OF SUFFERING AND SOCIAL NORMS: SOCIAL WORKERS' CONCEPTIONS OF TRAUMA IN CANADIAN CHILDREN AND YOUTH

by

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This work is dedicated to my mother, Nicole, who has always been my anchor in the hardest of times, and to my husband, Daniel, with whom every day is worth cherishing.

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Abstract

Social workers have long been involved in moral regulation projects. Historically and currently, children and families are frequently acted upon by social workers to govern and shape a morally desirable population. With trauma becoming an increasingly salient topic in Canada, it is important to interrogate how trauma discourses shape social workers' perceptions and practices to understand the role trauma discourses play in the moral regulation of children. Using critical discourse analysis (CDA), this master's thesis explores how social workers understand and use trauma discourses in their work with children and youth in Alberta. This research found that trauma discourses are implicated in processes of normalization by framing traumatized children's behaviours as deviations from social and biological norms. This research interrogates how biomedical discourses and professional expertise are simultaneously used and challenged by social workers and explores the ethical challenges social workers navigate in responding to the needs of this population.

List of Abbreviations Used

ACES – Adverse Childhood Experiences

ACSW – Alberta College of Social Workers

ADHD – Attention Deficit Hyperactivity Disorder

BPD – Borderline Personality Disorder

CASWE – Canadian Association of Social Work Education

CDA – Critical Discourse Analysis

COS – Charity Organization Society

DSM – Diagnostic and Statistical Manual of Mental Disorders

FASD – Fetal Alcohol Spectrum Disorder

NASW – National Association of Social Workers

ODD – Oppositional Defiance Disorder

PTSD – Post-Traumatic Stress Disorder

RSW – Registered Social Worker

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Chapter 1 – Introduction

I doubt I will ever forget the feeling of incredible awkwardness that came over me during my second practicum placement in social work. I had been chosen for a position as a social work research student at a child and youth mental health centre in Alberta, where I would undertake several different projects aimed at bridging the gap between social work research and practice. On this particular occasion, I and two of my peers were attending an educational session on trauma-informed care and "adverse childhood experiences" (ACES). As I looked through the list of ACES, I felt a growing sense of discomfort. "When a child has an ACES score of four or higher, that's when we start seeing those really negative consequences later in life," our supervisor explained. I thought to myself, *I have experienced at least four of these adverse events*. I snuck a glance at my peers who nodded somberly, faces filled with expressions of curious concern. Perhaps they were thinking the same thing as I was, but in that moment, I felt like an outsider – someone who should be on the other side of the service-provision divide. It felt as though my experiences, if disclosed to others, would result in a social transformation from 'normal' social worker to 'abnormal' former child. Little did I know my feelings of strangeness and unease would only grow as my work there continued.

I began to notice how social workers often employ ideas about trauma in ways that are both othering and wrapped up in moral judgements about caregivers, family members, and even the children themselves. When reviewing youth case files for information about childhood exposure to domestic violence, I read comments by clinicians that talked about "the violence in *that* [Indigenous] community" (emphasis mine) in ways that framed families as cruel or barbaric or the "promiscuous" ways of

female service users. In seeing for myself the way these 'traumatized'[1] youth were talked about by service providers, I became concerned about the potential impacts of the othering language and moral judgements coming from people who occupy positions of authority and power in the lives of the youth they seek to help. Further, I began to question how discourses about trauma are implicated in the moralization of youth by social workers and how this process shapes practice decisions in ways that may result in the coercive regulation of the most marginalized members of our community. I noticed that social workers seemed to be using trauma discourses in versatile ways that, at times, promoted flexibility and compassion in the face of what might be considered challenging behaviour (i.e. this child has been 'wired' to respond aggressively because of the harm they have experienced, this behaviour is not their fault) but at other times seemed to individualize and even dismiss their suffering (for example, this child had a 'messed up' childhood and that explains why they are 'manipulative' and cannot be trusted). I began to recognize that our ideas about trauma influence our perception of children and youth as moral agents, which in turn influences how we address issues of blame and responsibility for both harms caused and behaviours we see as consequences of that harm. Further, these understandings set the stage for which professional responses to experiences of distress are rendered normal. These are the tensions this thesis project explores.

From conversations about the lingering impact of residential schools (Meloney, 2020) to discussions about the experiences of sexual assault survivors (CBC News, 2020), trauma is an increasingly salient topic in the current Canadian landscape. As an

[1] Throughout this thesis, I will refer to children and youth as 'traumatized.' I am by no means suggesting that children should come only to be defined by their experiences of trauma, which I believe is problematic for many reasons. However, I refer to traumatized children as a discursive category.

indication of how broadly definitions of trauma are applied, the Canadian Psychological Association (n.d.) asserts that approximately 76% of Canadians will experience a traumatic event in their lifetime. Further, 8% of those exposed to traumatic events will be diagnosed with post-traumatic stress disorder (PTSD), a disorder characterized by intrusive thoughts, avoidance behaviours, negative feelings and cognitions, and hyperarousal or irritability. While the remaining 92% of people exposed to traumatic events do not go on to develop PTSD, 'trauma' can have many other, long-lasting impacts on the lives of individuals and communities (Canadian Psychological Association, n.d.). Trauma is of particular concern for those working with children and youth, as some studies on ACES have argued that as many as 64% of adults have experienced some form of child maltreatment or adverse event in childhood (Levenson, 2017). These numbers are purportedly even higher in children connected with child welfare services (Connell et al., 2019).

Those who have experienced a traumatic event, regardless of whether they develop the symptoms associated with PTSD, may seek professional support in responding to the challenges they face as a result. In addition to potentially seeking the support of medical doctors, psychiatrists, or psychologists, individuals working to address experiences of suffering are likely to encounter social workers. According to the Canadian Association of Social Workers (n.d.), social work is a profession "concerned with helping individuals, families, groups and communities to enhance their individual and collective well-being." Social work is a diverse profession and, as such, social workers may be employed in a range of agencies where they interact with individuals experiencing distress; these may include child and family service agencies, hospitals,

correctional institutions, and organizations providing mental health and counselling services (Canadian Association of Social Workers, n.d.).

Indeed, working for the welfare of children has been an essential component of the social work profession since its inception (Valverde, 1991). However, this work is often intricately connected with moral projects that attempt to regulate children and their families so that they better align with social norms and ideals (Valverde, 1991). As a result, social work has a complex legacy resulting from the role social workers have played as moral entrepreneurs who exercise their moral capital or resources in competition with others to define moral priorities and affect social change (Chapman & Withers, 2019; Ruonavaara, 1997). At best, social workers can provide essential support for people navigating considerable difficulties in their lives. At worst, social work's role in moral projects resulted in the removal of thousands of Indigenous children from their homes and communities (Chapman & Withers, 2019). Thus, how social workers understand and mobilize ideas about trauma in their work with children and youth may help us to explore the moral dimensions of social work practice.

This thesis project exposes and interrogates the moral and ethical dimensions of trauma discourses in social work practice with children and youth. Using moral regulation as a theoretical framework – which examines how people use ideas about right, wrong, normal, and abnormal to constrain behaviours and lifeways designated as 'immoral' in favour of supposedly 'moral' ones – I was able to explore how trauma discourses are intimately connected to ideas about normal and moral ways for children and youth to exist in the world. Further, using critical discourse analysis (CDA) methodology, I was able to analyze interviews and focus groups with registered social

workers (RSWs) in Alberta to explore how language is used to understand and shape these experiences. Together, this theoretical framework and methodology allowed me to answer the following research question: "How do social workers understand and engage with 'trauma' in their work with children and youth in Canada?"

In chapter two, I provide an overview of the academic literatures that helped to shape and inform this thesis project. First, I outline moral regulation as the primary theoretical framework that informs this thesis and describe how social workers have been implicated in moral regulation projects. Second, I explore the construction of the 'normal' child and examine how ideas about normalcy and health are connected to morality. Third, I unpack the connections between social work, medicine, and medicalization as they relate to moral regulation. Finally, I discuss 'trauma' as an idiom for distress that is inherently connected to ideas about morality in ways that make it an ideal discourse for the regulation of children and youth.

In chapter three, I introduce critical discourse analysis (CDA) methodology and how it shaped the design and implementation of this thesis project, outline the rationale of chosen methods and ethical considerations, and detail how critical discourse analysis (CDA) was used to analyze the data to answer the research questions.

In chapter four, I begin to explore the findings from this study. Chapter four explores how social workers see children's 'abnormal' behaviours as signals that trauma has occurred and how this process may obscure or disguise the moral judgements inherent in deciding what is, in fact, normal. This chapter explores how social workers describe trauma as a factor that may result in deviations from normal development and functioning, the many ways social workers describe seeing trauma manifested in

'abnormal' individual behaviours, and how social workers understand the relationship between trauma and 'abnormal' relationships.

In chapter five, I explore how biomedical knowledge is used by social workers to negotiate their own professional expertise. This chapter also explores the biomedical discourses social workers draw upon that legitimize normalcy in relation to child trauma. Finally, this chapter explores how social workers nuance, complicate, or outright challenge the legitimacy of certain biomedical trauma discourses.

In the conclusion, I briefly summarize the findings of the study and how they answer my research question. I explore how this study contributes to the academic literatures on moral regulation, trauma, and social work practice. I also highlight the limitations of this study and identify areas for future research. Finally, I discuss the implications of this study for social work practice with children and youth, particularly how social work's commitment to social justice is often lost when biomedical trauma discourses become dominant in social work practice.

Chapter 2 – Literature Review

This chapter will describe some of relevant literatures which serve as essential background information for understanding the findings of this study. First, I will outline moral regulation as the primary theoretical framework that informs this thesis and describe how social workers, throughout the history of the profession, have been implicated in moral regulation projects. Second, I will explore the construction of the 'normal' child and examine how ideas about normalcy and health are connected to morality. Third, I will unpack the connections between social work, medicine, and medicalization as they relate to moral regulation projects. Finally, I will discuss 'trauma' as an idiom for distress which, when used by professionals or by the public, is inherently connected to ideas about morality in ways that make it an ideal discourse for the regulation of suffering persons and communities.

2.1 Moral Regulation and the Profession of Social Work

The moral regulation literature explores how society engages in "a project of normalizing, rendering natural, taken for granted, in a word 'obvious', what are in fact ontological and epistemological premises of a particular and historical form of social order" (Corrigan & Sayer, 1985, p. 4). Moral regulation projects shape the behaviours or ways of life we perceive as 'normal' or moral and employ a range of discourses and technologies to enforce conformity to these norms. Though moral regulation projects are extremely diverse, Hunt (1999) argues that all moral regulation projects contain the following elements: a moralizing subject (who enacts moral projects), a moralized object or target (who or what is being acted upon), knowledge (informal or expert), a discourse within which knowledge is given a normative content (should or should not, right or

wrong), a set of practices (what to do), and a 'harm' to be avoided or overcome (what could go wrong if the prescribed actions are not followed). Of relevance for this thesis, people draw upon discourses and bodies of knowledge to construct some ways of being in the world as 'right' and 'normal,' which in turn shapes how social interventions are designed to correct the abnormality or immorality of persons or groups who stray from socially constructed norms.

Professionals like doctors, teachers, and social workers play essential roles in moral regulation projects because of the authority invested in them by our social systems. In the moral regulation literature, professionals have frequently been depicted as agents of the state, regulating citizens on behalf of the political elite. For instance, teachers may ultimately use education to benefit the bourgeois class by instilling discipline and work ethic into working class children, whose obedience to authority is intended to make them ideal workers (Barmaki, 2007). However, more recent works have drawn attention to the inherent multiplicity and conflict within 'the State,' which does not act as a unified and cohesive body. Fassin et al. (2015) demonstrate that state institutions, because they are composed of individuals and agencies with often conflicting objectives and priorities, are multifaceted and often contradictory in their regulation of citizens. Those in positions to implement policy do not just enact policies instated from above; rather, they interpret policy as they engage in its implementation. In the act of implementation, agents at times subvert and at others expand the reach of the policy in practice, which enhances the role they play in moral regulation projects. In their engagement in everyday work, professionals both shape and are shaped by wider social processes that impact the regulation of a state's citizens. For Fassin et al. (2015), this means that "in reality,

whether through over-zealousness or conviction, the agents often extend the realm of policies well beyond what is requested. In a sense, they are not content simply with implementing the policy of the state – they make it. They are the state" (p. 5). In fact, Valverde (1991) and Hunt (1999) have argued that in liberal democratic states, like Canada, much of the initiation of moral regulation projects is done by private and philanthropic agencies who, because of their separation from the state, are more able to overtly push for moral and social reform than liberal states with a commitment to more 'secular' public affairs. Because of the separation between state and church, liberal democratic states may struggle to initiate social reform projects whose aims appear overtly religious or moral. However, private and/or philanthropic agencies are under no obligation to distance themselves from moral or religious interests, and thus can act as interest groups that advocate for policy reforms that ultimately uphold religious or moral aims (for example, see Dauda, 2010). This interaction places social workers, who work both in state-run and private agencies, in a position to act as regulatory agents.

2.1.1 Moral Regulation in the History of Social Work

Social workers, particularly through their roles in both philanthropic and government agencies, have frequently been implicated as agents of moral regulation through their work with marginalized populations. As such, the moral elements inherent in the historical development and current operation of the profession are relevant to this discussion. The profession we know as 'social work' today exists because of a complex process of professionalization of social reform and 'helping' work that had been taking place since the late 19th century (Abramovitz, 1996). Beginning in England and taken up by workers in America and Canada in their own unique ways, present day social work is

linked to charitable activities undertaken by privileged women in late 19th century England to improve the conditions of the urban poor (Kennedy-Kish et al., 2017). These charitable activities became more formalized when multiple charities came together under the banner of the Charity Organization Society (COS), which carried out 'scientific' investigations of all persons applying for charitable support. These early social workers, called "friendly visitors," from the upper classes entered the homes of the poor, hoping to instill good manners and a constructive work ethic – which was a more favourable solution to the wealthy elite than providing financial support (Kennedy-Kish et al., 2017). In Canada, too, many philanthropists were concerned about how indiscriminate charity could increase the pauperization of the poor and advocated for 'scientific' philanthropy through charity organization, which would cut down on aid by emphasizing education and moral reform for the lower classes (Valverde, 1991; Hunt, 1999). These social reformers were not only interested in issues of poverty, but also in sexual and social purity, in which the moral subjectivities of citizens were seen as an essential component in building an industrious Canadian nation. In order to build the character of the nation, it was essential to turn attention not only to 'sinners' and the poor, but average girls and boys whose character must be molded through proper education and upbringing to ensure their moral uprightness (Valverde, 1991). This work, while initially being conducted by religious authorities, increasingly took on a 'scientific' or empirical tone through ideas about hygiene and eugenics; however, religious authorities, medical doctors, and early social workers worked relatively peacefully alongside one another, seeing moral and scientific elements of social reform in harmony with one another (Valverde, 1991).

Alongside the skepticism of early social workers who investigated charity recipients believed to be 'imposters' (Valverde, 1991), there also existed another branch of social work concerned with changing the underlying social conditions believed to cause poverty (Abramovitz, 1998). This group of early social workers, most closely associated with the Settlement House Movement in the United States, vied with Charity Organization Societies for authority over the budding profession and had a significant influence on some social reformers in Canada (Abramovitz, 1996; Valverde, 1991). The settlement house movement, which saw early social workers housing themselves within communities to better understand and respond to the social conditions believed to cause poverty (Abramovitz, 1998), never gained traction in Canada the way it did in the United States. The first settlement house, Evangelia Settlement, was established in Toronto in 1902, yet there were only 13 settlement houses in Canada by 1920 (Chapman & Withers, 2019). Jane Addams, a key figure of the Settlement House Movement in the United States, has been described as a founding figure for radical and activist social work practice. In addition to founding the most well-known settlement house, Hull-House, she rallied against war, imperialism, and racism (Chapman & Withers, 2019). However seemingly divided these two histories of early social work may appear at first glance, Chapman and Withers (2019) argue that, in reality, there was considerable overlap between the two that is frequently neglected in the 'standard account' of social work history. Regardless, social work practice continues to feel the impact of this social change-oriented social work, particularly in branches of social work that purportedly emphasize social justice.

In its transformation from informal 'helping' work by well-meaning individuals to a formalized profession, social work had to develop a set of organized theoretical principles about the kinds of work that social workers are uniquely qualified to do, along with practical ways to apply this knowledge. Despite the ongoing activism of social change-oriented workers, a 'scientific' social work gained authority in the professionalization of the discipline, in part because of a belief that only empirical and scientific knowledge could adequately unearth the roots of 'social ills,' but also in part because of the need to brand an appealing social work 'product' for consumers of services (Abramovitz, 1998). This new, scientific social work – which was inspired by those disciplines believed to have empirical methods for observing, measuring, and treating social problems – had the effect of individualizing social problems (Valverde, 1991; Abramovitz, 1998; Irving, 1992). In 1917, Mary Richmond published her book 'Social Diagnosis,' which became a key text in the development of the social work profession. This book established 'case work' as a fundamental component of social work practice and constructed a guide to teach social workers about how to collect evidence about people and their environments to assist social workers in their work with clients (McCallum, 1998; Abramovitz, 1998). Indeed, social work practice in Alberta built upon casework as a professional foundation to legitimize the profession as distinct from nursing and teaching. In 1942, social worker Mary Frost argued that the Eugenics Board and guidance clinics in Alberta would benefit from hiring social workers specifically because of their unique skills in casework and social investigation (Samson, 2014).

Inspired by medicine and the use of scientific knowledge, social work practice thus became focused on constructing individuals in need of help as 'cases' to be investigated and 'treated' by social workers.

> The problematic 'case' which became the object of a newly-theorized social work practice was produced through the mapping of individuals within a social field. Rather than having a general prior existence whose essence or truth is then subject to the historically repressive forces of eugenics or imperialism, 'the social' was formed for the discrete administrative objectives of 'social diagnosis' – in this instance an extension in ever-widening concentric circles of the spaces between individuals (McCallum, 1998, p. 80).

Therefore, one of the critical transformations in the profession included a significant alteration in the relationship between social workers and the people they worked with. For example, moral ideas about people being 'deserving' or 'undeserving' of aid began to be replaced by ideas about social diagnosis, social network analysis, the case and casework (McCallum, 1998).

Like other developing professions, such as nursing, social work modelled itself on medicine. In vying for professional status, social work borrowed from recommendations in Abraham Flexner's report on medical education reform, which included the development of formal, standardized training curriculums for prospective social workers (delivered at the university level), the compiling and development of abstract theories to train recruits, the development of codes of ethics, and the establishment of registration bodies meant to insure the integrity of the profession (Freidson, 1973; Ludmerer, 2010). Indeed, Flexner went on to query whether social work was, indeed, a profession, which ultimately served as impetus for professionalization to enhance social work's legitimacy and authority (Gelman & González, 2016). In Alberta, becoming registered as a social worker was voluntary until the instatement of the Health Professions Act in 2003, though

the Alberta Association of Social Workers (which would later become the Alberta College of Social Workers) had advocated for mandatory registration since its inception in the 1960s (Alberta College of Social Workers, 2005).

While social work distinguished itself from professions like psychology by emphasizing person-in-environment approaches to individual and social problems, psychologically oriented forms of social work practice were prominent in nascent social work bodies like the National Association of Social Workers (NASW) in the United States (Abramovitz, 1998). Similarly, those who were eligible for registration in Alberta, prior to changes in the 1970s, were predominantly master's level social workers with a clinical background (Alberta College of Social Workers, 2005), which enhanced the authority of psychologically oriented forms of social work practice over those practices more aligned with social reform and social justice. Indeed, despite the significant gains of social change-oriented social workers, who were eventually successful in solidifying social justice as a professional mandate after several decades of vigorous social reform efforts, existing divides in social work practice have had the effect of relegating much social justice work to the realm of community social work while individual and group work remains oriented toward changing individuals (Abramovitz, 1998). In effect, social workers who are working more intimately with children and their families may be more likely to draw upon this psychologically oriented branch of social work that is more obviously connected to moral regulation projects**.**

However, for both justice-oriented and individual-oriented branches of social work practice, social workers may struggle to achieve their professional aims under the current political and economic climate. Shdaimah and McGarry (2018) argue that the

current climate of resource-scarcity, high caseloads, and institutional hierarchies create practice environments in which social workers struggle to meet their professional responsibilities and mandates, which may lead to moral strain between one's practice goals and institutional realities. Though social workers have always had to juggle competing roles of care for and control over those they serve, neoliberal welfare policies have promoted a focus on short-term outcomes and managerialism that, consequently, has increased social workers' reliance on the social control aspects of their work at the expense of long-term relationships and community care (Harrison, 2018). Because of the ongoing impacts of neoliberalism on social welfare provision – in which social workers are expected to ensure greater outcomes with less time and fewer resources – social workers must increasingly find creative solutions to work around systems that put barriers in the way of practice (Shdaimah & McGarry, 2019) – a process that a mentor of mine often referred to as 'sneaky social work.'[2]

2.2 Constructing the Normal Child

When social workers work with children and youth, they do so with the understanding that childhood represents its own social, legal, and developmental category. The behaviours and experiences attributed to childhood are different from those expected for adults; therefore, social workers expectations for what kinds of experiences and behaviours are normal for their young clients is based on ideas about normative childhood. This section will explore the concept of 'normal' childhood and how our ideas about childhood are geographically, culturally, and historically contextual.

[2] A regular trope in my ongoing conversations with Dr. Yahya El-Lahib at the University of Calgary.

Age-related categories like 'childhood' and 'adolescence' are socially constructed[3] and intimately connected with the social values of the historical period and culture. The boundaries surrounding what constitutes 'childhood' or 'adolescence' are socially contested and negotiated and, thus, subject to change over time with shifting social values and material realities (Barmaki, 2007). For instance, Barmaki (2007) describes how children in Ontario from 1867-1900 were essentially expected to embody a Protestant work ethic focused on industriousness and decency, just as one might expect for middle-class adults. The distinction between 'child' and 'adult' was based not upon chronological age, but the ability to work. As soon as a child was able to perform labour, they entered the world of adults and were expected to conform to adult expectations – even being imprisoned or deemed insane when they failed to uphold these expectations. Consequently, expectations for 'normal' behaviour for a child in 1890 differ significantly from those for children today, whose childhoods instead are marked by an assumed need for nurture and kindness (Barmaki, 2007).

Social norms and expectations inform the roles that children are meant to assume within their communities and how, in turn, communities respond to them (Rogoff et al., 2008). For instance, attachment theorists argue that strong emotional attachments to a one or a few significant caregivers – observable through facial and vocal expression – are essential for the 'normal' development of children. However, attachment theory is based on the developmental and social patterns of Western, educated, industrialized, rich, and

[3] By stating that something is "socially-constructed," I am referring to features of our social worlds that would not exist how they currently do but for the meaning that people ascribe to them. For instance, there is no universal marker or indicator that a person has transitioned from childhood to adulthood; instead, our social systems dictate when such changes are noted and when social performances are meant to change according to our expectations.

democratic (WEIRD) families (Henrich et al., 2010), who only make up 5% of the global population. When applied to non-Western rural farming communities – for instance, in the case that recent non-Western rural migrants find themselves living in an industrialized Western nation and being assessed by teachers, social workers, or other professionals – the application of attachment theory could be used to argue that parent-child relationships and child development are wrong or abnormal despite the fact they meet their own cultural expectations (Keller, 2018). What this demonstrates is that ideas about 'normal' childhood are both historically and culturally contextual, and that 'childhood' as a social category and structural form is both socially constructed and subject to boundary policing (Corsaro, 2011). Indeed, social workers may contribute to this boundary policing in many ways, such as acting as child welfare agents who pass moral judgement about 'adequate' or healthy parenting for young children.

Since the early twentieth century, one way that the boundaries around childhood and adolescence have been policed is through discourses on development that are based on normalcy and standardization (Turmel, 2008). As the category of childhood became increasingly recognized as one separate from adulthood, public authorities became interested in measuring the qualities and characteristics of this population. This was facilitated largely through social statistics which analyzed various changes in child traits across children's chronological ages. (Turmel, 2008). This process can disguise the moral and normative judgements which inform how data is collected. For instance, though children with disabilities make up approximately 15% of the population, they are regularly excluded from mainstream research on child development. Consequently, the available data used to determine the 'normal' developmental standards against which all

children are assessed are not actually based on what is 'average' for all children (Feldman et al., 2013). Despite this gap, early developmental theories including those of Piaget, psychoanalysis, and learning theory asserted that child development was universal and, therefore, applicable to all children everywhere. This has been problematized by scholars who have revealed that the normative markers for a child's development vary across cultures and are dependent on cultural norms and expectations for how children are meant to behave. Though recent developmental theories have acknowledged the complex interactions between development, culture, and environment, older theories that minimize the impacts of social and cultural factors on child development continue to hold considerable sway in professions responsible for initiating investigations into 'abnormal' child development (Lee, 2010). When examining the role of statistics and developmental theory, it becomes clear that what began as a project to understand the way things are became a normative construct against which children become evaluated (Ben-Ari, 1994).

