Adversity and Trauma-Informed Practice

A short guide for professionals working on the frontline

by Rebecca Brennan, Dr Marc Bush and David Trickey, with Charlotte Levene and Joanna Watson.

YOUNGMiNDS

Anna Freud National Centre for Children and Families

Body & Soul
transforming trauma with love

Summary

This is a short guide for professionals working on the frontline.

- Adverse Childhood Experiences are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence.
- Adversity and trauma can have a long-lasting impact on young people's mental health and their relationships with other people in their lives.
- We should see people's reactions and responses to adverse and traumatic events as attempts to survive and make meaning in their lives.
- Not all young people who face childhood adversity go on to develop trauma-related symptoms, or wider mental health problems.
- These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.
- Young people make these adaptations in an attempt to; survive in their immediate environment, find ways of mitigating or tolerating the distress they are facing by using the resources available to them, establish a sense of safety or control, or to make sense of the experiences they have had.
- Relationships really do matter, and every contact with someone who has experienced adversity and trauma can be an opportunity for healing and growth.
- As professionals, we need to become adversity and trauma-informed, and this Guide gives examples of how to put this into practice, and how to take care of ourselves as well as those we work with.

Contents

Section 1: What is childhood adversity and trauma?

We all face emotionally challenging situations during our childhood and adolescence. For some people the environments they grow up in, the people they relate to, and the experiences they have are adverse, and have a potentially traumatic and lifelong impact on their development, physical and mental health, and ultimately their way of life.

Adverse Childhood Experiences (ACEs) are defined as highly stressful events or situations that occur during childhood and/or adolescence. It can be a single event or incident, or prolonged threats to a child or young person's safety, security or bodily integrity. These experiences require significant social, emotional, neurobiological, psychological and behavioural adaptations to survive.

We can best understand these adaptations to be people's attempts to;

- survive in their immediate environment,
- find ways of mitigating or tolerating the adversity, by using the resources available to them,
- establish a sense of safety or control,
- make sense of the experiences they have had.

ACEs are more common than you might think. Almost half of all adults living in the UK have experienced at least one form of adversity in their childhood or adolescence.[i]

This broadly reflects the picture of childhood adversity in other developed countries.[ii] A wide range of experiences can be described as adverse, including:

- **Maltreatment:** including physical, sexual, emotional and financial abuse and neglect.

- **Violence and coercion:** including experiencing, or directly witnessing, domestic abuse, assault, harassment or violence, sexual exploitation, sexually harmful behaviour, being the victim of crime or terrorism, experience of armed conflict, gang or cult membership and bullying.

- **Inhuman treatment:** including torture, forcible imprisonment, confinement or institutionalisation, non-consensual and coercive scaring and genital mutilation.

- **Household or family adversity:** including living in a household with adults or adolescents who misuse substances, engage in

criminal activities, are not supported to manage their mental ill health, making sense of intergenerational trauma (such as experiences of genocide). This includes living in poverty, destitution or facing significant social, material and emotional deprivation. It also includes being looked-after, leaving care, being detained in a secure children's service (i.e. young offenders institution) and family or placement breakdown.

- **Adjustment:** including moving to a new area where there are no social bonds, migrating, seeking and gaining refuge or asylum and the ending of a socially significant, or emotionally important relationship.

- **Adult responsibilities:** including being the primary carer of adults or siblings in the family, taking on financial responsibility for adults in the household and engaging in child labour.

- **Bereavement and survivorship:** including death of care-giver or sibling (including through suicide or homicide), miscarriage, acquiring or surviving an illness or injury and surviving a natural disaster, terrorism or accident.

- **Prejudice:** discrimination, victimisation, hate incidents and crime, other attitudes, chronic exposure to behaviours and institutional processes driven by LGBT+ prejudice, sexism, racism or disablism.

In reality, there are significant overlaps in people's experiences of these adversities. For example, a study from England suggests that 16% of adults experience two or three ACEs, and almost 1 in 10 experience four or more.[iii] This means that many children experience the cumulative impact from different forms of ACEs on their health and wellbeing outcomes in adolescence and adulthood.[iv]

The terms 'adversity' and 'trauma' are often interchangeably used by professionals. There are differences, however, between the two. Whilst adversity describes the situation and experience that a person has, trauma refers more commonly to the impact it has on their mental health.

Experiences of adversity can result in a number of different forms of emotional distress and mental health conditions, some of which are specifically related to traumatic-stress (usually involving a diagnosis of Post-Traumatic Stress Disorder). A recent study found that almost a third of young people are exposed to trauma by the age of 18 years.[v] Around 16% of children and young people exposed to these experiences, go on to develop Post-traumatic Stress Disorder (PTSD).[vi] International studies indicate that this might be a conservative estimate, with many finding between 56-68% of young people experiencing trauma.[vii]

Not all of the mental health impacts and consequences will meet a diagnostic threshold for PTSD. Therefore, as professionals, we need to be well attuned and sensitive to presenting patterns of behaviour, relationships or thought that might indicate an emerging trauma-related response and the presence of a current, or historic, adversity.

Section 2: What is the impact on young people's lives?

