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INSIGHTS

A SERIES OF EVIDENCE SUMMARIES

70

Trauma-informed approaches: a critical overview of what they offer to social work and social care

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Iriss

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Key points

- Past experience can have an impact on present-day functioning (although the nature of this connection is rarely direct or inevitable). Increasingly, this relationship between past and present is understood through a lens of trauma.
- The concept of trauma has become a major driver of Scottish public policy, with Scottish Government guidance stating that all social care and related practice should be understood and responded to through a trauma lens.
- Although it has become such a dominant feature of policy, professional practice and everyday talk, the concept of trauma remains ill-defined.
- Trauma-informed (TI) care offers little that any model of good social care should offer, and the evidence base for trauma-informed practice is, at best, inconclusive.
- There is a risk that a predominant focus on trauma may construct the kind of psychological conditions it professes to respond to.
- Social workers and social care workers need to demonstrate a sensitive appreciation of the possible impact of past experience on individuals, which requires a broad range of knowledge and dispositions. A primary focus on trauma in service delivery can limit alternative ways of thinking and practising.

Introduction

It is generally accepted that a particularly difficult experience or cumulative disadvantage in one's life can leave a legacy in respect of present-day functioning (Parker and Bullock, 2017). This has been understood, historically, through different psychosocial lenses such as grief, loss or attachment. More structural perspectives might reference the impact of what Bourdieu and Wacquant, (1992) call symbolic violence or the physiological and psychological impact of social inequality (Wilkinson and Pickett, 2010). Social work and social care operate at the intersection of private troubles and public issues (Wright Mills, 2000) and need to take both personal and structural determinants of human functioning into account.

While there is this variety of different ways we might seek to understand the linkage of past to present, Bath (2017) notes that in the space of little more than a decade, this has come to be understood through a lens of trauma.

It can be difficult to contest the concept of trauma, for to do so can be seen to question people's suffering

In everyday talk, the term has become naturalised. Joseph and Murphy (2014) argue that trauma should be adopted as a unifying concept for social work. In Scotland, the recently published National Trauma Training Programme aims to transform public services so that they are 'trauma-informed and responsive' and that 'every member of the Scottish Workforce has a role to play in understanding and responding to people affected by trauma' (NES, 2020).

It can be difficult to contest the concept of trauma, for to do so can be seen to question people's suffering. The result of this is that trauma 'escapes the need for definition' (Marlowe and Adamson, 2011: 623) and has 'remained largely unexamined' (Radstone 2007: 9). This *Insight* takes a critical look at trauma and the evidence base for the claims

being advanced that it should become the predominant lens through which we consider social suffering. In taking the position we do, we acknowledge that distress and suffering are real and can have a debilitating effect on individuals and communities

and that as practitioners and as a society we should seek to respond to these in sensitive and helpful ways.

Proponents of trauma informed approaches assert that they herald a shift to strengths-based from erstwhile bio-medical approaches to care. In this paper, we caution that the current turn to trauma does not necessarily reflect a radical shift away from a bio-medical model but risks reifying another similarly reductionist understanding of human experience and how to respond to it. Despite its claims to be strengths-based, trauma discourse often focuses on symptomatology, highlighting dysfunction and pathology within individuals who have experienced violence and abuse. This, as the feminist scholar Emma Tseris points out, 'seems to be at odds with widespread claims made about the empowering or de-pathologising capacities of trauma-informed practices' (2019: 44).

Our argument in this *Insight* is that trauma is but one perspective on human suffering, and it may not be the most helpful. We present an overview of the available research detailing reviews of trauma-informed approaches (synonyms TI care, TI practice, TI service system). A feature of such approaches is that they are to be enacted through a process of

organisational change in everyday workplace rather than trauma-specific clinical settings, where one might encounter more specific trauma treatments and specific therapies (Scottish Government, 2021). There is a separate body of literature for such trauma-specific interventions (eg Addis and colleagues, 2022; Han and colleagues, 2021), which is beyond the scope of this paper, where our focus is on the implications of TI approaches for social work, social care and related services. We have developed some of our arguments elsewhere (Smith and colleagues, 2021). In this paper, we refer tightly to the academic literature so that readers can follow up in more depth should they so wish.

What is trauma?

