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"This is an Accepted Manuscript of an article published by Taylor & Francis in Journal of Family Trauma, Child Custody & Child Development on 24th October 2020, available online: https://doi.org/10.1080/26904586.2020.1826026"

Trauma Recovery Core Capabilities for the Children's Workforce in the United Kingdom: A Q-methodology study

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Conflict of Interest: The authors declare that they have no conflict of interest.

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Abstract

Purpose: There are competency frameworks and trainings relating to the development of a trauma informed workforce and organizations. However, these have generally been developed outside of the UK and often involve lists of 20 to 40 competencies which can become overwhelming and often impractical to implement.

Methods: The aim of this research was to develop UK expert consensus on the key elements of what would make a worker / practitioner who engages with traumatized or neglected children and young people trauma informed and recovery focused. The use of the Delphi and Q-methodology allowed consensus across experts and practitioners in the UK to be developed. The Q-sort offers a way of clustering responses across participants to narrow this to a small set of overarching themes.

Results: This process led to three key components being identified (1) Recovery through new ways of coping with stress; (2) The role of the family system in the recovery process and (3) Understanding the longer-term development impact of trauma on the young person and the potential impact on the practitioner. These three components were linked to the types of professions/roles the experts held within the trauma recovery field.

Conclusions: It is hoped that these overarching components will guide workforce development activities including training, curriculum development, and professional standards for the various sectors in the children's workforce who engage with traumatized young people.

Keywords: trauma recovery; trauma-informed, trauma core capabilities; trauma competencies; children's workforce; q-methodology

Over the last twenty years advances in science have helped us better understand the devastating impact of trauma on young children. The impact of severe abuse, neglect, witnessing violence, and chronic exposure to stress have on early childhood brain development has been demonstrated using new neuro-imaging technology (Perry 2002, 2005; Shonkoff and Phillips 2000; Tronick 2007). Coupled with this research is the landmark Adverse Childhood Experiences Study (ACE) which confirmed that early exposure to negative childhood experiences leads to lifelong, debilitating mental and physical health problems, and ultimately, early mortality (Anda et al. 2006; Felitti et al. 1998). Although progress has been made in what we know about the impact of trauma on early childhood development, there remains a significant gap between what we know and what we do. An important ingredient in closing this gap is having a workforce that is knowledgeable about trauma and its impact on development and that can employ skills and strategies to support recovery in these children.

Attachment Awareness, Trauma Informed and Recovery Focused Practice

The literature on working with young people who have been traumatized can be categorized into three components: (1) Attachment Aware Approaches; (2) Trauma Informed Approaches and (3) Recovery Focused Approaches.

Attachment Aware Approaches

These approaches have tended to focus on work within school settings. The Attachment Lead Network (https://www.attachmentleadnetwork.net/) defines an attachment aware school as one that has a good understanding of the impact of significant relational traumas and losses upon pupils; has attachment principles firmly embedded within all their policies and uses an attachment framework to understand behaviors. Furnivall et al. (2012) explain attachment aware practice and provide a list of principles that should inform these interventions. Those

factors are seen as supporting the development of attachment-informed practice included: enthusiasm and commitment; organisational support; and excellent training and consultancy to embed application of practice. Factors that inhibited were: performance management and targets rather than relational and professional culture; bombardment; risk-averse culture; a lack of shared understanding and priorities; conflicting policies and guidelines; and conflicting models and theories (emphasis on behavioural "evidence-based" models).

Bath Spa University has an attachment awareness in schools project (https://www.bathspa.ac.uk/schools/education/research/attachment-aware-schools/attachment-in-school/) and has incorporated attachment awareness across primary and secondary Initial Teacher Education.

Trauma Informed Approaches

Harris and Fallot (2001) describe a trauma-informed approach as how a practitioner, program, agency, organization, or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma. In this approach, all components of the organization incorporate a thorough understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths through which people recover from trauma. A trauma-informed approach is designed to avoid re-traumatizing those who seek assistance, to focus on "safety first" and a commitment to "do no harm," and to facilitate participation and meaningful involvement of trauma survivors and their families in the planning of services and programs. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems (Harris and Fallot, 2001).

A practitioner, program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices,

and settings. In a trauma-informed approach, all people at all levels of the organization or system have a basic awareness about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals (Substance Abuse and Mental Health Services Administration, 2014).

Harris and Fallot (2001) and Ko et al. (2008) describe how service providers need to incorporate trauma-informed perspectives into their practices to enhance the quality of care for the children and detail the key principles and elements an organization should have in order to be trauma informed. Conners-Burrow et al.'s (2013) research into the impact of trauma-informed training indicated that it is critically important for a practice to be trauma informed as to prevent system-induced trauma.

There are several examples of where trauma informed practice has been utilized with specific populations of young people e.g. youth justice and homeless young people. Diamond (2009), whose UK-based programs focus on children in residential care, emphasizes the importance of the 'planned environment'. This means using the totality of the environment including the diversity of relationships, and everyday activity in service of recovery of the child. Skuse and Matthew (2015) developed a trauma recovery model in the UK as an intervention for young people in the youth justice system with complex needs. Tomlinson and Klendo (2012) developed an integrated systems trauma-informed care for homeless young people in the UK. They describe a trauma informed approach as one where the whole of the organization is organized in such a way that takes full account of the young people's trauma, and how the whole environment the young person is in is considered relevant to the recovery process. NHS Education for Scotland (2017) has developed a framework Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce; however it is not child specific.

There has been a lot of work done in the area of trauma informed schools (Cole et al. 2013; Downey 2007; Queensland 2013;). An example of an attachment aware and trauma informed approach to training teachers is offered by DeThierry (2015). This training informed them of: the neurobiological effects of trauma and how this affects development, the importance of attachments, symptoms associated with traumatized children, and the ability to recognize projection, transference and vicarious trauma. Martin et al. (2019) have developed a set of best practice principles for trauma informed schools.

