The A-Z of **Childhood Difficulty** Jargon Buster

Incredible things happen
when we believe in children.

Purpose

Lots of jargon and/or 'buzzwords' are used to describe difficult experiences in childhood from ACEs to adversity to trauma and many other associated ideas. Many professionals are aware of these concepts and trends already but may not have heard them described using particular terms. This jargon buster is designed to ensure that everybody is on the same page when it comes to the language used around difficult experiences in childhood. It aims to create a common understanding of language used to describe responses and support for people and their families who are currently experiencing or have experienced difficulties as children.

The language that we use to describe things can have very powerful consequences. Language has the power to create "them" and "us" divisions. It can make people feel excluded if they don't feel safe to access services there to help them. If people don't feel included or don't see themselves represented in the language used about them or for them, then they may not engage with the help being offered to them. Similarly, different professionals, community workers and volunteers may fail to communicate with each other unless they all understand each other's language.

Source: Parts of the jargon buster have been created with reference to an existing jargon buster from the ACEs Connection glossary of terms which can be accessed here: https://www.acesconnection.com/g/resource-center/fileSendAction/fcType/0/fcOid/466166364387046851/filePointer/466307103261466270/fodoid/466307103261466268/Glossary%20Terms%20for%20and%20from%20the%20Field_2017.04.07.pdf

How to use

The jargon buster is alphabetical. Any words underlined are hyperlinked to their definitions in other parts of the document.

The A-Z of Childhood Difficulty Jargon Buster

A
ACEs
ACEs Champion
ACEs Science
ACEs Score
ACEs Initiative
Adversity
Allostasis
Allostatic Load
ALTAR
Attachment
Attunement

C
CCE
Community Resilience
Compassionate Practice
Compassionate Practitioner
Complex Trauma
Contextual Safeguarding
CRH
CSE
Cultural Humility

D
DASH
Developmental Trauma Disorder
Domestic Violence Protection Order/ Notice

E
Emotion Coaching
Epigenetics
Evidence-Based Practice
Experts by Experience
Exploitation

F
'Fight or Flight' response

L
Lived Experience

M
MAAM
MACE
MARAC
MASH

N
National Referral Mechanism (NRM)
Neuroplasticity
Neuro-Sequential Model of Therapeutics

P
Plasticity
Post-Traumatic Stress Disorder
Protective Factors
Pruning
Police Protection Notice (PPN)
Psychologically Informed Environments (PIE)

R
Resilience
Restorative Practice
Re-traumatisation
Risk Factors

S
Secondary Trauma
Self-care
Six Domains of Resilience
Social Determinants of Health

T
Toxic Stress
Trauma
Trauma-Enhanced
Trauma-Informed
Trauma-Informed Champion
Trauma-Infused
Trauma-Responsive
Trauma-Skilled
Trauma-Specialist
Trusted Adult

U
Unconscious Bias

V
Vicarious Trauma

W
Wellbeing
Window of Tolerance

ACEs – Adverse Childhood Experiences. Traumatic or stressful events that take place during childhood. These are usually chronic in nature, taking place over a period of time but could also be a significant one-off event. The impact of these events on a person is related to the unique existing circumstances of the individual and their ability to process and cope with difficulty in their life (for example, their relationship with their main caregiver). It is also affected by their perception of the event(s). ACEs include (but are not limited to): Physical and emotional neglect; Physical, emotional and/or sexual abuse; Household Dysfunction: A significant relative in prison, mental illness in the home (particularly affecting the child's primary care giver), the child witnessing domestic violence, substance misuse in the home (alcohol or drugs); Other: A significant family member is part of a gang, the individual is being exploited or involved in other violent criminality, the child or young person is a victim of crime, the child has experienced migration (for a variety of reasons from warfare or economic migration to moving around frequently, possibly due to the child being in care or because the family has sought refuge from a previously abusive relationship or parental separation), the child has faced regular prejudice or discrimination, the child or young person has experienced adversity in the form of poverty or destitution, the young person is a carer for a relative, the child has survived chronic illness, accident or been bereaved by the death of a close relative or a parent/carer/sibling has suffered a chronic illness. Ultimately, an ACE can be any traumatic or stressful event occurring within childhood that is perceived to be, or experienced as, traumatic by the individual experiencing it. Where these incidents are repeated over a period of time it can lead to a child suffering from developmental trauma disorder.

ACEs Champion (also see compassionate practitioner and trauma-informed champion) – A person appointed within an organisation to lead on ACEs work. A person who understands ACEs, uses evidence-based approaches to move their organisation towards trauma-informed and trauma-responsive, relationship-building working practices and actively promotes/advocates for this approach. This could also be described as compassionate practice.

ACEs Science – A term referring to branches of different scientific enquiry relating to ACEs. The ACEs connection network refers to it as research that, "forms the foundation of the new understanding and knowledge about human behaviour; this science informs trauma-informed and resilience-building practices:

1. The epidemiology of adverse childhood experiences (the ACE Study and expanded ACE surveys),
2. The neurobiology of toxic stress caused by ACEs (effects on a child's developing brain),
3. The short and long-term health consequences of toxic stress caused by ACEs (effects on the brain and body),
4. The epigenetic consequences of toxic stress (how the effects of ACEs are passed on from generation to generation),
5. Resilience research, which shows that the brain is plastic and the body wants to heal."[1]

ACE Score – This refers to the number of ACEs that an individual has experienced or is experiencing from the list of ACEs outlined above. The score might be determined through the use of a screening tool or survey such as the Routine Enquiry of Adverse Childhood Experiences (REACh). A commonly discussed statistic is that those with a score of 4 or more ACEs are more likely than those with 0 ACEs to engage in risky or health-harming behaviours, leading to possible involvement in violence, substance abuse and/or

1 https://www.acesconnection.com/g/resource-center/fileSendAction/fcType/0/fcOid/466166364387046851/filePointer/466307103261466270/fodoid/466307103261466268/Glossary%20Terms%20for%20and%20from%20the%20Field_2017.04.07.pdf

criminality. The research in this area works on this basis of increased likelihood. However, this can overlook the fact that those with a score of less than 4 may still experience significant effects as a result of their trauma. Equally, a person with many ACEs may not experience negative impacts as a result of supportive relationships or resilience in their life. There is a lot of controversy over the use of ACE scoring. Many believe that it does more harm than good to ask somebody about their past or current experiences as you may re-traumatise this person by triggering them whilst re-living their experiences. Similarly, it sends a message that a person is doomed to experience negative outcomes as a result of their childhood experiences when this is not necessarily the case (see resilience, trusted adult and neuroplasticity).

ACEs Initiative – Any program or organised effort to help vulnerable and/or traumatised individuals to; address or heal trauma, avoid experiencing trauma or further trauma; or to develop 'trauma-informed' organisational working practices and transform organisational culture.[2]

Adversity – When discussing ACEs, this refers to the circumstances of a child's life or the circumstances an adult lived in as a child. This can refer to poverty or hardship as well as the environment they live or have lived in and any threats or difficulties within it, such as community violence and discrimination. However, it often means ACEs themselves such as differing types of household dysfunction, any adult responsibilities such as being a young carer, critical illness or lack of stability. An adult can of course still be experiencing adversity or experience it for the first time having not experienced it as a child.