The term trauma derives from the Greek word for a bodily wound (Luckhurst, 2013). In recent decades, it has been extended and employed to make sense of the psychological effects of events such as the Holocaust or the horrors of war or disaster. Fassin and Rechtman (2009) trace some of the cultural and political conditions that have seen the concept of trauma emerge as the master theory for making sense of human suffering. This shift reflects but also

drives the wider therapeutic turn that has exerted such a strong cultural influence in recent decades, limiting our capacity to understand individual suffering in the context of broader historical and political changes in society (Madsen, 2014).

The turn to trauma to explain distress is not rooted in psychology but in the work of a literary scholar, Cathy Caruth (1996), who proposed that past experience exists as memories that are not immediately traceable back to a particular event but involve interpreting or reinterpreting what may have happened in the past in the light of subsequent experience. Trauma's existence is said to be attested in physical or psychological symptoms such as flashbacks and night terrors. These symptoms can be used by therapists to suggest that they must have roots in something that has happened in the past. The important thing to note here is that this link between any putative traumatic event and a subsequent response to it is not scientific but interpretative and the nature of such interpretation can be influenced by a range of political, cultural and dispositional factors (Alexander and colleagues, 2004). Trauma is not an empirically validated diagnostic category but an interpretative tool used to make meaning

in the present through reference to the past (Lambek and Antze, 1996). Tseris (2019: 6) argues that 'trauma should not be viewed as an objective concept, but rather as a paradigm that has arisen within particular socio-political and professional contexts' and that the underlying assumptions that inform these should be subject to critical analysis.

Definitions of trauma

Despite trauma being, primarily, an interpretative phenomenon, it was identified as a psychological diagnosis through the inclusion of a range of symptoms, codified as Post-Traumatic Stress Disorder (PTSD), in the Diagnostic and Statistical Manual (DSM-111) of the American Psychological Association (APA) (1980). This classified trauma as a response to events existing 'outside the range of usual human experience'.

Subsequent iterations of the DSM expanded the notion of a traumatic event, describing this as one that could also involve experiencing or witnessing actual or threatened death or serious injury, or a threat to the physical integrity of self or others, thus associating trauma with a particular event rather than the interpretation of this event. This shift towards viewing

certain events, in and of themselves, as traumatic, either directly or vicariously, is problematic because different people will react very differently to the same experience; what is considered to be a traumatic event by some may hardly register with others.

Since the initial APA definition, symptoms have been added to the definition of PTSD. Through a process of ‘concept creep’ (Furedi, 2016; Haslam, 2016), trauma’s reach has broadened from being life-threatening to a point where difficult or untoward (but often everyday) events become identified as, not merely uncomfortable or distressing, but traumatic. Trauma discourse is now replete with metaphors of psychic scars and mental wounds (Haslam and McGrath, 2020).

Proponents of a trauma discourse have, in recent years, turned to neuroscience to give substance to their claims of psychic wounds analogous to the bodily wounds that are central to original understandings of trauma (Sweeney and colleagues,

2018). However, Munro and Mushold (2014) caution that claims to neuroscientific provenance can be employed in policy as a rhetorical device which can, and is perhaps intended to, foreclose debate on a topic. Even if such neurological links do exist, they are likely to be far more complex than is accommodated in popularised understandings of neuroscience. In reality, neuroscience as an academic discipline is at a very early stage of development and explanatory power (Wastell and White, 2017).

Plafky (2016) identifies the role of ‘knowledge entrepreneurs’ within the training community in determining how superficially appealing, but complex ideas such as

trauma become simplified for public consumption. In the training world, trauma’s impact on brain development is presented as established fact, most evident, perhaps, in Bruce Perry’s brain images that supposedly show the impact of neglect on a child’s brain. Trauma has become a global business with a variety of proprietary programmes (eg van der Kolk n.d) being offered to social care and mental health

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professionals. The kind of ‘brain claims’ made in many such approaches are argued to mark a depoliticised shift, taking social problems into the realm of neuro-biology (Macvarish and colleagues, 2014; Tseris, 2013).

The Scottish Government and trauma

The Scottish Government’s (2022) policy on trauma links it, explicitly, to the Adverse Childhood Experiences (ACEs) studies (Felitti and colleagues, 1998; Bellis and colleagues, 2016). We do not discuss ACEs here, other than in the connection made from them to trauma and to note that two journal special issues of *Scottish Affairs* (Davidson and colleagues, 2020) and *Social Policy and Society* (Edwards and colleagues, 2019) engage critically with the topic of ACEs.