Recovery Focused Approaches

Within the psychotherapy literature there is a focus on recovery approaches e.g. Bicknell-Hentges, and Lynch (2009). Dorrer and Schinkel (2008) and Piat et al. (2010) discuss competency frameworks for implementing a recovery focused approach to treating mental health that are in use currently. However, these are adult and mental health focused. Leese (2014) identify service users' and nurses' perspectives on recovery focused practice. More recently, Treisman (2018) has extended this in her work on trauma arguing services need to become more culturally, adversity, and trauma-informed infused, and responsive in their approach. This approach is not only trauma informed and systemic in its approach, it also emphasizes a responsive relational approach to recovery.

What is being argued for is an expansion on the ideas of trauma informed approaches that encourages practitioners and those engaged with traumatized young people to also be focused on recovery. Recovery approaches are not only conceptualized in terms of interventions or therapy to address the trauma but also focuse on the important role that environments, and relationships in those environments play in supporting recovery. Several of the competency frameworks and training guides are not only trauma informed but also have a focus on recovery e.g. Child Welfare Collaborative Group, National Child Traumatic

Stress Network (NCTSN) (2013), who developed the Child Welfare Trauma Training Toolkit (CWTT)).

Research

The field of trauma informed care is still in its early stages of development and research on the use of the competencies or principles is sparse. Many lists of proposed competencies or principles have been developed but most of these have been at the theoretical level and only recently has there been a shift to more concrete practices that can be measured and evaluated. Rivard et al. (2004) offers insight into the need for trauma-informed care for young people in residential treatment and also offers an example of their psychoeducation sessions that are undertaken and their impact.

Walsh et al. (2019) document the development of the CWTT and its delivery across the USA. Their conclusion is that "while the concept of trauma informed systems has received great attention in the recent years, it has become clear that general training on the essential elements of a trauma-informed child welfare system is not sufficient" (p. 422). Maynard et al. (2019) undertook a systematic review of the impact of trauma informed approaches in schools. They conclude that "(d)espite widespread support and growing adoption of trauma-informed approaches in schools across the globe, we found no studies to provide good evidence to suggest that this approach is effective in achieving the stated goals" (p. 2)

Rationale

In order to develop the knowledge and skills of the workforce supporting children to recover from the trauma and neglect they have experienced it was felt that the development of a higher-level set of core capabilities for the workforce that are attachment aware, trauma informed and recovery focused was needed. Currently, although there are trauma informed competencies and principles developed in the USA (Child Welfare Committee, National

Child Traumatic Stress Network 2008; The Multiplying Connections Initiative 2008) and Australia (Queensland Government 2013; Martin et al. 2019) there are none specifically developed for the workforce in the United Kingdom. These frameworks also offer an extensive range of competencies related to knowledge, skills, and values and it appears from the limited research that they are not easily translated into practice.

The aim of this paper was to define a set of higher-order core capabilities that children's services professionals need in order to provide attachment aware, trauma informed and recovery focused care for traumatized children. It is not the intention of the paper to provide a revised list of capacities but rather define a small set of higher-order components that can provide a focus for trauma informed and recovery focused work with children and young people. The intention is that once developed, this set of core capabilities could guide workforce development activities including training, curriculum development, and professional standards. The intention of these core capabilities is that the children's workforce shares a common base of knowledge, attitudes and values that are attachment aware, trauma informed, and focused on recovery for the child.

Method

To address the aims of the study most effectively (to develop an agreed upon set of overarching core capabilities) the research methodology needed to be able to do the following:

- To include an adequate number and diversity of people who work in the field of childhood trauma;
- to explore the opinions, experience and therapeutic practice of childhood trauma experts;
- to establish patterns of commonality and difference among the participants;

- to reduce the subjective influence of the researcher as far as possible;
- to include a range of sources in the study; to have a proven record of methodological 'robustness'.

Development of the Q-Sample

To accomplish the above, the research design had two parts, a Delphi poll and Q-methodology, with the study being framed primarily around Q-methodology. Using a Delphi poll and Q-methodology combined qualitative and quantitative methods to explore UK Trauma Experts' views on the core capabilities needed to support traumatized children to recovery. This methodological approach is based on the work of Wallis et al. (2009). See Figure 1 for a flowchart of the research methodology employed.

--Figure 1 about here--

To begin the process, a literature review was undertaken and experts in the field of trauma recovery were interviewed. Based on this data a list of possible competencies was generated. To further refine this rather long list of skills, knowledge, values and attitudes a Delphi Poll and a Q-sort were undertaken.

Literature Review

A literature review was undertaken to explore what had been written about attachment aware, trauma informed and recovery focused approaches to working with children and young people who had experienced trauma. Initially, only peer-reviewed articles were sought; however this only led to one article being found. The search also excluded articles that focused specifically on therapeutic interventions for working with children who had experienced trauma e.g. Golding (2007), Bentovim and Elliott (2014) and Chorpita and Weisz (2009). The search was extended beyond journal databases to include a Google search. This search indicated that there was much more grey literature available than published literature and that most of this was USA or Australia-based. The focus also tended to be on

attachment awareness and trauma informed approaches to working with young people. The focus was also on principles of being attachment aware or trauma focused or related to training outcomes in enabling practitioners to be more trauma informed. The program objectives for a UK-based trauma recovery training program were included (Walsh 2006). An expert in the next phase offered this program as it was unpublished but used in a foundation training program for residential care workers. Eight documents relating to competencies, or guidance on skills needed for working with traumatized young people were included in the study (see Table 1).

---Table 1 about here--

Interviews

Next, ten interviews were undertaken with experts in the field of trauma recovery and attachment awareness. These experts included two directors of residential care services for traumatized children, two trauma training experts, three trauma focused child psychotherapists, a trauma focused education expert, an attachment-aware schools' expert, and a foster care agency training manager. The experts were asked the three following questions related to recovery focused work with traumatized children:

1. How would you define a recovery approach to working with children and young people who have been traumatized?
2. What would you say are the key competencies that a practitioner needs when working with children and young people who have been traumatized that would indicate the worker was recovery focused?
3. What would you see as the essential elements of training to develop that set of competencies?

These interviews were transcribed and analyzed using thematic analysis (Braun and Clarke 2006). This was done inductively as we were looking for themes that emerged from the data. Braun and Clarke (2006) describe the phases of thematic analysis as:
Phase 1: Becoming Familiar with the Data; Phase 2: Starting to Generate Codes; Phase 3: Identifying Themes; Phase 4: Review of Themes; Phase 5: Final Naming of/ Defining Themes.

