"When, why, and at what cost?" Towards a trauma-informed pedagogy for learning about family violence in nurse education.

BOND, Carmel <http://orcid.org/0000-0002-9945-8577>, WATSON, Adrianna L and JACKSON AO, Debra

"When, why, and at what cost?" A Trauma-Informed Pedagogy for Learning About Family Violence in Nurse Education

Highlights

- Family violence is a global priority in nursing education
- Asks *"when, why, and at what cost"* family violence is taught
- Identifies re-traumatisation risks for students and educators
- Proposes trauma-informed pedagogy for safe learning

Abstract

Learning how to recognise and respond to disclosures of family violence is a core component of nurse education, yet this learning often occurs in classrooms and clinical environments where some students and educators may themselves be survivors. Across nursing programs, pedagogical approaches often emphasise recognising and responding to patients affected by family violence yet give limited attention to the vulnerabilities of students and academic faculty or the potential for re-traumatisation when the topic arises in educational settings. Using a trauma-informed lens, we examine the ethical dimensions of disclosure within classroom and clinical learning environments, focusing on how power, professional expectations, and institutional cultures shape what can be safely disclosed. We argue that unsolicited invitations to "share our stories", as well as blanket appeals to "professional boundaries", both risk harming those already living with family violence and obscuring the educator's duty of care. We propose principles for safer pedagogical practice, including explicit attention to role boundaries, advanced framing of sensitive content, meaningful opt-out options, and clear pathways for support when disclosures occur. While grounded in nursing, the issues explored are relevant across health professional education internationally, where family violence is taught within trauma-exposed student and academic faculty populations.

Keywords: family violence; domestic violence; intimate partner violence; trauma-informed pedagogy; teaching; ethics; nursing education; resilience

Introduction

Family violence, encompassing physical, sexual, emotional, and psychological abuse, including coercive control within family and intimate relationships, is recognised globally as a pervasive health and social issue (World Health Organization, 2024). It is highly prevalent and often hidden; many nursing students and educators are likely to bring lived experience of family violence into the classroom, whether disclosed or not (Jones et al., 2025). This creates a complex pedagogical tension: students must develop the skills to support patients who disclose family violence, while simultaneously navigating their own trauma histories. In some circumstances, these vulnerabilities may affect wellbeing and focus during practice, where patient needs remain a priority. Within this context, nurse educators face a dual obligation: to prepare students for the realities of practice and to uphold standards of safety, professionalism, and fitness to practise within trauma-exposed classrooms and learning environments. Regardless of increasing calls for trauma-informed pedagogy in nursing education, curricula addressing family violence remain predominantly patient-centred (Evans-Agnew et al., 2025).

International frameworks recognise nurses as primary responders to disclosures, advocates for victims, and central figures in safeguarding patients and families (ICN, 2021). Yet these frameworks provide little guidance for teaching topics like family violence within trauma exposed classrooms (Jones et al., 2025). This disconnect between clinical imperatives and pedagogical practice constitutes a pressing ethical challenge that demands systematic attention. In this paper, we argue for a trauma-informed ethics of teaching family violence within nurse education; an approach that recognises the prevalence of lived experience, honours the emotional realities present in the classroom, and establishes clear boundaries to protect learners, educators, and learning spaces. Our central question is not whether educators should engage directly with the topic of family violence, but "when, why, and at what cost?" By examining the ethics of disclosure, we seek to offer an approach to creating safer, more inclusive, and ethically robust pedagogical practices in the teaching of this complex and highly sensitive content.

