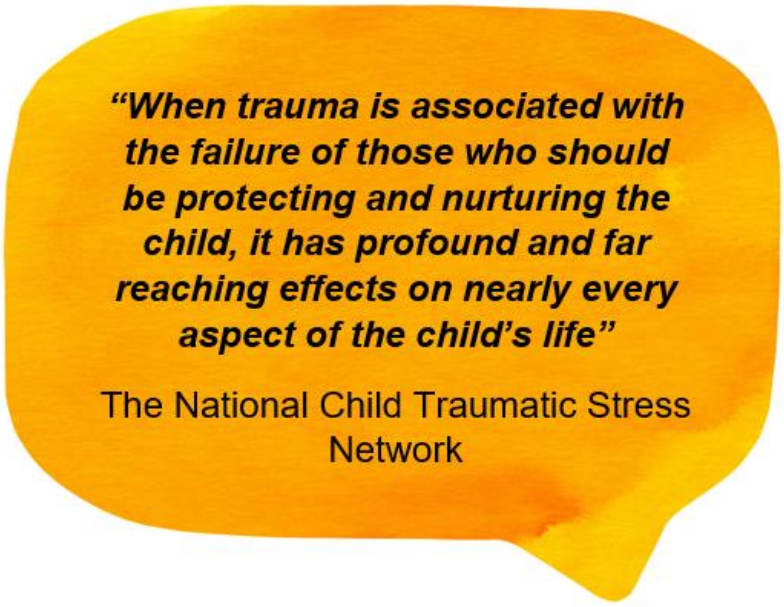
Trauma Informed Social Work Practice

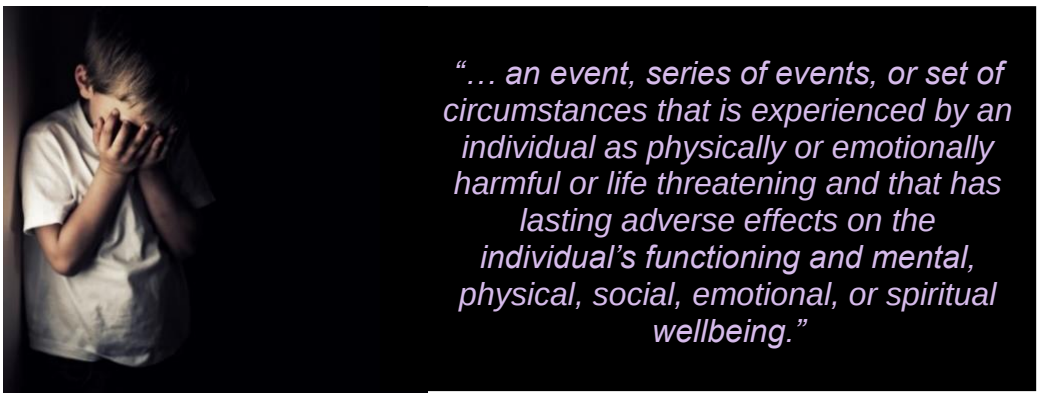


It is suggested that around 80% of human trauma occurs within a family setting, with the majority of children that have had local authority involvement being exposed to multiple and chronic traumatic events (Aarons, Brown, Hough, Garland & Wood, 2001; Ko et al., 2008). When working with children in a family justice context, trauma should become the expectation, as opposed to the exception, and social workers should consider the role that trauma plays in the child's lived experience (Harris and Fallot 2001).

This is an introductory knowledge bite to Trauma Informed Social Work Practice (TISWP) and is aimed at FCAs who want to begin to understand, identify and learn more about children and adults who may be exhibiting trauma-related behaviour. Whilst it is recognised that this document can not cover all aspects, it offers an overview of the salient points and proposes more reading and resources around TISWP.

Neuroscientific research is transforming our knowledge of how the brain understands and processes trauma and is offering pathways to recovery, treatment and services. Traditional service approaches are often experienced, by those who use them, as hierarchical, with care being imposed and treatments being prescribed. Services can feel, to the service user, that they are mirroring the power and control experienced in past abusive relationships.

