Psychological Trauma and Social Work in Late-Modernity: An Exploratory Discussion of Relationships in Transition

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Humanistic psychology has a long tradition in the field of social work theory and practice. Relational social case work has its roots in the work of Jesse Taft and relational therapy practiced by Otto Rank that was also a significant influence on Carl Rogers. Over recent years social work practice has been influenced by bureaucratisation, marketisation, managerialism and risk management yet maintains its focus on human relations and the humanistic approach. In this article, I will endeavour to provide both a brief outline of the relationship between social work and trauma with specific reference to the current context in the UK, and some tentative directions for future developments in this area. This discussion will include establishing how an event can be considered traumatic, questioning the epidemiological prevalence of these events and ascertaining how the subsequent repercussions are both medically and socially addressed, with reference to the unique role that social workers may play. This will be done, in part, by drawing upon some related research that I previously undertook regarding trauma survivors' perceptions of the professional relationships they experienced with student social workers employed within a specialist trauma service (Archard and Murphy 2010).

The development of trauma theory

Traumatic experience can have a severely debilitating effect on human functioning. Its multidimensional impact spans from the physiological and the psychological to the social and political. It renders victims powerless by overwhelming 'the ordinary systems of care that give people a sense of control, connection and meaning' (Herman 1992, p.33). In recent years, alongside the occurrence of global conflict, climate change, and technological advances, a high demand for specialised trauma services has been created (Wheeler and Bragin, 2007). There are many professions associated with this predominantly therapeutic provision such as psychiatrists, psychologists

and counsellors. Recent surveys have indicated that one professional group that is often notably absent, or at least underrepresented, is social work (Gavrilovic, et al., 2009). Social work's relationship with trauma does not end within these specialist settings. The term trauma is also applicable to a wide range of situations, many statutory social workers will encounter in their daily practice. These include, but are not limited to, childhood abuse, multiple bereavements and service users' suffering as the victim of serious crime or domestic violence.

The term trauma is derived from the Greek word for wound. It is still referred to literally today by the medical profession in reference to physical injury, but in the human services and the social work profession particularly, it is employed metaphorically to refer to invisible, psychological damage. Contemporary definitions establish that a traumatic event can be recognised by both its nature; which involves either witnessing or experiencing 'actual or threat of death, loss or serious physical injury, and the response that follows, which is characterised by 'fear, helplessness, and/or horror' (Roberts and Greene 2002: 848). Recent epidemiological studies concerning western societies have estimated that over the life course approximately ninety-percent of the general population will experience at least one traumatic event, and that approximately ten-percent of this majority will proceed to suffer psychological complications indicative of a trauma related disorder such as posttraumatic stress disorder (PTSD: APA, 1994).

Since the 1990's the PTSD diagnosis has unequivocally become a major focus of trauma studies, The PTSD diagnosis has securely emphasised posttraumatic stress as existing within an individuals mind and brain, for example in both impairments in memory (Buckey, et al., 2000) and/or cognitive functioning (Andrews *et al* 2000), and heightened cortisol levels and alterations in brain structure (Van der Kolk, 2005). Whilst the primacy of attention that the PTSD diagnosis has held in wider psychiatric and medical research is, to many, indicative of progress in the wider field, the diagnosis itself does not envelope all that is traumatic. Since its very inception, the concept of trauma has never been detached from wider social and political influences. For example, Freud's (1894) early psychoanalytic writings on the relation of early childhood trauma and later mental ill health, extended from Charcot's theory of 'traumatic hysteria', were forcibly disavowed in later work in favour of links to repressed fantasies due to Victorian society's unease with its implications regarding the prevalence of childhood sexual abuse. More recently, the PTSD diagnosis was only psychiatrically formalised following the high volume of American troops that returned from the Vietnam War suffering from intolerable mental distress.

