

SIG 1**Clinical Focus**

Conceptualizing Trauma-Informed Speech-Language Pathology Practice: Adaptations and Implications Across Levels of Practice

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https://doi.org/10.1044/2025_PERSP-24-00319**ABSTRACT**

Purpose: There is an increasing drive to integrate trauma knowledge and the principles of trauma-informed care into speech-language pathology (SLP) practice. While work has been done to move this forward, the concept of trauma-informed SLP practice requires a clearer conceptualization. In this article, we outline our current framework for conceptualizing trauma-informed SLP practice, developed through our work with SLP providers and leaders implementing and researching trauma-informed practice adaptations, and our engagement with mental health experts in childhood trauma and attachment disruption. We explain the key guiding principles that SLP practitioners, leaders, and decision-makers can adopt from best practices in the field of mental health to enhance service delivery, engagement, relationship building, and outcomes for all clients, as well as trauma-informed and trauma-responsive adaptations and implications to all levels of SLP practice.

Conclusions: It is important to recognize that many clients may have experienced trauma, whether or not care providers are aware; therefore, our systems should be designed to be responsive to everyone. This clinical focus article underscores the critical need for systemic change, to create supportive environments that foster healing and resilience for all individuals involved in systems and support services.

In recent decades, the field of speech-language pathology (SLP) has advanced in understanding the relationship between trauma and communication development and capacity. The focus has primarily been on establishing that trauma exposure correlates with communication abilities across various populations (e.g., Byrne, 2017; Casanueva et al., 2012; Hyter, 2021; Lum et al., 2015; Sylvestre et al., 2016). For example, Hyter (2021) has demonstrated important ties to particular social communication capacities and

Brien et al. (2021) highlight its effect on narrative skills through autobiographical memory. Although most research has specifically demonstrated a link between childhood maltreatment and communication, the relationship between trauma exposure and communication has also been demonstrated in children and youth in the criminal justice system (e.g., Chow et al., 2022), refugees and migrants (e.g., Dada et al., 2024; Kaplan et al., 2015; Verdon et al., 2022), and children and youth who have experienced serious medical procedures/interventions and/or accidents (e.g., Malarbi et al., 2017).

There have, however, been advocates of this crucial relationship for decades in both SLP and mental health, such as Pamela Snow and Nancy Cohen, who have described the more nuanced bidirectional relationship between communication and mental health, highlighting the foundational place of communication within mental

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health. Their work has emphasized the need for the involvement of speech-language pathologists in mental health services in various ways, for example, the unique potential of speech-language pathologists to engage in early identification of traumatized children (Snow, 2009) and the high prevalence of communication disorders among children in mental health services (Cohen et al., 1998). These children would benefit from collaborative, tailored care as mental health services often rely on communication abilities. Despite these strong advocates, to borrow from Judith Herman (2022), we require a social movement to expect any significant systemic change. There appears to be significant interest in this topic and perhaps hope that this interest will translate into systemic change. The literature demonstrating connections between trauma exposure and various language and communication domains is now widely recognized and accepted, although this remains under-integrated in professional training and practice. As interest in trauma-informed care (TIC) grows, its application in SLP is still developing and requires a clearer definition.

Resources relevant to SLP include key texts such as *Communicating Trauma* by Na'ama Yehuda (2016), *Working With Child and Adolescent Mental Health: The Central Role of Language and Communication* by Susan McCool (2023), and *Language Research in Post-Traumatic Stress* by Yvette Hyter (2024). Courses from providers such as Course Beetle and Language & Literacy Practices further enhance SLP training. Additionally, organizations such as the Harvard Centre on the Developing Child and the Alberta Family Wellness Initiative offer valuable resources that further emphasize the protective value of relationships and on building resilience when a child has experienced traumatic stress. Additionally, trauma knowledge is increasingly recognized in popular culture, with insightful, applicable books such as *What Happened to You?* by Bruce Perry and Oprah Winfrey (2021) and podcasts, such as *The Brain Architects* and *Two Sides of the Spectrum* (including episodes on trauma and autism)—all of which are contributing to moving the field forward. See the Appendix for a resource list.

Aside from the specific connection to SLP practice, trauma-informed service provision benefits all support services by trauma identification, facilitating more thorough assessments, enhancing treatment planning, and reducing the risk of retraumatization and/or further traumatization. It fosters relationship building, increases access to care/services, and enhances staff wellness (Fernández et al., 2023; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a, 2014b). These factors contribute to improving service efficacy, outcomes, and cost-effectiveness. Therefore, the SLP field, like other fields, must work through an emerging process of understanding

and, in some cases, reconceptualizing care through a trauma-informed lens.

Implementing a trauma-informed approach to care demands more than just responsive individual practitioners; it necessitates change at multiple levels of systems and leadership (SAMHSA, 2014a, 2014b). To effectively achieve this systemic change, advocates, scholars, and leaders must work together to improve the existing conditions. Frameworks play a crucial role in this process, as they help clarify principles, enhance understanding, and guide the design and assessment of systemic change while also representing its complexity (Foster-Fishman et al., 2007).

In this article, we will outline our current framework for conceptualizing trauma-informed SLP practice. We will discuss the key guiding principles that SLP practitioners, leaders, and decision-makers can adopt from best practices in the field of mental health. These principles aim to enhance service delivery, engagement, relationship building, and outcomes for all clients. Although SLP practitioners do not specifically treat trauma without additional qualifications, they do work with individuals who have experienced trauma. Therefore, it is crucial to recognize that, regardless of whether care providers are aware of an individual's specific experiences, our systems should be designed to be responsive to the needs of everyone.

Developing a Conceptualization of Trauma-Informed SLP Practice

Since 2019, the George Hull Centre (“the Centre”) Institute of Childhood Trauma and Attachment has, as one area of focus, brought together SLP and mental health practices related to trauma and attachment disruption to develop, refine, and research what it means to engage in trauma-informed SLP practice. As a first step, SLP practitioners in Canada were surveyed to explore their understanding, beliefs, practices, and needs regarding trauma in their work (Rupert & Bartlett, 2022). The majority of SLP practitioners revealed that they regularly encounter individuals who have experienced trauma, but lack training about trauma, inconsistently adapt care in response to trauma, and felt they needed to learn more to be effective in practice (Rupert & Bartlett, 2022).

To meet the needs identified by practitioners, in 2020, we began developing training and guidelines to support TIC in SLP practice. Due to the emerging nature of this work, our training and conceptualization of trauma-informed SLP practice are continuously revised and updated. Our work products (including the conceptualization of trauma-informed SLP practice we share in this article) have been developed through our collaboration

with the Centre’s Preschool Speech and Language (PSL) Program and with other SLP community partners who are implementing and researching trauma-informed SLP practice adaptations. In addition, our work is revised in response to discussions and feedback from SLP practitioners through training and consultation. We also collaborate with practitioners and academics working to advance this area of knowledge and practice.