2.3 The Normal, the Healthy, and the Moral

There is no singular conception of what is considered normal. What is 'normal' depends upon one's culture, which dictates which behaviours are acceptable and how to interpret the behaviours of others (McCurdy et al., 2016). Indeed, anthropologists entering cultures different from their own often must overcome the urge to assume that what is normal for them is also normal for the communities they are learning from (McCurdy et al., 2016). Therefore, an analysis of norms and normalcy must acknowledge the role of culture in shaping 'normal' lifeways. Additionally, how people are expected to behave is also influenced by gender, race, and class. For instance, people are expected to perform gender in socially acceptable ways and straying from these expectations might

be seen as socially 'abnormal' and cause for sanction (Schilt & Westbrook, 2009). In the discussion that follows, I will outline how 'normal' has come to be conceptualized in a Western context, as these ideas are currently dominant in Canada due to settler colonialism, though it is worth remembering that children in social workers' care are socially and culturally diverse and may have competing conceptions of normalcy.

The construct of 'normal' contains within it conceptions of the average, that which can be considered 'healthy,' and that which is acceptable (Turmel, 2008). By framing the average as healthy and/or acceptable, children who deviate from developmental norms are not only abnormal, but 'sick' and/or 'immoral.' As such, defining the 'normal' child has increasingly come under the authority of medicine, which plays an essential role in defining the 'healthy' child.

Though conceptions of 'normal' did not enter medical thought until ideas about pathology changed in the 1920s (Lock, 2003), medicalized discourses legitimize ideas about what is 'normal' in part through the application of statistics. In the mid-1800s, French statistician Quetelet developed the idea of the 'average man' by plotting measured bodily traits on a normal distribution curve. This newly theorized 'average man' was not just average physically, but morally, and, for Quetelet, being perfectly 'average' was associated with moral goodness. However, ideas about 'average as best' underwent an additional transformation. On either end of a normal distribution curve lie extremes in measured traits; however, one extreme may be socially preferable to the other. For instance, if most people are of average intelligence, there are also extremes of low and high intelligence. Though most people are within an 'average' range, the extremes of low and high are no longer weighted equally, for it is better to be of high than low

intelligence. Consequently, statisticians shifted away from idealizing the average and, instead, overlaid a scale of desirability over the normal distribution curve so that one extreme now represented a social ideal to be aspired to (Davis, 1995). Thus, the idea of 'normal' contains within it both ideas about 'average' and 'ideal' simultaneously (Lock, 2003). Indeed, Lock (2003) argues that ideas about normalcy bridge the gap between what *is* and what ought to be, which means labelling a bodily experience as 'abnormal' or 'sick' is loaded with moral import. Ideas about 'sickness' in a population have historically been connected to concerns about moral and social order, and many believed that a 'sick' population could result in moral depravity and social deterioration. Thus, **'**health' and 'illness' are moralized categories and being a 'healthy' citizen has become a moral responsibility (Lock, 2003).

Consequently, by linking 'normal' to 'healthy' and 'abnormal' to 'illness,' it became possible to link social norms and expectations to medical discourses about the body and mind. Thus, medicalization is one possible mechanism by which the 'deviant' behaviours of people become regulated. Professionals can pathologize 'immoral' behaviours – rendering them the consequences of individual sickness – and subsequently naturalize the use of technical solutions (medication, therapy, etc.) in response (Rimke, 2005). For instance, under 'scientific' eugenic paradigms, doctors justified the sterilization of so-called feebleminded women to ensure their 'condition' – which could have been anything from single parenthood to disability – would not be passed onto the next generation, thus impacting the character of the Canadian nation (Valverde, 1991). This eugenic paradigm was supported by ideas about 'normal' and 'average' – in particular, eugenicists believed that the population can be 'normed,' slowly shifting what

is ‘average’ toward that which is socially desirable (Davis, 1995). Thus, through medicalization, moral projects take on an aura of objectivity that allows them to shake off some of the overt moral tones associated with more religious and social reform projects.

2.4 Social Work, Biomedicine, and Medicalization

It is important to explore the interconnections between social work, biomedicine, and medicalization because of social work’s use of biomedical discourses to advance moral regulation projects throughout the profession’s history. Indeed, social work has been strongly affected by medicine both through the incorporation of biomedical discourses into social work practice and through working within the arena of ‘health’ which is governed by medicine (Conrad & Schneider, 1992). Gomory et al. (2011) argue that social workers benefit in both occupational prestige and salary from working closely alongside the biomedical industrial complex – a term used to describe the powerful interconnections between the medical profession and pharmaceutical and biotechnological industries.

The sociology of medicalization is a scholarly approach that explores the expansion of medical knowledge into the realm of social problems and human behaviours. This approach interrogates how medicine has expanded its professional jurisdiction and the consequences of these processes (Conrad & Schneider, 1992). While illness may exist as a biological fact, Eliot Freidson (1973) has also argued that illness exists as a social fact. In applying an illness label to a bodily experience, in imbuing the experience of illness with social meaning, and responding to bodily experiences in social systems, medicine is involved in the construction of illness as a social state. Through the

application of biomedical knowledge and technology, the profession of medicine has garnered near-complete authority over how illness is defined (Freidson, 1973).

When social workers draw upon medicalized discourses in their practices, they risk individualizing the problems experienced by their clients. Consequently, interventions may be targeted at changing the individual, rather than responding to the impact of social and environmental forces on individuals' lives (Gomory et al., 2011). And while social workers may resist the medicalization of their clients, they often must rely on medical technologies like the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (2013) to ensure that clients can access insurance to cover the costs associated with seeking professional support (Gomory et al., 2011). This occurs because of medicine's monopoly over definitions of health and illness, and the significant control physicians have over the working of other professionals whose occupations intersect with their own – a fact solidified by physicians' orchestration and supervision of all activities seen as 'medical labour,' which includes the everyday workings of many social workers (Freidson, 1973). For as long as professions like social work rely upon medical understandings of social problems, they may struggle to gain complete autonomy over their work and, consequently, integrate social justice work into their practice.

Though medicalization has subsumed a wide range of human experiences (for instance, birth and aging – see Lock, 2003), medicalization is not always connected to moral projects. However, medicalization may be involved in moral regulation projects when deviant or immoral behaviours come to be pathologized as illnesses. In such instances, biomedical discourses may be used to subject deviant or 'abnormal'

individuals to treatment and confinement in order to preserve or assert a dominant social order (Rimke, 2005). Indeed, the assumption that human problems can be addressed and resolved through the application of science lends a sense of objectivity to medicalized discourses used to explain deviance and abnormality (Rimke, 2005). Consequently, social workers may – perhaps neither intentionally nor willingly – draw upon medicalized discourses in their work that effectively disguise the moral and regulatory elements of their practice. For instance, through medicalizing human suffering as 'trauma,' moral notions about right or normal ways of being in the world may be obscured.

2.5 Understanding 'Trauma'

In reviewing the literature, it becomes clear that what constitutes 'trauma' is highly contested. In fact, trauma is described differently depending on the speaker, the circumstance, and the context. Consequently, rather than trying to define what 'trauma' *is*, we can understand 'trauma' as any number of diverse discourses used to account for and respond to human suffering. Borrowing from Purvis and Hunt's (1993) definition of 'discourse,' which they describe as "the way in which language and other forms of social semiotics not merely convey social experience, but play some major part in constituting social subjects (the subjectivities and their associated identities), their relations, and the field in which they exist" (p. 474), discourse here refers to the often linguistic way that knowledge about the world becomes solidified and regulated in ways that shape social action (Jäger, 2001). Since 'trauma' is only one of many ways of describing human pain, the use of trauma discourses over others should not be taken for granted and is worthy of further exploration since trauma discourses are mobilized to do different kinds of work.

The following section will describe the two main ways social scientists have talked about 'trauma' discourses and how they are used by individuals and communities. However, it should be noted that the distinction made here between 'medicalized' and 'sociocultural' discourses is artificial, and while this categorization can be helpful to identify competing perspectives in the academic literature, these discourses often intersect with one another in sometimes conflicting and otherwise complimentary ways that impact how communities respond to persons in distress.

2.5.1 Medical 'Trauma' Discourses

One of the ways trauma is talked about is as a biological phenomenon. While 'trauma' is also a word used to describe bodily injury, the idea of trauma has expanded significantly. Medical discourses, while diverse, often frame 'trauma' as the biological impact of challenging experiences on an individual's mind and body – in particular, experiences of distress are said to have long-term impacts on the sympathetic nervous system. Seeing distress as something occurring within an individual body makes it more likely that suffering is responded to as an individual problem that is 'treatable' through medical therapies (Young, 1995).

This way of understanding human suffering emerged only relatively recently and within Western contexts. Prior to and during the first world war, trauma was not conceptualized as a psychological problem; rather, doctors originally believed that the suffering seen in soldiers originated from a physical shock that caused physical damage to the body, which would eventually reveal itself through physiological examination. However, when physiological evidence did not prove forthcoming, doctors began to reconceptualize 'trauma' as something occurring within the human mind (Young, 1995).

Locating human suffering in the mind had complex moral and social consequences. For instance, prior to the development of PTSD diagnostic criteria, soldiers displaying mental distress were given various diagnostic labels related to 'war neurosis,' each with different social connotations. Lower ranking soldiers were diagnosed with 'hysteria,' as opposed to higher ranking officers of innately 'good character' who were given diagnoses of 'neurasthenia'. Unlike neurasthenia, which was morally ambiguous, hysteria was a sign of mental and moral weakness. Soldiers diagnosed with hysteria were not only weak, but they were also believed to be using their weakness to shirk their responsibilities in war – the treatment of which included major force and even electric shock to get them to give up their malingering ways (Young, 1995).

More recent medical discourses about trauma often focus on post-traumatic stress disorder (PTSD), which is a diagnostic category initially created to respond to the suffering of Vietnam veterans upon their return home from war. A far cry from the implications of 'war neurosis,' the PTSD diagnosis was not only created to help clinicians respond to the mental suffering of their clients, but to legitimate the experiences of war vets who were often seen unfavourably by their communities as having participated in a 'dirty war' (Young, 1995). By framing their suffering as a psychological disorder, a PTSD diagnosis attempted to morally exonerate veterans as 'victims' of the war, not perpetrators of violence (Summerfield, 2001). According to Summerfield (2001), not only do medical discourses exonerate veterans, but they also construct them as victims deserving of compensation by the military for the harms they experienced in the line of duty.

Now, a wider range of people are being diagnosed with PTSD. Additionally, medical discourses about trauma are sometimes applied even to those who do not meet PTSD diagnostic criteria. For example, biomedical discourses identify childhood trauma as a contributing factor in the development of many mental health disorders, including borderline personality disorder (BPD). Understanding BPD as the result of 'trauma' has the effect of destigmatizing it, or as Kenny (1996) says, "… it is far better to be a victim of traumatic child abuse than a troublesome pain in the neck…" (p. 165). Here we can see that medical trauma discourses can be used to address blame and responsibility, including trying to convince trauma 'victims' that the suffering they experience is not their fault (Lester, 2013). Medical trauma discourses may cast the victim as a person without agency, someone who was helpless in the face of an experience that wounded them physically and psychologically. Hence it becomes possible for social workers to use medical trauma discourses in compassionate ways, teaching a host of others (social work staff, teachers, foster carers, etc.) to be patient and gentle in their approach with children who are 'helpless' (i.e., not responsible) in the face of their suffering.

Additionally, medical trauma discourses are employed for many other reasons. For example, doctors may use medical discourses to 'prove' that a person seeking asylum has genuinely suffered, has been victimized, and is worthy of support (Kohrt & Hruschka, 2010). Even in this short discussion, we can see how the moral meanings of medical trauma discourses have shifted over time – where once trauma discourses were used to frame suffering people as illegitimate compensation-seekers, trauma discourses are now used to frame trauma victims as legitimate and deserving of compassion and

reparation (Fassin & Rechtman, 2009). What these moral meanings also demonstrate is that medicalized trauma discourses may be used to inform moral regulation projects.

2.5.2 Sociocultural 'Trauma' Discourses

However, medical discourses are not the only ones used to talk about experiences of distress. Human suffering is understood differently depending on the social and historical context in which it is being discussed and the term 'trauma' may or may not be used to describe these experiences.

Experiences of suffering occur within cultural milieus, which influences both how individuals in distress understand their own suffering and how their communities respond to them. Additionally, one's culture may provide conceptual frameworks and tools to either help or inhibit how someone copes with experiences of suffering (Scheper-Hughes, 2008). Cultural frameworks for understanding distress present alternative ways of making sense of human suffering. For example, in Central and South America, events we might understand as 'traumatic' could also be explained by the experience of the illness 'susto.' During this illness, a person experiences the loss, instability, or rupture of their soul because of a significant fright. Consequently, this necessitates a different response from the community than if the experience was labelled as PTSD; the individual would undergo soul healing under the consultation of a local expert, rather than receive pharmaceuticals or other Western 'treatments' (Kenny, 1996).

Communities may evoke discourses about trauma to explain experiences of communal suffering. For example, according to Alexander (2016), "*cultural trauma* occurs when members of a collectivity feel they have been subjected to a horrendous event that leaves indelible marks upon their collective consciousness, marking their

memories forever and changing their future identity in fundamental and irrevocable ways" (p. 4, emphasis mine). Though cultural trauma is comprised of the experiences of individuals within a collective, the threat to the collective carries significant spiritual, emotional, or intellectual import (Alexander, 2016). Additionally, collective trauma discourses can be used by communities to challenge official histories, particularly historical narratives that paint the actions of a violent group in a neutral or positive light that, in reality, caused significant harm to another (Das & Kleinman, 2001). For example, collective or intergenerational trauma discourses may be used to explain the suffering of Indigenous peoples, whose current suffering is framed by events which occurred before their own lifetime. Despite the chronological separation between the initial event of collective suffering, collective trauma discourses can help illuminate the connections between past and present, collective and individual suffering (Ball & O'Nell, 2016).[4] Here, we can see how sociocultural trauma discourses contribute to the 'moral economy' of trauma; 'trauma' is not just an experience (or the aftermath of an experience), but a *resource* used to support a right, and to advocate for access to supports, reparation, and more (Fassin & Rechtman, 2009).

It is important to note that sociocultural discourses do not inherently exist on their own apart from medical ones. Rather, medical discourses are often appropriated by individuals and communities, and become enmeshed in sociocultural discourses like the ones discussed above. Abramowitz (2014) describes this process as the "vernacularization of the concept of trauma" (p. 11). This concept of 'vernacularization' is used by Abramowitz (2014) to explore how Liberians have taken the concept of

[4] This is not to suggest that Indigenous individuals and communities do not also experience current harms; for instance, the removal of Indigenous children from their families is ongoing.

trauma, with both its local and biomedical connotations, and made it their own. However, drawing upon medical trauma discourses in these social contexts can also serve a depoliticization role. Medicalizing a person's suffering may individualize their experience, failing to address in 'treatment' the social complexity of harm. For example, 'trauma victims' who were tortured as revolutionaries may not see themselves as 'victims' and, instead, find that this label erases their experiences as political agents (Scheper-Hughes, 2008).

Thus, the literature demonstrates 'trauma' discourses – medicalized, sociocultural, and various combinations thereof – are used to do different kinds of work. Trauma discourses can be used to make 'treatable' intense experiences of personal suffering, exonerate or question acts of violence committed in the name of the state, validate claims of victimhood, fight for compensation and support following suffering or injustice at the hands of another, bind people together in solidarity, and make sense of intensely profound and often inexplicable human pain. Therefore, how we talk about human suffering or distress is not morally neutral.

When we consider the moral dimensions of trauma discourses, professionals in positions to respond to human suffering are particularly worthy of study. Professionals, like physicians or social workers, are consulted following hardship precisely because professionals are expected to *do something* about the suffering of those under their care (Freidson, 1973). Yet how they respond to suffering depends not only on the expectations associated with their professional roles, but how they understand and interpret the distress they are required to respond to. And in so doing, professionals like social workers negotiate issues of blame, responsibility, right, and wrong, which may be used to regulate

both the suffering individual and those connected to them. Like Fassin and Rechtman (2009), who aim not to question whether or not suffering individuals are indeed suffering from 'trauma,' but to trace the historical shift from illegitimate to legitimate victim, this thesis explores the flexible and curious ways trauma discourses are employed by social workers to respond to the experiences of Canadian children and youth. What I discovered is that social workers frequently draw upon biomedical ideas about trauma to distinguish 'normal' children and childhood from the abnormal experiences and consequences that traumatized children embody, but also that the moral dimensions of trauma also complicates this process considerably for social workers working with children and youth.

2.6 This Study

In the last several decades, experiences of distress have increasingly been explained using medicalized discourses that frame distress in terms of genetic susceptibility or neurobiological imbalance. The medicalization of distress, particularly as 'trauma,' has become widespread and frequently dominates over other, sociocultural explanations for distress. Increasingly, even social workers are using the language of biomedicine to explain their clients' challenges (Gomory et al., 2011). This may be true even for social workers in communities who draw upon medical trauma discourses in their activist work.

Social work has been engaged in projects of moral regulation since before it transformed from an informal set of practices to a unified profession. Thus, contemporary social work discourses that may inform how children and youth are regulated are worthy of further exploration. Moreover, how social workers employ medicalized trauma

discourses to engage in moral work remains understudied. As professionals aligned with social justice who aim to promote the wellbeing of the most marginalized, social workers may use trauma discourses in constructive ways to promote these aims. However, trauma discourses may also be used to govern and regulate those who social workers profess to help, perhaps aided by the supposed objectivity and moral neutrality of medicalized discourses that obscure trauma as frequently moral category. Consequently, this study contributes to the literatures on moral regulation and the sociology of health professions by exploring how 'trauma' is conceptualized and mobilized by social workers in their practices with children and youth, whose 'moral subjectivities' have long been the focus of moral and social reform, sometimes with disturbing consequences.

Chapter 3 – Methods and Ethics

Data for this study was collected using a combination of two synchronous, online, text-based focus groups and nine in-depth semi-structured interviews conducted online using collaborative teaching software (Collaborate Ultra by Blackboard). This chapter will introduce critical discourse analysis (CDA) methodology and how it shaped the design and implementation of this study, outline the rationale of chosen methods, describe ethical considerations for this project, and detail how CDA was used to analyze the data to answer the research questions.

3.1 Critical Discourse Analysis (CDA)

The goal of this study is to observe how trauma discourses are shaped and mobilized by social workers working with children and youth, and to inquire about how these discourses may inform social work practice. Critical discourse analysis (CDA) is a methodological framework used by scholars to make clear the various ways that discourse is connected to social practice and power (van Dijk, 2008). CDA is a critical linguistic approach that emerged in the early 1990s that understands text and talk as basic units of communication and recognizes that language may be used to legitimize and reproduce relationships of power and control. Thus, through examining how language does this, CDA scholarship opens up possibilities for resistance by drawing attention to the often-hidden way language is used to promote the interests of those in power. Unlike some other forms of discourse analysis, CDA scholarship creates strong connections between research interests and political commitments (Wodak, 2001). CDA scholars openly take the side of the oppressed or suffering and turn their scholarly attentions to analyzing those in power. For instance, in this study, I chose to turn my attentions to social workers as agents who have considerable power over the children they are meant

to serve. Rather than focusing on children themselves and how they are constituted as subjects – a secondary outcome of this study – I focused on how power operates through social work discourses as my point of analysis and critique. Perhaps uniquely, CDA scholars are more bound together by a shared research agenda than by a common theoretical or methodological framework, and there is no set of prescriptions or definitive guidelines that inform how CDA research should be conducted. Consequently, there is considerable heterogeneity in how CDA research is conducted (Wodak, 2011).

Discourse can be understood as that which is or can be said within a society at a given time, along with those strategies to constrain what should not be said. "Discourses exercise power as they transport knowledge on which the collective and individual consciousness feeds. This emerging knowledge is the basis of individual and collective action and the formative action that shapes reality" (Jäger, 2001, p. 38). Therefore, CDA scholars argue that discourses shape not only our perceptions of the world, but our actions which, in turn, shape the material world. For instance, trauma discourses may influence the attitudes and opinions of social workers, policy makers, and other stakeholders in ways that directly impact which programs get funded, which approaches to trauma are deemed appropriate or beneficial, and how traumatized individuals are socially responded to by professionals and members of their communities. Further, CDA scholars emphasize the ways that power and domination are produced and reproduced through everyday discourse (van Dijk, 2001). By turning one's attention and analysis toward those in positions of power, CDA scholarship helps to make clear what are often hidden relationships of power and control that manifest themselves through language (Wodak, 2001). Because CDA scholarship is attuned to the complex relationship between

discourse, social action, and social structures (van Dijk, 2001), CDA was chosen as a useful tool to help me analyze how social power is reflected in and reproduced by dominant social work discourses about trauma.

3.2 Recruitment

This study explored the perspectives of registered social workers (RSWs) in Alberta[5] who work with children and youth from birth to age 17. Though work with infants and very young children often involves whole families, this study included social workers who work with infants to explore at which age traumatization and moral responsibility are thought to become possible. Social workers in Alberta were chosen as the study population because of ease of recruitment (I was trained as a social worker in Alberta and therefore had extended personal contacts there).

Though it is not possible to draw definitive conclusions about how Alberta social workers' responses might be different from RSWs in other provinces without a comparative sample, social workers are undoubtedly influenced by the environments in which they work. Some of this study's participants noted that changes in provincial government and subsequent funding retrenchment have a significant impact on social service provision in the province:

> The system is chronically underfunded. The system it – um (pause) the underpinning ideologies of the system change every time the government changes. [Brooke: Mm] People working in the systems don't change, but, you know, the ministries responsible for the direction of those systems… every time

[5] This study aimed to recruit RSWs from both Alberta and Nova Scotia; however, it proved extremely difficult to recruit in Nova Scotia for reasons that remain unclear. One Nova Scotia-based RSW participated in the first focus group and the remaining participants practiced in Alberta. Because the Nova Scotian social worker participated anonymously in the focus group and it is impossible to distinguish their contributions from their peers, it is impossible to draw comparisons between practices in either province. Further, though the Nova Scotian social worker may have been quite active in the first focus group, the majority of the data used in this thesis comes from individual interviews with Alberta RSWs, which minimizes the overall impact that the Nova Scotia-based participant has had on the overall data set. Therefore, this thesis will focus on the Alberta social work context exclusively.

> governments change, ideologically can switch. And I think that's really hard on people. Um, you know, in places like Alberta where the predominant ideology is conservative, that doesn't necessarily fit well with a – with a well working, responsive, proactive, um, social service system. (Bryan, interview)[6]

Several social workers suggested that the chronic underfunding of social services in Alberta contributes to professional burnout and vicarious trauma in social workers. Consequently, it is entirely possible that this context of perceived scarcity plays a role in the responses I received in this study and that this study may have received different responses from a sample taken from another province.

To be eligible to participate, RSWs had to be registered with the Alberta College of Social Workers (ACSW) and practice primarily with children and youth either currently or within the past two years. Eligible social work practice included front-line care, counselling, or programing to children/youth, those who directly supervise youth-serving frontline staff, and social work researchers whose work focuses predominantly on child/youth issues. Social workers were excluded from this study if they were not currently registered with ACSW, if they only serve youth periodically in their practices, or if their work with children and youth was in a capacity outside of social work (for example, if they have volunteered with children and youth but not practiced as a social worker with this population).

Participants for focus groups and interviews were recruited using the same process. I distributed recruitment posters (Appendix A) through my own professional contacts using email and Facebook. Additionally, recruitment posters were sent to faculty members and field coordinators at the University of Calgary. The communications team

[6] All participants' names used here are pseudonyms, chosen by the author in the case of individual interviews or chosen by participants themselves in the case of focus groups.

at the Faculty of Social Work at the University of Calgary also shared my recruitment material on their website. Recruitment posters were forwarded to the Alberta College of Social Workers (ACSW). My recruitment poster was circulated to members of ACSW through a regular email communication to all members.[7]

Participants contacted me via email and completed screening during our email exchanges (Appendix B). In addition to confirming eligibility, participants were asked which agency they were currently working for so that participants working at the same agency were not placed in the same online focus group. All participants were provided with a copy of the informed consent document at this time and were encouraged to ask any questions they had. Both online focus group and interview participants had their consent documented via written or digital signature on the informed consent document prior to participation.