Allostasis – According to the Community Resilience Cookbook, "Allostasis refers to the way the brain and body respond to challenges or stresses: by reacting, adapting and then recovering. But if the stress is extreme, negative and unrelenting, the brain and body pay a price."[3] Different biological systems in the body can be negatively affected by the kinds of toxic stress that ACEs are known to cause including the immune system, the cardiovascular system and the neuro-endocrine system (responsible for making and releasing hormones that control bodily functions such as metabolism, eating and drinking behaviour, energy utilization and blood pressure).

Allostatic Load – According to the Community Resilience Cookbook, extreme stresses that cause "accumulated wear-and-tear, called allostatic load, can cause chemical imbalances, accelerate certain diseases, and even alter brain structures. Genetics, early brain development, the social and physical environment, diet and other behaviours can all influence a person's allostatic load."[4] Different biological systems in the body can be negatively affected by the kinds of toxic stress that ACEs are known to cause including the immune system, the cardiovascular system and the neuro-endocrine system (responsible for making and releasing hormones that control bodily functions such as metabolism, eating and drinking behaviour, energy utilization and blood pressure).

ALTAR™ – Dr Alex Chard has led an action research or practitioner based research project within the West Midlands looking at issues in relation to ACEs and trauma, which also included the Office of the Police and Crime Commissioner, Local Authorities and Marc Radley[5]. The research was conducted with Youth Offending Teams within the West Midlands using what is known as the ALTAR™ framework. ALTAR™ is an acronym that stands for; Abuse, Loss, Trauma, Attachment and Resilience. This is thought to better

2 ibid
3 https://communityresiliencecookbook.org/the-language-of-aces/
4 https://communityresiliencecookbook.org/the-language-of-aces/
5 https://governance.wmca.org.uk/documents/s2509/Youth%20Justice%20-%20Childhood%20adversity%20HWB%20board%2018th%20jan%2019.pdf

cover the range of difficult experiences that children can have rather than the ten ACEs listed in original studies completed in the USA. The research focusses on how risk within a youth justice context should be seen within the ALTAR™ framework; that a young person's previous experiences directly influence the potential risks they may or may not pose in offending/re-offending and the potential risk that they may or may not become a victim of offending.

The research has shed light on the fact that childhood difficulty can and should be viewed as wider than the original ten ACEs and that the ALTAR™ framework may be one mechanism for doing so. In particular, it can be used to assess risk in a practical way by Youth Offending Teams and may also have wider implications for other professionals and multiagency partnerships.

It is thought that the inclusion of loss gives more weight not only to the impact of bereavement (especially of a main caregiver) but any experience where an individual could be said to have lost something in an emotional, stressful or traumatic sense. This may include critical illness, for example, or being a young carer, where the child may lose a sense of identity or the chance to lead the life they expected to. Additionally, the framework allows for discussion of broader definitions of trauma that might include those experienced during migration, seeking asylum, facing prejudice etc that the original ten ACEs excluded. Finally, the inclusion of attachment and resilience also recognises the fact that individuals can experience consequences into adulthood stemming from their attachment relationships as children and that the resilience they may or may not have developed is linked to the strength of these attachments. The ALTAR™ framework builds on other similar attempts to widen the scope of ACES following learning from early ACE work in other parts of the UK, including the 'adjustment of ACEs' proposed by Young Minds[6]. It does not 'replace' ACEs, as ACE research still provides a basis from which to understand how childhood experiences can impact people into adulthood. Rather, it helps to widen the scope of what could or should be considered an ACE, or considered a risk factor for potential negative impacts on individuals' wellbeing.

Attachment – This refers to the attachment relationship between primary care giver (parent/carer) and child. Humans are born with a range of in-built behaviours likely to ensure their survival. At times of perceived threat or danger, one of these is attachment behaviour, eg: babies cry as this ensures that they stay close to their caregiver. If main caregivers consistently demonstrate love and attention to the child in their care, then children are able to form secure attachments. This secure attachment can be built by repetition of close interactions between caregiver and child such as eye contact and touch. Children with secure attachments or a secure base learn how to function in relationships. They learn that they are loved, valued and important and develop a positive sense of identity. This is the foundation on which other skills are taught and built such as how to manage and control emotions, problem-solving skills, the development of conscience, logical thinking, becoming self-reliant, coping with fear, worry, stress and frustration and reaching intellectual potential. People who experienced secure attachments as children are more likely to become resilient, confident adults who form healthy relationships with others and who are better equipped to cope with difficulty such as trauma and adversity.

Children who do not experience secure attachments and instead experience insecure attachments (avoidant, ambivalent or disorganised) may have distant, pre-occupied or inconsistent caregivers. Where this is the case these children are more likely to have the following experiences through childhood into adulthood (depending on the type of insecure attachment they experience(d)): difficulty controlling emotions, they struggle to

6 https://youngminds.org.uk/media/2141/ym-addressing-adversity-infographic-poster-web.pdf

develop intimacy, they find it hard to concentrate, have low self-esteem and they regularly experience jealousy which impacts their relationships.

Children with disorganised attachments with their caregivers, are more likely to experience outright abuse. In these circumstances, the caregiving is hostile or hopeless. The caregiver is a source of danger ***and*** survival, and there is no consistency for the child. A child with this experience will; not have experienced safety so will see others as dangerous, try to keep distance from others, think they are unworthy or bad, have no understanding that things could be different, not be able to empathise and may be over-controlling and aggressive. As an older child they may; display violent anger, be fearful and inattentive, be highly controlling, avoid intimacy, be unable to understand emotions and cause distress to others with little or no obvious provocation. As an adult they may go on to have difficulty caring for their own children.

It is just as important to provide caring, kind and compassionate services for people who may have experienced insecure attachments as it is for people who may have experienced ACEs or trauma in their childhood. Attachment relationships are an important factor in a child or person's ability to cope with stress and adversity. They help to give a framework within which to understand some aspects of a child/person's behaviour. It is important for trained professionals to observe interactions between children and their caregivers to better understand the relationship.

Attunement – Attunement refers to a caregiver being attuned or paying attention to their child's needs. The opposite is misattunement. Paying attention to the child's needs such as responding to crying babies helps to build neural networks in the child's brain that develop communication and social skills. Misattunement can disrupt how safe a child feels and leave them feeling hopeless and helpless. Misattunement can delay the brain development described above. Some have argued that misattunement could be considered as an additional, invisible ACE. Also see attachment.

CCE – Child Criminal Exploitation. See Exploitation.

Community Resilience – This refers to the capacity within a community to cope with adversity. The ability to adapt, evolve and grow in the face of the challenge presented by stress and trauma. The capacity to engage in preventative work, anticipating risks and enduring despite hardship. In a practical sense, community resilience can be improved through developments in infrastructure. It can also be improved through greater awareness of ACEs and trauma and the use of a bottom-up approach where the community takes a lead in helping to improve the health of the community.

Compassionate Practice – See trauma-informed practice.

