

Evidence-Based Guidelines for Conducting Trauma-Informed Talking Therapy Assessments

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With:

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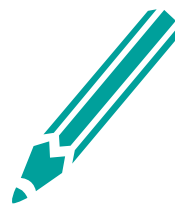
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Author and funder

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A note on language

We have used the term 'therapists' to refer to people who conduct assessments to encompass the broad range of people who conduct talking therapy assessments. We have used either 'clients', 'trauma survivors' or, where possible, 'people' to refer to people undergoing assessment. We recognise that no single term will feel appropriate to all readers/trauma survivors nor will any single term be able to represent all people who conduct or undergo talking therapy assessments.

Our qualitative research found that the term 'assessment' conveys something that is done to people, creating real fears in those undergoing assessment, for instance of being judged, considered unworthy or rejected from a service with a subsequent loss of hope. Consequently, some clients and therapists recommended a language shift to something more akin to 'initial meeting'. We have broadly retained the language of 'assessment' in these guidelines because this is the term most used in practice. However, we recommend that services shift towards replacing the term 'assessments' with that of 'initial meetings' wherever possible.

We have included several quotes from people who participated in our qualitative study, indicated by italics and/or quotation marks.

Background

About the guidelines

These guidelines are for people who conduct assessments or initial meetings in community-based talking therapy services in the NHS and third sector. The guidelines are intended to support the safe, trauma-informed assessment of all clients, including trauma survivors. They are not intended for trauma specific services only, but for all therapy modalities and services where there is an initial assessment or meeting, including cognitive behavioural therapy, psychotherapy, counselling, IAPT (Increasing Access to Psychological Therapies) and so on, as well as therapies that have arisen from grassroots communities.

The guidelines are based on robust, survivor-led research that builds on existing good practice in the sector. Rather than focusing on the technical aspects of how to conduct assessments, the guidelines aim to integrate trauma-informed practice into assessment processes, grounded in a thorough understanding of trauma and how it impacts on people, in order to ensure individualised and appropriate support. This reflects broader attempts to move away from technical, bureaucratic practice and towards humanised, compassionate care (e.g. Crawford et al 2013; Todres et al 2009) which can be critical in enabling people to remain engaged with services.



Background

Who will find the guidelines useful

The primary purpose of the guidelines is to support therapists conducting assessments or initial meetings in talking therapy services. It is important to acknowledge that NHS and third sector services are under immense financial pressures, impacting on the systems that practitioners are operating within. Given that, we hope that service providers and managers will find the guidelines useful to support and develop good practice, and also to defend existing good practice.

The guidelines may also be used by commissioners to inform evidence-based decision-making around the resourcing (time, supervision, environment and so on) needed to achieve good practice in this area. Finally, people who are seeking a talking therapy may find the guidelines helpful to prepare for their assessment and to understand good practice.



Background

How the guidelines were developed

The guidelines have emerged from a robust research programme called APTT: understanding and improving Assessment Processes for Talking Therapies. The research was conducted between 2014 and 2019, funded by the National Institute for Health Research (NIHR). The research was led by a survivor researcher with extensive experience of undergoing talking therapy assessments and guided by two Advisory Groups of people who design, oversee, deliver and/or have undergone assessments for talking therapy services. The research involved three main phases:

- 1) Extensive literature work including systematic reviews.
- 2) Qualitative research with clients and assessors (therapists).
- 3) An external review and modified Delphi study to finalise the guidelines.

Clients and therapists were involved at every stage of the research programme, meaning that the guidelines are based on robust evidence from different standpoints. For further information please see *Key publications arising from this research programme* (end of document).





Implementing trauma-informed approaches can enable trauma survivors to engage safely with the right services at the right time, promoting healing through positive relationships. Critical to this is creating the systems that enable people to come together in compassionate and empathic encounters.

Assessments & trauma-informed approaches

Trauma and adversity are common experiences (e.g. Ashton et al 2016; Felitti et al 1998). Note that we are adopting a broad definition of trauma to include interpersonal violence (such as rape), developmental trauma (such as childhood abuse), historic trauma (such as slavery or forced migration) and social trauma (such as poverty or racism) (see Sweeney et al 2018a for further discussion). Unsurprisingly, research has found that people who use mental health services have experienced higher rates of trauma than the general population (e.g. Mauritz et al 2013; Khalifeh et al 2015).

A person's experiences of trauma can shape every aspect of a talking therapy assessment encounter, irrespective of whether trauma is disclosed. Box 1 (further down) presents our key findings on people's experiences of undergoing talking therapy assessments, heavily informed by the experiences of trauma survivors. While assessments are typically a time of crisis and emotional turbulence for people seeking therapy, assessment encounters can be experienced as tick-box, administrative exercises that leave people feeling like a number to be processed through a system, or as though there is an exam to be passed to access therapy. As one client in the qualitative study commented, the assessment "*felt like it was a secretary taking the...you know like filling in the forms*". This misses opportunities to create relational, healing encounters that support ongoing service engagement: there is some evidence that difficult experiences at the assessment stage can cause people to disengage from a service either immediately or in the future (e.g. Morris 2005; Marshall 2016).

