Doing Trauma-Informed Work in a Trauma-Informed Way: Understanding Difficulties and Finding Solutions

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ABSTRACT: Trauma-informed practice (TIP) is expanding as a means of improving patient safety and engagement. Accordingly, professionals and other stakeholders increasingly come together in meetings and workshops to learn about, plan and evaluate TIP in health and social care settings. However, these kinds of trauma-informed work are sometimes carried out in a way that is not itself trauma-informed – missing an opportunity to 'model the model' and risking re-traumatisation and disengagement from further trauma-informed work for some attendees. Inaccurate use of language, the desire to destigmatise, and conflation of trauma-informed and trauma-enhanced practice may all be contributing factors. Careful attention to remit and content, accuracy of language and adequate provisions around the discussion of traumatising adversities can do much to reduce the risk of psychological harm and enable our trauma-informed work to be fully enriched by those who bring lived experience that is undisclosed as well as experiences that may be extant in their roles. Issues of relationality and context are not only central to traumatisation but offer a means to avoid it, both in our work as practitioners, managers, commissioners and researchers and in the ways that we come together to plan and reflect on that TIP.

KEYWORDS: Trauma-informed, patient safety, psychological wellbeing, trauma survivor, trauma-enhanced, trauma-aware

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Introduction

The phrase 'trauma-informed' is appearing with increasingly regularity in health and social care, referring not to physical injury but to the psychological and neurological impact of adverse events and circumstances.[1] Trauma-informed practice (TIP) is a growing phenomenon, for example, it is now integral to the NHS Long Term Plan.[2] The concept of TIP gained traction first in the US, fuelled by increasing awareness of the links between adverse childhood experiences and both poor health outcomes and challenges in healthcare engagement.[3] Similar to the UK notion of 'Psychologically Informed Environments' (PIEs),[4] TIP is advocated as a means of both improving service access (and ongoing engagement) and improving the psychological aspects of patient – or other types of service user – safety.[3] It has been argued, that in the absence of TIP '. . .*the traditional service relationship (may) replicate some of the most damaging dynamics of childhood trauma, in that survivors must often accept an unequal relationship in order to avoid worse treatment' (p. 19)*.[5]

The Nature of Trauma-Informed Practice and Work

'Trauma-informed' usually refers to the application of six core principles (Safety, Trustworthiness, Peer support, Collaboration, Empowerment and Cultural, historical and gender acknowledgements).[3] Adjunct to these principles are the '4 Rs' (**R**ealising the widespread impact of trauma, **R**ecognising signs and symptoms, **R**esponding in practice and policy and **R**esisting re-traumatisation)[3] (although the UK government omit the third.[6] These principles are applicable to individual practice, service design and delivery and even commissioning and systems-level practices – hence 'trauma-informed' is often used in conjunction with 'care', 'approaches' or 'services'. This paper uses 'TIP' to refer to both individual clinician/worker practice, and the wider practices we might undertake as leaders, commissioners, trainers and researchers. The term 'patient' is used for brevity, referring also to clients or service users of social care or third sector organisations.

Scotland has been at the vanguard of universal TIP,[7] while UK and international efforts have been embraced foremost by mental health and substance use services, reflecting how psychological trauma is a common cause of the difficulties with which those patients present. Different types of service and professional role may also offer different levels of trauma-related practice. 'Trauma-aware' practice is usually the province of those with minimal patient contact, such as porters or reception staff.[5] 'Trauma-enhanced' practice (sometimes called 'trauma-expert') encompasses a higher level of training and provision than 'trauma-informed' and is indicated when the nature of patient contact is directly concerned with psychological trauma. These levels can be useful in thinking about how different domains of healthcare might benefit from applying trauma knowledge through training and service planning. Increasingly trauma-enhanced practice is being explored in physical healthcare domains such as sexual healthcare,[8,9] while paediatrics and primary care are also seeking to embrace and research trauma-aware and trauma-informed practices.[10]

Services wishing to become trauma-informed will usually undertake activities such as trauma-informed training for staff teams, utilising tools[7,11,12] to explore current practice and identify strategies for improvement, running workshops and

stakeholder events and/or forming working groups (sometimes with patients and other service providers) to co-produce plans for trauma-informed service delivery and evaluate their implementation. Communities of practice also offer useful spaces for networking, shared learning and reflection. Collectively, these types of activities constitute the *work* of TIP. This paper is concerned with this work and uses the term 'attendees' to refer to those participating in it.

