A Practitioner's Response to 'Resilience in the Face of Trauma: Implications for Service Delivery'

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Summary: This paper is a practitioner's response to 'Resilience in the face of trauma: Implications for service delivery' by Aoife Dermody, Caroline Gardner, Sharon Davis, Sharon Lambert, John Dermody and Marisa Fein (*Irish Probation Journal*, 2018). That important paper highlighted research commissioned by the PALLS project, a Probation-funded project working with adults involved in the criminal justice system in the Mid-West region. The research focused on feedback from female service users on their needs and experiences of accessing local drug, homelessness and criminal justice services. The women who participated had experienced most forms of childhood adversity more frequently than people in the wider population. Importantly, the women gave some practical advice that could assist in the design and delivery of more trauma-informed services. As an operational manager, I work with young men who have experienced childhood adversity. This paper considers some of the main issues raised by Dermody *et al.* and reflects on similarities between the findings they outlined and my current work. More specifically, this paper considers Dermody *et al.*'s comments regarding 'trauma-informed practice', the findings of the research in relation to mental health/ substance misuse and parenting, and the issue of building resilience.

Keywords: Adverse childhood experiences, resilience, trauma, post-traumatic stress disorder, trauma-informed care, service user, masculinity.

Introduction

As an area manager with the Probation Board for Northern Ireland (PBNI), I have responsibility for managing the Aspire Young Men's Project.[1] Many of the men that I work with suffer from intergenerational trauma and have been exposed to community violence in a post-conflict society. Many have experienced multiple childhood adversities, including being the victim of

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[1] Aspire is a Probation-led project that works with men aged 16–30 to prevent them becoming involved in criminality.

sexual abuse, exposure to domestic abuse as a child, and a parent having served a prison sentence. Therefore the article by Dermody *et al.* was very relevant reading. The literature review was informative and reinforced much of the learning and training experienced over the course of my career. I found the research findings and recommendations particularly relevant to my current practice.

Adverse childhood experiences and interface with criminal justice

This paper begins with a literature review and cites Felitti *et al.*'s (1998) research, which found that those with four or more adverse childhood experiences (ACEs) had a 4–12-fold increased health risk for alcoholism, abuse, depression and suicide attempts. Felitti *et al.* state, rightly, that the focus of early research was on health outcomes but subsequent research pointed to the correlation between a high number of ACEs and future violence, and entry into the criminal justice system. The impact of multiple ACEs on recidivism is recurrently evident in my work with young men, aged 18–30 years, in the Aspire Project. These participants are at risk of criminality and come from families experiencing intergenerational trauma, live in areas of high social deprivation, have experienced mental health and addiction issues, are marginalised and may be in drug debt.

In Northern Ireland, suicide is now the biggest single cause of death for 15–19-year-olds and the rate of suicides is the highest in the UK. You are three times more likely to die by suicide if you live in the most deprived areas of Northern Ireland (Rainey, 2017).

Much of the research in relation to trauma in Northern Ireland has focused on the legacy of the Troubles and post-traumatic stress disorder (PTSD) related symptomology. The transmission of intergenerational trauma as a result of a close family relative having been exposed to the trauma of persistent violence or the sudden death of a loved one impacts on parenting practices, on mental health and wellbeing of future generations, and on childhood adversities (Fryers and Brugha, 2013).

Bunting *et al.* (2013) reported that PTSD rates in Northern Ireland were among the highest in the world as a result of conflict-related experiences (lifetime prevalence 8.8%). Betancourt and Khan (2008) found that prolonged war exposure is linked to family disruption, maladaptive attachment relationships and poor social support networks that may result in increased levels of childhood adversities. It is perhaps unsurprising that so many of the

young men on the project are impacted by multiple adversities which increase the risk of poor physical and mental health outcomes such as anxiety, depression and complex trauma.

There has been limited empirical research examining the prevalence and impact of ACEs in Northern Ireland. This paper is relevant to practitioners who are seeking to develop and enhance trauma-informed practice within their own organisation.