Compassionate Practitioner – A compassionate practitioner is a professional who helps to 'champion' compassionate ways of working. They will be working in a role where they are likely to come into contact with trauma survivors. The role involves encouraging colleagues and service or organisational leaders to review and adapt their service so that it is kind and that it shows empathy and compassion. The role could also be described as a trauma-informed champion. This would also involve taking part in a network of other compassionate practitioners to share case studies and best practice in 'trauma-informed approaches'.

Complex Trauma – Complex trauma is a term that refers to repetitive, chronic, long-term traumatic events experienced by an individual, often as a child and during critical developmental periods for the brain (though it can happen in adolescence and

adulthood too). In this way it is different to post-traumatic stress disorder in that the trauma experienced by the body does not revolve around one acutely traumatic event but instead is a pattern of incidents and experiences. Complex trauma is the term that describes the experiences children displaying developmental trauma disorder have had in their childhoods. ACEs Connection describes complex trauma as, "Another term used in place of 'ACEs'. When children are exposed to multiple traumatic events, such as on-going physical or sexual abuse, witnessing family or community violence, racism, bullying, or separation from family members, they may suffer complex trauma with deep and long-lasting effects on their ability to think, learn, and relate to others. Research has shown that the more ACEs a person has, the higher his or her risk for a range of consequences, including addiction to alcohol and other substances, heart disease, cancer, auto-immune diseases, depression, anxiety, self-harming behaviours, more marriages, more broken bones, and obesity."[7]

Contextual Safeguarding – According to the University of Bedfordshire, "Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships. Therefore children's social care practitioners need to engage with individuals and sectors who do have influence over/within extra-familial contexts, and recognise that assessment of, and intervention with, these spaces are a critical part of safeguarding practices. Contextual Safeguarding, therefore, expands the objectives of child protection systems in recognition that young people are vulnerable to abuse in a range of social contexts." For more information see the briefing paper here: https://www.contextualsafeguarding.org.uk/assets/documents/Contextual-Safeguarding-Briefing.pdf

Where it overlaps with childhood difficulty, ACEs, or trauma, is that many researchers believe that the context of a community can potentially represent adversity or an ACE in its own right. Contextual safeguarding is therefore an important part of any strategy to prevent or reduce ACEs, as well as an important framework through which professionals can approach their cases.

CRH – Corticotrophin-Releasing-Hormone. This is a hormone that in turn increases levels of other hormones linked to anxiety and a heightened state of alertness, such as cortisol. It plays an important evolutionary function in preparing the body to deal with a stressful situation. However, sustained high levels of CRH have a negative effect on the body. High levels of CRH have been linked to clinical depression, anxiety, sleep disturbance and the worsening of inflammatory problems such as rheumatoid arthritis, psoriasis, ulcerative colitis and Crohn's disease. High levels of CRH cause a high allostatic load. It has been suggested that such stress reduces the amount of an enzyme known as telomerase. Telomerase protects telomeres, and without the enzyme to protect them, the telomeres are thought to shorten. Telomeres are the protective tips of the four arms of a chromosome within our DNA. If telomeres are too short, then normal cell division and replication is inhibited or compromised[8]. Shortened telomeres are usually a result of ageing. Through the reduction of telomerase, it is believed that toxic Stress can lead to the altering of how telomeres function. It is this link that has been suggested as the cause of age-related non-communicable diseases such as type II diabetes, heart-disease and cancer being accelerated or more common in individuals who have ACEs. Another result of toxic stress

7 https://www.acesconnection.com/g/resource-center/fileSendAction/fcType/0/fcOid/466166364387046851/filePointer/466307103261466270/fodoid/466307103261466268/Glossary%20Terms%20for%20and%20from%20the%20Field_2017.04.07.pdf

8 https://www.theguardian.com/science/2017/jan/29/telomere-effect-elizabeth-blackburn-nobel-prize-medicine-chromosomes

levels in the brain, caused by ACEs or trauma, can be either a state of "hyper-vigilance", where threats are perceived to be all-pervasive or "hypo-arousal" where an individual dissociates from their surroundings.

CSE – Child Sexual Exploitation. See Exploitation.

Cultural Humility – In general terms, cultural humility refers to the need to be aware of how your own personal experiences, biases and assumptions can influence the way that you perceive the beliefs, culture and actions of others. Similarly, it is an awareness of how others' beliefs and culture will affect their actions and demonstrating sensitivity to this. In relation to childhood difficulty, cultural humility is the need to be humble when encountering people from other cultures. It is the need to avoid making assumptions that you know everything about what must happen for a group of people unless you have asked this group of people. It can be demonstrated through meaningful collaborative exercises or participation and engagement exercises that canvas the views of others and meaningfully use these opinions to re-design how you work. Being culturally humble and not assuming you know what others need without asking them is a core part of trauma-informed practice.

D.A.S.H – The Domestic Abuse, Stalking and Honour-Based Violence Risk Identification, Assessment and Management Model. This is a UK wide model used primarily by the Police Service but which is used and recognised by other professionals working in public-protection and safeguarding. The DASH assessment takes the form of a checklist to be completed by professionals when an incident where suspected domestic abuse, stalking or honour based violence has occurred. DASH is believed to be used most successfully by professionals who have received sufficient training in its proper use. Its aim is to lead to early identification, intervention and prevention. It creates a common language across agencies to refer a case to risk management meetings such as MARAC (Multi-Agency Risk Assessment Conference) and helps professionals know how to identify high-risk cases and to make appropriate referrals.

Developmental Trauma Disorder – Developmental trauma disorder can be caused by a chronic pattern of traumatic events, experienced by a child, whom also lacks protective and supportive relationships from a primary care giver to help them in building the foundational architecture of their developing brain. Gone unmitigated, this pattern can lead to the child failing to develop sensory and motor skills, language development, cognitive ability, emotional and social skills and has been linked to high numbers of psychiatric disorders in adolescents and adults such as schizophrenia, psychosis, substance abuse and other antisocial and physical disorders like eating, sexual, cardiovascular, immunological and dissociative disorders. Structured, clinical interventions for Developmental Trauma Disorder can often be based on Perry's Neuro-sequential Model of Therapeutics (NMT).

Children that have disorganised attachments are less likely to develop the ability to solve problems and may continue to experience distress when stressful situations arise. The children may not know how to process different "sensory fragments" experienced during stressful events and if they continue to lack support from caregivers then they may struggle to develop the ability to control their emotions. A child is then more likely to develop triggers for the traumatic event they have experienced and are prone to experiencing the traumatic event all over again within both their body (fight or flight response) and mind when encountering these triggers.

Such traumas often occur within the caregiving relationship for a child, though not exclusively. Traumatic events leading to a description of 'developmental trauma disorder' could include migration (as a refugee fleeing conflict) as much as say, neglect or sexual abuse and other Adverse Childhood Experiences (ACEs).

