

The Trouble with Trauma

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Abstract

This article explores how trauma theory has become influential in recent years in the fields of child welfare, out-of-home care and youth justice. It argues that this has brought with it some serious concerns. These include a belief that trauma-informed approaches provide the answer to most or even all the challenges faced in human service delivery and that it applies equally across a diverse range of clients. There is also a lack of clarity about the definitions and nature of trauma including the conflation of different types of adversity, and some evidence of rigid, unthinking applications of theory, research findings and clinical propositions.

Keywords

Trauma theory, child welfare, youth justice, therapeutic residential care, Australia

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Introduction

It is remarkable how in the space of little more than a decade, trauma theory has emerged as the dominant theoretical framework in human services. We have begun to look at our role and the needs of our clients through a fresh lens; we have developed a new therapeutic lexicon; and we are exploring a new set of support and intervention priorities and skills.

I recently came across a 2007 survey of theoretical approaches used by professional staff from a large child and family welfare agency. Solution-Focussed Therapy was in the list as was Attachment Theory, Reality Therapy, Narrative Therapy, Cognitive Behaviour Therapy, Strength-Based approaches, Choice Theory and a few others – but no mention of trauma. Today, there are numerous conferences with trauma as their theme, trauma inspired institutes, books, journal articles, regular tours by the stars of the burgeoning research and clinical literature, and everyone seeks to be ‘trauma-informed’.

I write this as a card carrying convert to the cause. I am one of the many that have been strongly influenced by the trauma perspective; it has revitalised my own work and brought new insights, coherence and motivation to the task of supporting struggling children, young people and families. In some ways I am a bit of a trauma theory ‘tragic’ – I devour what books and papers I can get my hands on, try to get to the various trauma-related conferences and roadshows, and have both published papers and developed a training course on trauma-related themes – but there’s a problem with trauma, several in fact.

It’s not all about trauma

The unbridled enthusiasm seems to be leading to an overreach. In child and youth services today, being therapeutic, it appears, is to have adopted a particular understanding of the impact of trauma on the brain, behaviour, and developmental processes; to see most human dysfunction through this lens; and to seek to remediate the negative impacts of trauma using mainly insights and strategies that are congruent with this particular perspective. It is a wholesale case of ‘out with the old and in with the new’.

This, for example, is part of the definition of ‘therapeutic care’ in a recent document from a state government agency:

‘Therapeutic care is a growing field of research and practice that embeds the latest developments from trauma theory, child brain development, and attachment theory into service delivery’ (Family & Community Services, 2017, p. 4)

It seems that in some quarters the trauma perspective may be on the way to *high-jacking* the very meaning of the word ‘therapeutic’. Attachment theory, arguably the dominant perspective in child-focused services in recent decades,

has not been abandoned, but has clearly been relegated to a supportive, secondary role. Some prominent attachment theorists and clinicians have now begun to re-cast themselves as trauma specialists.

In work with children and families in the child welfare and youth justice systems over the years, we have adopted a number of useful theories and theoretically-based intervention frameworks and there is evidence that many of them also promote growth and healing - that they too can be therapeutic.

For example, what about interventions based on Cognitive Behaviour Therapy (CBT, e.g. Child Welfare Information Gateway, 2013), on proven behavioural and learning principles (including Positive Behaviour Support, e.g. Tincani, 2007), on Relational Child and Youth work (Garfat & Fulcher, 2012), on Positive Peer Culture (Vorrath & Brendtro, 1985), on Multi-Systemic Therapy (MST, Henggeler, Schoenwald & Borduin et al., 2009), or the Re-ED (Re-EDucation) principles formulated by Nicholas Hobbs (1982)? None of these explicitly explore the role of trauma, attachment or the impact of severe adversity on the developing brain, so are they now *not* considered to be therapeutic?

The theories that inform our interventions help us understand why certain behavioural and mental health challenges have developed and suggest ways we might respond to address the concerns. The trauma perspective suggests that many of the behavioural and mental health and social challenges faced by young people in the care system derive from their exposure to early, chronic forms of trauma. It has been suggested that the emergence of this perspective represents a paradigm shift in the order of the one that occurred in the mid-1880s with the advent of germ theory and its new understanding disease. Sandra Bloom and Brian Farragher (2011) point out that:

'Trauma theory proposes that the origin of a significant proportion of physical, social, and moral disorder lies in the exposure to external traumatic agents' (p. 123).

A 'significant proportion' no doubt, but by no means all.

The trauma perspective is a particularly compelling one for understanding and responding to children in the child welfare and youth justice systems as so many of them have lives marked by various forms of trauma including abuse, abandonment and exposure to domestic violence. But not all behaviours have their roots in early adversity; many children have developmental, mental health and behavioural needs that are not directly related to any traumas they may have experienced.

