“At the end of the day, we’re all only human”: The emotional labour of performing trauma-informed care in a fractured homelessness system

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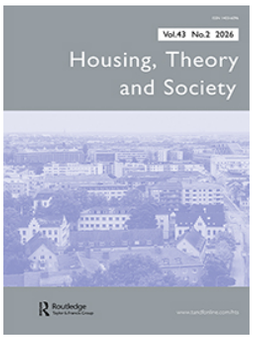

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ABSTRACT

Despite increasing international uptake of trauma-informed care in the homelessness sector, practitioners' experiences remain underexplored. Drawing on semi-structured interviews with 15 staff from homelessness organisations in a London borough, and four national experts, this article is the first to explore how professionals in the homelessness sector manage their own emotions amidst the complexities of a fractured homelessness system and housing crisis. Employing the concept of emotional labour, it asks how staff *feel* implementing trauma-informed care, while facing reduced funding, heavier workloads, and increasingly complex client needs. While staff attempted to shield themselves through containment of emotion, engagement in riskier practices was evident as staff internalised failings which were inherently structural. The findings provide much-needed knowledge about the implementation of trauma-informed models, disclosing ways in which their endorsement in the homelessness sector demands new forms of highly precarious emotional labour.

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Trauma-informed care; trauma-informed approaches; homelessness; emotional labour; homelessness practitioners

Introduction

Summing up a storm-like policy context of spending cuts, rising homelessness, and complexity of need, the UK homelessness sector has been conceptualised as a "traumatised", or "shocked", system (Blood et al. 2020, 3; ONS 2025; NAO 2023; Watts-Cobbe et al. 2025). Reductions in spending on housing-related support by successive UK governments since 2010 has seen a significant decrease in the value of commissioned contracts and providers having to do more with less (Beatty et al. 2024; NAO 2023). Research has found that reduced funding has created a homelessness workforce with poorer pay and conditions, often unable to rely on support from equally over-stretched statutory services, supporting a rising number of service users facing multiple disadvantage (Blood et al. 2020; Bullock and Parker 2014; Watts-Cobbe et al. 2025).

Meanwhile, national housing policy and local authorities' housing and homelessness commissioning specifications increasingly require the provision of trauma-informed approaches[1] (MHCLG 2020). Without adequate funding to back it up, this shift has been

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described as an "ethos" (Blood et al. 2020, 47). This article presents first-hand accounts of what it *feels like* for practitioners to perform increasingly relational approaches in a fractured homelessness system. Utilising the concept of emotional labour, it explores how staff uphold trauma-informed care while working in proximity to trauma. In doing so, the article examines new forms of emotional labour in the sector. It shows how staff failed to keep up the empathy required by trauma-informed care, and internalised structural and systemic failings, felt as being unable to successfully carry out their roles.

The paper begins by exploring the state of the homelessness sector. It traces the shift towards trauma-informed care, outlining the principles and focusing on how, in an ideal system, it should work for staff; and the realities of working within the sector. Subsequent sections outline the conceptual framing of emotional labour. An account of the methods follows, after which the article presents a discussion of the findings. The article's contribution is twofold: first, it provides much-needed empirical knowledge about the implementation of trauma-informed models; second, in contributing a new conceptualisation of trauma-informed care, it discloses the ways in which endorsement of the model in the homelessness sector demands forms of highly precarious emotional labour. This conceptual framing is applicable to other disciplines and sectors coming to terms with the model (Smith and Monteux 2023).

A Fractured System

Since the 2010 Conservative-led coalition government adopted austerity as its primary economic strategy, fiscal restraint remains a defining feature of UK economic policy, shaping public sector funding, welfare reform and local government budgets (Farnsworth 2021). This prolonged austerity has had far-reaching implications for the homelessness sector. Despite government initiatives to reduce homelessness, evidence shows the overall reduction in funding within the sector. Since 2009, there has been a 53 per cent cut in monetary terms to single homelessness services across local authorities, and a total reduction of £1 billion to homelessness services overall (St Mungo's 2019).

With cuts affecting related sectors – health, drug/alcohol, domestic abuse, social care, and criminal justice – homelessness services are becoming the "catch-all" for people facing multiple disadvantage as other parts of the system fail (Kerman et al. 2022, 3). In a study of the UK supported housing sector, homelessness providers met the gaps which statutory (health and housing) services once addressed (Beatty et al. 2024). With higher access thresholds and pushback from statutory services, the study found the need profile of clients within supported housing intended for people experiencing homelessness is becoming ever more challenging for services to meet without specialist input. This is combined with a precarious funding landscape within which a lack of inflationary uplifts to commissioned support contracts and rising day-to-day running costs are seen as posing significant threats to the sustainability of future provision (Beatty et al. 2024; NAO 2023). In their research into the commissioning of homelessness services, Blood et al. (2020) found that local authorities across the UK had adapted to budget cuts by reducing contract values and durations, pushing for hard outcomes that prioritise throughput, and developing integrated homelessness pathways to manage service access. As Blood et al. (2020, 3) found, in some instances

these practices led to maladaptive outcomes. Cuts in one area resulted in inefficiencies and higher costs elsewhere, while services were repeatedly decommissioned and recommissioned – referred to as the "goldfish effect". The authors describe the homelessness system as being traumatised. This terminology, however, obscures the political decisions that sit behind the crises in homelessness services. This paper employs the term, "fractured system" to convey the sense of being weakened by political choices at a national governmental level.

