2022

Trauma in Transition - Lived experiences of Trauma Informed approaches

Taylor, E

TRAUMA IN TRANSITION

Lived experiences of Trauma Informed Approaches

Emma Taylor and Katie McBride
University of Plymouth
December 2022

Trauma in Transition

The research

This report has been produced with the support of the Plymouth Trauma Informed Network with specific guidance and contribution from members of the Lived Experience Sub Group (??). The authors would like to thank both the Network administrators and its members for this support and guidance.

Increasing numbers of organisations are seeking the contributions of people who have experienced trauma in order to develop their services and support. The aims of this piece of research were to understand the lived experiences of trauma. In particular, how policy and decision makers can best learn from people with lived experiences of trauma to improve their service design and delivery. The overall ambitions of the research team in relation to this piece of work are to produce accessible knowledge that can be used to inform future research and the way in which trauma can be better accounted for and supported in both the design and delivery of services. This report represents a first step towards achieving this aim and further work is necessary to fully explore these important issues.

Introduction

Trauma can be defined as an event(s) or circumstance(s), experienced either emotionally or physically by an individual which is life threatening or emotionally and psychologically harmful, and has lasting adverse effects on the individuals emotional, physical, social, spiritual, or mental well-being (Chaudhri et al., 2019; SAMHSA, 2014). There has been an expansion in the awareness of trauma, not only with its relation to care but also its effects and prevalence within other specific areas such as physical health care, education, military, alongside society more broadly (Becker-Blease, 2017). The growing interest and acknowledgement towards the impact and prevalence of trauma (Harris and Fallot, 2001), has bought with it the increased awareness and practice of a trauma-informed approaches. These approaches recognise the existence of trauma and the multitude of responses and adjustments used to cope with trauma (Levenson, 2017; Smeaton, 2021), whilst emphasising emotional, psychological, and physical safety through the empowerment of individuals. This has been achieved in some areas through the modification of practice structures, shifting from solely medical and psychological perspectives to include both a psycho-social and recovery orientated framework (Plymouth.gov.uk, n.d). Trauma is ubiquitous (Kilpatrick et al., 2013), however, individuals and communities who are disproportionately burdened and exposed to isolation, poverty, and violence are more likely to experience traumatic circumstance(s) or event(s), as well as systemic discrimination due to their social and economic position (Chaudhri et al., 2019). Due to the cumulative effects of trauma (Shevlin et al., 2008), individuals who have experienced elevated levels of trauma throughout their life are more likely to access mental health services (Kessler et al., 2010).

The impact of trauma

The impacts of trauma are varied and multiple and can cause symptoms such as fear, depression, anxiety, anger and the need for hypervigilance due to the perception that there is a risk of re-experience (Kleber, 2019). An individual's response to trauma can be complex and is often dependent on factors such as personal resources and the presence of supportive communities, with future vulnerabilities exasperated for those who experience trauma throughout childhood (Kimber and Wheeler, 2019). In addition, Greenberg et al., (2018) highlight that for some trauma survivors, there can be the development of heightened pro-social behaviours and compassion. Trauma exposure varies in relation to demographic factors such as poverty, sexual orientation, gender, and socioeconomic status, with adults who have an intellectual disabilities experiencing heightened trauma exposure (SAMHSA, 2014). For individuals who have experienced trauma whether in childhood or adulthood, there is a strong association with the development of decreased physical health, eating disorders, suicidal behaviour, sexually transmitted diseases, reduced engagement in healthcare services, chronic diseases, and the increase in harmful behaviours such as drug, alcohol, and tobacco use (CDC, 2017; Chaudhri et al., 2019; Fuemmeler et al., 2009; Levenson, 2017; Mauritz et al., 2013; SAMHSA, 2014; Thordarson and Rector, 2020). The reason for substance misuse has been explained as an act to 'sedate' the effects of trauma and to suppress the feelings associated with adverse situations (Dye, 2018). Furthermore, it has been found that the impact of trauma can cause individuals to have a negative view of themselves and the world around them, displaying acts of hypervigilance and self-blame (Dye, 2018; Friedman, 2013). Additionally, survivors of trauma can potentially be "triggered" in both unconscious and conscious ways (Raja et al., 2015). The provocation of traumatic memories can often occur during a survivor's experience with a service provider, primarily due to the inherent power imbalance, thus the need for a compassionate, understanding and trauma-informed approach (Kimber and Wheeler, 2019).

Service interaction

It is the combination of systemic discrimination and the continual stressors experienced by trauma survivors that can impede an individual's ability to communicate, regulate emotion and manage conflict scenarios. This can be seen throughout service user interactions with care providers, and if left unaddressed can disintegrate the therapeutic alliance and truncate the quality of care provided (Rich et al., 2009). Subsequently, survivors of trauma often utilise relatively anonymized services such as emergency departments in order to limit the potential for follow-ups or further engagement (Chaudhri et al, 2019; Frank et al., 2014). For many individuals, the participation in non-trauma-informed services can lead to inadequate treatment, instability, heightened reactivity, and aggression (Thordarson and Rector, 2020). It has been shown that trauma can be detrimental not only in human, but also economic terms. The economic impact includes loss of employment, a decrease in productivity and the increased financial cost of additional mental health and support services (Sweeney et al., 2018). Many studies have examined the effectiveness of trauma-

informed approaches, particularly in healthcare services, evidencing an improvement in physical health and coping skills, a reduction in the use of restraints and seclusions and the most poignant result, a depletion in the number of in-patient stays and an elevation in treatment retention for trauma survivors (Sweeney et al., 2016).