The interlinking of ACEs with trauma in Scotland was made explicit in a lecture by Jane Stevens, an American proponent of trauma informed approaches, who claimed that ‘trauma-informed practices (underpinned by ACEs) are already showing remarkable results’ (GCPH, 2016:1). This rhetoric was picked up by the Scottish Government (2017), which set out to ‘embed a focus on preventing

ACEs and supporting the resilience of children and adults in overcoming early life adversity across all areas of public service, including education, health, justice and social work’. This direction of travel was cemented by the launch of the National Trauma Training Programme (NES, 2020).

The Scottish Government defines psychological trauma as referring to ‘a wide range of traumatic, abusive or neglectful events or series of events (including Adverse Childhood Experiences (ACEs) and trauma in adulthood) that are experienced as being emotionally or physically harmful or life threatening’. The definition goes on to acknowledge that ‘(w)hether an event(s) is traumatic depends not only on our individual experience of the event, but also how it negatively impacts on our emotional, social, spiritual and physical wellbeing. We are all affected by traumatic events in different ways’ (NES, 2020). Those adversely affected by trauma are said to experience a range of negative consequences if not supported (Scottish Government, 2022).

These assumptions around trauma and its consequences have led the Scottish Government to adopt a vision for Scotland as ‘A trauma informed

and responsive nation and workforce, that is capable of recognising where people are affected by trauma and adversity, that is able to respond in ways that prevent further harm and support recovery, and can address inequalities and improve life chances' (NES, 2022). The mechanisms through which TI approaches are imagined to address inequalities or improve life chances are not developed. Regardless, any commonly accepted definition of trauma remains a subject of controversy (Dalenberg and colleagues, 2017). Such controversy converges around 'the boundaries of the condition, diagnostic criteria, central assumptions and clinical utility' (Jones and Cureton, 2014: 257). A continuing lack of definitional clarity poses a difficulty for any interventions or approaches that might claim to be based upon it.

What is trauma-informed practice?

Those who are assumed to have experienced trauma are said to require services that are 'trauma-informed'. Sweeney and colleagues (2016:17) state, somewhat circularly, that 'in a trauma-informed service, it is assumed that people have experienced trauma'. The US Substance Abuse and Mental Health

Services Administration (SAMHSA), (Huang and colleagues, 2014) defines a TI approach as 'a program, organisation, or system that realises the impact of trauma, recognizes the symptoms of trauma, responds by integrating knowledge about trauma policies and practices, and seeks to reduce re-traumatization'. The SAMHSA document identifies four key elements of a TI approach: workforce development, practice change and use of evidence-based practices, trauma screening, and inter-system collaboration and communication. A more recent discussion of TI care describes it as guided by six key principles of safety, trust, collaboration, choice, empowerment, and cultural sensitivity (Lewis and colleagues, 2022). The Scottish Government (2021) model of being trauma-informed is underpinned by five principles: safety, trustworthiness, choice, collaboration, and empowerment. It recognises the importance of relationships and seeks to prevent re-traumatisation.

Such generic descriptions offer few tangible pointers as to how one might go about offering trauma-informed care (TIC). If one were to remove mention of trauma from the above definitions, it would be difficult to gauge what might differentiate them from any other form of care. Indeed, all of the principles

of TIC are, as Berliner and Kolko (2016: 169) point out, ‘essentially principles of good care and are not specific to trauma’. This case is consistently made in studies of TI care eg Asmussen and colleagues (2022) concluded that although TI care is widely used and perceived to add value, there is a high degree of overlap between TI care activities and standard good practice in children’s social care. Addis and colleagues (2022) note the considerable overlap between good practice and TI care, which limits the ability to identify what is unique to such approaches or to measure what difference they make for staff and people using services.

The (limited) evidence for trauma informed practice

The Scottish Government claims that ‘trauma-informed practice is effective and can benefit both trauma survivors and staff’ (2021: 9). Frameworks such as the recent Trauma-informed Practice Toolkit (Scottish Government, 2021) point to examples of research to support benefits for trauma survivors: for example, reduction of seclusion and restraint in mental health settings (Azeem and colleagues, 2011); reduction in time to discharge in youth secure

care (Greenwald and colleagues, 2012); increased engagement and reduction in substance misuse for ‘hard-to-reach’ populations (Cocozza and colleagues, 2005; Chung and colleagues, 2009). Yet, when these claims are traced back to source, one finds that the authors are more equivocal in their assessment of the impact of trauma-informed interventions than the Toolkit suggests, highlighting methodological limitations and cautioning against making more generalisable claims from their findings.

