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What researching the benefits system has taught us about being trauma informed when people encounter traumatising systems

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When considering how people experience and communicate their psychological difficulties, it is well recognised that clinical psychologists should consider the broader historical, cultural, systemic, organisational, and societal influences. Interactions with social security systems have the potential to be predisposing (Wickham et al., 2020), precipitating (Dwyer et al., 2020) perpetuating (Machin & McCormack, 2021) and even protective (Simpson et al., 2021) factors for people experiencing mental health problems which makes knowledge of the system of great relevance to applied psychologists. Many people claiming disability benefits for mental health problems in the UK report that the process is complex and can trigger feelings of powerlessness, threat, shame, humiliation, stigma and for some can be re-traumatising (McGrath et al., 2015; Ploetner et al., 2019). These interactions with the benefits system signal deeper intersectionalities of disability, poverty, culture, and identity and have profound implications for how clinical psychologists engage with and support people with experiences of claiming disability benefits.

In Scotland, all public service workers including mental health professionals are expected to deliver trauma informed care (The Scottish Government, 2021). While we acknowledge trauma informed care is not an uncontested concept (Birnbaum, 2019), with the benefits system being potentially both traumatising and re-traumatising it appears pertinent to consider how psychologists can support people they work with in a trauma informed way. Harris and Fallot (Harris & Fallot, 2001) propose that five main principles underpin trauma informed care: safety, trustworthiness, collaboration, choice and empowerment. Safety is constructed as being both physical and psychological. Trustworthiness relates to transparency and consistency. Choice offers individuals control and personal agency, important in the context of trauma where individuals have previously felt they had no autonomy. Collaboration aims to re-address the inherent power imbalances that often exist within services and emphasises the importance for clients to be actively involved in their care. Empowerment offers a strengths-based approach within a validating environment where people's experiences can be communicated and understood.

We are a group of psychologists in the West of Scotland who aim to do research that expands understanding of psychological, social, and interpersonal mechanisms underpinning distress, which means taking a focus on the complex systems in which people reside. Our loose collective is underpinned by a belief that lived experience membership in our group is essential because we want to do research that is useful for people living with psychosis and other complex mental health problems. We will consider key findings from the following three empirical studies:

- 1) A DClinPsy doctoral thesis exploring people's experiences of claiming Personal Independent Payment for Post-Traumatic Stress Disorder.[SS-CP1] (Roberts et al., 2021)
- 2) A book exploring people with mental health problems experiences of sanctions (Jamieson, 2020)
- 3) A participatory social welfare study (Ploetner et al., 2019)

through this trauma informed care framework. In this paper we will reflect on the research exploring people's experiences of the benefits system and consider the implications of these experiences for trauma informed clinical psychology training and practice. Specifically for practice, we identify how the benefits system may block each section and consider how psychologists can resist (or at least negotiate) the impacts of these in everyday clinical practice.

Safety

Common from the research findings was the sense that claimants feel they are unsafe. Claimants felt that the DWP had constant and unboundaried access to their lives, which came with the ability to inflict harm, and lived with a sense of dread and threat because of this. For example, many people spoke about a fear of finding a surprise "brown envelope" which could mean being summoned to a medical and losing benefits. Others described the impact of being sanctioned:

"It's fucking frightening man... my mental health was rock-bottom. I mean, I've been in children's homes, young offenders, rehabs, detox, you name it man, I've not missed it! For them to go like that, right, boom! Sanctioned, man. You're like that to yourself, 'Right, where do I go from here?' Where do I go from here?" (Jamieson, 2020, p.38)

Claimants accessing ESA worried that they would kill themselves if found fit for work. In keeping with this, a recent report by the BBC found 35 people with mental health vulnerabilities have died after the termination of their benefits (BBC, 2021). Claimants reported that this constant stress had a cumulative negative effect on how they managed their wellbeing. Some went as far as to describe that it felt like being on trial. Assessors can ask questions about self-harm and suicide in a way that is traumatising, i.e "why haven't you killed yourself yet?" and asking to see self-harm wounds/scars (Bloom, 2018) or asked invasive questions such as how often they changed their underwear (Hutcheon, 2021). Believing and validating the impact of people's negative experiences of claiming benefits could go some way to making people feel understood and sow the seeds of psychological safety. For both trainees and experienced clinicians alike, these findings suggest a real need to educate about the realities of the benefits system and to consider what blind spots we may hold when trying to hold a space that feels safe for claimants. Clinical psychology educators should consider specific teaching on the benefits system and include lived experience involvement in curriculum development. When working clinically, this sense of threat demands psychologists always consider the broader context of how this feeling of being watched can perpetuate behaviours we may observe such as people being afraid and avoiding doing valued activities like volunteering/engaging in hobbies which can then perpetuate continued psychological distress, loneliness, marginalisation, and isolation.

