initiate a compassionate conversation, exploring underlying challenges and co-developing solutions. This shift in relational dynamics fosters psychological safety and helps prevent retraumatization, especially for employees with a history of interpersonal trauma. Creating trauma-informed workplace environments also requires attending to systemic equity and justice issues. Trauma does not affect all employees equally. Racial and gender-based micro aggressions, economic insecurity, and exclusionary practices can exacerbate stress and create an unsafe environment for marginalized workers. As such, organizations must integrate trauma-informed care with commitments to diversity, equity, and inclusion. This intersectional approach deepens the capacity of organizations to truly support the well-being of all employees. Implementing trauma-informed practices has been shown to reduce burnout, enhance morale, and improve organizational outcomes. Workers in trauma-informed settings report greater job satisfaction, lower turnover rates, and stronger team cohesion. By addressing trauma proactively and cultivating emotional wellness, organizations not only protect their employees but also benefit from a more resilient, productive, and sustainable workforce. Ultimately, trauma-informed practices at the workplace are a win-win, reducing burnout, enhancing morale, and improving outcomes. In a time when mental health challenges and workplace stress are on the rise, shifting toward trauma-informed systems is not only ethical but essential for organizational success, strengthening working alliances, productivity, trust, and alignment with human values.

*7.1.1. The importance of trauma-informed communities*

Trauma is a widespread and often invisible force that shapes individual lives and collective well-being. Adverse experiences such as violence, neglect, systemic racism, poverty, and environmental disasters do not only affect individuals; they reverberate across families, schools, neighborhoods, and entire communities. In response, the movement toward creating trauma-informed communities has emerged as a powerful framework to promote healing, resilience, and social justice. A trauma-informed community recognizes the prevalence and impact of trauma and actively works to prevent retraumatization, build supportive relationships, and foster environments where individuals can heal and thrive. This approach is built on guiding principles such as safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender issues. Applying these principles at a community level means transforming how public systems, social services, educational institutions, and civic leaders respond to the needs of the population, especially those who have been historically marginalized and underserved.

One key rationale for trauma-informed communities is the prevalence of trauma. The original Adverse Childhood Experiences study found that nearly two-thirds of respondents had experienced at least one form of childhood trauma, with strong correlations to long-term physical and mental health issues including heart disease, substance abuse, depression, and suicide. More recent research highlights how trauma is compounded by systemic factors such as racism, economic inequality, and community violence. Creating trauma-informed communities means shifting the question from *"What's wrong with you?"* to *"What happened to you?"* and ultimately, to *"How can we support your healing?"*

A trauma-informed community is not just trauma-aware, it is action-oriented. This means ensuring that services and institutions are equipped to recognize and respond to trauma. Schools, for example, play a critical role in buffering the effects of trauma on children. Trauma-informed schools provide consistent routines, emotional safety, and opportunities for students to regulate and express their emotions. Similarly, law enforcement agencies that adopt trauma-informed practices can reduce harm, rebuild trust with the community, and improve outcomes for individuals in crisis.

One essential feature of trauma-informed communities is the empowerment of community members. Healing does not happen in isolation – it is relational, cultural, and collective. Engaging community voices – especially those with lived experience of trauma – in the design and delivery of services builds trust and ensures relevance. Resilience is deeply tied to social cohesion, cultural identity, and meaningful participation. Community-based initiatives, such as peer support groups, cultural healing practices and trauma-informed urban planning, can create spaces of belonging and recovery.

Moreover, trauma-informed communities address not only the effects of trauma but also its root causes. Structural inequalities – such as racism, housing insecurity, and lack of access to healthcare – are themselves sources of chronic trauma. A trauma-informed lens encourages systemic accountability and promotes equity. For example, the city of San Francisco has adopted a cross-sector trauma-informed systems model to train public sector employees and create a more compassionate, coordinated response to community needs.

Importantly, trauma-informed communities are also prevention-oriented. By cultivating safe environments, teaching coping skills, supporting parenting, and reducing community-level stressors, these communities can help interrupt the intergenerational transmission of trauma. Public health models of trauma-informed care emphasize that early interventions – particularly in early childhood and through wraparound family support – can yield long-term benefits for individual and collective health.

Creating trauma-informed communities also makes economic sense. The long-term costs of untreated trauma (ranging from healthcare and criminal justice expenditures to lost productivity) are immense. Individuals with multiple adverse childhood experiences are significantly more likely to experience unemployment, poor health, and substance use, leading to substantial social and economic burdens. Trauma-informed approaches, by contrast, emphasize prevention, early intervention, and systemic alignment, making them not only more humane but also more cost-effective.

In conclusion, trauma-informed communities represent a paradigm shift in how we understand and respond to human suffering. By embedding compassion, safety, equity, and empowerment into the fabric of community life, we can promote healing and resilience on a broad scale. These communities are not built overnight – they require sustained commitment, cross-sector collaboration, and the leadership of those most impacted by trauma. But the benefits are profound: a healthier, more connected, and more just society for all.

### *7.1.2 Why measuring impact is important*

Assessing the impact of trauma-informed practices is vital to confirming that they achieve their intended outcomes. Without systematic evaluation it is difficult to determine whether initiatives genuinely support healing, improve functioning or reduce harm. Measuring effectiveness allows stakeholders to differentiate between meaningful interventions and those that lack substance. It also highlights successful strategies worth expanding. Ultimately, evaluation ensures that trauma-informed practices remain more than a conceptual framework and become a demonstrably effective approach to care and support.

Clear, data-driven evidence of trauma-informed practice outcomes strengthens the case for supportive policies and sustained funding. When programs can demonstrate positive impacts – such as improved well-being, reduced crisis incidents or enhanced staff performance – they become more attractive to policymakers and funders. Quantifiable success builds credibility and trust, making it easier to advocate for trauma-informed integration across systems. Evaluation data thus becomes a critical tool in expanding these approaches and influencing the allocation of resources at local and national levels.

Continuous evaluation and research provide essential insights into what is working and what requires refinement. Feedback from assessment helps organizations adapt their strategies to better meet the needs of the people they serve. It encourages innovation, highlights areas of strength and identifies gaps or inconsistencies in implementation. This process supports professional development, enhances the quality of care and ensures that trauma-informed approaches evolve in

response to emerging knowledge, diverse populations and changing social contexts. Service users should be actively involved in the evaluation of services and their improvement, ensuring practices remain responsive and grounded in lived experience.

Measurement and evaluation also ensure that trauma-informed practices are implemented with integrity and consistency. Accountability mechanisms help confirm that programs adhere to the core principles of safety, trust, collaboration, empowerment and cultural responsiveness. Without assessment, organizations risk using the trauma-informed label without true fidelity. Evaluation promotes transparency and responsibility, ensuring that clients and staff experience the benefits of genuinely trauma-informed environments. It also helps safeguard against harmful practices disguised as therapeutic interventions. The active role of service users and their families can bring significant improvements, strengthening person-centered approaches and driving quality forward.

Demonstrating the measurable benefits of trauma-informed practices plays a powerful role in raising awareness and gaining public and institutional support. When stakeholders – including families, communities and professionals – witness tangible improvements in well-being and organizational performance, they are more likely to advocate for broader adoption. Public awareness fosters cultural shifts in how trauma is understood and addressed, encouraging schools, healthcare systems, decision makers and governments to embed trauma-informed principles into their operations. This momentum can drive systemic change rooted in compassion and resilience.

### *7.1.3 How to measure the impact of Trauma-Informed Practices*

Measuring psychological and behavioral outcomes is a key method for evaluating the effectiveness of trauma-informed practices. Standardized tools such as the PTSD Checklist, the Generalized Anxiety Disorder scale, and the Patient Health Questionnaire are used to monitor symptoms of trauma, anxiety and depression over time. Other instruments such as the Difficulties in Emotion Regulation Scale help assess an individual's ability to manage emotional responses. Behavioral indicators such as reduced aggression, improved interpersonal skills and greater emotional resilience further signal success. Together, these measures offer insight into how trauma-informed practices influence emotional and psychological healing in meaningful ways.

At the organizational level, evaluation involves examining a range of structural and cultural indicators. Staff training outcomes reveal whether employees understand and apply trauma-informed principles effectively, while reviews of institutional policies determine the extent to which trauma-informed values are embedded into daily operations. Data on behavioral incidents, disciplinary actions and crisis interventions show whether trauma-informed approaches reduce disruption and enhance safety. Employee surveys measuring engagement, burnout and job satisfaction provide additional insights into workplace climate. These metrics help assess whether trauma-informed practices are leading to systemic improvements in organizational health and performance. Transforming organizational culture requires an integrated approach that aligns policies, procedures and daily practices with a commitment to safety and healing.

Trauma-informed practices can also be evaluated through physiological and neurological indicators that provide objective evidence of stress reduction and healing. Biomarkers such as salivary cortisol

levels reflect changes in the body's stress response, while heart rate variability provides insight into emotional regulation and resilience. Advanced technologies such as functional magnetic resonance imaging and electroencephalography reveal brain activity patterns associated with trauma and recovery. These tools can track neurological changes in individuals receiving trauma-informed care, highlighting how such approaches may contribute to long-term healing at the biological level. The polyvagal theory underpins much of the biological rationale for trauma-informed care by linking autonomic flexibility with safety, connection and emotional regulation.

One of the most powerful indicators of trauma-informed effectiveness lies in social and relational outcomes. Trauma-informed practices often lead to improved communication, increased trust and stronger connections within families, peer groups and professional settings. These outcomes can be measured through interviews, surveys and observational data. When individuals feel safe, supported and understood, they are more likely to engage in services and build meaningful relationships. A heightened sense of belonging and community is also a key marker of success. These social gains not only support personal healing but also contribute to healthier, more connected environments across all domains of life. As has been emphasized in trauma theory, "reconnection" is a fundamental phase in the process of restoring psychological integrity. A large body of research has shown that some people grow psychologically and existentially from their trauma experiences, and there are relational qualities in trauma treatments and personal relationships that can facilitate growth from trauma.

Trauma can shatter the foundations of a person's worldview, identity and sense of safety. Yet amidst the emotional, psychological and physical toll, some individuals not only recover but also experience positive personal transformation – a phenomenon known as post-traumatic growth. Far from suggesting that trauma is beneficial or desirable, post-traumatic growth refers to the process through which survivors develop new perspectives, strengths and relationships as a result of their struggle to cope and make sense of what happened. One important framework emphasizes that the third and final stage – reconnection – is critical. In this phase, survivors move beyond the internalization of victimhood and begin to reclaim a sense of agency through meaningful relationships and social engagement. Rebuilding connections with others is essential to restoring psychological integrity, and healing is not an isolated intrapsychic event but a profoundly interpersonal process.

Building on this relational foundation, researchers have identified five key domains where growth can occur: increased personal strength, improved relationships with others, greater appreciation of life, new possibilities, and spiritual or existential development. Their work suggests that traumatic events can serve as a "seismic" disruption that prompts individuals to re-evaluate their values and life goals, leading to a reconstruction of self that integrates the trauma without being defined by it. The process of post-traumatic growth is often facilitated by relational and therapeutic factors. Supportive interpersonal relationships, whether in personal life or therapeutic settings, provide a context in which survivors can feel safe enough to explore and process traumatic experiences. Empathy, validation and the co-construction of meaning are critical ingredients in this healing journey. In trauma-informed care, relational safety is a cornerstone. When individuals are met with trust, respect and emotional attunement, they are more likely to access the vulnerability required for deep transformation.

Growth does not mean the absence of distress. Post-traumatic growth is not merely resilience or a return to baseline functioning – it is the emergence of positive change through the arduous work of grappling with suffering. Psychological growth often coexists with ongoing symptoms of post-traumatic stress. This duality underscores the complexity of trauma recovery – pain and growth are not mutually exclusive. From a neurobiological perspective, relational healing corresponds with findings in interpersonal neurobiology. Human relationships have the power to shape and rewire the brain. Experiences of emotional resonance and secure attachment can promote integration across neural networks that were previously dysregulated due to trauma. Thus, healing relationships – whether therapeutic, familial or communal – have the potential to support not only psychological but also neurophysiological reorganization.

Spirituality and meaning making are also important dimensions of post-traumatic growth. For many survivors, trauma challenges existing belief systems, often prompting existential reflection. In some cases, individuals emerge with a deeper sense of purpose or a renewed connection to something larger than themselves. The ability to reconcile global beliefs with traumatic events is a critical mediator in the pathway to growth. Furthermore, cultural factors influence how trauma and growth are experienced and expressed. What constitutes growth, and how it is valued, can vary significantly across cultures. Trauma-informed interventions that aim to support growth must be sensitive to cultural narratives and identities, integrating a lens of cultural humility to ensure that healing is relevant and empowering to diverse populations.

Post-traumatic growth is clear proof of human resilience and the capacity for the construction of meaning. While not all trauma survivors will experience it – and certainly not in a linear or predictable manner – there is hope in the recognition that growth is possible. At its core, post-traumatic growth is relational: it unfolds in the spaces where empathy, meaning and connection allow individuals to reclaim their narratives and reconstruct their lives.

### *7.1.4 Research methods for measuring effectiveness of trauma-informed practices*

Longitudinal studies track individuals over extended periods to evaluate the sustained impact of trauma-informed practices. These studies are crucial in understanding whether the benefits of such approaches – such as improved mental health, emotional regulation and social functioning – are maintained over time. By observing changes across months or years, researchers can determine the long-term effectiveness of interventions and identify which aspects contribute most to enduring recovery and resilience.

Randomized controlled trials are considered the gold standard in research and are used to compare the effectiveness of trauma-informed interventions with traditional approaches. Participants are randomly assigned to either a trauma-informed group or a control group, allowing for objective comparisons. While ethically complex, especially when withholding support, randomized controlled trials provide robust data on outcomes, helping to establish causality and validate trauma-informed care as best practice in various settings. Rigorous trials are essential for ensuring scalability and policy endorsement of trauma-informed programs.

Mixed-methods research combines qualitative and quantitative approaches to offer a comprehensive evaluation of trauma-informed practices. Surveys and data analysis provide measurable outcomes, while interviews and case studies offer depth and context. This approach captures both the statistical impact and the personal experiences behind the numbers, creating a fuller picture of effectiveness and helping practitioners understand the nuanced ways trauma-informed care affects individuals and communities.

Case studies document real-life examples of trauma-informed practices in action, offering rich insights into successful implementation. These studies detail the specific context, strategies utilized and outcomes observed, making them valuable tools for learning and replication. While not generalizable, they highlight best practices, illuminate challenges and provide concrete evidence of impact in schools, healthcare, social services and other organizational settings where trauma-informed care is critical.

Community-based research actively involves individuals with lived experiences of trauma in the design and execution of projects. This participatory approach ensures that studies remain relevant, ethical and grounded in real-world needs. By honoring the voices of trauma survivors, community-based research enhances authenticity and equity, making findings more applicable to diverse populations and increasing the likelihood that trauma-informed initiatives will be both effective and widely accepted. Moreover, this approach empowers all stakeholders, especially trauma survivors and their families, by fostering a sense of control and promoting effective coping mechanisms.

### *7.1.5 Challenges in measuring trauma-informed practices*

One of the key challenges in measuring the effectiveness of trauma-informed practices is the wide variability in how individuals respond to trauma and healing. While some people may show rapid improvement, others might need longer or different types of support. This diversity makes it difficult to apply standardized metrics, requiring researchers to account for personal, developmental and cultural differences in both trauma experiences and recovery pathways.

Another complication lies in the different forms of implementation. Trauma-informed practices are introduced differently across organizations, regions and countries, which complicates evaluation efforts. Without a uniform model or consistent training standards, it becomes challenging to compare outcomes or attribute success directly to trauma-informed care. This variability can lead to uneven results and misinterpretation of effectiveness, highlighting the need for clearer guidelines, shared benchmarks and fidelity assessments to ensure that principles are applied as intended. Several organizations are currently working toward establishing such standards, including SAMHSA, the Harvard University Trauma Project, the European Network for Psychotherapeutic Care, the Global Collaboration on Traumatic Stress, the American Academy of Experts in Traumatic Stress and the European Society of Trauma and Dissociation.

Tracking the long-term impact of trauma-informed practices also presents logistical and methodological difficulties. Recovery from trauma is often nonlinear and may span years, requiring sustained follow-up that many research projects are not equipped to manage. Participant attrition,

funding limitations and shifting life circumstances further complicate longitudinal research, making it hard to maintain consistent data collection and accurately assess enduring benefits.

Ethical considerations represent another important challenge. Evaluating trauma-informed practices often raises concerns, especially when using control groups that may not receive the intervention. Withholding potentially beneficial support can be problematic, particularly for vulnerable populations. Researchers must balance the need for rigorous evidence with the imperative to do no harm, adopting ethical designs that protect participants while still yielding meaningful insights into effectiveness.

Finally, limited funding for research remains a significant barrier despite growing interest in trauma-informed approaches. Comprehensive evaluation often requires long-term, multi-method studies that are costly and resource-intensive. Restricted financial support limits the scope and depth of research, slowing progress in refining practices and expanding their adoption across sectors where trauma-informed care could make a profound difference.

### *7.1.6 Future directions for trauma-informed research*

Developing standardized tools for evaluating trauma-informed practices is a priority for future research. Universal metrics would allow for consistent assessment across different settings and populations, improving comparability and reliability. These tools should capture both quantitative outcomes and qualitative experiences, ensuring a balanced view of effectiveness while also guiding training, policy development and program refinement at local and national levels.

Participatory action research involves trauma survivors as co-researchers, ensuring that studies are grounded in lived experience. This inclusive and empowering approach enhances the relevance and ethical integrity of trauma-informed research. By valuing community input and fostering collaborative inquiry, participatory research not only empowers individuals but also produces findings that are more applicable, actionable and attuned to the real-world challenges faced by those impacted by trauma. It also offers additional benefits for the recovery of survivors by grounding empowerment of all stakeholders and promoting effective coping, environmental control and safety.

Emerging technologies provide new possibilities for evaluating trauma-informed practices. Artificial intelligence and machine learning can analyze large data sets, identify patterns and predict outcomes, offering powerful tools for understanding effectiveness. Technology also supports digital data collection, remote surveys and real-time feedback, which enhance scalability and enable more dynamic and responsive approaches to measuring trauma recovery and organizational impact.

Future research will also benefit greatly from cross-disciplinary collaboration that draws on psychology, education, neuroscience and public health. Each field brings unique methods and insights that can deepen understanding of trauma and recovery. By integrating diverse perspectives, researchers can develop more comprehensive models, design more effective interventions and ensure that trauma-informed practices address the complex and interconnected needs of individuals and communities.

Culturally inclusive assessments are equally essential for accurately evaluating trauma-informed practices across diverse populations. Standard tools may not capture the unique expressions of trauma and healing in different cultural contexts. By designing assessments that reflect varied worldviews, languages and social norms, researchers can ensure equity in evaluation and produce findings that are valid, respectful and meaningful for all communities served by trauma-informed care.

Measuring the impact of trauma-informed practices is critical to validating their effectiveness and refining their application. By utilizing diverse psychological, physiological and organizational metrics, professionals can assess the benefits of these practices in fostering healing and resilience. Although challenges exist, continued research and innovation will strengthen trauma-informed approaches, ensuring they create supportive and empowering environments for trauma survivors. As these practices continue to evolve, a commitment to uniform measures, rigorous evaluation, evidence-based refinement and the active involvement of trauma survivors and their families will be essential in maximizing their effectiveness.

## 7.2 Continuous feedback, quality control and improvement in the application of Trauma-Informed Procedures

Trauma-informed procedures have become increasingly essential across multiple service sectors (including healthcare, mental health, education and criminal justice) due to the extensive impact of trauma on individuals and communities. These procedures are built on the principles of safety, trust, empowerment and collaboration. They are designed to minimize re-traumatization while promoting recovery (in accordance with the findings from SAMHSA. As organizations adopt these practices, ensuring their effectiveness requires systematic monitoring. Continuous feedback mechanisms, coupled with robust quality control and improvement processes, are of utmost importance to maintaining trauma-informed procedures that are responsive, adaptable, and aligned with emerging needs. Research highlights the importance of integrating continuous feedback and quality control measures into trauma-informed practices.

### *7.2.1 Trauma-Informed Procedures and the need for continuous improvement*

Trauma-informed procedures are grounded in the understanding that traumatic experiences can have long-lasting effects on mental, emotional and physical health. Influential works such as van der Kolk's *The Body Keeps the Score* emphasize how trauma imprints itself on both the mind and body, necessitating approaches that address its pervasive effects. Trauma-informed care extends beyond simple interventions; it involves creating an organizational culture that actively avoids re-traumatization and fosters healing. The guiding principles include safety, trustworthiness, peer support, collaboration, empowerment and cultural sensitivity. Due to the complexity of trauma and the evolving nature of best practices, organizations face challenges in maintaining the integrity of trauma-informed practices over time. Many interventions require adjustments to policies, staff training programs and service delivery methods. This dynamic environment makes continuous evaluation not only beneficial but essential for sustaining high-quality care.