A number of attempts have been made to ascertain an evidence base for TIC. A special issue of the journal, *Child Maltreatment*, issued a call for empirical papers on trauma-informed care. It received few submissions, leading the editors to speculate that ‘this could be due to our emphasis on empirical research rather than just broad descriptions of TIC efforts’ (Hanson and Lang 2016: 99). The same editorial reflected that none of the papers they received specifically examined the relationship between TIC and youth outcomes nor the costs or benefits of TIC, concluding that ‘without this kind of evidence, we may continue down a path which intuitively makes sense and is filled with good intention but lacks empirical support...’ (2016: 99).

Turning to the Scottish Government's claimed benefits for staff of TI approaches, the Toolkit highlights improvements in supervision, training and support to mitigate the potential for vicarious trauma and burnout (Scottish Government, 2021). However, it is unclear how or why these improvements require the specific focus of being trauma-informed. A review by Purtle and colleagues (2020) evaluating the effects of organisational interventions that included a TI staff training component is often cited as providing evidence for the benefits of TI approaches. However, what is reported is that staff knowledge, attitudes and behaviours related to TI practice improved following participation in trauma-informed training. It would be surprising if it didn't, but greater knowledge of TIC is only worthwhile if this results in improved practice or better outcomes for service users. The authors also note that it was unclear whether changes in knowledge were retained over time or whether they did translate to improved client outcomes. Further afield, a review of Australian youth justice (Armytage and Ogloff, 2017: 48) introduces a further critique of TIC, noting that it was 'not convinced that staff sufficiently understand, nor can put into practice, the essential elements of what is fundamentally a clinical approach to a therapeutic intervention.

Systematic and scoping reviews

Sweeney and colleagues (2016) support the implementation of TI approaches to be embedded in mental health care in the UK but, noting the lack of available evidence at that time, called for systematic reviews (which synthesise findings from individual studies and are therefore considered to offer more reliable evidence) to examine the effectiveness of TI care in mental health contexts and more generally.

The systematic reviews that have been conducted subsequently all tell a similar story. Maynard and colleagues, (2019: 3) concluded: 'We simply do not have the evidence (yet) to know if this approach works, and indeed, we also do not know if implementing trauma informed approaches in schools could have unintended negative consequences'. Another review of trauma-informed care programmes in outpatient and counselling health settings for young people (Bendall and colleagues, 2021) found that there was a need for greater consensus regarding an operating definition of TIC. Moreover, as only two out of the 13 included studies examined whether outcomes improved following TI interventions, further research was deemed necessary to draw any

meaningful conclusions. Two separate systematic reviews around the evidence for TI approaches in schools (Cohen and Barron, 2021) and (Avery and colleagues, 2021) found that limitations of research in this field, including a high risk of bias, made it difficult to generalise outcome results and thus make any concrete conclusions around efficacy. Both concluded on the need for further research.

In 2021, research funded by the NIHR Biomedical Research Centre in partnership with Bristol NHS Foundation Trust and the University of Bristol, embarked on a Cochrane style review of TI approaches in healthcare globally with the aim to synthesise the evidence to ‘inform the development of a UK specific model of TI care in primary care and community mental health care settings’ (Dawson and colleagues, 2021). Their pilot searches and consultations with experts found ‘extensive literature on articulating TI approaches and how and why we should implement and evaluate them’. It also ‘identified a booming market of training and certification on TI approaches’ (Lewis and colleagues, 2022: 8). However, despite ‘exhaustive searches’ of five databases covering 1990 to 2021, they were only able to include six studies,

all non-randomised. Although these reported some positive findings around improvements to patient readiness for treatment and reported sense of safety, they found that the evidence for patient satisfaction was conflicting and concluded that more methodologically robust evaluations of TI organisation change interventions are required (Lewis and colleagues, 2022).

Another recent review, published by the Early Intervention Foundation (EIF) (Asmussen and colleagues, 2022) examined the evidence around the use of TI approaches in children’s services in England. It concluded that TI activities rarely led to evidence-based interventions and recommended that the benefits of TI care must be identified and further evaluated, and that TI care should never be used as a replacement for evidence-based, trauma-specific treatments.