Worryingly, in the experience of the author, we sometimes fail to do these various kinds of trauma-informed work in a way which is itself trauma-informed, by not adhering to one or more of the six trauma-informed principles or '4 Rs'. These failures are not only a missed opportunity to 'model the model' but can also have important unintended negative effects. Just as services that are not trauma-informed may traumatise patients and make it difficult for them to engage, when we do trauma-informed work in a way which is not itself trauma-informed we may similarly have an inadvertently powerful negative impact on ourselves and our colleagues as individuals, teams and members of wider health and social care communities. Evidence suggests that lifetime prevalence of post traumatic stress disorder (PTSD) in the United States general population is 8.3%.[13] Detailed accounts of traumatising experiences and inadequate provisions to cultivate psychological safety are two key ways in which we can fail in our intention to do trauma-informed work in a trauma-informed way. In so doing, we risk the wellbeing and engagement of those who bring valuable insights from both professional expertise and lived experience, including those who may choose not to disclose the latter. So how and why do such failures sometimes occur?

Incorrect Use of the Term 'Trauma'

Trauma is *the impact* on our neurology, sense of self and feeling of safety in the world that occurs when adverse events or circumstances are not adequately contained by the individual, the environment or those around them[1]; it is *not* the events or adverse circumstances that precede trauma, which is how the term is often used colloquially. This misuse of the term means that the first of the 4Rs '**R**ealise the impact of trauma' may be misinterpreted as 'Realise the impact of traumatising adversities', leading to detailed personal accounts of those events and circumstances which may subsequently retraumatise attendees. Those new to trauma-informed work are likely to use the inaccurate colloquial understanding of the term, while those with expertise may also revert to it in a desire to be audience accessible or as an abbreviation of 'events and circumstances that lead to trauma'.

Poor Delineation Between Trauma-Informed and Trauma-Enhanced Practice

Inappropriate provision of detailed survivor histories that can retraumatise attendees doing trauma-informed work may also reflect a conflation of trauma-*informed* with trauma-*enhanced*. An important and intentional aspect of the latter is to ask not 'What's wrong with you?' but instead 'What happened to you?' – facilitating an empathic, de-pathologising and shame-reducing reframe.[14] As trauma-*enhanced* practice may also include facilitating the survivor to retell their story, survivors may be invited to contribute to trauma-informed training in part as a recovery opportunity. Conflation of trauma-informed and trauma-enhanced work may also involve more in-depth discussion of traumatising events that can similarly retraumatise attendees.

Lack of Awareness of Possible Existing Trauma Among Attendees

In reality, we have no way of knowing how training materials or in-depth discussions will affect attendees or whether they might be retraumatised by aspects of trauma-informed work – with the potential that we directly contravene the trauma-informed intention of Resisting re-traumatisation. That we do not always adequately consider this possibility is both concerning and also instructive in revealing how we conceptualise what it means to be traumatised and who is affected. Inclusion of detailed survivor stories in trauma-informed work may reflect an implicit assumption that no-one in the room will be re-traumatised to any notable degree by survivors' accounts- this is essentially an assumption that professionals cannot be survivors. These assumptions are part of the 'othering' of trauma – the notion that those wearing the hat of professional or academic are not the 'sort of people' to have experienced traumatising adversities. These assumptions are then also incongruent with a trauma-informed approach – the latter seeking to realise the impact of trauma and respond.