This study recruited 11 registered social workers (RSWs). Initially, I had hoped to recruit approximately 18 RSWs for this study; however, recruitment proved more difficult than I anticipated. I speculate this was, in part, due to the added constraints and pressures social workers may have been feeling because of the Covid-19 pandemic. However, it is also possible that recruitment was challenging because of my focus on social workers who practice primarily with children and youth, which narrowed the pool of prospective participants considerably. Finally, though I could have extended the duration of data collection until such a time that I reached my initial recruitment goals, I

[7] These same procedures were followed in Nova Scotia, including contacting social worker faculty at Dalhousie University, and connecting with the Nova Scotia Association of Social Workers and the Nova Scotia Association of Black Social Workers.

was surprised at how many participants were willing and interested in participating in both focus groups and interviews, which minimized the need to continue recruiting.

The first phase of data collection was conducted in October 2020 and involved one synchronous online text-based focus group with five RSWs, which used an online platform to facilitate a chat-room style conversation amongst participants. This first focus group was exploratory in nature, attempting to identify which discourses social workers use and how they are mobilized in their practice with children and youth (Appendix C). For the second phase of data collection, nine interviews were conducted between October 2020 and December 2020, five with participants who also attended one of the focus group discussions and four who participated in an interview alone. Additionally, all participants were invited to participate in a second online synchronous focus group at the end of the data gathering phase, which served as an opportunity to discuss preliminary findings and themes with participants to check the accuracy of data gathered and to clarify any remaining issues. The second focus group was conducted in January 2021 and included three RSW participants, two of which also attended the first focus group.

Demographic information – including gender, race/ethnicity, age, and years of practice experience – were collected to contextualize interview findings and to provide an overall picture of the diversity of perspectives accessed during data collection. Nine participants identified as White (or Caucasian), one did not identify themselves, and one identified as Southeast Asian-Canadian. Seven participants identified as female and four identified as male. Years of practice experience ranged from 2.5 to 35 years. The majority of RSWs interviewed were in their late 20s or 30s; however, three RSWs were aged 40 or older.

3.3 Data Collection

Data was collected using Collaborate Ultra, which is an online tool that includes both audio-visual and text-chat functions. During focus groups, participants were asked to type their responses to questions and to each other in a textbox on the screen rather than using audio-visual tools to maintain confidentiality. These text discussions were extracted to serve as focus group transcripts. The audio-visual feature of Collaborate Ultra was used for interviews.

3.3.1 Vignettes

Participants in the first focus group were asked to read three clinical practice vignettes sent to them via email in advance of their participation in the study (Appendix D). Vignettes involve the presentation of practice scenarios that participants are asked to comment on, particularly how they feel about the situation or how they would respond to it (Holley & Gillard, 2018). Participants draw upon their 'stock knowledge,' beliefs, and assumptions to inform how they would respond to the situation presented in the vignette (Jennings et al, 2010). The vignettes helped to provide structure to the focus group by introducing scenarios that encouraged group discussion on facets of social work practice. Vignettes were chosen for this study as they have been successfully used in exploring contested concepts that impact professional practices. For example, Holley and Gillard (2018) developed a series of practice vignettes to explore recovery and risk management discourses and how they shaped the work of mental health practitioners. "Vignettes offer a methodological tool which potentially enables the researcher to explore the varied meanings individuals might attach to particular constructs without overtly imposing their own understanding through the data collection process" (Holley & Gillard, 2018, p. 372).

As none of the vignettes used the word 'trauma', this allowed me to observe whether trauma discourses would be employed by RSWs in their responses to vignettes, or if alternate discourses would dominate.

3.3.2 Online Text-Based Focus Groups

On the day of the focus group, focus group participants received an online link to the Collaborate Ultra discussion 1 hour prior to the meeting time to minimize the likelihood that the link to the online session would be shared with others. Participants were asked to click on the link to join a discussion and enter a pseudonym to ensure confidentiality. The session settings were adjusted so that participants' cameras and microphones were disabled. During the first focus group, participants engaged in a real-time, text-based discussion about the vignettes and their practice experiences with other RSWs. Discussions were limited to 90 minutes to limit the demands on participants' time while also being long enough to gather sufficient data.

Focus groups were used here as a complement to in-depth interviewing. While interviews allow for an in-depth exploration of one person's perspective, focus groups help to cover the breadth of a topic, by exploring a multiplicity of perspectives and experiences simultaneously. For this reason, focus groups are frequently employed, as they were in this study, to generate initial data or to explore a topic about which not much is currently known (Liamputtong, 2011). Additionally, the focus group setting allows the researcher to build upon the collective experience of all participants in the room (Johnson, 1996). Because focus groups generate collective, discursive data, focus group methodology aligns well with analysis strategies that focus on discourse (Liamputtong, 2011). The use of focus groups in this study allowed me to observe how trauma

discourses are shaped and mobilized by participants as well as inquire about how these discourses inform social work practice.

Online focus groups also yield certain practical advantages. First, the use of an online platform allowed me to interview RSWs in Alberta from my home in Nova Scotia. Second, the use of text-based online focus groups eliminated the need for transcription, which was both time saving and ensured accuracy regarding participants' contributions (Williams et al., 2012). Third, though focus groups were conducted synchronously, brief lulls while participants were typing provided me with more time to think about probing questions and to verify understanding about what participants meant, which enhanced data analysis and may have contributed to improved rapport between myself and participants (Williams et al., 2012).

Additionally, conducting focus groups online may also offer some advantages for maintaining participant anonymity. For example, participants were required to enter Collaborate Ultra using a non-identifying username, which increased the anonymity of each participant by separating their participation in the focus group from their name, image, and email address (Bampton et al., 2013). Zwaanswijk and van Dulmen (2014) surveyed online focus group participants and found that the majority expressed a preference for online focus groups compared to face-to-face focus groups and one of the major reasons for this is the ability to participate from a preferred location, including home. This was essential since this research was conducted during the COVID-19 pandemic, which resulted in widespread use of social distance policies, the closure of many public spaces, and an increased number of people working from home that ultimately made data collection by other means virtually impossible.

Despite these advantages, moving focus groups to an online platform presents certain challenges. For instance, both the recruitment strategies used and the use of online focus groups and interviews limits participation to those with access to internet (Debenham, 2007). Consequently, this study may not have reached social workers without internet access. The use of online platforms also presents challenges in terms of technological proficiency and participants' comfort level with using online technologies. However, levels of technological proficiency have increased significantly in recent years (Bampton et al., 2013). This may be even more true during the pandemic circumstances in which this research took place, as technology provided many with the means to maintain ongoing contact in their social and professional networks in lieu of in-person communication. However, because text-based focus groups occurred synchronously, participants who could type faster had an advantage over participants who type more slowly; fortunately, some of this can be mediated through facilitation techniques (Debenham, 2007; Liamputtong, 2011). Though in an online setting it was not possible to delay the contributions of more active participants until quieter members had the opportunity, the contributions from quieter members were sometimes solicited directly by asking them for their thoughts on an issue before moving forward with additional questions or discussions. Additionally, through the text-based medium, it was possible for me to scroll back to quieter members' contributions to ask further questions for elaboration, which helped to prevent quieter participants from getting lost amidst the contributions of others.

Some scholars also worry that, compared to in-person focus groups or interviews, it is easier to 'hide' or construct a favourable persona in online spaces (Bampton et al.,

2013). However, some of these concerns may be mitigated by using secure online platforms and the fact that participants are 'hidden' may be liberating, permitting more honest, detailed, and reflective responses (especially about socially undesirable behaviour) than would be offered in an in-person focus group (Bampton et al., 2013; Liamputtong, 2011). While some scholars may express concerns about the information that is lost from facial, body language, and voice cues, others have observed that text notations, intentional misspellings, and the use of emojis is another way that participants add their unique expression to text-based focus groups (Liamputtong, 2011).

3.3.3 Online In-depth Interviews

Following the first online focus group, I began conducting individual interviews. As with focus groups, interview participants received a link to a Collaborate Ultra meeting 1 hour prior to the meeting time. Because interviews were one on one with the lead researcher, participants were not muted and could choose whether to have their cameras on. All interview participants attempted the use of the camera, though technological issues meant that two participants' cameras never connected, and cameras occasionally had to be turned off during the interview to account for connection issues. The length of interviews varied from fifty to eighty minutes and followed a semi-structured interview guide that encouraged participants to reflect upon their own practice experiences [Appendix E].

Conducting interviews online was chosen as a methodology because of the accessibility and pandemic considerations noted previously. While it should be acknowledged that body language, facial expressions, and voice intonations can be lost in some online research (Bampton et al., 2013), using the video conferencing feature of the

software in seven out of nine individual interviews permitted access to some of this valuable data.

Interviews built upon key themes and discourses identified in the exploratory focus group, but also delved more deeply into individual thoughts, beliefs, and knowledge that shape social work practice. Semi-structured interviews are scheduled activities that explore a list of topics and follow a general script, but questions remain open ended to allow for unexpected findings (Bernard, 2002). Individual interviews are important for assessing which trauma discourses are used by individual social workers, particularly those individual workers who may not feel comfortable discussing in front of their peers. Further, interviews allowed me to explore the agreements or conflicts individual social workers had with broader social work discourses that may not have been shared in the focus groups because of the discomfort some participants might feel discussing this in front of others. Finally, in-depth interviews are important for helping me to reconstruct and interpret the "landscapes of meaning" social workers use to make sense of 'trauma' and its impacts on themselves, their clients, and their practice (Pugh, 2013, p. 49). Pugh (2013) uses the above term to describe how interviews allow the researcher to simultaneously access different types of information that, put together, tell the researcher about culture. Contrary to the claims of cognitive culturalists who would argue that discourse (obtained through interviewing) represents only an after-the-fact rationalization of cultural knowledge that people enact unconsciously, Pugh (2013) argues that interviewing allows the interviewer to access and understand participants' thoughts, motivations, feelings, and beliefs in a nuanced and thoughtful way (Pugh, 2013, p. 49). For this study, these elements are essential to making sense of how individual

social workers' thoughts and beliefs make sense within broader social and cultural patterns. These elements are not separate from the trauma discourses studied here; rather, these elements provide essential context to understanding how trauma discourses influence the actions and social workers.

3.3.4 Confidentiality, Data Security, Risks, and Benefits

Participants were regularly reminded that they could discontinue participation at any point during interviews/focus groups. Interview participants could withdraw their interview in part or full up to one month after the interview date. Focus group participants were made aware that their individual contributions could not be withdrawn from the focus group because of its impact on the complete data set, which already contained other participants' responses to their contributions. However, participants were informed they could leave the focus group at any time, discontinuing further participation.

Focus group participation was anonymous, since participants entered the focus group discussion using pseudonyms that make participants anonymous to each other and that separate their contributions from their identities known to the researcher. Data collected through in-depth interviews was not anonymous; however, contributions were de-identified in the process of transcription. Only the primary researcher had access to participants' data for the purpose of data analysis.

Data was collected and stored entirely using the primary researcher's personal, password protected laptop. Text files for focus groups and interview transcripts were password protected and encrypted. Audio-recordings were captured using a personal, portable audio-recorder placed beside the lead researcher's laptop speaker during interviews. Interview recordings were deleted from the audio-recorder immediately after

being transferred to the password protected laptop. Audio-recordings of interviews stored on the laptop were deleted immediately following transcription, which was completed by myself.

This study posed few risks for participants. However, risks to participants included moral discomfort when discussing practice vignettes that present ethical dilemmas or challenges. Interview participants who participated in the final focus group were also made aware that their de-identified data from interviews could be raised as a topic for discussion. Even though they would not be identified as the source, hearing how other social workers respond to these tensions had the potential to be uncomfortable. Lastly, where complete anonymity and confidentiality could not be assured, it is possible that participation in the study could lead to some professional fallout over expression of unpopular perspectives. Though efforts were made to keep participants from the same agency in different focus groups, it is possible that participants may be known to each other in other ways. To address this, focus group participants were asked not to share any information discussed with anyone outside of the group (though their cooperation could not be guaranteed). Additionally, participants' identities were protected by entering focus groups using pseudonyms. With these precautions and by informing participants about limitations to confidentiality, they had the option to modify their contributions according to their comfort level. Therefore, these risks were minimized.

Participating in this study presented no direct benefits for participants, though participants were provided with a $10 gift card to either Starbucks or Tim Hortons as a thank you gesture for their contributions to this study. I believed that social workers may welcome an opportunity to share their experiences and concerns with others. Particularly

for those in front-line positions, participating in research is an opportunity to share practice expertise with those in other arenas. Indeed, several participants expressed that they enjoyed the conversations that took place during data collection.

3.4 Data Analysis

The text-files and transcripts from two focus groups and nine individual interviews, respectively, were analyzed using critical discourse analysis (CDA) methodologies. Though some scholars have argued that interview data is not conducive to discourse analysis because it is not 'naturally occurring' discourse, Taylor and Littleton (2006) have argued that interviews are a form of social interaction that are quite natural and widespread in western societies. As such, interviews follow social conventions that are familiar enough to participants to generate useful data. Further, many interviews – including the ones conducted for this study – often take on more conversational forms. I argue that for this study, the shared identity of 'social worker' between researcher and participant also enhances the familiarity of interview communications. Further, Taylor and Littleton (2006) argue that discourses produced through interviews are not separate from innate motivations and culture that researchers attempt to understand. Though participants may supply additional meanings and motivations to their actions in the retelling of things that were not, in fact, present during their initial actions, in doing so, they are "resourced and constrained by larger understandings which prevail in the speaker's social and cultural context" (Taylor & Littleton, 2006, p. 24). Thus, participants draw on pre-existing discourses in their responses to interview questions, which is relevant data for a study on social work 'trauma' discourses.

Interview and focus group transcripts were coded using van Dijk's (2001) basic categories for CDA analysis (discussed further below) which explore both the ways individuals and groups make sense and meaning from chosen topics as well as how broader social and historical context are interwoven into discourse. A CDA analysis inspired by van Dijk's (2001) socio-cognitive framework was chosen for this project because it takes into consideration some of the cognitive elements of discourse and its relation to society. Though CDA scholarship is methodologically diverse and any number of approaches – for instance, those that focus more on the historical, social practice, or other perspectives – might have been useful, a socio-cognitive approach was chosen for this study because it was the mostly likely to help me answer the research question, which focuses on social workers' *understanding* of and engagement with trauma discourses. van Dijk (2001) argues that the problems CDA scholarship is interested in studying are inherently both cognitive and social. Cognition refers to both individual and social thoughts, beliefs, goals, evaluations, emotions, mental structures, memory, representations, and more. Therefore, a socio-cognitive approach is useful for exploring social workers' thoughts, beliefs, and feelings about trauma in children and youth, as well as how they make sense of the connection between these ideas and their more tangible daily practices. Specifically, by turning my attention to how social workers make sense of childhood trauma, this framework allowed me to consider processes like internalization (personal meaning making following social events or encounters), individualization (how social phenomena or problems come to be framed as belonging uniquely to individuals), and responsibilization (the ways individuals are made responsible for circumstances not

entirely inside their own control) as mechanisms of social power that operate through the thoughts and beliefs of individuals.

First, data was analyzed for semantic macrostructures, which identify, globally speaking, what the discourses are about. Semantic macrostructures were listed as high-level ideas or topics that emerged in interviews and focus groups (for example, "child or youth age" or "functioning"). For this study, semantic macrostructures were the primary unit of analysis. Examining semantic macrostructures is useful because it allows the researcher to identify the essence of what participants are communicating. van Dijk (2001) suggests that this also corresponds to cognitive processes. For instance, it would be impossible for people to remember and process all facts they encounter; however, by cognitively connecting related pieces of knowledge and remembering things as themes or topics, people are able to retain larger amounts of information. This allowed me to identify the dominant trauma discourses employed by social workers and distinguish them from less popular counter-discourses. In the following chapters, this can primarily be seen in my initial presentation of dominant discourses.

Second, transcripts were analyzed for local meanings, which involved examining word choice and how propositions are structured. The choices a speaker makes suggest the mental models or assumptions that inform participants' discursive choices. Describing a disagreement as 'persecution' has a significantly different effect than describing it as a 'debate,' which signals to the researcher the meaning and import the speaker places on the topic of discussion (van Dijk, 2001). Importantly, there is no such thing as a complete CDA analysis as there are hundreds of relevant linguistic categories that could be examined (van Dijk, 2001). As such, this study was inherently limited by scope and by

my own analytical capabilities to date. However, by focusing on how propositions were structured – which facts needed to be justified (and how), what assumptions are left unstated that are necessary for propositions to be true, whose actions are discursively highlighted or disguised – I was able to piece together how social workers were making sense of broader discourses and, importantly, the limits of those discourses. This allowed me to explore in-depth both normalizing and technical language within 'trauma' discourses. For instance, in this thesis, normalizing language refers to discursive practices that frame particular experiences, behaviours, or life ways as 'normal.' These discursive practices may frame that which is considered normal in an overt or obvious way, or may imply an existing normal by framing other practices as abnormal. By paying attention to the unstated assumptions that social workers must take for granted as truth in order for their propositions to be true, I was able to draw attention to the way discourses are used to uphold normalization and the subsequent impacts this may have on children framed as abnormal.

Third, transcripts were analyzed for context models, which allowed me to identify how the professional, social, and political contexts were weaved throughout discourses. Context models can be identified when speakers refer to local or global context. For example, when social workers were asked about trauma, several referenced specific contextual factors seen to contribute to trauma, such as the impact of the Sixties Scoop on family dynamics. These contextual references allowed me to explore how professional, political, and social processes influence social workers' ideas about trauma. van Dijk (2001) argues that context models are often important for making the connections between individual cognitions and social processes. For example, by examining social

workers' references to professional context, I was able to see how social work practice with traumatized youth is influenced by social and economic trends that place pressure on front-line practices, thus establishing connections between individual thoughts and practices and systemic forces.

Finally, transcripts were analyzed for event models, in which participants identified cause-consequence relations – for instance, event models were coded for when participants made statements linking a particular event (like a traumatic stressor) to a specific consequence (a symptom of trauma). Surprisingly, this was less integral to this study because social workers suggested that many factors mediate the connection between events that cause trauma and outcomes of trauma, instead frequently focusing on outcomes themselves rather than cause-consequence relationships. Additionally, in children who have experienced many hardships, cause-consequence relationships are not always clear as social workers suggested that hardships may have a cumulative effect. However, the analysis of event models attuned me to these aspects of trauma discourses that I might not otherwise have been attuned to and allowed me to explore how trauma discourses are implicated in ideas about responsibility, blame, and recovery.

This chapter has outlined how data for this study was collected and analysed. van Dijk's (2001) socio-cognitive style of critical discourse analysis allowed me to examine the complex ways RSWs use 'trauma' discourses to make sense of the experiences of their child/youth clients and inform how they respond to the tensions inherent in their work. The remainder of this thesis will discuss the findings of this study, as well their implications both academically and for social work practice.

Chapter 4 – Non-Normative Suffering

Despite our nuanced and diverse conversations, when asked how they would define or describe what 'trauma' is, the social workers who participated in this study produced surprisingly similar answers:

> I think I – I identify trauma as anything – any event that has lasting impacts on somebody's either cognitive, mental, or behavioural development. (Tim, interview)

> I think, to me, trauma is anything that's had kind of a lasting effect on someone's life, whether it's the way they perceive things or the way that they experience things. (Janet, interview)

> I would describe trauma as, um, things that people have experienced that have impacted them and their, um, I guess long-term wellbeing. (Alyson, interview)

'Trauma,' here, is defined both by an experience and a subsequent outcome which is a result. Though social workers did not speak extensively to the kinds of experiences that are frequently considered traumatic (for reasons that will become clear below), social workers would often talk about these traumatic events in ways that noted their abnormality. In essence, social workers' understandings of trauma echoed some of the early ways that trauma came to be codified in the DSM as PTSD, namely that traumatic experiences are those "outside the range of *usual* human experience" (Young, 1995, p. 107 [emphasis mine]). Though some experiences of trauma – like a car accident or a natural disaster – perhaps have a kind of moral neutrality by nature of the fact that an experience of trauma is not necessarily someone's fault, many of the harms experienced by children have strong moral connotations because of acts committed against them by others. It is not just that these experiences are 'atypical,' they are 'wrong:'

> Some of the traumas that they've experienced are a little bit more taboo. Like being sexually abused by a family member, right? It's a little bit different than, you know, as a firefighter where, you know… you've maybe seen a lot of, you know, death and things like that. But I think people can understand that, and it

> may be hard to talk about, but I think that might be a little bit easier than saying, "oh, you know, my mom used to beat the shit out of me." Right? (Marshal, interview)

In fact, the abnormality of these experiences often justifies social work intervention to restore normalcy to children's experiences:

> So, it's finding, um, it's finding the compassion in all of that because it – in child welfare and child protection, we're – we have the authority of society that says certain things around children are just – they're not okay. Um, it's not okay to leave a two and a three-year-old at home alone. [Brooke: Right] It's not. (laughs) I don't think there could be argument… (Shannon, interview)

Experiences like the ones described above demonstrate the connection between a violation of social norms and the trauma that may result. Both Shannon and Marshal note how parents or family members may violate social expectations around parenting, which some social workers believe may consequently impact children. In such cases, the moral responsibility for harm falls onto parents or other adults in a child's life. Parents – mothers especially – are frequently subjected to moral regulation efforts as they are seen as the primary socializing agents for children who become moral citizens (Comacchio, 1993). Thus, ideas about what is normal and/or moral for children to experience inform social workers' perceptions of which events are generally considered traumatic.

However, social workers made it clear that not all negative experiences, even impactful ones, are necessarily traumatic. Indeed, social workers frequently noted that experiences of suffering are commonplace and, perhaps, the norm rather than the exception. In most cases, children are believed to be resilient, finding ways to make sense of their experiences and going on to lead normal, healthy lives despite their suffering. Resilience was often framed as a normative state – one in which most children and youth draw upon their relationships and resources to overcome hardships on their journeys.

However, for a minority of children – those who will be considered traumatized by social workers and others – resilience, while present, is not enough to exist normally in the world. When asked what distinguishes 'trauma' from everyday hardships, the social workers I spoke with suggested a few possibilities. Traumatic experiences are often described as more severe or as happening over long periods of time, which may distinguish them from the 'one-off' hardships that are more common. However, for many social workers, what distinguishes trauma from everyday hardship is not the negative event itself, but the long-term impacts it has on the individual. Similarly, this idea of trauma is also linked to the original diagnostic criteria of PTSD, which state that traumatic experiences are expected to cause "significant symptoms of distress in most people" (Young, 1995, p. 107). Thus, because people are innately resilient and may respond differently to the similar experiences, social workers' conceptions of trauma frequently focused on the consequence of distress as the true indicator that trauma has occurred. Social workers asserted that even experiences perceived as less 'severe' can be traumatic if the impacts are negative and significant:

> So, one identical thing may happen to different people and how it registers or how it impacts them is very, very different. So, there are things that happen to clients where I'm, like, wow, that's heartbreaking. That's incredibly sad, you know? Just the dialogue in my head. Uh, and their attitude is just like, hey, that's life, like… let's move on. And the same – a very similar incident could happen to somebody else, and they're devastated by it. (Jason, interview)

The quote above demonstrates that the trauma does not necessarily lie within the event itself, but rather in the attitudes, perspectives, and consequences resulting from the event.