Trauma-informed practice

Dermody *et al*. (2018) highlight the importance of service providers understanding trauma – how it manifests and how services can appropriately support trauma survivors. I concur with the authors' view of the importance of staff training to enhance practitioners' knowledge and skills, equipping them to better understand service users' behaviour through a 'trauma lens' and respond appropriately to a wide range of adversities including assaults, domestic violence, abandonment, separation and bereavement. Jacobson *et al*. (2010) make it clear that those involved in the criminal justice system are more likely than the general population to have suffered adverse emotional, social, neurological and developmental effects from these experiences, some of which are linked to their offending. Therefore it is critical for practitioners to have an awareness of trauma-related issues in order to generate positive resettlement outcomes. The challenges faced by service users in trying to comply with the criminal justice system are apparent when they have difficulty in controlling impulses, making plans, assessing social situations and recognising the longer-term consequences of their actions.

To enable a trauma-informed approach to develop and embed in any organisation, there needs to be a whole-system approach. This involves organisations seeking to develop coherent cultures, policies and practices across systems of care that promote and inform a shared understanding of the prevalence and impact of adversities and trauma. This holistic approach aims to develop pathways for recovery and healing while proactively seeking to avert the possibility of re-traumatisation. It should recognise the signs and symptoms of trauma in staff, service users and others involved with the system (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014).

Dermody *et al*. (2018) outline key components in order for an organisation to work in a trauma-informed way. A key message in this for me was the

importance of collaboration. The research highlighted the need for collaborative service delivery in working with the women interviewed, as different services engaged with the same women simultaneously without positive outcomes. This resonates with my experiences of working with men, as some have difficulty engaging with and sustaining involvement in services and interventions. It is evident that close collaboration between criminal justice, health, social and educational systems is required in order to effectively address complex trauma-related needs.

Within PBNI, staff have become aware of the need to understand the impact of trauma on how people behave in order to shape interventions and the supervision process. Many of the men in Aspire often feel isolated and have a deep mistrust of strangers, therefore interaction with the various service providers will be a highly threatening and distressing experience as they are poorly equipped to deal with such stress. Skuse and Matthew's (2015) Trauma Recovery Model argues that the impact of trauma on individual development tends to blunt the 'cognitive readiness' of service users in several respects. This in turn reduces their scope for deriving benefits from programmes such as anger management and victim empathy that are designed to promote desistance, as they fail to address the underlying developmental and psychological drivers of such behaviours, a contributory factor in their disengagement. The Aspire team exercise latitude in working flexibly with the men in order to respond to trauma-related issues. Trauma-informed approaches that are layered and sequential can have an impact on the readiness of service users to develop their non-offending narratives. Early stages of engagement should focus on basic routines and physical safety, addressing emotional issues relating to feelings of personal control and self-awareness. However, due to an escalation in their risk of harm, decisions to recall are sometimes inevitable.

Many of our service users are parents and are often challenged in that role arising from the deficits within their own experience of being parented. Reekers *et al.*'s (2018) 'Signs of Safety Model' used in child protection organisations draws on techniques from solution-focused brief therapy and has two core principles. The first is establishing a working relationship with parents, referred to as a 'cooperative partnership', with the aim of parental empowerment; the second is retaining a focus on the need for child safety at all times. This model more explicitly seeks to engage meaningfully with parents, and that direct work with children is central to the success of professional intervention, facilitating parents and professionals to collaborate

to reduce the risk to children without challenging the fundamental basis of the child protection system (Keddell, 2014).

PBNI is part of the Regional ACE Reference Group which was formed in 2017 to raise ACE awareness in Northern Ireland and to support the Early Intervention Transformation Programme (EITP) ACE Workstream Projects. The role of the EITP is to provide general awareness of trauma-informed practice across a multi-agency spectrum and specialised training for professionals. The programme also has trauma-informed advisers whose role is to inform culture and practice at an organisational level.