Misunderstanding About What It Means to be Traumatised

Conversely, the phrase 'We all have trauma' is increasingly used – as a well-intentioned rebuttal of the othering of trauma. However, this emerging counter-narrative may reflect a misunderstanding of what it means to be traumatised – which is to live with impacts such as chronic distrust, dysregulation and the continual fear of being triggered into flashbacks, as well as to experience hard-won post-traumatic growth.[15] In reality, although evidence indicates that 61.5% of the general population (of the US) have experienced 1 Adverse Childhood Experience (ACE) and 24.6% have experienced 3 or more ACEs[16] – not everyone will be traumatised by those experiences. ACEs are frequently the subject of trauma-informed training – comprising 10 types of abuse or circumstances experienced in childhood that are causally linked to a range of adverse mental and physical health outcomes. Importantly, ACEs in themselves are not necessarily traumatising, while other experiences not listed as ACEs may also cause trauma such that some scholars have sought to expand the list.[17]

'We all have trauma' is also a problematic phrase because it is may be used as a short-hand for 'we've all experienced distressing events or circumstances' – perpetuating the inaccurate

use of the term as an abbreviation as detailed above. Worryingly, by viewing trauma as ubiquitous we may then assume that our own personal response to materials and discussions will also be ubiquitous – that if we don't find aspects of trauma-informed work triggering, no one else will either so that we then fail to notice when provisions are needed in order to provide sufficient safety for all attendees. This inaccurate assumption of the ubiquity of trauma may then undermine the trauma-informed intention of 'responding in practice and policy'.

Inadequate Provisions and Use of Trigger Warnings to Create and Maintain Safety

Essentially, inaccurate assumptions may lead us to make inadequate provisions for psychological safety around trauma-informed work, thereby inadvertently contravening trauma-informed principles – particularly those of safety, empowerment and trustworthiness. Trigger warnings (TW), when given, are sometimes only provided at the beginning of an event after everyone has taken their (virtual or physical) seats. To leave at this point requires very quick decision-making by any traumatised attendees and may require unwillingly 'outing' oneself as a survivor in doing so – a disempowering experience. Sometimes facilitators will invite attendees to leave *if* triggered – this may only cement the stark choice between risking re-traumatisation by staying or signalling that you are in fact traumatised by exiting. Importantly, both the 'fawn' and 'freeze' neurological responses[18] may also *prevent* people from being able to exit or verbally advocate for themselves. Without carefully considered provisions we risk dysregulating and retraumatising attendees and inadvertently creating a space which is not sufficiently safe, trustworthy or empowering. We may even retraumatise by compounding the internalisation of shame (already a pervasive and distressing aspect of trauma) as the survivor notices how their own level of distress differs markedly from others – particularly if this is coupled with the message of 'we all have trauma'.

Together these challenges may not only miseducate, retraumatise and fail to 'model the model' but may lead to disengagement amongst those doing trauma-informed work who have valuable lived experience to offer – often alongside professional expertise. So what steps can and should we be taking when doing trauma-informed work?

Solution 1: Using the term 'trauma' accurately in our thinking as well as our practice

First, we need to use the term 'trauma' accurately – this would improve the extent to which our trauma-informed work adheres to trauma-informed principles firstly by moving us away from un-necessary detail of traumatising adversities which can retraumatise and reduce safety and empowerment. Relatedly, when we think about 'Realising the impact of trauma' we need to focus our efforts not on events and circumstances but on understanding *the consequences* of a dysregulated nervous system, and of a damaged sense of self and safety in the world. It can be a powerful learning moment for attendees who are not traumatised to hear someone recount their personal experience of trauma – of dissociation, hypervigilance and anxiety, depression and difficulty with forming established relationships to name a few. A focus on this true nature of trauma (rather than its preceding events) enables us to be trauma-informed by truly learning to 'Recognise signs and symptoms' and think about how we 'Respond in Practice and Policy' This does not require a detailed history and may offer a much more useful starting point from which to envisage how our health or social care services might be offered in a truly trauma-informed way to provide opportunities to counter or repair those effects.

As misuse is in part due to abbreviation it may be helpful to use acronyms and/or to replace the word 'trauma' with the term 'traumatic stress' (TS) – the latter being a more accurate conceptualisation of trauma that highlights neurological and biopsychosocial effects of traumatising experiences. When referring to the events and circumstances that precede trauma the acronym PTE (potentially traumatic events) may be useful, or alternatively 'traumatising adversities' as a term which encompasses both singular events and chronic circumstances and experiences. In this way, we bring truly trauma-informed practice to our trauma-informed work as we apply the principles and '4 Rs' through a conceptually accurate lens.