Domestic Violence Protection Order/Notice – These are orders used by the police to protect victims of domestic abuse. They can prevent exclusion or eviction from a property for a survivor of domestic abuse. They can prevent a person accused of domestic abuse from coming within a certain distance of the property, entering the property or force them to leave the property. The aim is to give 'breathing space' to a victim/survivor of abuse and to allow referrals to support services without interference. They can be pursued through court without the victim/survivor in attendance and it is possible to do it without their consent, though this is not always desirable.

Emotion Coaching – Emotion Coaching is an approach to working with children that helps them to understand and manage their emotions. It works best when used by caregivers, teachers and all other adults in a child's life. Dr John Gottman developed the model. He argued that adults should be aware of and able to recognise emotions in the child. Adults should take children's emotions seriously by demonstrating an understanding of what they are feeling and naming and labelling emotions. This helps children to develop a vocabulary for what they are thinking or feeling. It is important not to judge or criticise children's emotions or tell them how they should feel.

The approach is an attempt to regulate or control a child's emotions as they are experiencing them by calming and soothing the child and naming their feelings. It is important to connect with the child's feelings by showing empathy. Once the child is calmer or has had their feelings validated, set boundaries and limits if they have displayed 'misbehaviour'. Lastly, following any sanctions, it is possible to sit with the child and work out solutions for how to handle that feeling in future. In this way you have 'coached' the child in how to manage, control or regulate their emotions.

Emotion Coaching has been suggested as a key strategy for schools to use in helping children who may not have learned how to regulate and control their emotions within the home for a variety of reasons (see attachment and ACEs).

Epigenetics – Epigenetics is the study of gene expression (but not changes to the DNA itself) or in other words, the study of how genes are turned on or off by social and environmental factors. As it relates to childhood experiences, there are some studies which have suggested that exposure to ACEs can affect gene expression. At present findings are not conclusive as there have been small sample sizes. However, there is a suggestion that exposure to toxic stress (that has been shown to occur with ACEs) may have an impact on gene expression or how our DNA functions. It is thought that these expressions are also passed on from generation to generation (it could be observed for example in heightened states of alert being a characteristic passed from parent to child). In particular, it has been suggested that ACEs could cause the shortening of telomeres. Telomeres are the tips of our chromosomes which when shortened or damaged can make it more likely that a person experiences age-related diseases and ill health. Whilst there is still not conclusive evidence for this, the argument is that exposure to ACEs leads to an increased likelihood of age-related diseases as a result of shortened telomeres and changes to gene expression which can be passed on to the next generation. It should be noted that epigenetics is a hotly debated area of evolutionary science on which scientists regularly disagree.

Evidence-Based Practice – Evidence based practice simply refers to using methods or approaches in your daily work that are grounded in research and have evidence to support their use.

Experts by experience – As it relates to ACEs, 'Experts by Experience' is a term used to describe individuals who have experienced trauma, adversity or ACEs themselves. They work alongside professionals as experts in what it feels like to experience trauma and

adversity. Their knowledge and insights can be used in participation, engagement and outreach activities to help better design their services and any training they might wish to give to their staff. Professionals may also be experts in these experiences as they too may have had them.

Exploitation – Exploitation refers to a wide range of ways that a vulnerable individual can be taken advantage of, abused or victimised. It encompasses child sexual exploitation, child criminal exploitation, human trafficking and modern slavery among others. It is quite possible and explainable for individuals who are victimised in this way not to perceive themselves as victims or even to actively and aggressively defend those who have exploited them. An individual behaving in this way is still a victim. They should not be discounted because their traumatic experiences or their experience of being groomed and coerced still has a hold of them and makes them behave in unexpected or irrational ways, such as demonstrating hostility or distrust towards professionals trying to help them, such as police officers.

Child Sexual Exploitation – This refers to children being groomed, threatened or coerced into sexual activity. The children involved are often targeted due to their perceived or real vulnerability. Children can sometimes be trafficked for the purpose of being sexually exploited. In such cases a NRM form can be completed. Any child experiencing this type of exploitation will have suffered a traumatic event, a series of traumatic events or ACEs.

Child Criminal Exploitation – This refers to children being groomed, threatened or coerced into criminal activity. This can include a wide variety of criminal activity including drugs, violence and theft among others. Children can sometimes be trafficked for the purpose of being criminally exploited. In such cases a NRM form can be completed. Any child suffering this type of exploitation will have suffered a traumatic event, a series of traumatic events or ACEs.

Human Trafficking and Modern Slavery - Any person who has been recruited, transported, harboured, transferred or received either cross border or within borders can be considered to have been trafficked (the action of trafficking). Any person who has been threatened, coerced, abducted, defrauded, deceived or abused as a means of ensuring the individual is trafficked is a victim of exploitation/trafficking. The trafficking should have occurred for the purposes of exploitation such as sexual exploitation, criminal exploitation, forced labour or domestic servitude, slavery or the removal or organs.

Trafficking children and young people for the purposes of criminal and sexual exploitation is also an increasing concern. NRMs can and should be completed for children and young people who have been trafficked.

Fight or Flight Response – This is a phrase commonly used to describe the way the body responds to stressful or traumatic experiences. In fact there are five different responses rather than two; fight, flight, freeze, friend and flop. The way the body responds is a survival strategy. Early humans often faced dangers and threats to their physical safety. The body adapted to release stress hormones such as adrenaline and cortisol on these occasions. These hormones act to prepare the body to respond to the danger or threat. For example, the heart rate is raised preparing the body for the exercise needed in fighting or running and pupils dilate to improve vision. The body may also shut off any systems that are unnecessary for the response to the threat causing people to urinate or defecate. The fact that the body responds in this way is a good thing in times of danger or fear and a useful survival strategy in an evolutionary sense. However, where it relates to childhood difficulty or ACEs and trauma is that people who regularly experience traumatic or stressful situations have this 'fight or flight' response activated repeatedly. When stress hormones are regularly released a person experiences toxic stress levels in their body.

This can have the effect of increasing the allostatic load on the body and causing damage to the immune system, cardiovascular system and neuroendocrine system.

Freeze and flop responses are more extreme reactions to stressful episodes where a person's nervous system is overwhelmed by stress hormones and their body begins to shut down or they dissociate. This results in the person 'flopping' or 'freezing' and experiencing reduced movement, sensation or awareness of their surroundings. A friend response is when a person attempts to befriend (where relevant) the perceived threat or danger and to reason with them. This has been linked to Stockholm Syndrome.

Lived experience – In this context, lived experience means the experiences a person has had living through trauma and adversity. Their 'lived experience' may be the 10 years they spent as a child experiencing ACEs in their home or community and living through it.

MAAM – Multi Agency Action Meeting. Some local authorities use multi agency action meetings as part of their early help system. These are usually weekly meetings where families or individual cases are confidentially discussed by multiagency professionals. The group of professionals represents sectors such as the police, education, health, housing, youth work, the voluntary sector and can include invited guests with an interest in the case. The professionals share information about the case to ensure that any solutions are based on all of the available information. For each case the professionals will decide on actions to take going forward, whether any additional support is required and agree on who the lead professionals should be. The cases discussed at MAAMs are either self-referred by the families/individuals or referred to the group with the informed consent of the families/individuals concerned. The cases are not the most serious or complex. More complex domestic abuse cases will be heard at a MARAC.

