Children Australia
Volume 42 | Number 2 | pp. 104–107 | © The Author(s) 2017 | doi:10.1017/cha.2017.12

Practice Commentary

'Untying the Knot': Achieving Integrative and Collaborative Care within Trauma and Fear Saturated Systems – A Practice-Focused Discussion Paper

Dilip Balu
Social Worker & Clinical Senior Child Protection Counselling Service, Springfield Cottage, P.O. Box 63 Penrith NSW 2751

The author's clinical experience with the Child Protection and Mental Health Care systems informs this brief practice-focused paper. The author posits that Secondary Traumatic Stress and Vicarious Trauma are central to understanding the impact of relationally traumatic material and the experience of individuals, families, team and the wider ecology of care systems. In particular, the author hypothesises that the tendency of systems to become fragmented in operation, with silos of sub-parts working parallel to each other, may be a natural adaptation to the ways in which traumatic experience ripples across system boundaries. This 'ripple effect' may lead to increasing emotional and relational reactivity, and survival-oriented inward focus of energies and efforts. The metaphor of the brain and nervous system is used to explore ideas of connection and integration in care systems. Trauma-informed leadership by individuals and teams is also touched upon in relation to reducing fear-driven clinical practice.

■ **Keywords:** collaborative care systems, complex trauma, secondary trauma, vicarious trauma, neurobiology of trauma, trauma informed care

Introduction

This paper explores a central question that is relevant to the area of collaborative care:

> Can a support or treatment system that is fragmented by the demands of dealing with traumatic material and experience consistently provide care that helps individuals to experience a healthy and integrated sense of self?

This question has its genesis in the author's professional experience of working clinically within child, adolescent and youth care systems (mental health and child protection) and observations of the tendency for systems of care to work in isolation from one another. Working in 'silos' is often the expression used by those working within care systems to describe this inward focus and resulting lack of communication and collaboration in service provision. For highly vulnerable and often traumatised clients of services such as child protection, out-of-home care and mental health, this can result in confusion, difficulties with access, demoralisation and further disempowerment (Kirst, Aery, Matheson, & Stergiopoulos, 2016).

Franklin, Bernhardt, Palan Lopez, Long-Middleton and Davis (2015) provide an overview of what is currently known about the integration of interprofessional teamwork and collaboration within the field of primary health care. They also highlight that primary health care can no longer be delivered in silos of individual health professions and that workforce redesign is required to promote the overall health of individuals, families and communities. The authors also presented evidence to support the idea that mutual understanding and respect for roles, sharing of goals and values, and cooperation are needed to promote effective teamwork between health-care team members (Franklin et al., 2015).

ADDRESS FOR CORRESPONDENCE: Dilip Balu, Social Worker & Clinical Senior Child Protection Counselling Service, Springfield Cottage, P.O. Box 63 Penrith NSW 2751.
E-mail: dilipbalu@hotmail.com (personal) or dilip.balu@health.nsw.gov.au (work)

We know why collaborative health care is important, however, less is known about the reasons for the fragmentation of collaborative care and development of system silos from the perspective of individuals working within these teams and systems. This paper seeks to explore this question from a trauma-informed perspective.

Inter and Intra-Systemic Trauma

Care systems are complex ecologies made up of individuals and subcultural systems, including families, professional disciplines, multidisciplinary teams and wider health systems. Of particular interest in this paper is the idea of the vicarious transfer of trauma symptoms across the ecology of organisations and care systems (Tyler, 2012). This is a phenomenon widely noted and experienced in trauma-saturated fields of clinical practice marked by phenomena such as compassion fatigue, worker burnout, defensive practice and high staff turnover (Rothschild, 2006). One cannot and should not underestimate the impact of chronic exposure to disturbing and confronting stories and experiences of child abuse, neglect, sexual abuse, domestic violence and grief and loss on frontline workers and clinicians (Rothschild, 2006). The emotionally charged nature of this material can have significant impact on these professionals for whom compassion and empathy are key tools for relational connection, engagement and intervention (Rothschild, 2006). Just like direct victims of this trauma, clinicians must also adapt in order to survive the constant demands of their emotionally charged neurobiological responses (Tyler, 2012). The particular foci of this paper are Secondary Traumatic Stress (STS) and Vicarious Trauma (VT) as they relate to trauma transfer across care systems. Newell & McNeill (2015) describe the distinction between STS and VT as follows:

> ... vicarious traumatization [is] a cognitive change process resulting from chronic direct practice with trauma populations, in which the outcomes are alterations in one's thoughts and beliefs about the world in key areas such as safety, trust, and control ... Secondary traumatic stress, grounded in the field of traumatology, places more emphasis on the outward behavioural symptoms rather than intrinsic cognitive changes (pp. 60–61).