Furthermore, we are closely connected with a mental health community that includes clinical experts, researchers, and leaders specializing in childhood trauma and attachment disruption. This allows us to integrate

reflection, learning, discussions, and advancements from SLP and trauma to advance trauma-informed SLP practice. Figure 1 depicts our current conceptualization of trauma-informed SLP practice. Some components of this conceptualization include both widely recognized and espoused aspects of SLP practice—such as strengths-based care and cultural responsiveness—and emerging trends, such as the universal integration of TIC principles and therapeutic alliance. We have attempted to demonstrate how these elements come together under the umbrella of trauma-informed SLP practice and highlight their importance given the pervasiveness of trauma and its relevance to SLP. While we aim to apply scientific rigor to develop

Figure 1. 2024 conceptualization of trauma-informed speech-language pathology (SLP) practice.



this conceptualization further, we hope our current understanding can serve as a foundational starting point.

We propose that trauma-informed SLP practice includes two tiers of adapted practice and guiding principles upon which all practice rests. The two tiers mirror the distinction made in mental health between the universal application of trauma-informed practice, which accommodates the presence of traumatized individuals in practice, versus the more focused trauma-responsive approaches that are designed to serve traumatized clients specifically. The first tier is a foundational trauma lens to SLP practice, which integrates a trauma-informed perspective universally across individual, programmatic, organizational, and systemic levels of practice. During the development of our training, we realized we were asking participants to shift their practice by incorporating the trauma knowledge they were learning to fundamentally understand their clients differently and recognize that anyone they worked with may be impacted by traumatic stress. This foundational tier embeds TIC principles in all aspects of practice.

The second tier is trauma-responsive care specific to SLP practice. The definition of “trauma-responsive” care is not universally agreed upon in the literature and is sometimes used interchangeably with “trauma-informed” care. In some instances, trauma-responsiveness is understood to mean furthering the universal application of TIC principles. This “furthering” may be moving from individual to systemic applications or moving to include individualized care that considers the unique experiences of those who have experienced trauma (De La Rue & Ortega, 2019). This understanding of trauma-responsive care aligns with the notion that providers can have different tiers of response based on their knowledge of an individual’s trauma experiences and the provider’s scope of practice/role. For example, Tier 1 could involve general TIC application, while Tier 2 would focus on individualized care (Fondren et al., 2020).

At this time, we align with the latter perspective, suggesting that SLP practitioners can further their practice by integrating trauma-responsive best practices borrowed from mental health. We view this as an area where the field should conduct research to better understand how to be responsive, ensuring that we contribute to healing, do not cause harm, and remain within our profession’s scope of practice. While beneficial to all clients and people involved in systems, this tier allows for customized care based on the known presence or history of trauma. It ensures that care is tailored to meet the specific needs of individuals who have experienced trauma and enables provider–client interactions to be healing in and of themselves.

In addition to these two tiers, practice, service and system design, and decision-making must align with core

guiding principles that reflect what is currently known about trauma treatment in order to contribute to healing: Care must be relationship-based; safety needs to be prioritized above all else, and a felt sense of safety is required for all; multidisciplinary and collaborative care is crucial; and systemic barriers and implications must be identified, acknowledged, and addressed (SAMHSA, 2014b). Below, we explain each component further.

Tier 1: A Trauma Lens to SLP Practice

We have conceptualized the first tier of trauma-informed SLP practice as a trauma lens to practice, requiring the universal application of foundational trauma knowledge, TIC principles, and the integration of contextualized and reflective practice.

Foundational Trauma Knowledge

Core trauma knowledge includes recognizing that trauma is a subjective experience of an event, events, or a set of circumstances that overwhelm an individual’s capacity to cope and can have long-lasting impacts (Centre for Addiction and Mental Health, 2024; Gradus & Galea, 2023). This understanding shifts the common perception of trauma from being solely about the occurrence of a terrible event to recognizing it as both a physiological and psychological *response*. Individuals can experience various types of trauma including acute, complex, developmental, racial, and intergenerational trauma. It is important to recognize the signs and symptoms of trauma, as well as the associated risk and protective factors. Understanding trauma’s impact—particularly the neurobiological effects of traumatic stress during development—is crucial, as these effects can influence an individual throughout their life. For SLP practitioners, this foundational knowledge includes awareness and understanding of the unique and specific relationship between trauma and speech, language, and communication. As discussed in contextualized care, understanding the potential impact of experiences and circumstances is an essential part of a holistic understanding of those we work with.

While trauma is not traditionally part of SLP professional training (Rupert & Bartlett, 2022), anecdotally, it is increasingly being introduced and more often integrated into curriculum. This integration often happens through guest lectures and consideration of difficult family circumstances, such as housing or food instability or parental mental health issues, in practice-based learning activities. Despite these advances, trauma education is not systemically incorporated into SLP professional training, and additional training is required to more fully understand

trauma, its relevance, and integration into practice, even at a foundational level.

Integrating trauma knowledge into practice, particularly when it was not a part of core professional training, requires an SLP practitioner to consider an individual's history and current experiences, particularly relating to trauma, that may contribute to who they see before them. For example, practitioners can use trauma-informed interviewing/questioning techniques, create a safe and supportive environment, and collaborate with mental health professionals to provide holistic care. The SLP practitioner will also have to recognize that the perspectives and interactions of the people they work with can be shaped by their history and experiences with traumatic stress. In pediatric practice, particularly in early intervention services where SLP practitioners work closely with a child's caregivers, appreciating the role of trauma in the child's presentation can foster stronger, more genuine, and respectful relationships with caregivers. Additionally, being aware that caregiver(s) may also have their own trauma histories enable SLP practitioners to build compassionate, safe, and productive relationships with them.

Principles of TIC Universally Applied

The SAMHSA's (2014a) six trauma-informed principles include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, choice, and voice; and cultural, historical, and gender issues. The universal integration of TIC principles across all levels of practice recognizes and responds to the pervasiveness of trauma and reduces the possibility of retraumatization and/or harm for all those involved in systems and services (SAMSHA, 2014a).

At its core, TIC is a strengths-based approach through its focus on empowered holistic healing, which builds on resilience and protective factors rather than emphasizing deficits (Fernández et al., 2023; Poandl & Gutierrez, 2024; SAMSHA, 2014a; Speck et al., 2023). Every practitioner, leader, and system will align uniquely with the six principles depending on their own background, professional training, orientation to practice, continued learning, and so forth. However, given the field's movement toward universal adoption of strengths-based services, practitioners often align well with many TIC principles and simultaneously find opportunities for further alignment.

