The enduring and often devastating pattern of psychological response to what we refer to as trauma has been recognised for centuries or even millennia. References in literature, art, history, in the everyday conversations of people from all walks of life reveal an appreciation of the enduring influence of events long past on the lives not only of people who have experienced unbearable pain and loss, but also often in subsequent generations. This concept of the transgenerational transmission of trauma finds a welcome home in systemic therapy, but often is confined to the parameters of the nuclear or extended family. Yet trauma and the trauma-genic organisation of systems is neither solely linear nor transactional, it is developed out of multiple historical contexts (Bloom, 2010; 2012). The systematic oppression and persecution of communities, of countries, of people from different racial and religious groups reverberates long beyond the lifespan of those who are oppressed, their oppressors and the systems which embolden and enable their actions. The fragmentation of a sense of belonging, of pride and values, and the usurping of culture and language eventually culminate in groups who are disenfranchised, excluded, and seen as lesser. This reality has been brought to the forefront of collective consciousness over the last 18 months, a period which has exposed damning health inequalities in a global pandemic, brought the Black Lives Matter campaign to global attention, and seen an increase in rates of domestic violence, and mental health and social care crises (UK Parliament, 2021; NHS Strategy Unit, 2020).

Secure hospitals are reflective of the communities they serve. In consideration of traditional models of illness, people who have experienced oppression and exclusion experience treatment in ways that reinforce exclusion and isolation, coercive control, invalidation, and a violation of boundaries. Faced with the question of whether the care they offer or the way they practice emphasises abusive and unhealthy systems, staff are likely to be dismayed and horrified. Staff offer care in a controlled environment where it is necessary to enforce treatment or perhaps physically restrain for everyone’s safety. This is the critical issue: the practices, policies, and procedures of a
system, which are both the accelerator and the brake of the organisation function independently of the needs of all the individuals who comprise it, often at times in a manner wholly contrary to their requirements. This is the crux of re-traumatising systems, not only for patients but for staff. The axiom of trauma-informed care is that trauma-genic experiences are pervasive across, as well as within, groups. This is a fundamental aspect of secure mental health services bringing, therefore, a need to guard against the fallacy that the entirety of trauma in the system belongs to patients.

Thus, the consequences of injustice, powerlessness, oppression, and poverty are inherent in everyday life, and for millions of families their struggles within these societal systems show up in the interactions and meaning-making of their lives. The fragmentation of supportive systems, communities, and cultures makes each member of a family unit vulnerable to a range of harms that occur in their relationships; victim becomes perpetrator. Children are disadvantaged by adversity and learn to navigate their normality in ways that serve to maintain a status quo.

The significant prevalence of trauma and childhood adversity amongst people in forensic settings is increasingly well evidenced and the long-term consequences of these experiences are acknowledged (Karatzias, Shevlin, Pitcairn, & Thomson, 2019; Facer-Irwin, Karatzias, Bird, & Blackwood, 2021). An absence of a cohesive and systematic integration of trauma-informed practice, that is prioritised and supported at every level of the organisation, leads to a fragmented and inconsistent approach to care. This serves to perpetuate anxiety and insecurity at all levels of the system, and can lead to harmful, re-traumatising practices.

To implement trauma-informed care, there has to be an understanding of the structure of the current system and observations of how the people in the system function to stay safe and survive. For patients, safety is an act of self-preservation to predict the intentions and motivations of others, based on previous harmful relationships, and replaying actions that result in survival.

For staff, their intent is a moral endeavour to care (Seedhouse, 1994) and make people better. However, they are often caught up in the pressures of the role which are beset by policy and procedures that are challenges in the organisation; the ward, peers, and manifest and latent traumas in the patient group soon become a task beyond clinical teaching. This complex interrelationship frequently leads to high levels of anxiety and expressed emotion. In organisations or systems that lack an understanding of this, the default management position follows an organising principle of control of others in order to achieve outcomes (Carlisle & McGuire, 2020).