This, integrated with the outcomes from the literature review, resulted in a list of 153 possible competencies. These were then scrutinized by two researchers looking for overlaps and repetitions resulting in a final list of 95 competencies being identified.

Delphi Poll

The competency statements derived from the literature and interviews were piloted with a Delphi panel of experts to identify a series of statements they felt related to trauma informed recovery practice with traumatized children. The Delphi poll was adapted for this process following the lead of Wallis et al. (2009). Usually there are three components (Prochaska and Norcross 1982) but this was adapted to two, in order to better fit with a mixed methodology. Delphi panel members were asked to rate each statement according to whether they agreed, disagreed, were uncertain about the statement or found the statement unclear or inappropriate. As this process was being used to develop an agreed upon set of competencies, consensus statements (to indicate agreement) were kept and statements that provoked disagreement or inappropriateness were excluded while information about statements that lacked clarity was sought from the panel. More details on the Delphi poll developed from the literature are available on request from the corresponding author.

Q-Methodology

Finally, a wider group of trauma recovery experts ranked the statements using a Q-sort and made qualitative comments on their sorting. Q-methodology (van Exel and de Graaf 2005) is suited to the aims of this study as it intends to identify and describe a range of shared stories or discourses among participants (Curt 1994). In the Q-sort, participants arrange cards of statements about a topic into a predetermined grid, ranking them according to a scale following a specific instruction. In this study, participants sorted statements about narrative therapy according to those that were "most important to their perspective" and "least important to their perspective". Q-methodology focuses on the meanings people make or 'constructions' of a topic rather than the 'constructors' (participants). This focus means that Q-methodology is suited to topics that are socially contested or debated (Stainton Rogers 1995). Q-methodology offers a "unique form of qualitative analysis" (Watts and Stenner 2005 p.71). It does not reduce data into themes; rather it shows the "primary ways in which these themes are being interconnected or otherwise related by a group of participants" (Watts and Stenner 2005 p.70). Moreover, Q-methodology identifies "the range of viewpoints that are favored (or which are otherwise 'shared') by specific groups of participants" (Watts and Stenner 2005 p.71). The Q-sort was administered both face-to-face and online so as to increase the possible sample size. Snowball and opportunity sampling was utilized to further increase the sample size (Brace-Govan 2004).

As is the Q-methodological approach, participants were asked to rank order the 42 statements ranging from least important to most important. Prior to the detailed Q-sorting of items, participants were first asked to complete a rough pre-sort where participants sorted items into piles of most important, least important and neutral with no limitations on how many statements should be in each.

Secondly, from the pre-sort, participants were asked to sort the statements on a Q-sorting sheet in order of importance on a nine-point Likert scale from 0 (least important) to 9

(most important). The Q-sorting sheet followed a fixed, quasi-normal distribution (see Figure 2).

--Figure 2 about here--

The above Q-sort was created and administered using the online Q-sorting software Qsortware (www.qsortware.net; Pruneddu and Zetner 2011). The majority of participants (N=31) completed the Q-sort online. A number of participants (N=6) preferred to complete the Q-sort in person since they were not comfortable with the online Q-sort.

Ethical approval for all stages of this research was granted by a university Ethics panel. All participants gave informed consent.

Results

Demographics

The average age of the N=37 participants was M=49.08 (SD=11.63) with participants aged between 23 and 68. The majority of participants were female (N=31; 83.78%) and White British (N=30; 81.08%) with the remaining participants being White Irish (N=5, 13.51%) and White Scottish (N=1, 2.7%). One participant did not wish to provide information on their ethnicity. Most participants held a Doctorate or PhD (N=14; 37.84%), with 12 participants having a Master's (32.43%), seven participants a Bachelor's degree (18.92%), three participants a post-graduate certificate (8.11%) and one participant disclosing A-levels as their highest level of education. Participants worked in different professions relating to trauma including as a commissioner or consultant (N=3, 8.1%), Academic (N=4; 10.8%), mixed academic and practitioner (psychologist) (N=4, 10.8%), psychologist (N=7, 18.9%), psychotherapist (N=7, 18.9%), mixed manager/director/lead and practitioner (N=4, 10.8%), social worker (N=2, 5.4%), education staff (N=3, 8.1%), nurse (N=1, 2.7%) and carer or carer leaver (N=2, 5.4%).

Quantitative Results - Inverted Factor Analysis

Data was analyzed using an inverted factor analysis, which was completed using the R statistical software for computing version 3.4.2 "Short Summer". In R, the packages 'qmethod' and 'psych' were used (Zabala 2014). A three-factor solution was chosen using varimax rotation as has been recommended for Q-methodology (Watts and Stenner 2005). As a check, the analyses were repeated with a two-factor, a four-factor and a five-factor solution. However, it was decided that the three-factor solution best fitted the data since only very few to no items loaded on additional factors. Table 2 shows the factor loadings for each participant. A total of 14 participants significantly loaded on factor 1, and 9 participants each loaded significantly on factors 2 and 3, respectively. Five participants did not significantly load on a factor. Please refer to Table 3 in Appendix 1 for factor arrays for each of the 42 items. Please note, factors are referred to as components in the presentation of results.

---Table 2 about here--

Qualitative results

Component 1: Recovery through new ways of coping with stress

The recovery through new ways of coping with stress component had 14 significantly loading participants and explains 18.9% of the study variance with an Eigenvalue of 7.0. Twelve of the loading participants were female, two participants were male. The average age of participants was 54 (SD=11.14), 12 participants were White British, one participant was White Irish and one participant did not wish to provide their ethnicity; the highest education levels were Bachelor's degree (N=3), post-graduate diploma (N=1), Master's degree (N=5) and Doctorate/PhD (N=5). Twelve of these participants were practitioners with eight of them being psychologists or psychotherapists. Four participants were in a mixed academic or manager role. Several of these participants discussed that their responses were based on their roles as therapists working with traumatized young people.