Prevalence of trauma-exposed learning environments

Family violence is a major nursing and public health concern, with profound implications for both patient care and workforce wellbeing (Wilson & Jackson, 2025). The World Health Organization estimates that 30% of women worldwide have experienced physical and/or sexual intimate partner violence, with prevalence exceeding 40% in some regions (WHO, 2024). A

recent systematic review indicates that many nursing students enter higher education with lived experience of family violence, with lifetime prevalence rates of 23-50% among female nursing students and 6-34% among males, many report academic disruption that may compromise clinical learning and competence (Jones et al., 2025). These rates exceed those reported in the general population (Jones et al., 2025), positioning nurse education as a trauma-exposed learning environment. Within this context, students are expected to develop the communication and relational skills required to respond to patients experiencing family violence while potentially managing their own trauma histories or ongoing abuse. Dheensa et al (2022) report that healthcare professionals in Australia experience intimate partner and family violence at rates significantly higher than the general population, with nurses and female healthcare professionals consistently over-represented. Polyvictimisation, the experiencing of multiple forms of abuse such as physical, sexual, emotional, or economic violence, affects about half of survivors, and is associated with serious health consequences, including post-traumatic stress disorder; anxiety; depression that may directly compromise clinical performance and patient safety (McLindon et al., 2024). International evidence reflects similar patterns, for instance, in Arabian countries prevalence among clinical populations ranges from 30-60%, with nurses reporting both patient-related and personal victimisation (Hawcroft et al., 2019). Such abuse is often invisible and insidious as economic abuse can undermine financial autonomy and work performance (Usher et al., 2020). This creates conditions in which students, faculty, and the clinical workforce may encounter disclosures while managing their own lived experiences, which may impair focus or trigger trauma responses (Dheensa et al., 2022). The WHO (2020) frames this as ‘workforce violence vulnerability’, where occupational exposure compounds personal risk, threatening both individual wellbeing and patient safety. However, systematic preparation for teaching these realities within trauma-exposed cohorts remains limited, constituting a distinct pedagogical gap and raising significant ethical concerns that demand ethical responses (Pfeiffer & Grabbe, 2022).

Learning environment or site of ‘re-traumatisation’?

Family violence represents a clinical imperative for nursing practice and an occupational reality for those tasked with responding to disclosures. Recent research underscores the importance of nursing’s capability in responding to domestic and family violence, with nurse-led services being known to improve access to care through flexible, person-centred, and trauma sensitive practice (Currie et al., 2025; Pfeiffer & Grabbe, 2022). However, there is an established risk within the nursing profession for secondary traumatic stress (STS), otherwise referred to as ‘re-

traumatisation', defined as the stress response, that arises from indirect exposure to another person's trauma (Figley, 1995). Among student nurses, exposure to potentially 'traumatising' material is unavoidable, often occurring through narrative examples, case material, or personal disclosures encountered during training (Watson et al., 2025). As such, STS may arise through listening to or witnessing the impact of another person's trauma story within the learning environment.

To understand how STS may occur in the learning environment, Foli's (2021) Middle-Range Theory of Nurses' Psychological Trauma provides a conceptual scaffold that situates STS within broader occupational and systemic dynamics. Drawing on the structure established by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), the '3E' approach denotes (Event, Experience, Effects) that psychological trauma is understood as arising when exposure to emotionally charged stressors (Event) are interpreted and internalised through cognitive and affective processes (Experience), producing lasting cognitive, physiological, and behavioural characteristics (Effects). This formulation aligns with the cascade described above: empathic engagement and intrusive rumination mediate the movement from exposure to symptom activation. Crucially, Foli (2021) locates these processes within interlocking individual, professional, and organisational contexts, distinguishing between avoidable and unavoidable trauma and identifying cumulative exposure as contributing to allostatic load and adverse workforce outcomes. Within this framing, classroom engagement with family violence becomes not incidental discomfort, but a foreseeable occupational hazard requiring deliberate pedagogical structuring.

To operationalise this theoretical work, and when family violence is taught without adequate pedagogical safeguards or trauma-informed structuring, the classroom itself may become the site where exposure to trauma-related materials functions as the initiating event (Foli, 2021). Students are then required (and expected) to engage cognitively and emotionally with potentially traumatising content while simultaneously managing private histories of abuse or ongoing risk. Such scenarios increase the likelihood that educational exposure becomes a point of 'psychological activation' rather than skill development. Moreover, values-based and relational-focussed skills that are central to nursing, such as empathy and compassion may lead to STS; directly and indirectly through intrusive rumination on traumatising content (Watson et al., 2025).