Currently the Safeguarding Board for Northern Ireland (SBNI), which is made up of key partner organisations from the statutory, community and voluntary sectors who work to protect and enhance the wellbeing of children, is delivering trauma-informed practice seminars across all SBNI agencies. The focus of those seminars is to create a shared understanding of the impact of adversity and trauma in childhood, aiming to embed this in a whole-system approach. According to Hall *et al.* (2012), to deliver impact on ACE reduction at community level, interventions need to be multidisciplinary, multi-level and multi-year, as 'silo' interventions, focused on a single issue or group of problems, are unable to deliver such effects.

Staff in Aspire have been trained in trauma awareness, substance misuse, respectful relationships and strength-based programmes such as coping skills to enable them to deliver effective interventions in an attempt to break the generational cycle of harm and adversities. Service delivery aims to develop personal and social skills, improved mental health, emotional well-being and resilience, to build civic responsibility. Staff adopt a holistic and supportive approach to encourage pro-social development and desistance through negotiated, positive relationships. I believe this approach leads to more effective risk management. It enables staff to work in a creative and flexible way with vulnerable and chaotic men who have been excluded from services, thereby addressing the behaviour without rejecting the individual – this approach is sometimes called 'elastic tolerance' (Woodcock and Gill, 2014). Substantial investment in mental health support is required to improve health outcomes.

Dermody *et al.* (2018) explain the importance of service providers understanding the impact of trauma on the brain: how experiences of trauma frequently result in behaviours that may be regarded as 'aggressive, challenging, evasive and non-engaging'. These are issues that we observe daily with the young men within Aspire who have a tendency to externalise

their responses. 'Young males appear to learn from an early age that association with the world of emotions is to be avoided at all costs … Contemporary masculinity studies reveal that males typically report a lower frequency of verbally communicating their feelings than women … with a tendency to display anger and aggression' (Kring, 2000).

In Aspire we have observed that instrumental aggression may actually be reactive and trauma-related, as rage and aggression can mask the distress that young men experience. We know that trauma exposure creates aggressive pathways through hyper-arousal, hyper-vigilance and inappropriate hostile reactions. In Dermody *et al.*'s (2018) study, 91% of women reported being the victim of domestic violence; the men involved with Aspire have been victims of violent crime and have also been perpetrators of violence within a domestic context.

Some of the young men experience difficulty in articulating their feelings to other professionals such as their general practitioner (GP) or addiction services, which sometimes results in high levels of frustration and exclusion from services. Dermody *et al.* (2018) point to the importance of service providers taking a whole-service approach in order to provide an environment where clients can engage, heal and grow.

Findings in relation to mental health and parenting

The main part of Dermody *et al.* (2018) focuses on the research findings. There were many similarities between those findings and a recent evaluation carried out on the service users within Aspire. There were also some critical differences. These may be attributed to gender differences, and it would be interesting to conduct further research from a gender perspective on impact of ACEs. I will look at two areas from the research findings that I found to be of particular relevance.

Substance misuse and mental health

Critically, Dermody *et al.* (2018) found that all the participants interviewed for the research had current or previous difficulties with drug and/or alcohol abuse. Within the Aspire team approximately three-quarters (73.4%) of men had health issues largely relating to mental health/trauma, and 70% agreed that drug/alcohol addiction had been the reason for their referral to Aspire. Whereas Dermody *et al.* (2018) found that 39% of women reported daily/weekly drug use, many of them were primary carers, which made me question

whether some of the women had under-reported their substance misuse due to mistrust and fear of losing their children.

Women spoke about mental health and addiction services simultaneously and the need for services to work together. This is similar to men's experiences, as integrated mental health/addiction services are critical to positive resettlement. While the Aspire staff often accompany a service user to an appointment with mental health services to provide a fuller insight into their background due to previous non-compliance, mental health services have refused to work with those who misuse substances or miss appointments, regardless of their trauma. There do not appear to be specific assessments for trauma-related symptoms, with service users instructed to 'sort their addiction issues out'. Many of the men complain that they are asked numerous questions and then 'nothing happens', which leads to further disengagement. This reflects that assessment of need should enable access to appropriate services, rather than the individual fitting into services that are available.