MACE/MASE – Missing and Child Exploitation meeting or Multiagency Sexual Exploitation Meeting. The MACE/MASE is a multiagency meeting that ensures information is shared about cases where a child has gone missing or may be at risk of being exploited. The young people and their families may be invited to the meeting depending on the local authority. The meetings may also discuss locations where there is a concern or suspicion that exploitation may be taking place and also discuss adults or young people that may pose a risk as exploiters of other children. Professionals from a diverse range of agencies participate in the meetings and aim to take actions to safeguard children and young people at risk. The aim is to ensure that young people are appropriately supported following the meeting. Referrals to MACE/MASE are often centred on those cases already open to children's social care but which may not appear to meet the threshold for a child protection concern (section 47).

MARAC – Multi Agency Risk Assessment Conference. This is a meeting of professionals representing different sectors such as the police, probation, health, mental health, substance misuse services, education, housing or homelessness teams, social workers, voluntary sector workers, children and family court advisory and support service (CAFCASS), youth offending teams, youth workers and other specialists such as Independent Domestic Violence Advisors (IDVAs). The most high risk and complex domestic abuse cases are discussed at a MARAC. The aim is to share information between professionals to make sure that appropriate decisions are made that safeguard the families, children and adults concerned. Based on the information sharing a risk management plan is drawn up to provide professional support to all those at risk to reduce the potential for harm. This is supposed to prevent repeated victimisation and ensure there is adequate support for the staff involved in managing high risk domestic abuse cases. Referral to MARACs happen when a practitioner has concerns that a case is high risk and has met the threshold for risk set by children's social care within the local authority.

MASH – Multi Agency Safeguarding Hub. A multi agency safeguarding hub is a team

with representatives of local agencies such as the police, children's social care, domestic abuse advisors, health, fire and rescue service, probation, education, youth offending teams, among others. They are often co-located (work in the same office/building). Any safeguarding concerns or referrals are reported into the MASH team. Referrals may include self-referrals from parents or carers, a professional reporting concerns, a child or family who has come into contact with the Police, or a disclosure made by a child about abuse they have experienced. The MASH team are able to assess the risk posed to the individual by gathering information about the case. It is in effect, a triaging service. They then decide whether the case should be dealt with at an early help stage (for example heard at a MAAM if the family or individual gives consent, or if an early help assessment should be completed) or whether if it is a high risk domestic abuse case and should be discussed at a MARAC. Alternatively, the MASH team will devise an intervention themselves having triaged the needs of the case. There can be overlap between MASH and MARAC depending on the system used within each local authority.

National Referral Mechanism (NRM) – According to gov.uk, "the NRM is a framework for identifying and referring potential victims of modern slavery and ensuring they receive appropriate support"[9]. The NRM itself is a form that can be completed by "first responder" agencies (a list can be found on gov.uk) to report any potential victims of trafficking or modern slavery. The forms are logged with the Single Competent Authority (the Home Office) who take 5 working days from receipt of the NRM form to make a 'reasonable grounds' decision about whether the individual is a victim of modern slavery/ trafficking. A 'conclusive grounds' decision is then taken within 30 days which gives a more confirmed decision. The NRMs give individuals official status as a victim and are designed to ensure that individuals get appropriate support and also do not face prosecution for any criminal activities they have been forced or exploited to become involved in.

Any person who has been recruited, transported, harboured, transferred or received either cross border or within borders can be considered to have been trafficked (the action of trafficking). Any person who has been threatened, coerced, abducted, defrauded, deceived or abused as a means of ensuring the individual is trafficked is a victim of exploitation/ trafficking. The trafficking should have occurred for the purposes of exploitation such as sexual exploitation, forced labour or domestic servitude, slavery or the removal or organs.

Trafficking for the purposes of criminal exploitation is also an increasing concern for children and young people. NRMs can and should be completed for children and young people who have been trafficked.

Neuroplasticity – Despite the focus on early childhood, other studies have suggested that adolescents experience continued plasticity (adaptability) of the brain. In other words the brain continues to change and adapt beyond childhood and is not 'fixed'. This evidence has been used to argue that adolescent brains may be "amenable to interventions to help mitigate earlier emotional and/or physical trauma"[10]. This may be due to a process known as 'pruning'. Pruning is the concept that neural networks in the brain which are not regularly used or 'fired'/activated can 'die away' through adolescence and into adulthood. In reality, there is a decline in a fatty tissue known as myelin which wraps around the network to makes it more efficient and therefore the pathway becomes less efficient and can be said to have been 'pruned'. Simply put, use it or lose it[11].

Neuro-Sequential Model of Therapeutics (NMT) – The Neuro-Sequential Model of Therapeutics is an approach to providing support for people who have suffered

9 https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales
10 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3601560/
11 Frederiksen, L., (2018), The Developing Brain and Adverse Childhood Experiences, ACEs Connection, 26th April, accessed at: https://www.acesconnection.com/blog/the-developing-brain-and-adverse-childhood-experiences-aces

serious trauma within their childhood. It is used by trained therapists. Its goal is to match therapeutic activities within the context of therapy to the 'age and stage' of the individual. Age and stage refers to their 'developmental age' in terms of brain development. Children who have suffered trauma may have very underdeveloped neural networks in the brain as a result of their experiences, this can also last into adulthood. The approach therefore seeks to identify the developmental age of the individual and tailor therapy towards developing neural pathways in their brain (from the brainstem or lower brain upwards through repetition) that they may have underdeveloped as young children. This process is long and involves regular repetition of activities, building brain architecture upwards from the brain stem to the cortex. The building of brain structures proceeds in a sequence building sturdy foundations as an imitation of the natural development expected in young children.

Plasticity – See Neuroplasticity.

Post Traumatic Stress Disorder – Post-Traumatic Stress Disorder is a description of the characteristics displayed by an individual who has experienced a significant traumatic event[12]. The individual, during this event, is likely to have faced a significant threat to their person or an intense feeling of fear or powerlessness. PTSD can be said to become chronic if the symptoms are present beyond three months after the incident, however, there can also be delayed onset if symptoms occur 6 months after the incident[13]. Where it differs from complex trauma (that can lead to developmental trauma disorder) is that the traumatic incident is usually a one-off event or sequence of events. It is maintained in cases of PTSD (in contrast to complex trauma) that,

"immediately after a traumatic event, simple practical, pragmatic support provided in a sympathetic manner by non-mental health professionals seems most likely to help."[14]

This lends credence to the argument that support for trauma survivors can still be provided by non-specialists, even if trauma survivors require a later intervention by a trained therapist such as EMDR or CBT. Indeed, it is beneficial for this to be the case.

Protective Factors – Protective Factors are the name given to anything present in a person's life which can be a source of strength for them. This can also be referred to as a person's resilience. Protective factors can help to 'offset' any difficulties or risks a person may experience and ensure they are able to cope with them. For example, if a person had experienced ACEs or trauma then protective factors would help the individual to guard against the potential negative impacts of their experiences on their mental and physical health. Examples of protective factors include; a secure attachment, strong self-esteem, self-motivation, stability and security, living in a child-centred family, a strong relationship with a trusted adult, a strong relationship with an adult who has had positive childhood experiences, a history of the family coping with previous adversity, a positive experience of school, a positive peer group, adequate housing, participation in hobbies and interests which are supported by the family, among others.