A trauma-informed approach

Within its ideology, the trauma-informed approach aims to transform the experiences of survivors when accessing and engaging with services, primarily by changing the current paradigm of practitioners from questioning 'what's wrong with' to 'what's happened to' individuals (Elliot et al., 2005). Trauma-informed practices acknowledge how an individual's political and socio-economic context can shape past and current behaviours (Sweeney et al., 2018). Additionally, the approach notes that an individual's behaviours can signify the coping and adaptation mechanisms for trauma, further highlighting the need to understand the triggers, responses, and effects associated with a traumatic experience(s). This understanding therefore needs to be encompassed into professional programmes, conduct and services (Levers, 2012), with trauma-informed perspectives contributing to care providers understanding of survivors acts of impulsivity, aggression, heightened reactivity, self-injury, perceived shaming, and power differentials (Thordarson and Rector, 2020). A key principle of trauma-informed care is comprehending that all actions and behaviours have purpose and may be the response to additional issues which have been concealed due to an individual's discomfort, secrecy, and shame (Felitti and Anda, 2010). Within trauma-informed systems such acts can be reduced through the mitigation of harm and reduction in re-traumatisation at all levels (Muskett, 2013). Every employee/member of an institution or organisation must understand the plethora of ways in which trauma can affect an individual. This can aid in a more sensitive service delivery, reduce the potential for re-traumatisation and assist with recovery (Elliott et al., 2005). In addition to the individual effects, it is also important to understand the impact that an environment can have on a survivor of trauma. Entering any service or organisation can instil feelings of hopelessness, vulnerability and exposure thus triggering the development of traumatised coping mechanisms. Therefore, it is essential not only employees and members adopt a trauma-informed approach, but that the associated workplace and social contexts be adjusted to create safer, more peaceful settings for their users (Miller and Najavits, 2012).

Trauma-informed approaches are built upon principles of respect, choice, empowerment, trustworthiness, safety, and collaboration (Chaudhri et al., 2019; Harris and Fallot, 2001). They offer the possibility to improve individuals lives, however, such progress can only occur within systems or institutions that do not hold the potential to re-traumatize (Thordarson and Rector, 2020). Historically, trauma is inextricably linked to systems of power and oppression, with many survivors having their experiences denied in a plethora of ways. As such it is argued that a trauma-informed approach can bolster great potential for good (Becker-Blease, 2017). Unlike trauma-focused therapy, the trauma-informed approach does not seek to directly confront past trauma, but simply responds to a client exhibiting

problems through the context of their trauma (Brown et al., 2012; Levenson, 2017). By delivering a service which recognises the vulnerability of a trauma survivor, organisational members/employees can avoid inadvertently replicating traumatic interactions and dynamics within their assisting relationship (Elliott et al., 2005; Harris and Fallot, 2001; Knight, 2015; Levenson, 2017).

The development of a stable, trustworthy relationship between service user and professional can help expand a survivor's coping strategies through the promotion of self-determination (Elliott et al., 2005) and the practice of new skills (Levenson, 2017). In order to address any inherent power differentiation between professional and users of a service, the incorporation of a collaborative approach helps to create an alliance in the healing process (Fallot and Harris, 2009). A truly collaborative relationship within a trauma-informed approach, further allows for the combination of professional knowledge and unique trauma narratives experienced by the client. Subsequently, the client is able to determine the course of intervention thus empowering them to respond adeptly to challenges, by reframing their trauma responses as standard reactions to threatening situations (Levenson, 2017). It is important to understand and acknowledge the link between personal experiences of trauma and the extensive social systems which exacerbate trauma and oppression (Gomez et al., 2016). Regularly society appears alarmed at trauma survivors and their behavioural coping mechanism, more so than the traumatic event(s) themselves (Becker-Blease, 2017). This emphasises the need for trauma-informed interventions not only at an individual level but throughout all policies and responses that aim to address inequalities and decision-making (McKenzie-Mohr et al., 2012). In order for any community or system to become trauma-informed it can be beneficial for them to follow the 5Rs approach. This is to;

- *realise* the extensive impact of trauma and the multitude of ways for recovery,
- *recognise* the signs and coping strategies of trauma in survivors, communities, and organisations,
- *respond* by utilising knowledge of trauma-informed approaches and implement them within procedures, practice, and policies,
- *resist* re-traumatising individuals and communities through the avoidance of interactions and scenarios whereby traumatic memories may be re-triggered and
- to build *resilience* for both communities and individuals so that they may adapt to adversity (Mentalhealth.org, 2015).

If such practices and trauma-informed principles are not implemented or upheld, then the chances of trauma survivors accessing and maintaining engagement with services will reduce significantly (Elliot et al., 2005).

In order to reduce the risk of re-traumatisation, it can be beneficial to implement a trauma-informed approach within research. By collaborating with participants throughout the research process, to shape the purpose, approach and interpretation of findings can help to

ensure the safety, wellbeing, and empowerment of trauma survivors (Smeaton, 2021). The treatment, research and knowledge extraction of trauma are regularly accompanied by an increased sense of exposure, particularly during the personal recollection of their experience(s). Whilst it has been argued that continual exposure can increase tolerance for trauma triggers, the repetitive story telling can cause latent traumatic effects, with survivors often feeling afflicted before experiencing any benefits from sharing their narrative (Kawam, 2015). As a result, it is imperative that both service and community responses work to ensure not only resilience but also to prevent further harm. Adapting community-based services to facilitate the needs of trauma survivors can help to increase engagement and strengthen connections for individuals, further offering an innovative opportunity to heal the damage caused by trauma (Chaudhri et al., 2019).

