research
in practice

Frontline
Briefing

Trauma-informed approaches with young people

Dartington

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Introduction

Being traumatised means continuing to live your life as if the trauma were still going on - unchanged and immutable - as every new encounter or event is contaminated by the past.
(van der Kolk, 2005)

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of, and responsiveness to, the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.
(Hopper et al, 2005)

This briefing is an introduction to trauma research for practitioners working with young people whose experiences (either earlier in their childhood and/or in the present) may lead to complex traumatic responses across the lifespan. The focus is on older adolescents and young adults (c. 17-25 year olds) but the messages have some application for younger teens. Given the large body of literature on trauma, the briefing provides a broad introduction, with a focus on helping frontline staff to work more effectively.

The briefing is comprised of four sections:

1. What are the traumatic childhood experiences that adversely affect young people?
2. What is it like for young people to live with complex trauma and how can practitioners recognise it?
3. What can we do to support young people with complex trauma?
4. How can we develop as practitioners to do this work?

1. What are the traumatic childhood experiences that adversely affect young people?

Many young people involved with safeguarding, child protection and the care system may have experienced multiple forms of interpersonal harm. Research evidence on the impact of these experiences provides messages that probably come as no surprise to experienced practitioners - repeated adverse experiences in childhood and adolescence are associated with difficulties throughout childhood and into adult life across a range of domains of mental and physical health and wellbeing (Feletti et al, 1998; Hillis et al, 2000; Dube et al, 2003; Herman et al, 1997; Hughes et al, 2017). The body of work known as ACE research has been influential in bringing this issue to the attention of professionals in other fields.

The Adverse Childhood Experiences (ACE) studies

This work originated in the US in the 1990s and takes an epidemiological approach to analysing the impact of childhood adversity on individuals over the course of their life. The research focuses on ten selected areas of adversity (see figure on the next page) and the evidence on their harmful impact on various aspects of health and social functioning (see figure two).

Long-term follow-up suggests that 'the impact of ACEs appear to be cumulative, with risk of poor outcomes increasing with the number of ACEs suffered' (Hughes, Lowey, Quigg and Bellis, 2016). The term 'dose response effect' is used to refer to the cumulative impact of multiple, traumatic events in a young person's life.

The images in the infographics below were chosen by the Robert Wood Johnson Foundation to illustrate ACEs research.

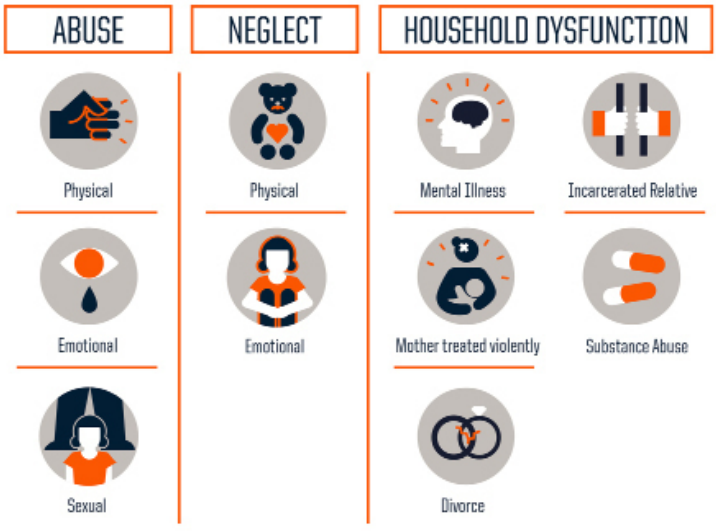

Figure one: The ten areas of adversity focused on in ACE studies
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While ACEs research focuses on divorce as an adverse experience, recent evidence suggests that it is the quality of inter-parental relationships rather than separation in itself that has the greatest impact on children. See: www.eif.org.uk/publication/what-works-to-enhance-inter-parental-relationships-and-improve-outcomes-for-children-3

