

SECTION 3.4

TRAUMA-INFORMED PRACTICE

3.4 TRAUMA-INFORMED PRACTICE

LETICIA FUNSTON

Trauma experienced in childhood and in early adulthood is increasingly being recognised as one of the primary social determinants of health and wellbeing. This is because violence and abuse experienced by young people can have severe, pervasive and lifelong effects on their health, 'identity, relationships, expectations of self and others, ability to regulate emotions and view of the world' (Elliott et al. 2005).

Young people, particularly those who face social marginalisation and who live in poverty, are more likely to experience both overt and covert forms of violence and poorer general health as a result. We also know that socially and economically marginalised young people can have reduced access to high quality health services (McKenzie-Mohr et al. 2012).

The experience of trauma affects each young person differently. That said, violence against young people (particularly child sexual assault) is associated with increased risk of self-harm and suicide, homelessness, risk-taking behaviours including drug and alcohol misuse, early involvement in the criminal justice system, chronic physical and mental health problems and gambling (Ferlitti 2002).

Given the relatively high prevalence of violence and abuse perpetrated against and by young people in Australia, it is critical that all health practitioners and those working closely with young people adopt trauma-informed practice. This framework recognises that:

- Many young people are victims of recent violence and abuse and/or may be at risk of future victimisation
- Young people sometimes victimise others
- Many young people live with the traumatic effects of past child abuse.

Service providers who take a trauma-informed approach to their work with young people are more effective in preventing ongoing and escalating violence against young people and reducing the risk of re-traumatising young people. The framework includes broad principles that provide the basis for a generalised approach, so the framework applies whether a young person has made a disclosure of violence or not. It does not, however, reduce the need for specialised trauma services and practitioners.

VIOLENCE, TRAUMA AND AUSTRALIA'S YOUNG PEOPLE

According to the Australian Institute for Health and Welfare (AIHW 2013), between 2011-2012 there were 252,962 notifications of suspected child abuse and neglect made nationally. Based on the substantiated reports of abuse in Australia, the percentage of primary abuse is as follows:

- Sexual assault (12%)
- Physical assault (21%)
- Neglect (31%)
- Emotional abuse (36%)

It is likely that the actual prevalence of abuse is much higher than this: many assaults are not disclosed by young people and it can be difficult to substantiate reports of abuse (Irenyi 2007). Young people are most likely to be abused by a family member, carer or people within their broader care-giving system. However, assaults perpetrated by strangers are also common. Young people experience violence and abuse from other young people including:

- Intimate partner violence
- Sexual harassment and assault
- Physical assaults
- Online harassment
- School and workplace bullying

Some young people also have experiences of collective or community trauma and violence including:

- Poverty
- Housing stress
- Lack of access to education and employment
- Racial and cultural tensions
- Theft
- Street assaults
- Multi-generational exposure to violence
- Oppression
- Discrimination
- Criminalisation
- War trauma
- Pre- and post-migration stress.

We can understand young people's exposure to multiple forms of violence as poly-victimisation.

SEXUAL VIOLENCE

'One time I was going to a party, and I was like... 'Well, I'm going to wear a big huge sweatshirt and jeans and a hat, and I'm going to be so unattractive and no guys are going to try to talk to me.' Opposite

was true. This guy kept trying to kiss me in front of his friends, and I didn't want to so he picked me up in the air. And like, the thing that surprises me, too, is like I am a big girl, and I think that is also a reason why I have not ever tried to lose weight is because it makes me feel like I have some arena of protection or something" (Katherine P Luke, 2009).

Sexual violence can include:

- Sexual harassment (e.g. showing a young person pornography)
- Sexualised bullying
- Unwanted kissing and sexual touching
- Sexual pressure and coercion
- Sexual assault including rape (Quadara 2008).

The Australian Bureau of Statistics reports that young people aged 10-24 years are eight times more likely to be victims of sexual assault than those aged 25 years and over (Australian Institute of Family Studies 2012). A recent meta-analysis of 55 international studies reported that the prevalence of child sexual assault ranges from eight per cent to 31 per cent for girls and three per cent to 17 per cent for boys, consistent with the estimated prevalence in Australia.

