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ORIGINAL PAPER

Trauma-Informed Social Work Practice: Practice Considerations and Challenges

Carolyn Knight

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Abstract Adult survivors of childhood trauma are an especially challenging group of clients, given the long-term effects of the victimization and the present day difficulties these individuals face. In this article, trauma-informed practice is explained, incorporating the most recent theoretical and empirical literature. The purpose is to educate and provide support to clinicians who encounter survivors of childhood trauma in a range of settings that are particularly likely to serve this population like addictions, mental health, forensics/corrections, and child welfare. The social worker neither ignores nor dwells exclusively on the past trauma. Rather, trauma-informed practitioners are sensitive to the ways in which the client's current difficulties can be understood in the context of the past trauma. Further, they validate and normalize the client's experiences. Trauma-informed practice requires the practitioner to understand how the working alliance, itself, can be used to address the long-term effects of the trauma. Emphasis is placed on helping survivors understand how their past influences the present and on empowering them to manage their present lives more effectively, using core skills of social work practice.

Keywords Childhood trauma · Sexual abuse · Clinical intervention · Indirect trauma · Child maltreatment · Adult survivors

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Introduction

Adult survivors of childhood trauma account for a majority of individuals seeking or required to seek clinical services (Bride 2004; Harper et al. 2008; Probst et al. 2011). Much has been written about working with this population, but most of this literature assumes that the past trauma will be the primary focus of the professional intervention. However, many practitioners encounter trauma survivors in settings like addictions, mental health, child welfare, and corrections/forensics, where these individuals are particularly likely to require or seek out services (Macy 2007; Pence 2011). The focus in these practice contexts typically is on the present-day difficulties with which the survivor is struggling, rather than the underlying past trauma.

Clinicians in these settings often feel ill-equipped to be helpful to survivors, mistakenly assuming they lack the required knowledge and expertise (Binder and McNeil 2007; Fusco and Platania 2011). Survivors' sense of urgency regarding their current problems-in-living, coupled with the limited role that many practitioners play in meeting their clients' needs, often results in the history of past trauma being overlooked, along with the impact that this may have on current functioning (Chemtob et al. 2011; Pence 2011; McGowan 2013). This is frustrating to clinicians and survivors alike. In fact, practitioners who do not attend to survivors' past, and the relationship it plays in the present, undermine their ability to deal with the underlying trauma *and* the present-day challenges that brought them into treatment in the first place (Harper et al. 2008; Twaite and Rodriguez-Srednicki 2004).

This article addresses a gap in the trauma literature by focusing on the many instances in which a survivor of trauma seeks out or is required to seek out treatment, not for the past trauma, but for current problems in living. It

begins with an overview of current theory and research regarding the nature and long-term consequences of childhood trauma. This is followed by an examination and discussion of what is referred to as trauma-informed practice (Brown et al. 2012; Layne et al. 2011), incorporating the most recent theoretical and empirical literature. Case examples illustrate core concepts. The case material reflects composites of actual client situations; all identifying information has been changed to protect clients and practitioners.

Nature of Childhood Trauma

The earliest definitions of childhood trauma emphasized the event, itself and the traumatizing effects it had on its victims. More recent conceptualizations recognize that the same event will be experienced differently, based upon a range of variables including cultural context and social and psychological factors unique to the individual (Elliott and Urquiza 2006). Williams and Sommer (2002) argue that, “Trauma is in the eyes of the beholder…” (p. xix). More recent conceptualizations of trauma also have moved away from a sole focus on pathology and dysfunction. Researchers point to the existence of “adversarial” or “posttraumatic growth” (Bonnanno 2004; Linley and Joseph 2004); survivors’ sense of self-efficacy, their ability to cope with challenging events in the future, and their spirituality can be enhanced as a result of exposure to trauma.

Childhood trauma, particularly in the form of interpersonal victimization like sexual and physical abuse, has been found to be associated with a host of difficulties ranging from emotional and psychological reactions such as depression, low self-esteem, and suicidal ideation; physical problems like chronic pain; psychiatric problems such as anxiety/panic, borderline, post-traumatic stress, and dissociative identity disorders; and behavioral problems including substance abuse, eating disorders, domestic violence, and self-injury (Farrugia et al. 2011; Kuo et al. 2011; Shafer and Fisher 2011; Spitzer et al. 2006).

Childhood trauma also distorts survivors’ thinking about their social world and leads to social isolation and problems with attachment (Waldinger et al. 2006). Survivors are likely to develop core beliefs about self and others that are characterized by low self-esteem and feelings of worthlessness, powerlessness, and vulnerability, as well as mistrust of others (McCann and Pearlman 1990). Childhood trauma robs its victims of a stable sense of self. This results in a lack of the “self-capacities” (McCann and Pearlman 1990), that allow individuals to “maintain a consistent sense of identity and positive self-esteem” (p. 21). These self-capacities reflect basic coping mechanisms like the ability to: soothe and comfort oneself when distressed; be alone and comfortable with oneself; experience a full range of affective reactions without being overwhelmed by or denying them; regulate emotions; and accept criticism and negative feedback.