Pruning – See neuroplasticity.

Police Protection Notice (PPN)/Order – These are safeguarding notices/orders issued by the Police where there is a concern over the risk of harm to a child. They give the police power to remove a child from a dangerous situation and place them into a temporary home with a relative or foster carer (via children's services) for 72 hours and with a maximum extension of up to 8 days (also see Domestic Violence Protection Orders).

12 Bisson, J.I., (2007), Post-traumatic stress disorder, BMJ, 334(7597), pp.789-793.
13 ibid
14 ibid

Psychologically Informed Environment (PIE) – A psychologically informed environment is a phrase often used within housing or homelessness services. It refers to a service that takes into account the emotional needs of people. A service that creates an environment that helps rather than hinders a person's recovery by understanding the way that the individual's experiences affect how they will perceive an environment. This also includes the knowledge of the staff providing the service on how trauma affects people. It is a very similar notion to that of trauma-informed practice but this term is more commonly used within homelessness and housing services. The PIE is an approach rather than a definite set of criteria and involves being reflective on how a trauma survivor may experience your setting/location/service, then making changes to improve that experience if any are identified.

Resilience – Resilience refers to a person's ability to cope with or 'bounce back' from difficult experiences. Resilience is not a quality we are born with. Instead, it is built through our experiences. Resilience can also be thought of as possessing several protective factors to shield a person from the possible negative outcomes associated with ACEs or trauma. Research has shown that the most powerful factor in resilience is having supportive relationships, particularly for children to have supportive relationships with a trusted adult. Within this relationship, a child can develop problem-solving skills, experience emotion-coaching, have a secure base and have somebody attuned to them who encourages their hobbies and interests. All of these experiences will build resilience and strengthen protective factors. However, to some extent, resilience is also built by having previously experienced difficulty and so some small controlled, adversity can be a positive force in strengthening a person's ability to cope. This is because it represents an opportunity for that person to exercise coping strategies.

Resilience is often seen as a solution to the issue of ACEs and trauma. This is because it is thought to help reduce the possibility that a person experiences negative outcomes. However, others with lived experience have criticised this approach as it assumes that people who have ACEs or who have experienced trauma and adversity lack resilience whereas often this is not the case. It is argued that in fact those experts by experience have been able to develop resilience as a result of their experiences. Instead it may be supportive relationships that represent the best opportunity for non-therapists to provide intervention.

Restorative Practice – Restorative Practice is an approach that seeks to repair relationships between people who have caused harm to one another or had a rupture in their relationship. It has been used in education, counselling, the criminal justice system and in work with families. Whilst it can be considered an offshoot of restorative justice, there is a key difference in that restorative practice can be proactive rather than reactive as restorative justice is. Restorative practice is also about pre-empting the rupture of relationships by acting to strengthen them before any further harm can take place. It usually involves bringing groups of people together in circles or 'conferences' with the support of authority or support figures (depending on the context) and encouraging 'victims' and 'offenders' or, put better according to restorative practice principles, those members of the group/community that are present, to discuss their concerns with each other, understand each other and the reasons for their actions and agree on a way forward to 'make things right'. However, this type of approach may not always be appropriate, for example for domestic or sexual abuse victims.

It should also be noted that to some extent restorative practice approaches work best where an individual is capable of empathy. It may be for some individuals that their developmental age (possibly as a result of past experiences) is lower than their chronological age. Such people may not have sufficient cognitive ability to empathise

with others in the same way that younger children have not yet developed the capacity for empathy. Some have criticised restorative practice as in their experience, it does "not always work". It is quite possible that in these circumstances the approach failed to work because it was attempted with an individual who had lower cognitive ability and a lack of empathy, perhaps as a result of developmental trauma disorder or insecure attachment relationships. A professional attempting to facilitate restorative practice may make assumptions that all those involved have the capacity for empathy when they may not.

Re-traumatisation – Re-traumatisation refers to the possibility that a person who has experienced stressful or traumatic experiences in the past could 're-live' their experiences. This may occur if a person is 'triggered' to recall or remember their experiences. This might be through a conversation, seeing a visual cue, hearing an auditory reminder, carrying out a physical action, visiting a location or any other experience that could remind a person of the past event. Re-traumatisation is on a spectrum. At its most extreme it may involve a person who is triggered to remember their trauma beginning to experience some of the same physical fight, flight, freeze, friend or flop responses that they experienced during the original episode. By raising a person's stress hormone levels this can potentially do them physical harm. At a less extreme end of the spectrum, encouraging a person to recall past trauma can cause them emotional distress. Potentially, for a person with reduced ability to cope with stressors or a small window of tolerance (perhaps as a result of past experiences), their interaction with a service or professionals can result in them being traumatised for a second time but for a new reason. This could also be considered 're-traumatisation'. However, the definition is most often used to describe the first scenario described above.

Risk Factors – The opposite of protective factors. Risk factors are things that describe a situation for a child/young person/family that put them at greater risk of experiencing adversity or demonstrate that they may be vulnerable. As it relates to ACEs, risk factors are those things that may act against a person when trying to cope with trauma or adversity and make it harder for them avoid the potential negative impacts of their experiences. In some cases, the risk factors can be traumatising or stressful experiences in their own right. Risk factors can be offset by protective factors. Examples of risk factors include; a person's age, if they have a disability, communication difficulties, an insecure attachment, self-harm, non-attendance at school, if they are an unwanted child, parents with a history of abuse/neglect, parents involved in criminal activity, parents who show little interest in their child or their child's needs, the economic/social status of the family, minority status, social isolation, instability, family breakdown, separation/loss/bereavement, poor housing, homelessness and poor home conditions, among others.

Secondary Trauma – Secondary trauma refers to the development of triggers as a result of hearing accounts of trauma second hand. Professionals can experience this. For example, a particular bodily movement, smell, sound or sight that was present or happened when listening to a story of trauma can be encoded into the brain with that description of trauma. The next time the professional experiences the bodily movement, smell, sound or sight they would be triggered to remember the description of trauma.

Self-Care – Given that there is a high likelihood that professionals working in caring professions are prone to hearing lots of stories of difficulties from the people they work with or in the course of their day, self-care is very important. Professionals are at risk of developing secondary trauma, vicarious trauma, burnout or compassion fatigue. As a result, taking time to prioritise their own needs and their own mental health both within the workplace and in their personal life is very important. Self-care takes different forms for different people depending on their interests and hobbies and what they find helps them to relax. Common suggestions include activities aimed at improving physical and

mental health such as exercise, yoga, mindfulness and meditation but could conceivably include anything that the individual enjoys doing that isn't harmful to their health.

Six Domains of Resilience – Alongside the resilience framework they developed, researchers Daniel and Wassell discussed the notion that there are six domains of resilience. These are six areas in which a person's resilience can be assessed and quantified. This acts as a basis from which their protective factors or general resilience can be built. The six domains are; education, a secure base, social competencies, positive values, talents and interests, and friendships.