Many young people have difficulty naming an incident as sexual assault and are reluctant to use the terms 'sexual assault', 'rape' or 'sexual abuse' to describe unwanted sexual experiences (Quadara 2008). Contributing factors include the common belief amongst young people that sexual assault cannot occur within a relationship that is theoretically based on trust and care. Sexual assault survivors also commonly experience deep feelings of shame and sometimes believe they are to blame for the assault or ongoing abuse.

Indigenous young people are 6.6 times more likely to be victims of a sexual assault than non-Indigenous young people (NSW Ombudsman 2012) despite comprising a minority of the total population (Demetrius and Ware 2012; Wood Special Commission of Inquiry into Child Protection Services 2008). The high prevalence of sexual assault for Indigenous young people occurs within a context of social and political marginalisation, racism, and intergenerational trauma.

FINDING OUT MORE...

The experience of trauma can affect a population. The trauma experienced by the Stolen Generation continues to echo for Indigenous people in Australia. For more information about the health challenges faced by Indigenous young people, see chapter 3.7 Resilience and Indigenous young people.

In Australia, there are twice as many substantiated cases of sexual abuse of young women (aged 18 and under) as cases of sexual abuse of young men. Young women are also more likely than young men to be sexually assaulted in dating and other intimate relationships. The higher rate of sexual abuse of young women may be associated with widespread sexist attitudes and a 'rape culture', which normalises sexual violence. As a result, young women are often blamed for being assaulted and are made to shoulder the responsibility for preventing their own victimisation. For instance, a recent study reported that 19% of male and female respondents aged 18-35 years believed that men are 'provoked' to sexually assault women if they appear to be 'drunk' or 'flirtatious' (Tutty 2011).

Sibling sexual abuse is highly prevalent in Australia. It is mostly committed by boys and young men and is more common than sexual assault perpetrated by step-fathers and fathers (Laing et al. 2006). The impact of sibling sexual abuse can be just as severe as sexual abuse perpetrated by adult caregivers and strangers. Sexually harming behaviours sometimes indicate that a young person has been sexually abused; however not all young people who sexually harm others have been victims (Laing et al. 2006).

PHYSICAL ABUSE

"She had experienced violence from a group of students who went to her high school. She said that, after she came out as a lesbian, she was harassed and bashed by this group. They followed her home from school every day for a month" (Attorney General's Department of NSW 2003).

Approximately 5.8% of persons aged between 15 and 24 years have experienced at least one physical assault. Physical assault includes:

- Pushing
- Hair-pulling
- Hitting
- Punching
- Kicking
- Biting
- Scratching
- Strangling
- Choking
- Use of a weapon

Again, young people are more likely to be physically abused by people known to them often in the context of family violence, dating and intimate partner violence. This is particularly true for young women. On the other hand, young men are more

likely to be assaulted by strangers in public spaces, such as pubs and clubs (Quigley and Leonard 2004).

EMOTIONAL ABUSE AND BULLYING

"Bullying is when someone picks on someone else because they are different – their race, height, weight, or looks ... (it's about) prejudice and discrimination and when someone gets hurt physically or mentally, or when someone is not respected". (Young woman, year 8, quoted in Oliver and Candappa 2007).

While all forms of physical violence inflict emotional damage too, emotional abuse does not always involve physical or sexual assault or neglect. Emotionally abusive behaviours include:

- Rejecting
- Ignoring
- Isolating
- Terrorising
- Corrupting
- Verbally abusing and belittling
- Withholding of affection or attention
- Failure to provide a child or young person with the appropriate support, security or encouragement (Higgins 1998; James 1994; US National Research Council 1993).

The effects of emotional abuse can have profound long term impacts on a young person.

Young Indigenous people and young people from CALD groups within Australia, are likely to experience high rates of emotional abuse and bullying particularly within the school system. In one Australian study, 31% of young people attending school reported being bullied at school and, of these, approximately 30% experienced racist name-calling and discrimination.

Young people who identify as gay, lesbian, bisexual, transgender, intersex or queer (GLBTIQ) also experience higher rates of emotional abuse and bullying.

DOMESTIC AND FAMILY VIOLENCE

Domestic and family violence includes any behaviour in an intimate or family relationship which is violent, threatening, coercive or controlling, causing a person to live in fear.