This component seems to be more individually focused on a traumatized individual's capacity to manage and regulate stress. It emphasizes the importance of understanding that the individual will have both internal and external stressors (item 4) and individual coping skills that are adaptive in terms of protecting themselves (item 24). Through this understanding relationship with practitioner or carer, the traumatized individual is able to perceive, assess and express emotions and model non-violent ways of communicating these emotions to maintain a safe environment for self and others (item 32). Given that the majority of participants loading on this component were therapists who worked with people who had experienced trauma, it makes sense that their focus is on the individual and their internal capacity to manage stress.

Through the qualitative thematic analysis, these participants were making the case that those working with traumatized young people need to understand attachment and trauma in order to know their ways of coping are adaptive and therefore do not result in blame. They see the relationship as key in bringing about this change. They emphasized that although an ability to identify and describe the key signs of the impact of trauma on the child was important, they felt it was subsumed into the other items. Item 42 (Able to identify and describe the key signs of the impact of trauma in children) was therefore included in this component. This component focused very much on the internal processes associated with recovery.

Component 2: The role of the family system in the recovery process

This component had nine significantly loading participants and explained 10.3% of the study variance with an Eigenvalue of 3.8. Seven of loading participants were female, two participants were male. The average age of participants was 48.78 (SD=11.33), six participants were White British, two participants were White Irish and one participant was White Scottish; the highest educational qualifications were Bachelor's degree (N=2),

Master's degree (N=4) and Doctorate/PhD (N=3). This component had the widest mix of participants with commissioners, consultants and academics making up over 50% of the group. It also included a person who was care-experienced.

This component focused on the family system around the young person and their role in supporting recovery. This component emphasizes the importance of involving the caregivers alongside the child as partners in the recovery process (item 23). It also emphasizes the impact that trauma can have on the family system and the way in which the services and system designed to support can re-traumatize the child and family (item 12). They also emphasized the role of addressing grief and loss in this work (item 39). Although this was quite a diverse group, the majority have a more family focused role, e.g. the clinical psychologist focused on systems and trauma, the commissioners were engaged in commissioning services around the child, the teacher held a focus on the role of parents and the care leaver focused on the role of carers.

Through the qualitative thematic analysis these participants emphasized how the important it is to understand how family system is impacted by trauma and the role the family plays in supporting the young person through the way they respond to the young person. The role of the relationship in the family was emphasized. In particular, they emphasized that this role is about the family supporting the young person to control and regulate. Item 3 (Understand that supporting and promoting positive and stable relationships in the life of the child is central to recovery from trauma) was therefore included in this component. This component focused on the family system both in terms of the impact trauma has on the system and also on the role of family relationships in the recovery process.

Component 3: Understanding the longer-term development impact of trauma on the young person and the potential impact on the practitioner

This component had nine participants significantly loading and explained 9.7% of the study variance with an Eigenvalue of 3.6. Seven of loading participants were female, two participants were male. The average age of participants was 49.44 (SD=12.83), eight participants were White British, one participant was White Irish; the highest educational qualification were A-levels (N=1), Bachelor's degree (N=1), post-graduate diploma (N=1), Master's degree (N=1) and Doctorate/PhD (N=5). Of the nine participants, eight were practitioners, of which five were clinical psychologists.

This component focused on the impact of trauma in two ways. The first was with a focus on the longer-term impact trauma could have on the young person. This related to understanding the role of secure attachment in the development of a child and the implications of this for future development (item 1) and understanding the impact of adverse childhood experiences on later-life health and well-being (item 37). The second strand related to the impact of the trauma on the practitioner in terms of understanding the signs and being able to address the risk of secondary trauma and the impact exposure to detailed histories of trauma and adversity can have on them (item 20) and linked to them being able to perceive and understand their own personal and professional stress. A third element to this component related to the role of safety and containment in the recovery process (item 26). This participant group included a large proportion of clinical psychologists and of people who ran services for looked after children or who were team leaders. This may indicate why they focused on the impact of the trauma on the practitioner.

Through the qualitative thematic analysis these participants emphasized the importance of being able to identify and describe the key signs of the impact of trauma on the young person, that the practitioner was able to create environments that are safe, comfortable and welcoming for all children, families and staff through respectful, consistent and predictable responses. Participants also emphasized that an understanding that supporting and

promoting positive and stable relationships in the life of the child is central to recovery from trauma. They felt that item 2 (Explain the relationship between trauma, adversity and disrupted attachment in the child/caregiver relationship) was subsumed into the other items included. It was decided that this item would be included since this component focused beyond the individual and family system to the long-term impact of trauma and also the impact on the practitioner.

Consensus Statements

An examination of the three consensus statements indicated that two items (items 15 and 34) were not trauma-related but were seen as being applicable across all children's workforces. Item 29, although more trauma-related, was a more general item relating to the impact of trauma on a sense of powerlessness. All three items did not load very strongly for any of the groups. For these reasons these were excluded.

Distinguisher Statements

There were 15 items where there was no consensus and participants rated these items significantly differently. Items 6 (Understand and teach skills required for effective emotional regulation, affect regulation); item 7 (Understand attunement and its role in developing self-regulation); item 13 (Understand the three branches of developmental trauma: 1. Executive functioning, 2. Affect regulation, 3. Psychological development); item 16 (Understand how people respond to stressful life experiences in various ways e.g. flight/fight/freeze/fade response/attack others) and item 21 (Able to teach children and caregivers calming and soothing techniques that help children who have experienced trauma) distinguished those practitioners with a focus on the longer-term impact of trauma and its impact on the practitioner from the other two groups. Given their focus on the longer-term impact and on the impact on practitioners, it would make sense that these more individually and therapeutically focused items would not have been of such importance. For this group

however, item 35 relating to understanding and respecting cultural diversity and how it influences perceptions and response to traumatic events and the recovery process and item 11 relating to providing opportunities for involvement at all levels of the system, facilitating support from a broad social network were rated more highly than for the other two groups. This may link to their focus on the longer-term impact of trauma and its impact on the practitioner.

Those loading on Component 1, which had a more individual therapeutic focus, distinguished item 8 (Understand the link between emotions, behaviors and decision-making) and item 9 (Able to support children and adults to regain a sense of control, choice and autonomy in their daily lives) most from the other two groups. Given their individual therapeutic focus, this makes sense.