There also is increasing evidence to suggest that exposure to trauma in childhood leads to neurobiological changes in the developing brain. These changes appear to be more or less permanent and reinforce the previously identified social, emotional, and behavioral consequences of the abuse (Coates 2010; Delima and Vimpani 2011; Rothschild 2003; Teicher et al. 2003).

Trauma-Informed Practice: Definition

When clinicians work in settings that are likely to serve adults with histories of childhood trauma, it is important that they entertain the possibility that the client could have such a history, regardless of whether or not the client presents her or himself as a survivor. Trauma informed practice doesn’t mean that the practitioner assumes the client is a survivor. It also doesn’t mean that the focus of the intervention will be on the past trauma.

Rather, the practitioner is sensitive to this possibility and to the ways in which the client’s current problems can be understood in the context of past victimization. The worker also recognizes the potential implications that being a survivor have for the client’s willingness and ability to enter into a working alliance; evidence suggests this may be especially challenging for survivors, given core beliefs characterized by hostility towards others, and their difficulties forming positive attachments (Monahan and Forgash 2000; Stovall-McClough and Cloitre 2006). “The development of the therapeutic alliance…is often a daunting challenge with an interpersonally victimized [client]. The [worker] may be perceived as a stand-in for other untrustworthy and abusive authority figures to be feared, challenged, tested, distanced from, raged against, sexualized, etc.” (Courtois 2001, p. 481).

Unlike trauma-*centered* intervention, where the underlying trauma is the primary focus of the intervention, trauma informed practice helps survivors “develop their capacities for managing distress and for engaging in more effective daily functioning” (Gold 2001, p. 60). The effects of the past childhood trauma aren’t ignored, but “extensive and detailed immersion in [traumatic] material itself is not encouraged, because…this tactic is…destabilizing and counter-productive” (Gold 2001, p. 60).

Importance of the Professional Relationship

Trauma-informed practice recognizes that the working alliance can provide a corrective emotional experience for

survivors (Banks 2006). The relationship can challenge distortions in thinking about self and others, and it can be a means through which self-capacities can be developed (McCann and Pearlman 1990). For example, when practitioners understand and anticipate "traumatic transference" (Spiegel 1986), whereby they represent those who have exploited the survivor, they can assist the client in confronting directly fear and mistrust of others (Dalenberg 2004; Horvath 2000). Further, the worker's affective reactions to the survivor and her or his story affirm and give voice to the client's own reactions (Courtois 2001).

The therapeutic potential of the relationship depends upon workers being knowledgeable about childhood trauma and its relationship to the client's current difficulties. The worker acknowledges the trauma directly and responds empathically, but does so in a way that is consistent with her or his professional role (Glover et al. 2010; Karatzias et al. 2012). The results of several studies reveal that survivors of trauma are likely to have been in treatment multiple times and to report having experiences with professionals that were not helpful and often counterproductive (Beutler and Hill 1992; Palmer et al. 2001; Schachter et al. 2003). Specifically, survivors reported as *un*helpful clinicians who: avoided addressing the trauma at all, asked for too much detail and encouraged expression of feelings when it wasn't appropriate, and minimized the significance of the trauma in the client's current life.

The therapeutic potential of the working alliance also depends upon the worker adhering to professional boundaries to enhance survivors' self-capacities. Survivors' sense of urgency can lead the worker to engage in practice activities that are inconsistent with her or his role in agency-based or private practice. It also can lead the worker to extend her or himself in ways that move the relationship away from a professional one into a realm that is more personal in nature. The following case example reveals how easily boundaries can be violated.

> Margaret was a twenty year old college student in her sophomore year. She was sexually and physically abused over a ten year period by her stepfather. She began to have problems managing the stress associated with her school work. She also began to have flashbacks and nightmares. One of her instructors referred her to the school's counseling center, where she began to see a professional clinician.
>
> The center has a twelve session limit, and once Margaret and her counselor reached the limit, Margaret pleaded with the counselor to continue to see her, since she believed the counselor was the "only one" who could help her. The counselor agreed to see Margaret "on the side", for free, in her home. Margaret began to have thoughts of suicide and the counselor invited her to spend the night with her each time these thoughts surfaced.

This practitioner's desire to help Margaret was understandable but misguided and ultimately undermined the client's self-capacities. The professional's sense of urgency could have been constructively channeled into advocating for a more trauma-informed approach to treatment in her agency, such as a change in policy regarding session limits for clients like Margaret. Survivors already struggle with entering into a therapeutic alliance; therefore, they benefit greatly from an ongoing, stable relationship with the clinician.