An intimate relationship refers to people who are, or have been, in an intimate partnership; whether or not the relationship involves or has involved a relationship of a sexual nature i.e. married or engaged to be married, separated, divorced, de facto partners (whether of the same or a different sex), couples promised to each other under cultural or religious tradition or dating.

A family relationship has a broader definition and includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, sibling and extended family relationships. It includes the full range of kinship ties in Indigenous communities, extended family relationships in CALD communities and constructs of family within GLBTIQ communities.

Around 1 in 4 Australian young people have witnessed domestic and family violence perpetrated against their mother or stepmother (Rutherford and Zwi 2007). It is important not to assume that witnessing domestic and family violence is any less traumatic than directly experiencing the abuse. The effects of experiencing domestic violence, either directly or as a witness, commonly include:

- Anxiety
- Depression
- Social withdrawal
- Low self-esteem
- Substance abuse (Fraser 1999; Evans and Sutherland 1996 cited by Domestic Violence and Incest Resource Centre Victoria 2005).

We also know that:

- Domestic and family violence is a strong predictor of sexual and physical assault against young people (Laing 2000).
- Witnessing violence in the home can contribute to other risk factors and stressors including "loss of home, disruption of schooling and friendships, adjustment to refuge living and the public reactions to 'breaking the secrecy' of violence" (Laing 2000).
- Domestic and family violence and child abuse are the primary causes of youth homelessness both in Australia and internationally.

Intimate partner violence often consists of multiple forms of abuse and assault (e.g. stalking and harassment, emotional, sexual, financial and physical abuses) which typically escalate in severity over time. Women aged 15 to 24 are three times more likely to be murdered by their partners and ex-partners than women aged 25 years and older (Tutty 2011).

Violence in young people's intimate relationships is mainly perpetrated by young men against young women. However, lesbian, gay, transgender, bisexual, intersex and queer-identifying (LGTBIQ) young people also experience violence and abuse in their intimate relationships. This group of young people is also likely to experience:

- Threats by an abusive partner to "out" them as a method of control and emotional abuse

- Increased isolation because intimate partner violence is commonly perceived as a heterosexual issue
- Additional difficulties in disclosing abuse because of the relatively small size of their communities, particularly in regional and remote areas
- Limited access to support service because only a small number of domestic violence services are both LGBTBIQ and youth-friendly in Australia (AIDS Council of NSW 2008)

TECHNOLOGY-BASED RISKS

"Some boy asked me, 'Can I have a picture of you', I was like, 'My display picture' and he was like 'No I mean a special photo' and I was like, 'What special photo' and he was like, 'Like you in your bra' and I was like 'No', and I was like, 'I have one of me in my bikini' And he was like, 'can you send it anyway'". (Jodie, year 8)

The rise of social media has delivered new and creative forums for young people to connect with others and to express themselves. However, easy access to new technology and to social media has also created new risks for young people. Social media, online dating, and web-based communication such as email and live chat have increased the exposure of young people to bullying and harassing behaviour. Predators have also used these technologies to gain access to young people.

Social media has facilitated an increase in online and telephone-based sexual harassment such as sexting – sending sexually explicit text, video and photographs to other people, groups and online communities. A study in the United States reported that 15 % of young people aged 12–17 years received sexually suggestive, nude, or near nude images of someone they knew via text messaging on their cell phone, and 4% had sent such messages (Lenhard 2009). Sexting is considered to be coercive and primarily targets young women as 'it is shaped by the gender dynamics of the peer group in which, primarily, boys harass girls'. (NSPCC 2012). Sexting is also increasingly becoming common amongst aged between 10 and 14 years.

HOW TRAUMA AFFECTS A YOUNG PERSON

Trauma is not only the experience of being harmed, violated or abused: 'what is traumatising to a person is symbolically invoked by the experience and how people respond to the person who has traumatised' (Brown 2004). In other words, the personal and cultural meanings of the trauma often compound the stressors caused by interpersonal abuse and violence (Toro, Dworsky and Fowler 2007; Kezelman and Stavropoulos 2012).