For patients, entering a therapeutic relationship with staff operating within a highly controlled environment serves to replay the very family/social care system they may be used to, which results in re-traumatising experiences. Events that are projected as “care interactions”, oscillating between compliance (perceived as “progress”) and independence (risking “breakdown”), can represent a misalignment of goals. Stability for both patients and staff is rarely achieved, particularly in the early stage of treatment. This represents a consuming existential risk. Great harm has occurred to them in relationships, sufficient to crystalise their mental maps of human interaction. They often find it psychologically excruciating to contemplate the prospect of other adults having control and authority over them. They do not have an
expectation of kindness, compassion, and benevolent care. Rather the opposite is true; the expectation is that the intent of people in positions of power is to harm them even though they initially may disguise this.

The features aligned to an abusive system can be observed in examples of failed care such as Wharton Hall and Winterbourne View. The organising principle of control of others holds within it actions of secrecy and silencing, invalidation, coercive control, violence, violation of boundaries, exclusion, and isolation. In few circumstances is this purposeful and planned. It is more a gradual and inexorable slip into unacceptable practice. Poorly led and ill-governed systems become self-organising. They form and shape to meet the needs of the decision-makers at every level with a combination of human and organisational factors (Carlisle & McGuire, 2020).

To some degree, most staff and patients in secure care are likely to have experienced some features of control in relationships and organisations. Whilst all have significant consequences to the recovery of complex trauma, developing therapeutic and healing relationships whilst navigating systemic philosophies that counter this will have insidious and damaging consequences to all involved. Boundaries become unclear, violations are increasingly likely, invalidation is common, and the trauma transmits, erodes, and erupts in all parties. A trauma-informed system not only focuses on adapting the environment, but also invests in care of the staff, understanding that they come with their own adversity and are sensitive to the transference of trauma of others.

The mental health difficulties of patients in secure services are predominantly viewed through the prism of sickness. This is an understandable position and, to a degree, is valid. Yet if we consider trauma in the context of its literal translation to mean “wound”, then the paradigm shifts. The perspective turns to people who have sustained multiple and repeated psychological wounds over many years. These are reopened time and time again in an attempt to cure or at least manage symptoms, rather than a focus on providing an environment and relationships that heal. The misalignment arises when “trauma-focused interventions” attempt to address past experiences while the patients’ energies are spent avoiding current and future harm. Trauma-informed care therefore must start in the here and now. Psychological and physical safety is the prerequisite (see Figure 20.1). This is not just the position of the organisation, it is the therapy. A therapeutic milieu is cultivated from the first contact, the building, the relationships with all staff involved in care.

A progressive trauma-informed system aims to develop a healing environment based on the organising principles of autonomy and fairness – something that has been compromised in those with complex trauma histories. It involves ensuring that relationships are based on safety, trustworthiness, choice, empowerment, collaboration, and respecting individuality with respect to culture, history, religion, and gender (SAMSHA, 2014).

**Implementing a Trauma-Informed Model of Care in a Secure Hospital**

Readers may expect the focus of this chapter to be on the trauma of patients or perhaps the secondary impact on staff of repeated exposure to traumatic narratives...
and material. In essence, though, it is only possible to arrive at a genuinely trauma-informed system through the exploration and active management of two other critical sources of organisational trauma, namely the impacts of the life histories of staff and of any trauma-generative practices, processes, or interpersonal patterns. Unaddressed, these factors are the touchpaper for re-traumatisation of patients and staff, and usually result in an over-reliance on long-established approaches that are often the only available defences against anxiety. Implementing this strategy at a women’s medium secure care ward is the focus of this chapter and is presented in a series of vignettes.

A trauma-informed administration will acknowledge the reverberations of the individual and systemic traumas of not only all the people but the organisation itself. When an organisation has endured a threat to its existence, this becomes a psychic component and is played out in staff who were not even there. The historical and social context of the service is critical to understanding the development of systems and processes and the psychological makeup of staff and patients.