The group that loaded on Component 2 that focused on the role of the family in recovery were distinguished by two items: Able to facilitate referrals and access to trauma informed and trauma specific interventions services for children and their families as needed (item 18) and item 38 which focused on assisting caregivers of children who have been exposed to trauma and childhood adversity to recognize and address their own risk for secondary/vicarious trauma and possible unresolved trauma in their own lives. Given the focus on the family and the system around the family this makes sense.

Participants that did not load on a factor

There were five practitioners who did not significantly load onto any of the factors. All of these participants were female with an average age of 54 (SD=11.14). Four of the individuals not loading on any of the factors were White British, one was White Irish; one participant had a Bachelor's degree as their highest qualification, one had a post-graduate diploma, two participants had a Master's degree and one participant held a doctorate. Four of these individuals were psychotherapists.

All of these participants describe finding the process very difficult as they felt that all the competencies were important. The thematic analysis distinguished them from the other groups in that they did not talk about feeling certain competencies were subsumed into others which was how the other groups managed the difficulty of ranking items.

Discussion

The aim of this research was to develop consensus from experts in the field of childhood trauma about what were the key competencies needed to develop a trauma informed and recovery focused children's workforce. What this research offers are three key areas of focus: (1) Recovery through new ways of coping with stress (2) The role of the family system in the recovery process and (3) Understanding the longer-term development impact of trauma on the young person and the potential impact on the practitioner.

The current study shows that childhood trauma experts' views on the core capabilities needed to practice in a trauma-informed and recovery-focused way varies according to their role. For those working in a direct one-to-one therapeutic role with traumatized children the focus tends to be on those competencies related to internal change processes particularly those related to helping a child learn to regulate stress. There was a diverse group of practitioners who focused on those competencies that related to the role of the family in the recovery process. For the group made up of service managers and clinical psychologists the focus was on competencies that related to the longer-term impact of trauma on the individual and on the impact on the practitioner.

Although the literature, and the aims of this research, describe competencies that are attachment aware, trauma informed and recovery focused, what emerged from the Q-sort were three clear components made up of clusters of capabilities related to: learning new ways to regulate of stress, the role of the family in recovery, and understanding the long-term impact of trauma on the child as well as on the practitioner. This offers a way of systemically

viewing trauma recovery that encompasses the individual level in terms of learning to cope with stress, the familial level, the broader organizational level in terms of in terms of impact of this work on the practitioner and the interactional level (individual impact and societal level impact interaction) in terms of the long-term impact of trauma.

The component *recovery through new ways of coping with stress* focused on the traumatized individual and their capacity to manage and regulate stress. It highlighted that the practitioner needs to understand the adaptive nature of the individual young person's coping skills in terms of their trauma and also to understand the nature of both the internal as well as external stressors on the young person. It was felt that through this understanding the practitioner could develop a relationship that would enable the traumatized individual to perceive, assess and express their emotions that would keep themselves and others safe. The majority of people who ranked these items as important were therapists working with traumatized young people and thus it would make sense that their focus was on the individual child and their internal capacity to manage stress.

The component *the role of the family system in the recovery process* focused on the impact trauma has on the family system around the young person and on the role of family relationships in the recovery process. It also emphasized the importance of including an understanding of the impact that trauma can have on the family and to also be aware that the services and systems around the family, designed to support, can re-traumatize both the child and the family. Part of the process they emphasized was the role of addressing grief and loss in the work with the family. These participants emphasized how important it is to understand how the family system is impacted by trauma and the role the family plays in supporting the young person through the way they respond to the young person. The role of relationships in the family was emphasized and that this role is about the family supporting the young person to control and regulate their emotions. This component cluster of items had the most diverse

group of practitioners however interestingly their roles did focus on systemic issues or they themselves focused their work on carers.

The component *understanding the longer-term development impact of trauma on the young person and the potential impact on the practitioner* focused beyond the individual and family system to the long-term impact of trauma on the individual and also the impact on the practitioner. In terms of the longer term impact these practitioners emphasized the importance of understanding the role of secure attachment in the development of a child and the implications of this for future development and understanding the impact of adverse childhood experiences on later-life health and well-being. With regards to the impact on the practitioner, the importance of understanding the signs and being able to address the risk of secondary trauma and the impact exposure to detailed histories of trauma and adversity can have on practitioners and how this is managed in terms of their own personal and professional stress was emphasized.

Interestingly there were a group of practitioners, all therapist and several of them systemic therapists within specialist teams working with young people in care, who did not load on any of the components. The qualitative data suggested that the felt they found it very difficult to rank the items as they were all important. Each of these clusters cut across what some competency frameworks (e.g. The Multiplying Connections Initiative 2008) would have classified as knowledge, values and attitudes communication, practice etc.

What the results indicated was that different practitioners/people who had different roles in organizations ranked different clusters of items together. This may point to an important issue when trying to implement an all-encompassing framework like the Child Welfare Trauma Training Toolkit (Child Welfare Committee, National Child Traumatic Stress Network 2008) or the Trauma Informed & Developmentally Sensitive Services for Children Core competencies for effective practice (The Multiplying Connections Initiative

2008). What may be needed is an acknowledgment that different members of an organization will feel different elements are important and trainers will need to consider what the implications of that are for how training is rolled out.

Most competency frameworks, even those focused on a specific setting, e.g. schools, have a large number of proposed principles or competencies. They are also often very broad and generic. The results may indicate that there is a need for more specific competencies that take into account the practitioner, the group of young people being worked and their developmental level. Each of these will be addressed. Firstly, the need for practitioner level appropriate competencies. Although all three components may be important the way they may be conceptualized will be determined by the type of practitioner, the group of young people and the settings they find themselves in. For example, helping young people learn to manage their stress is important in many settings such as schools, residential care setting from primary aged children or a worker in a youth offending setting. However, the actual practice-based competencies for a teacher in terms of helping traumatized young people manage their stress in the classroom will be quite different to a care worker in a residential setting helping a child manage their stress in that context, as it will be different for a youth offending worker helping a teenager regulate their stress in the context of the youth justice system. Practically, a teacher may be provided with training or support around relational approaches to behavior management that include a focus on self-reflection and containment. A care worker in a residential setting may need to consider how the residential setting is set up in order to support a young person's capacity to self-regulate and may need training in nonviolent resistance.