In trauma-informed approaches, there is an understanding of the complex and pervasive impact of trauma on a person's worldview, relationships and ways of engaging with services and staff (Sweeney et al 2016; 2018a). Consequently, services are organised and delivered in ways that prevent retraumatisation and ensure "choice, trustworthiness, collaboration, and empowerment" (Blanch and colleagues 2012). Implementing trauma-informed approaches can enable trauma survivors to engage safely with the right services at the right time, promoting healing through positive relationships. Critical to this is creating the systems that enable people to come together in compassionate and empathic encounters. To find out more about trauma-informed approaches see, for instance, Blanch et al (2012), Harris and Fallot (2001), SAMHSA (2014) and Sweeney et al (2016, 2018a).

We have not included information on how to ask about trauma experiences in these guidelines as detailed guidance already exists:

Ferentz L (2018) *Trauma Informed Assessments. A clinician's guide to safely identifying and exploring connections between clients' current struggles and prior histories of trauma, abuse, and neglect*. Maryland, US: The Ferentz Institute: Advanced Psychotherapy Training and Education.

Read J, Hammersley P, Rudegeair T (2007) *Why, when and how to ask about childhood abuse*. *Advances in Psychiatric Treatment*, 13: 101-10.

A note on the economic context

It is important to stress that NHS and third sector services are operating in a context of long-term underfunding, currently amidst a global pandemic. In the NHS, services are typically short-staffed with long waiting lists, with some services rationed to those who are most in need and/or most likely to benefit as a way of managing demand. In third sector services (e.g. rape crisis counselling), funding is often short-term and insecure creating a constant crisis state. Some of the services included in our research were operating from substandard buildings, with one therapist commenting:

“

the message that it gives staff and the message that it gives patients about how valued they are, that they are expected to be seen in buildings that probably would be considered by the Council unfit for people to be living in...And I know perfectly well that...parts of the health service have small budgets and pressures...[but] I have never seen a physical health hospital as bad as the mental health sites...And I feel both distressed and very angry that we're expected to operate in these kinds of [conditions]

”

It is in this context that we have produced these guidelines. We understand that therapists may not have the systems or morale needed to achieve all aspects of the good practice we outline here. However, we took the decision not to downgrade what constitutes good practice to fit current funding models. We found many examples of excellent practice through our research, and in capturing and describing good practice, we hope that services will:

1. have access to an evidence-based resource on ways of creating trauma-informed assessments, enabling a shift towards safer more healing encounters and;
2. be better positioned to argue for, or defend, well-resourced assessments.

Additionally, we believe that many of the principles are achievable in current contexts, particularly as relationship-based practice is at the core of trauma-informed assessments. At the same time, we do not underestimate the impact that these enormously difficult and unprecedented conditions are having on staff's ability to feel that they have the resources to go much beyond fire-fighting.

Using the guidelines

Our research indicates that implementing these guidelines into service organisation and delivery can create healing encounters between therapists and clients.

This can be vital for trauma survivors who may have waited years to seek help and are struggling to stay safe within the assessment process.

see Box 1 below – What is it like to undergo assessment for a talking therapy?

Therapists will have existing strengths in relation to the guidelines, as well as areas they wish to develop further. Some areas – such as power and institutionalised discrimination – will require substantial further exploration in the context of individual practice and wider services. The guidelines may also serve as a means of individual reflective practice and service development, alongside client feedback and input.



*"this assessment...feels like it's either
hope or it's the end...It's gonna make
or break you".*

Box 01.

What is it like to undergo assessment for a talking therapy?

Our research programme included a qualitative study of people's experiences of being assessed for talking therapies. Key findings included:

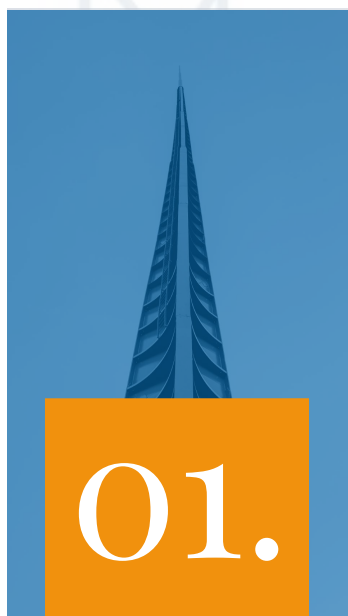
- Trauma frequently diminishes people's sense of self-worth and self-belief, and breaks their faith in others and in authority.
- Assessments are the present-day focal point for the desperation and accumulated trauma of a lifetime. Yet assessments can compound trauma where people feel that another person has the power to decide whether or not help is received: *"this assessment...feels like it's either hope or it's the end...It's gonna make or break you"*.
- Common feelings associated with undergoing assessment include worry, desperation, shame and fear of judgment alongside a fragile sense of hope.
- Trauma survivors may question their right to support, feeling that others have greater needs. Many feel that they need to prove they are worthy of support yet feel profoundly unworthy.
- There is potential for significant harm where a trauma survivor reaches out for help but is turned away, reinforcing shame, worthlessness and hopelessness. Survivors are aware of the potential for rejection which causes fear and anxiety, particularly where they have no alternatives.
- Because of the nature of interpersonal trauma, survivors can find it hard to trust people, particularly those in authority, with implications for relationship building and disclosures: *"it's a trust issue isn't it; you have to build up the trust that they're not gonna judge you"*.
- There is a dilemma at the heart of assessments between revealing experiences that are deeply personal and may feel shameful, and that carry the risk of judgement and retraumatisation, or maintaining safety by not disclosing experiences and risking not being seen as needing help: *"I think if you just completely give everything, for me if I make myself too vulnerable then I can put myself in quite a bad place"*.
- Authentic, human connection is vital in creating safe, healing assessments: *"it wasn't so much what she did...it's who she was"*.
- Validation coupled with compassion can help people to understand themselves in the contexts of their past trauma, and feel believed and worthy of help: *"She would say to me 'no you are not crazy it is part of the impact of what you are going through'. And that started making me a feel a little bit more normal"*.
- Collaborative assessment processes, where there are attempts to reduce power imbalances between assessor and service user, can support safety and healing. *"It was just like you were sat there and someone is in tune with you in your journey and feeling that pain"*. In reality, assessors always hold power where they decide whether or not a person goes on to receive therapy.
- Whilst some people feel *'wretched'* and *'deconstructed'* after the assessment, there are often also fragile feelings of hope.

"it's a trust issue isn't it; you have to build up the trust that they're not gonna judge you".

"She would say to me 'no you are not crazy it is part of the impact of what you are going through'. And that started making me a feel a little bit more normal"

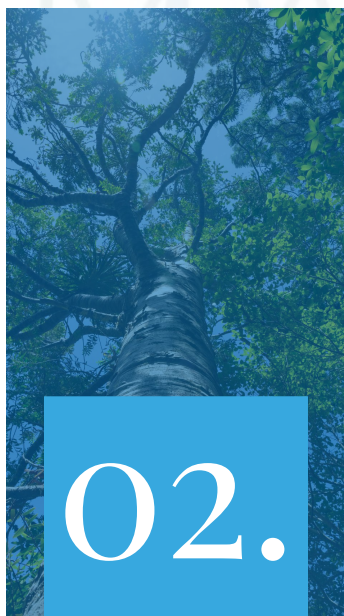


PRINCIPLES FOR TRAUMA-INFORMED TALKING THERAPY ASSESSMENTS



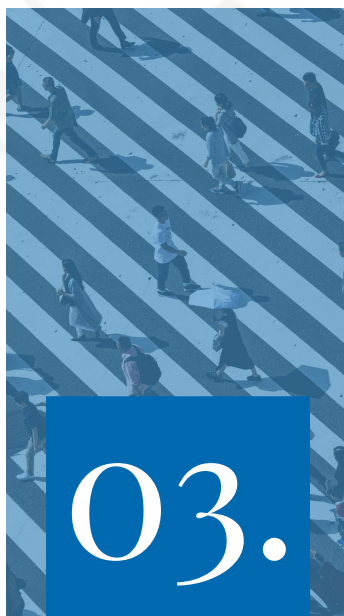
01.

Reflections
on power



02.

Focus on
relationships



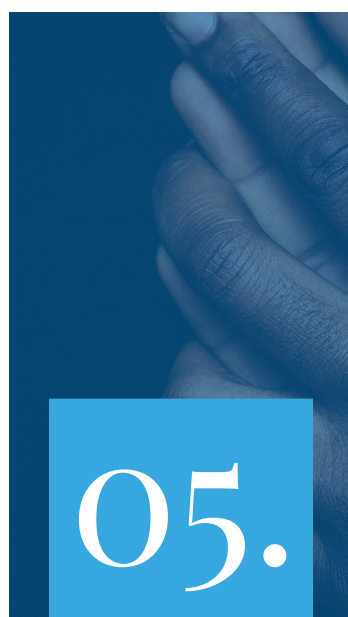
03.

From systems
to people



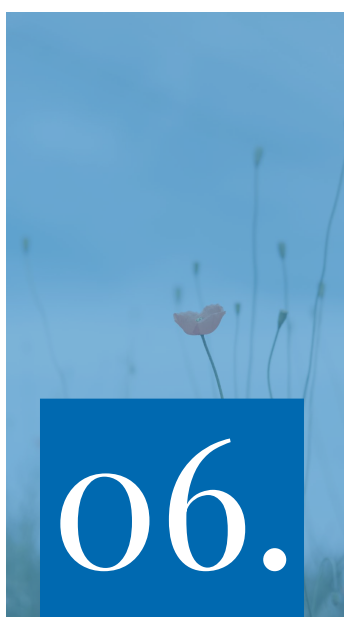
04.