However, as my conversations with social workers progressed, it became clear to me that social workers' understandings about the impacts of trauma were also closely connected to ideas about what is 'normal.' Not simply 'normal' in the sense that the

average person *would* experience symptoms of distress following a traumatic incident, but 'normal' in the sense that symptoms of distress may violate social norms and expectations. In essence, abnormal behaviours in children were often described as signs that trauma may have occurred. For instance, one participant described that it is sometimes difficult to determine if trauma has occurred, but that deviations from social norms serve as important signposts for social work investigation:

> You kind of just get to understand everything the best and hone in on what are the traumas – what are we seeing that's… behaviours that may be outside the norm. [Brooke: Mmhmm] And I think you try to figure out are there any other factors that could be influencing those behaviours. You know, whether it's cognition or personality, you know, you do your best to kind of rule that out and if you're still left with… you know, uh, you know a link to a traumatic event, then that's probably that person's experience of trauma. (Marshal, interview)

Thus, social workers often openly refer to social norms and children's inability to uphold them in the process of responding to experiences of suffering. However, social workers rarely questioned the social norms that inherently inform their conceptions of what it means to be 'normal.' Social workers frequently connected to these norms as social truths, as opposed to social constructions of a specific time, place, and culture (Corrigan & Sayer, 1985). Consequently, many of the moral judgements inherent in deciding what is 'normal' become effectively disguised, such that social workers may participate in morally regulating children and their families unknowingly (Valverde, 1991). For instance, a child whose troublesome behaviours are deemed 'abnormal' in some way may be subjected to interventions by social workers and others that are designed to bring the child's behaviours in alignment with 'normal,' 'good' ways of being. Consequently, social workers may contribute to the normalization of certain ways of being in the world in ways that are worthy of further exploration.

This chapter will explore how social workers see children's 'abnormal' behaviours as signals that trauma has occurred and how this process may obscure or disguise the moral judgements inherent in deciding what is, in fact, normal. First, this chapter will explore how social workers describe trauma as a factor that may result in deviations from normal development and functioning. Second, this chapter will explore the many ways social workers describe seeing trauma manifested in 'abnormal' individual behaviours. Finally, this chapter will interrogate how social workers understand the relationship between trauma and 'abnormal' relationships.

4.1 Disrupted Development

Almost all the social workers I interviewed noted the relationship between trauma and normative child development. Childhood development is understood as both a physiological and intellectual process whereby children progress through different stages of childhood and adolescence before transitioning into adulthood (Turmel, 2008). Ideas about development are highly normative, based on the assumption that there is a typical, normal, and healthy course of development that children are expected to follow (Turmel, 2008). The social workers I spoke with frequently described how the first few years of a child's development are especially important for their lifelong development:

> It [trauma] impacts the brain in so many ways, like, when children are developing, um, and those impacts can have long term effects throughout a person's entire life. Especially in the first, like, five years… of development. So, when there's trauma and exposure to stress, um, the neural pathways end up being, like, mis-wired or wired in a way that… is different from kids who live in stress-free homes or live without trauma. Um, and so it impacts how they function. How their brains work. (Lydia, interview)

As the quote above demonstrates, children who have experienced trauma may not develop 'normally.' Thus, trauma is seen as a force that interrupts the normal course of development, which can impact many different aspects of a child's life.

4.1.1 Abnormal functioning and missed developmental milestones

Many social workers talked about deviations from normal developmental patterns using the language of 'functioning.' When children are developing normally, they function in socially acceptable and expected ways. Indeed, when I asked social workers what things they see in children that make them think trauma might have occurred, problems with socially acceptable functioning were frequently mentioned:

> Yeah, so I think just there's – there's basically a whole host of things, and it's whatever is, um, like getting in the way of that functioning, if that makes sense. (Janet, interview)

This quote from Janet demonstrates how trauma is perceived to "get in the way" of normative functioning. However, what is considered 'normal' functioning is highly dependent on social workers' expectations for what children *should* be doing at a particular age. For instance, Tim occasionally spoke of child functioning in this way, suggesting that a child may chronologically be one age, but will have only obtained the necessary skills and behaviours attributed to a child of a younger age:

> So, trauma has rewired the brain for these youth to a certain way. So, we're often always talking about the cognitive functioning of a client, right? So, we have a 15-year-old client coming in but they're actually functioning at a 5 or 6-year-old level, right? And that's due to the impact that trauma has had on them growing up (Tim, interview).

Tim draws on developmental knowledge to describe how trauma impacts how children function. For instance, a 'normal' 15-year-old child is not meant to function in the same way as a 'normal' 5-year-old. The social expectations for older youth are different from

those for younger children, thus for an older child to behave in ways that would be normal for a younger child could be considered 'abnormal.'

Consequently, ideas about functioning are used by social workers to compare the social behaviours of traumatized children to social expectations about normal behaviour. Talking about how a child functions may run the risk of locating the problem social workers are responding to as one within the child and their individual development, which effectively disguises how socially contextual ideas about what is 'normal' shapes social workers' understandings of how children are meant to function. Social workers, like the rest of us, have certain expectations of normal things children and youth are expected to do. When they fail to meet these expectations, trauma may serve as an explanation that accounts for this deviation. For instance, in an interview with Janet, she discussed the case of a child who, among other things, failed to go to school or stay in school for full days. Children of this child's age are socially expected to attend school each day, and this child's failure to behave normally was something that needed to be explained. For Janet, one explanation for this abnormal behaviour was this child's experience of traumatic events.

It is not enough for social workers to identify the source of a child's inability to meet social norms. Frequently, social workers are called to work with youth in such a way that they can adjust their behaviours to be more in line with social norms. For example, in an interview with Jason, he mentioned how one goal of social workers is to help youth manage their trauma. When I asked what he meant by 'managing' trauma, he said:

> I guess managing it would be that the (pause) they're still able to function in a way that they determine is the healthy way to function for themselves. And that

> they're meeting their responsibilities, they're able to have healthy relationships… (Jason, interview)

Though Jason, like other social workers, may create space for people to define their own experiences, there remain underlying expectations that someone who manages their trauma well will be able to "meet their responsibilities" and have 'healthy' relationships. However, what goes unspoken here is how broader social norms may influence social workers' expectations of what normal or healthy functioning and relationships look like in children of different ages. Of course, it is worthy of note that labelling a behaviour as 'healthy' has a way of objectivizing what are inherently moral distinctions about 'good' ways of living (Conrad, 1994). Consequently, when social workers work with children to help them 'manage' their trauma in ways that allow them to meet social expectations – an integral component of social work's professional mandates and responsibilities – they may be complicit in regulating the moral subjectivities of children in ways that uphold some ways of being while subsequently marginalizing others (Valverde, 1991).

In addition to talking about deviations from normal development through the language of 'function,' deviations are also identified through "developmental milestones," which are normative markers that indicate whether a child is progressing through development at the anticipated rate or speed. Failure to meet expectations in these markers is seen as a potential signal that trauma has occurred. Consequently, the social workers I spoke with argued that it is important to have a good understanding of developmental milestones when working with potentially traumatized children. For instance, things like a child's physical growth or how they respond to a caregiver may serve as signals that their development is progressing normally or abnormally:

> So, I think especially with younger kids, things can get missed. Like, when you're, like, not unwrapping those babies, you don't see how small they are necessarily. Or, like, you don't know what, um, appropriate cueing looks like in little, little babies. And, like, you maybe don't know the developmental milestones and those things. Like, not necessarily indications of trauma, but they can be. (Lydia, interview)

Here, we can see Lydia describing how failure to 'unwrap' a baby to assess their physical size or not knowing how children of a particular age are *supposed* to respond to caregiver cues can mean that social workers miss important indicators that trauma has taken place. The social workers I spoke with generally agreed that having some education or training in developmental knowledge assists them in their assessments of a child's situation:

> I rely on research […] long, long term research about, um, development [Brooke: Mmhmm] about how children develop, markers along the way, um, so really having a grounding in that knowledge or being – knowing that that knowledge exists and finding it. And then, um, it's behaviour within the norm, what happened, what might have happened, what changed… (Shannon, interview)

Importantly, deviations from normative development are not merely 'atypical,' but indicators of something that is 'wrong.' In fact, entire constellations of services, programs, and relationships have emerged out of this need not only to study and classify children according to their normalcy or lack thereof, but to regulate these developmental pathways (Turmel, 2008). Abnormal development is seen as a problem to be remedied, lest it have long-term consequences on the child. Consequently, social workers – like other professionals – become involved in shaping the child's environment in such a way that promotes their ideal development and corrects any 'deviance' in their home environment that might lead to developmental abnormality (Comacchio, 1993; Valverde, 1991). Even when social workers mentioned this idea ironically, as Marie's sarcastic tone indicated in the quote below, there remains an underlying belief that normal child development is essential for becoming a fully functional adult:

> With kids and childhood development – that's what we do a lot is, like, brain development – so we always talk about how childhood trauma stunts you as an adult, right? And it impacts you moving forward. (Marie, interview)

Marie's quote suggests that discourses about normative adult functioning may serve as impetus for social workers to intervene in the lives of children experiencing trauma before their long-term development is affected.

4.1.2 Trauma and Disability

At times, the social workers I spoke with hinted at a complex relationship between trauma and disability. Particularly for children whose neurodevelopment is believed to be abnormal because of a traumatic experience, the lines between trauma and disability become blurred. In instances like the one described by Shannon below, social workers may attribute 'problem' behaviour to a traumatic experience, only to later discover a disability that better explained a child's abnormal behaviour:

> **Shannon:** Umm (pause) it was recently discovered – not sure how recently it was discovered – but […] a young person, um, was tested and had an IQ of 69. And yet, that person had been, uh, [unclear] social skills, good verbal skills […] so it was never queried. Behaviourally, though, and I know – I know the literature – I was so embarrassed and then said, "well, that explains everything." That one piece of information really shone a light on the behaviour and how a number of professionals just felt they were – they were hitting their heads against a wall.
> **Brooke:** Right, because they didn't know what was up?
> **Shannon:** Yeah – [the child] just didn't have the capacity to do the kinds of things that they were being asked for. And I – there's this whole shift now, it's working.
> **Brooke:** Mmhmm. So, it sounds like, um, when people are seeing, you know, unusual behaviour changes in children or kids aren't meeting the expected developmental markers, um, trauma is providing a kind of explanation for why that might be happening in situations where people didn't really have an explanation before?
> **Shannon:** Yes, and the – so the, the cautionary note is that – with the second example, this person had a life of trauma, but not only trauma! That there's actually a significant cognitive, um, impairment… (Shannon, interview)

Ideas about both trauma and disability are used by social workers to explain abnormal behaviour in children. However, as illustrated by the quote above, the two often occur together, which may complicate a social worker's assessment. Though Shannon notes how trauma disguised a child's impairment, several social workers also observed that a child's disability may further compound their experiences of trauma or interfere with their recovery. When Marshal observed that some children process traumatic experiences better than others, I asked what kinds of things make a child more or less likely to process things 'well.' He answered:

> I think a fair amount of it is, honestly, cognitive ability. [Brooke: Mm] Um, I think your intellectual ability to actually process things certainly helps you out and if you don't have that, you're – I do feel you're maybe at a bit of a disadvantage. I don't think it's impossible, I just think it's – you have to approach it in a different way. Um, yeah, so I think your cognitive ability… (Marshal, interview)

For Marshal, cognitive disability may put children at a disadvantage in processing their traumatic experiences in ways that promote positive coping.

Indeed, the relationship may be even more complicated. In 'trauma-informed' practice, the unusual or troublesome behaviours that children sometimes present with are often explained as 'coping' mechanisms – things that may seem unintelligible to outsiders but ultimately helped the child gain safety during a traumatic situation (Levenson, 2017; Ogden, 2015). However, for Tim, these behaviours may instead be rooted in disability:

> But I also don't want to discredit the impact that cognitive disabilities also have. Right? A kid with FASD, you know, they – I don't know enough to know why their behaviours are the way that they are, but I don't think it's as much of a coping skill as they don't know anything else. (Tim, interview)

Tim is suggesting that instead of being 'coping' behaviours, children's abnormal behaviours may be better explained by cognitive or neurological disabilities that impact a child's ability to perform in expected ways. Thus, social workers are not always able to discern if children's abnormal behaviours come from a response to trauma or from disability – a reality made more complex by the assertion that trauma may impact a child's physical and intellectual development.

What I find concerning here is how ableist assumptions underlying these distinctions were not once challenged by social workers during our discussions. For instance, a child's behaviours resulting from trauma are often rationalized or excused as an unfortunate by-product of harm and disabled children's behaviours are conceptualized as an inherent abnormality. However, nowhere do social workers explore the possibility that said behaviours could represent expected and acceptable facets of human neurodiversity. Indeed, these conversations demonstrate how ableness is constructed as a taken for granted 'normal' state in such a way that disability is rendered undesirable and subordinate (Campbell, 2008). How social workers reproduce and uphold ableism in their practice with children who have experienced hardship is a subject worthy of greater exploration, particularly as the lines between 'trauma' and 'disability' are often blurred. Further, the construction of developmental and other disabilities as 'abnormal' by social workers here needs to be understood within the broader social and cultural context that informs how people with disabilities are responded to. In Western social contexts, the 'abnormal' behaviours of people with disabilities are often framed as deviance, which has resulted in the criminalization and institutionalization of disability (McCausland & Baldry, 2017). By framing the behaviours of people with disabilities as 'immoral,'

'abnormal,' and 'unruly,' people in positions of authority have justified the coercive regulation and control of disabled bodies (Rodriguez et al., 2020).[8] Thus, it is important to explore the ways social workers' construction of 'abnormal' children and youth may, perhaps unintentionally, contribute to the unjust coercion and control children both abled and disabled.

4.2 'Abnormal' Behaviours and Internal Anguish

As the above section has demonstrated, social workers' understanding of child development plays a significant role in determining whether they consider a child's behaviour 'normal.' These behaviours, in turn, may signal to social workers that a traumatic experience has occurred in that child's life:

> Like, depending on what type of trauma the child had experienced, you have like… um, acting out or becoming withdrawn, issues with food, um, stomach aches, headaches, um… sexualized behaviours. Stuff like that. (Lydia, interview)

Social workers frequently look at a wide range of abnormal behaviours as indications of trauma, beyond those associated strictly with physical and intellectual development.

Though it is not always possible for social workers to connect unusual behaviour to trauma, some provided clear examples of how an abnormal behaviour might result directly from a specific traumatic experience:

> I know a youth that I worked with who had, um, who was living in a very unsafe house and the later it got in the night, the more people would come. So, people with weapons, people would assault their family members, things like that… and so this particular youth was quite freaked out at night. [Brooke: Mmhmm] And actually because of, you know, had actually gotten assaulted, and because of that had really associated – and I guess that's another part of trauma, what do you associate things with – um, the nighttime with, you know, a lot of worry. And feeling scared. And so, that totally threw off his sleeping abilities, his sleeping pattern. I mean, the kid does not have a normal sleep schedule, you know, he's

[8] The regulation and control of disabled people may also be amplified in racialized children, who are more likely to be subjected to segregation and control instead of care and resources (Nanda, 2019).

> wide eyed. His mind is, you know, instead of preparing to shut off, it is running. All the time. (Marshal, interview)

> So, a lot of the kids that I have do not like to sleep. They have fear around bedtime because there's a fear that maybe they'll go to bed, somebody won't be there in the morning. They have fear around transitions. So anytime they go from foster home to respite, that's a huge blow up. They're scared about being left alone again. (Marie, interview)

In these instances, the behaviour in question becomes intelligible through its connection with a traumatic experience that explains why children are the way they are. Indeed, without this connection, children's behaviours may be explained in other ways that could result in them being treated less compassionately by the adults in their lives (for instance, if difficulty at bedtime was interpreted as "attention-seeking" behaviour, rather than fear of abandonment).

For many social workers, unusual behaviours serve as indicators of an anguished internal state. Social workers frequently talk about trauma as something that causes emotional or psychological harm, which may become visible to social workers through concerning behaviours. The following section will discuss how social workers come to know a child's trauma through the behavioural signs they read as indications of internal suffering. For it is perhaps not enough for children to behave in socially acceptable ways, we also desire that they achieve an internal state of 'health' and happiness that promotes their productivity and contribution in society. Indeed, since the early 1900s, child health and welfare has been taken up by the Canadian state as a public priority to ensure the growth of a strong and productive nation – a process in which professions like social work undoubtedly played a major role (Comacchio, 1993). Thus, social workers serve an important role in helping children who have experienced trauma to address their suffering so that it does not interfere with their ability to life a 'good,' productive life.

4.2.1 Self-Harm and Suicidal Behaviour

The internal, emotional experiences of children and youth were sometimes framed as 'mental health problems.' Though trauma was frequently described as separate from mental health – as a potential *cause* of mental illness or as a subjective experience not neatly aligned with formulaic mental illness categories – social workers also noted that trauma causes negative thoughts and feelings, which may manifest as poor mental health. At times, this state of mental illness caused by trauma becomes identifiable through self-harm and suicidal behaviour:

> Um, those, like, they show up as mental health stuff, I think. Like, um, and I guess the other stuff I was talking about was mental health stuff but in a less, like, like people don't think of that stuff as mental health necessarily? But with teenagers, like, it's depression. It's self-harm. It's suicidal ideation. (Lydia, interview)

> You know, even though they're successful, they're maybe bankers or, you know, accountants, they're truck drivers… but they stay stuck at that emotional stage or in such an emotional state, depending on whatever it is. But they get stuck in ideas that really do negatively, um, you know impact them. Um, whether that's your mental health, and so you're like that youth I talked about who's relatively doing great by most typical standards of success or societal standards… you know, tried to take his own life. (Marshal, interview)

What is particularly noteworthy about Marshal's observation is that, despite entering adulthood and meeting social standards of success, youth who have experienced trauma still may fail to achieve normalcy because of negative internal emotional states. Within professions like social work, this is also cause for intervention and creates considerable tension for practitioners. In her exploration of Inuit suicide in the Canadian north, Stevenson (2014) notes that the work of helpers, like social workers, at suicide crisis lines often walks a fine line between genuine regard and concern for suicidal callers and a need to act in such a way that workers themselves can avoid liability in the event of

unsuccessful interventions. Likewise, I question to what extent social workers' concerns about suicidal behaviour in youth is connected to our own unease with suffering that, to the sufferer, may seem incompatible with life, rather than stemming from a place of genuine regard for the suffering individual. In essence, traumatized children *must* survive, for what does it say about us if they do not? Thus, social workers are compelled to act to correct children's 'abnormal' emotional states, lest they create moral and ethical implications for social work practice itself.

4.2.2 'Warped' Worldviews

However, even those who survive their trauma may have abnormal views about the world because of their experiences. Many social workers noted that experiencing trauma as a child or youth changes the way they see the world. Typically, this way of seeing the world is framed as a 'warped,' 'skewed,' or 'distorted' worldview, in which the child bases their assumptions about the world on their abnormal experiences:

> Trauma looks like a lot of different things. Um, you know, it can I guess materialize into distorted thinking, views about the world and reality […] in terms of, you know, just your fundamental views – is the world a good place or is it not a good place? Is it something that you always need protection from or is it something that, you know, is generally alright and there's some hiccups? Um, it will shape your views there. (Marshal, interview)

Despite being labelled as 'distorted,' social workers always acknowledged that these attitudes develop in response to harmful circumstances that the child has experienced. Ultimately, children's traumatic experiences teach them that the world is unsafe, when perhaps this view of the world is 'skewed' and no longer reflective of a broader reality. For instance, relationship dynamics that are considered traumatic between children and their parents may teach children not to ask for help:

> […] the foster carer would go into his room at like, really, really, um, like at 9 o'clock in the morning – which is really late for a child that age to be sleeping still [Brooke: Mmhmm] And he would just be up, lying in bed. And then it turned out that when he was at home with his parents, he would cry and cry and cry and cry and cry and no one would come get him, so he just stopped. [Brooke: Right] And then through the years, like, of or however long he was there, um, he just learned that if he cries, no one will come get him. So, you know, if that's not addressed in childhood in some way, uh – like I know it's never going to get back up to where it was in the beginning – like if it's not addressed in some way, like, you would imagine that as an adult, he would – his worldview would be, like, so why ask for help because nobody helps. (Janet, interview)

The foster parent in Janet's story was perplexed by the failure of the child to behave in a 'normal' way – when very young children wake up, they often cry for a caregiver to come to them to start the day. However, according to Janet, the trauma of neglect could cause this child to develop a perspective of the world that nobody ever helps and, subsequently, result in a failure to behave normally. This may be compounded in children who have experienced repeated harms that reinforce their beliefs about people and the world:

> But if we're just kind of on a superficial level here, at five years old if a terrible incident happens, that child is probably just more concerned about the immediate safety and wellbeing of themselves in the context of what's happened. [Brooke: Mm] Are they able to make parallels yet to, you know, a big philosophy of life and – probably not. The 15-year-old may have had that happen numerous times. So now, they have a confirmation bias at 15 that says, oh, of course! Of course, that's what all men are like – or adult men are like. [Brooke: Yeah] So now it's worse for him because it's reinforced this whole traumatic experience he's had, say, birth to 15. (Jason, interview)

Though social workers acknowledge children's experiences are harmful, describing children's subsequent worldviews as 'warped' or 'distorted' reveals an underlying assumption about what the world looks like for 'normal' people – a category that traumatized children become alienated from because of their trauma. What is, perhaps, concerning is the possibility that social workers unintentionally dismiss or invalidate a

child's right to continue to feel the way they do about the world, given that they have, in fact, experienced considerable harm. Consequently, there is an expectation placed on youth that, with support, they come to recognize their experiences as 'abnormal' and realign their expectations of the world in a more normative way. Further, social workers suggested that if youth fail to normalize their worldview, they may subsequently fail to form healthy relationships and become productive members of society.[9]

4.2.3 Inability to Self-Regulate

Social workers cannot themselves assess the internal states of children and youth without behavioural indicators. However, though some emotional states remain hidden from others, the social workers I spoke with suggested that the internal anguish caused by trauma may manifest itself through undesirable or unacceptable behaviours in social interactions. Frequently, this is framed as emotional 'dysregulation,' or the inability of children to appropriately manage their own emotional responses. For instance, in my interview with Lydia, she suggested that trauma can sometimes be missed by social workers because of the difficulty in connecting a child's behaviours to their internal experience of trauma. When I asked what kinds of things help serve as indicators, Lydia responded:

> Like, inability to handle big emotions. Dysregulation. Um, acting out… um, like, violent outbursts. Um, not being able to follow directions […] Like, I think dysregulation across the board, but that looks like swearing, threatening, crying… (Lydia, interview)

[9] I do not wish to give the impression that, through analyzing the uninterrogated assumptions that ground social work discourses about trauma, I recommend social workers completely abstain from normalizing in their practices. Without some sort of benchmark against which to work, it undoubtedly would become very difficult for social workers to perform the responsibilities that are expected of them. However, though I do offer some of my own reflections in the conclusion, the purpose of this thesis is not to outline what that benchmark should be, but rather to unsettle assumptions that otherwise get in the way of truly reflexive and anti-oppressive social work practice.

Here we can see how Lydia connects a child's behaviour – violent outbursts, swearing, crying – to "big emotions" that the child is incapable of handling because of trauma.

Thus, without socially acceptable or appropriate coping skills, children and youth may turn to unhealthy coping mechanisms to manage their emotional states. One such coping mechanism that was frequently mentioned was the use of illicit substances:

> When they get older, that trauma comes out usually in, like, mental health and risky behaviours. And substance abuse because you just feel like shit, and you're just trying to cope, right? (Marie, interview)

> I think I know enough about how people respond to trauma, like, in a long – like in a life arc, over time, that substance use is self – is self medicating, self soothing behaviour… (Shannon, interview)

> I'd say almost every single youth on my unit struggles with addictions and that's because of the trauma they've experienced and so, um, they use (pause) their response, um, to that trauma is to do something to make themselves feel better and that's use drugs or use alcohol or, um, use sex or whatever it's going to be. (Alyson, interview)

What these quotes show is that social workers clearly connect the pain experienced by children and youth to the trauma they have experienced and, subsequently, to the coping behaviours they use to address these emotions. However, they also recognize that substance use and other unacceptable coping mechanisms create negative consequences in children's lives because, socially, these are not acceptable ways of managing difficult emotions. Further, since many of these coping mechanisms are framed as morally wrong – for instance, substance use may be framed as substance 'abuse' or sexual behaviour may be described as 'promiscuity' – social workers' attempts to steer children and youth away from morally questionable coping strategies and toward more socially appropriate ones can be understood as moral regulation efforts.