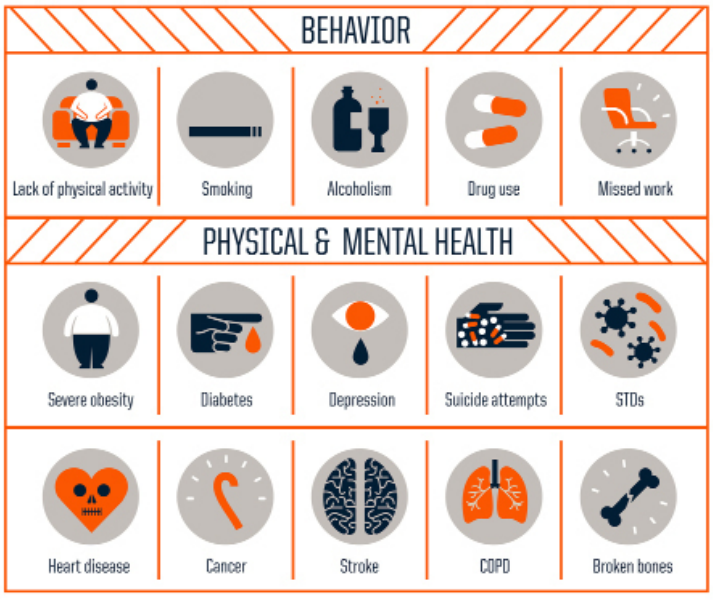

Figure two: Areas of increased risk across the life span identified in ACE studies
Copyright 2013. Robert Wood Johnson Foundation. Used with permission from the Robert Wood Johnson Foundation.

The ACE studies have found that, when people are asked to look back on their own experiences, these adverse issues are reported very commonly. ACE studies in the US, recently replicated in Wales, found that more than half of people reported at least one significant form of childhood adversity and a quarter reported two or more (Feletti et al, 1998).

A recent UK study found that around half the population sampled reported experiencing one form of adversity, with eight per cent reporting experience of four or more (Hughes, Lowey, Quigg and Bellis, 2016). For more details of the original ACE study visit: **www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences**

As with any body of research we need to think critically about the perspective offered and the strengths and limitations of ACE research. Edwards et al's (2017) submission to the House of Commons Science and Technology Select Committee Inquiry provides a useful summary:

- There is a strong critique that the ACE framework 'convert[s] complex social experiences into biological, chemical effects' (Edwards et al 2017) and does not attend to wider social factors that contribute to health and social problems, such as poverty, homelessness or hunger (though some ACE research is starting to engage with these issues, see Metzler et al, 2017).
- Another aspect of this critique is that ACE studies lead to 'a view of people as bodies and brains to be managed and treated rather than citizens who should be represented and engaged' (Edwards et al, 2018). We know that engagement with family support and social work is enhanced by practice approaches that 'do with' rather than 'do to' young people and families.
- The ACE analysis does not take account of individuals' power to interpret and respond to experience in a variety of ways (Edwards et al, 2018). Instead, the future can look 'set in stone' by past experiences. This fatalistic perspective is potentially very unhelpful for practitioners, and even more so for young people who may feel there is no escape from negative outcomes and irreparable harm.
- A further point of challenge is that these ten 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.

It is important to remember that ACE studies offer an empirical model for what happens *if trauma and adversity are not addressed*. Relationship-based practice can significantly influence this trajectory, and recognising trauma and embedding safety can offer young people other ways of living.

ACE methodology can be used to highlight need while keeping a focus on developing practice. A study by social work academics used the ACE methodology to analyse protective and risk factors for young carers. They found elevated risk factors for the young people with a parent with mental illness diagnosis and offered suggestions for social work practice which included both preventative strategies and how to work with young carers to better meet their needs (Spratt, McGibbon and Davidson, 2018).

What do we mean when we say trauma?

A broad definition of trauma is offered by the Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the US Department of Health and Human Services:

> *... an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing.*
> (SAMHSA, 2014)

Trauma research tends to distinguish between different sub-types of trauma:

Type 1 Trauma: Refers to either 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 per cent of cases persists to meet the criteria for a diagnosis of post-traumatic stress disorder (PTSD) (NICE, 2005).

Type 2 Trauma: Consists of multiple traumatic events over a period of time and is the focus of this briefing. Subtypes are known as Complex Trauma, Interpersonal Trauma or Developmental Trauma. 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 - it is 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 is crucial in understanding how we can help young people with complex trauma. It is often interpersonal difficulties between young people and professionals that get in the way of help; for example, when young people make sporadic engagement with practitioners or 'dis-engage' altogether.

Complex trauma and attachment

It is helpful when working with young people with complex trauma and disrupted attachment relationships to consider how a young person's attachment history interacts with trauma reactions. Attachment-based approaches can help us understand the potential of our role in children and young people's lives as surrogate care-givers and important attachment figures.

