(Mis)understanding trauma informed approaches in mental health

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The Journal of Mental Health has a history of publishing articles that explore the ways traumatic experiences lead to mental distress, and the experiences of trauma survivors (e.g. Xie, Jiuping & Zhibin, 2017; Kucharska, 2017; Karatzias, Ferguson, Gullone & Cosgrove, 2016; Cooke 2016; Salter & Richer 2012; Harper, Stalker, Palmer & Gadbois, 2008; Mueser & Rosenberg 2003). These articles join other evidence demonstrating that large numbers of people in contact with mental health services have experienced traumatic events (e.g. Khalifeh et al., 2015), that these experiences are causal in the development of mental distress (e.g. Feletti et al., 1998; Morrison, Frame & Larkin, 2003) and that there is a relationship between the severity, frequency and range of adverse experiences, and the subsequent impact on mental health (e.g. Dillon, Johnstone & Longden, 2012). For instance, there is evidence of a strong link between childhood trauma and adulthood psychosis (e.g. Varese et al., 2012), and intimate partner violence and depression (e.g. Devries 2013). It is also argued that social factors such as poverty and racism can be considered forms of trauma, and that trauma experiences are more common within ethnic minority and socially disadvantaged groups (Paradies 2006; Hatch & Dohrenwend 2007). This, coupled with evidence of iatrogenic harm in psychiatric services, has led to the development of trauma-informed approaches.

Despite growing international interest, trauma-informed approaches can seem fuzzy, complex, something that service providers already do, or a theorised call for practitioners to 'be nicer'. However, writing as trauma survivors and academics/clinician, the more we learn about trauma-informed approaches, the more we argue that these approaches have the potential to lead to a fundamental shift in how mental health services are organised and delivered, meaning that they are better able to meet the needs of service users. In this editorial, we will explore the central drivers for trauma-informed approaches, outline the key principles of the approach, discuss some common misconceptions and highlight some of the dangers associated with trauma-informed practices. We conclude by arguing for the need for survivor organisations to have a key role in shaping the agenda.

Key factors in the development of trauma-informed approaches

Research on adverse childhood experiences is a key driver of trauma-informed approaches. Instigated by Vincent Felitti in the US in the 1990s, the first Adverse Childhood Experiences study surveyed over 17,000 people and found that the more adverse events a person is exposed to in childhood, the greater the impact on physical and mental health and well-being, with poor outcomes including early death (Felitti et al., 1998; Anda et al., 2006; Anda, Butchart, Feletti & Brown, 2010). More recently, Public Health Wales found that nearly half of their population has experienced one adverse childhood experience, and one in seven has been experienced four or more (Ashton, Bellis & Hughes, 2016). These experiences were significantly related to negative outcomes, including having received mental health treatment (23 per cent of people without adverse experiences compared to 64 per cent of people with four or more adverse experiences) and having self-harmed or felt suicidal (6 per cent of people without adverse childhood experiences compared to 39 per cent of people with four or more such experiences). Similarly, a systematic review estimated that around half of mental health service users have experienced physical abuse, and more than one third have experienced sexual abuse (Mauritz, Goossens, Draijer & van Achterberg, 2013). Whilst these rates are not surprising from a biopsychosocial perspective, the rates of trauma and abuse experienced by people who go on to use mental health services is worthy of attention at a service development level. In the UK the NHS has outlined its strategic direction for working with victims of sexual abuse and emphasise the need for services to be trauma-informed, making explicit the links between trauma and mental health (NHS England, 2018).

A second driver of trauma-informed approaches is awareness of the iatrogenic harm built into the foundations of psychiatry. Psychiatric systems and practices are predicated on coercion and control (Harris and Fallot, 2001), whilst abuse of power often lies at the heart of traumatic experiences. Sandra Bloom has described the complex interactions that take place between service users, practitioners and organisations that can eventually come to mirror one another through 'parallel processes' (2006). These parallel processes can cause retraumatisation and prevent recovery:

> because of complex interactions between traumatized clients, stressed staff,
> pressured organizations, and a social and economic environment that is frequently
> hostile to the aims of recovery, our systems frequently recapitulate the very

experiences that have proven to be so toxic for the people we are supposed to treat (Bloom 2006).

Bloom argues that as well as proving toxic for survivors, parallel processes mean that trauma un-informed organisations are toxic for staff, many of whom will have lived through trauma experiences that are similar to those of service users. For instance, feeling unsafe in a trauma un-informed system can cause service users to become aggressive. This can in turn make staff feel unsafe, with organisations responding with authoritarian measures. The lack of control inherent to authoritarian operating procedures can increase survivors' sense of unsafety, increasing levels of fear and associated defensive behaviour such as aggression, and so the cycle continues.