The reality for staff is that the recognition of what is happening in the traumatised organisation is often hidden in rigid policies and procedures. In order to generate a sustainable recognition of stress there needs to be a series of emotionally contained conversations about how staff function in work amongst distressing circumstances, acknowledging how the organisation chooses to operate to manage the risk in the framework of its heritage. In secure care, with high rates of self-harm and restraint, high rates of staff injury and sickness, and a quick turnover of temporary staffing, a women’s ward can be a place many staff state active resistance to working into for their own concerns about managing distress; staff fight/flight/freeze is activated before they have taken on the shift.

Often a ward in crisis results in a change of clinical priorities. This can be seen as flight from intolerable anxiety. Relief is in short supply and space to safely reflect is extinguished. Yet there is an attempt to impose order on chaos, often at the expense of meaning. This is bound to fail and eventually will exacerbate the issues. In an environment where there is a sustained exposure to adversity and removal of protective

![Figure 20.1 Principles of trauma-informed care (adapted from SAMHSA, 2014)](image-url)
factors, prolonged stress and anxiety can lead to dissociation in the team and the system functions in an automatic state, losing direction or coherence. This can look like absenteeism, presenteeism, avoidance, vigilance, tardy work, or any acts that conserve the self from being overwhelmed.

When asked, staff can articulate the stress they hold emanating from direct patient care with relative ease. In addition to this they can project limitations to the recovery from the stress into the system – the availability of rest periods, formal or informal reflection or reviews. An unhelpful culture that can focus on responsibility can make staff take steps to avoid experiencing blame. Staff inevitably not only become anxious about their physical and psychological safety, and the safety of colleagues and patients, but also concerned to their profession and livelihood. It is not uncommon to hear staff talk about their professional registration in the event that something goes wrong.

When traditional models of reflective practice are available to help navigate individual and collective experiences of a stressful or risky nature, it tends to locate all of the experience within the single situation or setting, and in teams where the staffing is (by mechanism of shifts or organisational pressure) irregular, there are few opportunities for the development of psychological safety, cohesion, and growth.

To counter this, there must be a broader psychological understanding of the multiplicity of the trauma systems everyone is involved in, and the relative contribution of each. Yet staff do not routinely have access to a systemic framework to inculcate and maintain this level of awareness. Without an active framework which privileges the emotional containment and psychological safety of staff, individuals and teams will struggle to over time to maintain a reflective and compassionate understanding of the fluid dynamics of the network of attachment relationships across the system.

A team that is functioning under threat or in fear can remain silenced – no one wants to be the weakest link. They can invalidate their own experiences and that of others in the team. Boundary violations which feel like support and comfort, or exclusion and isolation are inevitable. The organising principle of controlling the self, controlling other, and ensuring compliance to the wider system of the ward and organisation are maintained. Articulating the true impact of events is avoided. The team is primed to experience dissociation. To this end, the care believed to be on offer is fragmented as a sequence of events which are poorly aligned to meet the needs of the patient group and can lead to an impoverished employment experience which reverberates outside of the workplace.

Left unaddressed a traumatised and dissociated team cannot navigate relationships with patients safely; the barometer for risk shifts towards either hypervigilant or avoidant. The attunement and psychological safety of all members of the ward (staff and patients) remains under threat.

Delivering such a cultural and operational change is a complex and challenging task. This model of intervention requires an integrative and reflective space. There is an emphasis on prioritising space and time for thinking and reflection and a primary objective of building a culture of compassion, support, and reflection between staff. With persistent trauma-informed reflective practice and supervision, staff can be receptive and attuned, reflect and respond in ways that are coherent to the demands of needing to respond to the trauma in others.
The objective of developing a trauma-informed model of care is to move towards a system organised around autonomy and fairness, upholding the principles of safety, trustworthiness, choice, collaboration, empowerment, and respecting individual differences (adapted from SAMHSA, 2014). In doing this, acknowledging and validating various levels of traumatic material in the team is an important task. Working with trauma is evocative and yet most of what it evokes remains enshrined in the daily hassles of working with complexity. It can remain hidden or invalidated. Staff bring with them their own history of adversity and to a large degree believe it to be resolved or managed. In effecting a cultural shift in the emotional management of a service in a trauma-informed way, interventions that realise the trauma is there, recognise its signs, respond by providing intervention, and actively resist re-traumatising are integral to the model and are supported via a circle of containment in validating relationships and developing relational security for all (Four Rs: SAMSHA, 2014).