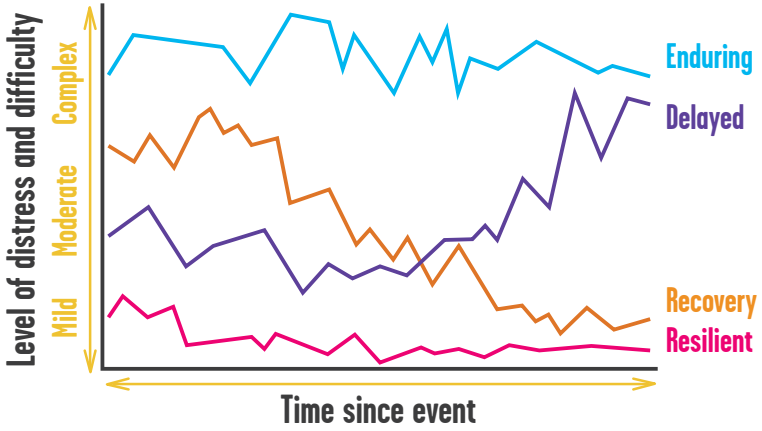
It is important to remember that young people can respond differently to different events. Their reactions and responses may change and develop over time. In very broad terms, we can think about these reactions as taking one of four paths, or what we might call trajectories. These four paths are:

Resilient: little impact on the person's level of distress or ability to cope with the situation - either immediately after the event(s), or later on.

Recovery: initially the person may be very distressed, and really struggle to cope. Over time this decreases, and they begin to manage again.

Delayed: at first there may be little obvious impact of the events, but at a later stage difficulties and distress begin to develop.

Enduring: people experience difficulties and distress during, or soon after, the events and they remain.



Source: adapted from Bonanno, 2004.[viii]

To help us understand people's reactions and responses to adverse and traumatic events, we can think about three Ms: **memory, meaning and maintenance.**

i. Memory

Memories of traumatic experiences tend to be stored in a different way to other memories. When we experience something traumatic, we retain all the different components that made up the actual experience. This includes the sights, sounds, smells, tastes, touches, sensations, feelings, and thoughts we had at the time, or afterwards. For other memories, we might retain some of these components, but we also have lots of words and stories that make up the memories of non-traumatic events.

The difference between everyday and traumatic memories explains why memories of trauma feel so volatile and vivid. A memory, or a component of that memory, might intrude into our consciousness, which brings with it the original emotions and sensations we experienced. These might include the bodily tightening of fear, the breathlessness of terror, the shaking of horror, and the numbing of helplessness.

The memory may be so vivid and immersive that it takes the form of a flashback where the person loses touch with the here and now and feels that they are re-experiencing the actual event rather than simply recalling a memory. The memories may also intrude into the person's dreams in the form of nightmares, or spill over into the person's life in other ways. Children may re-enact the events, or themes of the event in their play, young people may re-enact aspects of past relational traumatic events in current relationships.

ii. Meaning

Generally, we have certain expectations and beliefs about the world, ourselves, and other people. Traumatic events can fundamentally shatter our beliefs, which can have lasting consequences on our lives. The catastrophic "message" we take from trauma is that it takes precedence over all of our other experiences. As such, it begins to define how we understand our world and the people within it. If we feel worthless, or that things are hopeless, because of the trauma we have faced, we might also begin to feel depressed and isolate ourselves from those around us. This can include those we care about, and those who might care about us, and what we have gone through.

In essence, **we start seeing our world through trauma-tinted glasses**. For example, after an assault, we might begin to believe that we are very vulnerable, that everywhere is dangerous, and that everyone is violent. If you believe that you are in danger, it makes sense that you might end up being on edge all of the time.

We know that traumatised children and young people tend to have higher levels of physiological arousal. Therefore, they may struggle to sleep, they may be more jumpy, or they may lose their temper more easily than their peers. They might also find it difficult to pay attention to those things other people think are important (such as lessons in the classroom) because they are too busy paying attention to things that could be potential threats, such as a noise outside or someone at the window.

The way young people make meaning out of their adversity or trauma can become a focus of support they receive later in adulthood and over the rest of their lives. Some talking therapies actively focus on challenging and un-doing distorted meanings that people have attached to these experiences, the long-held beliefs or narratives about who they are, and what they have done. This can particularly be the case for those young people who feel they were bystanders and/or perpetrators within a cycle of violence.

iii. Maintenance

Intrusive memories and sensations can be very frightening, unpleasant and overwhelming. Therefore, many young people make a lot of effort to avoid thinking about the traumatic experiences they have had. However, the very act of trying NOT to remember can trigger the memory.

Some people get so upset or distressed, that they avoid talking to other people about what happened or asking for help or support. They might even try to avoid external cues that trigger the memory (e.g. interacting with people in authority), and therefore take steps to avoid triggers (i.e. not turning up to school or avoiding being in close physical proximity to others).

Avoidance can further complicate the distress and difficulty that young people are already facing. If they think that the experience was their fault in some way, this can provoke feelings of shame, guilt, disgust, confusion or significant distress. These thoughts and feelings might be so distressing in themselves that people may again try not to think about what happened. As a result, they can deny themselves the opportunity to better understand the experience and recalibrate the responsibility for the event. This avoidance is completely reasonable; however it tends to add to the complexity in coping with and making sense of adverse and traumatic experiences.

Section 3: How can we spot the signs of trauma?

Adversity and trauma can contribute to the way we think, feel and act. These may be expressed in very different ways according to who we are. **Sometimes the links between the original experiences and the expressed difficulty may not always be obvious.** The relationships between how people express their distress and the trauma they have experienced can elude both the individual concerned, and the people around them. That is why, as practitioners, we need to keep an open lens on the adaptive behaviours we encounter from the people we work with.