Quality control in trauma-informed settings ensures that interventions are delivered as intended. This process may include fidelity assessments, routine audits and standardized checklists measuring adherence to trauma-informed principles. Continuous feedback provides a mechanism for capturing data from various stakeholders – clients, staff and community partners – to inform adjustments and improvements. The integration of continuous feedback with quality control measures is fundamental to any dynamic system. In healthcare, quality improvement models such as the Plan-Do-Study-Act (PDSA) cycle have been instrumental in refining practices and achieving better outcomes. When applied to trauma-informed procedures, these models ensure that organizations remain agile, learning from both successes and setbacks to enhance service delivery.

Despite the growing adoption of trauma-informed approaches, significant variations exist in how these practices are implemented across different countries. Factors such as cultural values, national policy frameworks and resource availability influence how trauma-informed practices are adapted within educational, healthcare and social service systems. These inconsistencies can create barriers to quality care and hinder cross-border collaboration. Establishing a unified European network would support the development of standardized curricula, certification programs and practice guidelines, ensuring more consistent and equitable implementation across member states.

Standardizing training and qualifications would also enhance professional mobility by enabling trauma-informed practitioners to have their credentials recognized across borders. This would reduce barriers for those seeking to work in different countries while maintaining a consistent level of competence and ethical practice. Professionals could more easily transfer their skills to new contexts, ensuring continuity of care for trauma-affected individuals. Such mobility would also encourage knowledge exchange and foster international collaborations among trauma-informed professionals, enriching the field with diverse perspectives and innovations.

With standardization, trauma-informed care would benefit from clearer definitions, shared language and agreed-upon competencies. This would strengthen the credibility of the field by reducing ambiguity and distinguishing well-trained professionals from those lacking adequate preparation. Greater clarity allows advocates to present trauma-informed practices as a rigorously defined and evidence-supported approach in policy discussions, making it easier to argue for its inclusion in legislation and funding priorities. Consistency and clarity ultimately support broader acceptance and integration of trauma-informed practices across sectors and governments.

A standardized European framework would also streamline the dissemination of evidence-based strategies by creating shared platforms for education, research and resource distribution. Professionals across countries would have access to up-to-date materials, training tools and guidelines developed collaboratively by international experts. This would reduce duplication of efforts and ensure that effective practices reach a wider audience faster. Harmonized educational and clinical standards would support ongoing innovation while maintaining quality control, benefitting practitioners and, most importantly, the trauma-affected individuals they serve.

In doing so, Europe affirms a shared ethical commitment: that every trauma-affected person, regardless of geography or circumstance, deserves access to care that is safe and grounded in a deep understanding of human vulnerability.

*7.2.2 Continuous feedback mechanisms in Trauma-Informed Procedures*

An essential feature of trauma-informed procedures is the incorporation of continuous feedback from those directly affected by or involved in service delivery. By creating structured opportunities for feedback, organizations can stay responsive to evolving needs and experiences. Feedback mechanisms promote a culture of accountability, transparency and collaboration, allowing trauma-informed systems to adapt and improve in real time. These mechanisms must be inclusive, respectful and consistent to yield meaningful data and strengthen trust among stakeholders.

Clients are the most critical source of information when assessing trauma-informed care. Feedback can be gathered through satisfaction surveys, structured exit interviews or facilitated focus groups, all designed to assess whether clients feel safe, respected and genuinely supported. These tools provide direct insight into clients' lived experiences with services and highlight areas where trauma-informed principles are either upheld or lacking. Listening to clients not only empowers them but also reinforces the work alliance and guides practitioners in making evidence-informed, person centered adjustments that foster healing and enhance service quality.

Frontline staff, including educators, healthcare providers and caseworkers, interact daily with individuals affected by trauma and often have a nuanced understanding of how trauma-informed principles function in practice. Regular debriefings and anonymous staff surveys offer critical opportunities to surface challenges, identify areas where further training is needed and detect barriers to implementation. Supporting staff through structured reflection helps prevent burnout and secondary traumatic stress while improving adherence to trauma-informed models. When staff voices are heard and valued, organizations foster a climate of mutual respect and learning, leading to stronger work alliances and a closer alignment between trauma-informed ideals and everyday operations.

Trauma has ripple effects that extend beyond the individual to families and broader communities. Including family members and community partners in feedback processes can reveal valuable perspectives on service accessibility, cultural relevance and community-specific needs. The centrality of community voice and cultural identity in trauma recovery highlights the importance of engaging these stakeholders to tailor trauma-informed approaches in inclusive and contextually appropriate ways. Hosting community listening sessions, advisory boards or family forums strengthens partnerships and reinforces a collective responsibility for healing, equity and resilience within trauma-informed systems.

Advances in technology now facilitate real-time data collection on trauma-informed practices on a wider level. Digital surveys, mobile applications and online reporting systems provide platforms for stakeholders to share experiences efficiently and safely. Such tools not only enable trend analysis over time but also encourage honest communication through anonymous feedback. When implemented with attention to privacy and accessibility, technological tools can provide actionable insights to improve trauma-informed implementation at the individual, organizational and systemic levels. In this way, there is an opportunity to transform trauma-informed care from a patchwork of local practices into a coherent framework across many nations.

### *7.2.3 Quality control strategies in Trauma-Informed Procedures*

Quality control begins with defining clear, evidence-based standards and protocols. Organizations must establish measurable benchmarks such as client safety indicators, adherence to trauma-informed communication techniques and system-level metrics like reduced re-traumatization incidents. These protocols should be developed in consultation with experts in trauma care and quality improvement. Formalizing trauma-informed care standards helps promote consistency and accountability while supporting reflective practice.

Fidelity assessments ensure that trauma-informed procedures are implemented consistently and as intended. Regular audits conducted by internal quality control teams or external evaluators may include direct observations, reviews of case notes and interviews with clients and staff. Such assessments are essential for identifying deviations from trauma-informed principles and for designing targeted training or supervisory interventions. Fidelity tools, when combined with outcome measures, help create a feedback loop that informs continuous improvement.

For quality control measures to be effective, they must become an integral part of the organization's culture. Leadership support, ongoing staff training and transparent communication of quality standards are critical. In trauma-informed systems, organizational learning is continuous and participatory. Embedding trauma-informed care into performance review structures and staff development pathways ensures that practice fidelity is not merely monitored but deeply embedded into day-to-day culture. Empowering staff to co-create and refine these quality systems also improves morale and retention.

### *7.2.4 Continuous quality improvement: strategies and best practices*

The PDSA cycle involves planning a change, implementing it on a small scale, studying the results, and acting on the findings. In trauma-informed care, this model helps test and refine interventions based on real-time feedback. For example, if client feedback highlights that long wait times increase anxiety, an organization might plan and implement a new scheduling system (Do). After analyzing its impact (Study), further adjustments can be made before adopting the system fully (Act).

Moreover, continuous quality improvement relies on systematic data collection and analysis. Dashboards displaying key performance indicators (KPIs) like client satisfaction, staff adherence, and incident rates enable informed decision-making. Data-driven insights help organizations refine interventions and ensure accountability.

When we talk about challenges in implementing continuous feedback and quality control in trauma-informed settings, the main ones include:

- Variability in trauma-informed practices across organizations;
- Limited financial and human resources for quality improvement efforts;
- Difficulty in measuring qualitative outcomes like client empowerment and perceived safety.

To address these challenges, organizations can:

- Develop flexible quality metrics tailored to specific settings;
- Invest in ongoing staff training on trauma-informed care and quality improvement;
- Leverage digital tools for real-time feedback collection and analysis;
- Establish collaborative networks to share best practices and solutions.

In any case, future research should explore the long-term impact of continuous feedback and quality control in trauma-informed settings. Studies tracking these processes over time and evaluating their cost-effectiveness could further refine best practices. Additionally, developing standardized evaluation frameworks that accommodate diverse trauma-informed models will strengthen the field.

What is important to emphasize is that the integration of continuous feedback, quality control and improvement strategies should be seen as essential for sustaining effective trauma-informed procedures. By embedding continuous learning and adaptation into organizational culture, organizations can ensure responsive and compassionate care for trauma survivors. Overcoming challenges through innovation, collaboration and research has the propensity to further enhance trauma-informed care, ultimately leading to better outcomes for individuals, families and communities.

## 7.3 Assessment of the effectiveness of Trauma-Informed Practices

Despite the conceptual appeal and growing implementation of trauma-informed practices, evaluating their effectiveness remains challenging. One primary reason is the holistic nature of these approaches. Trauma-informed care involves changes to organizational culture, staff training, policy redesign and direct service delivery. Therefore, outcome measures must capture both individual-level changes such as reductions in post-traumatic stress symptoms and systemic shifts such as improved organizational climate. Assessing these complex changes necessitates robust and multifaceted evaluation frameworks.

**Quantitative assessment** of trauma-informed practices often involves standardized instruments and outcome measures. Researchers use psychometrically validated scales to assess mental health outcomes such as anxiety, depression and post-traumatic stress disorder symptoms. For example, pre- and post-intervention assessments can track changes in symptom severity among clients engaged in trauma-informed care. Additionally, reductions in emergency room visits, hospital readmission rates or behavioral incidents are used as indicators of service delivery improvements. Another quantitative approach involves tracking system-level indicators. Educational settings might analyze student attendance, disciplinary referrals and academic performance before and after implementing trauma-informed policies. Similarly, criminal justice settings may examine recidivism rates or behavioral improvements among incarcerated individuals. When collected systematically, such data provide insight into whether trauma-informed practices yield measurable improvements in organizational outcomes.

**Qualitative methods** also play a crucial role in assessing trauma-informed practices, capturing the nuanced experiences of clients, staff and other stakeholders. Methods such as focus groups, in-depth interviews and participant observations allow evaluators to explore the subjective impact of

trauma-informed interventions. For example, qualitative studies have revealed that clients often report feeling more respected and understood in trauma-informed environments, even when quantitative symptom measures show modest improvements. Evaluators also assess whether staff training translates into compassionate, non-punitive interactions with clients. In this way, qualitative methodologies contribute a richer understanding of how trauma-informed practices influence individual behavior and systemic change.

**Mixed-methods research** that integrates quantitative and qualitative approaches has gained popularity, most notably due to complexity of trauma-informed practices. This approach can triangulate findings from different sources, providing a more comprehensive evaluation of program effectiveness. For instance, quantitative data might reveal a decrease in post-traumatic stress disorder symptoms, while qualitative interviews can identify which aspects of the trauma-informed environment were most beneficial. This integration validates the effectiveness of trauma-informed practices while highlighting areas for refinement.

### *7.3.1 Evidence on effectiveness and challenges in demonstrating effectiveness*

Research suggests that trauma-informed practices improve client outcomes, though results can be mixed. Mental health interventions that incorporate trauma-informed care have been associated with reduced symptoms of depression and post-traumatic stress disorder, improved emotional regulation and enhanced overall functioning. In schools, trauma-informed approaches have been linked to better student behavior, engagement and academic performance, demonstrating their potential to mitigate trauma's impact on learning. Beyond psychological benefits, trauma-informed practices have also been associated with improved physical health outcomes. By reducing stress and the physiological burden of trauma, individuals receiving trauma-informed care may experience fewer stress-related health complications such as hypertension and cardiovascular issues. However, given the limitations of existing research such as small sample sizes or short follow-up periods, more extensive longitudinal studies are necessary.

At the organizational level, trauma-informed practices contribute to improved workplace environments and staff well-being. Employees in trauma-informed settings report greater job satisfaction, reduced burnout and an increased sense of efficacy in their roles. These outcomes are vital for staff retention and the sustainability of trauma-informed programs. Organizations integrating trauma-informed principles often experience lower staff turnover and enhanced workplace morale, resulting in more consistent and compassionate client care. System-wide, trauma-informed practices can lead to policy and procedural changes that minimize re-traumatization. For example, criminal justice settings adopting trauma-informed approaches may shift toward rehabilitation-focused interventions, reducing recidivism rates and promoting successful community reintegration. However, long-term data collection is essential to measure such systemic benefits effectively.

Despite encouraging evidence, evaluating trauma-informed practices presents challenges. The broad and evolving nature of trauma-informed care leads to variability in implementation across different settings, making direct comparisons difficult. Additionally, organizations often implement multiple simultaneous interventions such as expanded mental health services, which complicates

attributing outcomes solely to trauma-informed practices. Methodological limitations, such as small sample sizes and reliance on self-reported data, further hinder the generalizability of findings.

Trauma-informed practices represent a paradigm shift in service delivery across multiple sectors. By embedding principles of safety, trustworthiness, choice, collaboration and empowerment, these approaches can mitigate trauma's negative effects and foster healing at both individual and systemic levels. While research indicates promising outcomes, challenges in measuring effectiveness highlight the need for more rigorous evaluation methodologies. Moving forward, integrating quantitative, qualitative and mixed-methods research will be key to refining trauma-informed interventions and ensuring their sustainability. As trauma-informed practices continue to evolve, practitioners, policymakers and researchers must collaborate to enhance their effectiveness, address implementation challenges and promote compassionate, evidence-based care for trauma survivors.

## 7.4 The benefits of establishing and maintaining a European network of trauma-informed practices teachers and trainers

Despite considerable progress in individual European countries, the coordination of trauma-informed practice initiatives across the continent remains limited. Educators, healthcare professionals and social workers currently operate within national frameworks, often with little cross-border collaboration. The creation of a European network of trauma-informed teachers and trainers has the potential to bridge this gap by providing a structured platform for knowledge sharing, professional development and the dissemination of best practices. Such a network would not only enhance the expertise of professionals but also contribute to a more unified and effective trauma-informed care system across Europe and beyond.

A European network would offer diverse opportunities for continuous professional development through workshops, conferences, webinars and online forums where practitioners could engage in learning and skill-building. By exchanging insights, sharing case studies and discussing real-world challenges, participants would gain deeper knowledge and practical strategies for implementing trauma-informed practices. Networking would also foster peer support, reduce professional isolation and encourage a sense of shared mission and purpose. In fields where burnout and secondary trauma are prevalent, access to such professional support is invaluable. Mentoring programs, peer-led discussion groups and expert advisory panels could further help practitioners navigate challenges while maintaining their well-being.

Significant variations currently exist in how trauma-informed practices are implemented across countries, shaped by cultural values, policy frameworks and resource availability. These inconsistencies can create barriers to quality care and hinder cross-border collaboration. A unified European framework would support the development of standardized curricula, certification programs and practice guidelines, ensuring more consistent and equitable implementation across member states. Standardized training and qualifications would also enhance professional mobility, enabling practitioners to have their credentials recognized across borders. This would reduce barriers for those seeking to work in different contexts and encourage knowledge exchange and international collaboration.

Standardization would bring greater clarity and credibility to the field by establishing shared definitions, competencies and language. This would reduce ambiguity, distinguish well-trained professionals from those without adequate preparation and strengthen the credibility of trauma-informed care in policy discussions. Consistency would also support broader acceptance and integration across sectors and governments. In addition, a European framework would streamline the dissemination of evidence-based strategies by creating shared platforms for education, research and resource distribution. Professionals would have access to up-to-date training materials and guidelines developed collaboratively, reducing duplication and ensuring effective practices reach wider audiences more quickly.

A European or international network would also play a vital role in improving trauma care and building resilient communities. Structured training programs and shared research initiatives could equip professionals to provide care that acknowledges the complexities of trauma, while collaboration among educators, social workers and healthcare providers would facilitate more holistic and interdisciplinary approaches. Such a network would expand opportunities for participatory action research and contribute to a growing body of evidence on effective interventions. By prioritizing community engagement and education, it could promote resilience at both individual and societal levels. Training programs for parents, community leaders and frontline service providers would empower communities to adopt trauma-sensitive approaches and create environments that support recovery for all members.

Establishing and maintaining such a network presents logistical and financial challenges, yet strategic planning and innovation could ensure its sustainability. Key strategies include:

- **Securing funding**: Leveraging EU grants, governmental support and private-sector partnerships to provide financial stability;
- **Utilizing technology**: Implementing virtual collaboration tools such as online learning platforms, virtual conferences and digital resource libraries to facilitate cross-border engagement;
- **Forming strategic partnerships**: Collaborating with universities, professional associations and research institutions to integrate trauma-informed principles into academic and professional training programs;
- **Adopting an inclusive governance model**: Encouraging participatory decision-making structures that allow professionals from diverse backgrounds and regions to contribute actively to the network's development.

By addressing these challenges proactively, the network could evolve into a dynamic and sustainable initiative that benefits both professionals and communities.

The creation and maintenance of a European or international network for trauma-informed practices promises significant benefits. Enhanced professional development, standardization of best practices and improved trauma care outcomes are only a few of the advantages it could provide. By prompting collaboration and knowledge exchange, the initiative has the potential to transform trauma care and significantly improve the well-being of individuals across Europe and beyond. For this vision to succeed, sustained efforts in securing funding, expanding participation and developing strategic partnerships are crucial. With thoughtful planning and collective commitment,

such a network can serve as a powerful force for positive change, ultimately leading to a more trauma-informed society that prioritizes healing, resilience and well-being for all.

## 7.5 Creating trauma-informed cities, regions and state worldwide

*7.5.1 Trauma-informed cities*

The concept of trauma-informed cities has gained traction as municipalities seek to address the long-term effects of trauma on individuals and communities. A trauma-informed city applies the core principles of trauma-informed care to urban governance, planning and public services, ensuring that policies and environments support psychological healing and community resilience. This perspective emphasizes community engagement, housing, law enforcement, public health and the integration of trauma-sensitive governance.

Urban environments profoundly influence the psychological and physical well-being of their residents. Many individuals living in cities are exposed to trauma, including poverty, systemic racism, interpersonal violence, forced displacement and environmental disasters. Traditional urban policies have often overlooked these implications for public health, education, safety and social equity. In contrast, trauma-informed urban planning recognizes the need for inclusive, compassionate and healing-centered frameworks. Cities such as Philadelphia, San Francisco and Tarpon Springs have demonstrated the transformative potential of trauma-informed approaches, while Glasgow, Helsinki, Cork and Rotterdam are developing innovative European models. Together, these examples show how trauma-informed urban planning can promote well-being, social justice and resilience.

Trauma-informed urban policy is rooted in the broader framework of trauma-informed care, so when applied to governance, these principles shape inclusive housing strategies, trauma-sensitive policing, equitable education systems and integrated health services. Trauma-informed cities also emphasize the social determinants of health such as employment, housing, education and access to care. By addressing structural and environmental contributors to trauma, they seek not only to mitigate harm but also to build resilience.

Philadelphia has become a pioneer in trauma-informed governance, creating a task force to integrate trauma principles into public policy, education and social services. Training for police officers, mindfulness programs in schools and the redesign of public spaces have all contributed to improved community outcomes. San Francisco has focused on housing and public health, weaving trauma-sensitive services into shelters, clinics and peer mentorship programs. Newark has pursued a comprehensive model through partnerships with hospitals, schools and community organizations, prioritizing trauma screening, pediatric reform and early intervention.

In Europe, Glasgow has addressed historical and generational trauma through education and public health, with its Violence Reduction Unit focusing on mentorship and early intervention. Cork has emphasized relational healing and community collaboration, embedding trauma-awareness in all forms of governance. Helsinki has adopted holistic strategies that span mental health, education and urban design, particularly for immigrant and refugee communities. Rotterdam has integrated

trauma-informed practices across safety, housing and education, training police in empathy and de-escalation, and expanding restorative justice programs.

Across these cities, several best practices are evident. Trauma-informed governance requires embedding trauma-sensitive principles into structures, prioritizing participatory design and aligning public services with the lived experiences of trauma-affected populations. Stability in housing, restorative approaches to justice, supportive education systems and culturally competent health policies are central to these transformations.

The model also faces challenges. Sustainable funding is often lacking, with many programs dependent on short-term grants. Cross-sector coordination requires strong leadership and shared accountability, while local differences limit the easy transfer of strategies from one city to another. Future research should prioritize adaptable and scalable frameworks that remain sensitive to local conditions. Longitudinal studies will also be needed to assess whether trauma-informed urban policies produce lasting benefits for public health, safety and social equity. Still, as momentum builds, trauma-informed urban planning offers a compelling vision for cities committed to equity, inclusion, and holistic well-being.

### *7.5.2 Trauma-informed states and regions*

An increasing number of states and regions across the globe are adopting trauma-informed care and trauma-informed practices to create systemic, intersectoral frameworks that prioritize the well-being of individuals and communities affected by trauma. These frameworks foster people-centered processes in which policymakers, healthcare professionals, educators and community leaders are equipped to recognize trauma's impact and implement practices that promote healing and resilience. By cultivating trauma-informed cultures and institutions, these initiatives aim to mitigate the long-term consequences of trauma on both individuals and the society at large.