As a result of STS and VT, individuals and teams within systems under stress can tend to operate in survival mode (Bloom & Farragher, 2011). The response can mirror the internal responses of trauma victims, which makes developing and maintaining warm, connected relationships extremely difficult and can potentially lead to an increased risk of dissatisfaction and burnout (Bloom & Farragher, 2011). Stressed, reactive bodies and minds often find self-reflection on global experience and self-regulation of affect out of their reach (Meares, 2005; Schore, 2003). VT can also impact by reducing people's feelings of safety and security in their social ecology, starting with intimate relationships and working outwards, fear driven, into their professional and social/communal worlds (Rothschild, 2006).

Trauma Transfer: A Ripple Effect?

As authors such as Siegel (2009) have indicated, trauma theory assists in the explanation of how:

- Trauma and experiences of insecurity and fear are created within relationships; as is a sense of security.
- Our intimate personal selves are formed in relationships and through our social ecology.
- Trauma impacts profoundly on global development and, in particular, on the central nervous system with the brain at its core.

It may be useful to extrapolate these intrinsically personal traumatic experiences outwards in order to understand their effects on subsystems of our whole being (starting with our own central nervous systems, and moving to our relationships). By doing this, we may also better understand the resulting fragmentation and disintegration of these subsystems in response to experiences of traumatic stress (Siegel, 2009). Being in survival mode means individuals can become more reactive, short-term survival focussed, and less able to look at the bigger picture (Siegel, 2009). This can be adaptive in the short term, but problematic if it continues because of a lack of safety and reparation (Meares, 2012). Individuals develop within, and create relationships constantly, and it is these relationships that make up systems of interactions (Bloom & Farragher, 2011; Siegel, 2009). This means that trauma may also ripple out vicariously and interpersonally like the impact of a stone thrown into a still pond. If this is the case, trauma may place fragmentation pressures on systems and the relationships that constitute them, creating a cycle of traumatic experience and increased inward focus that is not consistent with reaching out across barriers; rather more consistent with operating in silos (Kulkarni & Bell, 2012).

Within our field of practice, we are starting to understand more keenly that it is extremely difficult to heal from traumatic experiences (Bloom & Farragher, 2011). These types of experiences teach people to be constantly on the lookout to protect themselves from more pain in the future (Wall, Higgins & Hunter, 2016). Without therapeutic support that helps individuals to work through their pain and to relate to people in safer and healthier ways, healing becomes extremely challenging (Higgins et al., 2015). Finding ways to break the cycle of traumatic self-preservation can also create opportunities to break intergenerational cycles of trauma in vulnerable families and communities (Australia's Indigenous Peoples in particular) (Atkinson, Nelson, & Atkinson, 2010).

Siegel (2012) describes the mind as an 'embodied and relational process that regulates the flow of energy and information' (p. 2). He also emphasises the interdependence of brain (mechanism), mind (regulation) and relationships

(sharing) in the developing mind. Trauma can impact on this interdependent, integrated and emergent process by breaking the linkages between differentiated parts of this complex process, thereby moving away from harmony and integration to chaos and rigidity (Siegel, 2012).

The effects of being part of a system of care that works with traumatic experience every day may range across a spectrum of limbic system originated responses such as:

- Strong and persistent avoidant urges to 'clock in and clock off' and focus on the basic tasks of each day.
- Preoccupied ruminative/obsessive urges and desire to 'fix' and 'save'.
- Disorganised 'mixed up' responses that comprise bits of each as well as completely unrelated adaptations (Tyler, 2012).

Meares (2005) also proposes a narrowing of creative capacity, which is the adult equivalent of play in the lives of children. This greyer, less full and less enjoyable existence is one that is adaptive in reducing the risk of further threat and stress in the short term. However, one might also see this 'greyer' existence as fitting somewhere on the dissociative spectrum of neurobiological response to threat and/or chronic stress (Meares, 2012).