While systematic reviews provide a more robust overview and evidence-base from which to judge the relative efficacy of TIC within specific contexts than do individual studies, scoping reviews (which identify and examine all the available systematic reviews) are useful in examining emerging evidence across a range of services and settings (Munn and colleagues,

2018). The most comprehensive UK scoping review to date was produced by the ACE Support Hub Wales (Cymru) and Wrexham Glyndwr University, with funding from the Welsh Government (Addis and colleagues, 2022). It included all the available systematic reviews published within the last five years related to trauma-informed approaches within high-income countries, comparable to the Scottish/UK context. A total of 17 systematic reviews were included, covering schools, child welfare, health services, justice services, mental health services, maternity and perinatal services, and system wide approaches. The findings highlighted concerns around methodological implementation, lack of definition and consistency across a range of settings compounded by a lack of coherent benchmarking in relation to national efforts to implement TI training. It concluded that 'the evidence of the effectiveness of a trauma-informed approach is limited' and concluded that a lack of definitional clarity impacts any ability to 'consistently implement and evaluate such approaches'(Addis and colleagues, 2022: 24).

On the basis of the current evidence, the best we can say is that further research is needed. It is a moot point when we may need to conclude that the research is not

going to provide the hoped for results. More broadly and tellingly, even trauma specific interventions are found to be less important in any change process than is extra-therapeutic social support or the therapeutic alliance formed between practitioners and clients (Norcross and Wampold, 2019). This might suggest that ensuring appropriate social supports and interpersonal connections, rather than specific trauma interventions, or trauma informed care ought to be the primary focus of social care activity.

Lived experience as evidence

An argument might be made that, even if improved outcomes are difficult to show empirically, TI approaches are nonetheless worthwhile because those who experience them find them to be so. The Scottish Government/NES documents draw on the voice of 'lived experience' to bolster the evidence base for trauma informed approaches (NES, 2020), reflecting a wider turn to 'lived experience' in policy formulation. We make a couple of brief points here: 1) 'lived experience' is not representative of any wider social reality, 2) 'lived experience' is constructed in historical, contextual, discursive and inter-subjective circumstances and reflects 'the ambiguity and

contradictions within and between individuals and their lives' (Grant, 2014, n.p). Woodiwiss (2013) describes how, in telling the story of our lives, we draw upon the cultural scripts available to us. So, if we are presented with trauma as the dominant cultural script about how we are to understand the past, then we are inclined to turn to that to constitute our 'lived experience'. Woodiwiss goes on to suggest that in doing so, we become victims, not so much of what has happened to us but of the limited number of cultural scripts through which we might make sense of this. Viewing the past through a singular lens of trauma may limit the ability of people to understand and tell the stories of their lives in alternative, more adaptive and hopeful ways (Haslam and McGrath, 2020).

Possible unintended consequences of TIC

Maynard and colleagues (2019, above) raise the question of possible unintended negative consequences of a focus on trauma. We need to consider that there may be. Any way of thinking that frames suffering in a particular way and classifies people within that frame will shape how they understand themselves and others (Hacking, 2007).

As we signal above, calling something trauma requires that people consider themselves to be traumatised. In this sense, trauma may be iatrogenic, ie induced by dominant diagnostic and cultural categories (Dineen, 1999; Lukianoff and Haidt, 2015). There is some evidence for this eg the expansion of APA definitions of trauma brought about a 59% increase in trauma diagnoses (Breslau 2002). This is not necessarily a positive development; it merely creates a cohort of self-identified trauma sufferers unable to make sense of their lives in more hopeful ways (and likely unable to access the mental health services they are led to believe they require). This asks questions of Sweeney and Taggart's (2018) claim that everyone is able to use services that are trauma-informed, regardless of whether they consider themselves to have suffered trauma. The very fact of calling services trauma-informed and proceeding on such a basis holds out the possibility of people starting to self-identify as traumatised where they didn't previously. This is problematic when the evidence for the efficacy of trauma-informed approaches is as equivocal as it is. Moreover, the traumatised identity is not a positive one but can act to imagine 'the human subject to be hopeless, lacking agency and prey to external events beyond their control' (Haslam and

McGrath, 2020: 525–26). This may, in turn, reduce an individual's natural resilience and ability to cope with distress and suffering (Jones and McNally, 2022).

Implications for the social services workforce

In raising the questions we do about the increasing dominance of trauma-informed approaches in social work and social care, we reiterate that we do not seek to detract from the possible enduring impact of people's past experiences of adversity or disadvantage. And we support the need for practice to incorporate key skills and dispositions around use of self, sensitivity to history and context, the importance of relationships, listening to people's stories, and seeking to interpret these with a view to mitigating any negative traces.

This is something, we would argue, that, historically, has been central to good social work practice, albeit this psycho-social aspect of the work may have diminished in the managerial climate that has persisted in recent decades. Spratt and colleagues (2019),

indeed, argue that the focus on the long term that is central to ACEs and trauma perspectives can be lost in the instrumental and programmatic approaches to practice that are a feature of managerialism.