People frequently describe a fight-or-flight response when they experience or re-experience trauma. These are some of the instinctive, survival responses that can be activated when we perceive a threat in our environment. In a state of fight, our body prepares to confront and fight the threat directly. This might include throwing an object at someone who we perceive as threatening, before they have a chance to attack us. In a flight responses, we may attempt to get as far away from the threat as we can, this could include running away from a confrontation.

In addition to these, we can also experience a freeze response, where we try to stay as still as possible, hoping that the threatening person would not see or recognise us, and will pass by. Alternatively, we might experience a fold response, where we seem as if we have surrendered to the threat, however in reality we are trying to minimise the impact on our body and mind by (for example) numbing ourselves to the pain and distress we are experiencing.

It is not possible to list every single way that the distress can be expressed, so below we have described some of the more common ones:

Intrusive memories: as we said earlier, memories for traumatic events are more volatile, more vivid, and can be easily triggered. Our bodies also remember traumatic experiences, and we can find ourselves fighting, fleeing, freezing or folding without being aware of the reason. Intrusive memories can emerge at any point, and they also appear in the themes or characters in our dreams, thoughts and play.

> A young woman walks past someone who is wearing aftershave. The scent is so faint that they are not consciously aware of it. It is just similar enough to the aftershave worn by someone who abused her when she was younger. The abuser was a friend of her parents. She finds that memories of the abuse are triggered and come flooding back into her mind and body. These memories are vivid and overwhelming, and yet she does not realise that the scent of this stranger was responsible for triggering the memories.

> A seven year-old boy witnessed domestic violence that led to his father killing his mother. Rather than re-enact the actual event, increasingly he introduces escalating violence between human and non-human characters in his fantasy play with his peers.

Avoidance: people may actively attempt to avoid anything that could even faintly be connected to the traumatic experiences they have had. They do this in order to try to avoid the memory being triggered, or events repeating themselves. They may avoid people that remind them of the events, conversations about their past, places and situations that bear any resemblance to the events. This avoidance can end up depriving people of mutual and loving connections and progressing in their day-to-day lives.

> A young man was severely bullied, and then assaulted, outside his college because of his learning disability. The college have agreed to meet with him, his family and the police to talk about what has happened and see how to keep him safe and thriving in his studies. The young man has not turned up for three scheduled meetings at the college and has stopped responding

to emails from his course tutor. He is increasingly angry with his parents and turns down offers from his friends to go to the local cinema. His father saw him leave the house earlier in the week only to come straight back in when he spotted a group of three young women laughing across the street.

Hyperarousal: experiencing trauma can leave us with the beliefs that we are vulnerable or powerless. Further, we start to perceive the world as dangerous, and other people as potential threats. This means that we can spend much more of our time on a higher level of alert than most people experience. Even at rest, there is a higher level of physiological arousal, so the body and mind are 'ready for action'. People can appear as if they find it difficult to concentrate and pay attention. In reality, they are probably very good at paying attention to things that could be potential threats, but this is at the expense of paying attention to things that do not pose an obvious threat.

A twelve year-old girl who had experienced years of physical abuse from her parents, would sit in lessons and was very good at paying attention to things that were potential threats. She would intensely watch the people outside the window, the person walking down the corridor, and her peers whispering in the seats behind her. In contrast, the teacher (who was talking about quadratic equations) was not seen to be a threat, and therefore she did not think she needed to prioritise paying attention to her teacher.

The teacher noticed the girl paying attention to everything apart from the content of the lesson. This frustrated him, he raised his voice, he spoke to her quite harshly, and he walked towards her. The girl has started with a heightened state of arousal. She saw an angry adult male, shouting and walking towards her. This triggered her stress response and she lashed out at the teacher. This event sparked a reaction by the school, which meant that all her teachers started to pay particular attention to her, which in turn increased the pressure that she felt and this meant that she found it even harder to pay attention to the content of lessons, and lashed out more frequently.

Eventually she was referred to a mental health specialist who diagnosed her with Attention Deficit Hyperactivity Disorder (ADHD) and prescribed her medication. Her particular ability for paying attention to possible threats in her environment, rather than content of lessons, was misunderstood as an inability to pay attention. Likewise, her hyperarousal was misunderstood as hyperactivity and conduct difficulties. This misunderstanding resulted in her receiving the wrong intervention, which was of course ineffective and meant that she took stimulant medication for no reason.

Depression and low self-esteem: If we interpret traumatic events as meaning we are worthless, powerless or useless, we might start to withdraw, and become increasingly isolated from the world around us. The less we do, the more our beliefs about ourselves are confirmed. If we think that no one values or likes us, we are less likely to bother to interact with other people. By isolating ourselves from others we start to lack any other evidence that could contradict these beliefs. The signs of low self-esteem and depression can sometimes be difficult to spot as the person may keep their thoughts to themselves, but there may be some clues in what they do and say.

A fifteen-year-old young man has been caring for his ill father, and he is an only child. Every weekend he used to play in a five-a-side football team. He had to take two weeks off as his father had more surgery and needed a bit more support around the house. The young man does not have a good relationship with his father and blames his alcoholism for driving his mother away from the family home when he was younger.