Solution 2: Understanding differential impact from potentially traumatic experiences

Alternative to detailed histories, trauma-informed work can usefully categorise different types of adverse experiences – such as those listed as Adverse Childhood Experiences that can *lead* to trauma. Importantly, such categorisation should not be seen as exhaustive. Other PTEs may also traumatise where there is insufficient environmental containment. Chronic adversity, such as the conditions created by poverty and other types of ongoing social disenfranchisement, is also a recognised cause of trauma and one which is increasingly overlooked (because it is much more difficult to 'measure' in studies of resilience and trauma).[19] Hence, an overview of the *breadth* of PTEs and experiences provides a useful jumping-off point for discussing differential experience and patterns. The distinction between PTEs or other traumatising adversities and TS can also help understanding of how we can be impacted differentially by the same events and circumstances to a very marked degree. This can open up discussion about the inaccuracy of 'we all have trauma' and the ways in which that thinking can be unhelpful as detailed above, noticing that our own experience of material as triggering or safe cannot be generalised to others. By working in this way we 'Realise the impact of trauma' and also Resist retraumatisation among attendees – only brief mention of the different types of PTEs is necessary.

Acting As If Everyone may be Traumatised in the Provisions We Make for TIP Work

Working with the knowledge that: we've all experienced adversities but we have not all been traumatised by them also opens up the space to consider that – when we are doing trauma-informed work – we simply *don't know* who amongst us has faced what kind of adversities or the degree to which any of us have TS as a consequence. It is from this awareness that a key tenet of TIP arises; namely – although we know trauma is not ubiquitous – nonetheless we must act *as if* everyone may be traumatised.[20] It is through this practice that we 'Resist retraumatisation' by attending properly to the six principles of TIP.

Acting as if all attendees may be traumatised means first and foremost vetting material and placing boundaries on discussions to ensure – as far as possible – that trauma-informed work is not retraumatising and is instead psychologically safe for all attendees and that material is not included because we are conflating trauma-enhanced work with trauma-informed work. Where it *is* deemed worthwhile to describe types of PTEs and traumatising adversities or to provide survivor stories this must be a considered decision and we can undertake practical steps to support attendee wellbeing by maximising empowerment, safety, trustworthiness and seeking out ways to create provisions that are culturally sensitive and designed collaboratively. Provisions are also important because it may not be possible to pre-determine a 'safe' amount of survivor story detail or discussion and even brief mention of different types of ACEs may be difficult for some.

Trigger warnings can support empowerment – by giving traumatised attendees more control over their own wellbeing. For example, TWs can be placed in the emails that accompany documents and event invites. We can also place them at the beginning of written documents – signposting where there is potentially triggering material and using text-shading or clearly demarcated boxes on the page to empower people to skip difficult content. Online self-completion courses can similarly have routing options that skip detailed stories and that provide TW both at the beginning of modules and on the page *preceding* that material's appearance.

For online and in-person events – whether team meetings, conferences, workshops or training sessions – we can deploy a number of additional strategies. First, we can provide TW not only in related emails and documents but in signage at events. We can also provide guidelines and/or set ground rules when we come together in virtual or physical spaces to not disclose trauma details about others or indeed *ourselves* – in line with TIP this creates a context of safety and of trustworthiness in facilitators of trauma-informed work. These may be worth repeating where there are Q&A sessions and other opportunities for open debate.

Second, we can invite attendees to 'step out for some air' (either online or in person) as a general self-care tool rather than 'if you're triggered' so that those needing this option don't feel they are indirectly disclosing their own traumatising adversities. We can also offer use of non-verbal signals if content is becoming difficult, acknowledging that freeze and fawn responses can make it difficult to exit a room or advocate for oneself in an articulate way – a 'stop sign' with the hand can be delivered discretely in face-to-face settings and a digital equivalent given via Chat functions. Together these strategies align with the TIP principles of 'empowerment' and 'safety'. By exercising principles of collaboration and of attending to cultural acknowledgements other strategies may also be identified and deployed.