Two examples of the relationship between trauma and attachment patterns

A young person with a more avoidant attachment strategy with accompanying trauma might present as very compliant initially, focused on keeping professionals happy in order to avoid expected punishment or rejection. This survival strategy may only come to light over time when the work fails to reap rewards and the young person quietly continues to engage in behaviour that exposes him or her to risk. In the context of relationship-based practice this can leave practitioners feeling manipulated and untrusting, and might trigger sanctions intended to ensure compliance.

Contrast this with another young person who has suffered similar trauma but has developed a more ambivalent attachment strategy. This young person also has a conflicted relationship to help but is much more overt about it, often angrily critical and unable to easily focus on one thing - jumping around between past and present grievances. This might leave a practitioner feeling exhausted and overwhelmed, with a barrage of feelings and little capacity for thinking.

As we can see from these two examples, traumatic injuries are often what bring young people to the attention of services, but their attachment strategy can define how they present. A practitioner will need to work in accordance with these patterns of relating to others. For a more detailed discussion of attachment theory see the Research in Practice Frontline Briefing on *Attachment in children and young people* (Shemmings, 2016).

2. What is it like for young people to cope with trauma and how can practitioners recognise it?

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).

While the reasons for this are multi-factorial, it is important to recognise the strong association between families' socio-economic circumstances and childhood abuse and neglect (Bywaters et al, 2015). To take one example, trauma-experienced young people are less likely to finish school and find employment (Metzler et al, 2016), so poverty and trauma exacerbate one another and limit a young person's chances of achieving interpersonal, economic or social safety. The implications for inter-generational patterns of poverty and trauma (Merrick, Leeb and Lee, 2013) will be familiar to practitioners working with families who have been 'known to social care' for a long time.

Vicarious or secondary trauma refers to the impact on staff of 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.

Trauma as a form of social harm impacts our ability to form relationships. The psychologist and trauma survivor Peter Sedgwick put it like this:

> *Trauma and resistance to trauma can, in the human case, be understood not in the analogy of a physical force striking a more or less brittle object nor on the lines of the invasion of an organism by a hostile bacteria,* ***but only through the transformation of elements in a person's identity and capacity to relate to other persons and social collectives.***
> (Sedgwick, 2015)

It is important to understand how trauma may impact on individual young people's ability to relate to others. It's also important to recognise how the harms that brought them into the care system may be compounded by system responses – leading to relationships lost through placement instability or changes of social worker, and loss of contact with parents, siblings and wider family.

Complex trauma can result in a broad range of difficulties that are varied enough to often touch on a range of psychiatric diagnoses but do not lead to a full diagnosis of any one type; some specialists have called for a separate diagnosis of Complex Trauma (Van der Kolk, 2005). This is one reason why practitioners who refer quite highly emotionally dysregulated and distressed young people to CAMHS teams often get frustrated when the young person is assessed but not eligible for treatment because they are deemed to not have a 'mental health problem'.

Adolescents in the care system are often diagnosed with a range of affective and behavioural disorders, none of which adequately acknowledge the role of trauma in the development of the disorder. One example is attention deficit hyperactivity disorder (ADHD). Hyper-vigilance (keeping alert for threats in the environment) can result in concentration difficulties, irritability in interpersonal relationships and a strong startle response. An ADHD diagnosis might be applied to one young person with a biologically grounded developmental disorder and another child with similar symptoms which emerge in response to interpersonal trauma (see ADHD column within the table on the following page).

Research findings suggest that exposure to interpersonal trauma is a significant risk factor for a diagnosis of ADHD (D'Andrea et al, 2012). If a young person has ADHD type behaviours as a result of trauma, we need to be confident, before we try to reduce or change those behaviours, that the young person is safe and no longer needs these ways of coping.

None of which is to say that *all* mental health problems young people face are as a result of interpersonal trauma. The biopsychosocial approach to mental health recognises that there are multiple pathways into most mental health problems, with many developing in response to a combination of factors. For social care practitioners referring young people into specialist mental health services, trauma may be a causal factor and specialist mental health services need the expertise to assess and treat complex trauma reactions.