During the two weeks after the surgery, the young man spends very little time with his peers, and apart from spending time at school takes responsibility for the shopping, cooking, cleaning and some personal care for his father. His father showed no understanding for the young man's want to spend time with his friends and he verbally attacked his son for neglecting him and even suggesting he'd play football.

After two weeks the young man goes to play a match but feels out of the loop as he's missed two weeks, his technique lets him down (he feels out of practice), and he lets the winning goal go through his defences. This attracts scorn from a couple of his peers. He concludes that his dad was right, and that he is neglecting him by playing football, and he is letting the team down by not practicing. The coach tries to cheer him up, but the young man takes him to one side and says he wanted to tell him that with all his homework and exams coming up he cannot commit to being part of the team. The coach seems supportive and accepts his resignation from the team, but the young man feels he is being punished in some way.

Dissociation: some children and young people react to events with what seems like the opposite to hyperarousal. Rather than being hyper-aware of everything that is going on around them, they may seem to block off thoughts, feelings or memories. They may feel disconnected from their surroundings or even from their own bodies. Sometimes this can be difficult to spot in children because there may be no obvious signs on the outside of what is happening inside their minds and bodies. They may feel as if they are living in a dream, or feel a sense of unreality. This is likely to affect their ability to learn and their ability to interact with others. To others, it may look as if someone is just daydreaming. But unlike daydreaming, dissociation is an automatic process in response to stress and involves an altered sense of perception. These sorts of reactions are sometimes referred to as derealisation (feeling as if things are not real) or depersonalisation (experiencing your own thoughts and feelings as if they don't belong to yourself).

An eleven-year-old girl's mother had died a year ago in a skiing accident, when the family were on holiday. She now lives with her father and maternal grandmother who moved in after the accident. The girl talks to her friends at Girlguides about being an ice queen and insists (during play) that her toes have frozen off.

Over the next few weeks she comes home from school with lots of bruises and scratches over her knees and arms. Her grandmother asks her what has happened and she replies flatly that her toes have fallen off. Her grandmother inspects her toes and sees they are all there and that they feel warm. Whilst out shopping that weekend the girl falls over many times, always tripping over her left foot.

Her grandmother takes her to the GP to see if anything is wrong. The doctor does a series of physical tests and can't see anything immediately wrong with the foot or the toes. The girl maintains that her foot is freezing cold, and that she has no toes.

The GP tries a different approach, she holds the girl's big toe, and moves it for her. The GP asks if she can feel it, and the girl looks confused. The GP asks her to reach down and hold her own toes and squeeze them. The girl does and then seems frozen, she looks up at the GP and cries loudly. Her grandmother leaps out of the chair and tries to comfort her by giving her a hug and stroking her hair.

Anxiety: Some children become very anxious after certain events and experiencing adversity and trauma can heighten these feelings of insecurity and lack of control. Some people develop new fears that they did not have before, and others find that they constantly feel anxious about everything in their life. In the face of adversity, some children and young people latch onto behaviours or beliefs that give them a sense of control. They may start to repeat certain

behaviours again and again and might ascribe magical beliefs to these behaviours (i.e. having to turn a lock four times to keep themselves safe). This gives them the illusion of having some control, which might in the short term be quite reassuring. But they may then start to feel anxious if they do not perform the particular behaviour and this then becomes a compulsion. This may be particularly true if children believe that they are in some way responsible for the events. They may think that if only they had done something different the bad things would not have happened. They then start to do various things in the hope that it will prevent any more bad things happening. Some people may not be conscious of why they are repeating this behaviour, and they may not make a connection between the traumatic event, and the need to behave in certain ways. They just know that the behaviours give them more sense of control and that ceasing to do them may result in something catastrophic.

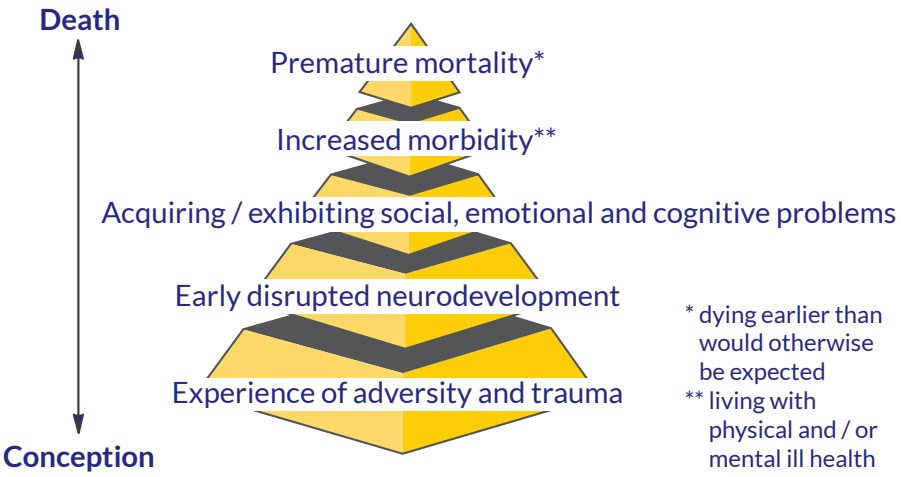
A twenty-year-old man was sexually abused by one of his parent's friends when he was a child. He starts his day by getting out of bed, opening the window, folding and refolding his bed sheets. He believes he has to do this three times, the first time to release the negative energy he experienced in his dreams, the second time to trap in the positive energy flowing in the fresh air coming through the window, and the final time to ensure that no one can reverse the first two steps whilst he is at work. He makes himself breakfast and has half a cup of fresh coffee; he takes the second half in a flask. He only drinks the first half before catching the bus to work, in order to avoid needing the toilet before he arrives. The first thing he does when he arrives is go to the toilet, and then return to his desk to open his computer and drink the second half of the coffee.