The same is true when considering the role of the family or carers in the recovery process. Again, the population being worked with and the setting as well as the role of the practitioner will determine the way in which this component is operationalized in practice.

Teachers and schools will engage carers in very different ways to that of social workers engaging with foster carers, as will a trauma therapist engage differently with families in supporting the recovery of their child. This will also be evident in the third component in terms of the impact of secondary trauma on the worker. All workers working with traumatized children will need to be supported, and this needs to be acknowledged, but a teacher may need very a different type of support from a police officer who supports victims of child abuse.

What is striking is the emphasis in all three components on the role of the relationship. The therapists focused more on the role of the relationship between child and therapist, the systems-focused workers emphasized the role that relationship with the family played in recovery as well as the family's relationship with the system supporting them. The commissioners and service managers focused more on the role of the relationship in supporting practitioners who are exposed to trauma through their work.

What the three components seem to offer is a higher-order cluster of capabilities that provide a systemic overview of the area including the individual level around stress coping, the familial level of support and engagement with the system and the broader implications of trauma and its impact on the practitioner.

Limitations

The Delphi and Q-sort sample were predominantly White, highly educated female practitioners. Although this is representative of the trauma-specialist children's workforce in the UK, this limitation needs to be taken in to account as these competencies may not be applicable in more diverse settings. Social desirability needs to be considered when looking at the results as many of the respondents knew the lead researcher who works in this field. This was alleviated by having the Q-sort online. The qualitative data thematic analysis of the respondents Q-sorts and from the interviews may have been open to bias from the researcher

who works in the field. This was managed by the researcher making use of fellow researchers outside of the field to discuss the analysis.

Implications for Practice

Given that different professional groups or those with different organizational roles seemed to highlight different clusters of competencies, it may be important for those looking at developing trauma informed organizations or delivering trauma informed training to take these different priorities into account. It could be argued that all components are equally important however, if different professional roles emphasize different elements then how do we accommodate this?

The research highlights specific higher-order components of being trauma informed and recovery focused however, this seems to need to be operationalized in terms of the population of young people being worked with and who the professionals engaging with them are. A key criticism of trauma competency frameworks has been that they are often not clearly defined in terms of practice and this needs to be done for those being trained.

The results indicate the need to ensure we include a section on self-care / supervision and support as it is not enough to be trained in trauma informed work. Given the impact of secondary trauma it is an ongoing process of support that is important for organizations to consider.

Implications for Research

Future research could explore the views of various practitioners/workers in terms of what they see as key areas for developing trauma informed practice. This should focus on workers in specific settings to explore how the various higher order components are operationalized in various settings. Future research could also utilize a more diverse group of practitioners to establish if this set of components is valid across a more diverse group of practitioners.

Qualitative in-depth research into what practitioner's views on the core components are could be explored.

These components reflect the views of UK-based trauma-informed practitioners and therefore may not be applicable outside of the UK. Given the finding that even within the same country practitioners with different roles seemed to prioritize certain competencies over others, this indicates a more bespoke approach to developing competency frameworks may be needed.

Conclusions

The aim of this research was to provide consensus across UK child trauma experts on a small set of higher-order components that are seen as key to trauma recovery work. This research into trauma recovery capabilities for the children's workforce in the UK suggest there may be three key components (1) Recovery through new ways of coping with stress; (2) The role of the family system in the recovery process and (3) Understanding the longer-term development impact of trauma on the young person and the potential impact on the practitioner. These three components were linked to the types of professions/roles the experts held within the trauma recovery field. This suggests that there may be utility in considering the traumatized populations (both in terms of age and specific needs), the practitioners and the type of work they engage in with young people when operationalizing these higher-order components for their specific settings.

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Tables and Figures to appear in text

Table 1

Summary of included literature

Authors	Title	Focus	Topic	Country
Rivard McCorkle, Duncan, Pasquale, Bloom, & Abramovitz. (2004).	Implementing a trauma recovery framework for youths in residential treatment.	Trauma informed	Offers training objective and curriculum overview for their psychoeducation sessions. The sessions have 7 main areas of focus encompassing 23 concepts	United States
Downey (2007)	Calmer Classrooms: a Guide to working with traumatized children.	Attachment aware, Trauma informed and relational practices for the classroom.	Offers 5 key relational focused approaches encompassing 26 practices. Also offers 11 classroom practices	Australia
Child Welfare Committee, National Child Traumatic Stress Network. (2008).	Child welfare trauma training toolkit: Comprehensive guide.	Trauma informed	Includes the 'Essential Elements' of trauma informed child welfare practice. 9 ways in which child welfare workers can work in a trauma informed way with children and care givers to help the child recover.	United States
The Multiplying Connections Initiative. (2008).	*Trauma informed & developmentally sensitive services for children. Core competencies for effective practice.*	Trauma informed	Offers a core set of competencies for trauma informed and developmentally appropriate care for all organizations who work with young children and their families. Encompasses 8 knowledge, 4 Values and Attitudes, 3 communication, 9 practice, 1 community and 6 organization and system competencies. 31 competencies in total.	United States
Child Welfare Collaborative Group, National Child Traumatic Stress Network, and The California Social Work Education Center. (2013).	Child welfare trauma training toolkit: Trainer's guide (2nd ed.).	Trauma informed and recovery focused	7 essential elements of a trauma informed child welfare system. The training program has: 18 Knowledge objectives 11 Skills objectives 7 Values objectives	United States
Queensland Government (2013)	Calmer Classrooms, A guide to working with traumatized children	Attachment aware and trauma informed practice in the classroom	Integrate theories of trauma, attachment and child development. Offers 5 key relational focused approaches encompassing 26 practices. Also offers 11 classroom practices	Australia
Cole, Eisner, Gregory, and Ristuccia (2013)	*Helping traumatized children learn: creating and advocating for trauma-sensitive schools*	Trauma sensitive	Offers six qualities of a trauma sensitive school	United States
Walsh (2006)	*The traumatized child recovery program: A learning and development resource for professionals working with children traumatized by abuse.*	Trauma informed and recovery focused	This is a training program for those working with traumatized young people. It offers 72 outcomes from the training. It is unpublished.	United Kingdom