We can also use knowledge of the nervous system in our trauma-informed work to help all attendees stay in or return to a regulated state, by co-regulating with fellow attendees. For example, we can encourage doodling during sessions, invite people to hum or do deep breathing or stretching either during sessions or after, or undertake a clapping game or other rhythmic practice which supports us to feel connected with each other. In this way we align with TIP by empowering traumatised attendees to participate and to collaborate, acknowledging that post-traumatic growth may be reflected and supported in these spaces.[15]

Lastly, we can give explicit permission for people to raise concerns on *behalf of others* as well as themselves – this not only removes the onus from traumatised people to 'out' themselves but also provides opportunities for everyone in the room to take responsibility for, and be allies in, creating psychological safety– practising in a trauma-informed way as they do so, particularly through the principles of collaboration and peer support, that help build a trauma-informed context of safety and trustworthiness.

Conclusions

The suggestions offered here are not intended to be exhaustive, but rather to ignite further ideas about how we might practically work with the *assumption* that everyone does have considerable TS, while also holding true the notion that the degree to which attendees are, or are not, traumatised will vary considerably. Importantly, these suggestions speak to the contexts that we create when doing trauma-informed work. As trauma itself can be conceptualised as a failure of context – an insufficiently containing environment around the difficult events and circumstances – it follows that attention to context is at the heart of TIP and hence must be at the heart of the work we do to support and enable TIP. This paper has sought to attend to the contexts of that work, identifying possible causes of difficulties and solutions that themselves operationalise trauma-informed principles and intentions. It is important to acknowledge that trauma-informed principles are not always absent from trauma-informed work and that the suggestions here may overlap with or be expanded on by the work of others. For example, a trauma-informed medical education project has incorporated co-design, peer support, frequent breaks and content advice into its approach[21] while sexual health service co-design has sought to incorporate trauma-informed and resilience-informed research principles.[8,9] There also exist a number of frameworks in the grey literature, and empirical work has sought to explore the nature of trauma-informed

co-production, finding particularly that for co-production to be trauma-informed there must be extra attention to issues such as power dynamics and boundaries.[22]

Also notable is that trauma-informed principles and the practice suggestions above are concerned with relationality; human connection is then the most vital component of context for trauma-informed work, (just as traumatising adversities are predominantly failures of relationality and safe human connection). There is much to be done to extend this understanding into our TIP – it must be understood as relational, not only between two staff members or staff and patient, but within and between teams and systems. Our trauma-informed practice, and our evaluation of it, must incorporate this relational and systems-level thinking; acknowledging how broader systems may be traumatising and thinking creatively about how we can generate and maintain trauma-informed ways of working that offer staff and system resilience as a way to transform (rather than simply cope with) systemic adversities.[23] Capturing staff experiences of doing trauma-informed work for evaluation and quality improvement purposes offers a useful opportunity to put front and centre-stage both trauma-informed principles and the relationality inherent within them. In particular, attention to relationality and connection- in both evaluation and practice- provides an opportunity to notice and operationalise the trauma-informed principles of collaboration and peer support in the trauma-informed work that we do.

Thinking about TIP, relationality and systemic adversities and solutions is also important in our attempts to do the work of TIP in a way that adequately considers cultural acknowledgements and competence. Perhaps the most overlooked trauma-informed principle, its consideration is important not least because our workforces are diverse in ethnicity, sex, gender and class and because trauma may accordingly present differentially. Indeed, there are concerning reports of people needing to 'perform' trauma in a Western-centric way in order to access help.[24] Evaluation and direct attention to cultural aspects of the work of TIP may offer useful starting points if we are to ensure that our trauma-informed work adheres to all of the trauma-informed principles and if we are to practice each of the '4 Rs'.

TIP itself is not easy.[14] Nor is the work we do to develop and improve TIP, including writing this paper. It is important that survivors neither feel silenced nor re-traumatised and this paper is written from a perspective informed equally by the author's academic expertise and by their experiences as a survivor participating in trauma-informed work. Quality improvement, patient safety and simple progress will always necessitate that we air and discuss uncomfortable truths – doing so can only bear fruit alongside careful attention to TI principles, content and remit, to our assumptions and to adequate provisions around our discussions. All must be a vital part of the work we do around TIP to both enrich our learning as we model the model and to make engagement in this kind of work accessible and safe for all.

Author Contribution

Dr Edelman conceived the paper idea, reviewed the literature, drafted and finalised it a solo endeavour.

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