In the context of teaching about family violence, this distinction is critical: pedagogical strategies that intensify empathic immersion without structured cognitive processing may inadvertently heighten STS risk. Moreover, trauma-informed education literature shows that exposure alone does not confer competence; containment, scaffolding, and institutional support determine whether trauma-related material educationally integrated or injurious (Thompson & Marsh, 2022). Such evidence also works to reframe the ethical question in family violence pedagogy. The issue is not whether students must learn to respond to disclosure, but how that learning occurs and at what cost.

Risks and ethical complexities of personal disclosures

The classroom is often the primary setting in which nursing students first engage with the health and safeguarding implications of family violence. This content is also delivered through simulation-based learning, where 'live' activities can cause 'psychological activation' (Foli, 2021) for students and faculty with lived experience. Despite the potentially impact of this content, curricula are often structured to focus on recognising family violence in patients but offer limited guidance on how to navigate these realities safely when they are also part of students' and educators' lived experience (Cleary & Jackson, 2025). Models such as "Dare to Ask" support the development of screening skills and are clinically effective in practice (Okenwa Emegwa et al., 2024). Yet, responding requires more than identification alone; it also involves navigating the ethical and emotional complexities that arise when violence is not only a patient issue but part of the learning environment itself. Family violence is not simply a 'difficult' topic: it is highly prevalent, frequently concealed, and profoundly triggering (Usher et al., 2020). Family violence content, whether clinical cases, research narratives, or media depictions, may activate trauma responses among students and faculty (Foli, 2021). Live personal disclosure, particularly from faculty positioned as authority figures, intensifies this risk by making violence suddenly proximal and uncontained, with the potential to re-trigger latent trauma among those engaged in learning (Jones et al., 2025). This raises an acute ethical tension: *How can educators cultivate clinically meaningful and realistic scenarios that encourage empathy for patient and family survivors while ensuring psychological safety for learners who may themselves carry histories of trauma?*

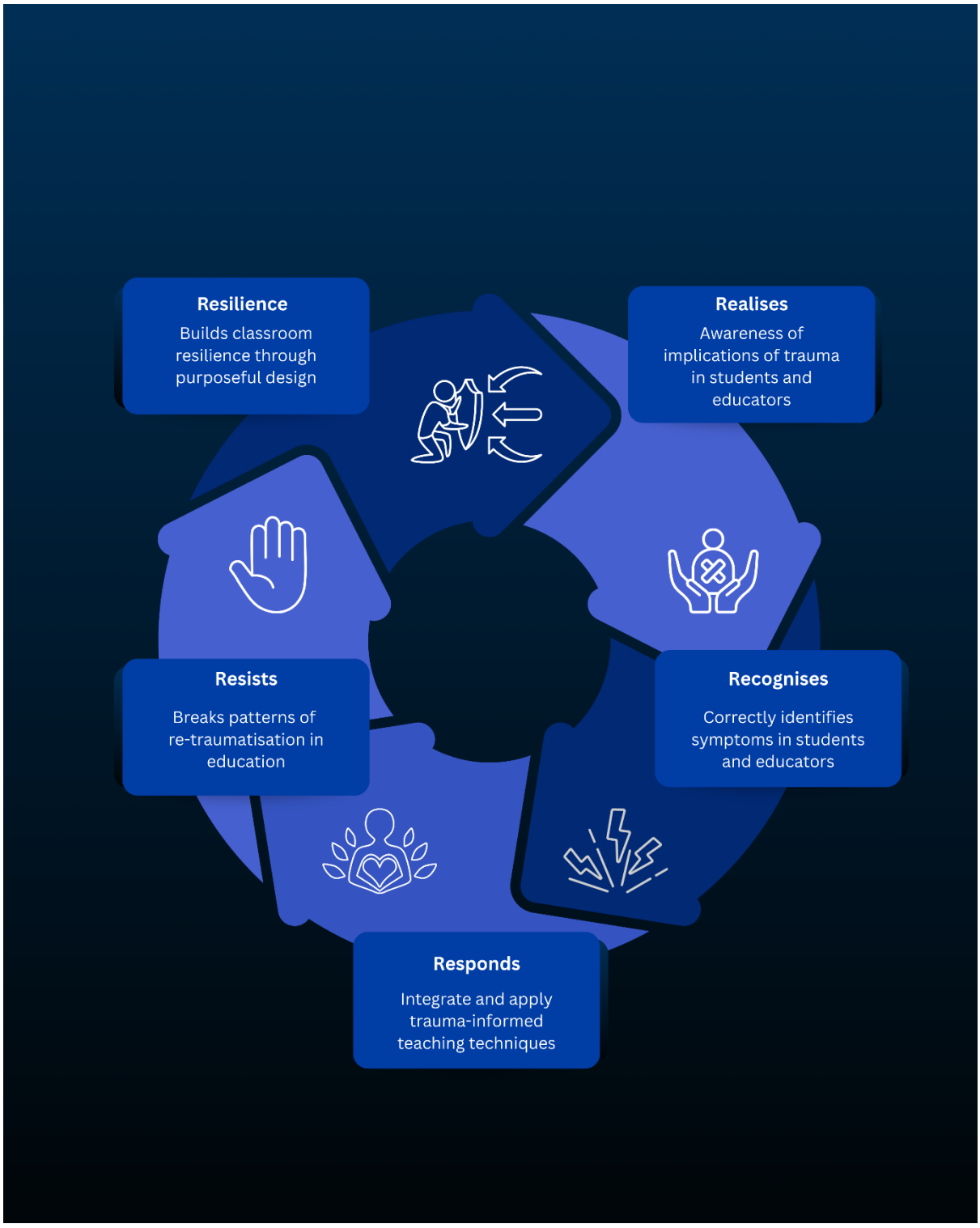
Faculty who receive student disclosures often carry a significant, and largely unrecognised, emotional and cognitive burden as they respond to trauma and support students, both within and beyond the classroom or simulation setting. The responsibility to respond appropriately (assessing immediate safety, managing group dynamics, making appropriate referrals) may