Section 4: What is the impact of adversity throughout the life-course?

Without timely and effective support, children who experience adversity can become adolescents and adults living with the social, emotional and health consequences of trauma.

Disruptions to the development of social and emotional skills and relationships can continue throughout someone's life, and ultimately lead to enduring isolation and distrust of the world. For some, this can lead to continued adversity (i.e. remaining in or seeking out abusive relationships), deeply negative ideas about who they are, and how they treat other people.[ix]

International research and studies from across the UK show there is a strong relationship between experiencing adversity and trauma in childhood, and poor social and health outcomes in adolescence, adulthood and later life.[x] For example, the chronic activation of the sympathetic nervous system can increase the risk of major physical illness like heart disease, stroke, and cancer. Likewise, relational trauma can lead to an increased risk of depression, anxiety, substance abuse, and suicidality. These impacts are illustrated in the graphic below:



Source: adapted from the CDC Kaiser ACE Study [1998]

The lifelong impact of adversity and trauma, can result in a 'cycle of violence', where families and/or communities transmit forms of adversity across the generations.[xi] For example, parents who have experienced or witnessed significant interpersonal trauma may struggle to build caring and trusting attachments with their children. If they have not been shown love, compassion, kindness and comfort, they may have a reduced ability to express empathy or to regulate their own emotions and behaviours in relation to their children. The necessary positive input for healthy childhood development is often not adequately provided because a parent's own trauma is limiting their emotional availability, and capacity to support their children. Children learn from their parents, so modelling these maladaptive behaviours and coping strategies means they are passed on through generations. That said, parents are not fated to go on to transmit adversity and trauma to their children, and many actively seek support and development to help them break the cycle of violence they have experienced.

So importantly, **the cycle of violence can be interrupted and broken.** With the proper support, people at any stage in their life can gain an understanding of how adversity and trauma has impacted their life and can build new ways of making meaning out of it and learning to live beyond the trauma. Understanding the deep-rooted and pervasive ways that someone can be impacted by adversity and trauma allows us to better deliver (as professionals) flexible and tailored support. This could include techniques to manage stress, skills to regulate emotions, and the development of supportive social networks for people at all stages of life.[xii]

Section 5: What is adversity and trauma-informed practice?

It is totally understandable to feel inadequate when we are working with young people who have experienced adversity and trauma. It is normal to fear that we might make things worse or be scared of confronting the adversity they have experienced. It can be challenging to support a young person to 'walk through a minefield', and therefore it is vital that we understand how our own work can be adversity and trauma informed.[xiii]

As Bruce Perry reminds us, relationships matter and every contact with someone who has experienced adversity and trauma can be an opportunity for healing and growth.[xiv] To make every contact count, we need to adopt a professional curiosity about adversity and trauma. It is vitally important to take time to listen to the people we work with, understand what lies behind the behaviours they present with, and avoid jumping to conclusions, making assumptions or offer solutions. To work in an adversity and trauma- informed way, is to be sensitive to the wider context of the person's life, and how this impacts them, and any support you might be able to give them.

> Adversity and trauma-informed practice is designed to enhance, and work alongside, existing safeguarding protections, policies and measures for children and vulnerable adults.

We have built on YoungMinds and Health Education England's **six principles for adversity and trauma-informed practice**.[xv] We have added new practice examples to help you think about how this might work in your own service or profession. This is not an exhaustive list and you might want to add your own as you go through the principles. Here are some ideas to get you started.

Principle	Description	Practice examples
1. Prepared	• Creates and maintains a priority in addressing the causes and mental health consequences of childhood adversity and trauma. This includes having this priority embedded in local commissioning, service and transformation, and school improvement plans. • Analyses available data on prevalence, and possible local need, at both a pre- / sub-clinical and clinical level. • Anticipates mental health needs arising from childhood adversity and trauma, by embedding knowledge, expertise and informed interventions in local commissioning and service pathways.	• Understanding of impact of adversity and trauma, and how to address this, embedded in induction and regular trainings to staff and volunteers. • All staff and volunteers are taught to think about what has led to the behaviour or challenge in a situation rather than 'what is wrong' with the person they are working with, and know a variety of appropriate responses. • Services with specific cohorts of children (i.e. schools or youth groups) devise simple indices to ascertain the level and severity of need, and plan resources accordingly to respond to them. • Continuous research and consultation with experts and people with lived experience is done on the prevalence of experience of adversity in different populations and the need for support so targeted services can be developed where appropriate. • Organisations work from an assumption that some young people in their setting will have experienced adversity and trauma – i.e. staff in a Children's Home will expect children to display trauma-related behaviours. A care plan for each individual child will be constructed prior to the child entering placement to ensure that all staff know how best to help the child with their experiences. This plan will be regularly reviewed.
2. Aware	• Ensures local agencies and partners have a good understanding of childhood adversity and trauma, and the associated symptoms and responses. • Has a common framework for identification and enquiry about adversity and trauma in childhood	• Framework and rationale for services is rooted in understanding and addressing the needs of people impacted by childhood adversity and trauma. This is on a publicly accessible website, promotional material for services and shared in outreach and with guests and newly accessing members.