Supported
trauma-
competent
therapists



05.

Understanding
trauma,
intersectionalities,
& anti-oppression



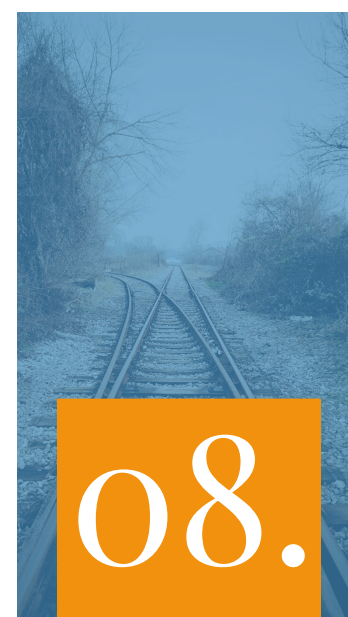
06.

Healing
environments



07.

Post-assessment
support



08.

Clarity & options
when therapy
is not offered

01.

Reflections on power

Why?

The foundational pillars of trauma-informed approaches include that people seeking support are heard, have choices, and are not labelled, judged, diagnosed or assessed. Undergoing a compulsory assessment in order to access support is the antithesis of this. There are multiple reasons for conducting assessments including screening for eligibility and suitability, understanding and mitigating against iatrogenic harm and deciding which therapy to deliver and by whom. In these approaches, therapists typically hold decision-making power in a top-down process.

Whilst collaborative approaches to assessments – in which inherent power imbalances are understood and there are efforts to create mutual, trusting relationships – are possible, and the foundation of these guidelines, our systematic review found that collaborative approaches are not the norm (Sweeney et al 2019a). We also found that even in services where (almost) all are accepted and only one therapy approach is available, assessments are still conducted, sometimes many months before therapy begins.

In a trauma-informed approach to talking therapy provision, there is no assessment in which a therapist controls the encounter, asks questions and decides on the outcome. Instead, time is taken to begin the process of establishing a relationship. Services and therapists reflect on the nature of power because: “however collaborative a therapist purports to be, if the therapist still determines the outcome in decision-making, the ‘collaborative process’ taken to arrive at that point is a nonsense” (Proctor 2017). More broadly, services work with people to co-produce the assessment process, considering its necessity and impact.

Whilst we urge services to consider replacing assessments with more informal initial meetings, we have continued to refer to assessments throughout the guidelines to reflect commonly used language and processes.

01.

Reflections on power

Key indicators

- **Assessment processes are developed by trauma survivors and the service through co-production.** Co-production is a key element of trauma-informed approaches, helping to ensure that people's needs and experiences are placed at the heart of service design and delivery.
- **There is an *initial meeting*, rather than an *assessment*** (where possible). Undergoing assessments can be difficult and frightening experiences for trauma survivors and for many services, replacing assessments with initial meetings is a real possibility.
- **A person's eligibility is established before they are offered an assessment** (or initial meeting). For instance, through brief referral screening. This means that people do not undergo an assessment for something they are not eligible for.
- **Service inclusion criteria are flexible** with criteria acting as principles, rather than rules to manage demand.
- **The main purpose of the assessment is to begin building relationships.** Top-down processes that are led by therapists and 'done to' people are avoided.
- **Therapists ensure that they need the information they are asking of people** in order to minimise burden and intrusiveness.
- **Therapists reflect on the implications of the forms of power that they hold.** Including the power derived from being a therapist (e.g. being able to define people's problems and decide whether someone receives therapy) and from belonging to dominant groups (e.g. identifying as male, White British, straight, cisgender, able-bodied and so on) (Proctor 2017).
- **Therapists use their power positively** to enable others. In systems where some people are helpers and others are helped, power differences cannot be erased and trauma survivors will be aware that therapists can exercise their power at any point (e.g. Proctor 2017).
- **Therapists understand that therapists and clients (may) have different historical experiences of powerlessness** and that this will impact on people's experiences of power within the assessment encounter (Proctor 2017).
- **People take decisions about the support that is meaningful for them.** This means therapists provide people with the information they need to decide whether or not to engage in therapy.

02.

Focus on relationships

Why?

Our research found that the most successful assessments were those where the therapist communicated their humanity to the client and this was experienced as authentic. This included through: prioritising building trust; avoiding pathologising language; demonstrating empathy, a lack of judgement, honesty and transparency; collaborating and negotiating; and clearly and actively listening. In the least successful encounters, therapists were experienced as cold, or as administrative gatekeepers who didn't care about the person before them, leaving people feeling like "a case". This can cause particular difficulties for trauma survivors who may have experienced being objectified and treated inhumanly as a core feature of abuse.