PTSD symptoms that overlap with other disorders	GAD*	ADHD	Phobia(s)	Depression	Conduct	Psychosis
Hypervigilance (or 'attending to the wrong thing')	X	X				
Problems with concentration	X	X		X		
Exaggerated negative beliefs about self, others or world	X			X		X
Irritable, aggressive		X			X	
Exaggerated startle response		X			X	
Avoidance of specific stimuli	X		X			
Exaggerated negative beliefs about self, others or world Persistent negative emotional state Diminished interest/participation in significant activities Feelings of detachment or estrangement Inability to experience positive emotions (eg, happiness, satisfaction, love)				X		
Dissociative reactions (eg, flashbacks) in which the individual feels or acts as if the traumatic event(s) are recurring						X

*** Generalised anxiety disorder**

Overlap between PTSD symptoms and other common child and adolescent mental health problems
Source: Dr David Trickey, Anna Freud Centre.

Trauma-informed approaches (TIA)

The psychiatric diagnoses of individuals who have experienced serious childhood abuse can be a form of 'discursive fig leaf' (Taggart, 2017) - a label that covers up the underlying trauma and abdicates societal responsibility by viewing a young person as a 'sick' or 'delinquent' individual. If we view these young people as victims of criminal acts that were often enabled by failings in the state, then our collective responsibility towards them becomes quite different.

Taking a trauma-informed approach in our work can enable this shift away from asking "What is wrong with you?" towards an orientation on "What has happened to you?", enabling the possibility of survivors of abuse being seen by themselves and others as just that - survivors. With this change of ethical orientation a child or young person's responses to trauma are seen as understandable and courageous attempts to survive which were absolutely necessary at the time. This gets to the heart of relationship-based social work in the context of trauma (Szczygiel, 2018).

For example, 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.

Another example might be a young parent seen as 'disengaged' from the child protection plan in place for their child. Using a trauma lens to understand that the parent's struggle with authority stems from an abusive and neglectful family environment in their own childhood (compounded perhaps by their own negative experiences of social care as a child) we can begin to approach them in a way that can enhance their sense of safety, reduce feelings of powerlessness and improve our chances of successful engagement.

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

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).

Adaptations arising from the experience of interpersonal trauma may have been developmentally appropriate and necessary responses to being exposed to repeated interpersonal danger. Nevertheless, we know from decades of clinical and epidemiological research that these difficulties have a significant impact upon psychosocial development across the lifespan. Individual young people may display different combinations of these at different times depending upon their stage of development and also the nature and severity of their experiences of interpersonal trauma(s).

For example, for one young person social withdrawal following sexual abuse in a familial relationship might be their best attempt to self-protect, while another with a similar abusive experience might engage in sexual behaviours deemed risky and lacking in intimacy in an effort to deal with their experiences. So while these responses are contradictory in *behavioural* terms, they both make sense *psychologically* as strategies to manage emotional distance in relationships.

What is even more important (but can be counter-intuitive for practitioners trying to make sense of young people's apparently chaotic lives) is that the same young person can use both strategies at different times. It is through focusing in on the traumatic harm that we can make sense of what is happening.

An example provided by Ford and Blaustein (2013) describes a traumatised young person entering 'survival mode' when faced with an authority figure trying to assert control. This evokes in the staff member a similar sense of endangerment whereby both parties assert themselves. The ensuing clash leads to a breakdown in the relationship and confirmation for the young person that 'survival mode' is necessary.

Taking a trauma lens to understanding oppositional behaviour can enable a different relationship to emerge, characterised by a respectful attempt to understand the function of the challenging behaviour and to respond differently. Carefully and sensitively addressed in the context of relationship-based practice, this shift can begin a process of recovery.

Carolyn Knight (2015) provides a useful overview of trauma-informed practice in relationship-based social work and makes the point that core social work skills are at the heart of trauma-informed practice. Key messages from this article include:

- Trauma-informed practice is not an assumption that everyone we work with is a survivor. Nor is it a proposition that the past trauma will be the focus of practice in the present. Trauma-informed practitioners will be alert to this possibility and the ways in which current problems might be understood in this light.
- A practitioner attempting to form a relationship with a young person may well be seen as another untrustworthy authority figure to be feared, challenged and tested.
- A practitioner acknowledging a young person's trauma and responding with empathy can affirm and validate their own responses to the harm they experienced. Expressing empathy does not require that a practitioner goes deeply 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.
- In longer-term relationship-based practice, forming a positive 'working alliance' can provide a radically different emotional experience for survivors.
- Survivors report the following as unhelpful: practitioners avoiding addressing the trauma at all; asking for too much detail or expression of emotions at an inappropriate time or place; minimising the significance of the trauma.