In the United States, trauma-informed care has become a foundational framework across multiple public sectors. States have integrated trauma-informed principles into education, healthcare, criminal justice and social services to create environments that are safe, compassionate and responsive to trauma. Oregon has led with a statewide initiative designed to embed trauma-informed practices across schools, healthcare and community services, with particular attention to workforce wellness and reducing provider burnout. Michigan has emphasized adverse childhood experiences, ensuring that children exposed to trauma receive timely support in schools through programs such as 'Handle With Care'. California has advanced a cross-sector initiative that includes training professionals in healthcare, child welfare and education, while also embedding trauma-informed principles into medical settings to improve health outcomes. New York has fostered collaboration through a statewide network, strengthening trauma-sensitive responses in education, healthcare and communities facing economic hardship and systemic adversity.

Similar efforts are taking place internationally. The United Kingdom has integrated trauma-informed approaches into its national health and child welfare systems, with schools increasingly trained to respond to students' psychological needs. Canada has developed a national framework that emphasizes cultural responsiveness, particularly by prioritizing Indigenous knowledge and

healing practices in trauma care. Australia has expanded trauma-informed training in healthcare and education, with particular attention to survivors of domestic violence and systemic inequality. New Zealand has emphasized cultural competence, embedding trauma-informed principles into services for Māori communities and historically marginalized groups. South Africa, still addressing the deep legacy of apartheid, has adopted trauma-informed practices in healthcare and community programs, with initiatives that promote local empowerment and dialogue.

Trauma-informed principles are also being applied in global humanitarian settings. Organizations such as the World Health Organization and UNICEF use trauma-informed frameworks to shape services for refugees, displaced populations and survivors of war and disasters. These approaches prioritize psychological first aid, culturally sensitive interventions and care that integrates both immediate relief and long-term recovery.

At the heart of trauma-informed practice is a shift in perspective from asking *"What is wrong with you?"* to *"What happened to you?"* This framework acknowledges the prevalence of trauma and its influence on cognition, behavior and social relationships. It seeks to prevent re-traumatization while building environments that support recovery and resilience. Empathy, cultural awareness and organizational change are central to this approach.

The worldwide spread of trauma-informed care reflects a collective recognition of the need for more compassionate and effective responses to trauma. By embedding these principles into public systems, societies can create conditions that promote safety, healing and empowerment. Examples from the United States, the United Kingdom, Canada, Australia, New Zealand, South Africa and humanitarian contexts show the diversity of strategies being adopted, while underscoring the importance of cultural and contextual sensitivity in creating effective trauma-informed systems.

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# Chapter 8: Moving beyond stigma – addressing emotional trauma in educational settings and promoting trauma-informed practices

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Emotional trauma represents a significant yet frequently overlooked factor impacting students' academic performance, social development, and mental health. In both formal and informal educational settings, trauma may manifest in a multitude of ways, often impairing executive functions and altering students' capacity to learn. The persistent stigma surrounding trauma in educational environments prevents many learners and service users from receiving the support they require, contributing to adverse long-term consequences.

Advocacy is essential in dismantling this stigma and promoting trauma-informed practices. This chapter examines the importance of trauma awareness in formal and informal educational settings, identifies the challenges posed by stigma, and explores the benefits of adopting trauma-informed approaches in creating supportive and inclusive learning environments.

## 8.1 The impact of emotional trauma on students and informal learners and the role of stigma

Adverse childhood experiences (ACEs), such as abuse, neglect or exposure to violence, are widespread in the general population. These traumatic events can significantly impair cognitive functioning, emotional regulation, and behavior, leading to academic struggles and social difficulties. Neuroscientific research highlights that prolonged exposure to trauma can alter brain development – particularly in the prefrontal cortex and amygdala – thereby disrupting learning processes and stress responses.

Symptoms of trauma may include aggression, withdrawal or hypervigilance. Unfortunately, these are often misinterpreted by educators as disciplinary issues rather than signals of psychological distress. Without appropriate intervention, trauma can result in long-term negative outcomes, such as decreased academic performance, increased dropout rates, and the development of mental health conditions including anxiety, depression, as well as post-traumatic stress disorder (PTSD).

Educational institutions (both formal and informal) must recognize these challenges and adopt trauma-sensitive policies and practices that respond effectively to the needs of learners. A trauma-informed educational setting acknowledges the impact of trauma on learning and enables an environment in which students can achieve their full potential. This approach is strengths-based, encouraging educators to recognize and support the competencies that traumatized learners already possess, rather than focusing exclusively on problems or deficits.

A trauma-informed approach requires an awareness of the widespread impact of trauma on relationships, behavior and learning; the recognition of trauma symptoms; the integration of trauma knowledge into policies and practices; and the proactive avoidance of re-traumatization. It is crucial to emphasize that trauma-informed practices do not involve turning educators into therapists.

Rather, the objective is to cultivate understanding, ensure students feel safe and respected, and promote appropriate referrals to trauma-informed mental health services when needed.

Despite growing awareness of mental health issues, stigma surrounding emotional trauma continues to hinder effective responses in educational settings. Misconceptions, such as the belief that children will naturally "grow out of it", or that acknowledging trauma reinforces victimhood, obstruct meaningful dialogue and timely intervention. Students exhibiting trauma-related behaviors are frequently labeled as problematic rather than recognized as individuals in need of support.

Stigma also deters students and families from seeking help due to fear of judgment or discrimination. This is particularly common in communities where mental health remains taboo or where access to psychological services is limited. Furthermore, educators lacking trauma-informed training may inadvertently reinforce stigma by misinterpreting behaviors or relying on punitive disciplinary methods.

Reducing stigma is central to improving mental health outcomes in education. It is argued that stigma is not only a personal issue but also a societal and economic burden, with evidence linking stigma to increased public health expenditures. Systematic reviews have further associated stigma with higher suicide rates, underscoring the urgency of confronting discriminatory attitudes.

Historical perspectives offer important context. For example, Hippocrates once challenged the notion that epilepsy was a "*divine disease*", highlighting how societal understanding evolves with scientific knowledge. In a similar way, continued advances in mental health research can shift public perceptions and reduce stigma associated with trauma and affective disorders.

Educational institutions play a vital role in reducing stigma through structured, evidence-based interventions. Schools can implement programs that correct misconceptions, promote empathy, and encourage acceptance of diverse psychological experiences. These initiatives should involve both students and educators, recognizing the influence of school culture on student well-being.

Non-formal education presents additional opportunities for reducing stigma. In Ukraine, for example, community-based organizations have implemented innovative programs beyond traditional classrooms. The "*Open Mind*" project uses arts-based activities—including theater, music, and visual arts – to challenge mental health stereotypes. Similarly, youth centers in Ukraine have established "conversation cafés" that offer safe, facilitated discussions on mental health, especially targeting youth who might not engage with school-based services.

## 8.2 Emerging trauma-informed initiatives and the role of non-governmental organizations – an example from Italy

In Italy, trauma awareness within education is still developing, and stigma remains a considerable obstacle to the integration of trauma-informed practices. Nevertheless, recent efforts have aimed to shift perceptions and to promote emotional well-being as a critical aspect of student development.

One national initiative is the *Progetto Benessere a Scuola*, launched by the Ministry of Education. This program includes the provision of psychological counseling services for students and teachers, training opportunities for educators to recognize trauma-related symptoms, and awareness campaigns to destigmatize mental health in schools.

*Telefono Azzurro*, a leading Italian child protection organization, has also been active in promoting trauma awareness. Their school-based interventions include emotional literacy workshops for students, teacher training in trauma recognition, and the operation of a helpline for children experiencing psychological distress.

At the European level, Italy has participated in the ENABLE Project (European Network Against Bullying in Learning and Leisure Environments), which focuses on the relationship between bullying and trauma. ENABLE promotes peer-support networks, trauma-informed educational resources, and policy recommendations that support non-punitive approaches to discipline.

Another significant development has been the adoption of restorative justice practices in Italian schools, referring to approaches that focus on repairing harm, rebuilding relationships and developing accountability through dialogue rather than relying solely on punishment. These practices shift the focus from punishment to dialogue and mediation. For example, schools are implementing structured conflict resolution techniques, emotional regulation programs such as mindfulness, but also classroom modifications that are aimed towards increasing safety and predictability.

Non-governmental organizations (NGOs) have played a crucial role in advancing trauma-informed education in Italy. These organizations address key challenges such as stigma, the lack of teacher training, and limited psychological services by delivering direct support to students, conducting educational programs, and creating emotionally safe learning environments.

For instance, CIES Onlus, through the MaTeMù center, offers artistic and theatrical workshops designed to help adolescents process traumatic experiences. EMERGENCY organizes educational programs such as "Raccontare la pace" ("Telling Peace") that foster awareness around war and trauma. The ENABLE Project contributes through anti-bullying initiatives that recognize bullying as both a cause and consequence of psychological trauma.

Other NGOs work directly with schools to advance trauma-sensitive environments. The group called 'Rete Dafne Italia' collaborates with schools to implement welcoming policies for trauma-experienced students, while AISTED advocates for classroom practices including mindfulness and grounding exercises. Telefono Azzurro supports schools through staff training and awareness-raising activities aimed at cultivating safe educational environments.

Research underscores the urgency of these interventions. It has been shown that stigma often prevents individuals from seeking psychological help, contributing to widespread under-treatment. An example from Germany shows that, although 5% of the population met the diagnostic criteria for depression, only 60–70% of affected individuals received care – of which only half were accurately diagnosed. Furthermore, only 10% of those in need received treatment in line with international standards. Such insights (that are supported by the literature) highlight the systemic

consequences of stigma and the necessity of embedding stigma-reduction strategies into educational frameworks.

Therefore, by emphasizing trauma awareness and normalizing discussions around mental health, schools and community organizations can contribute to a broader cultural shift. This shift can thus allow students to thrive academically, socially and emotionally.

## 8.3 Practical actions for informal educators to recognize and support trauma survivors

*8.3.1 Training and education on trauma-informed practices*

Informal educators play a crucial role in recognizing and responding to trauma in their learning environments. To support this responsibility, structured training programs can significantly enhance their ability to identify trauma symptoms and adopt effective strategies for intervention. These training opportunities – often provided by schools, community organizations or mental health professionals – may include hands-on sessions that incorporate case studies, role-playing and scenario-based exercises. Such experiential learning helps deepen practical understanding and build educator confidence.

Online resources also play an essential role in providing accessible education. Organizations such as the SAMHSA and the National Child Traumatic Stress Network (NCTSN) offer flexible, evidence-based modules that allow educators to engage with foundational concepts of trauma-informed care on their own time. These platforms ensure that even educators working in remote or resource-constrained environments can benefit from high-quality training.

Peer learning groups further enhance professional development by offering informal educators a forum to share experiences, exchange strategies and reflect on challenges. These collaborative settings adopt a culture of continuous learning and mutual support, which is fundamental to sustaining trauma-sensitive educational environments.

*8.3.2 Developing organizational policies on trauma awareness*

The development of formal organizational policies reflecting trauma-informed principles is a critical step in establishing consistent and compassionate practices. These policies should provide clear protocols for behavioral intervention, communication procedures and mandatory staff training. Standardization ensures that all members of an organization respond to trauma-related behaviors with empathy and consistency, minimizing the risk of re-traumatization.

In addition to institutional policies, it is valuable to identify and support trauma-informed champions within the organization. These individuals can serve as internal leaders, facilitating access to resources, mentoring colleagues and promoting a trauma-sensitive culture. Their presence reinforces the importance of trauma awareness across the institution and helps sustain momentum in adopting best practices.

To ensure effectiveness and relevance, policies and training materials should be regularly reviewed and updated in accordance with the latest research. This ongoing revision process guarantees alignment with emerging challenges and advances in the field of trauma-informed care.

*8.3.3 Recognizing trauma in informal education settings*

Trauma can manifest in diverse and often subtle ways, and informal educators should remain vigilant to a range of behavioral indicators. There are signs which, when considered in context, can offer valuable insight into a student's psychological state and signal the need for supportive intervention. Some of the common indicators of trauma can be found in Table**.3.3.1** :

**Table 8.3.3.1.** Recognizing behavioral indicators of trauma in informal education settings

| **Category** | **Examples of Behavior** |
|---|---|
| Emotional Dysregulation | Mood swings, difficulty calming down |
| Withdrawal | Avoidance of social interaction, disengagement |
| Hypervigilance | Easily startled, overly cautious |
| Dissociation | Spacing out, appearing detached from reality |
| Risk-Taking Behavior | Self-harm, substance abuse |
| Difficulty Trusting Authority Figures | Defiance, reluctance to engage |
| Physical Symptoms | Headaches, fatigue, unexplained pain |

*8.3.4 Creating safe and predictable environments*

Establishing environments that prioritize safety, consistency, and trust is essential to supporting trauma-affected individuals. Predictable routines and clearly articulated expectations provide structure, helping to reduce the anxiety and fear that often arise from unpredictability. This sense of stability is especially important for learners who have experienced traumatic disruptions in their lives.

Empowering students by offering small, age-appropriate choices fosters autonomy and helps restore a sense of control. Such practices can build confidence, reinforce a sense of self-efficacy, and contribute to the healing process.

When trauma-related behaviors occur, the educator's response is paramount. Calm, empathetic communication, non-threatening body language, and validating statements can help de-escalate emotionally charged situations. Rather than resorting to punitive measures, which may retraumatize students, educators should focus on building relational trust. A supportive and nonjudgmental approach contributes to an emotionally safe environment where students feel seen, respected, and capable of self-regulation.

## 8.4 The value of awareness campaigns and the importance of dissemination efforts

*8.4.1 Awareness campaigns*

Changing public perceptions of mental health often begins with awareness campaigns, which constitute one of the most powerful tools available to both educational institutions and informal organizations. Observational studies demonstrate that such initiatives can meaningfully shift social attitudes, transforming fear into understanding and isolation into solidarity. When schools publicly engage with issues of mental health, they generate ripple effects that extend far beyond the classroom. These effects may include parents initiating long-overdue conversations and community members re-evaluating long-held stigmas. What may begin as a poster campaign or classroom dialogue can evolve into a broader cultural shift in how psychological well-being is perceived and supported. Awareness campaigns are not merely vehicles for information dissemination; they are active instruments for transforming the social construction of reality and fostering environments in which individuals experiencing mental health challenges no longer face them in isolation.

The impact of such campaigns is particularly strong when they are culturally sensitive and age-appropriate. Research shows that high schools implementing peer-led mental health programs report increased mental health literacy and greater student willingness to seek help. It was shown that schools which maintained consistent mental health awareness initiatives saw a 32% increase in students' self-reported comfort when discussing mental health with teachers or school counselors.

At the core of effective awareness campaigns lies the normalization of mental health discourse. When students observe their peers openly discussing strategies for managing anxiety, or hear respected educators sharing their own experiences of stress, a powerful implicit message is conveyed: mental health challenges are normal, legitimate, and deserving of support. This normalization process helps to dismantle the silence, shame and isolation that frequently surround psychological suffering, most notably among adolescents undergoing identity formation and social pressure.

The effectiveness of awareness campaigns in addressing stigma has been well documented. Despite growing awareness, stigma remains pervasive even in relation to relatively well-understood conditions such as depression. Surveys indicate that approximately 50% of individuals are reluctant to work alongside someone with depression. Around 20% express discomfort with living near such

individuals, 30% avoid forming close personal relationships with them, and over half oppose the idea of marriage with someone experiencing depression. These statistics definitely underscore the necessity of targeted, stigma-reducing interventions.

Therefore, well-designed school-based awareness campaigns should adopt a structured approach involving lectures, simulations and facilitated group discussions. For example, a program focusing on adolescent depression might consist of three sessions of approximately 60 minutes each, covering topics such as the identification of symptoms, the significance of early intervention, as well as the availability of treatment options.

Beyond the boundaries of formal classrooms, informal education has proven highly effective in extending the reach and adaptability of mental health awareness campaigns. In Ukraine, where post-conflict challenges have strained mental health infrastructure, youth-led initiatives have adopted creative and accessible models for delivering education. Programs offered through community centers, digital platforms, and multimedia channels have made mental health education more engaging and culturally relevant.

Two Ukrainian programs illustrate this innovation. The *Mind Matters* initiative trains youth leaders to facilitate mental health discussions in informal settings using interactive workshops, art therapy sessions, and digital storytelling tools. Meanwhile, the *Mental Trek* program features six guided discussion stations, engaging adolescents in topics such as emotional resilience, the universality of mental health issues, and the importance of seeking help. With more than 2,200 teenagers trained and a companion mobile application available on Android and iOS, *Mental Trek* demonstrates how hybrid models can reach wider audiences and deepen impact.

Community-based approaches are particularly valuable in crisis-affected regions, where traditional education systems may be disrupted. By combining in-person facilitation with online accessibility, initiatives such as *Mind Matters* and *Mental Trek* demonstrate how mental health campaigns can be adapted to specific socio-cultural contexts while maintaining core goals – namely, increasing mental health literacy and reducing stigma.

It can be argued that awareness campaigns form the foundational layer of any school-based mental health support system. These campaigns represent the base of a broader intervention pyramid, setting the stage for more specialized services. By promoting empathy and understanding, they help cultivate school cultures in which students feel safe to seek help and empowered to support their peers.

In Italy, several campaigns have been launched to address the stigma surrounding mental illness and chronic health conditions, contributing to a broader effort to promote psychological well-being. One noteworthy initiative is *#STOBENEGRAZIE*, launched in Rome, which focuses on increasing public awareness of depression. The campaign involves patients, families, friends, and professionals, using inclusive and artistic languages to challenge prevailing prejudices. Its centerpiece is an interactive installation (referred to as "the BOX") that guides visitors through four immersive rooms designed to metaphorically represent the everyday struggles faced by individuals living with depression.

Another significant campaign is the *Awareness Campaign on Mental Discomfort*, promoted by the Italian Ministry of Health in collaboration with the National Association of Italian Municipalities (ANCI). This campaign enlists the participation of mayors to disseminate accurate information about mental distress and promote the social inclusion of individuals with mental health conditions.

A third initiative, #*Parliamone*, was developed by the BRF Foundation and involves well-known cartoonists and public figures in efforts to raise awareness about mental illness. This campaign leverages the cultural influence of the arts and public media to challenge stigma and foster open conversations.

With these examples in focus, the growing recognition is evident; mental health awareness campaigns are not ancillary, but central to systemic change. When implemented thoughtfully, such campaigns hold transformative potential. They can shift individual perceptions and reshape entire communities' understanding of mental health and trauma.

### *8.4.2 Dissemination efforts*

Dissemination is a critical component in embedding trauma-informed practices and mental health literacy within educational ecosystems. Effective dissemination involves more than the distribution of materials; it requires the development of supportive infrastructures that ensure consistent and sustainable application. These systems must be able to translate knowledge into practice across different stakeholders and institutional levels.

Dissemination should be implemented across multiple layers of influence, engaging students, educators, families and communities. This multi-tiered approach reflects the understanding that children operate within interconnected ecological systems. Consequently, meaningful mental health interventions must be aligned across home, school and society. Schools, with their daily contact with young people and their families, serve as ideal nodes for coordinating such efforts.

There are three primary avenues for school-based dissemination of trauma-informed support. First, schools can promote general psychological well-being by extending mental health education beyond the school community into family and local networks. Second, they can identify and support at-risk students by equipping them with skills to manage trauma, stress and academic pressure. Third, they can serve as gateways to professional care by identifying signs of complex mental health needs and facilitating appropriate referrals.

Informal educational initiatives complement these efforts by offering flexible and often more innovative dissemination channels. In Ukraine, youth organizations have embraced digital platforms and informal learning environments to expand the reach of mental health education. For example, the Mind Hub initiative provides interactive online courses, podcasts and engaging social media content tailored to younger audiences. Youth-led networks have also established peer support systems in both community centers and virtual spaces, enabling adolescents to explore mental health topics in culturally resonant and stigma-free environments.

These Ukrainian examples have proven especially effective in rural and marginalized communities where traditional mental health services are scarce. In response to the disruptions caused by the

COVID-19 pandemic and ongoing armed conflict, these organizations have adapted by offering telehealth options and scalable digital content, ensuring continuity of education and care even in periods of crisis.

The success of dissemination efforts depends on the availability of high-quality, evidence-based resources that are user-friendly and accessible to educators and community facilitators. Many of these resources are now freely available through online repositories and are often supported by public institutions. This accessibility makes large-scale adoption of trauma-informed programming increasingly viable.

However, deployment alone does not guarantee success. Dissemination must be accompanied by evaluation mechanisms to assess effectiveness. These include pre- and post-intervention assessments and the use of defined metrics to gauge behavioral, academic and emotional outcomes. A comprehensive monitoring and evaluation plan should be developed at the beginning of each academic cycle, detailing the tools, timelines and review processes. Annual reporting based on these evaluations enables institutions to refine their strategies and respond to emerging challenges.