Context to the Vignettes: The Women's Ward

All patients are cis-female with some identifying as male. The patients present as a risk of harm to self or others at a level that requires enhanced physical and procedural security along with robust relational security. These terms appear to be formal—the essence of the environment is a model of care that aspires to autonomy and fairness; however, this is difficult to achieve in an institution where care and control are intertwined, and where, for patients, restriction is the critical component of perceived unfairness—patients are of a mindset before care starts that they are being unfairly treated and controlled as their freedom is removed. Where the organising principle is one of control, the conditions of the care relationships can all too easily involve coercive practices, invite silencing, invalidation, exclusion and isolation, and have a lack of cultural respect.

Most harmful experiences for the patients have occurred within their family of origin or in the care system. The chronic and consistent exposure to neglect and abuse shape their personalities, functioning and, importantly, their expectations about treatment from others, particularly those people who are in positions of power over them. Coming into a secure care environment is likely to replicate the conditions of harmful relationship dynamics and re-traumatising.

On the ward, the patients are at differing levels of acuity of distress or recovery. The service has no place to move patients on within its own unit: you arrive, you recover amongst your peers, you move on. This presents a critical dilemma to service providers and to supporting a systemic model of care; the environment is likely perpetually entrenched in trauma responses amongst all of the people on the ward. In becoming trauma-informed, the task is to recognise this and respond accordingly reducing the risk of re-traumatising experiences.

The staffing on the ward is a complement of qualified nurses, nurses in training, and nursing assistants. This is augmented by a multidisciplinary team consisting of a consultant psychiatrist, psychologist, social worker, occupational therapist, and other allied therapists all of whom have a clearly defined and regular role on the ward in
relation to the team and the patients. Staffing is a problem for services; with sickness and injury there can be a high turnover of staff, and the women’s ward is no exception. A basic premise for psychologically safe service provision is a workforce that is equipped to provide a safe base and safe haven: one where the team are regular/familiar and can observe the three tenets of secure care (physical, procedural, relational security) in consistent ways (Department of Health, 2010).

In order to make conditions conducive to a healing environment, it is critical to have a truly systemic investment in trauma-informed care through the structure of the Trust and across the lifecycle of the employees. In a secure care environment, there are inherent problems in any attempt to shift away from dominance and control towards an organising principle of autonomy and fairness. It is important to raise awareness of the impact of trauma corporately and clinically, and to develop explicit and implicit ways of collaborating and empowering, validating people, providing choice along with respecting and upholding the cultural values and needs of all.

The following series of continuous vignettes are fictional characters and will outline an example of common scenarios, and the implications will be discussed throughout.

**Vignette 1: The Patient, Karen**

Karen was admitted to the unit after setting fire to her room in the hostel where she lived. Information from hostel staff indicated this followed a dispute which a man with whom she had a romantic relationship. Karen has a history of violence using weapons, with reports of numerous assaults on men. Her medical records revealed long-term mental health difficulties with frequent and severe self-harm, and substance misuse. She is often referred to as a “complex individual”.

Recognising the intensity of these difficulties, Karen’s clinical team focused on allowing her to settle into the ward and were responsive to her requests. However, despite their care and concern, she would become oppositional and aggressive, and staff developed a plan to “not reward acting out”. Often her behaviour escalated, and she was placed in seclusion.

Multi-disciplinary assessment revealed extreme childhood adversity. Karen was adopted aged two. Her adoptive mother was psychologically and physically unavailable, having developed a dependence on benzodiazepines and alcohol. From the age of six Karen was regularly sexually assaulted by her adoptive father. School was an unhappy place for her, and she was lonely, teased, and bullied. She suffered from enuresis throughout her childhood. As an adolescent she relied on alcohol and drugs to cope emotionally and was groomed and sexually assaulted by men after being befriended and introduced to them by girls older than her. She was pregnant at 14 and her parents arranged a termination. Shortly after she was placed in residential care where she was sexually exploited and subjected to repeated violence. She is known to have engaged in sex work and petty crime. Karen has three children all of whom were removed and placed in care.
Karen did not settle on the ward and appeared hypervigilant. She was often accused of getting involved in issues between staff and other patients and was seen to be interfering in matters that did not concern her. Her mood was deemed unstable and her interpersonal difficulties were attributed to her undiagnosed “personality disorder”. Staff adopted greater vigilance in maintaining boundaries. Karen experienced this as psychological unavailability, provoking intense attachment behaviour.