Instead, the clinician disregarded agency policy, which ultimately undermined Margaret's growth. What this practitioner failed to appreciate was that terminating with Margaret and referring her to another agency, though painful, would have provided Margaret with an opportunity to further develop self-capacities associated with beginning and ending relationships and managing the difficult feelings associated with these transitions. Unfortunately, the clinician was significantly impacted by Margaret's pain and abandonment issues, suggesting an enactment of countertransference, discussed later. Inviting Margaret to stay with her further compromised Margaret's ability to manage her feelings on her own. The clinician also left herself vulnerable to liability issues, because she no longer was operating under the auspices of her employing organization. This situation did not end well. The practitioner was forced to have Margaret hospitalized. Her involvement with Margaret became known to the school, and she was fired from her position.

Boundaries between workers and any client population should remain fluid and open to adjustment, in response to changing circumstances and contexts (Gabbard 1996; Lazarus 1994; Reamer 2003). With survivors, the worker may need to loosen boundaries to be more available in times of crisis without losing sight of professional role and responsibilities (Harper 2006). In the previous case, had the clinician not had to terminate with Margaret, she might have needed to be more available to the client to deal with the suicidal thoughts. This *doesn't* mean taking Margaret home. However, it could mean establishing a safety contract that required more frequent meetings with Margaret and/or keeping in daily contact via phone or email.

In contrast to the last example, this next case illustration demonstrates how the worker can empathize with a survivor but still set limits and maintain boundaries that promote empowerment.[1] The worker was a foster care worker and was providing ongoing case management to Ms. Davies, who lost custody of her young children after leaving them

[1] Adapted from Knight (2009).

unsupervised for long periods of time. The worker, Anna, visited Ms. Davies monthly to assess her progress on her contract with the agency, the goal of which was re-unification with the children. The following exchange took place as their meeting was ending.

> Anna: Well, I guess that's it for today, Ms. Davies. You're doing very well, making a lot of progress. If things continue on like this, I think you'll be able to have [her children] for an overnight visit very soon. Is there anything else for today?
> Ms. Davies: There's just this one thing. Maybe I actually already told you this. Did I ever tell you that when I was a kid, my father pimped me out? He was a drug addict, like me. He didn't have no job or nothing, so he used me to buy his drugs. He'd sell me to his friends. Let them do what they want to me, and then take money. Can you believe that? He sold his own daughter, just to support his drug habit. That son-of-a-bitch.
> Anna: Oh, my, what a terrible story! I had no idea. It took a lot of courage for you to tell me this. You must have so many feelings about what your dad did to you: anger, sadness, confusion. I guess maybe some of the reason why you were using drugs yourself was so you didn't have to feel all this stuff?
> Ms. Davies: Yeah, it hurts real bad. It got so, though, that even when I was using, I would still be thinking about what he done to me. It's like I just keep seeing what happened in my head over and over again.
> Anna: I'm sure that this must be so difficult. [Pats client on the shoulder.] What happened when you were so little, and then not being able to stop thinking about it now. You know that my job is to help you do what it takes for you to get your kids back, right? I am so glad that you have told me what you did, because now I can be even more helpful to you. I'm thinking that the fact that you have shared this with me means that maybe you are ready to talk about it with someone. What I'd like to do is refer you to someone who can help you to do that.

This exchange exemplifies trauma-informed practice in several ways. Most important, the worker responded directly to the client's disclosures of childhood trauma, conveying her appreciation of the importance of what had been shared. Anna empathized with Ms. Davies, which in turn normalized and validated the client's feelings. Yet, Anna didn't lose sight of her role. Anna didn't offer services she couldn't provide, nor did she delve deeply into Ms. Davies's past. Asking Ms. Davies for more information about her abuse could have been re-traumatizing and undermined her self-capacities; it also was inconsistent with Anna's role as a foster care worker.

In yet another implication of boundaries, there may be times when the worker wishes to use physical contact- in Anna's case a pat on the shoulder- to provide reassurance and convey empathy to an adult survivor. Conceivably, survivors can learn that touch can be soothing and comforting, not just harmful and exploitive. Yet, survivors of childhood trauma need to be empowered to control who touches them and how, as well as regulate the physical distance between the clinician and them. Ms. Davies and Anna had a longstanding relationship, and the client held a great deal of trust in Anna. In many instances these characteristics will not exist. Thus, the worker typically should take a conservative approach and avoid using touch as a therapeutic tool; in those rare instances when it is used, the worker must adhere to three fundamental principles: The client must be asked *in advance* if the worker can touch her or him, be reassured that she or he can say no, and be informed what the nature of that touch will be (O'Donohue and Bowers 2006).