The six principles outlined by SAMHSA can serve as practical and actionable tools for adapting practices. Practitioners and decision-makers can evaluate how their practice, programs, or systems align with these principles to identify strengths and opportunities for improvement in

TIC. For example, by reflecting on transparency, practitioners can evaluate how openly they communicate with their clients and where they could be more transparent. Team leaders can implement similar reflections within their programs, while system leaders consider this for both clients and staff. It is important to remember that TIC applies to everyone within systems, and supporting the caregivers—both personal and professional carers—is essential. Reflection and adaptations can continuously be made to further align with TIC principles.

Contextualized Care (Risk, Protection, and the Social Determinants of Health)

Providing contextualized care involves tailoring best practices to meet the needs of each unique client considering the broader context of their lives, appreciating the complexity and diversity of every individual (Pillay & Pillay, 2021; Weiner, 2022; World Health Organization [WHO], 2013). When a practitioner fails to understand and consider a client's personal and environmental context, they may miss opportunities to help clients achieve their desired outcomes, and support may even lead to undesired outcomes or harm (Weiner, 2022). This approach is in line with the WHO's International Classification of Functioning, Disability and Health, which promotes a holistic approach to practice by understanding health and disability as the interaction between health conditions and personal and environmental contextual factors (WHO, 2013).

From the fields of child development and neurodevelopment, we know that a child's experience of events, rather than the events themselves, matters most (Shonkoff & Phillips, 2000). Within these experiences lie the contextual protective and risk factors in a child's and family's life. For example, does the family have the financial resources to access support services right away? Do they have flexible, reliable employment to attend appointments? Does this family come from a community that has experienced historical, intergenerational trauma and continues to experience systemic trauma today? What are the family's cultural norms about accessing support and/or asking for help? What are the strengths of that community that support the resilience of the child and family?

Considering these factors helps SLP practitioners better provide education and information to families, connect them to necessary resources and services, make services responsive to family needs, and understand their priorities. This approach fosters nonjudgmental and individualized care, enhancing the practitioner's ability to support families effectively and build positive therapeutic (clinician–client) relationships in which families feel seen, accepted, and understood. As Peltier (2011) described, SLP practice with Canadian Indigenous people and

communities requires each family's and community's unique history to be considered in services. Furthermore, it must be acknowledged that many indigenous caregivers experienced trauma and devastating ruptures in their own caregiving relationships that impact their caregiving, as well as their feelings toward receiving feedback on how they interact with their child/children (Peltier, 2011).

One useful framework in SLP practice for providing contextualized care involves considering the social determinants of health (SDOH) during assessment and care planning (American Speech-Language-Hearing Association [ASHA], n.d.). SDOH refer to the nonmedical factors that influence an individual or population and can affect health outcomes (WHO, 2024). Trauma research shows that SDOH, such as education, employment status, income, food and housing security, social inclusion, and discrimination, can serve as both risk and protective factors regarding trauma exposure and its effects (WHO, 2024). While considering SDOH is beneficial across all areas of SLP practice, particularly in the context of trauma, the SAMHSA (SAMHSA, 2014b) underscores the importance of contextualized care. Various factors, including culture, life history, coping skills, and societal influences (i.e., SDOH), shape how individuals experience and respond to trauma. This facet of contextualized care enables practitioners to recognize signs and conditions that could increase a person's risk of trauma or exacerbate its impact.

The goal is always to address trauma as early as possible, minimize further exposure to trauma, mitigate risk factors (e.g., housing and food insecurity, parental mental health issues), and increase protective factors (e.g., connections to culture and community, access to needed health and social services). Incorporating SDOH into clinical practice allows clinicians to facilitate prevention and early identification, make appropriate referrals for additional services, and make more informed intervention recommendations while validating the client's lived experiences. Additionally, it empowers clients to make feasible decisions regarding their situations. This approach also situates the role of the SLP practitioner within the broader context of the client's life, highlighting how the SLP practitioner's support can significantly impact not just SLP-related goals but also the client's overall well-being.

Considering the SDOH is also crucial for program and system-level practices aimed at reducing health inequalities, which refer to the avoidable differences in health status among different groups of people. By incorporating the SDOH of the populations being supported, services can be designed to ensure equitable access to care and outcomes. Understanding these factors is essential as they significantly influence a client's ability to achieve desired outcomes.

Reflection-Required Practice

Reflection is vital in a trauma lens to SLP practice because it helps practitioners understand their own experiences, histories, social contexts, and emotional and physiological reactions in relation to their clients' presentations and experiences. What practitioners think, how they act, and the care they provide are all integral to their practice. Self-awareness is essential, as practitioners are a part of the therapeutic relationship and can significantly influence the healing process (La Torre, 2005). Reflective practice is unique to each practitioner and occurs in relation to every individual they work with, taking into account the unique context and factors affecting each client.

Reflection has long been considered a core component of SLP practice, particularly regarding reflecting on one's clinical skills and practices and a client's clinical complexity (Coty et al., 2016). The reflection-required practice in TIC, however, differs from traditional SLP reflection in terms of the depth and personal and introspective nature of the reflective practice in TIC. Additionally, it requires the practitioner to see themselves, and all they bring with them, as part of the therapeutic process, relationships, and encounters (Kimberg & Wheeler, 2019).

Reflection is a continuous part of practice, requiring openness to acknowledge mistakes, recognize that one's intent does not always match their impact, understand the need for repair when necessary, and recognize inherent power imbalances in the therapeutic relationship (Hansen et al., 2023; Kimberg & Wheeler, 2019). By acknowledging their role and influence in clinical encounters, practitioners can engage in genuinely interactive processes in which both the client and practitioner bring themselves as human beings, influencing the encounter reciprocally. This reflective practice is supported by continuous and interactive training, helping health care personnel identify and reflect on their comfort levels before working with traumatized populations (Speck et al., 2023).

From the field of mental health, we know that bringing the self into therapeutic practice is not a neutral experience; practitioners must work to manage their biases, preconceived notions, and emotional reactivity to be fully present with the client (Scheiner & Sleater, 2020). This self-management is crucial for creating a therapeutic environment in which clients feel understood, safe, and supported. Recognizing and addressing these personal factors allows practitioners to provide more effective and empathetic care, ultimately enhancing the therapeutic relationship and client outcomes.

While institutions and organizations have essential work to do to respond to the inequity in access and outcomes for racial and ethnically diverse individuals,

families, and communities, so do individual practitioners, which in large part translates to the reflection-based practice of culturally responsive care (also known as cultural humility in care; Terrance, 2021). The ongoing and active process of cultural humility, specifically among clinical practitioners, requires critical self-reflection regarding one's race, power, and privilege in relation to interactions with clients, colleagues, communities, and themselves (Hilliard, 2011). This is done to understand the differences and dynamics within relationships across these areas of practice (Hilliard, 2011). Continued engagement in and commitment to cultural humility enables clinicians to develop a practice that does not unintentionally perpetuate oppression and allows for more robust, safer, and more genuine therapeutic and professional relationships (Terrance, 2021). The field of SLP must reflect on its history and underlying ideologies that shape its typical practices. It is important to understand how these practices developed, how they interact with the goals of the services provided and with individuals' experiences of those services, the barriers that exist, and those that may have been unintentionally created (Brea-Spahn & Bauler, 2023).