As trauma is often experienced relationally, so too is healing (Perry and Szalavitz 2017). As trauma typically involves a profound lack of control, anything that recreates powerlessness can cause harm. Trauma-informed assessments ensure that relationship-based practice is prioritised and that people feel a sense of control over what happens to them (acknowledging that the therapist holds "role power", Proctor 2017). Such collaborative, trauma-informed assessments can determine whether people have positive experiences that create safety, trust and connection, promoting agency and hope, or negative experiences that reinforce distress, distrust, powerlessness and hopelessness.

02.

Focus on relationships

Key indicators

- **Therapists understand and acknowledge the potential for people to have previous negative experiences of services** and for this to impact the current assessment (Patel and Cohen 2016). This includes experiences such as pathologisation, disbelief, misunderstanding of cultural contexts, or being repeatedly passed between services.
- **Therapists acknowledge how difficult assessments can be.** For instance, because the therapist and client are strangers who haven't yet built a trusting relationship.
- **Therapists explore people's understanding and expectations of the assessment.** Ensuring that people understand the process can help facilitate trust and build realistic expectations.
- **Therapists clearly convey that the purpose of assessments is not to judge people.** This is because many survivors can feel that they will be judged, reinforcing a sense of shame and worthlessness.
- **The range of possible outcomes is explained.** Knowing whether or not a therapy place has already been allocated can also help people judge how much to disclose.
- **Therapists are honest (with compassion),** including those things that are difficult to say and hear, such as the potential for therapy to cause harm. This supports the development of trust.
- **Therapists endeavour to be warm, compassionate, empathic and sincere,** including in telephone assessments: *"talk to me as a person, not a case"*. This helps to create a safe, healing encounter. Therapists will have support and supervision needs to enable them to fulfil this.
- **Therapists do what they say they will do** (and don't do what they say they won't). A failure to deliver on offers or agreements will affect trust, even where clients don't state this explicitly.
- **Therapists actively listen.** Trauma survivors may have experienced their words not counting and their stories being disbelieved. Active listening includes asking open questions, conveying interest and showing that the person has been heard and understood. See the storytelling [resource pack](#).
- **Therapists recognise the expertise that people bring.** Trauma survivors have qualities and coping strategies that have helped them to survive the near unsurvivable.

03.

From systems to people

Why?

Our research found that everyone, including therapists, can feel that the needs of service systems are prioritised over people's needs, with therapists sometimes feeling that incentives to meet people's needs come second to incentives to meet system needs. To people seeking support, this can feel like "*box-ticking*", "*red tape*", "*jumping through hoops*" and being "*paperwork obsessive*". The common experience of 'wait – assess – wait – therapy/rejection' is frequently experienced as difficult and distressing. There was a sense that people with complex trauma histories are excluded from services through narrow inclusion criteria because services are unable to manage demand with existing funding.

In trauma-informed assessments, processes are co-created with trauma survivors that foreground safety and flexibility and provide therapists with the skills and structures they need to engage compassionately with the person before them. Whilst therapists are trained in particular therapy modalities and approaches, they tailor these to individuals, supporting people's emotional, psychological and physical safety.

03.

From systems to people

Key indicators

- **Referral pathways are simple and well publicised.** For trauma survivors, *"jumping through hoops"* to access support can be so difficult it prevents help-seeking. Commissioning structures can be complex and people may need support to navigate referral pathways.
- **Therapists listen closely to what safety - physical, emotional, psychological, and relational - means for each person** meaning that people are supported to feel safe in ways that are meaningful to them.
- **Therapists and services respond flexibly to people's needs, circumstances and preferences.** Systems are reviewed for the extent to which flexibility is incorporated into service design and targets, ensuring that this is sustainable for therapists.
- **Therapists and services accommodate people who struggle with fixed appointment times.** These can be particularly difficult where people face multiple disadvantages (e.g. homelessness, drug use) or current abusive relationships (which can prevent people from attending appointments).
- **People are offered a phone call/email contact before the assessment by the therapist.** For some, this can help overcome the difficult experience of being assessed by a stranger.
- **Rapid assessment and support are available where people are in intense distress.** Waiting for an assessment, and then for therapy, is particularly difficult for people in crisis and can undermine trust in the system, leading to drop out.
- **Assessment takes as long as is needed,** meaning that additional meetings are possible. This can be important for trauma survivors who may have complex experiences and circumstances to communicate.
- **There is sufficient time to listen to the person.** Feeling rushed can make the experience of disclosure painful and unsafe and prevent trusting relationships from developing.
- **Assessment tools (e.g. questionnaires, outcome measures) are used flexibly, are optional wherever possible, and are secondary to the relationship.** Measurement tools can cause distress for instance, intrusive questioning can feel objectifying, or questions about suicide triggering.
- **Therapist workloads are manageable.** Supporting staff wellbeing is the first step in enabling trauma survivors to feel supported. Manageable workloads can also prevent trauma survivors from feeling processed through a system.

04.

Supported trauma-competent therapists

Why?