Through consistent, strategic and data-informed dissemination, trauma-informed practices can become deeply embedded in the culture of educational institutions, transforming them into environments where emotional well-being is not only recognized but actively supported and celebrated.

## 8.5 Advocacy for trauma-informed education in formal and informal settings

*8.5.1 Key advocacy strategies*

Advocating for trauma-informed education requires systemic transformation across educational policy, teacher training, student engagement, and community collaboration. First, educational reform and policy development must prioritize the integration of trauma-informed principles into school curricula and institutional frameworks. A key component is the inclusion of social-emotional learning (SEL) programs, which foster emotional awareness, self-regulation, resilience and empathy among students. Moreover, advocacy should ensure universal access to mental health services (such as psychological counseling and assessment) within the school infrastructure as a standard component of educational support.

A second essential strategy is teacher training and professional development. Since educators are often the first to observe signs of trauma in students, they must be equipped with the competencies necessary to respond with sensitivity and efficacy. Advocacy efforts should emphasize continuous professional development that enables educators to recognize trauma symptoms and implement classroom strategies that support both emotional regulation and academic engagement. Additionally, training should aim to strengthen educators' capacity to build trust-based relationships with trauma-affected learners.

The third strategy involves student and parent engagement. Creating safe spaces for students and their families to openly discuss mental health can dismantle stigma. It can also lead to collective resilience. Advocacy initiatives should encourage schools to organize family workshops, mental

health awareness events and student-led forums where individuals can share experiences and coping strategies in supportive, nonjudgmental environments. Normalizing mental health conversations at the school and family levels empowers communities to seek and offer help more effectively.

The fourth strategy emphasizes community collaboration. Schools should actively cultivate partnerships with mental health professionals, social workers, nonprofit organizations, as well as with local health centers to form integrated support networks. Such collaborations expand the resources available to schools and promote comprehensive care for students facing complex emotional and/or behavioral challenges.

### *8.5.2 Integrating advocacy into educational frameworks*

Embedding advocacy within educational structures is essential to cultivating psychologically safe and supportive learning environments. A widely recognized framework visualizes mental health support as a pyramid. The base of this model comprises awareness and advocacy efforts, which lay the foundation for preventive interventions, mental health first aid, and specialized clinical services situated higher in the pyramid. This tiered approach ensures that students receive interventions proportionate to their needs.

Organizational structures within schools are vital for sustaining advocacy efforts. Establishing a dedicated mental health working group responsible for coordinating trauma-informed initiatives provides continuity and focus. Such groups should include representatives from a variety of stakeholders – school administrators, teachers, mental health professionals, parents and students – to ensure diverse perspectives and shared ownership. Their foremost task is to draft and institutionalize trauma-informed mental health policies that shape daily school operations.

Advocacy must be grounded in scientific evidence to ensure the legitimacy and effectiveness of implemented practices. Using interventions supported by strong empirical foundations is crucial for achieving measurable, replicable outcomes. Caution is warranted in relation to adopting untested approaches; instead, programs should be validated through rigorous methods such as randomized controlled trials. This ensures that trauma-informed initiatives are both credible and sustainable.

Informal education also plays a critical complementary role in trauma-informed advocacy. In Ukraine, youth-led networks have emerged in community centers, online platforms and social media to promote mental health awareness. One prominent example is the "Mental Health Ambassadors" initiative, which trains young leaders to educate peers, facilitate community discussions and advocate for policy change. Since the Maidan revolution – the 2013/2014 popular uprising in Ukraine that demanded democratic reforms, an end to corruption and closer alignment with Europe – these grassroots efforts have produced tangible results, including greater provision of mental health services in schools through collaboration with local governments and the creation of user-friendly mental health toolkits.

A structured implementation cycle strengthens the sustainability of advocacy efforts. This cycle typically involves identifying roles and responsibilities, assessing community needs, designing

interventions, implementing programs and systematically monitoring and evaluating outcomes. When followed carefully, such a model ensures that trauma-informed advocacy is intentional, contextually relevant and adaptable to evolving challenges.

The physical learning environment also plays a crucial role in psychological well-being. Features such as quiet rooms and flexible classroom layouts, and even sensory decompression spaces, can reduce stress and provide safety. Pedagogical routines can likewise be adapted to lower academic pressure and enhance student autonomy. Fostering emotionally attuned teacher-student relationships built on trust rather than control is central to creating classrooms that are sensitive to trauma and supportive of resilience.

## 8.6 The benefits of trauma-informed procedures in education

Trauma-informed procedures provide measurable benefits across multiple dimensions of the educational experience. One of the most widely observed outcomes is improved academic performance. When students are immersed in emotionally safe and stable environments, their capacity to focus and retain information increases significantly. The engagement is also higher. S By addressing the underlying psychological stressors, trauma-informed practices can create the conditions necessary for students to reach their full academic potential.

A second benefit is the reduction of behavioral issues. Educators trained in trauma sensitivity are more likely to interpret disruptive behaviors as expressions of distress rather than as acts of defiance. This understanding leads to a shift away from punitive disciplinary measures toward strategies that emphasize de-escalation. It also goes towards trust-building and improved emotional support. And as a result, schools implementing trauma-informed approaches often report fewer suspensions and classroom disruptions, contributing to a more inclusive and positive learning climate.

Thirdly, trauma-informed education enhances emotional well-being by equipping students with the tools to understand, articulate and regulate their emotions. Through programs focused on social-emotional learning and the consistent modeling of empathy by teachers, students develop healthier coping mechanisms that foster resilience and long-term mental wellness.

Perhaps most importantly, trauma-informed practices strengthen teacher-student relationships. Educators who adopt a trauma-sensitive stance are more likely to establish bonds grounded in empathy and reliability, which is also filled with respect. For students who have experienced instability or relational mistrust in other areas of life, these relationships can be profoundly reparative. A sense of being seen, heard and supported cultivates a feeling of belonging that benefits both emotional and academic development.

Advocacy for the removal of stigma surrounding emotional trauma (across both formal and informal educational contexts) is indispensable to cultivating inclusive, compassionate and resilient learning environments. By championing trauma-informed policies, investing in sustained professional development for educators, and implementing culturally responsive awareness

campaigns, schools and community organizations can empower students not merely to cope, but to thrive.

It is important to stress the following: when emotional trauma is addressed with empathy and supported through evidence-based practices, its impact extends beyond individual learners. It improves academic and social outcomes and contributes to healthier, and also more equitable societies. A trauma-informed educational system acknowledges adversity, affirms diversity, and nurtures a shared culture of care and hope.

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# Chapter 9: Curated case studies and best practices

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## 9.1 Case examples and lessons learned

This part of the handbook presents six field-based case studies that illustrate how informal educators encounter and respond to trauma across a range of different contexts: a migrant reception center in Lampedusa, a psychotherapy clinic, a children's martial arts class, an after-school program, an osteopathy practice and a Paralympic water polo team. Despite the diversity of these settings, common themes emerge such as the importance of active listening, recognition without judgment, respect for consent and personal space, awareness of overload signals and the need for clearly defined boundaries and timely referrals. Educators describe how they adapt their methods to create stability, inclusion and trust in learners under stress by slowing the pace, naming emotional states, incorporating play or humor or offering alternative roles that help restore a sense of control and belonging.

These experiences also highlight the limits that non-formal educators face: time constraints, lack of consistent family support, limited trauma-specific training, the risk of reactivating painful memories and the emotional weight of the work itself. Yet in each case, the educators maintain a core commitment to creating safe, responsive and human-centered environments.

The case studies should be read not as fixed models to replicate, but instead as grounded and evolving examples of trauma-informed practice in action. They offer practical insights into how trust is built over time, how communication and pedagogical approaches are adapted and how collaboration with families and professionals helps sustain long-term support. Above all, they show how trauma-informed care in non-formal settings begins with presence, empathy and deep respect for the learner's lived experience.

### *9.1.1 Case study 1*

Here is an experience of Dr. Enza Malatino, psychiatrist and psychotherapist, psychiatrist in charge of the Local State Health Agency of the Island of Lampedusa, Italy, the main disembarking spot of undocumented immigrants in Italy, who recounts the experience of a cultural mediator in the state migrants and refugees reception center in Lampedusa. The interview was conducted and transcribed by Serena Romano of the COPE Team.

**Serena:**
We are here because we are carrying out a training project for non-formal educators within the COPE Erasmus Plus project. Therefore, we are conducting a needs assessment to identify the training needs of informal educators. Today, we would like to ask you, Enza, who has great experience with trauma survivors, if you could share some situations in which you found yourself facilitating potential non-formal educators in contexts involving vulnerable groups.

**Enza:**
Thank you for this invitation, I am truly honored to participate in your training initiative. As you know, for many years I have lived experiences related to welcoming migrants in Lampedusa through my professional work as a psychiatrist and psychotherapist. When accepting your request to share some experiences I have had, I wondered how my background could be useful to informal educators who may not possess similar professional competencies. However, I have observed that sharing insights with individuals who are not medical or psychological professionals can have an extremely beneficial effect when working with multiply traumatized individuals coming from migration experiences – crossing deserts and facing life-threatening situations while losing loved ones and enduring torture.

Not every so-called non-professional figure encounters such extreme traumas, however, it is evident that every person facing suffering and trauma is part of a collective human dimension that reflects back like a mirror the same trauma experienced by another individual – perhaps manifested differently or accompanied by emotional detachment as they try to avoid excessive emotional engagement due to their own involvement. Whatever traumatic experience one may encounter – or even during professional activities unrelated directly to health – it remains true that any individual exercising their profession may sometimes find themselves confronted with abnormal reactions exhibited by others at those moments. My experience essentially begins from having deeply connected with the emotional involvement of the cultural mediator accompanying me during listening group sessions organized at the reception center. This seemed like the best condition for identifying psychiatric issues these individuals might not even recognize as problems but needed evaluation so support could be provided. These meeting groups became valuable resources given my background as a Rogerian psychotherapist. In these listening groups, collaboration was crucial from my cultural mediator who lacked relational competencies but had undergone dramatic journeys akin to those present at our sessions on the island's shores. He often appeared cynical when addressing ongoing requests made during our meetings since maintaining difficult emotional stability was challenging – they were profoundly traumatized yet primarily distressed over needing phone cards or basic items like toothbrushes or slippers.

Consequently, their requests fell upon this cultural mediator who had somehow become responsible for addressing all demands. He often seemed annoyed and cynical about tolerating such requests – not understanding why they would arise when other things were expected of him – as if he had compartmentalized his thoughts into rigid schemas regarding how people should follow strict patterns while navigating through reception processes. When we began working with migrant subjects within our group setting, I started discussing what was needed since he focused solely on tasks based on his formed ideas. It was crucial for him to precisely repeat everything I said verbatim, which allowed participants time to conduct themselves better. Whenever they made practical concrete requests like asking for toothbrushes, I read those aloud while relieving him from responsibility. Each time inappropriate demands relative to our group's concept arose I said: "This is necessary and important but perhaps right now we can make better use of this type of situation."

This focus on emotional aspects gradually led both this cultural mediator and participants toward understanding inherent value in care-taking along listening just-for-itself – not merely aimed toward obtaining benefits – but simply functional, enabling persons having someone listen, a seemingly

taken-for-granted aspect until one participant told me among migrants: "He stayed quiet because one's story mirrors everyone else's," making it seem almost pointless speaking up.

Slowly both he – the mediator – and participants began realizing expressing emotions without fear of judgment or being seen as weak could prove extremely beneficial later down the line when other psychologists initiated similar group experiences three years after my departure. By then he had transformed into a communication expert, learning through shared encounters and noting that others were not doing well since failing to listen allowed talkers to present solutions instead of silence. We had proposed conditions and models favoring active listening, reprocessing emotions naturally encountered, and helping subjects experiencing traumas capable of triggering traumatic activations under any condition. They could momentarily express severe emotional flow that needed to be managed appropriately following typical approaches including the absence of categorical judgment and the application of solidarity principles. This fostered trust and support for individuals encountering critical moments requiring a sense of being embraced, yet physical contact was never initiated without prior consent to avoid retraumatization. Even gestures such as handholding could be perceived as further abuse, humiliation, or an invasion of personal space, thus necessitating careful consideration and clear communication before any action.

This process emphasized the importance of attentiveness, alignment of actions, and clarity of intentions, ensuring comfort levels were respected. It also highlighted that even when physical gestures such as hugs were declined, this should not be viewed as rejection but as a relational signal. These observations gained through various encounters were valid for both parties, who learned together and created opportunities to witness shared traumatic narratives. This fostered profound human exchanges that enriched lives collectively beyond individual pain. The experiences demonstrated that empathy does not equate to ownership of others' suffering and that distinguishing between one's own emotions and those of others is a vital lesson. Mutual solidarity and shared learning transformed relationships, built trust, and restored hope in humanity, promoting fundamental values essential for nurturing environments where growth is possible. These insights remain highly relevant for the training initiatives ahead. Thank you.

### *9.1.2 Case study 2*

Case study narrated by Dr. Enza Malatino, psychiatrist and psychotherapist, psychiatrist in charge of the Local State Health Agency of the Island of Lampedusa, Italy, the main disembarking spot of illegal migrants in Italy. She recounts experience from her clinical practice. The interview was collected and transcribed by Serena Romano of the COPE Team.

**Serena:**
Here we are again with Enza. I wanted to ask you if you still feel like sharing another experience in which you were able to witness how, even by chance, it is possible to encounter a person who has survived trauma while performing your role. Additionally, I am interested in how one can recognize signs of such experiences or fail to recognize them when one has not been trained on this. I am briefly talking about what the visible signs might be that indicate a person is beginning to experience emotional states that are particularly intense.

**Enza:**

Of course, I am happy to share my experiences. This time I want to talk about an experience I had with one of my clients in psychotherapy. As you know, I am a psychiatrist and Rogerian psychotherapist. One of my clients came in to tell me about an event that happened to her: she had to undergo an MRI for a personal health issue. This required being placed inside the machine's tube, and she suffered from claustrophobia.

When it came time for her examination, we had already done some work on her phobia and fears. She accepted the challenge and said: "Yes, I will try my best, I will do it." During the exam, while inside the machine – let us say this tube – she began experiencing recurring flashbacks from early childhood. These related specifically to her painful relationship with her mother who was unloving and caused many humiliations, often involving her father as well. While inside, she experienced a rapid succession of memories, and tears began to flow. They were not tears of fear but tears connected with the painful memories that had resurfaced. When she finished the exam and came out of the machine, the operator – not even a nurse but a technician – looked at her disrespectfully and said: "You cry over so little." She later told me that this comment felt like an invasion of her emotional space, even greater than the painful memories themselves.

What does this mean? It means that if an operator, educator or any professional interacting publicly lacks sensitivity or knowledge of what someone might be experiencing, they can reinforce trauma instead of alleviating it. We worked together for several sessions to allow her to express that pain and anger out loud – anger that had been repressed since childhood but was amplified by the lack of recognition and the dismissive words from the MRI operator.

This made me reflect on how much competence people need when they interact with others. Superficiality or taking things for granted can be damaging. Often, reactions like crying, trembling, nausea or avoidance of physical contact are signals of deeper experiences, possibly linked to trauma. When these moments are ignored or dismissed, they can amplify feelings of being subjected to abusive or invalidating circumstances. This is also relevant for adolescents in schools or young people in sports who may display abnormal reactions that go beyond disappointment. Such reactions may reflect unresolved trauma. Even if operators are not psychologists, they still carry responsibility to provide basic acknowledgment and comfort when such experiences arise.

What would have helped this client? Simply being recognized without judgment. Instead of saying "you cry over so little," the operator could have asked: "Are you alright? What is happening?" Just a few supportive words can make someone feel welcomed and not judged. Non-judgmental listening and gentle inquiry are often enough to provide a sense of safety and recognition. Building these human connections matters greatly in fostering environments of support, trust and dignity.

**Serena:**
Thank you very much Enza, your contribution has certainly been invaluable.

**Enza:**
Thank you for the opportunity.

*9.1.3 Case study 3*

Experience of Annarita, Kung fu teacher

Interview conducted and transcribed by Francesca Settimelli, member of the COPE team.

**Francesca:**
So I would start by asking you what you do, that is, what your job is.

**Annarita:**
My main job fortunately doesn't have much to do with the public because I am a translator and work from home, so that's my main job. But I am here because I also teach kung fu to children. That's the most interesting part. In fact, I often found myself in situations where I didn't know how to behave, so I asked for advice.

**Francesca:**
How long have you been teaching kung fu?

**Annarita:**
I have been teaching kung fu for about seven years, but before that I also taught swimming. So I have been teaching for several years, both children and adults, in swimming as well. I have had a lot to do with children. It often happened, both in swimming and later in kung fu, that parents were unaware of their children's problems. For example, I sometimes suspected a child was on the autistic spectrum, but parents never mentioned it. The most striking episode happened in kung fu a couple of years ago. A child probably had an oppositional disorder, and the clash during every lesson was very strong.

**Francesca:**
So these are the situations where you found yourself not knowing how to respond?

**Annarita:**
Yes. I have always had many resources because I inform myself and study. It's not only a passion for teaching but also for understanding people. Over time, I have studied psychology and also started psychotherapy myself. So I had intuitions, but since I am not a professional, I asked for advice. I realized I couldn't teach that child the same way as all the others. I had to adapt methods, to behave differently depending on his needs. This was difficult because I had 15–20 children in the class. If I focused on protecting one child, I felt I was neglecting the others. Sometimes, when I was lucky enough to have an assistant instructor, I asked them to continue the lesson while I sat aside with the child to understand what he was feeling. Still, I knew a professional was needed.

**Francesca:**
What did you feel was useful in that circumstance?

**Annarita:**
At the beginning this child was intractable, always challenging and even using offensive language toward the instructors and the other children. Over time I dedicated myself to him, tried different strategies, and slowly gained his trust. He began to confide in me. I discovered he had a very problematic relationship with his father, while his mother tried to cushion things but it wasn't

enough. What was useful was listening to him. He did not feel listened to by his father. Taking the time to listen seemed to respond to his need. For someone without psychological training, it is difficult to know what to do. If you challenge the child back, he won't come to your lessons anymore and will simply return to his traumatic environment. But his mother told me he came willingly to kung fu, something he didn't do with any other activity. That meant something worked.

**Francesca:**
So listening was a step further. You didn't dismiss his behavior as a whim but tried to see what was behind it.

**Annarita:**
Yes. I also tried to recognize his qualities. Once I asked him to teach something to the others, and he lit up with joy. It was important not to label him behind his problem. The other children did label him as strange, which isolated him further and created a negative circle.

**Francesca:**
What did you feel was the limit in that situation?

**Annarita:**
The structural limit. In a kung fu lesson you have one hour and 15 children. You can't do much more. The limit was that I couldn't intervene further.

**Francesca:**
So the boundary with respect to your role, which must have been frustrating?

**Annarita:**
Yes. I could see something was not right, but I also had to manage the rest of the group. And I am not sure where my role as kung fu teacher ends. I wanted to help as much as possible, but I didn't know how far I could go.

**Francesca:**
What does "how far you can go" mean for you?

**Annarita:**
For me it would mean helping to resolve the situation, but I know that is not possible. At least I wanted to direct the parents, but you are always afraid of saying something wrong. Without training you could say things that are not right psychologically, which could harm more than help.

**Francesca:**
So even with the intention of helping, not having the tools can be risky.

**Annarita:**
Yes, especially in dramatic cases like this one.

**Francesca:**
You said earlier that you rely on intuition, that you couldn't just limit yourself to teaching kung fu, but felt the need to do something.

**Annarita:**
Exactly.

**Francesca:**
You have experience teaching both adults and children. Have you noticed differences in how they react?

**Annarita:**
With adults, they hide things better. With children, I feel more responsibility. I sometimes think that all children are traumatized by their parents, in different degrees. Raising a child is the most difficult thing. My responsibility is to limit the damage as much as possible when I see it.

**Francesca:**
So your role is protection?

**Annarita:**
Yes. Also because the longer trauma goes unrecognized, the more it becomes structured. The earlier you intervene, the better. Even in my own life I thought I had a happy childhood, but psychotherapy showed me there were silent traumas. So I believe many children carry such hidden wounds.

**Francesca:**
So the responsibility you feel is to limit the damage you see.

**Annarita:**
Yes. Often I can only guess from behavior, but in blatant cases it's clear that intervention is needed. That's why I really value this course.

**Francesca:**
So having tools can also help you define the boundaries of your role.

**Annarita:**
Yes. My teaching cannot be effective if I don't welcome the child's psychological side. Parents bring children hoping they will make friends and improve, but if underlying issues are not addressed, after a month or two they leave for another activity. The problem remains unresolved, and this is very sad.