Tier 2: Trauma-Responsive Care in SLP Practice

The second tier of trauma-informed SLP practice includes the integration of trauma-responsive care (implementing evidence-based and evidence-informed strategies from trauma intervention and research-based practice adaptations specific to SLP), "being with" our clients, and trauma-responsive leadership.

Implementing Trauma-Responsive Strategies and Best Practices

Key trauma-responsive strategies include creating a safe environment, using trauma-informed communication techniques, and providing individualized care based on a client's trauma history. Although SLP practitioners do not directly treat trauma, they can incorporate strategies explicitly developed to address the sequelae of trauma to better support their clients, tailor services more effectively, facilitate healing, set clients on a positive trajectory, and assist them in achieving their optimal outcomes. The impact of this approach will be evident in stronger relationships with clients, increased engagement in services and interventions, deeper and more open conversations, enhanced collaboration with other professionals, better clinician listening skills, and more honest and transparent interactions.

We can learn from intervention models, such as dyadic developmental psychotherapy (DDP), which was

developed originally by Dr. Daniel Hughes in the 1980s to support children with developmental trauma who had been in adoptive or foster care (Hughes, 2017). It focuses on reestablishing relational safety for children who have experienced chronic mistrust due to past abuse. Other approaches include body-based trauma treatments such as Sensory Motor Arousal Regulation Treatment, which address the significant somatic, behavioral, and emotional dysregulation resulting from trauma (Warner et al., 2020). These models provide potentially helpful concepts and strategies that can inform the work of SLP practitioners with traumatized children and families.

Specifically, these models explain some behaviors that can be seen in the context of SLP services and provide strategies SLP practitioners can implement. For example, DDP employs PACE as an acronym for a strategy intended to create a felt sense of safety in relationships that SLP practitioners can use in their own interactions with clients. PACE stands for Playfulness, Acceptance, Curiosity, and Empathy, a recipe for helping people move out of defensive states created by trauma into more open and engaged states. The strategy can be applied in sessions to respond to children, clients, and caregivers who, because of repeated experiences of harm, do not recognize signs of safety in relationships and who are in states of chronic mistrust. Practitioners can also inform caregivers about these strategies and why they are helpful.

The profound regulating impact of vestibular, proprioceptive, and tactile inputs brings clients out of trauma-induced states, in which they may be hyper- or hypo-aroused, and back into more regulated states that help bring their executive function, language, and learning capacities back online (Kearney & Lanus, 2022). In SLP, integrating body-based regulating strategies is not new, but understanding the overall connection to trauma and how these tools improve nervous system responses in individual clients contributes to a more holistic and integrated view of the client, their caregivers, and how we might support them. From a trauma-informed SLP perspective, helping children and their caregivers move beyond defensive or dysregulated states will allow them to be more accepting, engaged, and open to learning.

Overall, implementing trauma-responsive strategies and best practices involves accommodations that are essential for providing effective and compassionate care. Recognizing and validating the impact of trauma on clients' communication development and capacity is crucial. This acknowledgment helps practitioners and clients themselves understand the profound ways in which trauma can affect one's ability to communicate and interact with others, which in turn impacts all areas of a child's development and has widespread implications in an individual's

life. Therapeutic goals and expectations should be realistic and attainable, considering the client's specific experiences and needs. For example, an SLP goal in early intervention will typically center around increasing reciprocal interactions between a child and their caregiver(s) (to facilitate language development), but expectations and the starting place for this goal would differ for a child with interpersonal trauma history versus those without. Understanding that certain behaviors or symptoms may be manifestations of trauma rather than solely communication disorders allows practitioners to interpret clients' actions and responses through a trauma-informed lens, leading to more accurate assessments and interventions. Finally, tailoring intervention plans to accommodate the specific needs and experiences of clients who have experienced trauma ensures that the care provided is relevant and effective, fostering a supportive environment that promotes healing and resilience.

While remaining within the scope of SLP practice, the integration of trauma-specific principles and best practice strategies supports achieving optimal outcomes in SLP interventions. When these principles are implemented responsibly, reflectively, and collaboratively (see the guiding principle: Interdisciplinary Collaborative Practice), they are generally not contentious or risky. However, it is important to note that adapting practice has the potential to do unintended harm and should be approached with careful consideration and consultation.

Evidence-Informed Practice Adaptations

It is particularly critical to research and collect evidence of TIC in SLP practice when practice adaptations could impose a risk of harm and when specific adaptations represent more significant shifts in practice requiring systemic support. Integrating principles of TIC such as transparency, choice, and voice can generally be assumed to lead to positive, trust-building practice adaptations (such as explaining the rationale for policies, clearly identifying processes and making that information easily accessible, providing choice for in-person vs. virtual service delivery, etc.). Increasing peer support is another fundamental principle of TIC known to aid in healing (Herman, 2022). However, when implementing SLP peer or group programs in contexts where trauma prevalence is either known to be high or anticipated—such as with children and families in foster care, temporary housing, newcomer or refugee families, or caregivers of children with complex developmental and/or medical needs—caution is essential. When planning these SLP peer or group programs, it is important to consider the needs of these families beyond just speech and language, given the potential impact of their experiences. Care must be taken

to ensure that these programs are conducted safely for both participants and providers. Considerations should include how to establish safety within the environment and relationships among group members, which disciplines and service providers will be involved, and what level of supervision will be required for those facilitating the groups.

Another example of a trauma-responsive practice adaptation is the inclusion of universal screening of trauma exposure in SLP initial assessment as a risk factor associated with speech, language, and communication differences and difficulty and as a contextual factor impacting service planning. As noted by Snow (2009), speech-language pathologists are in a unique position to identify children exposed to trauma very early. This practice adaptation represents significant potential benefits in early identification, referral to services, and access to care for children with trauma exposure and their families. There are also potential risks, and it would be necessary to carefully plan and research such a practice change to ensure it is a nonharmful and beneficial practice in which to engage. It would also require the necessary protections, such as ensuring access to necessary follow-up services for anyone identified with trauma exposure and that SLP practitioners have adequate training and competency in TIC. The method of screening employed would also require significant planning, including consideration of appropriate screening tools for an SLP context, and concerns around the misuse of Adverse Childhood Experience scores to clinical versus research applications (Anda et al., 2020; Austin et al., 2024; Finkelhor, 2018).

This is a practice adaptation we have designed and implemented at the Center and has resulted in earlier identification and access to essential trauma services for children from the PSL. Speech-language pathologists have reported a more holistic and comprehensive understanding of the child and their family. Based on direct feedback from caregivers and the impressions of speech-language pathologists regarding caregiver responses, caregivers were either appreciative or accepting of being asked about trauma during their initial assessment appointment.