Plymouth

Plymouth, as a trauma-informed city aims to engage with the local community to strengthen their resources in order to prevent the conditions of adversity. This is done through the utilisation of a trauma-informed approach to support carers, parents, and communities to have the capacity to develop resilience (Plymouthscb.co.uk, 2021). It is during the initial stages of this research that the city of Plymouth experienced a collective trauma. On the 12th of August 2021 five individuals lost their lives during a mass shooting and two others were injured. Witnessed by an estimated 300 members of the community, Plymouth as a trauma-informed city has been able to consider the subsequent consequences of an event so traumatic and has therefore engaged in the development and provision of further support and collaboration with the wider community (hansard.parliament.uk, 2021). It is therefore an optimum time to consider the effects of trauma and how individuals with lived experiences perceive and interact with services, as well as how these experiences may be utilised to aid further development of policy and support services.

The Harms narrative

Criminology is a social science concerned with understanding the world and how it is constructed in order to acknowledge and explain harm in society (Hall and Winlow, 2015). This is done through the analysis of events; experiences; and structures which aid in the construction and drive of society (Lloyd, 2019). By adopting a social harms perspective, criminology can assist in situating trauma into a sociocultural context that explores the link between lived experience and the prevailing political economy, communities, and social organisations (McBride, 2019; Winlow and Hall, 2016). This perspective highlights how any individual is neither *good* nor *evil* (Winlow and Hall, 2016), but their interpretation and understanding of *self* is malleable (Hall 2012; Johnston, 2008) and constructed in relationship with the wider context. In contemporary society, this is arguably a necessary human trait as it allows us to adapt in a plethora of environments, further suggesting that individual action can be determined from the relationship between a person and their surroundings (Wakeman, 2017). In a contemporary context, this means that individuals'

sense of self is formed in interaction with the neoliberal consumer capitalist society. In this context community and society are erased with the emphasis placed on the individual as responsible for their own success or failure and 'good citizens' defined as those that do not burden the state for support (even when their circumstances are a result of state policies and practices). Harris, Walgrave and Braithwaite (2004) emphasize the negative impact of personal and psychological trauma, upon the ability for an individual to 'flourish'. Individuals, therefore, respond to this highly competitive environment by engaging in complex processes of daily management and risk assessment activities (McBride, 2019). This has implications for how people with lived experiences may feel compelled to act in ways that ensure they avoid the castigation of the state and its agents as a 'drain' on societies limited pubic resources and/or to engage in the development and delivery of services that meet their needs in the absence of appropriate support and care being otherwise available. These scenarios have impact on individuals living with the impact of trauma creating additional labour and can lead to re-traumatisation as a result.

Often the full range and extent of harms experienced by individuals in society goes unacknowledged with emphasis placed on visible, physical harms. Efforts to rectify this within academia have led to the adoption of a model of human flourishing based on work undertaken by Honneth in the 1990s (Honneth, 1996). Yar (2012) developed this model of human flourishing to highlight how denials of these fundamental human needs manifest as harm. For example, where there is a lack of recognition from others, including family, peers, agencies and the state, an individual cannot achieve a self of self-worth and this lack manifests as harm or trauma. It has been argued that in order to 'flourish', individuals must construct a positive sense of self (Yar, 2012b) which is achieved in interactions with others who provide love, esteem and respect (McBride, 2019; Yar, 2012a). Achieving recognition as a valued individual and member of a community allows for the development of healthy and positive future relations, self-esteem, trust in one's own instincts as well as a sense of security in an individual's surrounding environment (Honneth, 1996).

Methodology

As noted by Tseris (2013), the engagement in any research for trauma survivor's which does not participate within the realms of the trauma-informed movement, holds the risk of perpetuating the same victim-blaming, silencing, shaming, and retraumatizing practices. Therefore, it proved imperative that this research use a trauma-informed and highly collaborative approach throughout. It is due to the vulnerability of this demographic that Participants were recruited through their affiliation with the Trauma Informed Network Plymouth. In order to deploy a considered trauma-informed approach, 9 one-to-one, semi-structured interviews with individuals who self-reported lived experience(s) of trauma were carried out throughout 2022. The interview schedule was developed in consultation and collaboration with Network members and explored how policy and decision makers might best learn from people with lived experiences of trauma to improve their service design and delivery. The participants all resided in England and consisted of 2 males and 7 females

between the ages of 30 and 65. Each interview lasted between 1 and 3 hours, covering a range of topics, including experiences of support services and importantly the impact of sharing their experiences of trauma with individuals further discussing the developments and changes they would like to see in both policy and practice. The subsequent transcripts were then reviewed by the appropriate participant, prior to data analysis in order to ensure comfortability of content and the emphasis of co-production.

Research Findings

The Impact of trauma

As noted by Kleber (2019), the impact of trauma can be detrimental, complex and multitudinous, with the ability to affect a person's sense of safety, wellbeing and can even lead to feelings and acts of anger. Throughout this research, all the participants disclosed different traumatic experiences, and as acknowledged by Levenson (2017) and Smeaton (2021) the diversification of experiences, reflects the response to, and impact of such traumas. This further highlights the individualistic nature of trauma and its affects. For Ryan, the experience of physical and emotional trauma at the hands of his father throughout childhood, could potentially be illustrative of the refusal to grant love and respect. Therefore, dependency upon and the continual misuse of drugs and alcohol played a vital role in their adult life.