Acknowledging we all have distinctive personal definitions of trauma, we can nevertheless define trauma as an experience of real or perceived threat to life, limb and one's sense of self. Trauma can arise from a single event or repeated adverse events that threaten to overwhelm a person's ability to deal with the experience. Usefully, Research in Practice (RiP) suggest that we look to the broad definition offered by the Substance Abuse and Mental Health Services Administration (SAMHSA 2014), a branch of the US Department of Health and Human Services:



A trauma-informed approach commits to and acts upon the core principles of safety, trustworthiness, choice, collaboration and empowerment (Fallot, R. D. & Harris, M. 2009). It values and respects all individuals, along with their choices, autonomy, culture and values, while building hope and optimism for a better future. The purpose of a trauma-informed approach is not to treat or diagnose individuals, but to better support and understand the manifestations of previous trauma.

Recent research conducted by the Early Intervention Foundation (2015) found that:

- It is the quality of inter-parental relationships rather than separation in itself that has the greatest impact on children.
- You can find a link to the full report **HERE**.

They also argued that:

- The quality of the inter-parental relationship, specifically how parents communicate and relate to each other, is increasingly recognised as a primary influence on effective parenting practices and children's long-term mental health and future life chances.
- Parents/couples who engage in frequent, intense, and poorly resolved inter-parental conflicts put children's mental health and long-term life chances at risk.
- Children of all ages can be affected by destructive inter-parental conflict, with effects evidenced across infancy, childhood, adolescence, and adulthood.
- The wider family environment is an important context that can protect or exacerbate child outcomes in response to exposure to inter-parental conflict. In particular, levels of negativity in parenting practices can exacerbate or moderate the impact of inter-parental conflict on children.
- Inter-parental conflict can adversely affect both the mother–child and father–child relationships, with evidence suggesting that the association between inter-parental conflict and negative parenting practices may be stronger for the father–child relationship compared to the mother–child relationship.
- The quality of parental relationships, level of parental stress, and quality of family functioning also have a significant impact on children's well-being, in both intact and separated families.

The brain

Much of the research, around trauma in children, talks about the impact trauma has on brain development. Dr Van Der Kolk (2014 p.52) in particular noted that children, through adversities, usually take their signals from their parents. "As long as their care givers remain calm and responsive to their needs, they often survive terrible incidents without serious psychological scares". However, Dr Van Der Kolk (2014 p.21) goes on to say that it is "very difficult for growing children to recover when the source of terror and pain… comes from their own caregivers". Dr Bruce Perry and Erin Hambrick (2014) offer further insight into the impact trauma has on the growing brain particularly in very early childhood. The full article can be found here:
http://childtrauma.org/wp-content/uploads/2013/08/NMT_Article_08.pdf

You may find this YouTube video helpful in understanding how the brain is affected when children have a trauma history:
https://www.youtube.com/watch?v=lPftosmseYE

In addition, research is exposing the relationship between childhood trauma and the emergence of health damaging behaviors, poor health and social outcomes in adulthood (Hughs, Lowey, Leckenby, Bellis and Harrison 2013). Interpersonal harm also known as Adverse Childhood Experiences (ACEs) can place pressure on the child's ability to cope, as well as resulting in common emotional reactions such as anger, shock, helplessness and the loss of emotional stability.

Click on the video below to watch a short film about ACEs:

The background to the ACEs can be found here: https://www.youtube.com/watch?v=95ovIJ3dsNk

We need to understand that there are points of challenge in the ACEs analysis such as those highlighted by:

Edwards et al (2017)	•Noted that the paradigm which the studies are derived 'converts complex social experiences into biological, chemical effects'.
Metzler et al (2017)	•Suggested that wider social factors that contribute to health and social problems such as poverty, homelessness or hunger are missing.
Edwards et al (2018)	•Suggested that the ACE analysis does not take account of individuals' power to interpret and respond to experience in a variety of ways. Instead, the future can look 'set in stone' by past experiences.
Sweeney et al (2016: 175)	•Highlights that traumas can include varying experiences such as rape, domestic violence, homicide, war, neglect, abandonment and family separation. •The identified factors do not include a number of experiences that would be considered highly traumatic – such as bereavement of a loved one. People's individual perspectives regarding traumatic experiences are highly significant and cannot be overlooked in practice.