**Francesca:**
Thank you.

### *9.1.4 Case study 4*

Experience of Arianna, after-school operator

Interview conducted and transcribed by Francesca Settimelli, member of the COPE team.

**Francesca:**
You mentioned on the phone what you do. Let's start there – tell me a bit about your work.

**Arianna:**
I work for a social cooperative that runs several services, including after-school activities. Besides administrative work, I am an operator twice a week in a multipurpose center linked to a nearby school. We pick up the children at the end of classes – we have parental delegations, teachers hand them over – then we take them to the center where we run pre-scheduled activities. Parents know in advance which activities run on which days. Each day there are four staff on duty: two educators and two operators. The educators supervise and the operators set up and lead the workshops. In practice, the children are in the space from about 16:30 to 19:00. Educators arrive at 16:30, operators come in shortly after, we all do the pick-up together, then operators finish around 18:30. The last half hour is handled by the two educators who return the children to parents.

**Francesca:**
What labs do you run with the kids?

**Arianna:**
Monday is hip hop, Tuesday is theater. On Wednesdays another operator and I alternate – she runs yoga labs, I run coding labs. In theory we each do half an hour, but this year has been very chaotic with many first-graders still adapting. They are small, nervous and struggle to fit into a group that already includes last year's third and fourth graders. For now we pause activities, let them decompress outside for half an hour, then sit in a circle to talk directly with us. Thursday is hip hop again, Friday is homework day. I also work Fridays and stay a bit longer. Homework is important because teachers assign work for the weekend and some children come from immigrant families or foster arrangements where support with homework can be difficult. Friday is very busy – 25 children from different classes, first to fifth grade.

**Francesca:**
So it's a service open to the neighborhood?

**Arianna:**
Yes. When the cooperative wins the call, we open registrations, do flyering, put up posters and share contacts. Families already know us because we have managed this service for years. Parents fill out a form and indicate one or two preferred days because the room limit is 25 – we can't take a child all week, we try to give space to everyone. With the calendar in hand, parents choose the days that fit best.

**Francesca:**
Which neighborhood?

**Arianna:**
Piazza Mazzini, first municipality – central, with a rich social mix. We have children of judges, lawyers, journalists and others from different social backgrounds. Lately kids notice these differences more – "I have a designer pen, you don't," "I have a Fortnite card," "I have a designer dress." We often pause activities to address these comments. We also had a child apologizing for fascism this year, and last year a racist remark. They repeat what they hear, but we still intervene. Last year we worked on skin tones with makeup to show variation, then did drawings and reflections. This year we did a historical study.

**Francesca:**
A real 360-degree job.

**Arianna:**
I am lucky – there's a lot of attention to these issues and our service coordinator is very good at building teams. I'm less trained because I've been an operator for only two years, but the other operators are more experienced and the two educators are excellent.

**Francesca:**
Good teamwork?

**Arianna:**
Yes, communication during and outside service is good. Lately with many new children it's harder to pass information promptly the same day.

**Francesca:**
Timing issues?

**Arianna:**
Yes. If my shift ends while the educator is still on duty and I've been managing a large group, I might not brief them privately – I won't discuss sensitive matters in front of kids. Sometimes this delay means that when parents arrive the educator can't relay something that needed attention.

**Francesca:**
Have you faced complex situations you observed or managed firsthand?

**Arianna:**
Many. One last year struck me. A girl who seemed carefree and joyful – always laughing, never serious, even during homework – choked a little while eating. We ask them to sit while eating. She was standing, a bit of food went down the wrong way, she coughed, we patted her back and it resolved immediately. But she cried and screamed for her mother for half an hour, terrified. I didn't expect such a reaction to something resolved so quickly. The educator came, took her aside, talked to her and she calmed down. In the following days she seemed scared of many things. When another child mentioned a deceased grandparent she cried. One day we were alone inside while others were outside and she asked about my father; I said he was a teacher, and she asked why I used the past tense. When I said he had died, she cried desperately. I reported this to the educator. There were other episodes, including another girl provoking her about it. She showed unusual reactions related to death – even a scratch on another child scared her. The educators spoke to the parents. They mentioned a similar choking incident on holiday where the mother, a nurse, had to intervene. We thought her reaction was linked to that, but the crying spread to other topics. Later the parents said the mother talks at home about heavy hospital cases and hadn't realized she wasn't filtering what the child heard. So the educators worked to normalize, talk and support her. I did not handle those conversations – I called the educator because I didn't know how to manage them.

**Francesca:**
Beyond the single episodes, you noticed something deeper.

**Arianna:**
Yes – it felt obvious, like a neon arrow, but moving from intuition to hypotheses and actions is not my skill set.

**Francesca:**
What did being with her in those moments bring up in you?

**Arianna:**
I froze because I didn't know what to say. Even normal comments – like mentioning my grandmother – could trigger her. I worried a story or school text with something bad would set off another reaction. I'm not afraid for me – I'm afraid for her, and of making it worse. I have never felt unsafe at work, but when I don't understand a possibly traumatic situation I fear worsening it. So I avoid, change subject, distract with games, songs or video games they know.

**Francesca:**
Is that playful style a resource or a limitation?

**Arianna:**
In cases like hers, a limitation. In other moments it's a resource – breaking tension, making them laugh, regrouping.

**Francesca:**
A limitation because you feel you are not really welcoming what is happening?

**Arianna:**
Yes. I don't know how to help and I fear doing harm.

**Francesca:**
With this girl, what did you bring as a resource, and what was a limitation?

**Arianna:**
I mainly referred to the educators. We're lucky – they are very skilled. Another operator, the yoga instructor, stays calm even in stressful situations. I can get angry with noise; she remains steady. The educators even more so.

**Francesca:**
Watching colleagues, what do you see that works in complex situations?

**Arianna:**
They analyze. Where I see "a child misbehaving," they see more. They know family contexts, they talk with parents and they remind me it's not only about reprimand – it's also about acceptance and unseen difficulties. I've learned a lot with them, but I still reach a point where I need their lead.

**Francesca:**
Don't have the tools?

**Arianna:**
No. I don't have the tools – not the university background, deeper studies or experience they have. They prepared for this; I landed here a bit by chance.

**Francesca:**
By chance, but it sounds like you observe your surroundings closely.

**Arianna:**
Yes. Before this job I only tutored one-on-one in primary school. I don't have children – my stepchildren were already older when they came into my life – so I had almost no experience with this age group. I observe a lot. This year I notice small groups forming around a "cool" child. Others act out to get his attention. In reality he is friendly with everyone. When we discussed it, someone suggested intervening on him. I said he is not the problem – the issue is others projecting leadership onto him. Saying it out loud, I realized that earlier in my job I might have blamed him. You do learn, but every child is different – you can't just say, "I learned this, so it always applies."

**Francesca:**
So you can't objectify learning, but you gain different views.

**Arianna:**
Exactly. Perceiving more is useful, but standardizing procedures is wrong.

**Francesca:**
And you watch teachers and parents too.

**Arianna:**
Yes. On Fridays I stay longer for homework, so I sometimes see parents' interactions. One boy who once apologized for fascism has a sister who is lively but sweet. He can be overly physical and ignores space and objects. We noticed the mother often arrives on her phone, signs while still on the call, nods to the kids and leaves – no "How did it go today?" The only time she put the phone away was when we insisted on talking after a serious incident. She listened, then justified him. Observing parent–child and parent–staff interactions matters. Some parents are open but minimize issues. Others collaborate. Some treat it like free babysitting – they don't even tell us if the child is absent, and kids sometimes miss key activity days. We planned a theater show for parents – three children didn't show and didn't warn us. It's frustrating for us and for the children.

**Francesca:**
And that inconsistency shows up elsewhere too.

**Arianna:**
Yes. One girl is always picked up by her father, who treats her younger than she is. If she refuses homework, he says, "My princess does them with me on the weekend." We explain Fridays free the weekend, but he minimizes. I wasn't there for every talk, so I can only speculate, yet this kind of response creates discontinuity. Educators manage these conversations and report back, but there isn't time to convey every nuance gathered in those five minutes before the service starts.

**Francesca:**
Anything you'd like to add about your work?

**Arianna:**
It's fun. I do many jobs, but these two afternoons are the most joyful. Being with children is

fantastic. I do feel less prepared than the team – that's my own thing – and timing is our biggest constraint.

**Francesca:**
From listening, I hear strong intentionality in your work.

**Arianna:**
I also have fun. I promised myself as a kid to never fully grow up – and in some ways I kept that promise. I talk with them about video games and social media. I know TikTok trends and sometimes teach the dances. But I'm still the adult – I can't be a child among children.

**Francesca:**
You play the adult with a playful side…

**Arianna:**
Yes, which means they sometimes take me less seriously, even when I scold them. That's partly the role I carved out.

**Francesca:**
Peter Pan energy.

**Arianna:**
Yes. I actually joined the cooperative through a project called EduGamer on video games. I've played since I was little. It became a bit of a trademark.

**Francesca:**
Great. I was happy to meet you and listen.

**Arianna:**
I hope this was helpful.

**Francesca:**
Absolutely, thanks for your time.

### *9.1.5 Case study 5*

Experience of Cinzia, osteopath

Interview conducted and transcribed by Francesca Settimelli, member of the COPE team.

**Francesca:**
Since I don't know you, I have only a couple of details about your work. I'd like to start there – tell me a bit about what you do.

**Cinzia:**
I mainly practice osteopathy – treating patients. Osteopathy is largely preventive rather than pathology focused. I also work in the fitness sector, which brings a wide range of people who may have issues, including psychosomatic ones. In osteopathy you don't specialize in a single area, so

you see a bit of everything. Lately I have seen many people with psychosomatic problems. They don't come to me initially for psychological or emotional reasons, but those aspects often emerge during treatment.

**Francesca:**
When you say they emerge – do they come out because patients talk about them, or as a reaction?

**Cinzia:**
Sometimes both. Maybe not in the first session, but as trust grows and the setting feels safe, patients start to talk. Other times in osteopathy you encounter what we call emotional cysts – points where the body blocks feeling. When you touch or stimulate those areas, emotions can surface. So sometimes it happens spontaneously, other times the operator's manual contact triggers a reaction. It's not verbal – it is through touching areas like the diaphragm, the pericardium, the thoracic region or parts of the skull where emotional tension accumulates. You don't do it to learn the patient's private story – whether they speak or just cry, you let them vent and don't investigate. This matters when you realize the complaint isn't a sprain or a purely biomechanical issue but something deeper – there is no point treating a shoulder if the diaphragm is stuck because the person is angry, sad or depressed.

**Francesca:**
It sounds like you also encounter complex reactions.

**Cinzia:**
Yes. Recently there was a very young girl who described a major bereavement – she watched her father die at age 11. Hearing this at 13 or 14 is very difficult to manage. In those cases, when I don't know what to say, I prefer silence – listening, staying as externally present as possible. Then, because she is a minor, I speak separately with the parent. Bereavement is common – sometimes extremely traumatic, sometimes more contained. For example, someone may come with neck pain that is driven by clenching from anger after a loss. I work on the compensations, but there is also an emotional outpouring during the session. I listen and, if needed, suggest another professional if they cannot climb out of that black hole. Patients may also bring anger about other things – I can help them notice the real source of that anger.

Sometimes I learn about situations only after treatment – for instance, a male relative who had been abused by a woman. Men often feel shame crying and apologize for it. In one case I told him there was no need to be ashamed – I likely touched structures that released emotion – and gave him time alone to cry. He later thanked me. When someone tells you something they have not told close family, it means strong trust. My stance is to listen rather than judge. One clear message I do share is that blame never belongs to the victim – it belongs to the perpetrator. That helps reduce shame. Often people need a space to keep telling the story – if an emotion has been unsaid for ten years, it will affect physical pain, which is why they came.

**Francesca:**
A beautiful complexity of emotions.

**Cinzia:**
There are many. Sometimes it is "ordinary" anger. You assess – say, you treat the liver – and there

is nothing striking in ligaments or mobility, but emotionally something is there. You gently reflect – are you angry – and the "monster" emerges: conflict with a sister-in-law, a spouse, a teenage child. Once, after discussing a puzzling case with a colleague, she suggested the patient might not want to get better. In that instance, a heavy family burden related to the husband surfaced. The next day the patient said she felt lighter. In osteopathy there is a lot of emotion behind symptoms – repressed anger, humiliation, deep pain.

Training does not always prepare us well – psychological preparation is limited. I teach in a school and see students approach sensitive matters with little tact or empathy. Some dismiss emotions – "a dog dying can't cause this" – but it can. Another patient had a scar and repeated the same story every time – the story was more important than the scar: severe gynecological disease, fertility loss, medical delays. Young graduates may not grasp how these experiences shape a lifetime of discomfort.

**Francesca:**
So you try not to exclude any possibility; you start from the physical, yet recognize it may be a sign of something more.

**Cinzia:**
Yes. Society's stress and ambition are ever present. Clinically, there is the biomechanical model, but there is also the biopsychosocial model – you in relation to your environment and how you perceive others. Often the emotional component is minimized, but it is there.

**Francesca:**
From your stories I sense ease and intention in understanding people – and also the discomfort of not always knowing what to do. What resources do you use in that discomfort?

**Cinzia:**
Listening, active and passive. If I can, I just listen. If it seems we have only scratched the surface, I ask simple, non-intrusive questions to help things unfold. With high-trust patients I may share a small piece of my experience to reduce shame and help them feel understood – carefully, because it is their time, not mine. If someone feels ashamed – for staying in a toxic relationship or grieving a pet – I normalise and legitimise the emotion. I never judge. People have the right to feel what they feel. I am interested in how the emotion affects the body – not in processing it, which is not my role. Sometimes I avoid naming the psychosomatic link if I sense they are not ready – pushing that can rupture the therapeutic relationship. I might frame it as muscular tension from posture rather than an emotional cause, and wait.

**Francesca:**
So much responsibility in your work.

**Cinzia:**
Yes. Modulating is not easy and mistakes happen. I once worked on the diaphragm of someone in fresh grief. The next day they messaged that even a simple greeting made them cry. I thought they were ready – perhaps the anger was still useful as a shield. If I could go back, I might wait. Timing matters – both the patient's readiness and mine to name things. Sometimes the unconscious is ready even if the conscious mind is not.

With children, ethics are delicate. The young girl mentioned her trauma only when the mother stepped out. Do I tell the parent or not – to avoid worrying her, or because the girl has not processed it – there is no single answer.

**Francesca:**
What effect do these experiences have on you?

**Cinzia:**
It was harder before. Experience helps you shield. With long-term patients you care, and you can carry their distress with you. Empathy can slide into identification – imagining how I would process such a loss. I try to keep the boundary – it is their emotion, not mine. Still, when trust blurs roles, people may text outside sessions. I am not their friend, so I keep distance – otherwise it expands beyond my life.

**Francesca:**
So the boundary between work and personal life is a challenge.

**Cinzia:**
Yes, partly because I give too much and build strong bonds. Trust should not mean total availability. Detachment and clear roles are important.

**Francesca:**
One last question. You named listening, understanding, non-judgment and respect as resources. What limits become obstacles?

**Cinzia:**
Staying in my scope. I can be empathetic, but I cannot provide psychological tools – I can listen and understand, yet I may not equip someone to overcome the problem. Communicating about an emotional component is also tricky – some people are open, others close off. You need to sense whether to gently name stress, or keep quiet to avoid shutdown. There is a double limit: the operator's scope and the patient's readiness to accept what you say. Motivation is another limit – some people do not change habits or do exercises. At times it seems they want to feel unwell, perhaps to receive care at home or to remain central in the family dynamic. You cannot say that bluntly – communication must be calibrated. Otherwise they will leave.

**Francesca:**
Thank you for your time.

**Cinzia:**
You are welcome, it was a pleasure.

### *9.1.6 Case study 6*

Below is the experience of Salvatore, coach of the national paralympic water polo team. Salvatore had the opportunity to express which aspects, as a non-formal educator, he feels as resources and which as limitations during his activity. The interview was conducted and transcribed by Francesca Settimelli, member of the IACP team.

**Francesca:**
I'd like to start by asking you to tell me a little about your work. You mentioned something on the phone, but I'd like to understand better who you are and what you do.

**Salvatore:**
I'm a water polo coach. I have a degree in sports science with federation licenses from FIN and the Italian Federation of Paralympic Swimming. I work with non-disabled athletes, and my specific role is national technical referent for Paralympic water polo. I organize all competitive activities for the discipline: league, Italian Cup, Super Cup and so on. Paralympic water polo is very young. We started in 2021, so this is the fifth year. When athletes arrive, men and women, they have usually begun rehabilitation and know their "functional residue," for example after an amputation. Since water polo is demanding, most are already athletes in some sense. Some come from swimming, others are simply comfortable in the water. I am also on the national team staff as one of the two coaches, so I'm on the technical side and on the management side.

**Francesca:**
Told simply, but there's clear complexity.

**Salvatore:**
Yes. At base, water polo requires a strong swimming foundation even for non-disabled athletes. We work only with athletes with physical disabilities. Those with intellectual or relational disabilities are served by other federations. The range of disability is wide, which adds complexity to training and to group dynamics.

**Francesca:**
You said some arrive with a previous sports career as non-disabled, then after trauma they return to sport.

**Salvatore:**
Exactly. That's not easy to accept. A former Serie A or B player who is now an amputee may find himself alongside a paraplegic teammate who moves only with arms. It can feel like dropping several categories. The beautiful thing is that once they really enter the group and start playing, everything changes. Initial thoughts like "what am I doing here, I'm not disabled" tend to fade. I have seen athletes who struggled a lot at first become pillars of their club or even of the national team. Sometimes the shift happens faster than you would expect.

**Francesca:**
Fast, but also mentally and physically tiring.

**Salvatore:**
Both. An important piece is the group's ability to use irony to put everyone at ease. I sometimes bring my non-disabled swimmers to events as volunteers. They are always struck by how Paralympic athletes joke about their situation. I tell them not to be alarmed – it's a way to reduce tension for everyone.

**Francesca:**
So irony works as a resource.

**Salvatore:**
Absolutely. They use it a lot.

**Francesca:**
By the time they start a Paralympic discipline they've usually done psychological and physical rehabilitation, right?

**Salvatore:**
Yes. To compete they must undergo classification, which includes a medical exam and an in-water assessment to determine category. Most arrive having already worked through part of the acceptance process. Some still reject the new status, often because of how the accident happened or what they lost, so coaches and teammates have to show them they haven't stopped being athletes. They are athletes in another way, but athletes nonetheless.

**Francesca:**
In the tougher situations, especially at the beginning, what has helped most in your experience?

**Salvatore:**
I remember an open day in Lignano Sabbiadoro. It wasn't a competition but a recruiting event. A boy recently had an accident. He hadn't accepted his disability, didn't want to be with the group, stayed in his room, wouldn't even come out to eat. We tried a different entry point. He loved video and editing, so we asked him to be the content creator for the weekend. Feeling included through that role, he started coming out, then tried entering the water with a technician beside him. He still doesn't swim, but he's part of the team now. He doesn't play, yet he belongs to the group. For him the doorway was media, not water, and that was fine.

**Francesca:**
So a respectful nudge plus connection to his interests.

**Salvatore:**
Yes. Forcing the water piece would have failed. Involving him through something he loved worked.

**Francesca:**
How did you feel before and after?

**Salvatore:**
Motivation has a similar logic across contexts. With young kids who fear the pool after a bad experience, you find other doors to enter. Not to trick them, but to show you're there for their good. Another story: a strong water polo player had a motorbike accident with his girlfriend. She lost a leg, he didn't, but he took on guilt. She kept telling him it wasn't his fault and encouraged him to return to the water. He resisted. When we formed the national Paralympic team we brought him in and soon after took him to Spain for a friendly. That trip was a turning point. He accepted the new pathway, kept his lively edge but put himself at the service of the team. He became a reference point, even using his skills as a photographer to support teammates. We had thought he might try once and quit. Instead he stayed and became a spokesperson for Paralympic water polo.

**Francesca:**
So individual motivation and belonging to a group. And the satisfaction of seeing that change.

**Salvatore:**
Huge. Many are new to the discipline, the level is high, and they don't run away. They stay and want to improve.

**Francesca:**
You said it's been only five years, yet you speak as if it were always part of your life.

**Salvatore:**
I entered by chance. My first impact with the Paralympic world was strong. In the water there are no prostheses, so you see bodies as they are. Hearing an athlete say "can you pass me my leg" can catch you off guard. They do it partly to put others at ease. Over time you adjust. I recommend the Paralympic instructor course to everyone, whatever the sport. It teaches you to work with what we call functional residue, to stop demanding a "perfect gesture" and to understand constraints and adaptations. Swimming is established worldwide; water polo is growing. Seeing almost 250 athletes in Italy practicing Paralympic water polo is a big pride.