> *'I didn't have a drug problem, I had a life problem, and that all stemmed from the way I was treated when I was a kid and the drugs protected me, well, they hurt me, they kept me isolated from everybody'. – Ryan, 52*

It was stated that these substances provided a means of escapism for Ryan and prevented them from acknowledging their childhood experiences. This further illuminates the influence of societal causes upon individuals. Ryan's experiences can be deemed as secondary symptoms to their situation, combined with neoliberal consumer capitalisms lure towards self responsibilisation and blame. Thus, a further motivation for the use/misuse of these substances, as they appeared to provide a 'protective' (Dye,2018) element from previous and potentially future harms. Experiences of isolation were not uncommon and throughout the research several participants disclosed that they felt 'alone', or that they felt more comfortable being by themselves. As highlighted by Miller and Najavits (2012), the environment that individuals find themselves in can be potentially triggering and exacerbate feelings of vulnerability. It is due to these feelings that individuals found themselves 'hyper-vigilant' and 'risk managing', bound in a routine of daily management (McBride, 2019), in order to protect against any potential harm that may occur:

> *'…always risk managing, totally.' – Corrinne, 61*

> *'If I get on a train or a bus, I will sit next to the exit or sit in a seat that I know if the train crashes, if I'm at the back, the coaches will have less of an impact. I don't drive. I've never had children. It's all about risk assessment for me.' -Amy, 43*

Furthermore, the need to manage possible harms is also an act of self-preservation that extends to one that seeks to protect others.

> *'I hate unfairness. I hate bullying, anything that people are vulnerable, I'm all over it.' – Amy, 43*

> *'If I see something or someone says something to someone, I may be read too much into it. If I see the reaction of the other person and it hurt them, then I'm going to stand up to that person.' – Ben, 36*

Whilst it has been stated that those who have experienced trauma may participate in acts of hyper-vigilance and risk management, it has also been considered that trauma survivors display heightened pro-social behaviours and acts of compassion (Greenberg et al., 2018) as evidenced by Amy and Ben. Such preventative measures appeared to extend further for participants with children. Both Corrinne and Ben, as with other participants, shared experiences of complex childhood trauma, including physical and emotional harms. For these individuals, there was an apparent acknowledgement that 'history can repeat itself' and due to this, some participants chose to limit their own and their child's contact with their perpetrator:

> *'He did see his grandparents, but they were never left alone with him. – Corrinne, 61*

> *Uh my step mum, she met when she was 3 months old, but she didn't touch her, hold her, I'd never allow that. I don't want them to have a relationship with her. I'm getting married soon, they're not coming and that's because of my story.' Ben, 36*

This hypervigilance illustrates some of the effects of trauma highlighted by Dye (2018) and Friedman (2013). However, when negative situations arise, it becomes apparent that the impact of trauma and its propensity to generate feelings of self-blame and negative self-evaluation can lead to further negative effects on mental health and personal wellbeing:

> *'…Like I got a bit teary talking about my kids, but that's something that I felt I failed at. That was something that I felt I could've had more control over and when you think you're doing the right thing in the moment, and it turns out that it's not …' Leah, 34*

> *'I think it's hard to trust people and obviously your self-esteem and your self-worth and how you see yourself is low because basically you've just been pushed down all the time and treated like crap, so you just … like I always put myself last in the family. If things are needed to be done … it sounds silly, but it's me that will go without a shower or it's me that will not have dinner if there's not enough, whatever it is.' - Talitha, 36*

As acknowledged by Talitha, the impact of their trauma has caused negative perceptions of themselves, particularly due to the lack of respect and recognition from others (Harris, Walgrave and Braithwaite, 2004). However, it was also shared that they feared their

children would begin to notice the paucity of their self-worth and thus begin to mirror or act in ways that affirmed their negative self-image. Such behaviours are manifestations of internalised harms that facilitate the transmission of inter-generational trauma associated with an historic event (Yehuda and Lehrner, 2018).

Service interaction

The participants experience with mental health and support services varied throughout. Although all of the individuals were able to recollect a time in which they felt let down by the systems, for some, the empathy and compassion previously displayed by the participants extended to individuals who work within the support and mental health sector.

> *'I think that they do the best they can…. All of them, but I think every person in the mental health industry at some point has felt, including me, more could've been done, more could've been prevented or better service' – Camila, 28*.

> *'I was talking to a mate who works there over lockdown, and she said to me that the level of phone calls they were getting, sharing trauma experiences, was horrific, devastating, distressing, traumatising, upsetting, every possible fucking negative word you can think of, and because of COVID, supervision wasn't in place either and they were often on their own or with a volunteer.' – Amy, 43*

> *'They don't have the resources, they're underfunded, their workloads are outrageous and there's no support network or training in place for them really. I can sit here and blame things like social services, but they haven't got the resources, but also, they haven't evolved.' - Ben, 36*

Highlighting the influence of neoliberal ideology, Ben's understanding of the practices and limitation of services, such as social services highlight the normality of neoliberal ideology and the scarcity of resources which facilitate individual competitive consumerism (McBride, 2019). The emphasis on lack of resources further perpetuates the sense of unworthiness, as well as the removal of their right to be adequately supported and respected (Yar, 2012a) throughout their interactions. Although understanding was portrayed by a plethora of participants, a strong sense of injustice was felt by many. For Camila, their experiences with support services are extensive. They stated both positive and negative interactions and have relationships with several companies and services, including present volunteering roles. However, they are still reflecting upon their interactions with sectors, such as social services and the negativity encompassed with that experience:

> *'They should at least be mindful that they do not cause harm because when it goes wrong, it really does and with me, that's one of the outcomes. At the moment I'm still searching for justice.' – Camilla, 28*