These inappropriately regulated emotions are not just unpleasant for the child, they also have social consequences. When youth fail to regulate their emotions in acceptable ways, this may impede their ability to lead normal lives by impacting their interpersonal relationships and more:

> I'm thinking about it in terms of emotional regulation – if kids are experiencing big emotions or outsized reactions to situations and they feel out of control or don't understand what is going on for them, then it is very difficult for them to consider forming bonds, building rapport or thinking about consequences/outcomes of their actions or situations and thus making change. (Ricky-Bobby,[10] focus group #1)

Indeed, the social workers I spoke with suggested feeling torn between providing allowances for inappropriately managed emotions, while accounting for the consequences youth may face if they fail to regulate themselves in socially appropriate ways. For instance, Marshal recalled a group home where he previously worked and how the 'trauma-informed care' model they employed meant that workers tended to let difficult behaviours slide in ways that may lead to more difficulties for youth later in life:

> I think there needs to be some extra allowance, but I mean, I think it was really pushed to the max where these kids would learn that they can talk to people in the most disrespectful ways and it actually (pause) it actually set them up for failure because (laughs) they thought that was how you talk to people when you're upset and it cost them friendships and relationships… um, you know, they weren't able to work because, I mean, when they get a job they get fired if they get a little mad, you know… (Marshal, interview)

Consequently, interventions designed to help children manage their emotions in socially acceptable ways may be prioritized in social work practice with children and youth who have experienced trauma:

> I think it [understanding 'trauma'] means sometimes that – how do we help them gain skills to be able to navigate so young people have less – often have less capacity to, you know, understand or put into words what's going on for them.

[10] Shout out to the focus group participant whose movie-inspired pseudonym choice received an honourable mention from several of the reviewers of this thesis.

> And so, it may just be this feeling of being out of control and the only way you know how to do that is to… get negative attention, lash out, express yourself violently, whatever. (Bryan, interview)

Bryan suggests is that children sometimes lack the verbal skills to express their emotions in socially appropriate ways, which may lead them to act out. The objective for youth who have experienced trauma is to find acceptable ways of managing the harms they carry so they can work toward being normal, healthy members of society:

> Someone can have trauma in their past and they're very hurt by it, it affects them in the modern day as if it's happening right in that moment, and their life basically conforms to that kind of feeling and thought. But there's other people who may have had the identical trauma, uh, and because of positive work they've done, or just the way they've processed it in a different way over time, uh – not to minimize how the trauma resonates with them in their thoughts and feelings – but they're able to still be productive, still able to manage themselves, still able to be constructive and keep the trauma in a place where they're able to manage it. (Jason, interview)

Here, Jason talks about children and the "positive work they've done" to process and manage their trauma in ways that allow them to live their lives somewhat normally. Children are constructed as active agents who are ultimately responsible for managing their emotions and experiences through positive, constructive effort. Consequently, through helping to facilitate this process, social workers may be complicit in helping youth to shape their moral subjectivities as 'good' traumatized youth whose difficult journeys are overcome through personal effort and dedication. Social workers may morally regulate youth by intervening in ways that shape youth (and help youth shape themselves) into morally appropriate people. In essence, social workers help youth to take on their own emotional and mental wellness as a personal project (Conrad, 1994), perhaps unaware of the underlying moral obligations to put their pain behind them or "get over it" so that their experiences of trauma do not interfere with the things we expect

'good' productive citizens to do (maintain employment, pay taxes, and generally avoid doing things that disturb social order).

4.3 'Abnormal' Interpersonal Relationships

One of the most significant worries social workers have for their child and youth clients is that their experiences of trauma will prevent them from forming healthy relationships. Whether because of the emotional states or worldviews of children who have learned to see others as a threat, or because of the ways of relating to others they have learned from their families, children who have experienced trauma may act in abnormal ways toward others that may violate social expectations about appropriate and moral behaviour.

4.3.1 Disrupted Attachment and 'Healthy' Relationships

'Attachment,' a theoretical concept from developmental psychology (Perry et al., 2017), is used to describe the formation of early relationships between parents or caregivers and their children. In normal or 'secure' attachment, the parent and child form a bond with one another that facilitates the child's survival and development. Where this bond does not occur in a normal fashion, a child's attachment to a caregiver may be 'disrupted' (Perry et al., 2017):

> There's the need for – you know, their attachment is affected. So, like, they don't have that secure attachment. So, a lot of, like, my little kids have no stranger danger. [Brooke: Mm] They think you're their mom. Everybody's their mom. You know, so like, they've had multiple caregivers… so these are all different ways that that trauma is coming out for them. (Marie, interview)

One the most important elements of attachment theory is how parents or caregivers respond to a child's cues. Since attachment theory is based on Western standards of parent-child interaction, social workers' perceptions about how parents or caregivers

should respond to children is inherently loaded with moral and cultural meaning about appropriate parenting (Keller, 2018). Consequently, it is not surprising that social workers linked the idea of disrupted attachment to other socially 'deviant' parental behaviour:

> There's always that constant list of issues, like domestic violence and, like, parents fighting and inappropriate physical discipline and exposure to drugs and alcohol, and stuff like that. But all of that is – it very much, like, has an impact on how a parent can respond to a cue, I think. (Lydia, interview)

Here, Lydia clearly argues that these features of parents' lives impact on their ability to provide the attentive care to children that is socially required. Framing relationship difficulties between children and caregivers as 'disrupted attachment' has the effect of normalizing certain kinds of caregiver-child relationships. Attachment discourses draw upon assumptions about what normal relationships between children and caregivers *should* look like. When these relational expectations are not met, parenting behaviour may be described as 'unhealthy,' 'unusual,' or even 'cruel':

> Lack of support is very common. Um, finding that someone's – whatever their significant relationship is – their needs aren't being met, or they feel like there's a cruel, kind of unusual, dynamic happening towards them that they're still attached to the person, they want the relationship to work, but at the same time, they recognize that the patterns, dynamic, and functioning really impact them negatively, daily. (Jason, interview)

> A lot of the traumas our kids are experiencing are relational. You know, it's that loss. It's that, um… isolation. It's that grief. It's, you know, you didn't want me, or you weren't healthy enough for me. There's a lot of, just, trauma in relationship breakdown. (Marie, interview)

However, not all children experience disrupted attachment equally. Within social work, some communities are described as experiencing more disrupted attachment than others because of historical or structural factors:

> I mean, there's kind of multigenerational trauma that ends up impacting how people – how parents function, or how people are functioning. Like, you know, working a lot with Indigenous groups […] the generational trauma of Indigenous people is especially acute, right? [Brooke: Mmhmm] My parents didn't know how to parent, I don't know how to parent, my kid is the result of two generations that lost that – that connection to parenting, right? (Bryan, interview)

Here, Bryan is describing how disrupted attachment occurs across generations because one parent is unable to teach their children the appropriate way to form attachment bonds with their children, who in turn also struggle to form socially appropriate or acceptable attachments. Within social work discourse, this is frequently associated with Indigenous communities because of the removal of Indigenous children from their parents through residential schools and the Sixties Scoop (Bombay et al., 2013). Though social workers mentioned the structural forces that influence these dynamics, the focus remained largely on deviations in the parent-child relationship compared to societal expectations of acceptable parenting. However, I also recognize that social workers are often put in positions where they must respond quickly to perceived harms children are experiencing and the task of reflexivity considering children's immediate needs alongside systemic forces is no small task.

While the nature of the abnormal attachment may vary, disrupted attachments are believed to cause harm to the child. Attachment discourses create a cause-effect relationship, whereby poor attachment is directly linked to altered child development and emotional problems (Perry et al., 2017). Even when social workers did not speak to attachment directly, all participants noted that trauma affects the formation of healthy relationships because of the interpersonal nature of most childhood trauma. Children learn healthy relationships from their families, who may not provide them with a socially

acceptable example. Without appropriate attachment and relationships, children repeat unacceptable patterns with others:

> You can see unhealthy family relationships, uh, and dynamics in general, like with intimate partners and with family. They […] you get this sense of how you interact with others and it [trauma] warps that. Based on what they've seen, you know, they think certain things are okay, um, when you know they might not be. (Marshal, interview)

> I find a lot of my older kids, they have that… trauma has impacted the relationships that they build, right? So, they don't have – they don't choose healthy friendships. They don't choose healthy partnerships. (Marie, interview)

From the quotes above, we can see that social workers' assessments of youths' relationships are grounded in normative expectations about what is considered a 'healthy' relationship. Social workers' use of the word 'healthy' in the context of relationships was not in any way associated with physical or biological health, and therefore 'health' served more as a code-word for describing relationships that are considered wrong or immoral. What is interesting is that social workers rarely discussed what elements or patterns distinguish 'healthy' relationships from 'unhealthy' ones. This suggests that the assumptions underlying what morally and socially good relationships ought to look like seem so obvious as to be taken for granted by social workers themselves. However, one element that was occasionally discussed was 'unhealthy' sexuality in young people. Sexually 'inappropriate' relationships for children and youth were noted by several participants. For instance, when asked about what kinds of things social workers see in children and youth that make them think of trauma, Lydia answered:

> I would put sexualized behaviours in there for all ages, but I also sort of feel like it's a straw man, like… *obviously* that's a sign of trauma (laughs) so… [emphasis mine]

Sexualized behaviours are framed as inappropriate for all children and youth, seen here through the immediate connection between sexualized behaviours and trauma in a way that suggests in children without trauma, sexualized behaviours are rarely seen. Social workers draw upon wider social and legal conventions in Canada that relegate sexuality exclusively to adulthood; consequently, children who participate in adult behaviours are breaking social norms about childhood in ways that suggest to social workers that an underlying harm has occurred. Though the nature of childhood is socially and historically situated, social workers draw on idealizations of childhood to render certain kinds of behaviour 'normal' (Turmel, 2008).

Though certain sexual behaviours are almost universally condemned or prohibited in some way (such as forced sexual relationships and those occurring between blood relatives), there is considerable diversity in sexual behaviours across cultures (Hyde et al., 2015). The same can be said about the acceptability of children's involvement in sexual behaviours. For instance, attitudes about masturbation in children vary across cultures from encouragement to condemnation (Hyde et al., 2015). The social workers in this study did not specify which kinds of sexual behaviours and with whom sexuality is acceptable for children and youth. However, the quote from Lydia above seems to suggest that she views sexualized behaviour in general among children and youth as evidence of trauma.

4.3.2 Interpersonal violence

What is perhaps most significant given the potential social and legal consequences children and youth may face as a result, trauma is believed to contribute to physically violent interactions between those who have experienced trauma and others. Sometimes,

trauma leads to internal emotional states that may manifest as physically violent behaviours toward others:

> Whether that's even feeling a little down every morning when you wake up or having crisis outbursts and going on and beating people up in the community. It's still part of the same spectrum of trauma. (Tim, interview)

As such, physical violence is another signal to social workers that youth are experiencing negative emotional states (like "feeling a little down") because of trauma. At other times, social workers described how trauma may trigger a violent response to a stimulus that reminds the child or youth of their traumatic experience:

> I know that they [traumatized youth] find talking to transit police to be very traumatic. I've had that happen multiple times, where a youth didn't have a bus ticket or money to show transit police and they freaked out they've assaulted, like, an officer […] That's because they have this schematic, they're like, the world's unsafe, I don't trust authority figures, authority figures have removed me from my parents, or whatever, right? (Alyson, interview)

Alyson's response reveals that social workers may make clear connections between an experience of trauma and a youth's violent behaviours.

However, at another point in our interview, Alyson stipulated that even though she understands youths' violent behaviours as a direct product of childhood trauma, "I will say, physical assaults – obviously I'm not condoning that…" which signals that even though social workers *understand* where violent behaviours are coming from, they also uphold the idea that violence is not an appropriate response. Physical violence, particularly between strangers, is considered socially unacceptable and immoral behaviour and is, consequently, subject to legal consequences.[11] When youth break these

[11] Not all violence is socially categorized as the same. The violence of children and youth is often seen as "illegitimate" compared to the legitimized violence of state authorities (police, social workers, etc.). Thus, children who commit acts of violence carry the weight of socially ascribed moral wrongness that other members of society may not, depending on the circumstances (Scheper-Hughes & Bourgois, 2004).

social norms, the consequences can be significant. For instance, when I interviewed Tim, he described how criminal charges were laid against a youth who had committed a violent act. Though he expressed understanding how trauma may lead to violent behaviours, he also argued that consequences are important to enforce social expectations:

> Um, but I think those are some pretty good consequences because that's a reality. If you go and attack someone in the community, the cops are going to come and they're going to throw you to the ground. [Brooke: Mmhmm] Right? Um, you're going to get charged. (Tim, interview)

Though there were other social workers who adamantly argued that administering consequences through the justice system is punitive and unhelpful for traumatized youth, none of the social workers I spoke with suggested that violent behaviour is acceptable. Indeed, the issue around what consequences youth should face for socially unacceptable behaviour was more about being pragmatic and choosing which response is most likely to yield the desired outcome:

> My experience in the field is everyone wants to hold them [traumatized youth] accountable. […] For kids with FASD and trauma, you can hold them accountable all you want, like, have fun with that. It's not actually going to make behavioural changes that I think that you want to see. (Alyson, interview)

As Alyson states above, accountability in the legalistic or punitive sense, at least for traumatized children, rarely results in changed behaviour. This is not to say that the social workers I spoke with were not empathetic toward youth and their struggles; rather, participants did not always seem sure about how to balance understanding and compassion with the consequences children and youth are expected to face for behaviours that violate social norms:

> So, it [trauma-informed care] is not about a lack of accountability and responsibility, it's about appropriate accountability and responsibility. So, having

> people realize that, you know, even if you're super scared, beating the shit out of people isn't an appropriate response. (Bryan, interview)

4.3.3 Manipulative Behaviour

Within relationships, certain kinds of behaviour toward others are considered normal, moral, and healthy. Though unhealthy interpersonal behaviours were not always described, several social workers noted that traumatized children are often labelled as 'manipulative.' When children are perceived as manipulative by others, this indicates disrupted expectations about childhood innocence and honesty. However, this does not sit well with several of the social workers who participated in this study:

> A lot of our youth are called manipulative. [Brooke: Mm] Almost every youth is called manipulative. And, um, I actually struggle with that term and calling kids manipulative because for our youth, their trauma has taught them that they need to do certain things to have their needs met. (Alyson, interview)

> Kids use the skills they have and have learned to get their needs met. And so, that may look like manipulation because, yeah, some of the skills they learn is manipulation. [Brooke: Right] But ultimately […] if you look at, like, a kid that's been homeless or lived on the street, they have […] some, you know, suspect ways in terms of either deception or lying or stealing or whatever to get what they need… (Bryan, interview)

What is interesting here is how neither Alyson nor Bryan argue that youth are *not* manipulating others. However, both argue that behaviours like manipulation are adaptive responses to unmet needs. In these instances, trauma often stems from relationships that failed to meet a child's needs, which in turn leads children to develop social strategies to gain what they need from others. What these quotes demonstrate is how social workers may challenge the implicit moral judgement of a child's behaviours while simultaneously recognizing them as 'abnormal.'

4.4 Complicating Discourses on 'Normal'

What these findings demonstrate is that, within social work discourse, social norms play a prominent role in shaping how social workers understand trauma – both its causes and how we might identify trauma in children and youth. However, social workers also occasionally nuanced ideas about 'normal' behaviour and the expectations placed on children who have experienced significant hardship.

When I began interviewing participants, I was able to explore some initial themes that arose during the first focus group. One such theme was whether events are considered 'traumatic' if children and youth do not perceive them as such. Though many social workers argued that children are likely to be untraumatized by events they do not perceive as traumatic, several others complicated this discourse. In some cases, abnormal experiences are still clearly identified by social workers as wrong, but the people involved have normalized this experience for themselves – essentially failing to see their own experiences as abnormal despite what social workers see as a clear violation of social norms:

> Whereas the female clients will often be telling the female staff about how, you know, they've slept with multiple 30 plus year old's and are dating a 40-year-old man and that's just normal […] Because I mean, a 13-year-old dating a 30-year-old man… that's rape. But they perceive that as, "but he loves me!" You know? "He takes care of me!" (Tim, interview)

> But it… it certainly, um, I mean it affected that kid, you know, how this kid saw what was happening. You know, that kid did not see it as necessarily a bad thing. Not to say they weren't affected by it, you know, and their perception may change as they mature and (laughs) that may be an awakening for them later on. But, um, but it's not, um, but you don't see a lot of the impacts of trauma or I haven't seen them in some of those cases where their perception isn't that they've experienced a traumatic event. (Marshal, interview)

In both instances above, children have experienced what most of us would agree are significant harms at the hands of adults in their lives. In alignment with Canadian laws and social codes, social workers clearly identify these experiences as wrong and abnormal. However, social workers may be conflicted when the children they work with appear unaffected by these experiences – seemingly bypassing the abnormal impacts they expect to see. At times, social workers questioned whether youth are genuinely un-traumatized by their experiences – demonstrating resilience – or if the true impacts are merely repressed, delayed, or denied:

> At a certain point […] your perception is good, but your perception is a protective factor or, um, an enabling factor depending… if you ignore it or just sweep it under the rug, it comes [unclear] and it's going to hurt you and you're going to have no idea why, because until it's been intentionally addressed, you're just stuck with that. (Marshal, interview)

The quote above also suggests that a child's perception of what has happened may change over time, opening them up to healing or a newfound realization of the abnormality of their experience. In essence, the correlation between abnormal experience and abnormal outcomes is not always straightforward and often requires social workers to navigate considerable complexity. Indeed, exploring the processes by which children normalize experiences for themselves and the implications for social work practice warrants future research.

Additionally, ideas about 'normal' were not entirely unquestioned by the social workers with whom I spoke. While several referred to "what's normal for the client" and how this may differ from broader social norms, only one openly questioned the potential imposition of social norms in social work practice:

> I might see something as incredibly traumatic but, like, when it's somebody's norm that you live in every single day… [Brooke: Mmhmm] Like, this is another

> issue that we run into, again, and this is the struggle within child welfare is what, like – the white, you know, western norm is around what a healthy child and a healthy family looks like – [Brooke: - yeah –] - versus the reality of what the communities look like for a lot of our First Nations children, right? They have really healthy people in their lives but it's not our picture, right? (Marie, interview)

Here, Marie clearly identifies how factors like colonialism and racism may shape social workers' perceptions about normal ways of being that are imposed on children and their families. However, this was the only instance in our interviews where these conceptions were challenged explicitly. Perhaps not surprisingly given the present professional context – where responding to the historical legacy of harms resulting from social work practice with Indigenous communities is at the forefront of social work education – this issue was framed merely as a racial one and other social dimensions, like gender or social class, were left uninterrogated.[12]

Finally, the social workers I interviewed also recognized that children and youth may be experiencing trauma in ways that do not align with our expectations of what trauma is *supposed* to look like. One potential consequence is that "it's possible we might miss trauma with the social functioning behaviour" (Bill, focus group #2). Children may behave in socially acceptable ways that mask an experience of suffering for which support may be needed:

> **Brooke El Skaf**: How common is it in your experience that someone who's experienced trauma is behaving in a very socially functioning way that makes it easy to miss the trauma they're experiencing?

[12] Only a thorough investigation into the social and cultural circumstances in which children live can make sense of their behavioural patterns and what is 'right' for them. For instance, Kenny (2007) set out to study child labour practices in Brazil, concerned that child labour robs children of their childhoods, only to discover the integral role children's earnings play in overall family stability. Though we may find child labour practices unsavoury, it does not make sense to advocate for a complete end to child labour without addressing structural poverty that forces families to rely on income from all family members to survive. Likewise, as settler social workers, it is important to understand children's place in their communities and families before passing judgement about what 'normal' and 'healthy' looks like for Indigenous children.

> **Damien:** I can't speak much towards that as the clients I work with by the time they get to where I work, they have reached a point where significant intervention is warranted
> **Mac:** In my experience I would say I typically do not deal with people who are dealing with trauma in a socially functioning way, but I've seen a few […]
> **Bill:** For me, this links to the experiences of bullying and suicide thoughts and behaviours, often the person's trauma from bullying is unnoticed or dismissed or perfunctorily supported. (focus group #2)

Though social workers acknowledged that children may benefit from support to manage negative internal states caused by trauma that do *not* manifest in obvious ways, it is noteworthy that social workers' ultimate role in responding to trauma is addressing the abnormal consequences of a traumatic experience. In reality, those who may be suffering but are functioning in 'normal' ways are considerably less likely to end up on a social worker's caseload:

> I think typically, when people are referred to social workers it's because they're having some sort of difficulty with things. And I mean, I know obviously everybody has difficulties with things, but, um, typically it's the people that are having a really hard time overcoming that difficulty that need that extra support from social workers… (Janet, interview)

4.5 Conclusions

This chapter has explored how ideas about normalcy influence social workers understandings of trauma in children and youth. Social workers see abnormal behaviours in children as potential indicators that trauma has disrupted the normal pathways children *should* experience. However, this discussion has also shown that these discourses are complicated by children who normalize 'abnormal' experiences for themselves, and also by social workers' own critiques of social norms. Though the social workers I spoke with did not always indicate which strategies or technologies are used to morally regulate children and youth, these findings help to make sense of which lifeways are constructed

as normal and moral, as well as how trauma is implicated in children's deviations from acceptable ways of being.

What this chapter has not explored, and what is worthy of note, is that not all discourses about normalcy or morality are equally authoritative. In order to exercise sufficient power to shape material practices and realities, discourses must be widely subscribed to and become taken for granted as truth. The following chapter will expand upon this discussion by exploring how discourses about normalcy are legitimized, upheld, complicated, and challenged by social workers in their practices.

Chapter 5 – Legitimizing Normal

The social workers who participated in this study noted that trauma is not always the sole or primary reason for children's abnormal behaviours. Consequently, social workers rely on biomedical discourses about trauma and neurodevelopment to guide their investigations into what is causing the problems children and youth are experiencing. Social workers draw upon neuroscientific concepts like brain development, neural pathways, and hormonal stress responses to explain the impact of trauma upon the bodies of children and youth, thus locating trauma within the body itself. The use of biomedical discourses legitimizes particular ideas about what is considered normal, which, as the previous chapter demonstrated, are integral to social workers' understandings of trauma. However, social workers also provided counter-discourses that nuanced and, at times, complicated the legitimacy of biomedical discourses to define what is considered normal and what is trauma.

This chapter will begin by exploring how biomedical knowledge is used by social workers to negotiate their own professional expertise. Second, this chapter will explore the biomedical discourses social workers draw upon that legitimize normalcy in relation to child trauma. Third, this chapter will explore how social workers nuance, complicate, or outright challenge the legitimacy of certain biomedical trauma discourses. Finally, this chapter will argue that even when social workers distance themselves from normalizing biomedical discourses, they continue to engage with ideas about normal and acceptable ways of being in their trauma-related work.

5.1 Knowledge and Power

Though social workers draw upon other forms of knowledge in their work with children and youth, it is also true that not all knowledge is considered equally valuable,

and the perceived objectivity of scientific knowledge holds considerable sway in social work practice. In particular, the use of biomedical knowledge by social workers amongst colleagues and with service users enhances their perceived expertise to speak to what 'trauma' is and how it relates to conceptions of 'normal.' For instance, though social workers in this study frequently stated that it was essential to prioritize individual perspectives, it was interesting that, at other times, professional expertise was required to legitimize a trauma claim. Consequently, expert knowledge is often – though not always – prioritized over service users' knowledge about traumatic experiences:

> I would say […] trauma can be an all-encompassing word that if you haven't gone through some type of schooling to really look at what trauma is… [Brooke: Mmhmm] that you can use that – you can use trauma to define a negative experience. Well, just because it was negative doesn't mean it was traumatic. Um, people use trauma to define, like, a resonating feeling they have toward something or thoughts toward something – that doesn't necessarily mean it was traumatic even if it's negative. So, trauma really caught on to be this all-encompassing word to apply to a lot [Brooke: Mmhmm] … a lot of people who have not had the, uh, the time or the exposure to the deeper thoughts about trauma and what that actually means. (Jason, interview)

Jason suggests that trauma has become a widely used discourse and the word 'trauma' is applied more broadly than perhaps it should. Trauma is not meant to be applied to any negative experience, but particular kinds of negative experiences. Only with exposure to legitimized knowledge can one adequately distinguish between actual traumas and other negative experiences. Therefore, biomedical expertise on the subject of trauma is drawn upon by social workers to legitimize some experiences as traumatic, compared to others that – though they may have been unpleasant – do not qualify as traumas. Thus, the right to identify trauma is given to those with expertise. In fact, when I asked social workers to describe what trauma is, many of them minimized their own knowledge or referred to more 'expert' professionals, whose knowledge they draw upon in their practice:

> So, we often work with medical doctors, you know, who are going to have a very different perspective on trauma. You know, from a medical lens, they're going to be able to comment, um, you know, much more intelligently about the actual development. Not that social workers don't understand development – I'm sure they do, umm… but through a medical lens, you know, where are they on par with their milestones and what's normal, what's out of the range. (Marshal, interview)

> Um, that's… from talking to a psychiatrist, that's my understanding (laughs)… (Alyson, interview)

Both Marshal and Alyson legitimize their own understandings of trauma by connecting their knowledge to the knowledge of more expert sources like physicians and psychologists, who can speak "more intelligently" about what is 'normal' for children and how trauma impacts normal processes. Marshal notes the limitation of social work knowledge in areas like child development, which further legitimizes medical knowledge and the role of physicians in addressing childhood trauma. Though social workers are frequently called to respond to trauma, their authority is limited because of how biomedical discourses bring trauma under the authority of medicine (Conrad & Schneider, 1992). However, despite their perceived lack of expertise, social workers regularly draw on biomedical discourses in their understandings of trauma, which provide explanations for trauma that are not only helpful to social workers, but authoritative. Because of their 'objectivity' and authority, biomedical trauma discourses about normalcy may go relatively unchallenged, leaving their social histories and practices unexamined.