Boundaries should ensure that survivors remain in control of their bodies. This is especially critical given the findings of several studies which indicate that survivors of sexual abuse are at greater risk of being sexually victimized by therapists than other clients (Nachmani and Somer 2007). Practitioners also must be sensitive to the ways in which survivors of sexual abuse are prone to sexualize the relationship they have with the therapist, owing to their history of having been exploited in intimate relationships (Nachmani and Somer 2007; Somer and Nachmani 2005).

Practice Considerations

The four-fold principles of trauma-informed practice are: normalizing and validating clients' feelings and experiences; assisting them in understanding the past and its emotional impact; empowering survivors to better manage their current lives; and helping them understand current challenges in light of the past victimization (Courtois 2001; Martsolf and Draucker 2005; Wright et al. 2003).

Practitioners working in settings that address clients' present-day challenges often feel thwarted in their efforts to be helpful to survivors because they "only" are able to assist these individuals with their presenting problems. However, directly addressing the trauma before the survivor is psychologically and emotionally ready to do so may serve only to re-traumatize the individual and affirm core feelings of powerlessness (Classsen et al. 2011; Connor and Higgins 2008; Harper et al. 2008; Martsolf and Draucker 2005; Regehr and Alaggia 2006). In contrast, assisting a survivor in, for example, staying clean, finding employment, or remaining emotionally stable by taking necessary medications, is an *essential* step in addressing

the long-term effects of the trauma. When the survivor is better able to manage present-day challenges, her or his self-capacities are enhanced, and this addresses the past trauma in a powerful and important way (Glover et al. 2010).

Clinicians working in settings most likely to encounter survivors of childhood trauma also often assume they lack the skills necessary to be helpful to survivors. In fact, strategies that are traditionally used in social work practice have been found to be effective when working with survivors. Most fundamentally, the ability to convey empathy and understanding affirms and validates the survivor's feelings and experiences, reducing isolation and feelings of being alone and different. Cognitive-behavioral strategies challenge core beliefs and assist survivors in recognizing and challenging their distortions in thinking; they also serve to normalize and manage experiences, feelings, and reactions, and assist survivors in seeing the connection between present difficulties and the past trauma (Febbraro 2005; Messman-Moore and Resick 2002). Solution-focused techniques strengthen self-capacities by helping survivors identify positive ways they have coped in the past (Knight 2006; Brun and Rapp 2001; Fleming 1998; Tambling 2012). Techniques like writing, art, and other physical activities allow survivors to express feelings in alternative, non-verbal ways (Huss et al. 2012; Park and Blumberg 2002; Pifalo 2009).

More specialized strategies including guided imagery, hypnosis, and eye movement desensitization and reprocessing (EMDR) have been employed with survivors of childhood trauma. However, these are used most appropriately in trauma-centered intervention; they can be empowering to survivors by helping them learn to relax, self-soothe, and both express and manage feelings (Bisson 2005; Edmond et al. 2004; Harford 2010; Peace and Porter 2004; Solomon et al. 2009; Struwig and van Breda 2012). They do require specialized training and an understanding of the neurophysiological changes in the brain that have been found to result from childhood trauma (Delima and Vimpani 2011; Harford 2010). It is critical to note that the worker should never use any techniques, particularly those that require this more advanced knowledge, without appropriate training (Thayer and Lynn 2006; van Minnen et al. 2010).

Regardless of the techniques to be employed, the clinician should work in partnership with the client, informing her or him of what strategies the worker intends to utilize and why (McGregor et al. 2006). The practitioner also should avoid using any strategy for which there is little or no evidence of effectiveness or a sound theoretical foundation. While this would seem to go without saying, such techniques abound in treatment with survivors (Arbuthnott et al. 2001; Thayer and Lynn 2006). Finally, the worker must be prepared to help survivors either express or contain feelings, depending upon what is required to enhance self-capacities.

In the following example from a 30-day inpatient drug treatment program, the worker demonstrated her willingness to consider that the client may have a history of trauma, without jumping to firm conclusions. Notably, she uses basic skills of social work practice to address the client's relatively spontaneous disclosures. The client, thirty-year-old Rose, was meeting with the intake worker, Claire, for her initial introduction to the program. After Claire introduced herself and explained the policies and treatment options of the inpatient program, she asked Rose to describe her history of substance abuse. The following exchange then took place.