In Dermody *et al.*'s (2018) research the authors highlighted that some of the women seeking help from GPs and mental health providers felt judged. Similarly, many of the men within Aspire indicated that they felt judged by mental health service staff, and this was a barrier to attending appointments. This is a worrying finding and is an area that requires further research and discussion.

Parenting

Women in the 2018 research also spoke of the challenges of balancing care for children and care for themselves. Interestingly, some of the women highlighted a fear of losing custody of children as an impediment to engaging with services. In contrast, for many of the men within Aspire, the parenting work in the project serves as an encouragement to access services. The vast majority of men within Aspire do not have contact with their children, but are keen to obtain access and are therefore encouraged to complete the Barnardo's 'Parenting Matters' programme, an initiative that focuses on the child and the impact of offending on their development. Trauma can have adverse effects on socialisation and on the individual's scope for forming attachments. Caregiving that is neglectful or unpredictable can be traumatising, leaving a child vulnerable to retraumatisation and without an adequately secure base to turn to in the face of real or perceived threat.

For example, one man in Aspire – Mr Q, a 24-year-old with a significant criminal record – had suffered multiple childhood and adult adversities and

was motivated to work within the project as a way of gaining access to his children. Mr Q presented with an established history of attempting to resolve his emotional conflicts through the misuse of substances, and as a consequence behaved in an aggressive and violent manner. His substance misuse led to offending and criminality. Mr Q's oldest child was placed on the child protection register and he did not have contact with his other children. Building on a positive working relationship with Mr Q, intense and repeated interventions were delivered to calm emotional upset. This provided the basis for Mr Q developing a sense of trust, safety and control. He developed positive coping skills, and reached out to professionals who supported him to reduce his substance use, which led to positive change in his lifestyle. A referral to the parenting course delivered by Barnardo's afforded Mr Q a better understanding of child development and improved communication with his children. He is currently utilising these skills when he has contact with his children. Social services have been impressed by his engagement with Aspire, and this was a major influence in the decision to remove his eldest child from the child protection register.

Building resilience

Dermody *et al.* (2018) report that women were resilient when faced with adversities. This differs for the young men within Aspire, as many present in a permanent state of emotional arousal; are prone to emotional outbursts, frustration and depression; are impulsive; and take risks. Many lack resilience and that in turn leads to difficulties with substance misuse and mental health, as they mask their feelings and use poor coping techniques. Therefore intervention focuses on de-escalating emotional tensions rather than on sanctions. Staff in Aspire consistently work intensively with a strong and volatile range of emotions and are assisted to build their own psychological resilience. With more of a focus on trauma-informed practice, it is critical that staff are enabled to explore their own vulnerabilities and strengths to protect themselves against vicarious trauma and also to minimise any underestimation of the risks that service users may pose should they over-identify with them. Self-care is a critical component of practising in a safe and trauma-informed way. Therefore training, adequate supervision and support for staff working intensively with trauma requires further exploration to safeguard staff.

The role of resilience as a protective factor to mitigate the impact of ACEs is increasingly evident. Resilience is developed through the socialisation

process and secure attachment bonds. Even resilient children and adults can become overwhelmed by life events and stressors. Some people experience acute distress from which they are unable to recover. Others suffer less intensely and for a much shorter period. It is very much dependent on individual circumstances such as age, gender, previous history of traumatic events, and level of resilience. Some adversity early in life may be protective, helping to build resilience to other stressors. Rutter (2012) discusses the strengthening or steeling impact of early adverse experience; Schweizer *et al.* (2016) suggest that mild to moderate levels of ACEs may lead to enhanced emotional regulation capacity, which in turn can result in more positive psychological outcomes.