5.2 Biomedical Discourses of Trauma

5.2.1 Brains and Development

Many of the social workers interviewed for this study talked about childhood trauma in relation to their own understandings of neuroscience. Trauma is believed to

have significant impacts on the structure and function of the brain itself, particularly through the modification of "neural pathways." Social workers described the first few years of a child's life as a time when trauma is most likely to have a neurophysiological impact because of the rapidly changing and developing nature of the brain. As a result, social workers draw on biomedical language to explain trauma in children and youth. By drawing upon biomedical discourses that locate trauma in the brain, trauma is made seemingly more objective by connecting child behaviour to seemingly concrete neurobiological processes and rooting trauma within the body of the child. For instance, Marshal describes how trauma can alter the physical body of the child through neural connections in the brain:

> I mean, this starts getting a little bit more into the medical science, which I don't have a great, uh, great grasp on. Um, but I understand on a really basic level, on a physiological level – so, depending on the trauma, it can alter your physical makeup. You know, from the neuron connections in your brain, you know, which really impact everything. (Marshal, interview)

Social workers may draw upon these discourses to make sense of difficult to understand behavioural changes that are seen in children following a traumatic experience. In short, since trauma can alter neural connections which "really impact everything," social workers may find biomedical concepts discursively useful to explain the causes of very diverse outcomes.

Defining trauma in relation to brain science legitimizes ideas about normal child behaviour because child behaviours are believed to be grounded in the brain and how it normally functions in 'healthy' children. Biomedical discourses about development describe a normative trajectory for child behaviour from birth to adulthood, which is not just socially desirable, but supposedly grounded in physiological processes (Turmel,

2008). Consequently, when trauma disrupts 'normal' pathways of development, the effects can be seen physiologically – in brain structures and neural connections – and result in deviations from normal behaviour. Children who have experienced trauma are not just abnormal socially, but physiologically:

> It [trauma] impacts the brain in so many ways, like, when children are developing, um, and those impacts can have long term effects throughout a person's entire life […] So, when there's trauma and exposure to stress, um, the neural pathways end up being, like, mis-wired or wired in a way that… is different from kids who live in stress-free homes or live without trauma. (Lydia, interview)

As this quote from Lydia's interview demonstrates, biomedical trauma discourses distinguish normal children's brains from those of traumatized children. It is not just that their brains are qualitatively different; Lydia's hesitant 'mis-wired' denotes an understanding – however conflicted – that there is a normative way neural pathways or connections are meant to form and that, in children who have experienced trauma, this process does not happen in the 'correct' way.

Though framing trauma in relation to altered brain development may serve an explanatory purpose, it also may complicate how social workers respond to trauma. By rooting the source of a child's abnormality within the body, trauma comes under the jurisdiction of medicine (Conrad & Schneider, 1992), which may limit the extent to which social workers can facilitate change for their clients by narrowing the scope of potentially useful interventions. Though social workers may draw on biomedical discourses in their practice, attending to the neural pathways and brains of children is well beyond social work's scope of practice. Without adequate tools to respond to the physiological impacts of trauma, social workers may be left questioning whether trauma can be healed, to what extent, and what role social workers should play in this process:

> These are conversations I've had with other, you know, colleagues. Um, okay, so trauma's happened […] they may even understand some of the brain science that I was talking about earlier with neuropathways but, you know, I think taking that to the next level of okay, well how do you repair those? [Brooke: Mmhmm] Neuropathways, if that's what you believe? And some don't think you can. (laughs) You know, to a certain degree, and you can't for everything. For sure there are things that […] may just alter someone's um… who they are. You know, if they have brain damage or something like that, I mean, out of their control. But in general, I actually think a lot of trauma, you know, you can heal. You can grow from it. (Marshal, interview)

For Marshal, the question of how and whether damaged neural pathways can be repaired is an important one for social work that shapes a social worker's attitude toward practice. If trauma results in significant "brain damage," it is understandable why some of the social workers Marshal mentions speaking to may feel that repair is not possible. However, despite this ambiguity, all social workers I spoke with personally were optimistic about positive change over time, arguing that with support, children and youth may 'rewire' their brains to function in more normal ways. One social worker noted that, with consistency over time, it is possible to change the neural pathways that developed abnormally in children. Therefore, rather than disengaging from service provision when children seem to be doing well, these discourses may be used by social workers to justify ongoing support:

> I always encourage my staff and, for me when I do front-line, I still maintain the same contact I had with that young person, uh, when they're doing well as opposed to when they're doing not so well. Just maintaining consistency, because for kids with trauma or adults with trauma, they just need to see consistency over time. Um, because without those supports, kind of, for a lot of people with trauma, their brain… that's what supports them kind of, um, challenging those neural pathways. (Alyson, interview)

According to Alyson, ongoing support from social workers helps to counter or challenge damaged neural pathways. Therefore, how social workers make sense of biomedical

trauma discourses has the potential to directly affect the kind and quality of care they provide.

Though all participants expressed that healing from damaged neural pathways and development is possible, several suggested that some people are more 'helpable' than others. For several of the social workers I spoke to, the rapidly changing development of younger children may make them easier to help. Though the rapid development attributed to early childhood may make children more vulnerable to the brain injuring impacts of trauma, social workers also drew upon the concept of neural plasticity to explain how younger children's brains are more 'malleable' and capable of undoing damage:

> It would make sense to me that trauma is more easily addressed in childhood. This is due to their age (the trauma is not compounded) and neuroscience. Basically, children's brains are more malleable, and the long-term impacts can be avoided with protective factors (Mac, focus group #2)

> Um, (pause) you know, but like when you're a child, I think a lot of things are cemented in that, and like you know, you know there's stages where you can grow and your brain can kind of rewire and things… (Janet, interview)

For Mac, long-term neurological impacts from trauma might be avoided with protective factors because children's brains are still malleable. However, Janet notes that this plasticity only occurs at certain stages of a child's development. Because the brain is very actively developing in early childhood, it can 'rewire.'

Though speculative, one possible concern is that, in drawing on these biomedical discourses, social workers may be more inclined to support younger children than older youth. Indeed, older youth were occasionally described as less helpable because trauma has made changes to neural pathways that have solidified with age. Thus, biomedical discourses about trauma and abnormal brain development may contribute to challenges for social workers practicing with older youth. One participant, Janet, spoke at some

length about how she has seen older youth be neglected by social workers and others in the foster care system. Despite feeling frustrated about this reality, she also expressed that the 'right' kind of support for older youth can be hard to provide:

> When you're a teenager, like what – what are people going to do for you? Do you know what I mean, like if you're a teenager who's lived on the streets for however long and just gotten used to like, you know, doing what you need to – to survive (pause) what type of support *will* help you and who can provide that? (Janet, interview)

One possibility is that social workers will draw upon neuroscientific ideas to explain why trauma in youth is more likely to be 'cemented' and difficult to respond to than in younger children. "Like, again with fostering and adoption and stuff, like everybody wants the babies because they think it's just a clean – a clean slate." (Janet, interview). Thus, one potential consequence of using neuroscientific frameworks for understanding trauma is that, once children are perceived as embedded in their trauma, they may be seen as less likely to achieve a state of normalcy and less likely to be adequately helped through social work intervention. In essence, neuroscientific discourses may have strong explanatory power, but – if we accept their underlying premises as truth – may also pose unanticipated ethical tensions for social workers by foreclosing some of the possibility of healing in later life for individuals who may still be in need of support.

5.2.2 Trauma, the Stress Response, and Other Chemicals

Another way that social workers integrated scientific and biomedical discourses into their understandings of trauma was through the language of 'stress.' Though stress, itself, is not strictly a biomedical term and is frequently used by members of the public as a term for emotional experience, social workers frequently draw on biomedical discourses about the sympathetic nervous system and the release of stress hormones to

explain the immediate impacts of traumatic situations on the bodies of children and youth. Indeed, social workers used the language of stress to locate the effects of trauma physically within the body and its responses:

> I guess, in a lot of ways, trauma I think is stress. [Brooke: Mm] Right? Like, I think that's, you know… a statement for dummies, kind of thing, right? Like, it's an easy way of kind of, like, in my mind framing what trauma does to the body […] It's these impacts of the body that we don't know why we're doing this, and we don't feel good about it, but our body is just behaving this way (Tim, interview)

Here we can see how Tim uses the idea of 'stress' as a less complex stand-in for the more complex biological processes and impacts associated with traumatic experiences. Frequently, social workers described traumatic stressors as activating the 'fight, flight, or freeze' response of the sympathetic nervous system, which impacts the release of stress hormones:

> Another example is, you know, when you grow up, if you're – you've had a lot of different experiences that have made you feel unsafe, over a long period of time, especially if you're a kid… it starts to affect your, um, like bodily responses [Brooke: Mmhmm] You know, just whether or not adrenaline is going to be released, you know, all these different chemicals that kind of help you regulate. And it may put you – depending on how long and what happened to you – at a heightened, hypervigilant state, if that makes sense. (Marshal, interview)

> Um, so like, traumatic experiences can – can lead to lots of different things, right? So one is, you know, an overwhelming of that stress response system, so you end up now being unable to provide a, um, like matching response to a situation. So, you either underreact or overreact to stressful situations or adversity. (Bryan, interview)

For Marshal, traumatic events or situations result in 'bodily responses' in the form of hormones and chemicals being released inside the child. He suggests that these chemicals may also lead to children experiencing a 'heightened' or 'hypervigilant' state. What is noteworthy in this language is that it clearly distinguishes the normal chemical states of children from those of traumatized children, which are abnormally elevated. Likewise,

Bryan sees traumatic experiences as those that not only activate the stress response but overwhelm it – leading youth to respond in abnormal ways, such as 'underreacting' or 'overreacting' to stressful situations. Here we can see that social workers draw on scientific knowledge about biological systems and the brain's chemicals to make sense of the negative feelings that children and youth have when experiencing trauma. Not only does trauma cause youth to experience these chemical reactions abnormally, but social workers also suggest that trauma changes how these biological systems function long-term:

> So, the stress response, the arousal continuum, right? Those are all things that every single person has, or if we don't know that we have that, we just believe it to be our normal state of existence. Right? But that doesn't mean that we can't be impacted by that. (Tim, interview)

> There's also toxic stress, which I think is trauma as well. Which is, like, repeated exposure to stressful situations, which creates, like, a stress response like fight, flight, freeze, [unclear] and then the stress response happens in, like, what's the word… um, like not the right context? Like, it happens in safe environments even. (Lydia, interview)

What the above quotes demonstrate is that children's stress responses – something that *everyone* has – begin to function abnormally. Further, because of repeated or severe stressful situations like trauma, this results in long-term changes that cause children to experience ongoing stress responses in inappropriate social contexts. Essentially, social workers draw on biomedical discourses about stress to explain how trauma overwhelms the normal functioning of the body and then leads to changes in the body that render traumatized children biologically abnormal. Thus, scientific knowledge is used to legitimize ideas about how it is normal for youth to feel or react during adversity.

5.3 Challenges to Biomedical Trauma Discourses

5.3.1 'Trauma' as a Moral Discourse

Though this chapter has explored how biomedical discourses are used by social workers to legitimize certain conceptions of 'normal' that become the benchmark against which traumatized children are measured, social workers also complicated these seemingly objective discourses by noting their moral import. Describing a child's experience as 'trauma' has social consequences that are important for social work practice. For Marie, trauma is a word that she has seen used in many different ways, but most importantly:

> I think the word gets used a lot in this line of work as a way to really express the severity of what's gone on for our families, so that it's not – it's not like, well, you know, when kiddo was growing up, dad was drunk and, you know, he witnessed that a lot, he saw violence in his home… it's like, he was *traumatized*, it's embedded in him now, and that's something that needs to heal. It's not just what he witnessed or experienced, that's the impact of it. (Marie, interview)

For Marie, using 'trauma' to describe an experience of hardship makes it more likely that it will be recognized and addressed. Marie noted that trauma is an essential professional language that social workers use to advocate for better services and support for families. Therefore, this section will explore how social workers use trauma not just as a scientific or biomedical category, but also a moral one that may cultivate either compassion or impose a moral meaning upon children and their families that does not match their own understanding of their experiences.

One of the primary ways that trauma is used as a moral discourse in social work is to explain the challenging behaviours of children and youth. For parents, teachers, and members of the community, traumatized children may act in socially inappropriate ways that are perceived as destructive, disruptive, or otherwise wrong. For the social workers I

spoke to, trauma helps explain these behaviours in a way that lessens the child's or youth's responsibility for their behaviour. Simply, medicalizing a child's behaviours may mean that the inappropriate behaviours are not a choice:

> Trauma actually impacts the brain. Like, people don't know a lot about that and as soon as you explain their frontal lobe is impacted, it's actually physically impacted because of what they went through… [Brooke: Mmhmm] I've actually explained that to many teachers. I've actually brought out, like, you know, some evidence around it. And as soon as connect that to, like, oh okay! I get it now. Like, there's actual brain impact and damage because of trauma. As soon as people link that, they're like, oh, okay! Maybe it's not as much of a choice as I initially thought. (Alyson, interview)

> So, I just think, um, we have a responsibility to, um, to help kind of reframe that for people so that they understand that you know this – this – this isn't always within the control and capacity of an individual. (Bryan, interview)

For both Alyson and Bryan, trauma helps to provide a justification for behaviours as outside the control of the individual. Trauma is what makes children and youth act the way they do. These discourses may be used to distance youth from moral responsibility for their actions that are otherwise framed as 'wrong' and immoral. Additionally, both describe the role social workers play in conveying this information to others so that the behaviours of traumatized youth can be appropriately reframed. Thus, social workers play an important role as educators – helping others to see the impact of trauma so they will respond to troublesome behaviours with more compassion. For Janet, trauma is important to explaining to foster carers because their adolescents have more to cope with than the average teenager:

> That was one of my big bug bears was because you get these kids – well, these teenagers – um, and you know they're running away from your house everyday and trashing it or going out with older men or older whatever, um, and people would just be like, "teenagers are the worst" and it's like well, yes, but teenagers in foster care have a lot more going on than – than your average worst teenager. (Janet, interview)

Likewise, Alyson noted that she often has to explain this to parents who otherwise take troublesome behaviour personally:

> I think people are often, like, "they're choosing to do this and they – they're being unreasonable! And they're, um, out of control! And they're rude!" And I think it's actually the opposite, from my experience, that people don't understand, okay, it's actually not about you. (Alyson, interview)

What Alyson's quote also demonstrates that, when tied to neuroscience, trauma not only helps to explain children's abnormal behaviours and somewhat distances them from moral responsibility; trauma is also used by social workers to help shift the focus back to supporting youth, rather than responding to a perceived social slight. Another advantage to locating trauma within the bodies of youth seen here is how biomedical trauma discourses may be used to take some social pressure off of struggling youth. This practice is sometimes also required for other social workers who do not use trauma as a practice lens:

> **Bryan**: You know, social workers who don't have a good understanding of what trauma is or what trauma-informed practice is, and I think, um, that sometimes surprises me, for sure.
> **Brooke**: Yeah. In social workers that don't seem to have that understanding, um, like what are they seeing or how are they explaining what's going on that's different from the trauma perspective?
> **Bryan**: Well, I think – I think they tend to lean a little more towards the, um, you know it's kind of… individual responsibility or choice type stuff a little bit more. Or, um… or parental responsibility, or that kind of thing, you know? It's a little bit more placed on the individual as a – as a… manipulation or a choice or a, you know, attention seeking behaviour, or something like that (interview)

What this reveals is that, when trauma discourses are not employed, social workers may see abnormal or inappropriate behaviour in children as the result of poor individual choices or 'bad' parenting. Therefore, compassionate trauma discourses acknowledge existing social norms and a child's or youth's failure to behave in ways that uphold them. However, rather than strictly explaining a social abnormality, these discourses can be

used to advocate for more compassionate responses to abnormal behaviour. Thus, trauma discourses may be used to facilitate a kind of allowance for children who perhaps should not be expected to meet social norms because of what they have experienced. These moral trauma discourses are not separate from medicalized ones; in fact, what is clear from the excerpts above is that biomedical discourses lend objectivity to trauma discourses. However, to say that trauma is an exclusively scientific or medical category is to miss the important moral elements of trauma discourse in social work practice.

It is also important to note that trauma discourses are not only used to encourage compassion toward children and youth. Indeed, some social workers noted that trauma may be used in harmful ways. For instance, Jason described how family members may use trauma discourses "as a weapon" to accomplish particular social aims – like ensuring one parent wins child custody over another parent – regardless of whether this is an accurate way to describe a child's or youth's experience. In this instance, parents or guardians may impose ideas about trauma onto children where, perhaps, there is none. Other social workers I spoke with also acknowledged that trauma may be used in harmful ways, such as to promote stereotypes or impose upon service users. Nowhere was this clearer than in my interview with Marie, who argued that trauma – while helpful to advocate for services and important to acknowledge – can impose an inaccurate narrative:

> **Marie:** I think that to just kind of start labelling, like – everything is intergenerational trauma… and not actually take the time to really understand what's going on for that person, and what that story is for them, then that's dangerous.
> **Brooke:** Mmhmm. Could you, like – dangerous how? What are the potential consequences there?
> **Marie:** Well, I think that we're just perpetuating the narrative that we've been taught (laughs) which is, like, you know, I think it's dangerous in that you're not making it client-centred, you're not focusing on that family and where they're at

> and what their needs are. And I think it's dangerous in that it does feed into that larger narrative that Indigenous people are just broken. (interview)

Marie's concern is that social workers may be quick to label experiences as 'traumatic' for Indigenous children because of assumptions about trauma in Indigenous communities and this process occurs without understanding how people perceive their own experiences. For Indigenous children, trauma discourses may impose a narrative that feeds into stereotypes about Indigenous people and effectively erases Indigenous resilience and strength. Conversely, the use of biomedical trauma discourses – which locate trauma in the bodies of individuals – may contribute to a disconnection between the harms experienced by Indigenous children and the systems that perpetuate those harms (Ball & O'Nell, 2016), as well as a failure to explore how social norms are informed and enforced through powerful and often oppressive systems.

5.3.2 Institutionalization of 'Trauma' and Pharmaceuticalization

As noted in the previous chapter, social workers' conceptions of trauma are inherently connected to the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (2013).[13] The DSM definition of posttraumatic stress disorder (PTSD) outlines the criteria both for which kinds of events may cause trauma, and for the symptoms which, when resulting from a such an event, indicate that trauma has occurred (Young, 1995). Though trauma has its roots in this psychiatric diagnosis, trauma has also entered the vernacular and consequently broadened as a conceptual category

[13] The most recent version of the DSM is cited here, as it is the one that social workers and other professionals are currently using. However, it should be noted that there have been changes in the PTSD diagnostic category across editions. Though the original wording from the PTSD diagnostic criteria has changed from the original definition in the DSM-III (for instance, describing traumatic experiences as those beyond the range of 'typical' human experiences), ideas and discourses from the various iterations of PTSD continue to be circulated.

(Abramowitz, 2014). Social workers' conceptions of trauma, likewise, contain both elements of the original DSM diagnosis for PTSD and more social interpretations of trauma. At times, these different but related ways of conceptualizing trauma can create conflicts for social workers in their practices with children and youth. For instance, the social workers I spoke with suggested a complex relationship between 'trauma' and mental illness. At times, trauma was seen as an environmental cause of mental illness, which is more in line with the DSM and its construction of PTSD. At other times, trauma was seen by social workers in opposition to the DSM and its 'harmful' labelling practices. Instead, under these terms, trauma represents a more social way of understanding intense human suffering that may draw upon biomedical discourses to legitimize the impacts of harmful experiences yet does not reduce human suffering to a biological phenomenon. This section will explore how these tensions emerged and were being negotiated by the social workers I spoke with in this study.

Though the social workers I spoke with talked about trauma as a chemical experience – for instance, through stress hormones – some distinguished trauma from the supposed 'chemical imbalance' that contributes to mental illness. Like trauma, mental illness is framed as a state of abnormality through a comparison to a normative state – for instance, chemical 'balance.' However, despite the similarities and with some exceptions, social workers distinguish these experiences from one another:

> So, I think they [trauma and mental illness] can definitely be connected, um… but again, there's lots of people I know who were born with mental illness and have been living with it their whole life, but they wouldn't categorize themselves as traumatized, right? So, um, yeah, I definitely think they can be very closely connected, and they can definitely influence one another but they also can be separate. And so, it would be – I would be cautious to be, like, "oh well, you're anxious, well, what happened to you?" Right? [Brooke: Mmhmm] Like, "what was that big trauma in your life that led to all this anxiety and depression?" And

> it's like, "no, what if I was just born with a chemical imbalance," right? So, you know, it's just kind of… you have to be careful. (Marie, interview)

What this quote demonstrates is that the outward appearance of trauma and mental illness may be similar – and trauma itself may be seen as a potential cause of some mental illnesses – which can lead social workers to connect the two even when this may not be the case. Marie suggests that though trauma may be connected to mental illness – perhaps in a causal way – trauma may also be imposed as an explanation when an experience is really the result of a strictly biological phenomenon or other environmental factors that need to be addressed.

Conversely, one concern that several social workers expressed in our interviews was the possibility that childhood trauma is regularly 'misdiagnosed' as mental illness. For social workers who expressed concerns about the 'medical model' of mental health, trauma may be more appropriate explanation for a child's suffering than mental illness, in part because trauma may be positioned as stemming from a different etiology from mental illnesses. Whereas mental illness may be caused by a chemical imbalance alone, trauma is caused by social harms that have subsequent biological effects. This misdiagnosis of mental illness for children who have experienced trauma is described as harmful:

> Um, so there are things going undiagnosed, like PTSD, um, and then things going misdiagnosed, like if you get an ADHD diagnosis in a – after a week in hospital, but like, the physician doesn't really know very much about the trauma history or only gathers information from the parent, who has a very biased opinion on what's transpired because, like, people are still emotionally entangled. (Lydia, interview)

Lydia expresses a concern that when children and youth are admitted to mental health acute care, physicians diagnose a child without understanding the underlying issue which,

in many cases, is trauma. The ultimate problem Lydia identifies is that misdiagnosed problems in children and youth can lead to the application of solutions or treatments – namely medication – that fail to address the 'root cause' of the problem (assuming, of course, that medication can address the root cause of mental illness but not trauma). The consequence of misdiagnosing trauma is that children do not get the right support. This conversation reveals that social workers at times distinguish trauma from mental illness based on biomedical discourses about their supposed biological roots and impacts.

However, for some of the social workers I spoke with, the distinction between trauma and mental illness has a greater moral import than just being a matter of correct diagnosis. For these participants, trauma was positioned in opposition to the DSM, which they saw as a practice of labelling and individualizing human experiences that may have significant and detrimental effects on children and youth. In these instances, trauma was a more appropriate explanation for a child's difficulties that is less harmful than diagnostic 'labelling':

> **Brooke:** Mmhmm. It was interesting that you said, um, it's important to be looking at this [trauma] especially when we're working with young people. Um, why is it especially with young people as opposed to, perhaps, older populations?
> **Bryan:** Um, because I think young people have less, um, they're often in – in, um, down-power relationship dynamics, where they don't have power in those situations. So, people are able to – whether it's teachers, whether it's, you know, camps, whether it's programs, whether it's justice system, whether it's the child welfare system… wherever it is that people are able to make decisions about what happens to them and how their life is run, and if they get labelled a certain way, that can stick with them for a long time. (interview)

Here, Bryan notes how the process of labelling children is one that occurs within relationships of power – ones where children themselves rarely, if ever, have the upper hand. For Bryan, understanding children's difficulties as trauma, instead of labelling it in another way, helps to redistribute power. Essentially, some workers draw on more social

trauma discourses as a way to oppose some of the diagnostic labelling that occurs with the use of the DSM:

> I – we really need to do something about the DSM. I'm not – I swear I'm not super radical, but it just is not a good tool for social work. We need to stop aligning with that – with that, uh, model of labelling. We need to question it and we need to be actively in our, um, we need to be active in society in terms of really challenging that model. Because it's not working for kids. (Alyson, interview)

Alyson was particularly concerned about social work's alignment with the DSM. She described how traumatized children and youth are often given diagnostic labels, such as, "ODD, ADHD, um, borderline personality disorder […] there's a number of diagnoses" (Alyson, interview), which ultimately leads to the application of technical solutions like psychotropic medication (Rimke, 2005). For Alyson, using trauma as an explanation opposes how she perceives the DSM is used to categorize youth difficulties.