> Rose: I started using when I was about 10 or 11. I would sneak into my parents' liquor cabinet and drink whatever I could find. I would try to cover it up by adding water, and I guess it worked, 'cuz they never said anything. Of course, they were alcoholics themselves, and didn't give a damn about me.
> Claire: Wow…that's pretty young. Sometimes when children use at such a young age it means that they are trying to escape something. I am wondering if that might be the case for you?
> Silence.
> Claire: It appears as if I have struck a chord with you. I know it can be hard to talk about stuff that happened in the past, but we can be more helpful to you now if we know about anything that may have happened to you when you were little.
> Rose: Well, uh, my father would mess around with me, you know, touch me and stuff.
> Claire: I am so sorry to hear this, Rose. This must have been very difficult for you, very painful.
> Rose: (teary-eyed): I have always felt so dirty, so ashamed about what he did to me…
> Silence.
> Claire: So many of our clients, particularly our female clients, have had similar experiences. Using drugs and alcohol becomes a way to escape the pain, the sadness, the anger, all those feelings that go along with what your father did to you.

In this brief exchange, Claire normalized and validated her client's feelings and experiences through empathy but did not lose sight of her primary purpose which was to conduct an initial intake. She allowed Rose to give voice to what happened to her at the hands of her father, which was a critical first step towards coming to terms with the victimization. Yet, Claire did not press for a lot of detail or encourage Rose to engage in in-depth self-disclosure. This would have been counterproductive and undermined

Rose's self-capacities, particularly her ability to manage her feelings. It also would have been inconsistent with Claire's role as an intake worker.

As Claire sensitively observed, there is a strong correlation between substance abuse and a history of sexual abuse, particularly for women (Resnick et al. 2013; Ullman et al. 2013). This enhanced Rose's feelings of self-efficacy by helping her better understand her current behavior. Armed with this information, Rose, Claire, and Claire's colleagues could develop a treatment plan that took into account Rose's history but also focused on her current problems with addiction.

In contrast, in this next example, the worker, Joan, completely ignored the client's thinly veiled hints about his history. By doing so, she reinforced feelings of isolation and deep shame, which are common, particularly among male survivors (Alaggia and Millington 2008; Clark et al. 2012). The setting was a halfway house for men recently released from prison. Joan was assigned to work with Victor throughout his ninety day stay in her program. Victor had been incarcerated for 10 years for possession of drugs with the intent to distribute and for breaking and entering. Joan's role was to assist Victor in finding housing and employment once he was released from her program. The following exchange occurred in their sixth meeting together.

> Joan: So, last week, we were talking about your introduction to your drug of choice [cocaine]. I wonder how that was for you that your mother is the one who encouraged you to use with her?
> Victor: Well, at the time, I thought it was cool, you know? I mean, I was 14, and here I was allowed to snort coke.
> Joan: It must have been confusing for you…
> Victor (interrupts): Even at the time, when I was a kid, I guess I knew it was screwed up, that my mom shouldn't be using with her kid. But, it was a good escape from the craziness going on around me.
> Joan: So when do you think that it became a problem for you, when you couldn't stop anymore?
> Victor: From the beginning! The first time I got high, I was, like, WOW, this feels great! I just numbed myself out, when all the shit was going down with my mother's boyfriends.
> Joan: Sounds like a rough time for you, and the coke provided you with just the escape you needed. Before you knew it, you were hooked.

On two occasions, Victor offered Joan the opportunity to inquire about his past. But at neither point did she ask him for more information. When asked about this, Joan acknowledged that she picked up on Victor's hints, but wasn't sure what to do with them. She questioned whether it was "appropriate" for her to ask him about his past, given the need to help him transition back into the community. She worried that she would be opening a "can of worms" if she asked him what he meant by "the craziness" and the "shit" with his mother's boyfriends. Joan further conceded that she wasn't sure what she would do if Victor were to admit to a history of maltreatment, suggesting that countertransference also may have been a factor.

With help, Joan came to understand that exploring Victor's past in a purposeful way would provide her with valuable information about what he needed in the present. In the session that followed, Joan did follow-up on the comments Victor made previously; he reported that several of his mother's boyfriends had sexually and physically abused him over a five year period. For the remainder of his stay at her program, Joan assisted Victor in seeing the connection between his past and present problems. She also helped him better understand what happened to him when he was a child, a particularly important strategy since men, more so than women, are likely to assume their victimization was related to homosexuality (Alaggia and Millington 2008). She acknowledged and empathized with his feelings, encouraging him to express what it had been like for him. Since it often was difficult for Victor to put his feelings into words, particularly his anger, Joan suggested alternative strategies, including punching pillows and working with clay, examples of non-verbal techniques that have been found to be effective in helping survivors- and other clients- better manage and control feelings (Baljon 2011; Worthington 2012).

It is empowering for survivors to be able to put into words their experiences and feelings. But, they also need to remain in control of their emotions, since this enhances self-capacities (McGregor et al. 2006; Sweezy 2011). Further, clinicians need to be mindful of their professional role and function when encouraging clients to share their affective reactions. In the previous case involving Rose's intake interview, Claire empathized with the client without encouraging a great deal of self-disclosure, consistent with the fact that this was a one-session intake interview. In contrast, once Joan gained an appreciation for how she could be helpful to Victor during his ninety day stay, she adopted an interdependent focus on encouraging Victor to talk about and manage his feelings so they didn't undermine his ability to secure employment and permanent housing.