Principle	Description	Practice examples
	and adolescence. • Understands and responds to the cultural, identity and gendered contexts of the young people and the community in which they live – including situations where a child continues to live in adverse circumstances.	• Initial assessment with each registering member covers broad understanding of a person's past, present and hopes for future. • Schools and colleges ensure that support and interventions are culturally appropriate for the children and young people accessing them. • Social workers in an unaccompanied minors team have an understanding of the different contexts of adversity that children arriving from different countries may have experienced – i.e. a young person who has lived in the camps at Calais may be hyper-vigilant at night, as that was when they felt the most unsafe.
3. Flexible	• Provides stepped support to children and young people who face adversity or trauma at both a pre-/ sub-clinical and clinical level. • Provides models of care that enable alternative and more flexible forms of access and engagement (i.e. through street triage). • Provides targeted models of care to excluded groups of children and young people who live in adverse and traumatic environments.	• Variety of interventions available to members addressing all areas of a person's wellbeing, from membership in a community, being seen, valued and heard, to 1:1 psychotherapeutic intervention. • Referral routes are created to avoid/break down barriers to access such as active outreach, self-referral and simple phone call or online form to refer. • Individual engagement plan is created with each member following initial assessment. This is regularly reviewed and updated as members' strengths and needs change. • Organisational model of support is cornerstone for targeted support for various (often excluded) groups of people who have lived/are living in adverse and traumatic environments. • Services pilot adversity and trauma-informed interventions and support, in order to assess access, whether they are

Principle	Description	Practice examples
		appropriate for their needs, and are impactful for young people using them. • In educational environments, allowing children to choose members of staff to help them plan the support they need, rather than being led by the post holder, i.e. their pastoral lead. • Able to adapt and tailor clinical support to the needs of the young person – i.e. a child in foster care who may have been let down by many adults is unlikely to disclose their experiences in a traditional clinical setting. They may eventually develop a trusting relationship with the foster carer, and want to just talk to them, and therefore that carer should also be supported to build the network of resources the young person can access.
4. Safe and responsible	• Intervenes early to prevent an escalation of need and avoid preventable exposure to additional adversity and trauma in children and young people's lives. • Puts in place policies, practices and safeguarding arrangements that avoid re-traumatising the young people and stigmatising their behavioural or emotional response to trauma. • Ensures that safeguarding procedures are in place, are seen as part of interventions in childhood adversity, and work in a way that supports the child or young person to recover from the adversity or trauma they have faced. • Ensures that children and young people receive coordinated support from knowledgeable, qualified,	• Targeted programmes deliberately reach groups at risk of having experienced adversity and trauma. Programmes encourage referrals for people in these groups before traditionally obvious needs emerge. • Safeguarding policies and practice are proactive and continuous communication and whole-family support model allows early identification of potential issues, as well as a more integrated response. • Staff are qualified and have comprehensive staff support including 1:1 supervision and regular group reflective practice which address both the practical and emotional aspects of work that can affect wellbeing. • Senior leaders, governors and/or Board members, include trauma-informed responses within their safeguarding oversight and responsibilities.

Principle	Description	Practice examples
	trustworthy and well trained professionals who have suitable supervision and workforce support that can address vicarious or secondary trauma that may occur.	• Organisations regularly working with young people who experience adversity and trauma are mindful of becoming desensitised – i.e. avoiding labelling certain behaviours as criminal, pathological or just a problematic 'norm' of the service.
5. Collaborative and enhancing	• Meaningfully engages and involves children and young people who have faced adversity and trauma in decisions about their treatment, care and the design of interventions. • Adopts a strengths-based approach, recognising the resources and resilience that children and young people have drawn upon in the past, and creating positive and additional strategies for symptom mitigation and recovery – including self-soothing, emotional regulation and the promotion of self-care. • Ensures models of care recognise and harness (where possible) families, care-giving, peer and community assets as part of treatment and recovery.	• Member engagement plans are finalised in dynamic consultation with member, from explicit baseline of the resilience they have and have already shown throughout their lives. • Support ensures assets and achievements are recognised, valued and communicated, regardless of how a young person may be responding to trauma – i.e. a young person who has been the main carer in their home, may see this as a key part of their identity, therefore this needs to be incorporated into support to ensure that their sense of purpose or meaning is not taken away from them. • Social and emotional learning programmes include range of inspiring and challenging experiences so members can draw on strengths and discover new ones. • Organisation offers opportunities for peer mentorship, volunteering, and employment for members. • Support is offered for directly impacted member as well as members of their family, carers and close support network. • Life-membership model understands that life is not linear and that challenges can arise at any time. This means that members can access services when they feel the need.
6. Integrated	• Enables effective communication and data-sharing between agencies to ensure that the whole of the	• Support member through referral to other organisation where necessary.

Principle	Description	Practice examples
	child's needs are identified and met. • Co-commissioned (possibly with a lead agency) to ensure that there is a continuity of care and consistency of pathways across, and within, the services and interventions that children and young people will receive. • Ensuring smooth transitions between stepped care models, providing timely referral and treatment to specialist services, and proving access to enhanced mental health, adversity and trauma knowledge and expertise when required (i.e. through outreach and liaison models of care).	• Active communication with other bodies supporting members including regular contribution to care plans, cross-agency meetings as professional and advocate for members' needs and wants. • Schools should ensure that communication is clear between departments, year groups, schools and external agencies to prepare and support students through transitions and to empower them to be clear in expressing their needs.