Attempts to discuss her early adversity resulted in withdrawal and disengagement (dissociation). She would often engage in aggressive behaviour or self-harm the next day. She continued to feel unsafe and was constantly vigilant to indicators of threat, evaluating staff interaction with other patients as evidence of an abusive environment. This frequently led to emotive confrontation and seclusion.

Karen experienced overwhelming and intolerable feelings of shame about her past. This led to internally and externally directed rage which seemed inappropriate and incongruent to circumstances the next day. Staff perceived her anger and aggression as unjustifiable and without a trigger. It became clear that the impact of the past was not about the events themselves, which generally led to dissociation. Rather, it was the meaning of these events to her. She was terrified every day that therapists and nursing staff would want to talk about these things.

Staff with Complex Lives

It should be clear by now that a significant contribution to the trauma load in any organisation, particularly, in health and social care comes from the lived experiences and circumstances, past and present, of staff. Trauma and trauma-genic environments are pervasive and permeate the lives of people from all backgrounds and socio-economic groups. If trauma is considered merely as a matter of personal history, there is a fundamental and far-reaching error of logic, yet one which is common in organisational responses.

In a period of elevated anxiety on the ward, managing behaviour or illness can become the overriding objective at the expense of acknowledging the complex lives of staff. Chronic stressors such as domestic violence or relationship problems, living with sick or disabled family members and having care responsibilities, poverty, substandard housing, house moves, divorce, and bereavement are common amongst the workforce. Still staff turn up to work, and to a significant degree such life stressors undoubtedly influence their capacity to build healing relationship with patients. Helping others heal is a difficult process, doing it when you are continually hurt is often a burden which may on occasion be unbearable.

Human Resourcing can only go so far. It is indisputable that Trusts employ staff with complex lives, with unresolved or cumulative traumas of their own, or with on-going life events which serve to distract from the task at hand (Carlisle & McGuire, 2020). These issues are a challenge to systemic working: Who notices what is happening to staff? How do they navigate their emotions and not over-identify or
get overwhelmed with the emotions of others? Outsourcing these tasks to Human resources or occupational health is only a partial solution. A systemic approach to care treatment and culture which fails to integrate these elements will see interpersonal connections characterised by uncertainty, withdrawal, isolation, and negativity. This is often the context from which attributions of the patient emerge.

**Vignette 2: The Staff Member, Maria**

Maria has worked as a Nursing Assistant for eight years. She is of dual heritage. Her father is White British and her Mother is from Zimbabwe, although they separated when she was young. She has spoken to colleagues about her father’s excessive use of violence and his temper.

Maria likes her job although it can be stressful at times, she works on the women’s ward mostly. She regularly takes extra shifts on different wards but feels anxious and uncomfortable. She experiences racism at work but does not complain because other people do not see it. Maria feels lucky that she has good friends on the women’s ward and they look after her if she’s had a bad day or if she is faced with a risky patient.

Maria went through a contentious divorce a few years ago. Her relationship was characterised by violence and coercive control. Her husband denied these allegations and many of her friends stopped contact with her. She has three children at school but receives only inconsistent financial support from their father. She worries about them when she is at work. Often her salary is spent before the end of the month, she may have a week or so without money and she relies on pay-day loans.

**The Meaning-Making of Trauma**

If we are to accept then that the trauma load comes from multiple sources, then we must also accept that there are many different meanings given to trauma-genic experiences. These are individual, collective, and systemic, and often across the levels of the organisation, poorly aligned. Consequently, the needs of a person who has experienced chronic trauma (perhaps survival and managing shame) is at odds with both staff perceptions of their task and the objectives of the organisation.