It is not only the research and development of trauma theory that is embedded in wider cultures. It can also be argued traumatic experience is multifarious in both origin and effect. Adverse socio-economic circumstances, such as chronic poverty, with their tacit emotional and material problems, not only create a heightened propensity for eroding individuals' defences predisposing them to a greater susceptibility to the psychological damage that trauma can generate (Hernández de Tubert, 2006), but also engender feelings of powerlessness and disaffection that lead to individuals acting destructively or abusively and consequentially actively creating trauma. Whilst the prevelant diagnostic paradigm has tried to incorporate these wider dimensions, for example Gill and colleagues (2009) study of the PTSD symptomology present amongst urban women of low socio-economic status, there are limitations in the translation of the underpinning reductionist, medico-scientific orthodoxy to fluid, symbolic and often contradictory social processes. The diagnostic approach may have thus lost some of its emancipatory potential through its inherent requirement to medically treat what can be considered as the relational or even political experiences of conflict, loss and distress (Burstow, 2005). Although it would be inadvisable to dispute trauma's ability to significantly damage psycho-biological wellbeing, it is worth questioning whether an individualistic and broadly positivist agenda is universally suitable in professional and research settings. Bracken (2001) contends that the cultural and spiritual dimensions to trauma are not suited to quantification, for example western atomistic conceptions of self would be of little use in many non-western settings. This argument may also be extended and applied to more local settings. It can be argued that in our current late-modern age, the influences of globalisation and consumerism have led to identity and experience becoming more fluid and fragmented (Giddens, 1992) which in turn may lead to significantly altered forms of posttraumatic distress. As Stocks (2007: 89) has highlighted, one of the key constraints of trauma theory is that it 'has not evolved sufficiently to account for the complex and radical social changes that have occurred since the early twentieth century'.

Social work and trauma

Social work, as both an activity and academic discipline, is primarily concerned with assisting marginalised and vulnerable groups within society that may suffer trauma. Broader visions of the profession often appear to encapsulate sincerely altruistic credentials.

> 'Social Work is a profession that promotes social change, problem-solving in human relationships and the empowerment and liberation of people to enhance well-being' (International Federation of Social Workers, 2000).

Determining how this broader vision translates to the day to day practical considerations and activities of social workers is complex. This is predominantly due to qualified social workers fulfilling a wide variety of professional roles in a range of both statutory and voluntary settings. In the UK and the area of trauma alone, at least three broad legislative contexts can be identified. Firstly under the Civil Contingency Act 2004, local authority social workers, amongst other professionals can be enlisted as part of a structured response to deal with the immediate aftermath of critical incidents. Secondly, under the auspices of the Children's Act 2004 and the Mental Health Act 2005, statutory social workers will support and work with many service users who have suffered significant levels of trauma. This may include commissioning, co-ordinating or even undertaking individual therapeutic work. Thirdly, within NICE clinical policy for the treatment of PTSD, social workers are enumerated, alongside nurses, counsellors and psychologists, as a professional group suited to undertake psychotherapeutic approaches, most predominantly Cognitive-Behavioural Therapy (CBT), in the treatment of PTSD sufferers.

The NICE Clinical Guidelines (2005) do not differentiate between roles for the healthcare professions that are included. There is also no reference to the tailored psychosocial work that social workers may be well qualified to undertake. Social elements of recovery are, in fact, only given scant attention. On page 126 of these guidelines it is recommended that involved healthcare professionals assess and 'identify the need for social support', and if necessary 'advocate for the meeting of this need'. Fortunately, trauma-focussed models are not held in parenthesis across all specialist services. The independent centre in which my own research was conducted facilitated student social work placements, wherein the training practitioners were given a great deal of freedom to locate and employ their own approaches to working with trauma survivors. This was not limited to co-working with psychotherapists and psychologists on cases referred through the NHS, it also incorporated making contact with external clients who may face significant barriers to assessing this specialist type of provision through other statutory and voluntary organisations, such as homeless people and/or those involved in substance misuse and prostitution.

The reseach constituted an exploratory study within which a group of middle aged homeless males who had accessed the trauma services (but had not necessarily received a trauma-related diagnosis) were qualitatively interviewed regarding their perceptions of the relationships they had had with the visiting student social workers. The content and subsequent analysis of these interviews indicated that whilst the the intervention of the students had been beneficial, they felt that, at times that they were serving professional needs rather than their own, and that they tended to draw a

greater level of emotional support for the ongoing distress (that all of them appeared to be expereinecing) from their peers within the hostel.