Trauma Informed Practice: Challenges

Three particularly noteworthy challenges face clinicians who work with clients with histories of childhood trauma. First, there will be instances when the client doesn't report

a history of childhood trauma because of the shame and embarrassment that such a history engenders; this is reflected in Victor's indirect way of addressing his past victimization. With sensitive, informed questioning like that conducted by Claire in an earlier example, however, the worker is likely to elicit relevant information about a past history of trauma. Directly asking the client about possible childhood trauma, subtly but powerfully conveys to the client that she or he can discuss it when ready and also normalizes and affirms her or his experiences and feelings.

A related challenge occurs when the client presents with little or no memory of past trauma. A client's symptom cluster and presenting problem(s) may be strongly suggestive of a history of childhood trauma, but don't provide conclusive proof. Survivors may not report a history of childhood trauma because they simply don't remember it. One of the ways that these individuals cope with their victimization is through repression, typically manifested through memory loss (Ghetti et al. 2006; McNally et al. 2006; Nemeroff 2004). Survivors often have fragmented and disjointed memories that are confusing to both themselves and the worker; this can make assessment and collecting a social history difficult (Legault and Laurence 2007). Thus, the worker may have to tolerate a certain amount of ambiguity when working with clients who display difficulties symptomatic of a childhood history of trauma.

Specialized techniques discussed earlier such as guided imagery have been used to "recover" (or, according to some critics, *create*) memories of abuse, thus generating much controversy (Alison et al. 2006; Arbuthnott et al. 2001; Thayer and Lynn 2006). The recovered memory debate centers on the accuracy of memories that surface in the present regarding abuse that allegedly occurred in the past. Research supports the existence of such memories but the findings of other studies call their veracity into question (Bottoms et al. 2012; McNally 2003; Rubin and Boals 2010). There are documented cases in which memories of abuse have been manufactured- intentionally or unintentionally- by clients, often with the subtle encouragement of the clinician (Ashmore and Brown 2010; Fusco and Platania 2011; McNally and Geraerts 2009; Takarangi et al. 2008).

In the following example, the practitioner's preconceived notions about what "must" have happened to the client, Susan, resulted in her asking questions which confirmed assumptions she- the practitioner- already held. In addition, the clinician didn't appreciate the need to assist Susan in managing her feelings, which ultimately undermined the client's self-capacities and increased feelings of self-doubt.

> Susan, 35, was being seen in an outpatient mental health clinic for problems with depression. She reported few memories of her childhood, but did recall her parents' alcoholism and constant fights. During the course of therapy, Susan reported disturbing memories of her parents' bedroom and her father in the bed, naked. The therapist suggested to Susan that she was sexually abused by her father. Susan reported later that while she was skeptical of this, she assumed "the therapist knew what she was doing". She began to accept that her father "must have" abused her, even though she never remembered this happening. This resulted in an increase in her drug use, intensified her feelings of depression, and led to estrangement from her family and rage. Once Susan reached the agency's limits for the number of sessions she could be seen, she found another clinician with a great deal of experience and training working with adult survivors of childhood trauma. Working together, Susan and her new worker discovered, through the careful, informed use of guided imagery, that Susan was *not* sexually abused by her father. She recalled that she found her father in bed, naked, with another woman while her mother was at work. Her father warned her that she shouldn't tell her mother, as it would "kill" her. Further, he threatened to harm Susan if she told anyone about what she saw.

The prudent stance in a case such as this is for the worker to maintain a position of neutrality. The second, experienced clinician avoided making a priori assumptions about what Susan's disjointed memories might mean. After discussing with Susan in advance what she intended to do, the practitioner asked the client to describe what she saw on a movie screen, while in a state of relaxation, a typical strategy utilized in guided imagery (Leviton and Leviton 2004). The clinician avoided asking leading questions as well as arriving at conclusions as to what the client's descriptions might mean. Working together, Susan and the practitioner explored the possible meanings associated with what the client had visualized.

When memories surface in the present and/or are fragmented, the worker accepts that memories of abuse may be psychologically and affectively true, even though they may not be historically accurate (Reimer 2010; Rubin and Boals 2010). In those instances when the client reports no history of child maltreatment but presents with many of its symptoms, the worker remains focused on the present-day challenges the client faces. The clinician doesn't "reach for" memories that she or he assumes "must" be there. Rather, she or he considers the possibility that there may be a history of abuse and is prepared to respond should memories begin to surface, as they often do, on their own (Bottoms et al. 2012; Rubin and Boals 2010). This is

particularly important in those cases when the client has no memories *at all* of her or his childhood, as this has been found to be a common indicator of childhood victimization (Crowley 2007; McNally et al. 2006).