Types of trauma

What we also know is that there are different types of trauma. This diagram outlines the types of trauma that you may come across:

Type 1 trauma	• Denotes to one single event - such as a car accident, a single occurrence of sexual assault, a terrorist incident or a physical assault • This type of trauma often leads to no long-term psychological difficulties but in around 25% to 30% of cases continues to meet the criteria for a diagnosis of post-traumatic stress disorder (PTSD) (NICE, 2005).
Type 2 trauma	• Involves numerous traumatic events over a period of time. • The more serious impacts arise from either the cumulative impact of multiple forms of interpersonal trauma or any one form of abuse that leads to an ongoing sense of powerlessness (Finkelhor and Browne, 1985).
Complex trauma	• Consists of repeated, often multiple forms of abuse - physical, sexual and/or emotional (Kisiel, Fehrenbach, Small and Lyons, 2009). It also can arise in the context of extreme neglect (Cook et al, 2017). • Complex trauma is interpersonal in nature.
Interpersonal trauma	• Harm that occurs in the context of relationships and impacts on a child's or young person's capacity to develop positive future relationships. • This can be associated with young people "getting in the way of help" such as inconsistent engagement with professionals or disengaging altogether.
Social and economic trauma	• The harms experienced by children are embedded in wider social, economic, cultural and political contexts. • This is well understood in social work (eg, Davidson, Bunting, Bywaters, Featherstone and McCartan, 2017) with a recent study finding that the rate of child protection plans are around ten times higher in more deprived communities than in affluent ones, with a consistent gradient in-between (Bywaters et al, 2016).
Vicarious or secondary trauma	• This is the impact on staff working with traumatised young people. Problems associated with indirect trauma can include; staff burnout, compassion fatigue and the practitioner's own trauma histories being triggered by working with young people in similar situations. • Indirect trauma may well be 'an inevitable consequence' of witnessing the pain and distress of children and young people over time (Knight, 2015) but it can be reduced and contained by support built into a reflective practice system.

Why do we need to recognise and respond to trauma?

Fallot and Harris (2009) developed key areas that outlined why it is important to recognise and respond to the impact of trauma.

- ✓ **Trauma is pervasive:** The experience of trauma is not rare, in fact it is part of our social reality.
- ✓ **The impact of trauma is broad:** Experiences of trauma can increase the risk of a vast range of vulnerabilities including mental health issues, PTSD, hostility, anxiety, substance abuse, depression, interpersonal issues, eating disorders and suicidality. Often trauma impacts in such a way that is not obviously connected with trauma, therefore it is important to recognise the broad potential impact to stress the less evident links between trauma and behaviour.
- ✓ **Trauma can be life-altering:** This is particularly the case in children where the trauma has been inflicted by an individual in the caretaker role. Survivors tend to blame themselves and see the world as unsafe, this is where the trauma experience shapes an individual's vision of the world.
- ✓ **Violent trauma can be self-perpetuating:** Sometimes, victims of violence can have an increased potential in becoming perpetrators. Prisons can often perpetuate trauma rather than eliminate it.
- ✓ **Trauma is insidious:** Individuals who are marginalised e.g. experiencing poverty, homelessness or have mental health/substance misuse issues are at a greater risk of victimisation.
- ✓ **Trauma effects relationships:** Individuals who have experienced trauma may struggle to effectively engage with supportive services, as they are suspicious and often lack safety and trust.

Richardson, Coryn, Henry, Black-Pond and Unrau (2012), and Carolyn Knight (2015) argue that through understanding trauma in childhood social workers are better able to:

- Understand and acknowledge the child's lived experiences
- Recognise the effect that trauma has on the child's emotional behaviour, academic achievement and social development
- How best to engage with children – research tells us that children who suffer forms of trauma effects their ability to form relationships
- Understand how children relate to others
- See children from a perspective of a survivor
- Help understand current problems that may come out of previous traumatic experiences
- Recognise that a practitioner trying to form a relationship with a young person may be seen as another untrustworthy authority figure to be feared, challenged and tested
- Acknowledge a young person's trauma and through responding with empathy can affirm and validate their own responses to the harm they experienced

- Expressing empathy does not require that a practitioner goes deep into exploring a young person's disclosure – this may well not be appropriate. However, an empathic response can make a significant difference to a young person's experience of even a brief, one-off interaction.

What we know is unhelpful when working with children	What we know is helpful when working with children
•**Survivors report the following as unhelpful:** •Practitioners avoiding addressing the trauma •Asking too much detail •Minimising the significance of the trauma	•Rather than 'what is wrong with you' ask 'what has happened to you?'. See and understand the child's behaviour as a mechanism to manage their trauma (Szczygiel, 2018). •Through creating a safe environment

This is what it may look like in practice – presented by Rip:

"A young person with dissociative symptoms (the experience of not being able to remain in a consistent state of consciousness) may have developed this 'switch-off' mechanism in response to being placed in a state of fear or pain to the extent that the only way to survive was for their mind to 'leave' their body. In this light, the young person and practitioners can understand the dissociation as an adaptive, necessary response. Practitioners' and carers' roles will be to support conditions in which this response is no longer needed (in that the young person is safe) so that they are able to begin the process of remaining grounded in the here and now."