The objectives of secure care are centred around the recovery model. Commonly this can mean recovery to how someone was before they were sick or recovery from a defined illness. This often lacks meaning and therefore trauma-informed approaches remain fragile and perhaps out of reach. It is important to guard against linearity of thought (sickness or recovery model). A focus on the number of ACES as individual “ticks” will lead only to partial and perhaps off-centre interpretations of a person’s experiences and functioning. This is a key component in the emergence of re-traumatising environments. In the absence of routine enquiry (Felitti, 2010) there are few mechanisms to share meaning-making and plan for the environment.

Like many patients, for Karen, the devastating chronic impact was not merely what happened to her, terrible as this was. Far more powerful was the psychological
adaptations she had to make to survive in a hostile and withholding environment. Psychological chaos, borne from rejection, exclusion, threat, and malice coalesced in a self-concept characterised by shame, guilt, self-hatred, worthlessness, interspersed with threads of unbearable rage and anger. Emotionally Karen believes she was at fault, she is flawed and at times deserves maltreatment. Revisiting her experiences is to contemplate her reality, a person alone and shameful who is to be hidden from others.

Maria takes pride in her resilience in the face of adversity. She states that nothing gets her down because she has seen everything in life. She would complain about the racism, but it is useless because she believes she will be ostracised further, so works hard to fit in. She recalls that, at first, she did not like working with the women because they were “draining” but now likes working with them because she understands where they came from and nothing can affect her.

Understanding the meaning each makes of their experiences is fundamental to being trauma-informed.

Vignette 3: Working with Patients with Complex Trauma

Maria spends a lot of time supporting Karen on the ward. She can feel sorry for her having no family, and she feels sad that she has had her children removed. There are times when Karen is distressed and Maria “feels her heart sink” as she is put on her observations. Karen wants to talk about her distress, Maria thinks she should be over this by now and feels “stuck” with Karen’s story.

Karen used to like Maria but finds her dismissing when Maria is under stress. Karen would like to be able to talk about her children; she worries that what happened to her will happen to them. Maria says that Karen should count herself lucky because her own children are “nothing but trouble and great expense”, but she “loves them really”. Karen can feel the rage in her stomach and chest. She wants to punch Maria. Instead, she cuts herself for being so inept.

Maria is frustrated with Karen. She says she’s there for Karen to talk to and is annoyed with Karen’s self-harm. Maria attempts to cover up her annoyance, but suspects it leaks out a little. She thinks it doesn’t matter to Karen as Karen ignores her anyway. Maria returns to the staff office after observation and hands over that Karen is moody and has cut herself. Maria shows her annoyance to her colleagues who agree that Karen is “hard work when she is like that”. Maria feels validated by her colleagues.

The Challenges to Emotional Containment

Left alone to consider trauma-related presentations, in non-trauma-informed environments, practitioners are likely to feel overwhelmed and may even become traumatised themselves. The phenomenon of secondary trauma is a genuine risk to the health and
wellbeing of practitioners. The concept of secondary stress is well defined, established, and evidenced (Choi, 2011; Craig & Sprang, 2010). The evidence base reveals this vulnerability to secondary trauma responses in staff occurs across the spectrum of caring professions and is particularly pronounced in those organisations that work with trauma (Cohen & Collens, 2013).

The meaning of trauma is misaligned between Maria and Karen. Maria struggles to consider Karen outside of her own frame of reference. Indeed, any current life stressors Maria has only served to irritate her that Karen is given opportunity to “get better” but fails to do so even when she is in a place of safety. When Karen self-harms, Maria’s sense of helplessness leads to her re-framing Karen’s behaviour as attention-seeking and Karen is rejected by Maria.

In the care team, the discussion of the sense of helplessness could be a useful transaction – however they lose the context of this and view the event as Karen failing to respond to the care offered. Karen is blamed for poor responsiveness to treatment. Maria’s understanding is confirmed.