> *'I told them that their dad had raped me and that that was the reason why I was saying that I couldn't look after my child…. I told them that their dad had raped me and that he was very violent, they basically told me … they were very cold. They said it was about the child and not me. For me, that was really difficult. It was like meeting yourself with something like a stone wall that's concrete.' - Camila, 28*

This is further demonstrated by Ben, who stated that they had not accessed any services throughout adulthood due to the negative experiences held through childhood. For them there appeared no compassion or understanding and therefore they have been reluctant to seek support:

> *'A stranger asking me questions I'd think they don't really care and they're just doing a job. That's how I see the social workers as well. They don't really care; they're just doing a job.' - Ben, 36*

This negative view of the care sector further exemplifies the daily management and risk assessing of individuals who have experienced trauma (McBride, 2019). It is through non engagement that participants such as Ben have been able to protect themselves from further disappointment as well as the potential of further emotional harm from the revisiting of past events. In contrast, Ellen, an individual who has experienced secondary trauma through their child's experiences of trauma and foster care, as well as child to parent interpersonal violence, has found that when interacting with support services for their child that the approach was not concise enough, and therefore their child, was not able to engage with services that may have proved beneficial to their development.

> *'My child did have a therapist from a company in Cornwall because that's where they were living and she came up to see him, but they really didn't participate in the therapy very much and it was all very light, you know, getting them to draw things. All of their life with me, my child has struggled to accept any help. People can get so far with him and then he sabotages it when the hard stuff comes. So, unless people are willing to … if people are airy-fairy therapists, [inaudible] they will allow things to tick along on my child's terms.' - Ellen – 50*

As with the disparate nature of interaction experiences, Amy highlighted the subjective and at times, retraumatising (Tseris, 2013) nature of some services:

> *'I had social workers come to the house and you know, the social worker was lovely, she was. It was things like, well, normally we would ask to look in people's fridges, but we're not going to do that with you because we can see the house is nice, it's tidy, we've spoken to your children, they're well turned out and things. That was a massive, massive relief, a massive relief. But what happens if you go, well, tomorrow's actually my shopping day, so my fridge is pretty empty at the moment and then you're already worried about that and someone says, you don't have enough food in your fridge, so we're going to have to take this further. It's that re-awakening of the trauma again and again and again, and that sense of inadequacy and not being able to do things yourself.' – Leah, 34*

Negative experiences with support services, particularly in a scenario such as Leah's has the ability to further perpetuate feelings of inadequacy (McBride, 2019) and have further negative impacts upon self-esteem (Yar, 2012a) and trust in their own ability (Honneth, 1996).

Sharing of experience

It has been acknowledged that for survivors of trauma, that repeating their experiences can have negative effects, including the feeling of affliction, before any benefits may be seen (Kawam, 2015). However, many of the participants disclosed positive feelings in relation to disclosing and sharing their trauma, such as Corrine and Ryan:

> *'I feel quite liberated actually'- Corrinne, 61*

> *'I'll leave here, and I'll feel buoyant about it. It's getting all the stuff out that I've kept up here (points to head)' – Ryan, 52.*

For many of these individual, this was not the first time sharing their experiences. For instance, Ryan volunteered and participated with numerous organisations, sharing his story as a way of inspiring others who may be going through a similar experience. It is these positive connotations which were further acknowledged by Nicola and Amy:

> *'I don't think you can underestimate how that sharing of experience can be really powerful for some people in their recovery.' - Nicola, 51*

> *In my opinion, asking lived experience people is empowering, it's validating, it's meaning making for them, its knowledge, it's allowing them to vocalise because obviously our brains process the spoken word different to the written word.'- Amy, 43*

However, it is imperative for organisations who wish to utilize a person's lived experience, that they do it in a safe manner, one which does not require additional unacknowledged labour or inflict further harm on the individual sharing their trauma. For some, the extractive nature of such approaches can be detrimental (Kawam, 2015). As with Ryan, Camila has also shared her experiences with organisations that she works with. Her experiences are shared and used as a means for learning and development, however, these experiences have not always been positive, and some negative effects have been experienced:

> *'I'm just used to sharing my details, my story and sometimes it's difficult. Sometimes when I share things, in psychotherapy especially, it gets really deep and can be really difficult because I'm left with thoughts and things…… automatically I keep it very short when I speak about things. I do keep a summary of the main things, but I keep it quite short. I don't go into details, but I think that through art it's more possible to express things that have been repressed.'- Camila, 28.*

Kimber and Wheeler (2019) denote that such feelings may be due to the inherent power imbalance that can manifest between a service provider and service user, it is important to note however, that using lived experiences can be beneficial for organisations as evidenced by Ellen and Talitha:

> *'What everybody has said is, they benefit from the reality of it. You know, it's having that reality sat in the room with them and talking about our experiences as a family.' - Ellen, 50*

'I think if somebody was able to share their experiences, it's really powerful to hear someone's voice when that person's right in front of you.' – Talitha, 36

For Talitha, who is a social worker, using her experience has helped her throughout her work, and it could be suggested that the services which interact with Ellen, do so in a compassionate and trauma-informed way (Kimber and Wheeler, 2019). An approach which emphasises respect, safety, empowerment, and trustworthiness (Chaudhri et al., 2019; Harris and Fallot, 2001). These are key aspects of the trauma-informed approach, with the Plymouth Network's vision being to create a city whereby individuals are able to trust one another and learn reflectively and collaboratively in order to empower each other in the aims of making a difference (Plymouthscb.co.uk, 2021). Subsequently, it could be suggested that by being a part of the trauma informed network that these individuals have begun to develop their resilience and self-esteem, therefore allowing them to feel comfortable and more secure in sharing their experiences with others. However, Nicola notes a potential issue with organisations utilizing lived experiences:

'Yeah, and I think services, well there's always that tendency to identify really palatable tendencies which are typically, white women who are articulate, and articulate things in a certain way and are interesting in becoming a part of the service so aren't always necessarily really critical, or disenfranchised voices and I think that's with lived experience work, can be really problematic.'- Nicola, 51

Furthermore, the participants were also able to acknowledge the diversity amongst trauma survivors and the differences in their needs and stages:

'Not everybody's thing is talking. People have experienced much harder trauma than I have. I'm not sure that I would want to talk about that.' -Ellen, 50

It is due to the multiple and complex experiences of trauma, that other methods of sharing experiences have been recognised, as well as the need to develop and review the current use of lived experiences in order to ensure the safety and wellbeing of trauma survivors.

Policy development

For many of the participants, there is a desire for the current policies and practices amongst many organisations to be modified. For Ben this has transpired into a desire to use his experience to aid such a transition.

'I want to do something with my experiences that help others, and show people, I suppose 'in the power' that their lack of involvement, or that they think they've got the right type of involvement, that uh, they just don't know. They're following documents, policies, regulations but they're not fit for purpose in my opinion and based on my experiences.' – Ben, 36

This was mirrored throughout the interviews, with Amy stating the belief that individuals who have been affected by trauma are the experts due to their first hand, lived experiences or otherwise understood in a healthcare context as 'Experts by Experience' and how they

may be beneficial in the construction of both policy and practice throughout a range of settings and delivery organisations:

> *'So, you know, I think that's been a big difference and I think encouraging lived experience into the mix and creating that peer support and the lived experience policy sort of impact has widened that. However, I do think experts in this field are people affected by trauma and they're not included because they're problematic sometimes or they're difficult or they don't rock up or … however, it takes one to know one with trauma.' – Amy, 43*

It has been suggested that there are benefits to the incorporation of individuals with lived experiences, due to their potentially heightened levels of compassion (Greenberg et al., 2018). This is something that Leah felt strongly about, particularly when the topic of trauma-informed training was raised:

> *'Yes, you can educate people, but can you really teach them how to be compassionate? It's a difficult area.' – Leah, 34*

Both the occurrence and effects of trauma are complex and widely experienced as highlighted by Nicola:

> *'Although trauma is very unique, over the course of a lifetime its common'. – Nicola, 51*

It is due to this that many of the participants felt that the incorporation of trauma-informed practice and policy were not widespread enough, and as with the aims of the Plymouth Network (Plymouthscb.co.uk, 2021), Leah and Amy were able to articulate the need for a widespread and comprehensive approach to trauma-informed training and practice:

> *'Yeah, yeah, and I think to be trauma aware, at least, it should be a community project. It should be something that everybody knows about. If you're going to say we're a Trauma Informed school, well, why are you Trauma Informed? How are you Trauma Informed? What do you do? How do parents know what you do?' – Leah, 34*

> *'Trauma Informed training, as an organisation, should be done from the cleaner to the cook to the whatever. Everyone should be Trauma Informed and live it day to day. The manager of the organisation should instil Trauma Informed practice day to day. So yes, you've the training, you're not Trauma Informed yet, but you're certainly trauma aware'. – Amy 43*

It is due to the expansive knowledge and lived experiences that Nicola has that through the discussion of training Nicola was able to offer a critical insight into the appropriate and at times questionable practices of organisations and their learning 'tools':

> *'I've gone to conferences where there has been lived experiences and yes it has had an emotional wallop, but they're not talking about their learning or what could be different. That for me feels like it could have been potentially traumatic for them and actually triggering for audiences. So, I think if you're going to do that individual sharing you need to be really clear on 'what is the learning here and is there going to*

be any change?' and if there isn't, the risk of re-traumatisation seems higher than any potential benefits. So, I think it needs to be carefully done, I see a lot of stuff which people called lived experience and I'm thinking it's pretty exploitative'. – Nicola, 51

This highlights the potentially detrimental effects of utilizing individuals and their lived experiences through speech. This is not only for the sharing individual, but also for the audience. As previously stated, it is due to the commonality of trauma that there is a risk of traumatisation to the listeners of the experience. This is due to the sensitive, emotive and at times startling nature of trauma, and although it has been argued that there may be potentially positive outcomes, these approaches need further consideration to the safety and wellbeing of all that may be involved. This has been summarised by Ben, who shared some of the recent events and some acts or experiences which have the ability trigger him and the recollection of his trauma:

'I think there's got to be different mediums. Some are great in training, and it can set the tone for what is going to be discussed, others may get more from reading a story, they can really visualise it. Or even a film, there are a lot of things I don't watch because they trigger me but there are loads of mediums that I think would help based on the audience.' – Ben, 36.

Conclusion

The individual testimonies highlighted throughout this report demonstrate important illustrations of the impacts of trauma. The number of interviews completed as part of this introductory piece of research were small but even within this sample of experiences the unique and nuanced nature of trauma is evident. The findings also emphasise the role that the wider context and social environment play in prolonging or alleviating the impacts of individual's trauma as they navigate the world. It is imperative, to acknowledge the benefits that have been experienced by our participants and others through sharing their trauma experiences and the benefit of a community approach to trauma informed practice, which has evidently aided in the security and wellbeing of our participants. However, where the impacts of trauma go unacknowledged or individuals are insufficiently supported there is evidence that the internalised harms associated with trauma can be generative of further trauma of younger generations as feelings of inadequacy and unworthiness transmit through generations in such a way as to impinge upon the ability to form loving and valued relationships with children and other loved ones.