Additionally, avoidance likely extends to areas which impact psychological research and development such as participants taking part in clinical research or patient and public involvement groups. While surveillance has been written about extensively here in relation to the benefits system, it is important to highlight that surveillance and always being accessible to threat is a feature of other systems such as the asylum-seeking process. Being trained in formulation means psychologists have a skillset to ensure what clients describe as material is not dismissed as psychological but a reflection of the broader political and societal context of living in poverty (Ahmed, 2017). Clinicians who do not know much about the benefits system and its impact on the people we work with may become uncertain and anxious themselves when working with people encountering adversity. Therapist anxiety is linked with increased likelihood of therapist drift with anxious clinicians even going as far as to decrease key therapeutic processes such as exposure for clients - reducing client access to the best evidence-based treatments (Waller & Turner, 2016). Education about the benefits system may even reduce uncertainty and empower clinicians to do their best work.

Trustworthiness

The social security system can act as a block to trust. Throughout the studies, claimants frequently spoke about feeling disbelieved by assessors during their medical and felt that their mental health problems were not taken seriously, dismissed and minimised. However, another key theme was that claimants could be mistrustful of other claimants believing them to be not genuine.

“The press with benefit scammers going on holiday, blah blah ... the wrong type of people have been claiming it, but they make it worse for the majority who are genuine” (Ploetner et al., 2019, p.15)

Narratives about benefit claimants being fraudulent are widespread in society and public stigma towards claimants is common (Baumberg et al., 2012). While benefit fraud happens, it is rare (Department of Work and Pensions, 2021) and the focus on ‘fraudulent’ behaviour has been encouraged in the media for many years in such a way that it seems to have entered into the public consciousness (Jamieson, 2020). The extent to which participants spoke about their suspicion of other claimants warranted comment. Coming at this belief from a psychological lens, claimants distrusting each other may give credence to the role of shame and stigma in claiming benefits. The blaming model of stigma proposes that people with stigmatised identities (Saeed et al., 2020) use defence mechanisms such as splitting to reduce anxiety associated with having that stigmatised identity. The negative views expressed towards “other” fraudulent claimants in opposition to the claimant describing themselves being genuine may function through this process. Psychologists working with claimants should be aware of the potential for claimants to internalise societal stigma, be curious about where the person’s response has come from, consider the ways in which this may intersect with how clients understand their own identity and could even act as an isolating block to accessing peer support from other claimants. When working with people, psychologists likely have power to affirm or debase stigmatised identities by rejecting or upholding mainstream discourses about claimants and communicate this with clients through their words and actions.

Collaboration

All three pieces of research foregrounded the importance of claimants feeling that they needed support in the system, often with practicalities such as completing forms. As a group, we reflected that this could sometimes sit awkwardly within clinical practice where there might be concerns about whether providing evidence to support a client's claim was a role for a clinical psychologist. Additionally, because DWP forms are typically focused on what people cannot do or struggle with and foreground clinical diagnoses as explanations for problems (Syrett, 2018) it may feel opposed to how psychologists are used to working with and writing about clients. However, supporting claimants on their journey and providing evidence in the form of supporting letters means collaborating with a claimant towards a shared goal. Furthermore, poverty can mean people struggle to attend appointments both in person and online. Previous research has indicated the importance of welfare rights staff supporting claimants and being dependable as a factor associated with lowering stress in claimants, even if the welfare rights staff could not resolve their issues (Mustafa et al., 2020). Clinical psychologists encountering people on their journey in the mental health service can play an important role in normalising people's difficult experiences and validating their emotional reactions in the context of a bounded and dependable therapeutic relationship.

Choice

As opposed to choice, our research suggests people claiming benefits for mental health problems frequently described feeling that they often had no choice within the benefits system and had to endure rigid bureaucracy. People claiming benefits also are made to answer questions in a structured format and may not ever get to set an agenda for what is spoken about in terms of their experiences and problems. Where possible, psychologists should offer choices in how and when people engage with appointments. Writing letters to support claimants can be done in a manner which is trauma informed by collaborating in a way wherein the claimant is able to control what is shared about them. Transparency can be offered by co-writing or at least sharing letter content if a person wishes to see it. Additionally, when writing letters more generally about clients that we work with, it is important to be mindful that even everyday clinical letters may be seen by the DWP and an awareness of this should be embedded when trainees are taught how to write up clinical encounters in a way which both empowers and honours the experiences of individuals that psychologists work with.

Empowerment

“the fact that I've got to get my psychologist to give proof, it's quite crap... like I've got to get evidence from a higher up person that you're speaking to” (Roberts et al., 2021, p.84)

Claimants reported that having decisions made about their disability by strangers both during assessments and later by anonymous decision makers made them feel powerless. Clinical psychologists should take care to not replicate disempowering dynamics. While our results spell out a useful role for psychologists in supporting claimants by providing evidence in the

form of letters, some claimants reported that it felt inherently disempowering that the DWP system needed the words of a clinician to validate their struggles. While some claimants reported valuing access to a clinician whose professional testimony would give their case credibility, it seems the case that mental health professionals should be aware that they usually hold more power than the claimant to define what problems they have in the eyes of disability benefit services. When supporting claimants, psychologists could emphasise that the client is ultimately the expert in their life and while psychologists can bring certain expertise about mental health problems and clinical letter writing, this in no way dismisses or invalidates how someone understands their own experience. Ultimately, clinical psychologists have a potential opportunity to support claimants and can empower someone that is in an incredibly disempowering position.