Thus, inevitably the misalignment in the dyad extends to the whole clinical team who are unable to detect the different perspectives of the staff and patient. Systemically the care delivered by the service does not attend sensitively to Karen’s trauma, and instead attends to the risk of her self-harm or disengagement in a way that renders Karen helpless (i.e., expectation of concordance, threat of seclusion if she is distressed): the staff feel stressed and helpless. The risk of re-traumatising Karen is elevated as the team move towards coercive methods or exclusion and isolation to manage the care objectives.

Thus, without reflection, the trajectory of sickness/problem behaviour is located solely in the patient. Without context or a space for all of the people involved in Karen’s care to consider their own responses and where that might come from, the discussions about care focus on the need for restraint or seclusion, rather than a psychological understanding of Karen’s experiences: control is perpetuated and the risk of re-traumatisation continues.

Safe Space to Reflect and Grow

This chapter has set out the importance of a socially aware and responsive organisation with strong and sustained investment in trauma-informed policy, practice, and procedures. At ward level there was a programme of trauma awareness training which incorporated a bio-psycho-social understanding of attachment, developmental trauma, and adverse childhood conditions. The training emphasised the role of reflection on transference and the impact of working with the traumatic material and resultant difficult relational dynamics that commonly occur. This became the foundation for consistent reappraisal in the work environment between the ward psychologist, ward-based staff, and the wider care team.

Prior to the introduction of a trauma-informed model of care, the supervision strategies for nursing staff were often based on management targets and performance indicators ahead of clinical issues. The recording of supervision was variable. Senior staff ensuring supervision occurred were provided with support to make their
supervision trauma-informed. The framework for this was based on the “Four Rs”. This holds key assumptions that people *realise* that trauma and stress exist and are likely to be experienced by everyone; that the people can *recognise* the signs and symptoms of stress and trauma; can *respond* in a timely trauma-informed or trauma sensitive way; and make efforts to know about and *resist* re-traumatisation (SAMHSA 2014). Supervisors and senior staff became comfortable with enquiring about supervisee’s psychological well-being and developing psychologically safe clinical relationships that supported reflection.

An additional intervention to the ward was weekly trauma-informed reflective practice. This joint thinking space was facilitated by the ward psychologist. Creating a safe space to explore and validate staff experiences working with the traumatic material and difficult relational dynamics of the patients, staff became accustomed to reflecting on their own bodily responses and thought processes and behaviour that were elicited.

**Vignette 4: Maria’s Participation in Reflective Practice**

Maria is scheduled into the reflective practice session each week. In general, she likes these sessions as she can learn a bit more about the patients and also at least when she is in the session she’s not “on obs” and is grateful for the time away from ward-based tasks.

In the session, the discussion turns to supporting Karen. The team are asked to consider what they understand about Karen and how they experience her. Maria reports that she likes Karen but expects that Karen should be better behaved and then she would be easier to manage. Curiosity and openness are fostered in the group and Maria’s notion is explored in tandem with a psychological understanding of Karen’s developmental trauma and life experiences. Maria reframes this and believes that Karen’s self-harm is “just behaviour” which is a common label for a non-thinking approach to dismiss distress.

The team is asked, if behaviour is communication, what might Karen be communicating? The team start to volunteer their reflections not only on Karen, but other patients they see self-harming. Maria thinks Karen is communicating stress. Other staff remember that Karen has felt invalidated and powerless in her relationships and begin to wonder if that was happening prior to the last episode of self-harm. Maria at first reflects her frustration that most women are powerless in their relationship with their parents or men but just get on with it. She reflects that she gets on with it when she feels invalidated because of her heritage. As she makes this reflection, she feels a burning sensation in her face and stomach. Maria becomes aware that she has betrayed her pain to her colleagues – the very people who invalidate her. She feels vulnerable. The psychologist picks up on this instantly and offers Maria validation and support. The colleagues in the room also acknowledge their lack of awareness of this. It is agreed that this issue will be followed up safely in another forum.
Maria reflects that Karen has had very few experiences of being in control or having a say. Maria says “it must have been awful to have her children removed. She must be scared about what is happening to them too”. Maria identifies feeling a “heart sink” when she is on Karen’s observations. She suspects that this is linked to not being able to help Karen; Maria says she is frustrated and feels powerless. The team begin to reflect on the potential fear, powerlessness, and possible anger in Karen, knowing that she will likely be silenced by invalidating reactions from others, including eye rolling, sighing, or abruptly exiting the care dynamic. In considering this, the team reflect on how they can collaborate to develop a validating and soothing relationship with Karen where she is empowered to voice her concerns, Maria starts to have thoughts of hope for her working relationship with Karen.