This is what trauma might look like in public law practice

A fourteen-year-old female teenager has in the past suffered neglect from her mother and from her father emotional and physical abuse. She has complex and interpersonal symptoms of trauma which can be seen through her inability to develop positive relationships; she keeps running away from her foster carers and staying with adults and her 'boyfriend' of six years her senior. She is angry and suspicious of professionals. The teenager's current relationship with her 'boyfriend' is volatile and violent. She has expressed lack of self-worth, through self-harming, and often returns to her abusive 'boyfriend' after arguments. The teenager has learnt to be highly vigilant and alert. With professionals she can be distant in her approach and often blames herself for the arguments with her 'boyfriend' and the situation she is currently in.

The impact of trauma has resulted in her feeling judged and angry. She cannot see that she is at risk and vulnerable. In this case, the role of the practitioner is to recognise the impact the trauma is having on her ability to keep safe and to help her be safe both physically, mentally and emotionally, and to help the teenager see the 'boyfriend' as an abuser. It is to help her to develop the language to discover and talk about her traumatic experiences – "learning to experience and understand deep emotions is vital for recovery from trauma" (Van Der Kolk 2015). It may be useful to move away from asking her to tell you "how it feels" and to move towards language such as "Did you notice any specific feelings that came up when we talked about...?" This moves away from the judgement part of the brain. Through being returned to her foster carers she will notice that she is wanted and cared for and not further rejected. As a professional we need to encourage this young person to develop a sense of agency to become associated with themselves.

This is what trauma might look like in private law practice

A twelve year old boy lived with his mother, in the UK, until his parents separated when he was eight years old. The relationship between his father and mother was volatile and domestic abuse was a feature when they were together. Mother had postnatal depression. The boy heard and witnessed both parents engage in physical as well as verbal abuse. The boy was returned to his father's care 18 months after the parents separated. The mother went to live in Australia with her new partner. Both parents have dual citizenship and the boy also has Jamaican and British citizenship. Three years later the mother has applied for the son to return to her care and to live with her in Australia. The boy has suffered from social and economic trauma as his father is in low paid work, and has few family members that live in the UK to support the father. The boy is getting into trouble at school, described by teachers as having memory and concentration problems. He is known to the police for being at risk of joining a gang and is angry and aggressive towards professionals. He finds it hard to relax and sleep and is dissociated which is manifested through him verbalising feeling unloved by either parent and helpless. The father is planning to return to his country of origin, Jamaica, with his son.

Trauma shapes the brain, in that: parts of the memory of the traumatic event intrudes into the present where they can be relived. Therefore, the boy is likely to have developed his belligerence and aggression through his lived experiences of trauma. In addition, Lyons (2008) suggested that there is a relationship between maternal disengagement and mis-attachment during the first two years of life and dissociated systems. Knowing that we are seen and heard by important people can help us feel safe and calm whilst "being ignored or dismissed can precipitate rage reactions or metal collapse" (van Der Kolk 2015 pg. 78). Therefore, hearing and giving language to the boy may be a method of engaging with him. Encouraging his parents to listen to his wishes and feelings may give him agency. Anchoring the boy in the present, whilst talking about his trauma, may help him to see that past events are not anchored in the present; he can then start to rewire his understanding of the fight or flight response. Listening to the trauma narrative increases vigilance and stress hormones and, ordinarily, as soon as the threat is over cortisol puts an end to the stress response and the body returns to normal. In contrast, traumatised people can overreact to threat and disproportionately respond and the body does not return to normal, potentially causing them to become aggressive and hard to reach.

TISWP and domestic abuse

Interpersonal, premeditated, planned, and perpetrated in relationships of care is more damaging and constitutes complex trauma. Children exposed to violence in the home are especially vulnerable and can experience profound impacts on their physical, psychological and emotional health and wellbeing.

According to research, children who witness domestic abuse in the home, or who are themselves abused, will struggle as a result of the changes to their brain development and functioning which arise from this traumatic exposure. Research suggests that the younger the child, the more harmful the traumatic experiences. The abuse of power and control, experiences of betrayal, secrecy, silence, fear and shame are common elements in families where abuse is a feature.