Table 2

Component loadings for each participant

	Component 1	Component 2	Component 3
Participant 26	**0.813***	0.138	-0.241
Participant 12	**0.785***	-0.144	0.073
Participant 16	**0.717***	0.058	0.052
Participant 3	**0.698***	0.294	0.108
Participant 31	**0.63***	0.173	-0.089
Participant 28	**0.609***	-0.035	0.278
Participant 32	**0.605***	-0.138	-0.017
Participant 33	**0.591***	0.253	0.214
Participant 5	**0.578***	0.508	0.175
Participant 1	**0.571***	0.187	-0.297
Participant 17	**0.534***	0.441	0.164
Participant 10	**0.512***	0.112	0.218
Participant 6	**0.434***	-0.285	0.197
Participant 27	**0.359***	0.337	-0.084
Participant 34	-0.034	**0.698***	0.227
Participant 4	0.225	**0.679***	-0.022
Participant 2	0.281	**0.526***	0.018
Participant 8	0.343	**-0.516***	-0.034
Participant 20	0.165	**0.461***	0.042
Participant 7	0.332	**0.451***	-0.127
Participant 15	-0.008	**0.358***	-0.23
Participant 21	0.136	**-0.326***	-0.059
Participant 29	0.223	**0.307***	-0.003
Participant 19	0.111	0.224	**0.653***
Participant 18	-0.074	-0.219	**0.65***
Participant 9	0.005	0.038	**0.628***
Participant 37	0.229	-0.121	**-0.561***
Participant 22	-0.096	-0.056	**0.502***
Participant 11	0.216	0.231	**0.473***
Participant 36	0.404	-0.004	**-0.408***
Participant 24	0.345	0.164	**0.395***
Participant 30	0.338	-0.127	**0.37***
Participant 13	0.461	0.144	0.483
Participant 14	0.3	-0.256	-0.029
Participant 23	0.407	0.291	0.397
Participant 25	0.281	0.111	0.28
Participant 35	0.425	0.48	0.224

Note: significant results in bold: *$p<0.05$

Figure 1

Overview of the Research Methodology

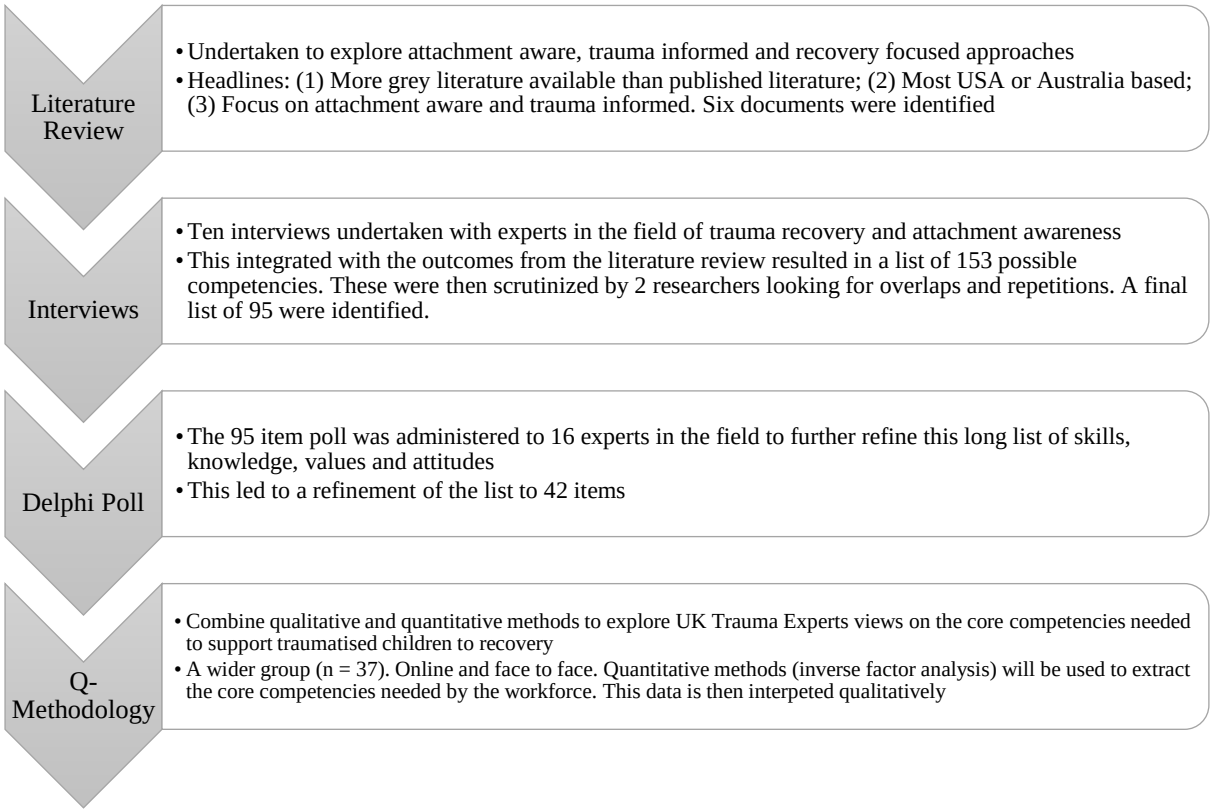
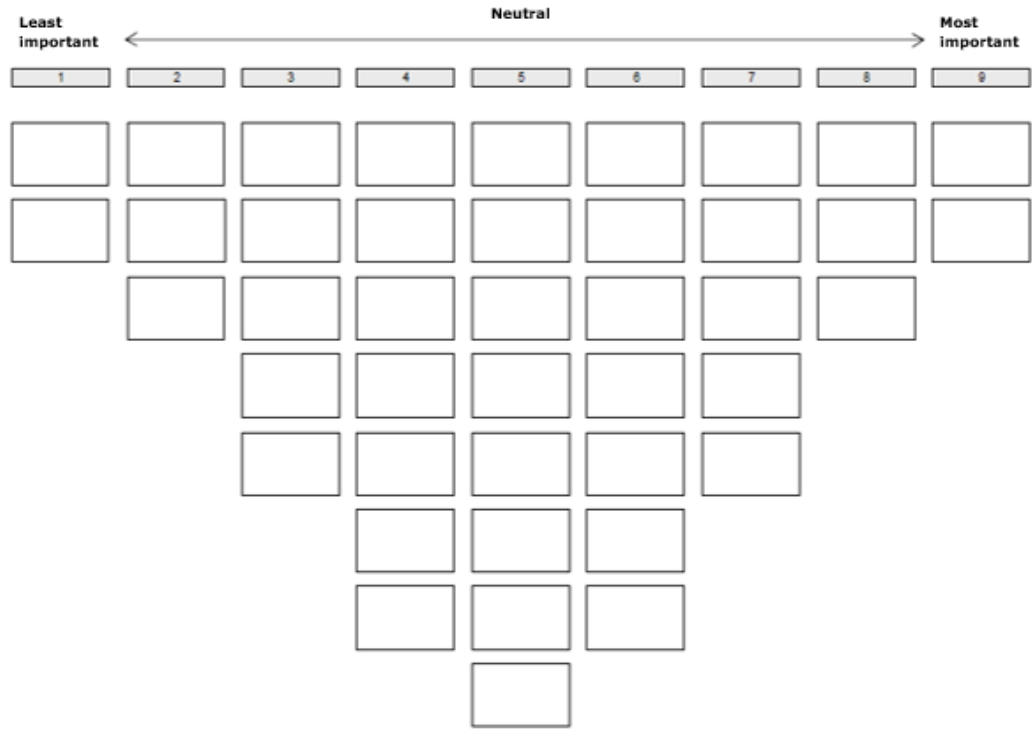