It does not address the needs of all clients

The children and young people in child and youth welfare and justice systems are diverse in terms of developmental histories, ethnic backgrounds, presenting

issues, diagnoses and therapeutic needs. It's inconceivable that one particular perspective could hold all or even most of the answers we need. Yet there are now encompassing intervention frameworks that are based solely or predominately on the role of early trauma and/or the impacts of trauma on the developing brain.

But what about being therapeutic with young people with developmental challenges such as autism spectrum disorder and their specific needs around structure, predictability, communication, or sensory sensitivity? This is likely to look a lot different to work with other young people in the care system and other developmental theories and research findings necessarily come into play. The same applies to those with a range of other congenital conditions, those with a Foetal Alcohol Spectrum Disorder (FASD) or global intellectual delay as well as that group of young people with entrenched antisocial attitudes and behaviours.

The trauma framework may have supplanted CBT, learning theory, narrative therapy and the like in the clinical discourse and even the popular discourse, but we continue to need the insights and skills from numerous theoretical perspectives in our work. To borrow Bruno Bettelheim's famous adage about love - *being trauma-informed is not enough*.

Definitional ambiguity

The trauma perspective suffers from a lack of clarity about the definition of psychological or emotional trauma itself. There are numerous definitions of trauma in the literature and a quick review reveals that they differ as to whether the word refers to a significantly adverse *event or circumstance* (as in 'a psychologically distressing event...'); the subjective *experience* of the victim (as in 'an emotionally distressing experience...'); the *response* of the victim (as in 'an emotional response to a terrible event...'); or the *harm done* (as in 'a type of damage done to the psyche...'). Others focus on the capacity to cope with threat. Trauma occurs:

'...when external and internal resources are inadequate to cope with an external threat' (Bloom & Farragher 2011, p. 67).

Following Lenore Terr's (1991) lead, researchers and clinicians have distinguished between a single traumatising event (Type 1, acute or simple trauma) and exposure to multiple traumatising events over time (Type 2 or complex trauma). However, this broad classification does not capture the range and complexity of the phenomena of interest. When, for example, does a Type 1 trauma become a Type 2 one? Does a single episode of being kidnapped and held for weeks, qualify as a severe Type 1 trauma or should it be considered a Type 2 trauma given that it occurred over time? Likewise, how would we classify the time-limited but terrifying journey of an unaccompanied teenager journeying from Asia to Europe or from Central to North America?

The definitional issue gets a little muddier when we consider the detail of current definitions being offered. Bessel van der Kolk (2005) defines complex developmental trauma as:

'The experience of multiple, chronic and prolonged, developmentally adverse events, most often of an interpersonal nature...and early life onset' (p. 402).

Such a definition suggests that complex trauma (also sometimes referred to as developmental or relational trauma) is something that usually occurs early in life (excluding the experiences of older children and teenagers) and suggests that the term applies mainly to interpersonal types of adversity. How then should we classify the seriously adverse experiences of older children and teenagers or the mostly impersonal traumas experienced in an active war zone?

Not all adversities are traumas

Even more concerning, is the loose application of the term 'traumatic'. Apart from the frequent throwaway use of the term to describe any experience that is emotionally stressful, it is applied to extremely acute, isolated events as well as those that are less acutely harmful but are experienced over extended periods of time.

Neglect, for example, may not involve acute harm or imminent danger, but it tends to be experienced by many children for extended periods of time and sometimes throughout their childhoods. The impacts of early neglect are arguably more pervasive than those of physical abuse and often lead to more developmentally adverse outcomes for the children involved (National Scientific Council on the Developing Child, 2012; Teicher et al., 2003). Some researchers tend to use the term 'traumatic' to apply to both abuse and neglect. For example, Bruce Perry (Perry & Szalavitz, 2006) has detailed a number of case studies of child neglect that he identifies as being traumatic for the child. Both direct abuse and chronic neglect can have devastating developmental consequences but it may not be helpful to refer to these quite different adversities as being the same phenomenon.

In a similar vein, Louis Cozolino (2016) points out that there are some other relatively common early childhood adverse experiences that we may not immediately consider to be traumatising, but which may indeed have an overwhelming negative impact on development. He highlights the problem of maternal depression which sometimes leads to mothers being 'deflated, slowed, and emotionless' and thus unable to respond to the pressing needs of their children:

'Although we would not consider these infants traumatized in the traditional sense, the loss of maternal resonance, engagement, and vitality are all experienced as life threatening by a totally dependent infant' (p. 220).