Brain as Metaphor for Care System

What if we were to use the brain as a metaphor for a care system? The brain represents a complex, dynamic living system of interconnected sub-parts that function in an integrated way under particular conditions (Siegel, 2012). Our knowledge of the impact of traumatic stress on integrative brain function is growing all the time. We now understand that survival-focused regions of the brain (such as the brain stem and limbic system) take precedence, and reflective regions (such as the prefrontal cortex) go offline when exposed to traumatic and other significant stress (Siegel, 2012). In our metaphorical model of the care system, neurons function like the individuals within a care system (e.g., a multidisciplinary mental health team) and the parts of the brain function like teams within that care system (e.g., limbic system, brain stem, pre-frontal cortex, etc.)

If we look at Siegel's (2012) model of the mind, we can see that experiential neuronal connections are made in the context of these healthy and safe relationships that link sub-parts. Securely attached, play-based and integrated relational interactions support exploration and encourage these connections. These, in turn, form neural pathways and maps, which then become integrative at the level of emotional development and self-regulation (horizontal and vertical) and non-linear in nature (i.e., formed by free creative associative processes). Further exploration into the world of relationships allows for this emergent process to continue unimpeded. In a care system this might take the form of:

- Safe, open and transparent communication together with resolution of conflict and difference;
- The blossoming of creativity in service development, clinical care and problem solving, and;
- An integration of the different sub-parts of the system (e.g., professional disciplines, teams, agency partners, etc.).

Care systems may also have emergent properties related to connection and integration of differentiated parts. If so, then what happens when chronic stress triggers evolutionary survival responses that disrupt the formation of these harmonious, flexible and non-linear connections and maps between neurons (people)? Perhaps different connections/pathways can be formed that are more rigid and linear in nature and less integrative of differentiated parts. Some ways of describing this could be: fragmented, disconnected, dissociated (Meares, 2012), but in care-system terms, this might be described as the formation and maintenance of silos operating mysteriously in parallel to each other without connections — something like traumatic memory pathways that have no direct knowledge of the experiential content of each other (Meares, 2012).

Conclusion: Towards Integrative Trauma-Informed Practice

The Sanctuary Model™ is a knowledge and evidence-based, trauma informed and responsive whole of culture approach to organisational change (Bloom & Farragher, 2011). It emphasises the essential primacy of relationships to the healthy functioning of individuals and the systems that these individuals inhabit and interact with (Bloom & Farragher, 2011). As discussed earlier, systems, both formal (e.g., professional) and informal (e.g., families) share this common factor of relatedness. As Allan Schore (2003) notes 'The most significant consequence of early relational trauma is the loss of the ability to regulate the intensity and duration of affects' (p. 141). In order to support a person of any age with self-regulation difficulties that stem from relational trauma, relational coregulation within a context of safety is an imperative starting point (Bath, 2008). This 'containing' relational dynamic is less likely to be found within a system that is emotionally reactive, non-reflective and saturated with trauma (Bloom & Farragher, 2011). Given what we know about trauma and systems, it is more likely that this process will be visible to a person who exists outside of a direct system of care who can take an observer perspective (Bloom & Farragher, 2011).

This means it may be useful for those within a stressed care system to be open to transparent care delivery and feedback from observers to help inform the understanding within systems of their ways of operating (Bloom & Farragher, 2011). Collaborative care is an approach that can encompass this kind of living process. It means working beyond boundaries that impose unnecessary barriers and within necessary limits, both personal and professional (Ko et al., 2008). This approach may be the systems embodiment of secure attachment as indicated by warmth

with clear limits and the ability to balance aloneness and togetherness (Meares, 2005; Siegel, 2009). The ability to make overt and discuss 'wicked' interpersonal problems that are patterned and fixed in nature is also likely to be critical (Dunoon, 2008). There can be many elephants in many rooms within service-system structures.