Many of the young men engaging with Aspire have not experienced secure attachments and experience difficulty in putting their thoughts and feelings in relation to their childhood into words: 'As such, personal development with the assistance of a Probation worker offers a taste of a secure base' (Ansbro, 2008: 239). Creating positive conditions of worth and using a person-centred approach is crucial in helping build resilience. An available trusting adult who demonstrates consistency and a non-judgemental approach, is available and endeavours to create a relationship of safety is a critical element in fostering a positive working relationship, enabling the individual to transition from the role of victim to survivor. For the service user, exercising choice and control in decisions that impact on them will help minimise re-traumatisation: the women in Dermody *et al.* (2018) refer to 'support, mutual respect and genuine caring'. McNeill (2009) advocates that a healthy balance between service user, service provider and the public can be reached if each perspective is appreciated, respected and considered, with practitioners recognising that service users are people with important stories to tell.

PBNI also uses its partnership arrangements, particularly with the community and voluntary sector, to help build resilience in individuals. Building relationships through the use of mentoring with a community partner, NIACRO, has been particularly beneficial. 'Well-implemented mentoring interventions amongst young people who have faced adversities have shown effectiveness across multiple outcomes, including drug misuse, crime and violence' (Di Lemma *et al.*, 2019). The approach provided by Probation and the impact of the 'pro-social role' provided by mentors is greatly valued by service users. Mentors accompany service users to GP appointments, help source benefits and housing, advocate and help with communication as well

as enhancing service user confidence; breaking down and explaining information helps reduce anger and frustration. Many of the women in the Dermody *et al.* (2018) study felt 'alone', especially at weekends and times when isolation kicks in. With the men, Aspire peer mentoring provides a flexible and responsive service, with mentors providing support at weekends. This has proved to be an effective method of working with young men to help them fulfil their potential. It has provided service users who have experienced multiple ACEs with a positive adult role model.

Conclusions

Dermody *et al.* (2018), a research-based paper, identified that women who engaged with a range of services were more often affected by multiple childhood adversities than people in the general population. This paper juxtaposed those findings with the reported experiences of males, many of whom suffer from intergenerational trauma and have been exposed to community violence within a post-conflict society. Similarly to the women in the Dermody *et al.* study, many of the men have developed destructive coping mechanisms to deal with their distress, are distrustful and reject those in authority.

Trauma has implications for the brain structure and decision-making processes, and impacts on an individual's ability to engage effectively with services. This may present real challenges for the management of compliance with court orders. As highlighted in this paper, intervention needs to be individually tailored and person-centred, acknowledging individual traumatic experiences to support service users in developing new coping skills, in building their resilience and in the development of protective factors. This will enable individuals to access social and positive support networks where they feel valued and respected – this was not the case in feedback provided by the female service users in Dermody *et al.*'s research.

It would be useful to explore gender differences in the impact of ACEs and trauma, as women seemed more resilient when faced with adversities, whereas young men tend to present in a highly emotional state, are prone to a display of reactive and emotional behaviours and overall lack resilience.

There are inherent challenges for practitioners and organisations. Trauma-informed care can be difficult due to the dilemma of meeting the needs of the service user, upholding agency policies and standards and expectations of the public, and ensuring that adequate steps are taken to protect the

public from harm (Renn, 2010). ACE- and trauma-informed practice does not necessarily mean that completely new approaches or interventions have to be developed, but rather requires ongoing evaluation of how agencies may co-operate to improve current service delivery (Ford *et al.*, 2016). This is reflected in the model adopted by the Aspire Project.

It is recognised that effective implementation of trauma-informed care is not without its challenges, with leadership commitment required. It is an opportunity to explore organisational culture and current systems within the various sectors, and how they can work collaboratively to share information and develop practice, for example within the health arena to address mental health and addiction issues simultaneously. This will enable organisations to identify what creates resilience to cope with adversity and will encourage organisations to develop policies and practice to embed trauma-informed practice in the workplace. Service user and practitioner involvement in this process is critical to inform the delivery of quality services. A trauma-informed organisational focus on staff self-care and how frontline staff are supported is important to minimise vicarious trauma, enabling staff to deliver practice safely and effectively.

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