Evidence for the (re)traumatising effects of mental health services include: increased use of coercion among black and minority ethnic groups (McKenzie & Bhui, 2007), the effects of restraint and seclusion in inpatient settings (Cusack, McAndrew, McKeown and Duxbury, 2018) and exposure of inpatients to violence, invalidation and disrespect (Robins, Sauvageot, Cusack, Suffoletta-Maierle & Frueh, 2005).

A third key driver has been the knowledge of many trauma survivors and their organisations. Beth Filson, a trauma survivor and trauma-informed educator, has written:

> "I knew that what I was experiencing made sense given what had taken place in my life. Even then I understood my reactions as sane responses to an insane world. I was told, *whatever else might be going on with you is not relevant – it's your mental illness that matters.* This drove me into a frenzy, for now *help* was just another perpetrator saying, *you liked it, you know you did; that wasn't so bad; it's for your own good*" (2016).

By recreating abuse through 'power over' relationships, services can revictimise service users, preventing recovery. This highlights the need for psychiatric services to *do the opposite* of trauma: from fear to safety, from control to empowerment, and from abuse of power to accountability and transparency (Concetta Perot, Survivors Voices, personal communication 2018).

Understanding trauma-informed approaches

Trauma-informed approaches are an organisational change process, focused on preventing (re)traumatisation within services. Key principles include (adapted from SAMSHA 2014; Sweeney et al., 2018; Elliott, Bjelajac, Fallot, Markoff & Read, 2005):

1) *Seeing through a trauma lens*, meaning that there is understanding and acknowledgment of the links between trauma and mental health.

2) *Adopting a broad definition of trauma extending beyond PTSD*, including recognising social trauma and the intersectionality of multiple traumas.

3) *Making trauma enquiries sensitively* and with knowledge about how to respond (Read, Hammersley & Rudegair, 2017).

4) *Referring people to evidence-based, trauma-specific support*, where indicated.

5) *Addressing vicarious trauma and retraumatisation* (e.g. through reduction in the use of control and restraint, Muskett, 2014).

6) *Prioritising trustworthiness and transparency* in communications, such as limiting the professionals a person has to repeat their traumatic history to.

7) *Moving towards collaborative relationships* and away from helper-helpee roles based on trust, collaboration, respect and hope.

8) *Adopting strengths based approaches* that reframe symptoms as coping adaptations, e.g. dissociation as an adaptive strategy to escape unbearable experiences.

9) *Prioritising emotional and physical safety* for service users and providers.

10) *Working in partnership with trauma survivors*, e.g. to design, deliver and evaluate services.

Many of these principles have strong overlap with other ways of implementing good practice, such as service user involvement, co-production, shared decision-making, and cultural and gender competence (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018).

Mis-understanding trauma-informed approaches
There are a number of misconceptions about trauma-informed approaches, and we outline some of the most common ones.

Misconception # 1 trauma-informed approaches claim that all mental health service users have experienced trauma

This is probably the most commonly held misconception. Whilst trauma-informed approaches are based on the knowledge that trauma is widespread and causal in the development of significant mental distress (Filson 2016; Sweeney, Clement, Filson & Kennedy, 2016), it is not seen as the cause of *all* mental distress. Instead, it is argued that whilst everyone is able to use services that are trauma-informed, and that these services could be considered gold standard, if services are not trauma-informed then trauma survivors – who by varying estimates make up the majority of mental health service users - will find it difficult to use them (Elliot et al., 2005).

Misconception # 2 trauma-informed approaches treat people who have experienced trauma

Trauma-informed approaches are distinct from trauma specific services. In the latter, the aim is to treat people experiencing the effects of trauma using, for example, CBT or EMDR. Conversely trauma-informed approaches are a whole-systems approach within which staff would be knowledgeable in referring on to trauma specific services, where this is wanted (Sweeney et al., 2016).

Misconception # 3 The shift from asking what's wrong with you, to considering what happened to you, is a literal one

This is intended as an orienting shift, rather than a literal one; it is not intended to suggest that everyone should always be asked what happened to them, or that no-one is currently asked their life history.

Misconception # 4 trauma-informed approaches are purely conceptual

It is sometimes assumed that trauma-informed approaches are primarily conceptual with fuzzy practice implications. However, trauma-informed approaches are an organisational change process operating at the whole systems level (Harris & Fallot, 2001).

Misconception # 5 trauma-informed approaches are implemented by individual practitioners

Whilst individual practitioners can implement trauma-informed practices even where they work in trauma-uninformed organisations (see Sweeney et al., 2018), trauma-informed approaches primarily operate at an organisational level (Harris & Fallot 2001).