3. What can we do to support young people who have experienced trauma?

The following key points for trauma-informed practice are drawn from an open access YouTube webinar, *Teaching trauma-informed practices to students in health care fields*:

Think...

- Environment.
- Body positioning / Language / Self-awareness.
- Ask permission, ask permission, ask permission.
- Listen for, and reflect, underlying needs.
- Listen for, and reflect, underlying values.
- Acknowledge strength and retire the professional jargon.
- Help people find their feet, and help their feet find the ground.
- Treat young people as partners.

(Seaman and Cochran, 2018)

www.youtube.com/watch?v=CMR7Y--JSBo&t=88s

> *Practitioners who do not attend to survivors' past, and the relationship it plays in the present, undermine their ability to deal with the underlying trauma and the present-day challenges.*
> (Knight, 2015)

In considering how best to design and deliver practice to meet the needs of survivors of complex trauma, a key requirement is to recognise the ways in which traditional services have not only struggled to understand and meet these needs but have often inadvertently made things worse.

Retraumatisation

An example of retraumatisation would be a young person who, following a physically abusive relationship with a boyfriend, has started experiencing extreme mood fluctuations and copes with this by self-harming. One safeguarding response might be to restrict her liberty by placing her in residential care and trying to prevent her from hurting herself through control and restraint techniques.

From the young person's perspective, what is happening is a repeated pattern of the coercion and control that characterised the abusive relationship with her ex. In this light the service response is not just unhelpful but actively *harmful* in recreating the abusive relationship. This is known as retraumatisation.

Retraumatisation is a major issue when working with young people, particularly when it involves figures in authority taking control away and enforcing interventions. As can be seen in the table on the following page, repeating patterns of abusive relationships can be a feature of interpersonal trauma and services are left with no choice but to restrict liberty and enforce treatment if the young person is at risk of harm. However, this does not negate that the *experience* for the young person is retraumatising and in designing and delivering services for young people we need to find ways to minimise the risk of retraumatisation. The first vital step here is the recognition of its likelihood.

In direct response to the risk of retraumatisation, services have begun to use Trauma-informed Approaches (TIAs). TIAs started off in the US but have recently begun to develop in the UK, spearheaded by the work of Dr Angela Sweeney and colleagues (2016), who have written an important and accessible paper on adapting public services to be more trauma-informed. They identify nine features of TIAs in relation to working with young people in social care environments.

Features of trauma-informed approaches and their application to working with children, young people and parents (based on Sweeney et al, 2016)

	What this means for services	What this feels like for children, young people and parents
Recognition of trauma	Practitioners recognise the prevalence, signs and impacts of trauma and find a way to check if anything has happened to the person. Some people may not volunteer information about their past trauma due to feelings of guilt and shame; questions need to be sensitive to this to avoid retraumatisation.	*"I am being seen and believed."* Creates feeling of validation, safety and hope.
Avoidance of retraumatisation	There is an understanding that practices can lead to retraumatisation and that staff may suffer secondary trauma. Try to minimise taking control away from the person and be transparent.	*"They are not like the people that hurt me."*
Cultural, historical and gender contexts	Being sensitive in selection of key workers and treatment to the individual's specific identity.	*"They thought about me as a unique person. Me as a whole person."*
Trustworthiness and transparency	Being explicit at all times regarding what services are doing and why.	*"When they say they will do something they do it."*
Collaboration and mutuality	Understanding power imbalances and working to 'flatten the hierarchy'. There is a focus on building relationships based on respect, trust, connection and hope.	*"We are working through this difficult stuff together."*
Empowerment, choice and control	Enable the development of agency through access to resources. Practitioners adopt strengths-based approaches.	*"I am taking control of my life now."*
Safety	Developing safe systems, from admin processes through the entire organisation, to be trauma-informed.	*"I feel like I can finally begin to trust people again."* *"It might be worth seeing if they're trustworthy."* *"I feel emotionally and physically safe."*
Survivor partnerships	Peer mentor, peer support and co-production of services.	*"Meeting other people like me makes me feel less alone."*
Pathways to specialist trauma treatment	Development of links and clear pathways to specialist, evidence-based psychological therapies - CBT, EMDR, 3-Stage model of trauma work.	*"I go somewhere safe to talk through what happened to me."*

4. How can we develop ourselves and each other as practitioners to do this work?

Empathic, relational practice is the underpinning of all good social work and family support. One critique of TIAs is that they simply describe 'good practice' in general. Nevertheless, 'good practice' with young people who have been harmed in traumatic ways may not be straight-forward. As seen in the examples above, it can be hard to recognise that the 'challenging behaviour' a young person expresses is a symptom of underlying trauma. When that behaviour is directed towards ourselves it can provoke a moral response and a fear reaction characterised by rejection and punishment.