According to Women's Aid, "Children can experience both short and long term cognitive, behavioural and emotional effects as a result of witnessing domestic abuse. Each child will respond differently to trauma and some may be resilient and not exhibit any negative effects." According to the Royal College of Psychiatrists (2004) the effects may include:

- Becoming anxious or depressed
- Difficulty sleeping
- Nightmares or flashbacks
- Being easily startled
- Complaining of physical symptoms such as tummy aches and may start to wet their bed
- Temper tantrums and problems with school
- Behaving as though they are much younger than they are
- Becoming aggressive or they may internalise their distress and withdraw from other people
- Having a lowered sense of self-worth
- Older children beginning to play truant, starting to use alcohol or drugs, beginning to self-harm by taking overdoses or cutting themselves or having an eating disorder.

Children may also feel **angry**, **guilty**, **insecure**, **alone**, **frightened**, **powerless** or **confused**. They may have ambivalent feelings towards both the abuser and the non-abusing parent.

TISWP in practice

The two YouTube videos below offers an insight into how types of trauma are seen in practice and ways that may help us re-frame how we work:

- https://www.bing.com/videos/search?q=you+tube+truma+infomred+social+work&&view=detail&mid=8C247A5F4E1AD02EE31D8C247A5F4E1AD02EE31D&&FORM=VDRVRV
- https://www.youtube.com/watch?v=MNH3LOE5nKI

Impacts of trauma

The impacts of trauma on physical, psychological and social functioning, and how they might be experienced by young people, are summarised in the table below.

Cognitive	Hypervigilance - watching out for danger, particularly in new relationships and with people in authority (ie, professionals).	Thinking style - making negative judgements about myself, other people and the future.	Mentalisation - struggling to accurately interpret what other people are thinking.	Appraisal of risk - struggle to make safe decisions because stress shuts down thinking capacity.
Affective	Emotional arousal difficulties - struggle to manage life stressors.	Shame - a sense of being bad deep down, abandoning oneself with the belief "I deserve the worst", feeling like you want to hide away.	Emotional literacy - struggling to put into words what the distress is about in the moment.	Anger - upset with injustice of trauma and, if unresolved, may struggle to focus anger and lash out at people trying to help.
Physiological	Dysregulation - over or under responding to perceived threats, particularly in relationships.	Physically shrinking when feeling judged or exposed and physically withdrawing.	Dissociation - feeling that things are not real, out of body experiences, time passing more slowly, memory problems.	Sleep and appetite - over or under stimulated systems.
Interpersonal	Problems with boundaries - relationships do not follow safe patterns.	Social isolation - it is easier to be on our own than risk being around others.	Sexual behaviours that can cause harm as a substitute for real intimacy	Patterning - repeated abusive relationships, struggle to move away from abusers.
Behavioural	Internalising behaviours - self-harm, suicide, drug and alcohol abuse.	Externalising behaviours - physical and verbal aggression, behaving in ways that invoke social sanctions and exclusion.	Impulsivity - struggles with delayed gratification and decision-making.	Avoidance of triggers - staying away from environments, people or reminders associated with the trauma.

Summary of some of the impacts of trauma on physical, psychological and social functioning and how they might be experienced by young people. Based on Cook et al (2005) and Ford and Blaustein (2013).

Making use of Cafcass Practice Experts

Cafcass Practice Experts are a small pool of Cafcass practitioners and managers who have built up considerable learning and insight in specialist practice areas that feature less often in our cases. Whilst there is no one single expert for trauma-informed work, several of the portfolio areas relate to cases that, by default, often have a trauma-informed element.

Following a similar model to the National Psychology Service, the Practice Experts are available to offer case consultation to Family Court Advisers (FCAs) over the phone. To make an appointment with a Cafcass Practice Expert, please email nissupport@cafcass.gov.uk with a brief description of your case and any documents that it might be helpful for the expert to read in advance. NIS will then make arrangements for a mutually convenient time for you to speak.

Additional resources

Adverse childhood experience video
https://www.youtube.com/watch?v=XHgLYI9KZ-A

Brain Development video
https://www.youtube.com/watch?v=FOCTxcaNHeg

Early Intervention Foundation (2015) Report
https://www.eif.org.uk/files/pdf/what-works-to-enhance-interparental-relationships-and-improve-outcomes-for-children.pdf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