However, we caution against any singular approach to how this linkage of past to present is understood. Social work draws on a wide range of sources of knowledge, which includes the psycho-social but also incorporates structural and cultural insights from sociology, politics, philosophy and anthropology as well as experiential, tacit and reflexive knowledges. These cannot be reduced to a singular lens as trauma policies explicitly seek to do, but call for an artistic and interpretative response, which may (or may not) consider a notion of trauma within a range of other possible modes of understanding.

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A trauma lens reflects a particular perspective on the impact of past experience (Edwards and colleagues, 2019), one that is rooted in a (clinical) psychological worldview, which can act to biologise social suffering

(Canter, 2012). While there is passing mention of poverty and other oppressions within trauma-based approaches, these lack substance and do not draw on any social scientific literature to back them up or to propose how they might offer any suggestions of how they address structural issues in society. Indeed, the Scottish Government's policies are premised

on an interpersonal view of suffering. The Ministerial Foreword to one of their trauma initiatives, for instance, talks of how understandings of trauma have been brought to the surface through the bravery of those who 'have spoken out about their experiences of having lived through terrible events and been subject to horrific crimes, often behind closed doors' (NES, 2017:4).

Most adversity, however, is not interpersonal. The failure of trauma discourse to take a more social view of human suffering has led to critiques of trauma as medicalising distress (Bracken, 2002) and of failing to incorporate sufficient analysis of the structural causes of suffering, be those economic (Lang, 2018) or

gender-based (Tseris, 2019). Lang (2018: 156) argues that trauma 'limits the ways political grievances can be articulated and trades recognition of trauma for recognition of the causes for human suffering in social inequality, political power struggles, and economic interests'. In Scotland, the roots of most social suffering and despair can be attributed to austerity

and social inequalities (Walsh and colleagues, 2022). Any social welfare response to suffering needs to offer a well-developed structural critique of the current economic and political systems. Without this, trauma-based approaches, even if they could be shown to be effective, which they

have not, will do no more than place sticking plasters on more serious social wounds. Lasch, as far back as 1978, recognised how psychologising the social origins of suffering acts to forestall more effective and lasting solutions to social problems.

At another level, the turn towards psychological explanations of social problems raises questions for the practice base and identity of the social services

The roots of most social suffering and despair can be attributed to austerity and social inequalities

workforce. It poses a tension between trauma as an essentially clinical (and largely individualised) concept and care as an everyday social practice (Monteux and Monteux, 2020), and imposes a hierarchy in the relationship between these, within which care is devalued. Premised on the notion of trauma being ‘everyone’s business’, the Scottish Government’s National Training Plan, nonetheless, sees this business as operating within a hierarchy of expertise from novice through ‘trauma-informed’ through to ‘trauma specialist’. Trauma specialists, however these may be identified, are at the top. The expertise of those engaged in everyday care work is subordinated to these ‘specialists’. Baron and Mitchell (2018) highlight this in designating residential care workers in a Scottish secure unit, not as highly skilled experts in everyday care (Cameron, 2020) but as ‘novice therapists’ beholden to the ‘trauma specialist’. A further, fundamental, point to note with regard to the social services workforce is a structural one – we are currently experiencing a social care crisis. Trauma informed (or indeed any other model of) care cannot be implemented in conditions of high levels of staff churn and major recruitment difficulties. Addressing this crisis might constitute a more appropriate use of resources.

Conclusion

Clearly, those who promote trauma perspectives do so from a position that wants to see more compassionate responses to people’s suffering. However, Bloom (2017) argues that decisions that are overly shaped by a seemingly empathetic response risk having deleterious consequences. He argues that compassion needs to be augmented with deliberative reasoning. This requires more critical attention to the many critiques of trauma some of which are outlined here but also needs greater structural and political analysis. If we become too narrowly focused on what is essentially a clinical construct of trauma transposed onto social care, we risk failing to name structural causes of social suffering but also of diminishing the importance of everyday supportive social networks, care relationships and access to good resources and, ultimately, the innate capacity we all have to move on in our lives. These goals require a broader disciplinary lens and need to be located in an appropriate professional frame such as community social work (Turbett, 2018) or social pedagogy (Smith and Monteux, 2019), which recognise the interplay of the individual in social context and are rooted in relational care.

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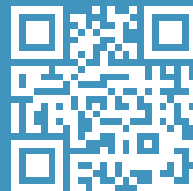
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