The following example underscores yet again the need for the worker to maintain a neutral stance and avoid making a priori assumptions about what a client's memories might mean.[2]

> Charles, a client in an inpatient psychiatric facility, had unclear, fragmented memories of his childhood, but believed that "something" happened to him in the basement of his home. He had recollections of being face down in a pile of laundry and had physical sensations of being penetrated in his rectum. He also was able to visualize the shadow of a man standing over him. Finally, he recalled seeing a tool belt hanging on the wall in the basement, and believed he was sodomized with the handle of one of the tools by his father, who was an abusive alcoholic.

Based upon these recollections, it would be easy for the practitioner to come to the same conclusions as Charles. In fact, as Charles talked further about his victimization in group and individual therapy, his memories of what happened to him became clearer, a common phenomenon (Colangelo 2009; Malmo and Laidlaw 2010; Raymaekers et al. 2012). Charles ultimately was able to see the face of the person who abused him, and it wasn't his father. It was an uncle who had lived with his family, something that he had not remembered initially. Charles also came to believe that tools were not inserted in him though he was sodomized. Rather they were in his line of vision, and he focused on them, so he did not have to think about or feel what was being done to him by his uncle. This example should serve as a cautionary tale to all practitioners. The client needs to be able to tell and make sense of her or his story without the worker assuming in advance what the story might mean (Bedard-Gilligan et al. 2012).

A second challenge associated with working with a client with a history of childhood trauma is related to mandatory reporting requirements. In many jurisdictions, mental health professionals must report disclosures from adult survivors about their abuse as children (Morton and Oravecz 2009). The worker actually can meet legal requirements in ways that empower survivors, even though clients' initial reactions often include fear of exposure and vulnerability (Farber et al. 2009). The practitioner should adhere to three principles. First, the worker must be well-versed in what her or his legal responsibilities actually are. Second, the worker should uphold legal mandates in a way that minimizes risk to survivors. Finally, the worker assists the client in determining what courses of action to take and avoids making those decisions for him or her. This, again, implies that the worker adopt a neutral stance.

In this next example the practitioner handled the client's disclosures in a way that undermined his self-capacities and, ultimately, re-traumatized him. George, the client, reported the following experience:

> When I went to the [outpatient mental health] agency, they asked me a bunch of questions about my history. They asked me if I had experienced any type of sexual abuse. I was embarrassed, man, with them asking about this shit. But I told them I thought a neighbor might have fooled around with me when I was about five or six years old. The person I spoke with told me that she would need to report what I told her to the authorities. I begged her not to do it! I didn't want anyone to know about what happened, and I couldn't really remember much of it anyway, and now she was going to tell the police?! The guy still lives next door to my parents! She said that this was a good thing: that I should file charges against the guy who molested me. She said I had a right to get justice for what happened to me. She kept asking me for more and more detail, and it got me really upset, particularly since so much of it was really fuzzy. All I want is to stay healthy!

The practitioner was required by her agency to ask about possible childhood victimization, due to her state's reporting requirements. Therefore, she had to report what George disclosed to her. What seems like an arbitrary mandate that will undermine the therapeutic relationship actually can become a way that the worker and client initially engage with one another and create a partnership (Oz and Balshan 2007). What *does* undermine the working alliance is when such a mandate comes, from the client's viewpoint, out of the blue, as it did for George. In other words, it's not the mandate itself that creates the problem, it's the way the worker presents it to and handles it with the client (Morton and Oravecz 2009).

The author's state is one that requires clinicians to report an adult client's disclosures of childhood abuse. The author tells her clients about the mandatory reporting law at the outset of the first interview. She and the client then craft a statement together that satisfies the legal requirement, but also protects the client, to the extent that is possible. This strategy actually is empowering for the survivor, despite the mandated intrusion into her or his privacy.

Another aspect of George's experience that was counterproductive was the practitioner's continued questioning; she really didn't need additional information to do her job as a case manager conducting an intake or to fulfill her state's mandatory reporting requirements. Collecting

[2] Adapted from Knight (2009).

detailed information about George's past was de-stabilizing and undermined his self-capacities. Further, the clinician's persistence in encouraging George to take legal action against his abuser was misguided, particularly given his disjointed memories of what may have happened to him. Recovered, fragmented memories are particularly suspect from a legal perspective (Alison et al. 2006; Binder and McNeil 2007). It is not up to the worker to decide how or even whether the client should use the legal system or in some other way confront abusers or others who may have been complicit in the victimization (Regehr and Alaggia 2006). The worker's position should be to provide support, information, and guidance to the client about available options but not to tell the client what to do. Given survivors' core feelings of powerlessness, this is an especially important consideration.