Figure 2

Q-sorting sheet, quasi-normal distribution including ranking values



Appendix 1

Table 3

Factor arrays by statements

Statements	**F1**	**F2**	**F3**
1. Understand the role of secure attachment in the development of a child and the implications of this for future development.	7	7	8
2. Explain the relationship between trauma, adversity and disrupted attachment in the child/caregiver relationship.	8	8	4
3. Understand that supporting and promoting positive and stable relationships in the life of the child is central to recovery from trauma.	9	6	8
4. Understand that each individual will have internal as well as external stressors and they are different for everyone.	5	2	4
5. Understand that the trauma continuum is influenced by many factors including: duration & number of incidences, psychological resilience and response from carers.	6	7	7
6. Understand and teach skills required for effective emotional regulation (affect regulation)	7	6	2
7. Understand attunement and its role in developing self-regulation.	7	6	3
8. Understand the link between emotions, behaviours and decision-making.	5	3	2
9. Able to support children and adults to regain a sense of control, choice and autonomy in their daily lives.	6	5	6
10. Able to educate children and caregivers to recognise signs (physical, emotional) of stress responses in themselves and others.	6	4	3
11. Able to provide opportunities for involvement at all levels of the system, facilitating support from a broad social network.	1	3	6
12. Define re-traumatisation and identify ways that children and their families can be re-traumatised/triggered by the systems and services designed to help them.	3	5	3
13. Understand the three branches of developmental trauma: 1. Executive functioning, 2. Affect regulation, 3. Psychological development.	5	9	2
14. Educate children to recognise other people's personal boundaries and their own feelings about personal boundaries.	4	3	4
15. Able to help children to create their own boundaries in interpersonal relationships.	4	4	4
16. Understand how people respond to stressful life experiences in various ways e.g. (flight/fight/freeze/fade response/attack others).	8	6	1
17. Describe local resources for trauma specific interventions and trauma informed services for children and their families.	1	5	5
18. Able to facilitate referrals and access to trauma informed and trauma specific interventions services for children and their families as needed.	5	8	6
19. Define and explain the important role of safety (e.g. psychological, physical, social) in the role of recovery.	5	5	7

20. Understand the signs and be able to address the risk of secondary trauma and the impact exposure to detailed histories of trauma and adversity can have on them.	3	4	5
21. Able to teach children and caregivers calming and soothing techniques that help children who have experienced trauma.	7	4	1
22. Recognise and address low engagement and other barriers to service seeking as part of the impact of trauma.	2	4	4
23. Recognise that involving the child and caregivers as partners in the process of recovery from trauma and childhood adversity maximises the potential for recovery.	6	8	7
24. Understand and explain that individuals learn coping skills to protect themselves and survive, that these coping skills are adaptive.	7	3	3
25. Understand the impact personal beliefs about and experiences of trauma and childhood adversity have on interactions with clients, colleagues, organisations and systems.	3	5	5
26. Understand the role of emotional containment in helping traumatised young people regulating their responses.	6	6	7
27. Able to perceive and understand their own personal and professional stress.	4	3	5
28. Able to work with children to facilitate thinking about the future and helping them to make plans.	2	1	6
29. Understand how childhood trauma could lead to a sense of powerlessness and exploring themes of control, choice and autonomy.	5	6	4
30. Demonstrate sensitivity to children's caregivers who often have unaddressed trauma issues that can impact their ability to help their children.	3	5	5
31. Understand that behaviour is a form of communication.	9	1	8
32. Able to perceive, assess and express emotions and model non-violent ways of communicating those emotions in order to maintain a safe environment for self and others.	6	2	3
33. Able to assist children to recognise and understand their feelings and emotions and help to develop coping mechanisms.	6	4	6
34. Understand the need to integrate the child's strengths, including the importance of resilience.	5	6	5
35. Understand and respect cultural diversity and how it influences perception and response to traumatic events and the recovery process.	2	2	7
36. Able to assist children and caregivers to recognise their own and others' feelings in conflict situations.	4	5	5
37. Understand the impact of adverse childhood experiences on later-life health and well-being.	4	5	6
38. Assist caregivers of children who have been exposed to trauma and childhood adversity to recognise and address their own risk for secondary/vicarious trauma and possible unresolved trauma in their own lives.	4	7	4
39. Recognise and address grief and loss when working with the child.	4	7	5
40. Understand the possible impact of issues of grief and loss on caregivers.	3	4	6

41. Able to create environments that are safe, comfortable and welcoming for all children, families and staff through respectful, consistent and predictable responses.	5	7	9
42. Able to identify and describe the key signs of the impact of trauma in children.	8	9	9