Further examples of future research include joint intervention by speech-language pathologists and mental health providers for children and families with identified trauma exposure and further exploration of universal trauma screening in SLP services based on models of service and service populations. Research into specific adaptations to practice is an area to further develop in the field. Ideally, as more research is conducted, trauma-responsive changes to practice will become more concrete. Additionally, research into the unique experiences and

needs of specific populations who also have experienced trauma, such as autistic and neurodivergent individuals, nonspeaking individuals/those who do not communicate using spoken language, and those with an intellectual developmental disability, is also tremendously important, requiring further understanding and responsiveness from the SLP field and practitioners.

Trauma-Responsive Leadership

Working with trauma and hearing painful stories can be taxing for clinicians, leading to vicarious trauma, empathic fatigue, and moral injury (Akhtar et al., 2024). This is even more likely when SLP practitioners, who are often working in silos, do not have clear referral pathways to mental health services for their clients and processes for collaborative practice. Therefore, SLP practitioners must have sensitive and supportive supervision that helps them process the stories they encounter, preventing them from feeling overwhelmed. To our knowledge, reflective supervision, in which a clinician meets with a supervisor to process how clients' stories may affect them personally or resonate with their own experiences, is not standard practice in the SLP profession. This lack of standardization is understandable, given that the recognition of trauma as part of SLP practice has not yet become a norm.

Unlike mental health professionals, SLP practitioners are not traditionally oriented to the self in the therapeutic relationship, and the inclusion of that in supervision. Yet, as explained in reflection-required practice, SLP practitioners must understand their own history, triggers, and self-regulation when engaging in this work (Kimberg & Wheeler, 2019). They must establish a strong therapeutic relationship and create a safe environment in which clients can feel understood, find meaning, and express vulnerability (Podolan & Gelo, 2023). This cannot be done without understanding the self as part of that relationship, affecting the therapeutic relationship they build with clients, which in turn impacts client engagement and the outcomes of their services. The reflection required for this practice and the content of client interactions themselves require supportive professional relationships, self-care, and supervision that acknowledges the emotional load and complexity of the work. This includes leadership recognizing that this work often requires working in teams, as working in isolation with traumatized families can be overwhelming and lead to burnout (Smith et al., 2018).

Reflection, self-care, and teamwork are vital for clinicians, as is the ability to know they are making a difference and to have the tools and structure they need to make that difference. For example, leadership must understand that the clients in SLP services are at an increased likelihood of needing mental health services (Law &

Stringer, 2013). Leadership, therefore, has a responsibility to ensure the appropriate services are available through systems of care known to SLP practitioners (e.g., where and how to refer), enable collaboration between speech-language pathologists and mental health clinicians, and be advocates where these needs are not readily accessible.

Leadership should model the principles of TIC within the organization, benefiting staff and clients. Trauma-responsive leadership is essential in trauma-informed practice as it helps prevent the retraumatization of staff. It is crucial to support staff in processing their clients' stories and understanding their roles in witnessing and intervening. It is also crucial to provide ongoing consultation and training to ensure SLP practitioners feel prepared to engage in their necessary work. Effective leadership ensures that every aspect of a client's experience is addressed, from the initial contact with the agency to the final interaction with the service provider. Without trauma-responsive leadership, implementing these crucial changes across practice and systems of care becomes impossible.

“Being With” Our Clients

The field of SLP, originating from a medical model, traditionally focuses on identification or diagnosis and targeted treatment. Speech-language pathologists assess strengths and needs, set goals, and develop plans to meet those goals. This clinical stance is caring and compassionate but focused on solving problems, which is fundamentally different in trauma-responsive work.

Borrowing from mental health professions, trauma-responsive SLP practice also emphasizes the importance of “being with” clients in their experiences. This stance involves witnessing the client's pain resulting from trauma and other difficult circumstances in their lives without moving quickly to solutions, without falsely reassuring the client (e.g., “don't worry,” “all will be okay”), or becoming overwhelmed by the content. Instead, the stance of “being with” allows clinicians to acknowledge and validate the pain and hardship, demonstrate empathy, and give space for the client's emotions. This approach considers both the client and the practitioner, recognizing and valuing the subjective experience of each other in the clinical encounter as healing (Galbusera et al., 2022). Through acknowledging the client's pain, empathizing with their experience, and accepting their thoughts and feelings, the clinician helps to co-regulate the client's affect and distress.

This stance might look like saying, “I am so sorry you have had to go through this experience. That must have been so difficult,” and then making space by waiting and pausing. Such statements validate the client's experiences and emotions, fostering for clients a sense that they

can feel seen, heard, and supported, ultimately enhancing the therapeutic relationship and outcomes. While “not jumping to solutions” is a helpful counseling strategy sometimes discussed in SLP practice, the concept that the clinical encounter itself can be healing, whereby the clinician can “be with” a client’s pain, is foreign for many. It is, however, a concept and clinical capacity taught in mental health programs, specifically in trauma approaches, and is a skill further developed in practice. What we are finding through our work with practitioners in trauma-informed SLP practice is that this is a very valuable and important clinical capacity to validate and develop, yet it is not widely understood or acknowledged.

This impacts trauma-informed leadership in that when working with trauma, it is essential to provide support as it is well understood that hearing details of others’ traumatic experiences can result in vicarious trauma or secondary trauma in the practitioner. Those who have their own history of childhood trauma may be particularly empathic and attuned to others’ trauma as they resonate with their experiences (Greenberg et al., 2018). However, this can also lead to increased susceptibility to vicarious trauma (Michalopoulos & Aparicio, 2012), and SLP supervisors need to understand this potential vulnerability for their staff.

On the other hand, understanding the healing nature of the clinical encounter and the simple ways in which clients can feel understood and validated is a benefit, especially when an SLP practitioner is working in a resource-constrained environment. Knowing that the appointment itself contributes to a client’s healing, if conducted in a trauma-informed way, can mitigate feelings of powerlessness when working with and within systems that are not trauma-informed. This is an argument for making sure that trauma-informed practice is a key priority in the work and that the importance of making space and time for the guiding principles for trauma-informed practice is understood systemically.

Guiding Principles for Trauma-Informed SLP Practice

In addition to the two tiers of adapted SLP practice, TIC in SLP requires alignment with core guiding principles informed by trauma research and trauma clinical best practice.

Relationship-Based Practice

SLP practitioners have long recognized the importance of relationships and a relational approach to practice, particularly as caregivers, family members and other

important people, and communication partners are integral to SLP work. SLP practitioners are also intricately familiar with the importance of relationships because speech, language, and communication develop and occur within the context of relationships. More generally, relationships are central to all human development, primarily through secure attachment, and impairments in these relationships can have as profound an impact as significant trauma (Doyle & Cicchetti, 2017; Schore, 2002). For children, strong, supportive relationships with caregivers are the most protective factor against the adverse effects of traumatic stress (Shonkoff & Garner, 2012).