Despite the fact that social workers argued that trauma was a better way of understanding children's difficulties than other DSM diagnostic categories, some also expressed concerns that trauma is becoming 'institutionalized' in the same way as the medical model approach to mental illness. For these social workers, instead of being a more fluid and open concept for exploring children's experiences, trauma becomes yet another standardized diagnosis – a fact that may be less surprising considering the impact of the DSM's criteria for PTSD on broader conceptualizations of trauma. One social worker argued that this 'institutionalization' may have harmful effects on children and youth:

> "Oh, this kid was beat up, so he's going to act like this. And this kid has FASD, so he's going to behave like this. And that dude was neglected or sexually assaulted, so this is what we should do." It should very much be like you learn-by-learn basis, which sucks because we don't have the capacity within front-line to do that [Brooke: Right] So, I do recognize why we need to have these

> approaches across the board, but I think anybody working in trauma-informed care needs to understand that we have to be very careful of approaching trauma from a very (pause) you know, "blank, blank, blank" [fill in the blanks] approach and compartmentalizing it. (Tim, interview)

Tim's concern is that social work has begun to respond to trauma in a formulaic way, merely filling in standardized blanks, rather than taking the time to understand each child individually. Tim notes that there are limitations within front-line work, where there is rarely the organizational capacity to employ individualized approaches that he argues are necessary for 'trauma-informed' work. Tim also expressed concerns that children's experiences are much too complex for a formulaic medical approach to be helpful:

> You know, there's no right or wrong way of doing anything with anyone because human beings are way too complex for that. So, yeah, like, if you have a cut on your finger, put a Band-Aid on it and stop the blood flow. But if you have a, you know – a cut on a finger is not the same thing as a kiddo hiding underneath their blankets. (Tim, interview)

What this quote reveals is that some social workers do challenge how biomedical approaches to trauma make concrete what are complex human experiences. By rendering human suffering a biological phenomenon – like a cut on one's finger – professionals are meant to respond in kind, with a straightforward solution. Though this was perceived by Tim as problematic, Lydia saw how using trauma as an explanation without a more formulaic approach can backfire as well:

> I also think that a lot of times, especially in professionals who are, um, not people who provide diagnoses, like, people who do like the family counselling work or facilitate the groups or, um, do like street outreach and stuff like that… they use trauma as an umbrella term and it doesn't describe anything specific […] I think that it can be… really hard for kids and families to hear and to not have any idea what to do with that […] I think the medical model is a little bit more formulaic and sometimes, that's what kids and families need. Especially in moments of, like, high stress, high trauma, like, high emotions. (Lydia, interview)

Lydia suggests that social workers and others sometimes employ a trauma label in ways that are not subsequently linked to helpful solutions. Conversely, a more formulaic medical response can be helpful for families when they are overwhelmed, even if this over-simplifies a complex social experience. Regardless of how trauma is conceptualized, none of the social workers I spoke with suggested that responding to trauma is a straightforward endeavor.

In addition to potentially erasing the complexity of a child's experience by reducing it to a medical diagnosis, social workers expressed concerns about how medicalized approaches to trauma can lead to the overmedication of children and youth. This is particularly a concern for children and youth in the care of Child and Family Services who have all experienced significant hardship by the time apprehensions have occurred and whose lives are dictated by and unfolding in the context of resource scarce social service provision (Bell, 2013). Biomedical trauma discourses uphold this process because locating human suffering within the body allows practitioners to seek technical, medical solutions (Rimke, 2005). And this process is furthered through professionals, like educators, who are quick to refer children experiencing difficulties to prescribing doctors (Bell, 2013). However, social workers are not oblivious to the normalizing intentions behind medication use – by prescribing medication to traumatized youth who behave in problematic and socially inappropriate ways, the aim is to realign children and youth with social norms. Indeed, like others, Alyson openly challenged whom this process is meant to serve:

> It's also easier to treat kids, in my mind, from that [medicalized] perspective. It's not successful. I don't think it's successful, at all. But is it easier? Yeah. You just give the kid a label, you give them medication, send them home. Um, trauma-informed work takes a lot more skill and takes a lot more effort […] We need to

> stop putting kids on medication. Like, it's just… um, I don't know. I'm not anti-medication, by any means, but it's just being over-used and abused. And it's being done that way to service – not the kids. To service the more general public. (Alyson, interview)

Like Tim, Alyson attributes the medicalization and pharmaceuticalization of trauma to pressures in front-line practice. In resource-scarce environments, it may feel necessary to lean on biomedical discourses that simplify and standardize professional responses. However, she argues that this process, while easier, serves the public and not children and youth themselves. Indeed, Alyson also raises the possibility that pharmaceutical medications may be used as a technology to morally regulate and control 'troublesome' traumatized children that otherwise disrupt social order.

The other thing that Alyson's quote above demonstrates is how social workers use their conceptions of trauma to engage in 'boundary work' that demarcates the professional practices of social workers from other professionals (Gieryn, 2011). By arguing that trauma is a more fluid social category and experience – one that requires a social response, not a pharmaceutical one – social workers construct a space for their own professional authority, which focuses on social interactions and environments. However, social workers must draw on biomedical discourses about trauma not only because scientific knowledge is seen as authoritative, but also because operating in the same institutional sphere as medicine requires some submission to medicine's authority. Thus, social workers employ biomedical discourses about trauma to enhance their own professional legitimacy while simultaneously emphasizing the social aspects of trauma to carve out a distinct professional space for social work practice.

5.3.3 Child and Youth Perspectives

Despite the standardizing and formulaic approaches that biomedical understandings of trauma might inspire, social workers also emphasized the individuality of trauma and the importance of understanding each child's or youth's experiences as unique. As social workers recognized that resilience factors may influence whether someone perceives an event as traumatic or not, they argued that it is important to prioritize the individual's perception of the events they have experienced:

> I come back again and again to really the experiences in the eyes or the body or the mind of the person who experiences that… [Brooke: Okay] Meaning what, um, people can be side by side in an event, one person could be – call it trauma and the other person right beside them could say, "well, that's life." (Shannon, interview)

Shannon's call to attend to the experiences in the eyes, body, or mind of the individual draws upon this notion of a child or youth's perception of the event. When social workers spoke to this approach, they suggested that it sometimes exists in tension with other ways of understanding trauma. For instance, experts may assert that certain kinds of events are always traumatic or interpret particular signs in children and youth as signs that trauma has occurred even though youth themselves do not share the same interpretation. As such, social workers suggested that it is important to listen to what individuals themselves have to say about their experience:

> So I think the best way for me to describe trauma is events that occur in people's lives that the *person* identifies as having a traumatic impact… meaning, to me, that there's been a long-term… there's something lingering, umm, something that it – is holding them in a place […] So, really, [I'm] taking on board all of the literature, the research, the science of trauma and not putting it in place of what people are telling me about what's traumatic for *them.* (Shannon, interview)

For Shannon, an individual's understanding of an experience may not align with what research or 'science' tells social workers to expect when responding to trauma. However,

in stating that she regularly "takes on board" expert knowledge about trauma in addition to listening attentively to what individuals are telling her, Shannon suggests that there is a balancing act whereby social workers negotiate both expert and lay knowledge about trauma in their practice. Likewise, Marie suggests that social workers must exercise caution not to impose expert knowledge on the experiences of service users:

> In my experience, I don't think there's definitive answers to anything. I really think that, um, I think it helps us as social workers to be able to label and to say, "this is what it is, and this is why it's not, and this is why it is…" but I just think that it's not fair for us to make those assumptions about people's lives. (Marie, interview)

Marie's response suggests that avoiding the imposition of expert knowledge is important not only because it is impossible to come up with 'definitive' – or, perhaps, universal – answers to questions about trauma, but also because of the 'unfairness' of imposing assumptions on the lives of others. In essence, she alludes to how expert knowledge can be used problematically to overshadow children's interpretations of their own experiences. Thus, discourses about putting the child's perspective first occasionally challenge the legitimacy of expert or biomedical discourses in social work practice. Though these discourses may operate in tandem, when expert and lay perspectives conflict, privileging the person's perspective aligns with social work values about seeing people as the experts of their own lives (Strier, 2007).

However, privileging the child's perspective above all else may not be as simple as it seems. Some social workers noted that placing the sole focus on how the child perceives their own experiences may raise ethical challenges. The importance of a child's perception in shaping their experience of trauma arose during the first focus group discussion. When I began conducting interviews, I told participants that some social

workers suggested that events are only considered traumatic if children and youth perceive them to be and asked whether they agreed. Though some agreed, others pushed back against this idea:

> And I don't really think it's fair to, like, put that responsibility on the kid to perceive, like, what's traumatic or what's stressful or what's creating toxic stress. Like, they've never had a different experience than the one that creates that trauma and toxic stress […] I wouldn't want to downplay them and, like, say – I wouldn't even want to say, like, that I'm in a position to disagree with someone's perception or experience. So, I would not to say, like, oh […] I'm right, you're wrong. [Brooke: Mm] But I would say I don't think that's a fair (pause) expectation for kids to be able to say, like, what caused them to be traumatized if it's, like… it's complicated, you know? (Lydia, interview)

> I've had quite a few discussions with kids, uh, where they'll tell me a story and they'll be confused when I'm like, "oh my god! Are you okay?" And they're like, "What? That's just – is this actually a bad thing?" and I kind of have to do the teaching around, like, yeah man, you have rights. You have more dignity than that. You shouldn't be getting treated like that, right? And they're like, "well, what do you mean? That's just something I went through every single day. Is that not how everybody's treated?" And the genuine shock I see in their eyes when it's like, "no man, that's not how people should be treated. That is not how you should be treated as a person. You have a lot more rights than that." (Tim, interview)

For Lydia, prioritizing a child's perspective over professional knowledge can be problematic in that it places responsibility on children to make judgements about what is normal, acceptable, and healthy. Though she agrees that social workers should not dismiss a child's perception of their experiences, she argues that child's perception is limited. Indeed, this tension was also raised by Tim, who noted that children may normalize harmful experiences for themselves. In short, just because a youth perceives something as 'normal' for them, does not mean that it is acceptable or right. However, in social workers' responses to children's experiences of injustice – by overtly pointing out that children's experiences are morally wrong and abnormal – there perhaps exists the potential that social workers undermine the resilience of children who normalize

experiences for themselves and carry on with their lives. Thus, prioritizing a child's perspective also raises questions about how social workers promote social justice as a professional value in their practice. In navigating the ethical complexities of working with children and honouring their experiences, social workers still navigate issues about what is normal and acceptable. One might challenge the legitimacy of medical authorities to define 'normal,' but ultimately social workers' professional decisions too are founded on normative values whether they challenge medical authority or not.

5.4 Conclusions

This chapter has explored how biomedical discourses are used by social workers to legitimize ideas about normal that inform social workers' understandings of trauma. Social workers draw upon neuroscientific concepts like brain development, neural pathways, and hormonal stress responses to explain the impact of trauma upon the bodies of children and youth, thus locating trauma within the body itself. However, social workers recognize that trauma discourse serves other important moral roles, including distancing children and youth from moral responsibility for actions not entirely under their control and, instead, advocating for more compassionate care. Additionally, social workers weigh their expert knowledge against the perspectives of children and youth in attempt to provide the best support possible. However, this chapter has also highlighted how the authority of biomedical trauma discourses has the potential to overshadow other important perspectives and how, even when other perspectives are prioritized, trauma discourses remain inherently interconnected with normative ideas about the way children and the world *should* be.

Chapter 6 – Discussion and Conclusion

In this thesis, I explored how registered social workers (RSWs) in Alberta understand trauma in children and youth and how these conceptions are entangled in the moral dimensions of social work practice. This study employed moral regulation as a theoretical framework to interrogate how certain ways of being in the world are constructed as 'normal' and 'moral,' despite their historical and social specificity (Corrigan & Sayer, 1985). Inspired by van Dijk's (2001) socio-cognitive discourse analysis, I employed critical discourse analysis (CDA) methodology to help unpack how social workers use 'trauma' discourses to make sense of the experiences of their child and youth clients.

This research project asked the question: "How do social workers understand and engage with 'trauma' in their work with children and youth in Canada?" This question was inspired by my own experiences as a social worker in Alberta and the complex ways I saw trauma discourses employed by my colleagues. Indeed, the findings of this study – though limited by its small scope – raise important concerns about some of the ethical challenges social workers may be experiencing that warrant further exploration. For instance, though trauma discourses can be used in compassionate ways to cultivate understanding and flexibility, the use of biomedical trauma discourses that locate suffering within the bodies of children may also individualize suffering that is inherently social and result in stereotypes about 'broken' youth for whom healing is potentially out of reach. Consequently, this study aimed to explore how social workers make sense of what trauma is and how these conceptions inform their practices. This study found that ideas about trauma are inherently connected to socially and historically contextual ideas

about what is ‘normal’ and ‘healthy’ for children and youth. When traumatized children’s behaviours deviate from social norms, trauma discourses may be used to mediate the relationship between abnormality and immorality – for instance, through medicalizing behaviours such that they are seen as outside of a child’s control and, subsequently, moral responsibility. Additionally, I found that social workers draw heavily on biomedical discourses to legitimize ideas about what is normal and how trauma represents a deviation from normal experiences. One potential consequence of this process is that trauma becomes located strictly within the bodies of children and youth, which become sites of intervention by helping professionals. However, social workers also challenged and problematized the exclusive authority of biomedical discourses and, at times, challenged the objectivity and application of social norms to ‘traumatized’ children.

6.1 Non-Normative Suffering

This thesis project explored how intricately ideas about normalcy are entangled with social workers’ conceptions of trauma. In particular, ideas about what is ‘normal’ for children to experience and how it is ‘normal’ for children to behave inform social workers’ investigations and interventions. For instance, certain kinds of experiences are considered abnormal or unhealthy for children and youth to experience. Social workers described how experiences like childhood sexual abuse or exposure to domestic violence can make ‘traumatized’ children different from their peers. In part, these experiences are marked apart as different because of a sense of moral wrongness or ‘taboo’ that may be internalized by individuals. It is here than the connection between abnormal and immoral become most clear and where social workers most clearly identify the moral harms that children experience because of their social environment. These judgments about normal and moral are based upon socially and historically contextual ideas about children and

childhood. Childhood is a socially constructed category that individuals inhabit for a time but exists outside of individuals as a stable social entity – for instance, though individual children may process through and graduate from pre-school, the child-centric institution remains along with other social institutions and structures that regulate childhood and children (Corsaro, 2011). Social workers may participate in the regulation of childhood by designating some experiences as 'normal' and 'healthy' for children to experience, while relegating other experiences as outside of expectations for what childhood *should* look like. However, in so doing, social workers frequently fail to interrogate how such norms are socially constructed and which lifeways are upheld through these practices (Corrigan & Sayer, 1985). For instance, social workers working in child welfare frequently draw upon attachment discourses in assessing and intervening in families – discourses that, by their design, uphold White, Western, and economically advantaged parenting practices as a social and moral ideal against which others are judged (Keller, 2018). My concern is the possibility that, by holding racialized families to standards that claim neutrality but are fundamentally grounded in particular cultural ways of being, social workers may unknowingly uphold racism and colonialism in the moral regulation of children and their families.

Social workers also described how deviations from 'normal' behavior and attitudes may serve as signals that trauma has taken place. Trauma may become visible to outsiders when children deviate from expected patterns of physical, cognitive, and emotional development. Social workers suggested that trauma is a force that may cause children's development to stray from a universal and linear progression (Turmel, 2008). However, conceptions about 'normal' child development are not merely objective

evaluations against an average, but inherently linked to a normalizing process by which individual children have their development weighed against an idealized norm (Ben-Ari, 1994). By nature of the way these idealized developmental norms have been constructed, some children – those with disabilities, most clearly – are inherently constructed as 'less than,' and the ableist assumptions and ideals that uphold 'normative' child development are effectively disguised (Feldman et al., 2013). Additionally, trauma may become visible to social workers through 'abnormal' behaviours like interpersonal violence between traumatized children and others, as well as through relationships that are seen as socially inappropriate. Social workers described how trauma causes children to experience internal anguish and 'warped' worldviews that prevent them from having normal or healthy relationships and can interfere with children's ability to meet their responsibilities as they become adults. Trauma discourses were used by social workers in ways that complicate the straightforward connection between abnormality and immorality. For instance, trauma discourses may be individualizing and, in that sense, may be used both to remove responsibility from an individual (the trauma is in their individual body and they cannot help themselves) or to responsibilize (children must do positive work to overcome and manage their experiences of trauma to achieve normalcy) (Hunt, 1999). However, ultimately, by conceptualizing certain experiences and ways of being as trauma and juxtaposed to that which is normal, social workers help render 'natural' what are ways of being that are socially and historically situated (Corrigan & Sayer, 1985).

However, social workers sometimes challenged this idea that trauma is both caused by and causes deviations from social norms. Indeed, the social workers I spoke with noted that children may not perceive an event as traumatic, even when others

assume it is. Social workers showed some ambivalence whether this means children are genuinely untraumatized by these experiences, or whether they have simply normalized for themselves something that is abnormal and inherently harmful. At times, social workers also questioned where our social norms come from and how this may lead to the imposition of Western, colonial values on Indigenous families and others.

6.2 Legitimizing Normal

The social workers in this study drew considerably on biomedical discourses both to determine what is normal and to define and describe trauma as a deviation from these norms. However, social workers also challenged the seemingly objective authority of biomedical discourses to define a child's or youth's experience of trauma. Biomedical discourses played an important role in how social workers negotiated their own expertise as professionals, which is constantly being negotiated in an environment constrained by medical authority (Conrad & Schneider, 1992). Additionally, these discourses complicated social workers' ability to simultaneously hold their own professional authority while validating and upholding the lived knowledge and perceptions of the children and youth with whom they work.

The social workers I spoke with frequently described trauma in relation to children's developing brains. Early childhood is seen as a time of rapid development, which makes children both susceptible to trauma and able to recover quickly when bolstered by protective factors. Social workers described how children's traumatic experiences shape their brains through the development of neural pathways that inform how children see and interact with the world. Social workers also described how trauma results in changes to the stress responses of children so that these systems come to

function abnormally. These misfiring stress responses are believed to cause children to 'underreact' or 'overreact' to stimuli in their environment. Using ideas about altered development and abnormal stress responses, social workers described how trauma disrupts normal cognitive function in children and youth who have experienced hardship. Through these biomedical explanations of 'deviations' from normal childhood, we can see how social workers' use of biomedical discourses to explain trauma locates trauma within the bodies of children and youth. Thus, the authority to define what trauma is often falls to 'expert' professionals like physicians or clinical psychologists. These are all examples of the medicalization of suffering in children and adolescents, whereby social experiences come to be understood in biomedical terms and results in the expert control of physicians to define and diagnose 'trauma' (Conrad & Schneider, 1992).

However, social workers also openly discussed how trauma discourses are moral ones that help social workers to accomplish particular aims in their work. Trauma discourses often provide a framework for understanding children's 'abnormal' and troublesome behaviours so that others – like parents and teachers – can see that children are not entirely at fault for the way they are. By medicalizing a child's suffering as 'trauma' and locating the effects of trauma within the individual body, children's troublesome behaviours are not seen as an individual 'choice,' thus distancing children from the connotations of immorality that might otherwise be connected with their abnormal behaviour (Kenny, 1996). Trauma discourses may be used by social workers to advocate on behalf of communities for better access to resources and services but may also have the unintended consequence of erasing resilience and feeding into stereotypes about 'broken' children and communities (Fassin & Rechtman, 2009). Therefore, in their

intentional use of trauma discourses to accomplish certain moral aims, social workers contribute to the 'moral economy' of trauma as moral entrepreneurs that lend their professional authority and expertise to moral projects (Fassin & Rechtman, 2009).

Some social workers also expressed concerns about the medicalization and pharmaceuticalization of trauma. Several social workers spoke about how trauma is often a better way of conceptualizing children's hardships than the medical model of mental illness, which sees the problem lying in chemical imbalances that fail to account for what has happened in a child's life. Indeed, social workers frequently draw on more vernacularized trauma discourses that have been appropriated, modified, and given complex social meanings by communities (Abramowitz, 2014) to highlight the social and environmental elements of trauma that more closely align with social workers' expertise with person-in-environment approaches to social problems. However, some social workers also expressed concerns that trauma as a conceptual framework may also become 'institutionalized' and formulaic like other medical diagnoses, which not only decreases social workers' authority to respond to the problem by bringing trauma more under the authority of medicine but makes it likely that complex human suffering will be responded to in technical ways. Some social workers noted how trauma is frequently addressed using psychotropic medications, which may not adequately respond to the underlying problem, but have the effect of placating teachers, parents, and courts. Thus, social workers express concerns about how the medicalization of childhood suffering may result in the use of medical, technical solutions that are potentially harmful (Rimke, 2005).

Finally, this study also noted that because social workers frequently draw on authoritative biomedical discourses to understand and respond to trauma, this may create tensions in social work practice when social workers attempt to genuinely integrate the perspectives of children and youth. Social workers are left negotiating the divide between expert knowledge and children's lived experiences, which sometimes conflict with one another. Regardless of whether social workers prioritize authoritative biomedical trauma knowledge or the perspectives and experiences of children and youth themselves, addressing trauma often raises moral and ethical issues. Who gets to decide what is 'normal'? Who has the right to define experiences of hardship? And, perhaps most importantly, what do we as service providers hope to accomplish in our work with traumatized children and youth and do our models of conceptualizing their experiences help or hinder us in meeting these professional goals?

6.3 Contributions and Limitations

Though this study was small in scope, it does have some contributions to offer. First, this study contributes to the academic literature exploring the moral work of 'helping' professions. In alignment with the objectives and political underpinning of CDA, this study interrogates how discourse and language are connected to the operation of professional power, which in turn may contribute to the marginalization of traumatized children (van Dijk, 2008). This exploratory study, to my knowledge, is unique in its examination of social workers' use of trauma discourses in the moral regulation of children in Canada. Additionally, many of the moral regulation studies that focus on children tend to examine the role of education (see Barmaki, 2007) and parenting (see Comacchio, 1993) as sites of socialization whereby children become moral citizens. As

such, this study contributes to the literatures on moral regulation that focus on children, social work, and the medicalization of social problems by examining how social workers use trauma discourses in ways that may contribute to the moral regulation of children and youth (for other examples, see Fassin et al., 2015; Béhague, 2009). Social workers may use ideas about trauma to justify professional intervention in children's lives, which at times goes as far as to remove children from familial homes because of the trauma believed to unfold in some of these environments. Further, this study found that what is perhaps unique about social workers' use of trauma discourses is how they interchangeably draw upon biomedical and vernacularized discourses to not only navigate the issue of children's care, but establish their own professional authority to respond to traumatized children. Finally, by examining how trauma discourses are intricately linked to ideas about 'normal' children and childhood, this study also contributes to the sociological literature on childhood by exploring one mechanism through which 'childhood' as a social construct is regulated in Canada in the early 2020s.

The findings of this project may be of interest to others because of the current social and political climate. Our knowledge about trauma is currently undergoing significant shifts, in part due to recent advancements in epigenetic knowledge and due to public outcry regarding traumas caused by residential schools and the Sixties Scoop, racism and police brutality, and ongoing sexual violence toward women and sexual minorities. These social movements frequently draw upon vernacularized trauma discourses to legitimize the harms caused by these experiences and will no doubt have significant impact on the academic study of these phenomena. Social workers draw upon both vernacularized and distinctly biomedical trauma discourses in their practices, and

like the rest of us, are subject to shifts in their understandings resulting from changes in public discourses. These shifts may have very real consequences on how social workers advocate for clients, design and implement programs, and engage in social change activism. As such, this study offers a preliminary opportunity to explore social workers' understandings of trauma during this time of considerable change and how tensions between established and emerging trauma discourses are negotiated in practice. Thus, this study contributes to our understandings of social work practice by interrogating the discourses social workers use to make decisions about traumatized children's care and regulation.