The impact of trauma and violence is intensified when the violence is experienced in the context of an emotional betrayal. For example a child expects a parent or caregiver to provide a safe, secure, nurturing environment in which they are protected from harm. The experience of violence or abuse at the hands of that parent or carer is compounded by the betrayal of the child's trust in the older, more powerful person in the relationship. This is often referred to as complex trauma.

While children and young people may experience trauma from natural disasters and accidents, complex trauma has comparatively more intense and long lasting effects. Suicide, self-harm and suicide ideation are strongly associated with young people who are victims of sexual assault, particularly CSA, and physical violence. Complex trauma is also linked with higher risk-taking behaviours. Young people are more likely to act out their distress:

- They may be more likely to use drugs (particularly tobacco and marijuana) and to drink alcohol than young people who have not been abused
- They are more likely to become pregnant during adolescence and are significantly less likely to practise safe sex
- They are also more likely to experience early involvement in the criminal justice system. In a self-report survey of young people in juvenile detention in NSW, 81% of females and 57% of male young people stated that they had been abused or neglected (Indig et al. 2011).

Family members, schools, employers and service providers sometimes misunderstand and dismiss this behaviour as disobedience, delinquency, attention-seeking or as an indication of a mental illness. However, from a trauma-informed perspective, the young person's behaviours may be seen as coping responses – ways of surviving.

Research has highlighted the adverse effects of early onset trauma on the developing brain. Early onset trauma requires a shift from a 'learning' brain to a 'survival' brain and disrupts neural integration, which is necessary to respond flexibly to daily challenges (Courtois and Ford 2009). The adverse effects of complex trauma on individual functioning are pervasive and deeply disruptive of key developmental processes in at least three major domains (Kezelman and Stavropoulos 2012; Siegel and Hartzell 2004):

- Attachment – the capacity to form and maintain healthy emotional and mutually safe and supportive relationships
- Self-regulation – the capacity to modulate emotions, manage impulse control and self-calm during times of stress and turmoil

- Development of competencies – particularly to achieve educational outcomes and complete basic developmental tasks of adolescence

TRAUMA-INFORMED PRACTICE

"We are not suggesting that agencies and staff ignore inappropriate behaviour. Instead, we are asking staff to work with young people to identify the behaviour that was problematic, put it in the context of trauma, and to help the young person find different ways to express their anger, frustration, or sadness. We want youth to know that we can see far beyond the 'problem behaviour', and see the youth's capabilities and potential" (Stefanidis et al. 2010).

Trauma-informed practice has been described as a paradigm shift in service provision (Elliott et al. 2005, p. 462). Certainly, for many practitioners, it represents a new way of responding to 'problem' behaviour. Instead of drawing on a traditional, pathology-based approach (asking 'what is wrong with you?'), A practitioner adopting a trauma-informed approach seeks to understand the young person's experiences (asking 'what happened to you?'). This approach recognises the impact of external, socially-embedded causes of distress, trauma and disadvantage (McKenzie-Mohr et al. 2012).

While members of the sector may define trauma-informed practice differently, seven principles are widely accepted as being at the core of trauma-informed practice. Trauma-informed practitioners focus on:

1. Providing a physically and emotionally safe environment
2. Sharing power with the young people of the service, maximising their choice and control
3. Providing training and education for practitioners about the impacts of trauma and developing safety and crisis plans
4. Providing ongoing supervision and support for practitioners to mitigate the impacts of vicarious trauma
5. Providing a culturally safe and gender-sensitive service
6. Ensuring communication is open and respectful
7. Supporting young people's goals and interests
8. Referring young people to trauma-specific services and interventions

(Hopper et al. 2010; Cusack et al. 2008; Fallot and Harris 2006; Hummer et al. 2010).

Trauma-informed practice is inherently strengths-focused and emphasises the young person's ability to survive. It specifically resists the idea that a young person has a distorted or pathological world view

in the aftermath of violence (Burstow 2003) and instead requires the practitioner to understand that a young person's responses or ways of coping have developed in the context of trauma. Trauma-informed practitioners will validate and attempt to understand a young person's resilience even if the chosen coping strategies are now causing difficulties.