The worker also should help clients identify what it is they hope to get out of pursuing legal action or confrontation. It is very difficult for adult survivors to prove their abuse in a court of law, and this is particularly true of sexual abuse (Alison et al. 2006; Binder and McNeil 2007). Survivors' testimony about their recollections of what happened will be subject to cross-examination. It is not surprising that *all* of the author's clients who have been through the legal system referred to it as being "raped all over again."

A final challenge when working with adult survivors reflects the impact that this has on workers, themselves. Survivors often present themselves as overwhelmed with myriad problems and, as discussed, with heightened feelings of mistrust and hostility towards the practitioner (Bride 2004; Cunningham 2003; Harper et al. 2008; Shafer and Fisher 2011). Further, their disclosures about what happened to them, their "trauma narratives" (Etherington 2000), can be extremely hard to hear and their reactions to the narrative can be hard to witness. Thus, countertransference is a common reaction among practitioners who work with survivors (Cramer 2002; Pearlman and Saakvitne 1995). Typical reactions range from disbelief and avoidance such as that displayed by Joan, Victor's worker, to over-identification and rescuing behavior such as that displayed by Margaret's worker. While countertransference is often assumed to be the result of the worker's unresolved issues, in the case of working with survivors, it is best viewed as a natural consequence of working with challenging, highly distressed clients (Walker 2004).

Workers also are at risk of being indirectly traumatized through their work with survivors (Adams et al. 2006; Knight 2009, 2013; Harr and Moore 2011; Thomas and Wilson 2004). Three different manifestations of this phenomenon have been distinguished: secondary traumatic stress, which includes intrusive symptoms comparable to those that accompany PTSD; vicarious trauma which refers to the changes in the worker's views of self and others analogous to those that occur with survivors; and compassion fatigue in which the worker is unable to generate feelings of empathy for the client. Indirect trauma is viewed as an inevitable consequence of working with clients with histories of childhood trauma over time and witnessing their pain and distress firsthand (Bride 2004; Baird and Kracen 2006; Jenkins and Baird 2002). Indirect trauma is not the same as countertransference, which occurs in response to a particular client (Berzoff and Kita 2010). Yet, each can reinforce the other (Pearlman and Saakvitne 1995).

It is imperative that workers take steps to minimize the impact countertransference and indirect trauma have on them personally and on their work. This includes adopting self-care strategies that focus on nurturing oneself, establishing fulfilling relationships, and being pro-active in managing stress (Bell et al. 2003; Bober and Regehr 2006). Clinicians need to be vigilant in assessing the impact their work with survivors has on them. In the following example, an intake worker in child protective services described his reactions to a child client, revealing manifestations of secondary traumatic stress and countertransference.

> Now that I have my own child, I find it a lot harder to turn off my thoughts about the kids on my caseload. I just finished up an investigation involving allegations of physical and sexual abuse of a 4 year-old boy. Mom was a drug addict and lived pretty much on the streets. Apparently, she left her son with a series of boyfriends. The child has signs of having been repeatedly sodomized. Also a lot of physical injuries. I have a son who's five. I look at my son and can't help but think of this little boy, and all the other kids that I've seen over the years. My son is happy, carefree. This little kid, he's already gone in a lot of ways. He's got these dead eyes. I keep seeing those dead eyes of his every time I look at my son.
> I also find myself being so f…ing angry with this boy's mother. I need to work with her, but I blame her for her son's injuries. She doesn't deserve to have a child! It's really hard for me to hide my feelings and do my job, which is to work toward reunification.

The worker's honesty in disclosing his feelings and reaction was the first step towards managing them. His feelings of anger towards the child's mother were understandable; he is, after all, human. Having a son the same approximate age as his child client only exacerbated these feelings. Workers need a place to talk about their feelings. Thus, agency culture and the supervisory climate should encourage honest discussion in a way that normalizes, validates, and helps clinicians manage manifestations of indirect trauma and countertransference (Brockhouse et al. 2011; Stebnicki 2000).

Conclusion

Adult survivors of childhood trauma are a particularly challenging group of clients given the long-term effects of the victimization and the present-day difficulties they face. In this article, trauma-informed practice is explained, incorporating the most recent theoretical and empirical literature. The purpose has been to educate and support practitioners who encounter survivors of childhood trauma in settings that are particularly likely to serve these individuals such as addictions, mental health, forensics/corrections, and child welfare. The practitioner neither ignores nor dwells exclusively on the trauma. Rather, trauma-informed practitioners are sensitive to the ways in which the client's history affect her or his present-day challenges and normalize and validate the client's experiences, consistent with their professional role. Trauma-informed practice requires the practitioner to understand how the working alliance, itself, can be used to address the long-term effects of the client's childhood trauma. Emphasis is placed on helping survivors understand how their past influences the present and on empowering them to manage their present lives more effectively, using basic skills of social work practice. Trauma-informed practitioners are, in fact, well-served by their core training as social workers.

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