When it comes to trauma, the importance of relationship-based practice cannot be overstated. Trauma can significantly impact interpersonal relationships, as survivors may struggle to trust others (Herman, 2022). This dynamic can be recreated in therapeutic encounters, so it is essential for SLP practitioners to understand that their clients may struggle to trust the provider and recognize signs of safety because of previous experiences of harm from other humans. In these cases, multiple experiences of safety, reliability, and empathy over time—all demonstrating one’s trustworthiness—are required to start building relationships experienced as safe enough (Perry & Winfrey, 2021). Relationships are central to TIC, as they provide the foundation for trust and healing.

Recovery from trauma takes place within the context of relationships (Herman, 2022). This is particularly true for children. It is also true for adult trauma survivors who have supportive relationships with peers and important people in their lives. A trauma-informed lens deepens the understanding of relationships, emphasizing their role in intervention and healing, including the client–clinician relationship, which has been shown to be the most significant predictor of successful treatment outcomes (Norcross, 2002).

In mental health therapy, the therapeutic alliance includes establishing therapeutic relationships, agreeing on the tasks and goals of therapy, and addressing ruptures (Wampold, 2015). This has proven to be one of the most important factors in successful mental health therapy across various models and interventions, and no model of trauma intervention can be effectively applied without trust, alignment, and buy-in (Norcross, 2002). Therapeutic alliance is a concept described and explored within the specific context of SLP practice to deepen how SLP practitioners view their relationships with clients and the importance of relational competencies as core skills (Connery et al., 2022; Sylvestre & Gobeil, 2020). Clinicians must build trust and relationships with caregivers to achieve engagement and optimal outcomes. Clinicians’ qualities, such as genuineness, compassion, and kindness, contribute to this relationship and can create therapeutic

opportunities. Ignoring the importance of relationships can have detrimental implications.

In the public sector in particular, the importance of relationships can be overlooked and/or deemed impossible due to systemic constraints, such as limited time with families and fragmented service processes. Fortunately, relationships can be built quickly through the principles of TIC; when people feel seen, heard, and cared for, positive relationships can form rapidly. Furthermore, some models of care, such as the biomedical model, often fail to acknowledge the value of healthy relationships in mitigating trauma's impact (van der Kolk, 2015). However, increasingly, there is recognition that systems, such as the medical system, can be more effective if the whole person is considered, rather than just the “parts that are being presented for expert treatment” (Mauder & Hunter, 2021, p. 5), and that relationships that espouse qualities such as “compassion, respect, empathy, validation, collaboration and honesty” (Mauder & Hunter, 2021, p.154) are one of the key ways to support clients and to prevent retraumatization by systems.

Systems should strive to design services that prioritize relationships, recognizing their benefit to therapeutic outcomes and engagement. This requires a conscientious shift in system culture to value relationships and ensure that policies and practices, accountability mechanisms, training, and leadership examples align with the elevation of relationships as a key component of quality care. This essential element of practice also extends to practitioners, who require relationships (e.g., with colleagues through team-based care) for their own support and safety, and to improve client outcomes and deliver higher quality care (Herman, 2022).

An important example of the necessity of relationships comes from Peltier (2011, p. 133) who said, “Since first European contact, Aboriginal people have faced extreme challenges to their survival in Canada. . . . It is, therefore, difficult for Aboriginal people to trust individuals from mainstream society, and initially, they may not welcome the speech-language specialist into their community or home. It is crucial that relationship-building be the focus of initial contacts so that the clinician is valued as a caring and respectful individual.”

The Importance of Safety

For individuals who have experienced trauma, establishing a sense of safety is essential before effective therapeutic work can begin. Trauma distorts perceptions of safety, making it difficult to trust and engage in therapeutic processes. This is especially true for children, whose development can be severely impacted by trauma and

whose nervous systems frequently hijack their ability to stay emotionally, behaviorally, and cognitively regulated when sensing reminders of unsafe experiences (Ford, 2020). When safety is established, children can better learn, regulate their emotions, and remember, highlighting the neurobiological underpinnings of trauma. A felt sense of safety, therefore, allows interventions to be effective. Fostering such a felt sense of safety, however, often requires creating safe environments across multiple contexts over time to counteract the defensive wiring of the brain caused by traumatic stress.

Research emphasizes that feeling safe is crucial for positive therapeutic outcomes. The polyvagal theory suggests that neuroception, a neural process that evaluates risk and triggers adaptive physiological responses, mediates feelings of safety. When clients perceive safety through social engagement cues—such as facial expressions, body language, and vocal tones—defensiveness decreases, promoting effective therapy (Geller & Porges, 2014). In SLP, practitioners can foster safety by incorporating TIC principles, such as SAMHSA's six principles of TIC, and mental health strategies, such as DDP's PACE approach.

It is equally important to ensure caregivers feel safe, as their involvement is critical for successful interventions. When caregivers feel safe and valued, they are more likely to actively participate in the therapy process, reinforce speech and language techniques at home, and more effectively communicate and collaborate with the SLP practitioner—all leading to better outcomes for clients. Furthermore, if clients (children and/or other dependent persons) experience their caregivers being engaged, calm, and confident with the SLP practitioner, they are more likely to feel engaged and secure in the intervention.

Creating a sense of safety for caregivers of children, for example, involves recognizing their feelings of vulnerability and responsibility regarding their child's communication difficulties. It is essential to be aware of the caregiver's cultural background and values, as well as to consider factors such as historical and racial trauma, past experiences with traumatizing systems, and fundamental needs such as shelter and food. Every step of a client's journey through the system—from registration and intake to clinical services and advocacy—must be trauma-informed to ensure they feel safe at every point of contact. Additionally, when a person or family is in crisis, addressing their immediate need for safety must be the top priority. This underscores the importance of integrating collaborative practices so that all aspects of care work together to support the client's sense of safety.

As well as being crucial for clients, safety is necessary for staff. SLP practitioners and other health and

social professionals are at risk of vicarious trauma and burnout. Ensuring that staff feel safe and supported in their work environment is essential for their well-being and effectiveness. This includes honest and compassionate communication, consistency in interactions, and a supportive organizational culture. Creating a safe environment involves anticipating and managing potential triggers for trauma survivors, such as lighting, access to exits, seating arrangements, and emotional stimuli. Consistency in client interactions and treatment processes, following through on agreements, and being dependable are key elements in establishing safety. When providers and leaders handle situations with honesty and compassion, it fosters a sense of safety and collaboration (SAMSHA, 2014b).