Trauma-informed practice has a lot in common with anti-oppressive practice. It recognises that there is a power imbalance in the relationship between the practitioner and the young person and asks practitioners to 'do their best to flatten the hierarchy' (Elliott et al. 2005). Without even realising it, practitioners can actually cause further trauma if they exert power over young people by using a punitive or authoritarian style, because it repeats the experience of coercion and 'power-over' used by the perpetrator.

Trauma-informed practitioners work on educating the young person and their support network about the effects of trauma and helping them to reflect on and understand their behaviour within the context of trauma. This helps the young person understand what has happened to them without shame or blame.

TABLE 8 - COMPARING THE APPROACHES

(HENDRICKSON 2010)

Punitive Approach
<ul style="list-style-type: none"> • Punishment is used to enforce obedience to a specific authority. This can re-traumatise young people who have been abused by caregivers and other adults who are in a position of power. • Punitive language and rules can escalate conflict. • Punishment is usually used to assert power and control and often leaves a young person feeling helpless, powerless, and ashamed. • Punishment often benefits service providers but not young people who may be expressing extreme distress and trauma.
Trauma-Informed
<ul style="list-style-type: none"> • Intentionally designed to teach and to shape behaviour within firm limits using non-blaming, non-shaming and non-violent communication. • Trauma-informed practice means discussing consequences that are clearly connected to the behaviour, delivered with genuine empathy and respect. • Trauma-informed practice uses words that encourage thinking, and preserve connections between people.

SAFETY: PHYSICAL, EMOTIONAL AND CULTURAL

Safety is the cornerstone of trauma-informed practice (Herman 1992). Young people who have experienced trauma may have very few places where they feel safe. Services working with young people have the opportunity to be that safe place for young people. The safety of the young person must be established before any therapeutic work is attempted. In trauma-informed practice, establishing safety means:

1. Taking action to ensure a young person, who has been recently harmed and or who is at risk of ongoing harm, is physically safe
2. Developing emotional and cultural safety with a young person and their non-offending family members, carers and supports.

Practitioners should not assume that a young person attending a service is no longer at risk of harm. Young people need to be informed of their rights and supported to obtain police protection and take legal action.

It is important to work with the young person and safe adults (that is, non-offending parents, carers or other trusted adults) to develop a safety plan. A safety plan is a written or verbal set of strategies developed collaboratively to enable them to remain calm and safe in risky situations which may include the home, school, public transport, at parties, during dates, in intimate situations and online. It is important to convey that a safety plan does not make the young person responsible for preventing victimisation, and a safety plan does not take the place of police or legal protection when that is required.

The concept of safety also extends to how the health practitioner and broader service increases the young person's sense of emotional and cultural safety while engaging with the service. Health services are increasingly recognising that 'cultural diversity and a connection to one's own culture is the key to recovery' (O'Hagan 2004). Culture also profoundly influences the way in which a young person has experienced trauma and violence and is central to healing.

Trauma-informed practitioners must be aware of their own cultural worldviews and histories and how this may influence engagement with young people (Elliott et al. 2005). Invite the young people you work with to educate you about their cultural identity and what they need to feel safe. Cultural safety also means, whenever possible, moving outside the service building to engage young people in safe places in their communities.

Once a young person is physically, emotionally and culturally safe, you can encourage them to tell their stories and reconnect with others. You can encourage this by creating spaces for young people to meet informally or to share experiences through supportive group work contexts.

UNDERSTANDING DISCLOSURE

Many young people feel very reluctant to disclose experiences of abuse or the threat of violence. Young people can be intimidated out of making disclosures or withdraw a disclosure for many reasons, including:

- Pressure or threats from the perpetrator
- Relationship to the perpetrator
- Anticipated consequences of telling (e.g. physical injury/death, family separation, parental distress)
- Pressure from family members
- Fear of negative reactions from parents or family
- Fear of not being believed
- Feelings of embarrassment, shame and self-blame
- Fear of stigmatisation (Hunter 2011).

It is important to explain to young people the limits on confidentiality. This gives young people the opportunity to choose how and when they make a disclosure of abuse or violence, and gives them as much power as possible. Granting young people power to make decisions is important: the experience of trauma and abuse is one of disempowerment and control. Survivors need to exercise choice over how, when and to whom they make a disclosure, and understand the possible outcomes of disclosure.