**Francesca:**
And Italy helped create the discipline.

**Salvatore:**
Yes. Five years ago Paralympic water polo didn't exist. With two colleagues we helped launch it here. It feels like our creation and we're proud of that.

**Francesca:**
How did your very first approach with these athletes go?

**Salvatore:**
The first match I saw was mixed, with physical and intellectual disabilities together. I had experience with autistic kids, so that part was familiar. Seeing several amputees swimming and competing was impactful. Once I started talking and training, they put me at ease. The best approach was to treat them as athletes. Of course you don't assign a leg drill to someone without legs. You adapt. In a squad of 15–20 each person's disability is different: hemiparesis, paraplegia, amputation. The goal is the same, but the path to the technical gesture changes person by person. At first it felt overwhelming. Now it's a stimulating challenge. On national duty we also work with a physiotherapist and a doctor, both for safety and for recovery after sessions.

**Francesca:**
What about emotional reactions, especially at first contact?

**Salvatore:**
Very subjective. It depends on how recent the disability is and on personal history. With someone new to disability, the work is trust, encouragement and motivation. We acknowledge that life has changed. As a non-disabled coach I can't fully imagine life without an arm or legs. So I try to understand who is in front of me, from the boy who wouldn't leave his room to the person who has already accepted and just needs to learn a new discipline. Family support matters a lot. Our universal starting tool is motivation, but without false promises. We don't say "you'll go to the Paralympics." We set concrete goals, like the national championship, and build from there.

**Francesca:**
I hear deep empathy, even though stepping into another's shoes is complex.

**Salvatore:**
True. Once they're in the water they are athletes. We keep standards and discipline without victimizing. If a leg is missing, we work with the other leg and adapt the technique. We're collaborating with engineers at Tor Vergata to study technical gestures with sensors, aiming to bring disabled athletes' technique as close as possible to the standard model. The message is consistent: you can execute the skill, maybe differently, but you can do it. My job is to work on resources – in Paralympics that means functional residue.

**Francesca:**
It mirrors daily life too – how to approach difference.

**Salvatore:**
Exactly. The first reflex might be "poor thing," but many people with paraplegia live fully, work, drive, do everything. They're not "poor things." They live differently and live well.

**Francesca:**
Trust and respect for the person's timing seem central.

**Salvatore:**
Yes. Respect for individual timing is essential, even more with physical disability. Goals must remain. Dropout is a failure as it is for non-disabled athletes. What we've seen in these five years is growth, not abandonment. If a club closes for economic reasons, athletes move and keep playing.

**Francesca:**
What motivates you?

**Salvatore:**
Sport itself. The competitive drive and the desire to show that despite what happened you can do things many non-disabled won't do. An example: an 18-year-old from Verona now plays in Naples. Two weekends a month he travels to train, stays with a teammate, gives up nights out and this year won the league and the Super Cup. His disability is evident, an obstetric palsy with very limited movement of his right arm, yet he became decisive for his team and a national standout. That is motivation.

**Francesca:**
Advice for those approaching complex situations like the ones you face?

**Salvatore:**
People often say "put yourself in their shoes," but everyone is different. I'd say learn to observe and learn to listen, including those who don't want to talk, and adapt to their way of relating. Some want questions, others need silence. Understand who is in front of you, wait, then enter the relationship. If you go in hard with your technique, even if it's excellent, in the wrong context you can do damage.

**Francesca:**
It sounds very calibrated to who you have in front of you.

**Salvatore:**
I'm not very talkative with people I don't know. That helps me observe first, then find the key to enter.

**Francesca:**
Anything to add?

**Salvatore:**
I recommend engaging with disability. Not because it "pays," but because it builds empathy and sensitivity. The shift is to see the person not as "poor thing," but as someone who does what others do with a motor deficit – and still does it.

**Francesca:**
Thank you so much for coming.

**Salvatore:**
You are really welcome.

## 9.2 Adapting best practices for different settings

Trauma-informed informal education recognizes the impact of trauma on learning and development, creating supportive environments that foster resilience and empowerment. It emerged from an understanding that adverse childhood experiences and other traumatic events profoundly influence cognitive, emotional and social development. While trauma-informed approaches have been integrated into formal education systems, informal education – learning outside structured school environments – has yet to fully embrace these principles in many regions, particularly in Europe.

Trauma-informed informal education incorporates strategies that promote safety, empowerment and healing, aiming to create environments where all learners can thrive. A foundational element of this approach is the creation of physically and emotionally safe spaces, where learners feel secure, respected and valued – an essential condition for engagement and growth. Equally important is the development of trusting relationships between educators and learners. Consistent positive interactions foster a sense of stability and connection that is especially important for individuals with trauma histories.

To support learners in managing stress and emotional challenges, trauma-informed informal education emphasizes the teaching of self-regulation skills. Practices such as mindfulness, breathing exercises and movement-based activities are commonly used to enhance emotional regulation and reduce anxiety. In parallel, learners are empowered through opportunities for choice and autonomy. Providing options in how and what to learn helps build resilience and a sense of self-efficacy.

Cultural responsiveness is another critical aspect of best practice. Recognizing and respecting the diverse cultural backgrounds of learners and tailoring interventions accordingly ensures that learning environments are inclusive and affirming. Finally, these practices must be underpinned by adequate training for educators. Informal educators and facilitators need to be equipped with an understanding of trauma and its effects in order to provide appropriate supportive responses and foster healing-centered engagement.

Informal education takes place in a wide range of environments – such as community centers, afterschool programs, youth organizations and refugee support groups – each with distinct challenges and opportunities. Adapting trauma-informed best practices to these different settings is crucial for their effectiveness.

In refugee and migrant contexts, trauma-informed approaches must address the specific stressors related to forced displacement, loss and cultural dislocation. Programs in these settings benefit from strategies that support cultural integration, promote psychological safety and incorporate multilingual communication to ensure accessibility.

Youth work and mentorship programs are well-positioned to implement trauma-informed principles through peer relationships and creative activities. These environments can enhance resilience by fostering belonging, encouraging emotional expression and providing consistent adult support.

Outdoor and experiential learning contexts offer unique opportunities for trauma recovery. Nature-based approaches – such as ecotherapy – can facilitate emotional regulation and self-awareness in ways that traditional indoor settings may not. Immersive experiences in natural environments support sensory integration and can reduce hyperarousal in trauma-affected individuals.

While the core principles of trauma-informed education – such as safety, trust, empowerment and cultural sensitivity – remain consistent across contexts, their application must be flexible and responsive to the specific needs and strengths of each community and learner group.

In recent years, the importance of trauma-informed practices has gained widespread recognition in education and in many areas of community life. This development has moved beyond formal systems and entered the realm of informal education, where relationships, empathy and flexible learning environments form the foundation of engagement. Informal educators – working in youth centers, community programs, shelters, after-school clubs and other non-institutional settings – play a vital role in supporting vulnerable individuals, especially those with lived experiences of trauma. They apply specific principles and engage in intentional daily practices to create safe, empowering and healing-centered environments.

Trauma-informed care has become an essential framework for ethical and effective practice in psychological, educational and social fields. It emphasizes understanding the pervasive effects of trauma and fostering environments that prioritize safety, empowerment and recovery. Both institutional systems and civil society initiatives are increasingly adopting these frameworks, particularly in response to the growing awareness of the psychological burden caused by adverse childhood experiences and cumulative trauma.

The trauma-informed approach is not a technique or a therapeutic method but a way of being, thinking and acting that places safety, choice, collaboration, trust and empowerment at the center of the relationship. Even for those without clinical training – such as educators, social workers, volunteers and teachers – the adoption of daily practices that create a safe and welcoming environment can serve as a powerful transformative lever both for those who have experienced trauma and for the quality of relationships in general. It is within this framework that the following daily practices are proposed: accessible, non-clinical yet consistent with the principles of the person-centered approach and the trauma-informed framework.

### *9.2.1 The importance of the "Emotional weather report"*

The "emotional weather report" is a simple yet deeply rooted exercise in the principles of Carl Rogers' person-centered approach. It consists of listening non-judgmentally to one's emotional state in the present moment, the here and now. When done in a group, everyone is free to share whatever they wish about their inner experience. This activity helps people connect with what they are truly feeling in the moment, to become aware of their internal experience and to express it with authenticity. In a group setting, when others listen without judgment or interpretation, a climate of acceptance is created, fostering authentic communication and mutual respect. It promotes deep respect: any emotion expressed – sadness, anger, confusion, joy – is considered valid and worthy of being heard and accepted as it is, without the need to change or fix it. Each participant is recognized in their uniqueness and lived experience – not as a bearer of a role or a problem but as a person with an inner world deserving of respect and space.

This is a practice that promotes mindful presence, respect for subjective experience and the creation of a safe, warm and facilitative relational climate. In Italy, this activity has been integrated into various training programs, highlighting its effectiveness in facilitating authentic emotional expression. From a trauma-informed perspective, it fosters psychological and relational safety as it offers a predictable and welcoming space where one can express themselves without fear of negative consequences. It promotes emotional awareness and authenticity – key aspects in restoring a sense of agency for those who have experienced internal fragmentation or dissociation. It makes the person visible in their wholeness, not only in their role or observable behavior but in their lived, recognized and accepted experience.

### *9.2.2 Giving yourself credit: a practice of self-recognition and empowerment*

Those who have experienced trauma often develop a self-perception focused on failure, inadequacy or guilt. The "giving yourself credit" activity offers a change in perspective by focusing on a gesture, a thought, a choice or a quality one is proud of – even something small. The exercise invites individuals to recognize and name something they can give themselves credit for – a strength, a valuable action, a small or large success or even simply a genuine and committed attempt.

It is an invitation to see and honor who we are beyond judgment or perfectionism. This activity helps individuals become aware of parts of themselves that are often overlooked or diminished,

contributing to a more integrated and authentic self-image. It supports a sense of self-continuity, sustaining identity narratives.

It cultivates deep self-respect: recognition begins from a non-critical, welcoming gaze that values what is present without the need to be better to deserve esteem. It fosters trust in internal resources – this exercise reinforces the perception of personal efficacy even in small gestures, countering the learned helplessness often associated with trauma histories. It is an act of self-awareness and self-compassion, useful in building a sense of self-worth beyond external approval. Proposed in a warm relational context, the exercise also becomes a way to nurture a positive self-image, essential for growth and self-actualization.

### *9.2.3 Listening to your breath*

Breath awareness is an accessible mindfulness practice that allows one to gently reconnect with the body. In post-traumatic recovery, the body may be perceived as a place of danger but also as a potential resource for regaining stability and presence. This practice supports neurophysiological regulation through activation of the parasympathetic system, helping to exit the chronic alert state typical of trauma responses. It promotes gentle, non-invasive self-knowledge based on non-judgmental awareness. It aligns with the principle of deep respect: the breath is welcomed as it is, without pressure to improve or perform, supporting authentic presence. This technique is particularly helpful for trauma survivors, as it provides a safe anchor in the present. In Italy, mindfulness has been integrated into various training programs, showing benefits in managing stress and anxiety.

The practice of "Listening to Your Breath" offers a simple and powerful way for individuals to reconnect with their bodies in the present moment, gently and non-invasively. For trauma survivors, this experience can be a first step in reclaiming internal safety and restoring contact with the self in a way that does not require words or direct emotional exposure. It fosters coherent body awareness – people learn to stay with what they feel, moment by moment, without judgment or needing to change anything. This supports alignment between internal experience and awareness, even in subtle ways. It offers deep self-respect: by focusing on the breath as it is – shallow, calm, short, deep – one cultivates an attitude of listening and acceptance toward their current condition, without force or expectations. It restores a basic sense of control and agency. Trauma survivors often feel disconnected from themselves and powerless. Reclaiming the experience of breathing as something personal and continuous can help restore a foundation of stability, continuity and belonging to one's own body. It creates conditions for perceiving internal safety. In an empathetic relational climate, this exercise allows one to experience being with oneself safely, gradually and at one's own pace – an essential experience for trauma survivors.

**Sample script**

*Sit comfortably, with your feet touching the ground. Close your eyes, if you like, and simply bring your attention to your breath. You don't need to change it – just notice it. Where do you feel it most? In your nose, your chest, your belly? Let it come and go, just as it is. If thoughts arise, thank them and let them pass. Return to your breath, to its continuous presence, its rhythm. Remember, your breath is always with you – it accompanies and sustains you.*

*9.2.4 Guided visualization: "Restoring mind-body waterfall"*

Imagination is a powerful tool when working with trauma survivors, as it allows access to reparative experiences without the need to relive traumatic content. The "restorative waterfall" guides the person in imagining a beneficial flow moving through the body and mind, offering a sense of lightness and care. Guided visualizations like this one are used to induce relaxation and promote self-healing. These practices are based on the idea that imagination can positively influence a person's physiological and psychological state. In Italy, such techniques have been used in therapeutic settings to support recovery from stress and trauma.

The restorative waterfall visualization is both an imaginative and somatic practice that invites the person into a state of relaxation and self-repair through the image of a healing waterfall flowing over their body and mind. It is especially helpful for creating a sense of relief, lightness and connection between mind and body, particularly during emotional fatigue or following difficult experiences. It promotes internal congruence – through imaginative connection with the body and sensations, the person can come into contact with their real and authentic inner experience, even without words, and welcome it without needing to explain. It offers an experience of self-regulation and self-empathy. Imagining a waterfall gently flowing over the body is like offering oneself an empathetic and caring gaze – soothing, accepting and refreshing. It creates conditions for welcoming the self as it is. Every part – tired, in pain, restless – can be touched by the waterfall without needing to change or function better. It can simply be. The practice supports self-regulation by helping the person enter a state of calm and relaxation. In doing so, they activate internal resources for rebalancing and recovery, which are especially important in post-traumatic pathways or periods of emotional overload. It offers a symbolic experience of containment and restoration, particularly useful in times of stress, fatigue or vulnerability.

**Sample script**

*I invite you to close your eyes, if you wish, and imagine yourself in a natural place, safe and peaceful. In front of you, a waterfall of clear, fresh yet gentle water is flowing. Step closer and stand beneath this flow. Let the water pour over you, slowly, from head to toe, as if washing away heavy thoughts, tension and fatigue.*

*Feel the coolness on your head, your face, your shoulders… the water flows down your body, carrying away tiredness, heavy thoughts, tension.*

*Each drop washes away what you no longer need and at the same time nourishes every part of you, purifies you, recharges you.*

*The water refreshes you, recharges you, embraces you. Stay here for as long as you need, noticing what shifts in your body…*

*Then, slowly, come back to the present.*

*9.2.5 Finding a safe place in your mind*

Creating a "safe place" through visualization is a strategy used to provide a sense of security and emotional stability. This technique is particularly effective for individuals who have experienced trauma, as it offers an internal refuge that can be accessed during moments of distress. It makes the experience of protection tangible, even for those who have never known safety in real life. It also strengthens the sense of personal agency by showing that there is a mental space one can access independently. This helps reduce anxiety and hyperarousal and supports mindful presence and learning.

Educators, facilitators and volunteers can offer this practice in a simple and respectful way. The "finding a safe place in your mind" exercise is a guided visualization that helps individuals create a protected and peaceful internal space they can return to whenever they need to feel safe. It is especially helpful for trauma survivors but can also be used during times of stress, anxiety or emotional instability. It fosters internal safety through an empathic atmosphere where the individual can proceed at their own pace. There is no pressure to perform or feel anything in particular – only an invitation to be present with whatever arises. This supports trust in one's own inner resources. Even those who feel vulnerable can discover that they hold within themselves a safe and accessible place. It strengthens the sense of continuity and personal identity. The safe place becomes a mental space where the person feels fully at ease – protected, free and welcomed exactly as they are. It asks nothing and allows every part of the self to simply be. In times when the present feels overwhelming, this internal sanctuary offers emotional regulation and gentle containment. It doesn't deny pain but surrounds it with care.

**Sample guided script**

*Close your eyes, if you like, and begin to breathe slowly…*

*Now imagine being in a place where you feel completely safe. It can be real or imaginary – a cozy room, a natural landscape, a secret corner that's just yours. Explore the details – what do you see around you? What sounds are there? What scents do you notice? What's the temperature?*

*In this place, no one can harm you. No one judges you. You are safe. You can be as you are – no one will disturb you. This is your space, and you can return to it whenever you need. It lives inside you, and no one can take it away.*

*Notice what shifts within you while you are there and carry this feeling of protection with you even as you open your eyes.*

## 9.3 Building trust through relational presence

Creating a sense of safety is foundational in trauma-informed work. Safety must be both physical and psychological. Practitioners are encouraged to attend to the sensory and relational cues of the environments they help shape, minimizing unpredictability and promoting calm through structured routines and clear boundaries. Safety arises not only from environmental design but also from how the professional uses their presence, tone and body language. Attunement to non-verbal cues and sensitivity to potential trauma triggers – such as raised voices, closed doors or touch – are critical

components of fostering this sense of safety. Routine behaviors like explaining what will happen next, asking permission before proceeding with potentially sensitive topics and offering grounding exercises can significantly reduce anxiety for trauma survivors.

A core activity for trauma-informed informal educators is being emotionally present and reliable. This involves consistent non-judgmental interactions, showing up on time, keeping promises and being transparent about decisions and limitations. Greeting young people by name, asking about their well-being and remembering details from past conversations builds trust. Even informal chats over a shared meal or during art-making can be moments of connection. Daily routines often include check-ins – brief one-on-one conversations that give participants a chance to express how they are feeling.

Relational presence also involves co-regulation. If a participant becomes dysregulated, the educator might model calm breathing or use grounding techniques to help them return to a state of balance. These practices are subtle yet deeply impactful. Clear, honest and consistent communication in all professional relationships is key. This includes explaining the limits of confidentiality, outlining the structure of interventions and being dependable in follow-through. When individuals know what to expect, their nervous systems are less likely to default to hypervigilance or dissociation. Transparency is not only about content but also about emotional congruence – professionals who are authentic and emotionally present support a relational climate in which clients or students feel seen and respected. Predictability in tone, timing and boundaries contributes to a sense of security, especially for those with a history of relational trauma.

Trauma-informed informal educators prioritize empowerment, recognizing that trauma often involves a loss of control. Daily practices are designed to return a sense of agency to participants. This might include offering choices in activities – such as whether to participate in a group game or spend time quietly journaling – or inviting young people to help plan the weekly schedule. Educators encourage reflection and self-expression through methods like storytelling, art or group discussions. These methods help participants develop a sense of identity and voice.

Respecting "*no*" is also a vital part of empowerment. If a young person declines to participate, educators respond without pressure or punishment, reinforcing the message that boundaries are valid and honored. A central tenet of trauma-informed practice is the commitment to avoid re-traumatization through authoritarian or unilateral approaches. Professionals are urged to work with rather than on the individuals they serve, recognizing their agency and expertise in their own lives. Co-regulation and participatory decision-making help restore a sense of control often lost in traumatic experiences. This may manifest in everyday practices such as offering choices in how to proceed in a session, asking for feedback or explicitly affirming the person's autonomy. Such practices not only strengthen engagement but also rebuild a sense of personal efficacy and dignity. Co-regulation and shared responsibility help reframe power from a top-down directive to a relational process of mutual recognition and growth.

Empowerment is both a process and an outcome of trauma-informed engagement. Practitioners are encouraged to adopt a strengths-based lens, highlighting individuals' capacities rather than deficits. Daily interactions should aim to affirm resilience, highlight successes and encourage skill-building. This includes supporting the development of self-regulation skills such as grounding, mindfulness and reflective practices, which help trauma survivors manage emotional arousal and

make sense of their experiences. This kind of support is critical for preventing retraumatization and promoting psychological integration. Sometimes there is a need for institutions that offer training and clinical support in complex trauma and stress management, with a focus on capacity-building for both professionals and clients. Such daily practices help individuals reconnect with a sense of agency and possibility, central goals of trauma-informed recovery.

A trauma-informed lens means that informal educators are attuned to behaviors that may be expressions of distress rather than defiance. A young person who storms out of a room, for example, might be responding to a trigger rather than intentionally being disruptive. Educators remain vigilant for signs of dysregulation – such as sudden silence, agitation or withdrawal – and respond with calm, non-invasive strategies. Daily activities may include moments of emotional regulation, such as offering access to a calming space, providing fidget tools or suggesting a movement break. Rather than focusing on punishment, educators use restorative responses – they might hold a gentle debrief with the participant afterward to explore what happened, what was needed and how to restore safety or trust.

Informal education settings are often collaborative environments. Trauma-informed educators engage daily with colleagues, supervisors, social workers and occasionally therapists or school staff, especially when working with high-needs populations. They may participate in daily or weekly team check-ins to discuss participant needs, reflect on challenging situations and co-develop strategies. This peer collaboration helps mitigate the emotional toll of the work and supports reflective practice.