The compelling research of Felitti and his colleagues (1998) has demonstrated how a number of seriously adverse experiences in childhood have a deleterious impact on a child's longer-term health and social/emotional development. They identified 10 relatively common adverse events and demonstrated that the sheer number of such events was strongly correlated with the risk of later impacts on health, behaviour, and social relationships. Some of the 10 adverse events they identified (such as physical, sexual and emotional abuse and exposure to domestic violence) could be classified as being traumatic in the commonly understood use of the term, but others (such as living with parental mental illness or substance abuse, or experiencing parental separation) are not necessarily so. These could more accurately be seen as being chronically stressful experiences. The common elements are severe stress and adversity, not trauma per se.

Rather than using the words *trauma* or *traumatic* to describe all adverse events, it would be more accurate and therapeutically useful to use a broad descriptor such as *severe adversity*, and more specific terms such as *chronic stress* and *trauma* where these apply.

There is an almost universal imperative to be 'trauma-informed' – it is arguable that we have as much need to be informed about the developmental impacts of chronic and cumulative stress.

Trauma and labelling

An accurate diagnostic descriptor such as depression, intellectual disability or autism spectrum disorder can be helpful to the child and their family and guide our endeavours to provide therapeutic support. But even these can add to the stresses on young people who already feel different, defective, or disempowered. Sometimes, an apparently objective label like ADHD or ODD can inadvertently sap a child's motivation to change and grow and sometimes such labels have been used by young people themselves as an excuse for bad behaviour or for not taking responsibility.

The trauma label brings with it a compelling new perspective on human development and behaviour that can be liberating and motivating. However, it is still a label and carries all the risks that are inherent in attempts to label and categorise. With its focus on what has gone wrong, the term 'traumatized child' risks defining a young person as dysfunctional, as being damaged or defective, or a helpless victim. Moreover, it can sometimes lead to a focus on trying to fix what has gone wrong rather than strengths, resilience, and post-traumatic growth.

As with any label it is important to refer to trauma as something that has been experienced by a person, not something that defines them. Sandra Bloom points out that the trauma perspective should change our fundamental question from

'What is wrong with you?' to 'What has happened to you?' (Bloom & Farragher, 2013, p. 7).

The evidence on treatment outcomes

The rapid emergence of trauma theory is due in no small part to the compelling research on the impact of severe adversity on the developing brain and the longer-term developmental outcomes documented by researchers such as Vincent Felitti and his colleagues (Felitti et al., 1998). The research on efforts to remediate the impacts of trauma is naturally at an earlier phase of development and the literature is replete with as yet unproven clinical strategies and theoretically-driven propositions (see, for example, Wastell & White, 2012). It is sometimes difficult to sort out the evidence-based and sound from the promising or even speculative - some of the 'body-based' or activity-centred therapies (e.g. Levine, 2015; Perry, 2006; van der Kolk, 2014, Part 5, pp. 203-347) fall into these latter categories. These therapeutic strategies may have strong anecdotal support and clinical utility but they are frequently afforded a scientifically-proven status they have not yet earned.

In one of my areas of interest, Therapeutic Residential Care (TRC), there are already a number of intervention models being promoted internationally that are based around particular understandings of the impacts of trauma. There have been some promising outcomes from evaluations of TRC services (e.g. Verso Consulting, 2011) but this type of evaluative research is not the rigorous, scientifically-valid type that involves comparison groups - the findings should therefore be considered to be indicative and promising rather than definitive. A recent international review of the support literature for TRC provides this caution: 'Our efforts...yield no gilt-edged models of TRC, no panaceas, no definitive answers' (Whittaker, del Valle & Holmes, 2015, p. 334).

In short, clinical practice relating to the remediation of the impacts of trauma is currently informed by research findings that vary greatly in their quality and rigour and by clinical propositions that range from soundly evidence-based to speculative.

Trauma fundamentalisms

The field of trauma-informed practice has seen the development of a number of competing schools of thought with differing priorities and emphases. Although the prominent researchers and authorities such as those I have cited here, are mostly balanced and reasoned, this is not always the case with enthusiastic followers who hold strongly to particular canons of belief that can be interpreted in rigid and potentially harmful ways. The rigidity of belief and the inflexible application of propositions can sometimes resemble a form of religious dogmatism.

In the course of my work with programmes that work with vulnerable children and young people, I have come across some in which the total focus seems to be on the traumatic experiences of children and the putative impact of such experiences on their developing brains. All their challenging behaviours seem to be interpreted from within this single frame of reference with scant attention paid to normal developmental processes and needs (such as the need of adolescents to individuate and develop autonomy); to the shared needs of children living apart from their natural parents; or to other possible ecological or endogenous causes.