Misconception # 6 This happens already

Perhaps the most damaging misconception is the belief that this is what practitioners do already. Whilst many practitioners do work in trauma-informed ways, and a number of organisations are implementing trauma-informed approaches, we know that within the UK for instance, people are often not equitably involved in decisions about their care (Russo, 2018) that Community Treatment Orders are used extensively, with a year on year increase of 10 per cent (Care Quality Commission 2014); that the use of restraint in inpatient settings is widespread, with adverse outcomes including risk of death (MIND 2013); and that people voluntarily on inpatient wards are subject to the same loss of autonomy as those under section (Sweeney et al., 2014).

Potential pitfalls

Although we are advocates of trauma-informed approaches, we are aware of the need to proceed with caution. In particular, trauma-informed approaches could be seen as trying to replace one dogma – a biomedical illness model - with another, relating to trauma-only explanations. Although the notion that all service users have experienced trauma is a misconception, there nonetheless remains some concern than an overly determined emphasis on the relationship between trauma and mental health could position service-users primarily as victims, limiting our access to other, less vulnerable identities. In an age where victimhood is an increasingly important signifier for access to social validation and resources (Fassin & Rechtman, 2007), trauma-informed approaches must enable mental health service users to develop our own narratives, rather than imposing one-size fits all explanations.

The development of trauma-informed approaches is underpinned by neuroscience (van der Kolk, Roth, Pelcovitz, Sunday & Spinaazzola, 2005). This is a relatively new and contested area, and for many, can create a sense that trauma-informed approaches are a new way of

medicalising human responses to traumatic events (Wastell and White, 2017). For instance, it has been argued that epigenetics recreates dominant brain disease paradigms by reducing psychosocial influences to "subsidiary, modifying or mediating" (Cromby, Chung, Papaopoulos & Talbot, 2016).

There is an inevitable risk of co-option: that trauma-informed approaches will come to mean little more than treatment as usual repackaged as trauma-informed. Like the recovery movement (Harper & Speed, 2013), the reforming agenda of trauma-informed approaches and the need for a realignment of knowledge base, power and responsibility could become co-opted, diluted and misrepresented. Given the centrality of trust in working with trauma, transparency is crucial and rebranding of services needs to be accompanied by real systemic change.

In attempting to do differently, trauma-informed approaches have the task of providing reparative healthcare in times of economic austerity, responsibilisation and time-limited treatments (Spandler, 2016). The responsiveness and patient control in trauma-informed approaches requires negotiated and flexible service design which at the same time cannot equate to limitless care.

Any development of trauma-informed approaches must include a social justice component, as 'trauma' can be considered both a psychiatric category, and a complex set of social discourses that transcend psychiatry while emerging from it. This has developed through what has been referred to as 'looping effects' (Hacking, 1995), whereby trauma was originally a psychiatric category but by entering into public discourse not only described human experience but also influenced how people saw themselves, i.e. trauma-survivor became an identity marker in addition to a psychiatric description. 'Trauma' as a category therefore has political and social implications as well as psychiatric ones, and mental health services not only need to change their practices, but to engage with communities where trauma occurs and groups identifying as trauma-survivors.

In spite of the statutory requirement to ask about experiences of trauma and abuse, reported rates of asking are low (Xiao, Gavrilidis, Lee & Kulkarni 2016). It may be that service managers struggle to talk about and manage trauma, with a corresponding anxiety in staff that asking about difficult, distressing and dangerous events may overwhelm both them and service users. Given that health and social care professionals have experienced higher rates of trauma than the general population (Esaki & Larkin, 2013), and that service providers experience vicarious

trauma (Sage, Brooks & Greenberg 2017), there is a challenge to negotiate complex interpersonal dynamics arising from trauma histories. Reflexive, open practice demands much of clinicians meaning that support, training, supervision (e.g. Hummer, Dollard, Robst & Armstrong, 2010), and leadership (e.g. Ashcraft and Anthony, 2008) are needed.

Final word

As well as providing peer support based on shared experiences around the impacts of trauma, grassroots organisations such as Survivors' Voices and Survivors' Collective educate service providers and others about the specific needs of trauma survivors and the dangers of iatrogenic harm. Moving forward, there is a need to place survivor knowledge at the heart of the development and implementation of trauma-informed approaches. This is because it is survivors who understand, through lived experience, what heals and what harms; and the importance of reversing 'power over' abuses. Given the centrality of trust and empowerment to healing for trauma survivors, it is vital that grassroots survivor organisations shape research and service development agenda in this area.

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