Interdisciplinary Collaborative Practice

ASHA (2024) states that interprofessional collaborative practice (ICP) is a contemporary approach to collaboration whereby multiple professionals from various disciplines come together to learn from and with each other to improve outcomes for individual clients and populations. ASHA (2024) further explains that ICP is founded on a thorough understanding of other disciplines, their value, and contributions to support and reinforce the involvement of one another. Through considerable research, ICP has been shown to lead to improved outcomes and patient satisfaction with services (Cadet et al., 2024). The WHO (2010) Framework for Action on Interprofessional Education and Collaborative Practice outlines how ICP can support health care systems that are fragmented, support professionals with overburdened caseloads, allow professionals to support one another, and provide better care with improved outcomes.

ICP is often seen as a core component of TIC and as a necessity to practice with increasingly complex clients and increasingly complex systems of care (Black et al., 2023; Felter et al., 2022). Also specific to trauma-informed practice in SLP is the requirement to include mental health professionals to support the mental health needs of clients when trauma or potential trauma is identified and to remain within the SLP scope of practice. Interdisciplinary collaborative practice entails not only referring to mental health professionals but also working together in understanding, planning, coordinating, and delivering client care. Another reason for the importance of ICP between SLP and mental health professionals is the relationship between communication and mental health. Each field needs the other to improve their understanding of their clients and contribute to the effectiveness of their client care.

Communication skills are relied upon in mental health treatment and are relied upon for the establishment and maintenance of relationships. SLP practitioners can

provide insight into a client's communication abilities (e.g., a child needing concrete language to understand, using visuals to support comprehension, providing guidance on an augmentative communication system an individual uses), to support the mental health provider in successful communication and relationship building with their client. Mental health professionals can consult to the SLP practitioner shedding light on the relationships in a client's life. In pediatric practice, understanding the child-caregiver relationship and how that manifests in their behavior and emotions will allow the SLP practitioner to better understand how to establish a felt sense of safety. The mental health professional can also support the SLP to understand relationship dynamics or psychological presentation. For example, a mental health professional might help make sense of a sexually abused youth's difficulties interacting with male adults in school (e.g., a new male teaching assistant in the classroom), or their fearful response to touch.

Referral, information sharing, and collaboration are not limited to mental health professionals. Within trauma-informed SLP services, many other professionals may be involved with clients and be beneficial to collaborate with, including early interventionists, occupational therapists, and pediatricians/developmental pediatricians, to name a few. In addition, integrating interdisciplinary collaboration in education is also vital. It supports a workforce that values collaboration and input from other disciplines, understands that collaborative professional skills are core skills to develop, and appreciates perspectives outside of one's own (Cadet et al., 2024).

Engaging in ICP brings inevitable challenges, with leadership playing a crucial role in its facilitation. Practitioners need practice settings that prioritize and reinforce the importance and goals of ICP. This includes allowing time for collaboration, building interdisciplinary teams, or, where that is not possible, creating bridges between professions, programs, and sectors to ensure clients accessing disparate services receive more coordinated, collaborative, and comprehensive care. Financial limitations and budget constraints are significant challenges. Cost-benefit considerations are critical, and in resource-constrained settings, ICP often gets pushed aside. However, we implore leaders to look beyond surface-level cost savings to recognize the tremendous cost-effective potential of ICP and relationship-based care. These approaches can unlock increased engagement in services and improved outcomes.

Acknowledging and Addressing Systemic Implications

The last guiding principle requires practitioners and leaders to acknowledge and address the impact of systemic

biases and barriers, and the role systems can play in harm, despite the best of intentions to provide care and support people. Health and social care systems and services are known to unintentionally traumatize or retraumatize people, particularly people and communities with historical and intergenerational trauma and experiences of current systemic trauma, such as Black, Indigenous, and LGBTQ+ people and communities (Grossman et al., 2021; SAMHSA, 2014b). This emphasizes the importance of applying TIC principles universally, enabling service providers and professionals across all levels and points of contact within systems to interact with people in a way that addresses the pervasiveness of “hidden” trauma, such as those undisclosed or based in historical and structural/systemic trauma (Grossman et al., 2021; SAMHSA, 2014b).

Understanding systemic implications also allows for individualized care and support in response to the specific needs of individuals and communities, given the known systemic biases and barriers that exist. For example, Black children are three times less likely to receive an autism diagnosis than White children in their first visit to a specialist, often require three or more visits to receive a diagnosis, and, on average, receive their diagnosis 3 years after parents express concern (Habayeb et al., 2022). In education, Black children receive harsher discipline, are put in classes below their abilities, and their cultures are pathologized (Lopez & Jean-Marie, 2021). By paying attention to such biases, we can do better for and with the clients we aim to support and be better advocates with them in other systems.

As practitioners understand the history and experiences of the communities they intend to support, they understand that trauma can present in many implicit ways, for example, hesitancy to participate in a health care appointment or nonadherence with a professional’s recommendations (Grossman et al., 2021). Such understanding can promote a system’s response that can acknowledge and allow for the behavior or responses to be met with trauma-informed practice, including flexible, responsive, and nonjudgmental policies; focus on the development of trusting relationships; and prioritization of a felt sense of safety.

It is imperative to understand that the systems we work in—those external to our work and those designed to directly address trauma—can cause harm. The criminal/legal systems, child protection and foster care, policing, shelters, and school systems can all cause unintended harm to children, families, and communities (Rich & Garza, 2022). Harmful experiences in systems prior to meeting an SLP practitioner can influence how a client enters services, predisposing clients to certain expectations based on previous experiences. For example, a family who experiences

microaggressions in their interactions with their primary care provider may expect the same from their SLP practitioner, entering services with an understandable lack of trust or even reluctant to engage in services at all. However, this also means SLP practitioners have an opportunity, particularly those in early intervention, to engage in safe, supportive, and healing interactions with families and provide positive experiences, which can then encourage clients that future instances in our and other systems can also be safe, supportive, and healing. SLP practitioners can also support clients to foster advocacy skills to use as they move through systems in the future, particularly should they experience systemic harm.

Understanding and acknowledging potential systemic harm requires practitioners to see themselves as part of the systems, which ties into what we previously discussed regarding critical self-reflection. This means examining and identifying what role we may inadvertently play in contributing to new harm or retraumatization of the people with whom we work, by virtue of not practicing in a trauma-informed manner or by not engaging in repair when inevitable unintentional ruptures occur. This may also include advocacy—for leadership to consider changing policies, processes, and practices that may cause harm; for leadership to understand the role of SLP practitioners in traumatized clients’ care when appropriate; and for ways to engage in interprofessional collaboration. One example of this in practice is the common necessity for clients to have to retell their trauma story frequently as they meet new practitioners and engage with new services, even within the same organization. This is a clear example where system processes could reduce this burden on clients. We have an ethical duty to support our clients as best we can to move through systems unscathed and help systems do what they are intended to do—which is to be helpful and to do good.