For example, the trauma perspective tells us that a key issue with affected children is their struggle to effectively self-regulate emotions and impulses (Schore, 2012, p. 65; Bloom & Farragher, 2011, p. 108). Many problematic behaviours could therefore be interpreted as resulting from emotional dysregulation, but this does not mean that *all* externalising behaviours should be understood this way.

The research is clear that while some (maybe even most) aggressive behaviours result from the inability to safely manage internal turbulence, others may be instrumental, learned and purposeful and as such, should elicit a quite different response from care givers (Dodge et al., 1997; Holden et al., 2009). Unfortunately, some trauma-informed programmes tend to rigidly interpret all problematic behaviours through the lens of dysregulation and feel that the young people always require 'co-regulation' and understanding rather than positive behaviour support and clear boundary setting. For some young people such responses can be tantamount to freeing them of personal responsibility leading to a reinforcement of the behaviours, the abuse of peers or property, and a loss of safety for peers and staff members.

A related issue pertains to the use of consequences. There are some who seem to believe that any consequences for behaviour can re-traumatise children and should therefore be avoided. Trauma theory does indeed alert us to the fact that some imposed consequences for behaviour problems have the potential to re-traumatise. Often such concerns are associated with the ill-considered use of isolation, physical punishment or unwarranted physical restraint. But other consequences such as expulsion from school, the denial of a home visit or a prized outing, the confiscation of personal possessions, or restrictions on freedom, can also re-traumatise in particular instances. Having acknowledged this fact, there is no evidence that reasonable consequences that are natural, developmentally appropriate and expected, will result in re-traumatisation – indeed, most young people expect there to be a consequence of some nature for behaviour that is clearly outside accepted norms.

The trauma perspective does suggest that when we consider the use of consequences we must assess our options carefully to determine whether other responses may be more useful, effective and sensitive to the young person's

trauma history. In particular, we will want to avoid using 'secondary pain' to deal with behaviours rooted in 'primary pain' (Anglin, 2002, p. 55).

The manager of one trauma-informed treatment program I visited told me that crisis de-escalation and management systems such as Professional Assault Response Training (PART, now known as Predict, Assess & Respond To challenging/aggressive behaviour) and Therapeutic Crisis Intervention (TCI, Holden et al., 2009) were incompatible with a trauma-informed approach. This was ostensibly because of the fact that complex trauma often occurs in infancy (a largely pre-verbal stage of development), and verbally-based interventions were therefore pointless with such children who required nonverbal, sensory or body-based responses.

It is broadly accepted that significant trauma can occur during infancy and that traumatic memories are primarily encoded implicitly and viscerally. As such, a reliance on verbal interventions alone can be problematic, especially when a child is highly aroused. However, the assertion that de-escalation programmes that use words should not be used, makes no sense at all. As children develop a vocabulary, they gradually learn to understand, describe and ultimately manage their internal states. It has been pointed out, for example, that:

'A critical element in healing traumatized children is helping them find words for emotional states. Naming feelings gives a sense of mastery' (van der Kolk, MacFarlane & Van Der Hart, 1996, p. 427).

Van der Kolk (2014), a strong advocate of nonverbal therapeutic strategies, has more recently asserted that:

'While trauma keeps us dumbfounded, the path out of it is paved with words' (p. 232).

Words are therefore a priceless tool for managing the impacts of trauma. It is not a question of words versus nonverbal strategies, but the considered use of both.

Conclusion

The advent of trauma theory has resulted in a paradigm shift in the way we understand and respond to our clients but the unbridled enthusiasm it has generated, brings with it some serious concerns. These include a belief that it is the answer to most or even all the challenges we face in human service delivery and that it applies equally across a diverse range of clients. There is also a lack of clarity about the definitions and nature of trauma including the conflation of different types of adversity, and evidence of rigid, unthinking applications of theory, research findings and clinical propositions.

That these issues exist does not mean that the trauma perspective is fundamentally flawed but they do suggest that we need to interpret and apply the research and clinical literature with wisdom, caution and balance. It is always helpful to have clear, relevant and theoretically coherent intervention frameworks such as those inspired by trauma theory, so long as they encourage flexibility in responding to the diverse needs of our clients and can accommodate a range of intervention approaches, strategies and tools. The needs of our clients rather than globally-applicable theoretical assumptions must drive our intervention and support strategies.

About the author

Howard Bath provides consulting and training services for organisations across Australia and internationally. Trained as a Clinical Psychologist, he has a long history of work with children and young people in the child welfare and youth justice systems that has included time as a youth worker, therapist, and agency director. From 2008 to 2015 he was Children's Commissioner for Australia's Northern Territory.

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