The nature of this research and its collaborative co-production with members of the Plymouth Trauma Informed Network influenced the types of experiences individuals reported having with service providers in the process of seeking care and support but also in terms of their experiences of sharing their experiences as a learning tool for the development of better trauma-informed provision. The experiences reported here demonstrate the existing of re-traumatising practices but also highlights important ways in which individuals can be supported to safely engage with service development and

improvement in a positive way and empowered to use their experiences for these purposes. The experiences of the participants of this research also point towards the need for further future developments to the modes through which Experts by Experience might be supported to share experiences that provide vital insights into the impact of non trauma-informed service provision, for example by exploring more creative means of recording and communicating experience as reported by Camila.

Finally, there was also important reference to the need to ensure that the experiences and learning being sought by policy makers and organisations is drawn from a representatively diverse range of Experts by Experience. This point identifies another area in need of further research and points towards areas of development that public sector and large private sector delivery organisations should already be conscious of under their Public Sector Equality Duties of the Equality Act (2010).

References

Becker-Blease, K., (2017). As the world becomes trauma–informed, work to do. *Journal of Trauma & Dissociation*, 18(2), pp.131-138.

Brown, S., Baker, C. and Wilcox, P., (2012). Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(5), pp.507-515.

Centre of Disease Control and Prevention (CDC). (2017). *Preventing Intimate Partner Violence*. [online] Available at: <https://www.cdc.gov/violenceprevention/pdf/ipv factsheet.pdf> [Accessed 22 June 2021].

Chaudhri, S., Zweig, K., Hebbar, P., Angell, S. and Vasan, A., (2019). Trauma-Informed Care: a Strategy to Improve Primary Healthcare Engagement for Persons with Criminal Justice System Involvement. *Journal of General Internal Medicine*, 34(6), pp.1048-1052.

Dye, H., (2018). The impact and long-term effects of childhood trauma. *Journal of Human Behavior in the Social Environment*, 28(3), pp.381-392.

Elliott, D., Bjelajac, P., Fallot, R., Markoff, L. and Reed, B., 2005. Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33(4), pp.461-477.

Fallot, R., and Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol*. Retrieved from: I (traumainformedoregon.org).

Felitti, V. J., and Anda, R. F. (2010). *The Relationship of Adverse Childhood Experiences to Adult Health, Well-Being, Social Function, and Healthcare*, In R. Lanius, E. Vermetten, & C. Pain (Eds.). The Impact of Early Life Trauma on Health and Disease; The Hidden Epidemic (pp. 77-87). New York: Cambridge University Press.

Frank, J., Wang, E., Nunez-Smith, M., Lee, H. and Comfort, M., (2014). Discrimination based on criminal record and healthcare utilization among men recently released from prison: a descriptive study. *Health & Justice*, 2(1).

Friedman, M., (2013). Finalizing PTSD in DSM-5: Getting Here From There and Where to Go Next. *Journal of Traumatic Stress*, 26(5), pp.548-556.

Fuemmeler, B., Dedert, E., McClernon, F. and Beckham, J., 2009. Adverse childhood events are associated with obesity and disordered eating: Results from a U.S. population-based survey of young adults. *Journal of Traumatic Stress*, 22(4), pp.329-333.

Gómez, J. M., Lewis, J. K., Noll, L. K., Smidt, A. M., & Birrell, P. J. (2016). Shifting the focus: Nonpathologizing approaches to healing from betrayal trauma through an emphasis on relational care. *Journal of Trauma & Dissociation*, 17, 165–185.

Greenberg, D., Baron-Cohen, S., Rosenberg, N., Fonagy, P. and Rentfrow, P., (2018). Elevated empathy in adults following childhood trauma. *PLOS ONE*, 13(10), p.e0203886.

Hall, S. and Winlow, S., (2015). *Revitalizing criminological theory: Towards a new ultra-realism*. London: Routledge.

Hansard.parliament.uk. (2021). *Keyham Shootings*. [online] Available at: https://hansard.parliament.uk/Commons/2021-09-22/debates/E43EC26C-6B30-4AB8-A164-C0922B3D3209/KeyhamShootings.

Harris, N., Walgrave, L. and Braithwaite, J. (2004) 'Emotional dynamics in restorative conferences', *Theoretical Criminology*, 8 (2), pp. 191-210. doi: 10.1177/1362480604042243

Harris, M. and Fallot, R. (2001). *Using Trauma Theory to Design Service Systems.* New Directions for Mental Health Services. San Francisco: Jossey-Bass.

Honneth, A. (1996) *The struggle for recognition.* Cambridge: Polity Press.

Johnston, A. (2008). *Žižek's ontology: A transcendental materialist theory of subjectivity*. Evanston: Northwestern University Press.

Kawam, E., 2015. *Trauma Informed Care, Ethics, and Social Work Education • SJS*. [online] Social Justice Solutions. Available at: http://www.socialjusticesolutions.org/2015/09/01/trauma-informed-care-ethics-social-work-education/.