Disclosures must be understood as a process: the young person will tell their whole story over time as they feel safe to do so. Young people rarely disclose the full extent of a traumatic event or abuse while making an initial disclosure. You can support a young person making a disclosure by:

- Telling the young person that you believe their disclosure
- Making it clear that whatever has happened is not their fault
- Telling the young person that the perpetrator is responsible for the assault
- Reassuring the young person that they did the right thing by making a disclosure
- Listening carefully to and reassuring the young person, including explaining any actions they will take next.

FINDING OUT MORE...

Learn more about confidentiality and its limits in chapter 3.5 Medico-legal issues.

CASE STUDY: SUPPORTING VIV

This case study looks at the experience of Viv – a 19-year-old female-identifying transgender person. In the first snapshot, Viv receives standard care. In the second snapshot, she receives care under a trauma-informed practice model.

PART ONE: STANDARD CARE

Viv voluntarily admitted herself to a psychiatric unit feeling distressed and suicidal. She was assessed to be at high risk of suicide and nursing staff were required to be with her at all times. Viv was placed on a mixed gender ward and became increasingly distressed in the psychiatric unit. She felt unsafe at night as there were no locks on her door. During the day, she felt some of the men in the unit were staring at her in a sexually aggressive manner. She asked to leave; however, because she had been assessed to be at a high risk of suicide, her admission had become involuntary.

Viv became extremely distressed at this news and began crying, screaming, kicking and hitting her head against the wall near the nurses station. Three male nursing staff wrestled Viv to the ground and administered a chemical restraint. This incident profoundly re-traumatised Viv, who had been repeatedly sexually assaulted as a child by her uncle.

When Viv was discharged two weeks later, she still felt suicidal and depressed. She no longer felt that the mental health system could help her.

PART TWO: TRAUMA-INFORMED PRACTICE

Viv is admitted into a women's trauma-informed psychiatric unit. Nursing staff spend a lot of time with Viv learning about what she needs to feel safe (emotionally, physical and culturally) in the environment, and develop an emotional and cultural safety plan. The plan is shared with the team.

Viv asks to have only female staff work with her and for all staff to refer to her using the female pronoun. A female health practitioner asks Viv about her trauma history. Viv discloses being sexually assaulted as a child and also discloses being recently assaulted by her ex-boyfriend who had been physically, sexually and emotionally abusive while they were together.

The recent experiences of intimate partner violence had preceded Viv's suicidal thoughts and admission. The health practitioner provides crisis counselling which includes discussing the impact of trauma and exploring Viv's strengths and resources. The health practitioner works with Viv during her admission to report the assaults perpetrated by her ex-boyfriend and to obtain an Apprehended Violence Order.

The health practitioner also involves Viv's chosen supportive network (her mother and one close friend) to participate in joint safety planning discussions. The health practitioner supports Viv to make referral to the Gender Centre, which provides many services for transgender women including accommodation, counselling and peer support groups.

Viv still feels depressed and has many bad days following her discharge from the unit; however, she feels much safer than when she was admitted. Viv feels more hopeful and knows that she has a wide range of supports including the trauma-informed in-patient unit to draw on if she becomes distressed and suicidal again.

CHAPTER SUMMARY - WHAT TO REMEMBER

Trauma-informed practice requires health practitioners to prioritise the safety of young people and to appreciate the impact that experiences of trauma, abuse and disadvantage can have on a young person.

It also requires them to work in a way that challenges and seeks to break down the power imbalances that are often present in traditional care environments, and which can be re-traumatising for young people with a history of experiencing violence or abuse.

Research suggests that young people experience practitioners who use trauma-informed principles more positively than those that do not use the framework. And because young people often learn about helpful and safe services through word of mouth, the principles of trauma-informed practice are likely to boost youth engagement.

REFLECTION QUESTIONS

How does your service cater to the needs of young people with a background of complex trauma?

Have staff been sensitised to or received training in understanding the effects of complex trauma?

What steps could your service take to ensure that your organisational protocols and systems provide an environment of safety for young people and promote trauma informed practices?

What training does your service need to enhance practitioner skills in working with young people with a trauma background?

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