Social Determinants of Health – The social determinants of health means the factors that influence a person's health. This includes the conditions that a person grows up in or is born in. It also refers to the conditions people live, work and grow old in, the way that money is distributed across the nation and region, how power is distributed and other factors that influence inequality in health care and discrepancies between people's standard of physical and mental health.

Toxic Stress – Toxic stress refers to high levels of stress hormones being present in a person's body as a result of repeated, stressful or traumatic experiences. The body has adapted to release stress hormones such as adrenaline and cortisol on occasions of high tension or danger. These hormones act to prepare the body to respond to the danger or threat. For example, the heart rate is raised preparing the body for the exercise needed in fighting or running and pupils dilate to improve vision. The body may also shut off any systems that are unnecessary for the response to the threat causing people to urinate or defecate. The fact that the body responds in this way is a good thing in times of danger or fear and a useful survival strategy in an evolutionary sense. However, where it relates to childhood difficulty or ACEs and trauma is that people who regularly experience traumatic or stressful situations have this 'fight or flight' response activated repeatedly. When stress hormones are regularly released a person experiences toxic stress levels in their body. This can have the effect of increasing the allostatic load on the body and causing damage to the immune system, cardiovascular system and neuroendocrine system. High levels of toxic stress have been linked to an increased risk of engaging in health-harming or risky behaviour in adolescence and adulthood. Toxic stress has also been linked to an increased risk of non-communicable diseases such as heart disease, cancer and type II diabetes. However, this is not a guarantee that experiencing these types of stressful events will definitely lead to negative health outcomes. A person's resilience and supportive relationships can off-set these impacts.

Trauma – Trauma in this context refers to psychological trauma rather than physical trauma. SAMHSA (2014, p7) defines trauma as, "an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening."[15] NHS Education for Scotland (2018)[16] categorises trauma in two ways. Type 1 trauma: these are usually single incident events such as rapes, assaults or serious accidents. Type 1 trauma could include road traffic accidents, terrorist attacks or other types of major emergencies. Type 2 or 'Complex Trauma': this form of trauma and abuse is usually experienced interpersonally, persists over time and is difficult to escape from. Complex trauma is often experienced in the context of close relationships (e.g. childhood abuse, domestic abuse) but can also be experienced in adulthood in the context of war, torture or human trafficking. It is not uncommon for people to experience

15 Substance Abuse and Mental Health Services Administration (SAMHSA), (2014), SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration

16 NHS Education for Scotland, (2018), The Scottish Psychological Trauma and Adversity Training Plan, Scottish Government, accessed at: https://www.nes.scot.nhs.uk/media/4236974/FINAL%20REVISED%20CONSULTATION%20NESD0715-NATIONAL-TRAUMA-TRAINING-STRATEGY-V7-DL.pdf

both types of trauma during their lives[17]. Trauma in a psychological, rather than a physical sense, refers to the multi-sensory experience of a disturbing or distressing event[18]. This may mean witnessing or hearing for example. The word trauma itself derives from Greek origin meaning to 'pierce' or 'wound'. Trauma creates 'bio-psycho-social' wounds that affect an individual's physical and mental health and consequently their relationships with others[19]. Trauma is not something that just happens ***to*** a person, but also happens inside them, physically and mentally, and leads to alienation; from work, from others and from nature[20].

Trauma-Enhanced – There are various phrases that are used in connection with trauma and this is one of them. Trauma-enhanced refers to a 'level' of responsibility for dealing with potentially traumatised people used by the national trauma training framework used in Scotland. It is the 2nd highest tier in their model.

Trauma-Informed – Being 'trauma-informed' means using a knowledge of psychological trauma and its potential effects to be kind, considerate, empathetic and compassionate. Being kind is at the heart of everything you do as a professional or organisation. Trauma informed practice means recognizing how common trauma is, its potential impacts and acting to avoid the possibility that people are 're-traumatised' or unnecessarily stressed by interacting with you or your service. It may also mean reviewing/auditing your service to make sure this is the case and changing practice.

Trauma informed practice is not designed to 'treat' trauma related difficulties. Instead it seeks to address the barriers that those affected by trauma can experience[21]. Trauma-Informed Practice means using knowledge of the impact of trauma on individuals, services and organisations to influence practice. This insight is used to design or review services and interventions that respond to the needs of people who have experienced trauma. It refers to the practice, support or care given by individual professionals in their roles, as well as to the creation of a compassionate, empathetic environment and workplace culture[22].

SAMHSA (2014) refers to four 'Rs' in trauma-informed practice; realise, recognise, respond, resist re-traumatisation[23]. Organisations or systems need to realise and understand that trauma is a widespread concern and the ways it can affect people, families, organisations, services and communities[24]. There needs to be a recognition of the ways in which trauma can influence behaviour and a compassionate response from practitioners that recognises and accommodates these behaviours. Organisations need to recognise signs and symptoms of trauma. This can be accomplished through workforce development, supervision or assessments[25]. The service or organisation must then respond to the needs of trauma survivors by applying principles of trauma-informed practice to all areas of their organisation, including policies[26]. This will infuse and embed

17 Terr, LC (1991) Childhood trauma: An outline and overview, American Journal of Psychiatry 148 (1), 10-20
18 Joseph, S., (2012), What is Trauma? Is it time to dump the diagnosis of PTSD?, Psychology Today, available at: https://www.psychologytoday.com/gb/blog/what-doesnt-kill-us/201201/what-is-trauma
19 Maté, G., (2019) Fostering Resilience in a Stressed Culture, 11th June 2019, Glasgow
20 ibid
21 Harris, M. & Fallot, R. D. (2001). Using trauma theory to design service, San Francisco: Jossey-Bass
22 Substance Abuse and Mental Health Services Administration (SAMHSA), (2014), SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration
23 ibid
24 ibid
25 NHS Education for Scotland, (2018), The Scottish Psychological Trauma and Adversity Training Plan, Scottish Government, accessed at: https://www.nes.scot.nhs.uk/media/4236974/FINAL%20REVISED%20CONSULTATION%20NESD0715-NATIONAL-TRAUMA-TRAINING-STRATEGY-V7-DL.pdf
26 ibid

therapeutic responses to trauma into every facet of the organisation[27]. Staff can then use their knowledge of trauma to resist possible sources of re-traumatisation for clients and staff. This can be achieved through identifying possible triggers in the environment or the working practices[28]. This includes staff resisting practices in which they encourage trauma survivors to retell their story. Whilst some survivors may choose to retell their story, it is not necessary for effective recovery or support. Additionally, it involves a continuous process of reviewing policies, the use of language and cultural norms to ensure they reflect key principles of trauma-informed practice[29].

Trauma-Informed Champion – See Compassionate Practitioner.

Trauma-Infused – This is a variation on 'trauma-informed' proposed by Dr Karen Treisman[30]. The idea is that knowledge of trauma (trauma-informed) and how to respond to trauma is ***infused*** into every aspect of a service or organisation. This means that a recognition of how trauma can affect people is considered and at the heart of everything each professional does.