Challenges to Implementation

Implementing a Lens

Through our experience in training SLP practitioners and implementing a trauma lens in our Centre’s PSL Program, we have observed that integrating TIC in SLP services can be challenging. Unlike a new clinical intervention or tool, there is no clear protocol with steps and decision trees to follow. While there is a place for developing tools and practice protocols, integrating TIC into SLP can be understood as shifting the perspective with which one approaches work and decision making.

This approach requires introspection, curiosity, learning and unlearning, and being comfortable in the

“gray.” The development of an approach to practice differs for each practitioner based on their role, training, interaction style, social location, and life experiences. It can also vary significantly based on the practitioner’s work setting and constraints. For some, it will mean small shifts in how they approach their work. For others, it will require more profound reflection and changes to long-standing practices. Some programs may see small but significant opportunities to engage clients differently (e.g., allowing clients to include more than one supportive person with them in services increasing their sense of safety and validation that the practitioner understands the importance of this to them and/or their culture), while others may require larger changes and different decision-making frameworks (e.g., ensuring interpreter services are available to all clients, allowing clients a choice as to whether they receive virtual or in-person services).

The feeling of not doing enough and/or of moral injury can arise when transitioning to a practice that emphasizes spending time with clients and families to explore their feelings, rather than in a solution-focused approach (more traditional within SLP). Additionally, recognizing the various aspects of a client’s reality and care—such as mental health needs—without having the necessary referral and collaboration pathways for holistic care highlights the role of advocacy and the importance of strong, committed leadership. For those whose practice naturally aligns with TIC principles and who have dedicated time to many of the elements outlined in this article (e.g., ICP, relationship-based care), the feeling of not “doing enough” can arise. We want to emphasize that there is always something to reflect on, improve, and learn to move this work forward.

Breadth and Depth

The breadth and depth of what we have described here could feel overwhelming. Our hope is that this article is comprehensive. While we have included numerous elements under the two tiers and guiding principles, many practitioners may find it to be an evolution of concepts they have already begun to learn, integrate into practice, or specialize in. Reflection-based practice, for example, may be a particular area of personal and professional development for some; others may already see the primary goal of their encounters as building relationships, while another group may prioritize safety in clinical services and systems of care. TIC encourages SLP practitioners to reevaluate their roles and the potential impact they can have, as well as to make decisions differently within SLP systems of care. Importantly, it integrates and unifies many individual concepts already deeply valued by many in the field.

Emerging Practice

Implementing new practices can be challenging. It requires practitioners to stay updated on advances, be open to new learning, change directions, and reflect on past practices they would not repeat, along with processing the associated feelings. There are many areas where future research is needed, including specific practice modifications/adaptations, collaborative and joint care, peer support programs, clinical best practices, and advancing the specifics of trauma-informed SLP practices. We are encouraged by the adaptations we have made in the Centre’s PSL Program, which include foundational trauma training for all SLP practitioners, direct pathways between SLP and mental health services, processes that support interdisciplinary collaborative practice, and acknowledgment from leadership at the Center of trauma as an integral part of SLP practice. Feedback from clinicians has indicated that they believe services are now perceived as more supportive and holistic, fostering increased trust and safety with the practitioner and the system. Additionally, they feel better equipped to understand family priorities and needs, ultimately leading to better outcomes. We hope this discussion provides a starting point for conceptualizing this area of the field so that we can continue to learn and improve through collaboration.

Conclusions

Integrating TIC into SLP practice is not just an enhancement; it is a necessity for providing comprehensive and effective services. This approach acknowledges the profound impact of trauma on communication development and capacity, and it emphasizes the importance of addressing these effects through a holistic, relationship-based, and interdisciplinary framework. By adopting TIC principles, SLP practitioners have an opportunity to significantly improve service delivery, client engagement, and therapeutic outcomes.

Our conceptualization of trauma-informed SLP practice is continually evolving as we expand our understanding of trauma and integrate insights from various fields. Such ongoing adaptation is crucial for ensuring that SLP practitioners can effectively address the complex needs of their clients. We argue that TIC represents a holistic therapeutic approach that considers the whole person, their experiences, and the impact of trauma. By doing so, SLP sessions become moments for healing and opportunities to guide families toward a more positive trajectory.

Ultimately, this comprehensive, trauma-informed approach enhances the therapeutic experience, fostering

deeper connections and more meaningful outcomes for clients and their families. By embracing these principles, we can create a more responsive and supportive environment that truly meets the needs of those we serve. This clinical focus article highlights the critical need for systemic change and advocates for the universal application of TIC principles across all levels of SLP practice. The collaborative efforts of SLP practitioners, mental health professionals, and other stakeholders are essential in creating a supportive environment that fosters healing and resilience. As we continue to expand our understanding of trauma and its implications, it is vital that we remain committed to integrating these insights into our practice. This ensures that practitioners are appropriately supported in their essential work and that every client receives the compassionate, informed, and effective care they deserve.

Data Availability Statement

No data sets were generated or analyzed to produce this article.

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Appendix

Resource List*

SLP-Specific Books:

- *Communicating Trauma: Clinical Presentations and Interventions With Traumatized Children* by Na'ama Yehuda (2016)
- *Working With Child and Adolescent Mental Health: The Central Role of Language and Communication* by Susan McCool (2023)
- *Language Research in Post-Traumatic Stress* by Yvette Hyter (2024)

SLP-Specific Courses/Training:

- The Course Beetle: <https://coursebeetle.co.uk/field/speech-language-and-communication/>
- Language & Literacy Practices: <https://www.languageliteracypractices.com/>
- The George Hull Centre Institute of Childhood Trauma and Attachment: <https://georgehullcentre.ca/institute/training/>

Additional SLP-Specific Resources:

- American Speech-Language-Hearing Association: <https://www.asha.org/practice/trauma-informed-care/>
- Royal College of Speech-Language Therapists: <https://www.rcslt.org/speech-and-language-therapy/speech-and-language-therapy-factsheets/>
- The Informed SLP: <https://www.theinformedslp.com/review/what-does-it-mean-to-be-trauma-informed>

Non-SLP-Specific Trauma-Related Learning Resources:

- Harvard Centre on the Developing Child: <https://developingchild.harvard.edu/>
- Alberta Family Wellness Initiative: <https://www.albertafamilywellness.org/resources/>
- National Child Trauma Stress Network: <https://www.nctsn.org/>
- Substance Abuse and Mental Health Services Administration: <https://www.samhsa.gov/resource/dbhis/trauma-informed-care-webpage>
- *What Happened to You?* by Bruce Perry and Oprah Winfrey (2021)
- *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma* by Bessel van der Kolk (2015)
- *Damaged: Childhood Trauma, Adult Illness, and the Need for a Health Care Revolution* by Robert Maunder and Jonathan Hunter (2021)

*Note. This is not an exhaustive list, and additional helpful resources are available including many academic articles and publications, websites, podcasts, and social media accounts.