Summary

In conclusion, the purpose of this paper was to consider a slice of the findings from a programme of research exploring the psychological consequences of claiming benefits for people with mental health problems through a lens of trauma informed care. Psychologists should be aware of the potential for being impacted from the work they do when supporting claimants in such a challenging system and continue to make use of ongoing and regular supervision and practice self-care (Karatzias & Buxton, 2016). Systemic problems usually require systematic change, and we cannot do it all alone. Not all psychologists wish to be active on social issues, but those who do they may also consider becoming involved in groups such as Psychologists for Social Change to find community with others, access social support and resist oppressive systems. In the interests of space, we have not described specific benefits in detail and have assumed some prior knowledge on topics such as sanctions, if this is new to you - we recommend reading organisations such as Child Poverty Action Group for more information (Child Poverty Action Group, n.d.).

We end with some small yet powerful ways in which psychologists can empower the people we work with to access benefits to which they are entitled for mental health problems:

- 1) Offer to write supporting evidence to access benefits or challenge sanctions
- 2) Read service user led writing: <https://recoveryinthebin.org/> or <https://deargp.home.blog/>
- 3) Consume mainstream benefit claimant coverage critically
- 4) Read guides on how best to write supporting letters: <https://asylummagazine.org/2018/08/supporting-claimants-a-practical-guide-by-jay-watts>
- 5) Collaborate with service users in delivering teaching about the benefits system
- 6) Conduct research on this topic which includes people who have experienced the benefits system in positions of influence and leadership during the research process.
- 7) Discuss poverty and how it intersects with other identities such as race, gender and migrant status within any Equality, Diversity and Inclusion (EDI) work that you do. We conclude with providing an example below of how this has been implemented by some of our group in Glasgow.

Implementing EDI in routine practice – a case example

We (Dr Vik Nair and Dr Moya Clancy, Clinical Psychologists) developed an EDI reflective group for research assistants involved in the Glasgow site of the AVATAR2 (Garety et al., 2021) clinical trial. AVATAR2 participants (individuals with a diagnosis of psychosis), are often from marginalised ethnic and socioeconomic groups and experience higher levels of stigma – with many claiming benefits and likely familiar with the issues highlighted in this paper so far. Empowerment is central to the AVATAR2 trial, and we soon recognised that issues of culture, diversity, accessibility were crucial considerations in our interactions with participants. EDI is currently being incorporated into the delivery of trial and therapy across the AVATAR2 trial. We hoped that a space to reflect on these issues would benefit the work we are doing so we decided to meet once every three weeks for an hour and a half over Microsoft Teams.

Having had no previous experience of setting up such a group, we aimed to apply Harris and Falloot's (2001) principles of safety, trustworthiness, collaboration, choice, and empowerment throughout. This provided us with a theoretical framework for trauma-informed practice across settings and imparted a common language for speaking about EDI issues. To establish safety and trust, we spent time in initial sessions establishing group boundaries, clarifying processes and expectations for the group. To facilitate discussions of EDI related topics, we discussed our understandings of power means, blending our own individual reflections along with existing avenues of thought. We discussed Smail's definition of power (Smail, 2005), incorporating notions of subjective experience along with behavioural and social understandings of power as regulation mechanisms for humans living in hierarchical social structures (Gilbert, 2001; Leary & Baumeister, 2000). Following this, we discussed the idea that features of identity frequently have implications for individuals' status, such that many participants perceive themselves as being less worthy than others, despite the aspirations set out in the Equality Act (*Equality Act*, 2010).

We encourage group members to discuss ideas related to these topics, inviting dissent while acknowledging that this can be hard to voice even within a nominally 'safe space'. To embody choice, members bring discussion topics of their own, and raise issues arising out of their contact with either trial participants or previous life experience. We facilitate discussion and often share our own professional reflections to encourage broader formulation or discussion about how we operate in the various, and the roles we and others potentially play. We hope that providing this space for consideration of the inequalities facing the people with whom we are working will help research assistants to improve understanding and empathy for participants and represent participant experiences more faithfully and accurately. We hope that this space allows us all to reflect on, acknowledge and consider the impact of our biases, power, and assumptions and to minimise the impact these have on our work. While the example provided here speaks to providing training and support for junior psychology staff, for senior staff working in clinical settings an aim could be to help our clients by better understanding their needs and how to offer help. While this is largely uncharted territory in clinical trials, we believe that this is a worthwhile and meaningful venture that adds to the value of the work we are doing and its possible impact on people's lives.

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