Educators are trained to maintain professional boundaries – referring participants to specialized services when needed rather than assuming a therapeutic role. Part of their daily responsibility includes tracking observations and, when necessary, sharing relevant information with the appropriate professionals in a confidential and ethical manner.

The value of peer support is widely acknowledged in trauma recovery, as relational ruptures often lie at the heart of trauma. Peer support is one of the core principles of trauma-informed care, encouraging the creation of opportunities for individuals to engage with others who share similar experiences. In daily practice, this may mean integrating group formats or peer mentoring models into service delivery. Even within one-on-one settings, promoting connection to supportive networks can be healing. Professionals are encouraged to model empathy and mutuality in their interactions, thereby helping individuals internalize new relational templates that are safer and more empowering. This relational shift moves away from hierarchical models and supports the reparation of trust through shared humanity.

Trauma-informed practices promote relational approaches that are empathic, grounded in active listening, free of judgment and centered on the authentic recognition of emotions. Some examples can be observed in Italy, where the MaTeMù center offers artistic and theatrical workshops that enable adolescents to explore and reprocess traumatic experiences through group expression and peer validation. In that way, art and theatre become relational tools capable of building meaningful connections, promoting trauma processing and the reconstruction of a sense of self. Similarly, EMERGENCY's project "*Raccontare la Pace*" uses storytelling and cooperative learning in schools to help students understand and express their experiences related to conflict, migration and loss.

These initiatives reflect how peer-based, relationally attuned environments can become vehicles for resilience and integration.

Modeling is a powerful tool in trauma-informed informal education. Educators consciously model respectful communication, emotional regulation and healthy boundaries. For instance, they might narrate their own self-care practices ("*I need to take a few deep breaths before we start*") or respectfully assert a limit ("*I'm happy to talk with you, but I can't be yelled at*").

Daily self-care is essential to prevent burnout and vicarious trauma. Educators often integrate moments of reflection or peer support into their routines. Some organizations encourage practices such as journaling, movement breaks or mindfulness for staff. By caring for themselves, educators model resilience and show participants that it is okay to prioritize well-being.

Though informal educators are not bound by standardized curricula, they frequently design and lead educational activities that support social-emotional learning and trauma-sensitive goals. These may involve facilitating group discussions that address emotions and conflict resolution, guiding collaborative art projects that explore themes such as identity or community or organizing outdoor games that promote cooperation and stress relief. Educators might also use story circles or creative writing prompts as tools to encourage personal reflection and growth.

These activities are delivered with a high degree of flexibility. Informal educators are attentive to participants' emotional states, adjusting tone, pace and structure as needed to maintain a sense of safety and inclusivity. They are adept at transforming everyday experiences – such as cooking together, repairing a bicycle or making music – into meaningful moments of connection, learning and healing.

Reflection is a critical part of trauma-informed informal education. At the end of the day, educators often engage in reflective journaling or team debriefs. They review what went well, what was challenging and what could be improved. Reflection allows educators to recognize patterns – such as when certain participants are more likely to become dysregulated – and to adjust their approach accordingly. It also helps them stay grounded in their values, preventing emotional reactivity and preserving a sense of purpose amid complex and emotionally charged work.

Trauma does not occur in a vacuum but is shaped by sociocultural, historical and political factors. Cultural, historical and gender awareness is a critical principle in trauma-informed care. This requires an ongoing commitment to cultural humility, anti-oppressive practice and attention to systemic injustices. Recognizing intersectionality and the specific ways trauma may be experienced and expressed across different populations is essential. In daily practice, this means asking respectful questions about identity and context, avoiding assumptions and being willing to engage in reflexivity and supervision to identify potential biases. Trauma-informed people seek to honor the whole person in their social and historical context rather than isolate their suffering from its roots. Being trauma-informed means recognizing the intersectionality between trauma and identity – racial violence, sexism, social inequalities and discrimination can themselves be forms of trauma or factors that exacerbate its effects. Organizations which support parents and families during the coming out process of LGBTQ+ children work through a culturally aware lens, offering spaces for listening and the deconstruction of stigma, thereby contributing to the creation of more inclusive environments.

Trauma-informed informal educators perform crucial, often under-recognized work. Their daily activities – while varied and flexible – are rooted in a commitment to safety, empowerment and relational healing. Through consistent presence, emotional attunement and purposeful engagement, they create environments where individuals affected by trauma can reconnect with themselves and others in meaningful ways. These educators do not fix trauma, nor do they replace professional mental health services. That would be punished by law and would seriously damage their clients. They instead know how and where to refer trauma survivors to local mental health agencies and trauma-informed mental health professionals. Trauma-informed informal educators provide the safe space in which resilience, growth and recovery can take root. In the small, everyday interactions – offering a listening ear, honoring a boundary, celebrating a small victory – trauma-informed informal educators plant seeds of trust and hope that can profoundly affect lives over time.

As awareness of trauma's widespread impact grows, so too must our support for and recognition of these vital educators. Their work exemplifies how human connection, patience and intentionality can turn everyday settings into safe places of healing and learning. Trauma-informed care is a dynamic, context-sensitive approach that can be practiced daily across disciplines. By integrating the principles and practices of trauma-informed care into the cultural and institutional framework, professionals can contribute to more humane, inclusive and healing environments. Whether in schools, clinics or community settings, trauma-informed care calls for a relational ethic grounded in safety, collaboration and cultural respect. Through everyday practices that honor vulnerability and foster resilience, professionals not only support individual recovery but also participate in a broader social transformation. The daily discipline of being trauma-informed involves presence, intentionality and a commitment to holding power responsibly, in service of healing rather than harm. Adopting a trauma-informed approach is not a protocol, but in fact a relational and organizational transformation that requires awareness, ongoing training and ethical reflection.

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# Chapter 10: Revealing the blind spots – gaps and needs in trauma-informed care for informal educators identified by the COPE project

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The COPE project was created to address urgent gaps faced by non-formal educators and volunteers who work with individuals affected by trauma, particularly refugees and displaced persons. Many of these learners struggle with post-traumatic stress disorder, depression and anxiety, yet access to appropriate mental health support is limited because of stigma, lack of resources and insufficient trauma-focused training. At the same time educators and volunteers themselves are often unprepared to respond to trauma-related needs and in some cases may also experience secondary trauma through their work.

To ensure that the training program developed by COPE responds to these challenges, a needs assessment was carried out as a foundational step. The aim was to identify the competencies educators already possess, the gaps in their preparation and the specific support they require to recognize and manage trauma in diverse educational and cultural contexts. The needs assessment ensures that the resources created will be relevant, practical and transferable across Europe.

This process is essential because the project seeks to adapt established methodologies such as simulation-based learning to the realities of non-formal education (alongside providing the knowledge). The needs assessment therefore acts as both a diagnostic tool and a bridge, in order to connect the broader objectives of COPE. These are to equip educators with skills and competences that strive for integration and resilience with the everyday challenges encountered in classrooms, but also in community centers and volunteer-led initiatives.

## 10.1 A mixed-methods approach for needs assessment of trauma-informed informal educators

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A needs assessment therefore served a dual purpose. On the one hand, it provides evidence to inform the content and design of the training program. On the other hand, it acts as a participatory process, giving educators themselves a voice in shaping what the program should offer.

In the mixed-methods approach for needs assessment, the first objective was to identify the current competencies of non-formal educators and the areas where they lack preparation, most notably in recognizing trauma and responding in ways that are safe and supportive. This helped establish a baseline of strengths and weaknesses within the profession.

The second objective was to determine the specific needs of educators in different cultural and educational contexts. Trauma does not present in the same way in all settings. A strategy that works

in one community may be less effective in another. By paying attention to context, the program could be designed to remain adaptable and relevant across Europe, but also globally.

The assessment was carried out using both qualitative and quantitative methods in order to capture a wide and detailed picture. The first step was a literature search to establish the current state of the art in trauma-informed approaches and training of non-formal educators. This provided a theoretical and comparative background in Europe, with comparisons beyond.

The next step involved non-directive interviews with educators. For this desktop research, all partners contributed interviews highlighting national case studies and everyday practices, which served as the foundation for the analysis. The qualitative data were carefully analyzed to identify patterns and recurring themes.

To broaden the scope, a qualitative questionnaire was distributed to non-formal educators across several European countries. This provided data on their day-to-day experiences with trauma, their level of knowledge, and their perceptions of what training would be most helpful.

An additional questionnaire was conducted with experts from a range of professional backgrounds and age groups. Their input brought in different perspectives, allowing the research team to compare the experiences of practitioners with the views of specialists in related fields.

A quantitative questionnaire complemented the qualitative work by offering measurable indicators of preparedness, knowledge gaps, and confidence levels. This mixed-methods design ensured that both subjective experiences and objective data were included.

Finally, the team reviewed best practices and guidelines already available in the field of trauma-informed training. This step was important for situating the findings within the broader European and international landscape and ensuring that the training program would be informed by proven strategies while still responding to local realities.

### *10.1.1 Results and implications for the COPE project*

Upon analyzing the results, most non-formal educators demonstrated limited knowledge of trauma and trauma-informed practices, as well as techniques for working with individuals who have survived trauma. Many of them had not received any specific training in this area, which highlights a fundamental gap in preparation and/or capacity.

At the same time, educators expressed a strong desire to receive training that would improve their skills in recognizing and managing trauma and in supporting emotional regulation. Their responses underscored the importance of a curriculum that is not only theoretical but also practical and applicable to real-world situations.

The creation of safe and supportive environments was universally recognized as essential. Educators and experts agreed that opening a door for a culture of safety and trust, where open communication and active listening are prioritized, is pivotal for effective engagement. However, there remains a clear need for targeted training on how to consistently create such environments, particularly in diverse and complex educational contexts.

Cultural differences also emerged as a significant factor in shaping perceptions of and responses to trauma. This finding underscores the importance of developing a training approach that is sensitive to the different cultural realities of both educators and participants, ensuring inclusivity and effectiveness across a plethora of settings.

There was a strong recognition of the need for ongoing support and accessible resources after initial training. Educators emphasized the value of having reference materials, professional support networks, and opportunities for continuous professional development. Training on self-care and burnout prevention was also seen as crucial, given the emotional demands of working with trauma-affected populations.

The results of the need assessment provided a solid foundation for the development of the COPE Erasmus project training program. The findings could objectively guide the structure and priorities of the training to ensure that it directly addresses the gaps identified by non-formal educators and experts. In accordance with that, training should be designed to fill these gaps through specific modules on recognizing the signs of trauma, coping techniques and approaches that are sensitive to different cultural contexts. Also, a practical and experiential approach should be emphasized throughout the training. Case studies, role plays and realistic scenarios should be integrated into the program so that non-formal educators are exposed to theory, but also prepared for the concrete situations they may encounter in their daily work.

Support should not end once the training sessions are completed. Additional resources and professional networks should be made available through the project's online platform. These can actually provide opportunities for continuous learning, and in a way guarantee that educators remain supported in the long term. It is also important to think about cultural and linguistic diversity in order to make the content relevant and applicable across different educational settings.

The analysis revealed that non-formal educators have fragmented knowledge of emotional trauma and its manifestations. There is a clear need for ongoing training and support to develop practical skills in the trauma-informed approach. These results suggest a perceived gap between the training received and the skills required in professional practice, highlighting the need for more targeted and in-depth training programs.

Experts recognized the need for further training in managing emotional dynamics, addressing cultural diversity, and applying trauma-informed practices in complex contexts.

Based on the results obtained, it is recommended to develop specific training programs for non-formal educators that include:

- Detailed training on the concept of emotional trauma;
- Modules on trauma and its psychological and emotional effects and trauma-informed practices;
- Practical tools to recognize signs of trauma and respond effectively without re-traumatizing;
- Exercises to develop empathic skills and maintain professional boundaries;
- Exercises to build Strategies for adapting intervention techniques to the emotional reactions of clients/users;
- Skills to promote self-regulation and autonomy in individuals who have experienced trauma;

- Relationships and trust with users, based on best practices in trauma-informed care;
- Additional resources to support the practical application of acquired knowledge;
- Accessible and free continuous training, preferably online.

### *10.1.2 Conclusions, recommendations and avenues of future action*

Beyond initial training, it is clear from this analysis that informal educators would benefit from continuous support to address the challenges of their work. This ongoing support could include access to resources, regular supervision and peer support networks to enhance their ability to apply trauma-informed principles in their daily interactions effectively.

Training courses should be created that combine theory and practice on emotional trauma, with specific modules tailored for informal educators. These courses should include content on understanding trauma and techniques to avoid re-traumatization. The approach should follow internationally recognized guidelines for trauma-informed education.

Regular supervision and peer review programs should also be implemented for informal educators. These would provide opportunities to reflect on practice, address challenges and improve skills. Supervision should include components of critical reflection on educational methods and strategies for managing complex cases. Such measures would enhance the quality of interventions and also help to reduce burnout.

Efforts should be made to raise awareness among informal educators about the importance of trauma-informed practice. Online resources, workshops and easily accessible materials can be used to promote understanding of trauma and its implications. This awareness is fundamental for embedding trauma-informed principles in daily educational work.

Training should also include modules that focus on building empathy and relational skills, which are essential for effective educational interventions. Practical exercises should be incorporated so that informal educators can refine these skills and apply them in real-world contexts. The interviews highlighted a strong need for more structured and specific training for informal educators on emotional trauma. Current levels of knowledge and empirical strategies are insufficient to meet the complexities that arise in trauma-related educational contexts. To improve outcomes, it is thus necessary to implement comprehensive training programs, provide continuous supervision, and strengthen the relational capacities of educators. These recommendations, supported by both research findings and practice-based evidence, can improve the skills of non-formal educators and positively influence the quality of support provided to learners.

To address these challenges, European policymakers, funders and educational leaders must work together to promote a coordinated and comprehensive approach. Developing standardized but adaptable guidelines for trauma-informed informal education is an important first step. These guidelines should allow for regional and cultural flexibility while maintaining consistent core principles. Expanding training opportunities is equally important. Accessible capacity-building programs, mentorship and ongoing supervision are essential for ensuring that informal educators are prepared and supported. At the same time, sustainable funding mechanisms must be secured

for trauma-informed initiatives, particularly in underserved or marginalized communities where exposure to trauma is often higher and resources more limited.

Cross-cultural collaboration and policy alignment will strengthen these efforts by encouraging knowledge exchange, innovation, and mutual support across European contexts. Public awareness campaigns should also be promoted to reduce stigma, normalize discussions of trauma, and encourage community-level support for trauma-informed practices.

Ultimately, addressing these gaps requires embracing a bio-psycho-social approach. Trauma must be understood not only as an individual experience but as a societal challenge that demands systemic, holistic and intersectoral solutions. Learners, educators, caregivers, institutions and policymakers: all of them have a role to play in building safe and empowering learning environments.

Promising models such as trauma-informed communities, trauma-informed cities and trauma-informed nations (as tackled in previous chapters) provide inspiring examples of how these principles can be scaled and embedded across systems. These approaches demonstrate that trauma-informed practice is not limited to individual interventions but can become a collective framework for healing and resilience.

## 10.2 A descriptive and inferential quantitative approach for needs assessment of trauma-informed informal educators

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To better understand the needs and profiles of adult educators working with emotionally traumatized learners, a quantitative study was also conducted within the framework of the COPE Project. This aimed to inform the development of tailored resources and training materials by identifying the current level of knowledge, challenges and support needs among professionals engaged in non-formal education across Europe.

The study employed an online questionnaire as its primary data collection tool. The questionnaire included several thematic sections: sociodemographic information; self-assessed level of feeling informed, as well as experience related to person-centered trauma-informed care, empathy, deep respect and congruence; suggestions for improvements or additional resources for the creation of an online teaching course; and self-assessment of participants' levels of work-related stress and symptoms of depression, anxiety and stress. All participants first read and confirmed their agreement with an informed consent form before proceeding to complete the questionnaire. The collected data were then analyzed using descriptive statistics and, where appropriate, inferential statistical methods.

The questionnaire was opened a total of 446 times, and 321 participants completed it in its entirety. Of note, although 321 participants completed the questionnaire in full, individual items had varying levels of item-level nonresponse; therefore, the total number of valid responses (n) in the tables below may be lower for certain questions. Completed questionnaires were submitted in several languages, including Polish, Croatian, Italian, Ukrainian and English. The gender distribution of

participants was overwhelmingly female, with 90.7% of respondents identifying as women. Such demographic imbalance raises important considerations regarding gender representation in trauma-informed professions and voluntary participation in surveys. Given the high prevalence of female respondents, it may be useful to explore whether this reflects the actual gender distribution in the field or if it suggests an underrepresentation of male professionals in trauma-related work.

The average age of the participants was 43.54 years with a standard deviation of 10.62. The median age was 43, with the youngest respondent being 18 years old and the oldest 77. This demographic characteristic may influence the reported need for additional training and support, as professionals with more experience might perceive certain challenges differently from younger colleagues who are still developing their expertise.

In terms of educational attainment, 4.9% of participants reported having completed high school, 1.1% held a vocational school diploma, 10.3% held a bachelor's degree, 46.6% had obtained a Master's degree, 2.9% held a Ph.D. and 5.8% selected "other" as their highest level of education. This suggests that the sample consists of highly educated professionals, which could affect perceptions of preparedness in trauma-informed care.

The most frequently cited challenge was insufficient training on trauma-informed care (61.11%), reinforcing the need for systematic educational programs in this domain. Additionally, lack of institutional support (33.76%) and lack of resources (32.48%) were major concerns, indicating that while professionals recognize the importance of trauma-informed care, structural and organizational barriers limit their ability to apply these principles effectively.

Interestingly, only 1.71% of participants selected "Other" when asked about challenges, suggesting that the predefined categories accurately captured the main difficulties faced in the field. These findings align with previous literature highlighting the necessity of institutional commitment in trauma-informed work.

**Table 10.2.1.** Participants distribution regarding: Occupation

| | n | % |
|---|---|---|
| Social worker | 72 | 30.77 |
| Informal Educator | 37 | 15.81 |
| Educator | 28 | 11.97 |
| Physical therapists | 28 | 11.97 |
| Teacher | 23 | 9.83 |
| Volunteer | 15 | 6.41 |
| Healthcare professional | 8 | 3.42 |
| Lawyer | 4 | 1.71 |
| Medical doctors | 4 | 1.71 |
| Emergency and disaster personnel | 3 | 1.28 |
| Cultural Mediator | 3 | 1.28 |
| Massage therapist | 3 | 1.28 |
| Immigrant and refugees services personnel | 2 | 0.85 |
| Boy Scout leader | 2 | 0.85 |
| Rehabilitation specialist | 1 | 0.43 |
| Nursing professionals | 1 | 0.43 |
| Total | 234 | |

**Table 10.2.2.** Participants distribution regarding: Work context

| | n | % |
|---|---|---|
| Social Service Agency | 39 | 19.31 |
| Non Governmental Organization (NGO) | 39 | 19.31 |
| Professional in private practice | 30 | 14.85 |
| Non Profit Organization | 27 | 13.37 |
| Local, Regional and Municipal public Health Agencies | 20 | 9.9 |
| Hospitals and other healthcare institutions | 13 | 6.44 |
| Municipal agency for the needy | 11 | 5.45 |
| For Profit Organization | 7 | 3.47 |
| Charity | 6 | 2.97 |
| Center for mental health | 5 | 2.48 |
| Service for migrants and refugees | 3 | 1.49 |
| Organization focused on Immigrants and/or refugees | 2 | 0.99 |
| Total | 202 | |

**Table 10.2.3.** Reported frequency of main challenges as a non-formal educator working with trauma survivors

| | n | % | Total % |
|---|---|---|---|
| Insufficient training on Trauma Informed (effective communication, non-judgmental approach, etc.) | 143 | 100 | 61.11 |
| Lack of institutional support | 79 | 55.24 | 33.76 |
| Lack of resources | 76 | 53.15 | 32.48 |
| Difficulty in identifying and managing trauma | 70 | 48.95 | 29.91 |
| Other | 4 | 2.8 | 1.71 |

The distribution of professional roles indicates that the majority of participants are engaged in social work (30.77%) and education-related roles (27.78%), emphasizing the relevance of trauma-informed approaches in these sectors. Additionally, NGOs and social service agencies (38.62% combined) were the most frequently reported work environments, underscoring the importance of trauma-informed training outside traditional healthcare institutions.

A noteworthy finding is the low representation of medical doctors (1.71%) and nursing professionals (0.43%). Given that healthcare professionals frequently encounter trauma survivors, this may suggest an insufficient integration of trauma-informed care in medical education or a lower engagement of healthcare workers in non-formal trauma-related education initiatives.