Our research found that assessments can represent a focal point for the emotional pain that people have been carrying, with some trauma survivors feeling unworthy, desperate, ashamed and afraid of judgment and rejection. As most assessments bring people into contact with their traumatic experiences, whether or not those experiences are verbalised, there is a risk of harm.

A key challenge is understanding trauma in all its forms, including trauma experienced as a consequence of belonging to a minority group or oppressed community including women, BME communities, LGBTQ+ communities and people with learning difficulties or sensory impairments. See, for instance, Bains (2010) who reflects on racism as trauma in therapy contexts.

In trauma-informed assessments, it is understood that trauma is self-defined. This means that trauma narratives are not imposed on people who do not understand their experiences as traumatic, for instance because they had the resources and relationships to minimise the impacts. Therapists receive the support, supervision and professional development that they need to understand the person before them and their context, minimise the risks of harm, engage in best practice and help prevent vicarious trauma and burnout. Trauma survivors are involved in training, with a strong focus on input from those facing more than one form of discrimination.

Staff may bring with them their own histories and have a challenging job to maintain solidarity and empathy for both the trauma narratives and the resulting impact on people's minds and lives. Services need to pay sufficient attention to the emotional health of their workforce.

04.

Supported trauma-competent therapists

Key indicators

- **Therapists receive ongoing training on trauma and trauma-informed practices.** This is essential in a rapidly changing field.
- **Therapists understand historical, structural and social traumas** (such as racism, homophobia, poverty, the legacy of slavery: see Blanch et al 2012). If these forms of trauma are not understood, their presentation and impact on people could be misunderstood and therapists might not reflect on their privilege and power in this context.
- **Therapists receive training in anti-oppressive practice.** This includes considering the ways in which discrimination and oppression impact on people from marginalised groups e.g. people who identify as LGBTQ+, BME, low-income, neurodiverse or as having physical or sensory impairments or intellectual difficulties.
- **Therapists receive training to respond to the needs of women with histories or current experiences of violence and abuse.** Violence against women and girls is endemic, and gender-based violence is likely to be experienced in unique and highly damaging ways.
- **Therapists can share trauma knowledge in ways that help people understand their feelings and behaviours.** There is potential for healing when therapists support people to understand what has happened to them and its impacts, without imposing an unwanted trauma narrative e.g. understanding people's difficulties as survival strategies that are no longer needed (such as dissociation as a way of escaping the intolerable).
- **Therapists are supported to manage the demands of frequently assessing trauma.** Conducting assessments can bring therapists into contact with their own trauma histories, and therapists are at risk of vicarious and secondary traumatisation and burnout. Support should include regular supervision that supports wellbeing (e.g. Nosowska and Ford 2019).
- **Therapists recognise the signs of burnout and/or vicarious trauma and take action.** This includes reflection and self-care, as well as services ensuring there is time and space for supportive supervision (qualitatively different from case management supervision).
- **Therapists with lived experiences of trauma are well supported.** These experiences are an asset to a service, yet may mean that additional support is sometimes required.

05.

Understanding trauma, intersectionalities, and anti-oppression

Why?

People can experience trauma on account of their social identity - for instance, women are more likely than men to experience serious and repeated violence in domestic settings, whilst people who identify as LGBTQ+ may be at risk of attacks from strangers. People who do not identify as white, straight and middle-class face stereotyping and discrimination creating or compounding trauma: "You are not one of us", "You deserve violence", "You are unworthy" (Sen 2017). We found that feeling able to share aspects of yourself sometimes requires a sense of shared identity with a therapist. Yet we all hold intersecting and sometimes competing identities (mother, churchgoer, male survivor, Deaf and so on) and it is important not to make assumptions about who a person might want to see and which aspects of identity are currently most important (King et al 2007).

Dominant models of therapy provision in the UK are typically rooted in white Western approaches that can fail to understand the oppression and discrimination that can cause and compound mental distress. Implementing anti-oppressive practice - which is consistent with trauma-informed approaches - can help to address this. Blanch and colleagues (2012) define trauma-informed cultural competence as "using information from and about individuals and groups to transform our skills and behaviours to match the health beliefs and practices of the people we support" (whilst remembering that the best person to learn from and explore with is the individual before you). It is vital, they continue, that nothing is assumed and space is created for people to explore and define their own cultural identity. See Blanch and colleagues (2012), Patel and Cohen (2016) and McKenzie-Mavinga (e.g. 2009, 2016) to further support good practice. The term "intersectionality", used below, describes the complex way in which different social categories (e.g. race, gender, class, sexual orientation, disability) combine or 'intersect' to create different experiences and systems of oppression and disadvantage.

05.