Even if we do see beyond the presenting behaviour we may still be confronted by the young person covertly or overtly rejecting our best attempts to help because they experience our attention as intrusive and threatening. A central aspect of working in a trauma-informed way is understanding that these interpersonal responses to us are *trauma responses* and need to be considered as part of the original 'injury'.

Like a patient's body rejecting medication because of an infection, many of these young people will initially struggle to accept help because it feels toxic. Getting past that with the young person so they can trust is the key ingredient in trauma work.

Practitioners need self-care, support and training to work with trauma effectively, sustainably and safely. Regular reflective supervision is essential. Given the strong unconscious patterns of retraumatisation operating, this ought to include space for practitioners to reflect upon their own relationship to interpersonal trauma. The prevalence of trauma (as set out in the first section) means that all of us are likely to have been affected in some way, either directly or through the experience of a loved one. In addition, there is evidence to suggest that levels of trauma in some helping professions may be higher than in the general population (Esaki and Larkin, 2013).

Further reading

See the Research in Practice *Reflective Supervision: Resource Pack* (Earle et al, 2017):
www.rip.org.uk/reflective-supervision

Practice example: TIAs Norfolk Parent Infant Attachment Project

Established to address high levels of child removal from birth parents, many of them under 25, with histories of trauma and attachment-related problems.

Of the population the project worked with:

- 63 per cent had already had at least one removal and were at risk of further removals
- 36.2 per cent of mothers had been in care themselves
- 84 per cent of the families had recorded instances of domestic violence.

The inter-agency, DfE-funded, project used attachment and trauma-based approaches, which included longer-term psychological therapy alongside short interventions designed to improve parental attunement. The project enabled 85.4 per cent of the families to remain together in comparison to the approximately 50 per cent expected based on national data.

The project involved integrated health and social care services working to understand issues such as 'non-engagement', parental mental health and substance use through a trauma lens in order to reduce the cycle of removal from families living in disadvantaged communities. The project demonstrates that TIA can be embedded in existing service structures and that using this service-level philosophy can improve outcomes and reduce costs in repeat child removals from young parents (McPherson, Andrews, Taggart, Cox, Pratt, Smith and Thandi, 2018).

Conclusion

These experiences may offer the possibility of practitioners developing an enhanced empathic understanding and capacity for compassion in their work. It can also lead into complicated patterns of relating to young people where our own history interacts with theirs, increasing the likelihood of retraumatisation for the young person and burnout for the practitioner. Regular supervision, training and a non-blaming organisational culture can all contribute to practitioners being able to work in a safely trauma-informed way (Sweeney et al, 2016).

Much about trauma is unspeakable, unspoken and silenced by perpetrators, while society at large can struggle to recognise trauma and speak out. Traumatised children and young people often struggle to put into words what has happened to them. We often hear young people say things like "I have no words to describe how I feel." Part of our task (in appropriate practice contexts) is to help them find means to express what has happened to them and how it affects them in daily life. Translating the unspeakable into words might be the young person's first step in their recovery.

Child abuse, neglect and trauma have profound, long-lasting and far-reaching effects. It is the role of practitioners across social care to help young people manage the fallout and try to recover their lives. There is hope for these young people, particularly if we identify the trauma early and work in a trauma-informed way.

This briefing is underpinned by a profound principle, which sounds obvious but is nevertheless something service responses do not always attend to. In order to help trauma survivors we need to listen to them much more carefully, as active partners in creating personal, organisational and societal change.

The words of Sally Smith, a UK-based survivor of trauma who subsequently experienced significant retraumatisation within the psychiatric system, elegantly embody the struggle to live day-to-day with the effects of trauma, but also the possibility that things can improve if we work together - professionals and young people with equal voice, to bring about systemic change and restore justice to those in our communities who have been given the most difficult of starts in life.

> *I have little doubt that the work I have to do on myself will never be complete and my dependency on unhelpful ways of coping and on mental health services will not be resolved overnight. But I do have hope, hope for me, hope for this culture change in services and hope for all people that use them.*

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