Reflective spaces, whether they are in a group or a more intimate forum like one-to-one supervision, are important barometers for the impact of the care dynamics, monitoring risk, and supporting the health of the individuals in the team. There are inherent difficulties in the practitioner–patient relationship with power and control; however, cultivating and nurturing the team is about an authentic understanding of all participants and is critical to responding to trauma (wherever that trauma lies, in staff or patients) and preventing re-traumatisation. This should not stand alone, or be part of a project around a patient, it is a long-term investment in a trauma-informed model of care that should build consistency and have a regular reappraisal of the team’s wellbeing.

Vignette 5: Safe, Collaborative, Empowering Practice

It is the week of Karen’s eldest child’s 10th birthday. She ruminates upon the birth and the precious time she had with her. She believes she can smell her daughter and feels an overwhelming surge of grief coupled with anger and distress. The loss feels like it happened yesterday. Karen cannot distract herself from the fear that her daughter is being harmed. Her urge to self-harm is strong and she loses her appetite. She wants to die.

At the initial assessment, alongside her developmental history, the care team sought to understand when significant anniversaries or trigger factors/emotional detonators were likely to occur. They discuss the upcoming birthday and predicted the impact upon Karen and prepare to provide extra support. The team prepare with a reflective space taking a compassionate focus on Karen’s experiences. They make plans to draw up advanced decisions and a detailed care plan designed by Karen to help her through the week. Maria is looking forward to supporting Karen and hopes she will engage with the preparation.

Maria takes time to consider Karen’s experiences and believes that they are developing a psychologically safe and trustworthy relationship. Karen appears to respond warmly nowadays, and she has learned from Karen that
when she does not feel safe, she will withdraw. Maria has developed confidence in the way she speaks to Karen when she is like that.

Karen does not like to share her private thoughts; she has been invalidated too often. She worries that people will think she is a bad person for losing custody of her children, although she reflects that Maria seems more tuned in to what it is like to be a mother. Karen thinks she might be able to let Maria help her with the care plan once she has begun to set out what she might need to get through the next few days. Maria offers Karen some choices in terms of company, activities, therapeutic tasks that will offer comfort. Maria acknowledges that the week will be difficult for Karen, and Karen believes that she will be able to be upset without being told off or intensely scrutinised and gets through the week safely without feeling abject loneliness.

Summary

The vignettes have their limitations. However, they are designed to illuminate some of the intricacies that exist in trying to develop trauma-informed practices in systems that hold onto historical trauma, and in services that are ill equipped to consider multiplicity of trauma in staff and patients, particularly where the focus on outcomes is based on vague recovery models.

The Department of Health (in press) defines trauma-informed care as

a whole system approach that adopts a lifespan perspective informed by the person’s history and actively seeks to understand the impact of previous trauma and adversity on current functioning, emotional experiences and relationships. The model of care is structured to identify and eliminate process and practices which inadvertently recreate or reinforce the traumatic experiences of service users and staff.

This chapter has reflected upon the implications of the multiplicity of trauma in navigating the implementation of a trauma-informed model of care. Service developers should consider the context of the lives of both staff and patients in the communities they come from and return to. It is incumbent upon them to ensure that there are adequate resources with time to think, and that safe reflective space and trauma sensitive supervision are in place. These are fundamental expectations ahead of services delivering trauma-informed systemic interventions or direct trauma interventions/therapy.

Note

1 The response to the whistleblowing of Winterbourne view set off a process of transforming care for people with Learning Disability that was a fundamental shift for practitioners and legislators (Department of Health, 2012).
References