Understanding trauma, intersectionalities, and anti-oppression

Key indicators

- **Therapists and wider services actively work towards anti-oppressive practice.** This means that services have strong anti-oppressive policies, strategies, training and supervision in place.
- **Therapists understand and recognise institutional discrimination** and the ways in which this may prevent trauma-informed practice and/or prevent people from using the service.
- **Therapists are aware of any ways that their discipline and/or its theoretical frameworks have – historically and now - pathologised minority groups and trauma survivors.** This includes because of race, sexual orientation, physical or learning disability or abuse experiences. For instance, individualised models that assert that it is how people respond to bad experiences that counts, or the historic and continuing use of conversion therapy.
- **Therapists are aware of the potential for an individual's experiences of discrimination and oppression to be pathologised.** This includes through focussing on individual distress without understanding wider contexts (including abuse, racism, homophobia, transphobia, ableism and misogyny).
- **Therapists are aware of common assumptions and stereotypes about minority groups** as a failure to do so can result in collusion with potential self-blame and internalised racism, homophobia, transphobia and so on.
- **Therapists are aware of common assumptions and stereotypes about gender and sexual violence and abuse.** For instance, assumptions about the natures of men and women, damaging narratives around false allegations and false memories, victim-blaming and so on.
- **Therapists understand and reflect on their differing levels of knowledge, awareness and experiences in relation to diversity and oppression** ensuring that the person before them is seen and understood as an individual. Therapists use reflective supervision to consider and address personal and theoretical biases.
- **Therapists do not assume that minority identity (e.g. being black, gay, transgender and/or disabled) is causal in current distress.** Minority stress may or may not be part of the reason that a person is seeking talking therapy (e.g. APA 2015).

05.

Understanding trauma, intersectionalities, and anti-oppression

Key indicators

Continued

- **Therapists discuss with individuals what they need to participate in assessments** through sensitive and supportive discussion.
- **People are offered a therapist of their preferred age, gender, language and/or cultural heritage** without assumptions about what those preferences might be. It is acknowledged that where this is not possible, a person's ability to feel safe and to make disclosures may be impacted. Services attempt to recruit from diverse groups to enable this.
- **Therapists do not assume similarity with a client based on shared demographics** as this can prevent people from exploring their own understanding of themselves and their identity.
- **People have access to an independent trained interpreter, materials in their first language and/or easy read materials.** For further guidance on the use of interpreters see Patel and Cohen (2016 e.g. pp37-8).

06.

Healing environments

Why?

Our research found that the physical environment, including waiting areas and assessment rooms, can signal to therapists and clients their worth and create a sense of community or belonging which, at its most successful, counteracts the isolating impacts of trauma. We also found that some NHS therapy services are in very poorly maintained hospital settings that are often inappropriate for trauma survivors (particularly those with negative experiences of coercive psychiatry) and create difficult working conditions for staff, and that staff go to great lengths themselves to improve the environment.

Whilst it is primarily therapists who create feelings of safety and inclusion through relationship building, and there are limits on the extent to which service managers and providers can change the environment, nonetheless in a trauma-informed service steps are taken to improve the environment to increase emotional and physical safety, communicate value and worth, and support regulation and calm. For more information, [click here](#).

06.

Healing environments

Key indicators

- **Sterile and/or clinical environments are avoided or softened.** These environments, particularly in hospitals, can be difficult for trauma survivors, especially those with negative experiences of coercive psychiatry. Be mindful of the potential for people's threat responses to be heightened.
- **Physical layouts are reviewed to maximise accessibility and welcome.** Layouts can prevent trauma survivors from using a service e.g. unlit doorways, unwelcoming public areas, blind corners or excessive noise.
- **All staff understand the ways that trauma may be impacting on people.** Trauma-informed approaches extend to all the staff that people may come into contact with. For instance, reception staff can be critical in creating a safe and welcoming environment.
- **Waiting rooms are staffed (if possible).** Unstaffed waiting rooms can mean that trauma survivors feel vulnerable and unsafe.
- **Artwork and images are diverse.** This includes in terms of culture, gender, sexual orientation and disability. Ideally, artwork is created by service users/trauma survivors.
- **Assessment rooms create a sense of safety.** This is critical to support regulation and calm. Multiple aspects of the environment are considered e.g. windows, window coverings, daylight levels, lighting, room layout, visibility of exits, and use of posters, pictures and plants.
- **People have choices over their environment** such as door open or closed, blinds open or shut, lights lowered or not, sitting opposite or besides one another, distance from the therapist etc.
- **Assessment rooms are private and not overheard.** A private, quiet space can be essential for trauma survivors to feel safe (with choice over whether to open doors and windows).
- **People have access to sensory objects.** For trauma survivors, having access to smells (e.g. aromatherapy oils), images (e.g. displays or bundles of postcards), tastes (e.g. strong mints) and objects (e.g. pebbles) can help them to stay present.

07.

Post-assessment support

Why?

Our research found that in the aftermath of assessments, trauma survivors can feel “*deconstructed*”; as though a wound has been surgically opened and left unstitched. Whilst people can also feel hope that support is coming, there can be a fear of rejection, strong emotions (such as shame) at what has been disclosed, and a feeling of being unable to hold yourself together until therapy begins. Simultaneously, assessments can create opportunities to be heard, acknowledged and validated, potentially supporting people to arrive at new understandings of themselves and the adversities they face.