Section 6: What support might I need?

Adversity and trauma does not only impact the person who has experienced it directly, but also affects people around them. Professionals working on the frontline, such as teachers, social workers, counsellors, therapists, nurses, and others directly supporting the person are at risk of 'taking on' their experiences. This can also be the case for family members, close friends or advocates supporting the person.

It is vital we recognise the negative impact that hearing about people's experiences of adversity and trauma can have on our own physical, mental and emotional health. If we are; consumed by feelings of anger at the injustice they have faced, distracted by the despair at the treatment they endured; or dissociated from the sadness we experience, then the quality of care, attunement and empathy we have for the person may be diminished. This can be extremely difficult, especially when we are working with children, young people or adults who have had experiences that are similar to our own. If we do not recognise the effects of witnessing distress on our own lives, we might try to make sense of it in inappropriate ways, such as in relationships with our own children, parents or work colleagues.

When we 'take on' someone else's trauma we are not acting in an adversity or trauma-informed way, nor are we saving them from confronting the distress they have experienced. This is why therapists talk about the importance of a therapeutic frame and the need to bracket our own experiences, so that we can focus on what the person in front of us needs, and to clarify what the best form of support we can offer is.

'Taking on' someone else's trauma is sometimes known as 'vicarious traumatisation', 'compassion fatigue' or 'secondary traumatic stress'. Whatever you call it, it is important to watch out for signs that you are struggling to deal with the emotions relating to someone else's experience, and/or the distress it brings up or triggers about your own experiences, and seek support early.[xvi]

It is understandable to be stressed out, overwhelmed or tired from work every once in a while, but if this becomes a regular occurrence, or if you are feeling very detached from the people you work with, and emotionally exhausted by people who use your service, then you might be experiencing secondary traumatic stress. Feeling shame, helplessness and hopelessness about your work, poor concentration, intrusive thoughts about traumatic experiences, and finding it harder to manage your emotions are also important signs to look out for.[xvii] You might also notice changes in the way that you respond to the people you work with, your family or friends. For example, some people say they feel less joy or satisfaction, have unexplainable bursts of anger, or find themselves being tearful when doing everyday tasks (like shopping or the washing up).

There are things that we can do to protect our own mental health, so that we can continue to provide the very best care and support for the people we work with. Maintaining a healthy work-life balance is important, as is ensuring that you do not 'take your work home with you'. Having time for yourself, or to do something you enjoy or value gives you the time to reset any worries, stress or tension from the workday and focus on yourself before coming back the next day. Similarly, a healthy lifestyle including exercise, good nutrition, and making sure you get enough sleep will make a big difference to how you are able to manage the stress of supporting others who are struggling.

In the workplace, staying connected with other members of your team, and management allows you to get things off your chest, and to work more challenging things out together so you are not holding it on your own. Some teams include briefing and debriefing sessions to ensure that all staff have the chance to reflect on and identify the way that working with someone else's adversity or trauma might be affecting members of the team. This might be done through a Multi-Disciplinary Team structure, where professionals from different backgrounds come together to share insight on the people they are working with, and the wider impact on the service or members of the support team.[xviii]

Sharing your social and emotional responses with colleagues can help you to feel like you're not alone and know that there is support out there for you if you need it. Even if it might seem like something small that you cannot get out of your head, do seek support earlier on to prevent things from escalating. Importantly, do take advantage of supervision or counselling services that may be available in your workplace.

Your GP, local mental health services, or speaking to a friend or colleague are good ways to seek help too.[xix] This might feel like a very difficult and challenging thing to do if you have been triggered, or if you are working with people who have experienced neglect, abuse or violence from institutions or those in positions of authority.

Our employers can make a big difference too, by ensuring that their staff are adequately trained and supported. This might include providing regular reflective practice sessions, and adequate supervision to explore any issues that arise, and to give them space to be addressed in a timely and non-judgemental way before they escalate. Promoting a culture of cohesion and group support is a key part of protecting staff's mental health and wellbeing and should be a priority in all workplaces, especially those supporting people living with the impact of adversity and trauma.[xx] Finally, it is vital that senior leadership are committed to listening to staff about their support needs, and provide a proactive approach to ensuring that all those working with experiences of adversity and trauma, have on-going access to spaces to reflect and active forms of support.

References

[i]Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C. and Lowey, H. (2014) 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England' BMC Medicine 12:72. doi.org/10.1186/1741-7015-12-72.

Bellis, M. A., Ashton, K., Hughes, K., Ford, K., Bishop, J. and Paranjothy, S. (2015) Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Cardiff: Public Health Wales / Centre for Public Health.

[ii]Kessler, R. C. and McLaughlin, K. A. (2010) 'Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys' British Journal of Psychiatry 197(5): 378–385.

McLaughlin, K.A., Green, J.G., Gruber, M.J., Sampson, N.A., Zaslavsky, A., and Kessler, R.C. (2012) 'Childhood adversities and first onset of psychiatric disorders in a national sample of adolescents' Archives of General Psychiatry 69: 1151-1160.

[iii]Bellis, M.A., Lowey, H., Hughes, K. and Harrison, D. (2014) 'Adverse Childhood Experiences: Retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population' Journal of Public Health36(1): 81-91: http://jpubhealth.oxfordjournals.org/content/36/1/81.full.pdf+html

[iv]Schilling, E.A., Aseltine, R.H. and Gore, S. (2008) 'The impact of cumulative childhood adversity on young adult mental health: measures, models, and interpretations' Social Science and Medicine 66(5): 1140-1151.