**Table 10.2.4.** Reported frequency of resources that participants consider essential to address the specific needs of trauma survivors in the context of non-formal education

| | n | Relative % | Total % |
|---|---|---|---|
| Psychological support for non-formal educators | 124 | 100 | 52.99 |
| Specific training courses | 118 | 95.16 | 50.43 |
| Informational material on trauma management | 55 | 44.35 | 23.5 |
| Practical manuals | 50 | 40.32 | 21.37 |

The results indicate that the most frequently requested resource was psychological support for non-formal educators (52.99%), followed closely by specific training courses (50.43%). This highlights the emotional burden of working with trauma survivors and suggests a pressing need for both personal and professional support mechanisms.

The relatively lower preference for practical manuals (21.37%) suggests that professionals favor interactive or experiential learning methods over static instructional materials. These findings should inform the development of future training programs by emphasizing dynamic, real-world application rather than purely theoretical content.

**Table 10.2.5.** Reported frequency of skills participants believe are essential for non-formal educators working with individuals who have experienced trauma

| | n | Relative % | Total % |
|---|---|---|---|
| Empathy and active listening | 137 | 100 | 58.55 |
| Knowledge of Trauma Informed principles | 117 | 85.4 | 50 |
| Effective communication abilities | 117 | 85.4 | 50 |
| Stress management skills | 102 | 74.45 | 43.59 |
| Genuine Respect | 100 | 72.99 | 42.74 |

Participants identified empathy and active listening (58.55%) as the most essential skills, which aligns with the core principles of trauma-informed practice. Additionally, knowledge of trauma-informed principles (50%) and effective communication abilities (50%) were considered equally important, indicating a need for both theoretical knowledge and interpersonal skills.

Interestingly, stress management (43.59%) was also frequently cited, suggesting that professionals recognize the importance of regulating their own emotional well-being while supporting trauma survivors. This raises an important question: are current work environments providing adequate stress reduction strategies for professionals in these roles?

**Table 10.2.6. Perceived incidence** of the ways that participants organization support their emotional well-being and skills in dealing with trauma-related situations

| | n | Relative % | Total % |
|---|---|---|---|
| Mentorship and team support | 48 | 100 | 20.51 |
| Psychological support programs | 30 | 62.5 | 12.82 |
| Professional counseling services | 25 | 52.08 | 10.68 |
| Trauma management training courses | 20 | 41.67 | 8.55 |

Despite the emotional and professional challenges reported, only 20.51% of participants indicated receiving mentorship and team support, and even fewer had access to psychological support programs (12.82%). These low figures suggest that organizations may not be prioritizing the well-being of their employees who work with trauma survivors.

When asked about improvements they would like to see, participants most frequently requested continuous training opportunities (40.6%) and the establishment of support networks (38.03%). The emphasis on professional development over material resources implies that organizations should focus on long-term educational and structural solutions rather than short-term interventions.

**Table 10.2.7.** Reported frequency of improvements or additional resources participants would like to see implemented in the context of your training and support as a non-formal educator

| | n | Relative % | Total % |
|---|---|---|---|
| More opportunities for continuous training | 95 | 100 | 40.6 |
| Establishment of support networks among educators | 89 | 93.68 | 38.03 |
| Access to professional counseling services | 78 | 82.11 | 33.33 |
| Increased financial resources for training | 63 | 66.32 | 26.92 |

**Table 10.2.8.** Reported frequency of the ways participants organization could promote a more trauma-aware culture and provide a more sustainable work environment for non-formal educators

| | n | Relative % | Total % |
|---|---|---|---|
| Awareness through workshops and informational materials | 97 | 100 | 41.45 |
| Creation of spaces for discussion and sharing | 87 | 89.69 | 37.18 |
| Implementation of psychological support policies | 74 | 76.29 | 31.62 |
| Promotion of work-life balance policies | 66 | 68.04 | 28.21 |

**Table 10.2.9.** Reported frequency of challenges participants face as a non-formal educator when working with trauma survivors

| | n | Relative % | Total % |
|---|---|---|---|
| Insufficient training on Trauma Informed (effective communication, non-judgmental approach, etc.) | 86 | 100 | 36.75 |
| Lack of institutional support | 71 | 82.56 | 30.34 |
| Lack of resources | 60 | 69.77 | 25.64 |
| Difficulty in identifying and managing trauma | 46 | 53.49 | 19.66 |

**Table 10.2.10.** Reported frequency of topics participants would like to further explore in the future

| | n | Relative % | Total % |
|---|---|---|---|
| Conflict management | 83 | 100 | 35.47 |
| Person Centered - Trauma Informed Best Practices | 83 | 100 | 35.47 |
| Vicarious/compassionate Trauma prevention and management | 75 | 90.36 | 32.05 |
| Stress prevention and management | 73 | 87.95 | 31.2 |
| Evaluation of post-traumatic stress disorder (PTSD) | 73 | 87.95 | 31.2 |
| Trauma Informed Best Practices | 66 | 79.52 | 28.21 |
| Emergency management | 65 | 78.31 | 27.78 |
| Treatment of Post-Traumatic Stress Disorder (PTSD) | 62 | 74.7 | 26.5 |
| Communication and active listening | 58 | 69.88 | 24.79 |
| The rights of minors, rights of vulnerable people | 57 | 68.67 | 24.36 |
| Effective welcoming techniques | 47 | 56.63 | 20.09 |
| Cross- Cultural Communication | 31 | 37.35 | 13.25 |
| Protection of fundamental human rights | 30 | 36.14 | 12.82 |
| Working alliance | 25 | 30.12 | 10.68 |
| Victims of human trafficking | 21 | 25.3 | 8.97 |
| Refugee policies | 10 | 12.05 | 4.27 |
| Refugee rights | 10 | 12.05 | 4.27 |
| The geo-political context of the countries of origin of migrants and refugees | 9 | 10.84 | 3.85 |

**Table 10.2.11.** Reported frequency of topics related to migrants and refugees that are trauma survivors which participants would like to study in depth

| | n | Relative % | Total % |
|---|---|---|---|
| Psychological trauma of various kinds | 114 | 100 | 48.72 |
| Work in small groups | 94 | 82.46 | 40.17 |
| Supervision | 93 | 81.58 | 39.74 |
| Analysis and discussion of cases | 86 | 75.44 | 36.75 |
| Interactive session | 67 | 58.77 | 28.63 |
| Discussion debate | 62 | 54.39 | 26.5 |
| Physical trauma linked to war or accidents | 55 | 48.25 | 23.5 |
| Technical demonstrations | 54 | 47.37 | 23.08 |
| Living long periods of time without caregivers | 53 | 46.49 | 22.65 |
| Sexual abuse during wars and terrorism | 42 | 36.84 | 17.95 |
| Peer supervision | 39 | 34.21 | 16.67 |
| Torture | 34 | 29.82 | 14.53 |
| Sexual abuse during the migration trip | 31 | 27.19 | 13.25 |
| Trafficking and trading of human beings | 28 | 24.56 | 11.97 |
| Frontal lesson | 27 | 23.68 | 11.54 |
| Trauma resulting from genital mutilation | 21 | 18.42 | 8.97 |

**Table 10.2.12.** Reported impact of the influence of trauma on ...(Scale 1-3).

| | Mean | Median | Mode | SD | Minimum | Maximum | N |
|---|---|---|---|---|---|---|---|
| increase in empathy | 3.76 | 4 | 4 | 0.808 | 1 | 5 | 168 |
| impact on trust and relationship | 3.59 | 4 | 4 | 0.965 | 1 | 5 | 167 |
| changes in activity organization | 3.24 | 3 | 3 | 0.929 | 1 | 5 | 169 |
| modification of educational strategies | 3.20 | 3 | 3 | 0.902 | 1 | 5 | 167 |

1 - Not at all, 2 - Slightly, 3 - Moderately , 4- Very, 5 - Extremely

**Table 10.2.13.** Reported degree of difficulty for participants to manage their emotions (scale 1-5)

| | Mean | Median | Mode | SD | Minimum | Maximum | N |
|---|---|---|---|---|---|---|---|
| fear | 2.65 | 3 | 3 | 0.970 | 1 | 5 | 161 |
| guilt | 2.59 | 3 | 3 | 1.101 | 1 | 5 | 158 |
| anxiety | 2.52 | 2 | 2 | 1.019 | 1 | 5 | 161 |
| anger | 2.48 | 2 | 2 | 1.054 | 1 | 5 | 159 |
| shame | 2.30 | 2 | 2 | 0.983 | 1 | 5 | 160 |
| sadness | 2.28 | 2 | 3 | 1.023 | 1 | 5 | 158 |
| disgust | 2.16 | 2 | 2 | 0.968 | 1 | 5 | 158 |
| surprise | 1.75 | 1 | 1 | 0.984 | 1 | 5 | 158 |
| envy | 1.73 | 1 | 1 | 0.900 | 1 | 5 | 158 |
| happiness | 1.32 | 1 | 1 | 0.678 | 1 | 4 | 158 |

1 - Not difficult at all, 2 - Slightly difficult, 3 - Moderately difficulty, 4 - Very difficult, 5- Extremely difficult

**Table 10.2.14.** Reported alignment of work team relationships (1-3 scale)

| | Mean | Median | Mode | SD | Minimum | Maximum | N |
|---|---|---|---|---|---|---|---|
| Relationships between colleagues | 1.81 | 2 | 2 | 0.616 | 1 | 3 | 126 |

1 - Supportive, we do an excellent team work, 2 - Good enough, but we could improve, 3 - There are various difficulties between us that prevent us from doing as a good team

**Table 10.2.15.** Reported level of perceived work stress (1-5 scale)

| | Mean | Median | Mode | SD | Minimum | Maximum | N |
|---|---|---|---|---|---|---|---|
| Work stress levels | 3.17 | 3 | 3 | 1.132 | 1 | 6 | 143 |

1 - Little or none, 2 - Moderate and manageable, 3 - There are stressors in periods of very intense work but after that there are less frenetic times in which we can recover, 4 - Very high but I can manage my workdays effectively, 5 - Too high and this has a negative effect on me and the quality of my work, 6 - Too high for everyone and this affects the members of the working team and the quality of the work of our group

Participants reported moderate levels of work stress (M = 3.17, SD = 1.13), with a subset experiencing significantly high stress. The data suggest that while many professionals manage their workload effectively, there are critical periods of intense stress that may impact performance and well-being.

When examining emotional regulation, participants reported the most difficulty managing fear (M = 2.65), guilt (M = 2.59), and anxiety (M = 2.52). These emotions are commonly associated with secondary trauma and burnout, reinforcing the need for targeted mental health interventions for professionals working with trauma survivors.

Interestingly, happiness (M = 1.32) was the least difficult emotion to regulate, suggesting that while the work is emotionally demanding, it also provides personal and professional fulfillment for many individuals.

**Table 10.2.16.** Participants' perceptions of whether they have examined the impact of traumatic experiences on individuals' behavior and relational patterns. The table distinguishes between respondents who have not yet had the opportunity to explore these consequences (Option 1) and those who have actively investigated how trauma affects a person's behavior and their relationships with others (Option 2).

| | n | % | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| 1 | 109 | 24.4 | 44 | 44 |
| 2 | 139 | 31.2 | 56 | 100 |
| Total | 248 | 55.6 | 100 | |

1 - I have not had the opportunity to investigate the potential effects of the trauma on behavior and the way people relate to each other.
2 - I have investigated the potential effects of the trauma on behavior and on the way, people relate to themselves and others.

The results indicate that trauma exposure has a substantial influence on professional behavior. The highest-rated impact was an increase in empathy (M = 3.76), followed by changes in trust and relationships (M = 3.59) and modifications in educational strategies (M = 3.20).

These findings align with previous research suggesting that professionals who work closely with trauma survivors develop enhanced relational and communicative skills. However, the simultaneous increase in work stress and emotional burden highlights the complexity of this dynamic.

This complexity highlights why the COPE project places equal emphasis on strengthening professional competencies and creating supportive institutional frameworks. While increased empathy and improved communication are valuable outcomes, they cannot be sustained without addressing the parallel rise in stress and emotional fatigue. This suggests that enhancing trauma-informed skills should be coupled with embedded protective mechanisms that reduce burnout and promote long-term resilience among non-formal educators.

**Table 10.2.17.** Participants perception regarding their experience on the ability to establish an effective relationship with a trauma survivor is the use of a neutral and supportive language

| | n | % | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| 1 | 79 | 17.7 | 31.9 | 31.9 |
| 2 | 78 | 17.5 | 31.5 | 63.3 |
| 3 | 91 | 20.4 | 36.7 | 100 |
| Total | 248 | 55.6 | 100 | |

1 - I have not had the opportunity to elaborate on topics of effective communication with trauma survivors
2 - I learned the importance effective communication with trauma survivors only on a theoretical level
3 - I have explored topics on effective communication with trauma survivors on theoretical level and I have been able to put them into practice

**Table 10.2.18.** Participants perception regarding opportunities to receive feedback on their ability to deeply respect others also when they hold beliefs, values, cultures, and behaviors different from their

| | | n | % | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| No | 1 | 26 | 5.8 | 16.1 | 16.1 |
| Yes | 2 | 135 | 30.3 | 83.9 | 100 |
| | Total | 161 | 36.1 | 100 | |

Participants expressed the greatest interest in conflict management (35.47%) and trauma-informed best practices (35.47%). Notably, topics related to refugees and human trafficking were of lower interest (<10%), despite these populations being highly trauma-exposed. This could indicate either a lack of direct engagement with these groups or limited awareness of their specific needs.

The high preference for interactive learning formats (e.g., case discussions, small groups) over frontal lectures (11.54%) suggests that professionals value experiential and participatory training methods.

In terms of mental health outcomes, 16.25% of participants reported significant or high levels of anxiety, 12.5% reported significant or high levels of depression, and 10% reported significant or high levels of stress.

In the analysis exploring potential associations between reported variables, we found a moderate positive correlation between work stress and symptoms of depression, anxiety, and stress, reinforcing the notion that trauma-related work can contribute to mental health difficulties ($p < 0.05$). However, the use of relaxation techniques were not significantly correlated with anxiety, depression, or stress symptoms, suggesting that while they are commonly used, they may not be sufficient as standalone coping strategies.

Interestingly, participants who perceived greater organizational changes reported lower anxiety levels, implying that workplace adaptability may serve as a protective factor against work-related stress.

The analysis revealed a weak negative association between symptoms of anxiety and participants' perception that organizational changes influence their educational approach and relationships with the individuals they support. In other words, when participants observed more changes in the perceived activity of their organization, they tended to report lower anxiety levels.

A moderate positive association was observed between symptoms of stress, overall scores on depression, anxiety and stress, and levels of work-related stress. This indicates that participants experiencing higher work stress also reported higher levels of stress and more pronounced symptoms of depression, anxiety and stress overall.

A moderate positive association was also found between the belief that trauma influences participants' educational approach and their relationships with the individuals they support. This was evident in areas such as the modification of educational strategies, changes in organizational activity, and the perceived impact on trust and relationships. These same changes were also linked with a reported increase in empathy.

A weaker positive association was noted between the belief that trauma influences participants' educational approach and relationship with learners, particularly in relation to increases in empathy, changes in organizational activity, the adjustment of educational strategies, and the development of practical experience in working with trauma survivors.

Finally, participants with higher levels of education were more likely to report opportunities to investigate the effects of trauma on behavior and relationships, as well as to explore effective communication strategies. They also more frequently emphasized the importance of empathy and active listening when working with individuals who have experienced trauma.

### *10.2.1 Conclusions, recommendations and avenues of future action*

The findings of this analysis underscore the critical need for enhanced training, institutional support and psychological resources for professionals working in trauma-informed settings. With 321 completed questionnaires, this can be seen as an initial snapshot of challenges, needs, and perceptions among a sample of individuals engaged in non-formal education and social work. The gender distribution, with 90.70% of respondents being female, suggests that trauma-related professions may have a gender imbalance, potentially influencing both the experience and support structures within these fields, although this imbalance may also be due to gender-related participation biases in who is completing the on-line survey. There is also a body of literature on women having higher participation rate. Therefore, it is important to acknowledge that women may be more represented in the informal education settings represented in the survey, it is important to ensure that men in these settings can engage with the materials, and as needed, they can be adapted to any additional needs they have that are different, Also, participants' demographic characteristics, particularly the high proportion of individuals holding master's degrees (46.60%), suggest that the study population is well-educated, yet they still report significant gaps in trauma-informed training and support. This indicates that formal education alone may not be sufficient to prepare professionals for the complexities of working with trauma survivors. Still, it has to be noted that, while this may to some extent reflect the reality, men in these settings also need to have the skills and may require different things.

The results highlight several key challenges faced by participants, with insufficient training (61.11%), lack of institutional support (33.76%), but also lack of resources (32.48%) emerging as predominant concerns. These barriers indicate systemic issues that impede the implementation of effective trauma-informed practices. Furthermore, the limited representation of medical doctors and nursing professionals suggests that trauma-informed care is not yet fully integrated into traditional healthcare education and practice.

A striking finding is the reported need for psychological support among non-formal educators (52.99%) and the demand for specialized training (50.43%). The emphasis on psychological well-being suggests that working with trauma survivors places a significant emotional burden on professionals, necessitating stronger organizational support mechanisms. Additionally, the preference for experiential learning approaches, such as small-group discussions and case-based learning, suggests that future training initiatives should prioritize interactive and applied methodologies over theoretical instruction.

The analysis also revealed concerning levels of work-related stress and emotional challenges among participants. While relaxation techniques and mindfulness practices were frequently employed, their effectiveness in mitigating symptoms of depression, anxiety, and stress was reported to be limited. Work stress was found to be significantly correlated with higher symptoms of psychological

distress, underscoring the urgent need for targeted mental health interventions. Importantly, the study identified that greater organizational adaptability was associated with lower anxiety levels, highlighting the protective role of workplace flexibility and institutional responsiveness. These findings suggest that policy reforms aimed at fostering adaptive work environments, promoting continuous professional development, as well as implementing structured psychological support systems could significantly enhance the well-being and effectiveness of trauma-informed professionals.

This analysis, when taken everything together, provides valuable insights into the realities of working with trauma survivors and offers actionable recommendations for improving training, institutional support, but also mental health resources in trauma-informed settings. Addressing these gaps is essential for ensuring that professionals are adequately equipped to provide high-quality care while maintaining their own psychological resilience. It is notable that, while participants demonstrate high levels of empathy and a strong commitment to their roles, they face significant barriers in terms of training, institutional support, and personal well-being.

This translates to several implications for policy and practice:

- Institutions should prioritize training in trauma-informed care and ensure that it is integrated into professional education curricula, and also identify ways to ensure men as well as women are able to engage with the material;
- Organizational support structures, such as mentorship programs and psychological support services, need to be expanded to mitigate the emotional toll of working with trauma survivors;
- Financial investment in professional development should be increased, as lack of funding was identified as a key barrier to accessing continuous training;
- Workplace flexibility and adaptability should be promoted, as greater perceived organizational change was associated with lower anxiety levels.

In light of these findings, the COPE Project plays a critical role in translating evidence into practice and policy. It gives a policy-relevant framework for embedding trauma-informed care into European education and social inclusion strategies. Its emphasis on continuous professional development and structured support systems offers a scalable model that policymakers can adopt to reduce stress among educators in order to ensure consistent quality of care for trauma survivors. Linking local practice with systemic reform, we demonstrate how targeted investment in training and organizational change can strengthen individual resilience and also the broader capacity of societies to respond to trauma in humane and sustainable ways.

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# Final Reflections

*The Editors*

Trauma does not belong only to the past. It reverberates through classrooms, group sessions, community spaces and digital learning platforms, shaping how learners connect, express, trust and grow. In non-formal education, where flexibility and human connection are central, educators have both the challenge and the opportunity to become catalysts for healing.

Consequently, this handbook has provided not only detailed theoretical insights into the nature and consequences of trauma, but also practical tools/approaches, pedagogical strategies and case-based examples that can support real-world application. From understanding trauma's biological and psychological roots to navigating its cultural, intergenerational and systemic dimensions, each chapter contributes to a broader vision: a vision of non-formal education as a safe and inclusive space for all. A space that empowers.

Yet, trauma-informed practice is not a checklist. It is an ongoing commitment to humility and responsiveness. It asks educators to remain attentive to both what is visible and what is not – to behaviors, silences, shifts in tone and unmet needs that may be quietly shaping learners' experiences. It also asks organizations and systems to look inward: to question how their own structures, expectations or policies may reinforce harm or exclusion.

The COPE Project and this handbook have shown that even small shifts (in language, posture, process) can create profound changes in how learners feel and function. When safety and trust are prioritized, learning becomes not just possible, but actually transformative.

As we conclude this handbook, we invite you to view trauma-informed work not as a destination, but as a practice of presence. It is a way of being – with learners, with colleagues, and with ourselves – that holds space for pain while making room for growth.

In a world that often overlooks invisible wounds, your trauma-informed approach can offer something rare: safety without judgment, presence without pressure. Sometimes, just showing up with care is a quiet act of transformation.

On behalf of the COPE Project Team

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