leave educators feeling overwhelmed, exposed, or psychologically unsafe. “Trauma dumping,” referred to as the unsolicited, uninvited, and unfiltered sharing of intensely personal or traumatic experiences, exacerbates this burden and may harm listeners (Cleary & Jackson, 2025, p.503). Trauma-dumping differs fundamentally from intentional, structured pedagogical disclosure by lacking contextual safeguards and reciprocity. In classrooms that valorise “authentic sharing,” educators may inadvertently engage in trauma-dumping when personal narratives blur into unprocessed disclosure, imposing a silent, compounding weight on students already navigating prior trauma or current exposure (Cleary & Jackson, 2025). Such dynamics may also destabilise the learning environment, shifting it from a structured educational space to one where students and educators are exposed to uncontained trauma narratives. Repeated exposure to unprocessed trauma, without therapeutic boundaries or structured debrief, risks longer term faculty fatigue, which may lead to compromised teaching capacity. Without clear protocols, access to specialist support, and mechanisms for referral, educators may become de facto therapists in contexts for which they lack training (McLindon et al., 2024). While universities typically provide wellbeing services designed to support students, educators may feel pressured to manage these conversations themselves, particularly when disclosures occur in teaching contexts where students occupy a dependent relationship with faculty. These interconnected risks highlight the need for a more deliberate and ethically grounded approach to teaching family violence. A trauma-informed pedagogical framework offers a structured way to balance educational goals with the psychological safety of learners and educators. Though, it is important that these considerations be understood within the context of institutional and professional responsibilities, including safeguarding, mandatory reporting, and fitness-to-practise obligations, which may shape how educators respond to disclosures in classroom, simulation, and clinical settings

Application of trauma-informed pedagogy

Drawing on trauma-informed care principles (SAMHSA, 2014), we propose a pedagogical framework that supports educators in working safely within trauma-exposed learning environments (Figure 1). These principles apply across classroom, simulation, and clinical learning contexts. Moreover, this framework is intended to be adaptable across diverse international contexts, for example, in resource-constrained settings where access to specialist support services may be limited, trauma-informed pedagogy may rely more heavily on clear boundaries, peer support, and structured teaching approaches that prioritise psychological safety within existing institutional capacities.