As discussed in principle one, through minimising the assessment process, the impact on people seeking support should be minimised. In traditional assessments, given that people have often arrived at a point of desperation before seeking services, post-assessment support may well be needed. This might include developing (optional) self-care plans with people, communicating outcomes as soon as possible, facilitating support whilst waiting for therapy and making appropriate onward referrals.

07.

Post-assessment support

Key indicators

- **The assessment period is transitioned sensitively towards what is agreed next.** Trauma survivors may feel opened up, distressed and vulnerable, making abrupt endings difficult.
- **Immediate emotional and physical safety is considered.** Ensuring that people are safe before they leave the assessment. *'We've talked about some really painful things, and that often brings up lots of feelings for people. How are you feeling now?' (Read et al 2007).*
- **Therapists offer to develop a plan with people for the hours and days after the assessment.** As people may feel opened up or retraumatised, a clear focus on self-care can be important in validating the need to be kind to oneself.
- **People can use quiet, private or communal spaces.** It is important that people have a safe space to use to gather and re-orientate themselves before leaving.
- **People are able to contact the service if they need support in the days/weeks following the assessment.** So that people who are in crisis or experiencing extreme distress are not left to cope alone.
- **People understand what will happen next and when** and this is adhered to as far as possible.
- **People can negotiate what is written about them in reports and letters and correct any misunderstandings.** As well as improving accuracy, this can facilitate trust through transparency.
- **People are involved in the outcome of the assessment process, and know the reasoning behind any potential therapy plan, as soon as possible.** Trauma survivors can feel that the assessment is "either hope or it's the end" and benefit from knowing the outcome at the earliest opportunity.
- **People decide whether or not to begin therapy, with support from the therapist.** This includes discussing the potential for negative outcomes, such as iatrogenic harm.
- **People are involved in deciding which therapist to see.** It can be difficult to disclose trauma to one therapist and then be allocated to someone different. Where continuity of therapist is not possible, people should be forewarned.
- **Consent is obtained before information is shared with any third party** including referring or onward agencies.

07.

Post-assessment support

Key indicators

Continued

- **The conventions (unwritten rules) of therapy are clearly explained.** This can help demystify therapy and create a sense of control and safety (Trivedi, 2020).
- **People waiting for therapy are supported and engaged,** though waiting lists are avoided by adequate capacity wherever possible. Trauma survivors can feel forgotten and concerned about their place. Regular brief contacts can reassure people that they are still on a waiting list. Support whilst waiting for therapy might include service facilitated peer-led support, such as art groups, or referrals to mental health cafés, user-led organisations, local projects and so on.
- **Referrals to specialist trauma services are facilitated, where people want this.** This requires good knowledge of local services e.g. women's organisations, LGBTQ+ organisations, survivor-led organisations. There is also support to access services for immediate difficulties (where wanted) e.g. housing, benefits, debt, domestic violence.
- **There are clear formal and informal complaints and feedback procedures.** By the time trauma survivors undergo assessment they may feel exhausted by everything they are managing. Formal and informal complaints and feedback procedures should be in place so that people can report problems in ways that feel manageable. Services reflect on and learn from feedback.
- **Independent complaints are possible.** People may not feel safe to report complaints to a service, or there may have been a serious abuse of position (e.g. unwanted physical contact).

08.

Clarity and options when therapy is not offered

Why?

Experiencing rejection from a service can be particularly painful for trauma survivors who may have waited years without support before reaching out for help. Compounding this is that people often feel unclear about the reasons why, potentially causing intense upset, anger, frustration and feelings of worthlessness. It is the responsibility of all members of the organisation to professionally bear the expression of these feelings and how they are communicated, up to a reasonable limit.

In a trauma-informed approach, people decide whether to undertake therapy, with therapist support. Where it is deemed not possible to offer people therapy, care is taken to communicate the reasons for this sensitively and compassionately, making clear that this is not because they or their trauma are unbearable or because their trauma doesn't count. Appropriate onward referrals are made, with the knowledge that the person may have multiple experiences of being passed on stretching back many years. There should be a clear path ahead, including whether, how and when people might return to that service. Any options should be clearly explained and communicated in a way that meets the person's communication needs.

Key indicators

- **Clear reasons for not being offered therapy are given**, although rejections are minimised through solid front-end processes. Where rejections do occur, people are given a clear rationale to help prevent feelings of self-blame and hopelessness.
- **Outcomes are given face-to-face/by telephone and in writing**. Whilst conversations are important to enable questions and to discuss onward referrals, trauma survivors may find it hard to recall details making a written account important.
- **Alternative options are discussed and appropriate referrals made**, where wanted. This means having good knowledge of, and relationships with, relevant local services.
- **Onward referral and assessment processes are explained**. Having just undergone a potentially retraumatising assessment, people may be concerned about onward referrals. Understanding what might happen and when can be helpful.



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