Of course, this study also has several limitations. First and foremost, this study was conducted with a relatively small sample of RSWs in Alberta. Though social work education in Canada is regulated by the Canadian Association of Social Work Education (CASWE) and should be similar interprovincially, there are always variations in how policies are interpreted and implemented, particularly as social services fall within the domain of provincial responsibility. Additionally, social workers' perspectives are influenced by the social and political environments in which they work. Therefore, the perspectives explored in this study are not necessarily representative of all social workers in Canada, and are more likely to reflect the current political, economic, and social climate in which social workers are practicing. The social workers I spoke with suggested that the current climate of budget cutbacks has had a significant impact on social work practice, making it even more difficult for social workers to attend to the unique needs of traumatized children in their care. Perhaps another limitation of this study, given its size, is the inability to fully explore the nuanced ways that social workers' professional

environments shape their practices with traumatized clients. However, the exploratory findings from this study are still worthy contributions, in that they enhance our knowledge about the different ways social workers are making sense of trauma and ways these conceptions may impact upon their practices with children and youth in a Canadian context.

Additionally, it should be acknowledged what people say they do and what they actually do often differ to varying extents. Indeed, one social worker I spoke with was very transparent about the divide that sometimes occurs between social workers' conceptual and practice frameworks and what actually takes place when working with individuals. Bryan expressed that he is a firm believer in providing youth with extra opportunities for support, even when they do not engage in services in ways that social workers would like them to. However, he also noted that it can be hard to hold to one's principles in practice:

> I think when we're talking about it – it's easy to be, you know (pause) philosophical and adhere to our approaches and our models, but I think sometimes we're just people, too, and if – if kids just treat us like shit and never call us back and don't ever arrange anything and we've got to chase them down all the time, eventually that just gets old and tiring and sometimes you're just, like, I can't do this anymore. (Bryan, interview)

Likewise, the social workers I spoke with in this study may have provided me with their thoughts and reflections, but this may not be reflective of how they respond to challenges in their day-to-day work. In particular, the social workers I spoke with noted considerable service-provision challenges from changes in government that affect funding, staff turnover, and vicarious trauma and burnout in social workers themselves. For instance, Tim noted that working in resource scarce environments means that traumatized children do not get the personalized care needed to address their unique needs and Bryan noted

that social workers may be limited in their ability to provide traumatized youth with flexible access to care because program funding is limited and youth who fail to engage consistently may be removed from services to make room for others. Thus, while social workers may speak to how they would ideally like to respond to traumatized children given their understandings of trauma, service provision challenges may affect the work that actually gets done in practice. However, the study of discourse remains a worthwhile pursuit because of how discourse shapes our attitudes and perceptions about the world, which in turn inform our actions (van Dijk, 2001). For instance, during my conversation with Lydia, she noted that learning more about trauma in her role as a child welfare worker made her more cautious about signing off on psychotropic medication use for children on her caseload because trauma was a better explanation for a child's troubles than another diagnosis, like ADHD, and made it less likely that medication was an appropriate solution. Thus, changes in her understanding of trauma resulted in very material and tangible changes in her practice and, consequently, in the lives of children in her care.

The limitations of this study also point to possible directions for future study. First, I believe that this research area is ripe for ethnographic research. Institutional ethnographies may be useful for enhanced exploration of the complexities between social workers' conceptions of trauma, daily practices with children and youth, and the impact of institutional policy and environment (for example, see Fassin et al., 2015). Further, it may be fruitful to explore interprovincial differences in how 'trauma' is conceptualized and, subsequently, the moral and ethical issues that arise as a result of these different conceptualizations. Finally, I anticipate that as conversations about trauma and

epigenetics become increasingly mainstream, studies on the moral and ethical dimensions of trauma will yield new and fascinating insights.

6.4 Implications for Practice

This thesis would not be complete without a brief consideration of the implications of these findings for social workers and their practices. Throughout this thesis, I have alluded to some of the ethical tensions that arise because of how trauma is conceptualized. In social work, trauma is largely framed as a compassionate remedy to other ways of framing child/youth distress and hardship. While absolutely true in some instances, this study also problematizes this process by arguing that trauma discourses may also further marginalize youth by framing some individuals and their experiences as 'abnormal.' For instance, I am concerned about how the use of biomedical discourses on development are used by social workers in ways that inherently – if unintentionally – frame children and youth with disabilities as 'abnormal' and, consequently, inferior to able children. I am also concerned about how biomedical discourses that focus on the impact of trauma on children's bodies and minds may incidentally divorce children's experiences of harm from their social contexts and the systems of power and oppression that may directly contribute to the harms children experience. Further, I am concerned about how medicalizing very social experiences of suffering places the agenda-setting authority in the hands of professionals like doctors and psychologists, rather than in the hands of those who have experienced harm. Though social workers historically have caused plenty of harm through their involvement in moral projects without the use of biomedical discourses to aid them, I worry about how social work's position relative to medicine – one in which social work practice is subjugated by medicine's professional

authority – may lead social workers to privilege biomedical discourses and expert knowledge at the expense of other ways of knowing. Consequently, I would advocate that social workers, when necessary, question and challenge biomedical discourses when they are used to impose upon or marginalize some children and families. However, what is also clear from this thesis is that these are concerns I share with other social workers, who respond to the needs of children and youth every day. Additionally, I recognize how biomedical discourses can be used as a tool to legitimize and support children and youth who have suffered. Indeed, what this study reveals is the ethical grey area in which social workers attempt to work and, perhaps, the allure of applying discourses that attempt to paint a straightforward picture of cause and consequence that distances us from the often heart-wrenching and morally uncomfortable realities we are called to respond to.

I have, until now, avoided offering what I think are solutions or remedies to these tensions for reasons I will endeavor to make clear here. First, any scholarship that grounds itself in a postmodern theoretical orientation must resist essentializing or universalizing as it is incompatible with postmodern theoretical aims (Singleton, 1996). I have endeavoured to demonstrate the nuance of trauma discourses by showing how different ways of framing trauma may be either helpful or harmful depending on the circumstances. If I were to propose a single solution or mandate for social workers based on my findings here, I would not be doing justice to the complexity of trauma discourses in action in social workers' practices and in children's lives – the answer to the question "so what should we be doing?" is, quite often, "it depends" (Singleton, 1996). Second, as a researcher and as a former practitioner, I am faced with recognizing that my own thoughts, feelings, and perspectives are also situated and connected to the social positions

I occupy and the historic and cultural circumstances in which I live. My scholarship is not value-neutral – nor should it be. However, I aim to be "value-interrogating" (Whelan, 2018), which means that, in addition to challenging the underlying assumptions that ground social work practice with traumatized youth, my own values are open to scrutiny, analysis, and potentially change. As a result, I will offer my own personal and political musings about "what should we be doing" – lest in failing to position myself I leave myself open to being positioned by others (Whelan, 2001) – but wish to emphasize that my intention in doing so is not to be prescriptive, but rather to open possibilities for ambivalence, negotiation, and reflexivity (Singleton, 1996).

Social work is a normative profession in that it builds upon a code of ethics which outlines not only the professional roles of social workers but a commitment to social justice. By committing to values of justice and equity for all, the social work profession speaks not to how the world is, but how it *should* be (Abramovitz, 1998). The last question I asked my participants in the final focus group was about why they think social justice was hardly discussed by the participants of this study, despite being an essential tenet of the social work profession. Though participants mentioned the difficulty of responding to injustice in service contexts where the immediate needs of service users take priority and how any action they might take as individuals could be constrained by organizational mandates, one comment in particular stood out to me: "the trauma narrative is so different from the social justice narrative" (Damien, focus group #2). While this thesis did not explore social justice and trauma specifically and might have yielded very different insights if it had, the disconnect between social justice and trauma is hardly surprising given the dominance of biomedical trauma discourses in social work

practice which frequently separate the individual experience of trauma from social context. Additionally, the seemingly split roots of the profession have resulted in something of a schism between the so-called "micro" social work practices, where clinical work with individuals is frequently prioritized, and the "macro" social work practices that take up the mantle of social justice through community and social policy work (Chapman & Withers, 2019). Consequently, prioritizing social justice often becomes relegated to the realm of "macro" level social work and of lesser consideration – and is perhaps regarded as less of a responsibility – for practitioners in front-line practices with children and youth.[14] However, if we take seriously the notion that social work is a normative profession concerned with how the world *should* be and we also recognize that social workers' conceptions of 'trauma' are intricately linked to what is 'normal' for children and how their lives *should* be, then the separation between social justice and trauma-related practice is unintelligible. It is not enough to recognize that children have suffered because of social injustice in a profession where making the world a more just place is a professional mandate. And, further, I would suggest that this thesis has demonstrated clearly that there is considerable space in micro-level practices – in the conceptual frameworks we, as service providers, use to guide our work, in whose perspectives are prioritized, and in interrogating the relational dynamics between us and the people we serve – for justice-doing. If these tensions are more openly explored in

[14] This is, of course, complicated and it should be acknowledged that there are micro-level social workers who prioritize social justice in their work with individuals and the 'micro' and 'macro' mutually influence one another. Further, as this thesis has suggested, social workers may feel constrained by the environments in which they work which further limits their ability to enact justice-doing in their micro-level practices.

social work practice, social workers may be more likely to actively question and reflect on the social norms that inform their practice.

I am by no means suggesting that social workers abstain from normalizing in their practices. Like the social workers I spoke with, I do not believe that children (or anyone) should be exposed to violence, abuse, and systemic harms. I also believe that we have a responsibility as a community to hold space for those who have experienced significant harm, ideally in ways that serve the individual and their needs, rather than merely shape and mould them into quiet, productive, 'normal' citizens. However, I think it is important to be vigilant in questioning the neutrality and usefulness of scientific and biomedical discourses in paving the way for just responses to human pain. As this thesis has demonstrated, scientific and biomedical discourses may be incredibly useful in legitimizing experiences of suffering, in questioning the moral judgement and responsibility placed on youth who have suffered, and in validating calls to action. For instance, biomedical investigations of 'stress' on cardiovascular health and immunity can be used to affirm what racialized communities have always known – that racism negatively impacts health (McEwan, 1998; James et al., 2010). However, I worry that – if left uninterrogated and without an acknowledgement of the complex moral histories and uses of biomedical discourses in practice – the use of biomedical discourses in social work may employ a veil of 'objectivity' that, at times, serves to disguise what are ableist, racist, and colonial assumptions about what it means to be 'normal' in this world. Indeed, what is perhaps a concern are the ways that biomedical discourses may distance practitioners from responsibility for addressing the moral and ethical tensions in their work by disguising that they are, in fact, there. What this research has made clear is that it

is no small challenge for social workers to parcel out when and how which discourses are helpful or harmful, and that social workers' agency to choose which discourses they employ may be limited given the professional contexts in which they work. Perhaps by leaning on social work values of justice, equity, and dignity for all persons, social workers may interrogate their own conceptual frameworks in ways that bridge social justice and 'micro' level practice – especially since it is unlikely that social work will divorce itself from medicine and biomedical ways of knowing entirely. Where does our knowledge come from? What perspectives might I be missing? How do I best uphold justice-doing in my work with this child or family and what knowledge will help me get there?

This thesis research has demonstrated that there is a significant relationship between discourses about trauma and what we understand to be 'normal' experiences and ways of being. Social workers have a responsibility to question which knowledges inform their conceptions of normal and what this might mean in interactions with those who have been socially designated as 'abnormal' in some way. Biomedical knowledge does have a place in social work practice and may be very useful in some contexts and situations; however, the use of such knowledge unreflexively may contribute to significant and harmful consequences for children and youth. As members of a shared community, we have a responsibility to one another to hold space for each other's pain in ways that are reflexive, critical, and justice oriented.

6.5 Final Reflection

I am sitting here at my desk, reflecting on the journey this thesis research has taken me on. I have just as many questions as I had when I began, though some of the

mystery and general weirdness I once noticed as a practitioner now makes more sense for me than it once did. I cannot, as yet, imagine what a community of care for children and youth who have suffered ought to look like. And perhaps that is because each child's community of care ought to be unique to them, their needs, their struggles, their strengths, and their journeys. But I will leave you, reader, with a moment from these interviews that has stayed with me and will be the starting place for my imaginings and aspirations:

> **Brooke**: Mmhmm. So, what do you think are more appropriate responses to the kinds of things – like, these criminal behaviours, for example, that are more appropriate when we consider the trauma that kids have been through?
> **Lydia**: In a perfect world, where I could, like, wave my magic wand and make everything great?
> **Brooke**: Mm
> **Lydia**: Um, I would say like – I would say that the more appropriate thing is to find a way to, like, fill these kids' cups and get them connected to people who are safe and healthy and understand them and want, like – you know, want to see them succeed and can help them to believe that they will succeed, that they will be successful, that they are, like, valuable and… good. And, um, and… I don't know. Cherished. Cherished is the word that I want to use.

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Appendix A: Recruitment Poster

Appendix B: Email Screening and Demographic Questions

Email Screening Questions

Preamble: "Thanks for showing interest in this study! Before I share more information about the study with you, I have a few questions to ask that will help me determine if you are eligible to participate. The information you share with me here, over email, will not be shared with anyone else or used in the research study – they are only intended to help me assess your ability to participate. If you would prefer, we can arrange a phone call to discuss these questions instead."

Are you currently registered as a social worker?

Which social work college are you registered with?

How often do you work with children and youth (birth to age 17)?

How would you describe your social work practice area in one sentence?

What agency do you currently work for?

How long have you worked there?

Do you have access to a stable internet connection?

Are you comfortable participating in English?

Demographic Information Questions – Participants:

Preamble: "Thanks for agreeing to be part of this study! I'm really looking forward to getting started. While we are in the process of scheduling your interview/focus group, I have a few demographic questions to ask you. You can, of course, choose not to answer anything you do not feel comfortable answering. However, this information can help me to make sense of research findings later down the line."

Which gender do you identify as?

How would you describe your racial/ethnic identity?

How old are you?

How many years have you practiced as a social worker?

Appendix C: Online Focus Group Script

DALHOUSIE UNIVERSITY

ONLINE FOCUS GROUP SCRIPT, QUESTIONS, AND PROMPTS

INTRODUCTION

"I really appreciate all of you making the time to join me in this focus group today. I'm looking forward to learning from your collective experiences. Before we get started, I want to provide you with a quick overview about what to expect and cover some ground rules for discussion. Then I'll check in to see if anyone has any questions before we get started."

"We will spend most of our time today going over the discussion questions included at the end of vignettes I emailed to you previously. While this is meant to be a general discussion and you can feel free to comment on any particular vignette that interested you, I'm hoping we will touch on all three vignettes as we go along. I'll finish with one or two additional questions before we wrap things up."

"This focus group is a discussion between you. Feel free to respond with your own thoughts and questions to other's contributions. I am just here to ask a few questions and keep us on track. The conversation should last about 90 minutes, does that still work for everyone?"

"You all had a chance to review the consent form that I emailed to you previously. Do any of you have any questions about your consent?"

"You will have noted that this focus group is intended to be an anonymous text-based discussion amongst registered social workers. For this reason, I have asked you to use a pseudonym and will ask that you keep your cameras and microphones off to ensure your confidentiality. I ask that everyone keep our discussions here private and do not share anything we discuss here with those outside the focus group – that being said, I cannot guarantee that others will respect this boundary, so please take precautions to remain anonymous. This means, as much as possible, avoid sharing personal details that could identify you and please use pseudonyms when talking about colleagues and clients. Throughout this discussion, you are encouraged to express your thoughts and experiences, even if this means disagreeing with one another. However, I would ask that everyone works to keep our conversation respectful."

"Remember that your participation is voluntary, so you may stop participating in the focus group at any time, and you can pass on answering questions that you would rather not respond to (even if I call on you to ask for your thoughts). I think we're about ready to get started – any final questions before we begin?"

DISCUSSION QUESTIONS FROM VIGNETTES

1. How would you approach your work with each of these cases and why?
    a. (probe) How is this similar/different to how you would approach (other vignette)?

2. Based on the information you have, how would you explain the behaviour of each child/youth?
    a. (probe) How does this compare with the explanation you would use for (other vignette)? What distinguishes them from each other?
3. What consequences, if any, would you recommend for the behaviour of each child/youth and why?
    a. (probe) Why would you take this approach as opposed to the one we discussed for (other vignette)?
4. Who would you say is ultimately responsible for each child/youth's behaviour and why?
    a. (probe) In terms of who's ultimately responsible, how does this vary across cases if at all? Why the difference?
5. What would a positive outcome look like for each of the cases presented above and how likely do you think a positive outcome would be?
    a. How does this compare to (other vignette)? Why?

Probing Questions:

- Would you agree or disagree with ____? Why or why not?
- Would you like to comment on what (participant pseudonym) just said?
- Could you use an example to explain what you mean by ____?
- Could you tell me more about ____?
- How does this relate to your practice experiences?

Preamble: "We only have (X) number of minutes left in our discussion. Before we wrap up, I have a few final questions."

Additional Questions (if 'trauma' not brought up as main topic of discussion):

1. One of the things this study is interested in is whether and how social workers use ideas about 'trauma' to make sense of experiences of children and youth. Throughout this focus group, I've noticed that (insert observations about the discussion so far). How important was trauma to your understanding of the cases we've talked about today?

WRAP-UP/CONCLUSIONS

Preamble: "We're at the end of our discussion today. I'm very grateful to all of you for sharing your thoughts and experiences with me. Do you have any final questions or comments for me before we part ways?"

Appendix D: Vignettes

Project title: Social Worker Conceptions of 'Trauma' and Practice with Children and Youth in Canada
Lead researcher: Brooke Thomas-Skaf, MA Student – Department of Sociology and Social Anthropology, brooke.thomas@dal.ca
DISCLAIMER: The vignettes presented here are fictionalized accounts of cases social workers might be called to responded to in their day-to-day practice. The stories presented below are **not** representations of actual cases known to the research team.

Vignette #1: Samuel

Samuel is a 17-year-old refugee from Colombia. He arrived in Canada when he was 9 years old. He and his family were displaced within Colombia several times before making the journey to Canada. During his childhood, he lost several family members including an older brother to paramilitary violence. As such, he has witnessed a lot of violence from an early age.

Since coming to Canada, Samuel has been doing fairly well in school. Though there were some early challenges adjusting to schooling in a new country and language, his teachers describe him as bright and hard working. However, recently his grades have started to slip. He has had a hard time making friends and his high-school experience has been fraught with bullying from other kids his age. Samuel received a lot of help with English as a student and his parents' English skills aren't as strong, so he finds himself frequently responsible for helping his parents with adult jobs, such as calling the bank or interpreting unexpected bills.

You are called to work with Samuel because of his recent justice system involvement. In the past two years, he has been caught defacing public property and stealing. Most recently, he was arrested for attempting to steal electronics from a neighbour's home and was found to be carrying knives on his person. To make matters worse, the day before the incident in question, Samuel was suspended from school for a violent altercation with a classmate. Your job is to support Samuel and his family through a case hearing with a youth justice committee that includes a juvenile judge. During this time, a decision will be made about how Samuel will be held accountable for his recent actions.

Vignette #2: Zoe

Zoe is a 14-year-old white female. She was recently admitted to a short-stay inpatient mental health program at a youth residential care facility. Zoe was referred to the organization where you work because of a self-harm incident that occurred in her mother's home that resulted in her being admitted to hospital. After an argument with her mother, Zoe locked herself in one of the bathrooms and used a razor blade to cut her legs and wrists.

When you interview Zoe and her parents, you find out that Zoe is an only child who has been fighting with her parents recently because of sexual behaviour and recent drug use. Her parents divorced two years previously and have a very difficult time communicating. This most recent argument with her mother occurred because she told her father that she was spending the night at her mother's house when she was actually spending time alone with an older boy. Her untruth was discovered when her mother called her father's house to talk to her. This is not the

first time she has been in trouble with her parents for lying about her whereabouts. Recently, she also came home from a friend's house after school smelling of cannabis. Her parents are concerned about her behaviour and frustrated that she shows little interest in confiding in them.

Aside from her parents' divorce, Zoe appears to have had a pretty normal childhood. However, when you ask about family history, you find out that Zoe has an uncle on her mother's side with whom the family is no longer in touch. When you probe further, you are told that the parents didn't like the way he behaved around Zoe, but they refuse to tell you more about the behaviour they found upsetting. Zoe also refuses to talk about her uncle. You begin to suspect that Zoe may have experienced physical or sexual abuse at some point in her childhood.

Vignette #3: Iris

Iris is a 10-year-old girl from Siksika Nation. She lived with her biological parents until the age of two, when she was apprehended by child welfare. She came to be known to children's services when her mother was admitted to hospital following a violent altercation between Iris's parents. Upon investigation, child welfare found that domestic violence was a significant problem in the family.

Iris has been living with her white foster family since the state obtained a permanent guardianship order (PGO) that removed her permanently from her family's care. Children's services were unable to find kinship carers to care for her. You have recently taken over Iris's case since her previous case worker retired.

Iris's foster family has called you for your help because they are at their wits' end with her behaviour. Iris's school calls home all the time because of fights with classmates, disruptive behaviour in the classroom, and unexplained absences. Things have also been challenging at home, with increased levels of conflict between Iris and her five foster brothers and sisters. According to her foster mother, these problems have been slowly escalating over the past 8 months. Everything they have tried so far to address the issue isn't working and they are beginning to wonder if Iris might need to be placed with another foster home.

Questions for Discussion:

2. How would you approach your work with each of these cases and why?
3. Based on the information you have, how would you explain the behaviour of each child/youth?
4. What consequences, if any, would you recommend for the behaviour of each child/youth and why?
5. Who would you say is ultimately responsible for each child/youth's behaviour and why?
6. What would a positive outcome look like for each of the cases presented above and how likely do you think a positive outcome would be?

Appendix E: Semi-Structured Interview Script

ONLINE IN-DEPTH INTERVIEW QUESTIONS

INTRODUCTION

"I really appreciate that you've made the time to join me for this interview. While I do have a list of questions to guide our conversation and to help keep us on track, I'm hoping this will feel more like a conversation between the two of us about your experiences as a social worker. There are no right or wrong answers to any of these questions, I'm looking to learn from your experiences. The conversation should last about 90 minutes, does that still work for you?"

"Before we get started, I want to take this opportunity to remind you that you may stop participating at any time. Your participation here is entirely voluntary, which also means that you are completely free to pass on answering questions that you would rather not respond to. Do you have any remaining questions about your consent?"

"One last reminder: as much as possible, please only refer to others using pseudonyms. It is important for you not to reveal any identifying information about service users or staff. I think we're about ready to get started – do you have any final questions before we begin?"

"I'm going to turn on my portable audio-recorder now and place it by my laptop speaker. I'm doing this so that I can capture our discussion. Am I okay to turn this on now so we can get started?"

SEMI-STRUCTURED INTERVIEW QUESTIONS/PROMPTS

FOR PREVIOUS FOCUS GROUP PARTICIPANTS ONLY

"Having participated in the focus group, I am wondering if there was any particular reason you are interested in continuing this discussion in an interview?"

QUESTIONS (for all participants)

- How would you define or describe what trauma is?
    - How do you think your understanding of trauma compares to that of other social workers?
- What role does trauma play in your work?
- How common is trauma in the children/youth you work with?
- How would your practice approach be different for a child or youth who has experienced trauma from a similarly presenting child who had not experienced trauma?

OPTIONAL (For focus group participants only): How did you feel when we discussed the vignettes together in the focus group? Were there things people said that you really agreed or disagreed with?

TRANSITION (for all participants): "Thank you for sharing your thoughts and experiences with me. As you know from the consent form, interviews are one part of the information I'm collecting for this study. Before starting interviews, I completed focus group discussions with registered social workers asking them how they would respond to three different case scenarios. I'd like to share some of my observations with you and ask you a few questions based on your experiences."

QUESTIONS (for all participants)

- I noticed that (insert observation here) …
    - Why do you think that …?
    - How common is …?
    - In your experience, …?

(Probing questions)

- Could you use an example to explain what you mean by ____?
- Could you tell me more about ____?
- How does this relate to your personal/practice experiences?
- How do you feel about ____?

WRAP-UP/CONCLUSIONS (for all participants)

Preamble: "We're nearing the end of our time together, so I'm going to begin wrapping up our discussion here. I'm very grateful to you for sharing your thoughts and experiences with me today."

- Do you have any comments about this interview? {probe: Anything that surprised you or that you thought I missed?}
- Do you have any questions for me before we end?