Figure 1. Framework for trauma-informed pedagogy



This offers a robust ethical approach to teaching family violence, shifting the focus from whether to share personal experiences to "*When, why, and at what cost?"*, thereby prioritising

learner safety over performative authenticity. Trauma informed practice demands explicit pre-emptive strategies rather than treating re traumatisation as an inevitable collateral of 'authentic' teaching (Pfeiffer & Grabbe, 2022). We suggest that safety must be pre-emptively established through explicit ground rules, content warnings (advance notice that sensitive or potentially distressing material will be discussed), and penalty-free opt-out warnings that protect academic standing; thereby rendering "engage or fail" dynamics obsolete. Importantly, opt-out options should not remove students from achieving core learning outcomes; rather, alternative learning activities be provided though simulation-based scenarios or guided reflection to ensure students still develop the competencies required to recognise and respond to family violence in practice. Safety could also include the use of physical space (i.e., groupings and seating arrangements), emotional space (e.g., pause protocols), and relational elements (e.g., no unsolicited personal questions). With this approach, safety creates the foundational trust essential for the realities of classroom and/or clinical placement learning environments without unnecessarily placing the nursing student or educator at risk for re-traumatisation. Choice and collaboration should replace implicit coercion. Learners may co-create session agreements specifying disclosure boundaries and support pathways, ensuring voluntary participation rather than authority-driven compulsory sharing. Such efforts move to counter the established educator-student power imbalance, where silence risks misinterpretation as disengagement from the material or skill set. Trust and empowerment emerge when educators model vulnerability within clear limits, demonstrating clinical response skills through structured scenarios rather than unprocessed narratives. Empowerment means equipping students with both patient-response competence and personal-regulation strategies.

This transforms potential ethical minefields into defensible professional practice. In circumstances where the perspectives of survivors are incorporated into teaching, careful safeguards are essential. Rather than relying on spontaneous or unstructured sharing within the classroom, educators may draw on the expertise of individuals who participate voluntarily as lived-experience educators within appropriately supported professional roles. Such contributions should be carefully planned, clearly framed within the learning objectives, and delivered within environments where the speaker retains control over the extent and nature of what is shared. Equally important is the availability of immediate and accessible support for students who experience distress during or after such sessions. These measures recognise that survivor perspectives can offer valuable insight while ensuring that educational practices

remain ethically grounded, trauma-informed, and responsive to the wellbeing of all participants.

Conclusion

Family violence poses profound challenges for both nursing practice and nursing education. Given its prevalence among patients, students, and the healthcare workforce, teaching this topic is unavoidable; however, it must be approached with deliberate ethical care. Preparing nurses to recognise and respond to disclosures of family violence is a core professional responsibility, yet this preparation must occur in learning environments where trauma exposure is a statistical reality. Ignoring this context risks reproducing harm within the very educational spaces intended to promote compassionate and competent caring professionals. Ultimately, the challenge is not whether students should learn about family violence, but how this learning can occur safely and responsibly within trauma-exposed educational environments. A trauma-informed pedagogy provides a defensible and ethically grounded pathway for preparing future nurses to respond to family violence while protecting the psychological safety and integrity of the learning environment. By foregrounding psychological safety, through structured learning approaches, and clear pathways for support, educators can ensure that family violence education enables clinical competence without compromising the wellbeing of learners or faculty.