[v]Lewis, S. L., Arseneault, L., Caspi,A., Fisher, H. L., Matthews, T., Moffitt, T. E., Odgers, C. L., Stahl, D., Teng, J. Y. and Danese, A. (2019) 'The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales' The Lancet Psychiatry 6(3): 247-256.

[vi]Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., and Smid, G. E. (2014) 'Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis' British Journal of Psychiatry 204(5): 335-340.

[vii]Copeland, W. E., Keeler, G., Angold, A. and Costello EJ. (2007) 'Traumatic events and posttraumatic stress in childhood' Archives of General Psychiatry 64(5): 577-84.

Landolt, M. A., Schnyder, U., Maier, T., Schoenbucher, V and Mohler-Kuo, M. (2013) 'Trauma exposure and posttraumatic stress disorder in adolescents: a national survey in Switzerland' Journal of Trauma Stress 26(2): 209-216.

McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M. and Kessler, R. C. (2013) 'Trauma exposure and posttraumatic stress disorder in a national sample of adolescents' Journal of the American Academy of Child and Adolescent Psychiatry 52(8): 815-830.

[viii]Bonanno, G. A. (2004) 'Loss, trauma, and human resilience' American Psychologist 59: 20-28.

[ix]Trickey, D. and Black, D. (2000) 'Long-term psychiatric effects of trauma on children' Trauma 2(4): 261-268. doi. org/10.1177/146040860000200403.

[x]Bellis, M.A., Hughes, K., Leckenby, N., Hardcastle, KA., Perkins, C. and Lowey, H. (2015) 'Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: a national survey' Journal of Public Health 37(3): 445-454.

Bellis, M. A., Ashton, K., et al (2016) Op. cit.

Smith, M., Williamson, A. E., Walsh, D. and McCartney, G. (2016) 'Is there a link between childhood adversity, attachment style and Scotland's excess mortality?: evidence, challenges and potential research' BMC Public Health 16: 655.

Couper, S. and Mackie, P. (2016) Addressing Adverse Childhood Experiences in Scotland (Scottish Public Health Network): https://www.scotphn.net/wp-content/uploads/2016/06/2016_05_26-ACE-Report-Final-AF.pdf

Brown, D. W., Anda, R. F., Tiemeier, H., Felitti, V. J., Edwards, V. J., Croft, J. B., and Giles, W. H. (2009) 'Adverse childhood experiences and the risk of premature mortality' American Journal of Preventive Medicine 37(5): 389-96.

Ford, J. D. (2010) 'Complex adult sequelae of early exposure to psychological trauma' in R. A. Lanius, E. Vermetten and C. Pain (eds) The Impact of Early Life Trauma on Health and Disease: the hidden epidemic. Cambridge: Cambridge University Press. pp. 69-76.

[xi]Hertzman C. (2013) 'The significance of early childhood adversity' Paediatrics & Child Health 18(3): 127-128.

[xii]Herman, J. (1997). Trauma and Recovery: the aftermath of violence. New York: BasicBooks.

[xii]Albaek, A. U., Kinn, L. G. and Milde, A. M. (2018) 'Walking Children Through a Minefield: how professionals experience exploring Adverse Childhood Experiences' Qualitative Health Research 28(2): 231-244.

[xiv]Perry, B. with Szalavitz, M. (2017) The Boy Who Was Raised as a Dog: and other stories from a child psychiatrist's notebook (3rd Revised Edition). New York: Basic Books.

[xv]YoungMinds and Health Education England (2018) Addressing Adversity: prioritising adversity and trauma-informed care for children and young people in England. London: YoungMinds. http://youngminds.org.uk/addressingadversity

Also see: NHS Education for Scotland (2017) Transforming Psychological Trauma: a skills and knowledge framework for the Scottish workforce. Edinburgh: NHS Education

for Scotland. www.nes.scot.nhs.uk/media/3983113/NationalTraumaTrainingFramework-execsummary-web.pdf

[xvi]Pearlman, L. A. and Saakvitne, K. (1997) Transforming the Pain: a workbook on vicarious traumatisation. New York: W.W. Norton.

[xvii]Figley, C. R. (1995) Compassion Fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner-Routledge.

Figley, C. R. (2002) Treating Compassion Fatigue (Psychosocial Stress Series 24). New York: Brunner-Routledge.

[xviii]NHS England (2014) MDT Development: working toward an effective multidisciplinary/multiagency team. Leeds: NHS England. www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf

[xix]For more information see: www.nctsn.org/trauma-informed-care/secondary-traumatic-stress

[xx]For more information see: www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress

Published June 2019.

Published by YoungMinds, registered Charity in England (1016968) and Scotland (SCO39700). This guide is licensed from 2019 by; The YoungMinds Trust, Anna Freud National Centre for Children and Families, and Body & Soul, under a Creative Commons Attribution-ShareAlike 4.0 International License.

For further detail of the issues raised in this guide, see Trickey, D. (2020) Helping Your Child with Loss, Change and Trauma: a self-help guide for parents. London: Little, Brown Book Group


YOUNGMiNDS


Anna Freud
National Centre for
Children and Families

Body & Soul
transforming trauma
with love