Trauma-Responsive – Being trauma-responsive is also an off-shoot of trauma-informed. It refers to the principle that just knowing or being informed about trauma is not enough. Professionals and organisations need to respond to traumatised or potentially traumatised individuals, families, services and organisations using their knowledge of trauma. The actual interventions, programmes or changes made to practice as a result of this knowledge constitute a 'trauma-responsive' organisation or practitioner.

Trauma-Skilled – There are various phrases that are used in connection with trauma and this is one of them. Trauma-skilled refers to a 'level' of responsibility for dealing with potentially traumatised people used by the national trauma training framework used in Scotland. It is the 3rd highest tier in their model.

Trauma-Specialist – There are various phrases that are used in connection with trauma and this is one of them. Trauma-specialist refers to a 'level' of responsibility for dealing with potentially traumatised people used by the national trauma training framework used in Scotland. It is the highest tier in their model. A trauma-specialist refers to a professional providing therapy services for traumatised individuals. These services are known as trauma-specific services.

Trusted Adult – A 'Trusted Adult' in the context of ACEs and trauma is a person that a child experiencing trauma can rely on to offer a supportive, therapeutic relationship (but not actual therapy). The trusted adult is able to make the child feel secure and safe from harm. This can be a parent or caregiver but could also include a teacher or other professional. This adult will be able to help the child to learn coping strategies for when things become difficult. They might teach problem solving skills or how to control emotions. A trusted adult would champion the child's hobbies and interests and look for opportunities for them to take part in these. All of these activities would help the child to become resilient into adolescence and adulthood.

27 Treisman, K., (2018), 'Becoming a more culturally, adversity, and trauma-informed infused, and responsive organisation', Moving Towards Being and Sustaining a Trauma-Responsive Barnardo's, presented at the NEC, Birmingham: 1st-3rd May 2019, London: Winston Churchill Memorial Trust

28 Substance Abuse and Mental Health Services Administration (SAMHSA), (2014), SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration

29 Treisman, K., (2018), 'Becoming a more culturally, adversity, and trauma-informed infused, and responsive organisation', Moving Towards Being and Sustaining a Trauma-Responsive Barnardo's, presented at the NEC, Birmingham: 1st-3rd May 2019, London: Winston Churchill Memorial Trust

30 ibid

Unconscious Bias – Unconscious bias refers to people holding stereotypical views about others in an unconscious or unknown way rather than an obvious or overt way.

For example feeling unsafe around, or suspicious of, another group of people without having any specific or obvious reason for feeling like this and without ever having taken any action to outwardly criticise this group. It would therefore be possible to say that you have never consciously demonstrated prejudice towards this group but your instinctive behaviour demonstrates an unease that would not be present if you didn't hold some form of mistrust unconsciously.

This can involve any protected category of people but may also extend beyond obvious minorities or marginalised groups to making assumptions based on the way a person is dressed or the things they are interested in.

Unconscious bias is important when it comes to childhood difficulty or trauma. This is because professionals may hold unconscious feelings about the culture or background of individuals they are working with. As a result, this can create divisions between professional and service user, or alternatively, it can lead to professionals making assumptions about how a person may behave that may be based on stereotypes rather than grounded in evidence for that individual. This can be extremely damaging to relationships formed between professionals and service users. There are plenty of organisations offering unconscious bias training.

Vicarious Trauma – Professionals must consider the risks that are associated with regular work with trauma the impact it can have on their own wellbeing. Vicarious Trauma refers to this effect. Regular exposure to stories of the trauma of others can cause a professional to experience changes to their character and beliefs[31][32]. For example, if an individual often worked with suicide, traumatic injuries or death they may experience a heightened awareness of the fragility of life. Working with families experiencing adversity, neglect, domestic abuse or community violence may lead professionals to question the essential goodness of people or have altered feelings about their basic safety in certain environments[33]. Working with marginalised people every day makes it difficult to empathise with the struggles of relatives or friends which may seem trivial by comparison, leading to a sense of alienation[34]. Professionals can also suffer secondary trauma. Over time, such secondary traumas can add up to create vicarious trauma and an alteration of character, beliefs or worldview. Similarly, these feelings can lead to compassion fatigue and any impatience, judgements or assumptions towards clients or service users that would accompany this. Ultimately, a person would experience burnout and the overwhelming exhaustion, disconnectedness and isolation that go along with this. Practitioners must therefore be mindful of their own wellbeing and to look for the signs of vicarious trauma in their colleagues. This is because the care and support provided by professionals to clients/service users will not be effective if professionals themselves are not resilient to the challenges of working regularly with vulnerable or traumatised people. This is why self-care and staff wellbeing is vital to infusing trauma-informed practice within an organisational culture[35].

31 Lodrick, Z., (2007), Psychological Trauma; what every trauma worker should know, The British Journal of Psychotherapy Integration, 4 (2), 1-19

32 Treisman, K., (2018), 'Becoming a more culturally, adversity, and trauma-informed infused, and responsive organisation', Moving Towards Being and Sustaining a Trauma-Responsive Barnardo's, presented at the NEC, Birmingham: 1st-3rd May 2019, London: Winston Churchill Memorial Trust

33 Lodrick, Z., (2007), Psychological Trauma; what every trauma worker should know, The British Journal of Psychotherapy Integration, 4 (2), 1-19

34 Treisman, K., (2018), 'Becoming a more culturally, adversity, and trauma-informed infused, and responsive organisation', Moving Towards Being and Sustaining a Trauma-Responsive Barnardo's, presented at the NEC, Birmingham: 1st-3rd May 2019, London: Winston Churchill Memorial Trust

35 ibid

Wellbeing – Wellbeing is the emotional, physical, mental and spiritual health of a person and the ways that this is impacted by social determinants of health. Wellbeing and contentedness, hopefulness and happiness can be ensured through resilience and protective factors.

Window of Tolerance – A notion proposed by Dr Dan Siegel. This is the idea that each person has a zone in which they are most able to function effectively. This refers to the processing of information, receiving ideas, learning or responding to everyday life. A person is able to think clearly, rationally and logically. However, when a person experiences extreme stress and their nervous system is overwhelmed they may experience either 'hyper-arousal' or 'hypo-arousal'. In this scenario, a person shifts outside their optimal zone, or window of tolerance, and loses the ability to think clearly, rationally and logically. Hyper-arousal refers to the fight or flight response and is often displayed as panic, feelings of anxiety, over or rapid thinking and perceiving threats everywhere (hypervigilance). Hypo-arousal is a freeze or in extreme cases flop response evidenced through reduced physical movements, numbness, emptiness and a person being withdrawn. In both of these states, activity in the prefrontal cortex of the brain is reduced and becomes functionally detached from other regions of the brain. In this way a person can be said to be outside their window of tolerance. Toxic stress can cause a person to experience these hyper or hypo-arousal experiences. Toxic stress can be caused by ACEs or trauma. A person with a history of trauma is more likely to have a squashed or reduced window of tolerance as a result of their experiences. They may therefore experience, hyper or hypo-arousal more frequently.

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