References

Cleary, M., & Jackson, D. (2025). A silent weight: the cumulative toll of 'trauma dumping' or unexpected self-disclosure in social situations, *Contemporary Nurse*, (61)6, 503-506, https://doi.org/10.1080/10376178.2025.2588827

Currie, J., Nelson, C., Papas, L., Quinlan, T., Reddan, K. and Hollingdrake, O. (2025), A Mixed Methods Evaluation of a Nurse-Led Domestic and Family Violence Service. *Journal of Advanced Nursing*, 81: 8885-8896. https://doi.org/10.1111/jan.16836

Dheensa, S., McLindon, E., Spencer, C., Pereira, S., Shrestha, S., Emsley, E., & Gregory, A. (2022). Healthcare Professionals' Own Experiences of Domestic Violence and Abuse: A Meta-Analysis of Prevalence and Systematic Review of Risk Markers and Consequences. *Trauma, Violence & Abuse*, 24(3), 1282. https://doi.org/10.1177/15248380211061771

Evans-Agnew, R., LaValley, K., & Fromm, T. S. (2025). Trauma-informed pedagogy in nursing: A participatory action research exploration of individual and system approaches for increasing resilience. *Nurse Education Today*, 153, 106827. https://doi.org/10.1016/j.nedt.2025.106827

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). Brunner/Mazel.

Foli, K. J. (2021). A middle-range theory of nurses' psychological trauma. *Advances in Nursing Science*, 45(1), 86-98. https://doi.org/10.1097/ANS.0000000000000388

Hawcroft, C., Hughes, R., Shaheen, A., Usta, J., Elkadi, H., Dalton, T., ... & Feder, G. (2019). Prevalence and health outcomes of domestic violence amongst clinical populations in Arab countries: a systematic review and meta-analysis. *BMC public health,* 19(1), 315. https://doi.org/10.1186/s12889-019-6619-2

International Council of Nurses. (2021). *The ICN code of ethics for nurses* (Revised 2021). https://www.icn.ch/sites/default/files/2023-06/ICN_Code-of Ethics_EN_Web.pdf

Jones, C., Farrelly, N., & Barter, C. (2025). UK prevalence of university student and staff experiences of sexual violence and domestic violence and abuse: a systematic review from 2002 to 2022. *European Journal of Higher Education,* 15(2), 223-244. https://doi.org/10.1080/21568235.2024.2302568

McLindon, E.V.M., Spiteri-Staines, A., & Hegarty, K. (2024). Domestic, family and sexual violence polyvictimisation and health experiences of Australian nurses, midwives and carers: a cross-sectional study. *BMC Public Health*, 24(1), 2290. https://doi.org/10.1186/s12889-024-19680-7

Okenwa Emegwa, L., Paillard-Borg, S., Wallin Lundell, I., Stålberg, A., Åling, M., Ahlenius, G., & Eriksson, H. (2024). Dare to Ask! A Model for Teaching Nursing Students about Identifying and Responding to Violence against Women and Domestic Violence. *Nursing Reports*, 14(1), 603-615. https://doi.org/10.3390/nursrep14010046

Pfeiffer, K. M., & Grabbe, L. (2022). An approach to trauma-informed education in prelicensure nursing curricula. *Nursing Forum,* 57(4), 658-664. https://doi.org/10.1111/nuf.12726

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014*). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. SMA 14-4884).* U.S. Department of Health and Human Services. https://mivan.org/wp-content/uploads/2026/01/samhsa_trauma_concept_paper.pdf

Thompson, P., & Marsh, H. (2022). Centering equity: Trauma-informed principles and feminist practice. In *Trauma-informed pedagogies: A guide for responding to crisis and inequality in higher education* (pp. 15-33). Cham: Springer International Publishing.

Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. *International journal of mental health nursing,* 29(4), 549. https://doi.org/10.1111/inm.12735

Watson, A., Bond, C., Madeux, A., Tobe, H., Harper, D., Blank, S., & Detrick, R. (2025). When the wounded walk: Exploring the lived experience of secondary traumatic stress in the emerging nursing workforce. *Journal of Advanced Nursing.* https://doi.org/10.1111/jan.70086

Wilson, D., & Jackson, D. (2025). Nursing and family violence. In D. Jackson, A. Bonner, J. Bloomfield, & J. Daly (Eds.), *Contexts of nursing: An introduction* (7th ed.). Elsevier.

World Health Organization. (2024). *Violence against women prevalence estimates, 2023* https://www.who.int/news-room/fact-sheets/detail/violence-against-women