In this kind of relationally centred model there must surely also be a central role for compassion and kindness-based interactions in the face of fear. In addition, there must also be a role for the promotion of safety as an overt process with an approach/lens that promotes the development of a shared language of collaborative and integrative care (e.g., Sanctuary model) (Bloom & Farragher, 2011). The embodiment of trauma-informed care in individual clinicians and teams reaches far beyond specialised language and into lived experience. Courageous, creative and visionary leadership towards process-based change and understanding of existing system cultures is a very valuable commodity (Dunoon, 2008), but to grow this leadership capacity in systems, there must first be an awareness that something is not right (based on one's own observations of stress levels and dilemmas and how they are shared with colleagues) and a will to lean into these unpleasant and threatening experiences. As Nhat Hanh (2012) so beautifully describes:

> Fear keeps us focused on the past or worried about the future. If we can acknowledge our fear, we can realize that right now we are okay. Right now, today, we are still alive, and our bodies are working marvelously. Our eyes can still see the beautiful sky. Our ears can still hear the voices of our loved ones. (p. 4)

Acknowledgements

The clinical team at Redbank Integrated Adolescent Service, Redbank House, Institute Road, Westmead NSW 2145, Associate Professor Loyola McLean, research supervisor, and the team at Integrated Violence Prevention and Response Service (IVPRS), Nepean Blue Mountains Local Health District are acknowledged in the development of this paper.

Declarations

The author, Dilip Balu, declares this paper is an original work and that he has no conflict of interest.

References

Atkinson, J., Nelson, J., & Atkinson, C. (2010). Trauma, transgenerational transfer and effects on community wellbeing. In N. Purdie, P. Dudgeon, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (pp. 139–144). Canberra ACT: Commonwealth of Australia.

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth, 17*(3), 17–21.

Bloom, S. L., & Farragher, B. (2011). *Destroying sanctuary: The crisis in human service delivery systems*. New York: Oxford Press.

Dunoon, D. (2008). *In the leadership mode: Concepts, practices, and tools for a different leadership*. Victoria, British Columbia: Trafford Publishing.

Franklin, C. M., Berhnardt, J. M., Palan Lopez, R., Long-Middleton, E. R., & Davis, S. (2015). Interprofessional teamwork and collaboration between community health workers and healthcare teams: an integrative review. *Health Services Research and Managerial Epidemiology, 2*, 1–9.

Kirst, M., Aery, A., Matheson, F. I., & Stergiopoulos, V. (2016). Provider and consumer perceptions of trauma informed practices and services for substance use and mental health problems. *International Journal of Mental Health Addiction*. Retrieved from http://link.springer.com/article/10.1007/s11469-016-9693-z/fulltext.html?view=classic.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, Brymer M. J., & Layne, C. M. (2008). Creating trauma-informed systems: child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39*(4), 396–404.

Kulkarni, S., & Bell, H. (2012). Trauma and the organization: understanding and addressing secondary trauma in a trauma-informed system. Presented at the Moving Forward in Challenging Times Conference July 6–8, 2011, SafePlace Austin, TX Trauma and the Organization. Retrieved from http://safeaustin.org/wp-content/uploads/2013/12/Paper2-Trauma-and-the-Organization.pdf.

Meares, R. J. (2005). *The metaphor of play: The origin and breakdown of personal being*. East Sussex: Routledge.

Meares, R. (2012). *A dissociation model of borderline personality disorder*. New York: W. W. Norton & Co.

Newell, J. M., & MacNeil, G. A. (2015). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue. *Best Practices in Mental Health, 2*, 57–68.

Nhat Hanh, T. (2012). *Fear: Essential wisdom for getting through the storm*. New York: Harper Collins.

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York: W. W. Norton & Co.

Schore, A. (2003). *Affect regulation and the repair of the self*. New York: W. W. Norton & Co.

Siegel, D. J. (2009). *Mindsight: Change your brain and your life*. Brunswick, Victoria: Scribe.

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York: Guildford Press.

Tyler, T. A. (2012). The limbic model of systemic trauma. *Journal of Social Work Practice, 26*(1), 125–138.

Wall, L., Higgins, D., & Hunter, C. (2016). *Trauma-informed care in child/family welfare services* (CFCA Paper No. 37). Melbourne: Child Family Community Australia information exchange, Australian Institute of Family Studies. Retrieved from https://aifs.gov.au/cfca/publications/trauma-informed-care-child-family-welfare-services.

■