Kessler, R., McLaughlin, K., Green, J., Gruber, M., Sampson, N., Zaslavsky, A., Aguilar-Gaxiola, S., Alhamzawi, A., Alonso, J., Angermeyer, M., Benjet, C., Bromet, E., Chatterji, S., de Girolamo, G., Demyttenaere, K., Fayyad, J., Florescu, S., Gal, G., Gureje, O., Haro, J., Hu, C., Karam, E., Kawakami, N., Lee, S., Lépine, J., Ormel, J., Posada-Villa, J., Sagar, R., Tsang, A., Üstün, T., Vassilev, S., Viana, M. and Williams, D., (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *British Journal of Psychiatry*, 197(5), pp.378-385.

Kilpatrick, D., Resnick, H., Milanak, M., Miller, M., Keyes, K. and Friedman, M., (2013). National Estimates of Exposure to Traumatic Events and PTSD Prevalence UsingDSM-IVandDSM-5Criteria. *Journal of Traumatic Stress*, 26(5), pp.537-547.

Kimberg L., Wheeler M. (2019). *Trauma and Trauma-Informed Care.* In: Gerber M. (eds) Trauma-Informed Healthcare Approaches. Springer, Cham.

Kleber, R., (2019). Trauma and Public Mental Health: A Focused Review. *Frontiers in Psychiatry*, 10.

Knight, C., (2015). Trauma-Informed Social Work Practice: Practice Considerations and Challenges. *Clinical Social Work Journal*, 43(1), pp.25-37.

Levenson, J., 2017. Trauma-Informed Social Work Practice. *Social Work*, 62(2), pp.105-113.

Levers, L. (2012) *Trauma counselling: Theories and interventions*. New York: Springer Publishing Company.

Lloyd, A., (2019). Harm at Work: Bullying and Special Liberty in the Retail Sector. *Critical Criminology*, 28(4), pp.669-683.

Mauritz, M., Goossens, P., Draijer, N. and van Achterberg, T., 2013. Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, 4(1), p.19985.

McBride, K., (2019). *A critical analysis of harms experienced by transgender individuals.* Available at: http://hdl.handle.net/10026.1/14562.

McKenzie-Mohr, S., Coates, J., & McLeod, H. (2012). Responding to the needs of youth who are homeless: Calling for politicized trauma-informed intervention. Children and Youth Services Review, 34, 136–143.

Mentalhealth.org. 2015. *Trauma-Informed Approach and Trauma-Specific Interventions - MentalHealth.org*. [online] Available at: https://www.mentalhealth.org/get-help/trauma

Miller, N. and Najavits, L., (2012). Creating trauma-informed correctional care: a balance of goals and environment. *European Journal of Psychotraumatology*, 3(1), p.17246.

Muskett, C., (2013). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, 23(1), pp.51-59.

Plymouth.gov.uk. (n.d). *Trauma Informed Practice | PLYMOUTH.GOV.UK*. [online] Available at: https://www.plymouth.gov.uk/adultsandchildrenssocialcare/childrenssocialcare/academysocialworkplymouth/informationandresourcespractitioners/traumainformedpractice.

Plymouthscb.co.uk. (2021). *Envisaging Plymouth as a Trauma Informed City*. [online] Available at: http://www.plymouthscb.co.uk/wp-content/uploads/2019/04/Trauma-Informed-Plymouth-Approach-FINAL-April-2019.pdf.

Raja, S., Hasnain, M., Hoersch, M., Gove-Yin, S. and Rajagopalan, C., (2015). Trauma Informed Care in Medicine. *Family & Community Health*, 38(3), pp.216-226.

Rich J., Corbin T., Bloom S., Rich L., Evans S., Wilson A. (2009) *Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Young Men of Color*. Philadelphia, PA: Drexel University School of Public Health.

Shevlin, M., Houston, J., Dorahy, M. and Adamson, G., (2008). Cumulative Traumas and Psychosis: an Analysis of the National Comorbidity Survey and the British Psychiatric Morbidity Survey. *Schizophrenia Bulletin*, 34(1), pp.193-199.

Smeaton, E., (2021). *Trauma and trauma-informed researchers*. [online] The-sra.org.uk. Available at: https://the-sra.org.uk/SRA/Blog/Trauma%20and%20trauma-informed%20researchers.aspx.

Sweeney, A., Filson, B., Kennedy, A., Collinson, L. and Gillard, S., (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Advances*, 24(5), pp.319-333.

The Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *Concept of Trauma and Guidance for a Trauma-Informed Approach*. SAMHSA's Trauma and Justice Strategic Initiative. U.S. Department of Health and Human Services.

Thordarson, H. and Rector, T., (2020). From trauma-blind to trauma-informed: re-thinking criminalization and the role of trauma in persons with serious mental illness. *CNS Spectrums*, 25(5), pp.577-583.

Tseris, E. J. (2013). Trauma theory without feminism? Evaluating contemporary understandings of traumatized women. *Affilia*, 28(2), 153–164.

Wakeman, S. (2017). The 'one who knocks' and the 'one who waits': Gendered violence in Breaking Bad. *Crime Media Culture,* 14(2), 213–228.

Winlow, S., & Hall, S. (2016). Realist criminology and its discontents. *International Journal for Crime, Justice and Social Democracy*, 5(3), 80–94.

Yar, M. (2012a) 'Recognition as the Grounds of a General Theory of Crime as Social Harm?', in O'Neill, S. and Smith, N.H. (eds.) *Recognition theory as social research: Investigating the dynamics of social conflict.* Basingstoke: Palgrave Macmillan. pp. 109-126.

Yar, M. (2012b) 'Critical criminology, critical theory and social harm', in Hall, S. and Winlow, S. (eds.) *New directions in criminological theory*. Abingdon: Routledge. pp. 52-65.

Yehuda R, and Lehrner A. (2018) 'Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms'. *World Psychiatry* 17(3), 243-257.