Although this study was of very small scale, some useful coclusions can be drawn from the results. Firstly, it is apparent that the claim that the PTSD diagnosis or other trauma related diagnoses do not envelope all that is traumatic retains a level of validity. All of the participants had suffered some kind of significant adversity with psychological complications but had not been made the subject of psychiatric classification in order to enable them to draw on professional support. Commentators, such as Davis (1999) have previously debated whether PTSD should in any way be considered a 'disorder', through claims that the diagnosis has the capacity to further marginalise already disadvantaged groups. Secondly, and perhaps more crucially, is the indication that the individualistic, trauma-focussed therapeutic interventions may have distinct limitations when not considered holistically through reference to the both wider support networks and structural influences. Beauchomp (2003: 270) claims that individualistic interventions in the field of health often create a victim blaming culture.

'Victim-blaming misdefines structural and collective problems…as individual problems, seeing these problems as caused by behavioural failures or deficiencies of the victims. These behavioural explanations for public problems tend to protect the larger society and powerful interests from the burdens of collective action, and instead encourage attempts to change the 'faulty' behaviour of victims'.

Social work may thus have a crucial role to play at this intersection of personal and structural. It not only must endeavour to account for individual service user's psychological distress but is also a vanguard for drawing attention to the manner in which inequality asseverates and creates the conditions contributing to psychological distress. Within this role the humanistic and relational dimensions of social work practice are thus not superfluous. Even the most hardened, structurally orientated social worker would be naïve to refute the need for empathic and sensitive interpersonal skills so as to build trusting and constructive relationships that would aid collective action. In the enquiry cited, it would appear that if the student social workers have strived for a greater level of congruence regarding the dual reasons for their professional involvement (in line with Roger's (1951) key conditions) then some of participants' frustration may have been avoided. However it is inadvisable to assume that humanistic relational conditions alone are panacea in their ability to accommodate wider constructive change. Foucauldian critics, such as Rose (1999), have highlighted that there have been used in a variety

of professional settings creating a falsely benign character to what can actually be controlling and destructive enterprises.

Conclusion

The above analysis has indicated that social work may have a decisive part to play in the development of professional knowledge and practice concerning work with those suffering the psychological repercussions of traumatic experience. Some tentative recommendations have been made regarding apposite future social work practice in this sphere. However, it must be acknowledged that social workers in the UK's statutory services are consistently faced with such a volume of work that little time or emotional resource can be dedicated to introspection. One area within which social work may be of value is in future empirical research. Research of a more comprehensive nature than the above, that incorporated a range of investigation in a variety of relevant settings, would definitely be of value. Moreover, this research could be furthered by definitive attempts at articulating the changing nature of traumatic experience which may serve to assist trauma theory to break free from its prevailing orthodoxy and begin to adapt to a increasingly fluid and fragmented late-modern world.

Notes

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2. This article is dedicated to Fearghus Archard, born: 1st July 2010.

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There's to be NO Statutory Regulation for Counselling & Psychotherapy

The Government's Command Paper 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers' (Cm 8008) suggests there is to be no regulation for professions such as Counselling and Psychotherapy under the method proposed by the HPC and will continue to be regulated via voluntary registers. The Alliance for Counselling and Psychotherapy have released a report that can be viewed on their website and state the "a voluntary system for unregulated professions will be developed under the umbrella of the new Professional Standards Authority (previously the Council for Healthcare Regulatory Excellence: CHRE)." The Alliance have pledged to continue their work and hope that this announcement will "herald a more flexible and client-centred approach, not only with regard to regulatory policy, but also in other areas of concern such as the National Institute for Clinical Excellence (NICE) guidelines and the limited range of therapies which are currently available within the Increasing Access to Psychological Therapies (IAPT) programme." More next time in S&S on these developments.