Working within such a system has a detrimental impact, as an emerging body of literature demonstrates (Kerman et al. 2022; Peters, Hobson, and Samuel 2022; Schiff and Lane 2019). This work highlights the immense weight of responsibility and multifaceted demands inherent in the support worker role. In addition to addressing service users' needs, staff must carefully navigate professional boundaries and provide emotional support, while working demanding shift patterns (Peters, Hobson, and Samuel 2022).

Frontline staff in homelessness services are often immersed in environments steeped in trauma. Exposure to service users – with historic and present-day trauma – can lead to secondary traumatic stress (STS), a form of trauma that results from prolonged exposure to the traumatic experiences of others (McCann and Pearlman 1990). Schiff and Lane (2019), in their study with frontline workers in Canadian homelessness services, found that 33 per cent showed symptoms of post-traumatic stress disorder (PTSD). In a study of work-related distress in the homelessness sector, Kerman et al. (2022) found a higher proportion of participants (89 per cent) reported direct exposure to one or more critical event in the workplace, including service user death. While STS has been shown to be a contributing factor to burnout in frontline workers, studies suggest it remains underreported due to stigma and shame (Lenzi et al. 2021). With the recruitment of people with lived experience into homelessness services, many workers bring personal histories of trauma into their roles, further complicating the effects of exposure to re-traumatising events (Lemieux-Cumberlege et al. 2023).

The system has been shown to introduce further challenges, with workers contending with under-resourcing, funding cuts and excessive workloads (Peters, Hobson, and Samuel 2022). Due to how homelessness services are funded, job security is undermined by short-term contracts (Wirth et al. 2019). Others argue that shifts towards more rigid performance metrics have eroded capacity for value-driven practice, with Dzeng and Wachter (2020, 409) describing this disconnect as "moral distress", where workers are unable to align their actions with professional values. This sense of workers being "stuck in the middle" is highlighted by Scanlon and Adlam (2012, 78), who show how workers navigate the distress of unhoused clients and the limitations of under-funded systems. These pressures create an environment where emotional exhaustion is rife.

The psychological and systemic challenges of working within a (dis)stressed sector often lead to high staff turnover (Scanlon and Adlam 2012). When workers leave, less experienced staff take up higher responsibility positions, perpetuating a system in which neither workers nor service users are adequately supported (Lenzi et al. 2021). This body of literature shows how the fractured homelessness system is not only a challenge for its users (Blood et al. 2020), but a deeply affecting environment for those working within it. One potential solution to these challenges is the adoption of trauma-informed care (Scanlon and Adlam 2012). The article now turns to explore the extant literature on the shift towards these approaches, and whether and how it features the voices of staff.

The Shift to Trauma-Informed Care in Homelessness Services

In recent years, scholars have highlighted a notable shift in the way homelessness is addressed in service interventions (Johnsen, Fitzpatrick, and Watts 2014; Parr 2019). This shift is characterised by a move away from more conditional towards softer approaches that prioritise care. This transition encompasses a range of strategies, including trauma-informed care, psychologically informed environments, person-centred, strength-based and therapeutic models.

These interventions have been argued to represent a significant departure from punitive and condition-based models that have historically dominated the homelessness service landscape, becoming what Johnsen, Fitzpatrick, and Watts (2018, 1115) refer to as the "nascent countertrend". Watts, Fitzpatrick, and Johnsen (2018, 237) characterise these contrasting approaches as moving from hard (interventions which use elements of force and coercion such as the arrest of people for begging), to soft (influencing people to change their lifestyles or behaviours, for example through assertive outreach), to no (tolerant, non-interventionist approaches offering unconditional access to support) means of exerting power. Trauma-informed care could be placed within the softer category. With origins in the criminal justice and mental health systems of the US, trauma-informed care has been defined as an "organizational change process centered on principles intended to promote healing and reduce the risk of retraumatization for vulnerable individuals" (Bowen and Murshid 2016, 223). It revolves around five core principles appearing in similar form across the literature: safety, trustworthiness, collaboration, empowerment and choice (for more detail on principles, see Elliott et al. 2005; Fallot and Harris 2001, 2006; Hopper, Bassuk, and Olivet 2010; SAMHSA 2014). Literature highlights the whole-organisation approach to trauma-informed care; that principles must apply equally to both staff and service users (Johnson and Haigh 2011; Sweeney et al. 2016).

Scholars have argued that different categories of homelessness interventions are not as straightforward as they first appear, and it should not be assumed that tolerant models of practice are radically different or any more ethical than more interventionist ones (Parr 2019; Watts, Fitzpatrick, and Johnsen 2018). Employing and extending Grant's (2006) three criteria ("legitimacy of purpose", "voluntariness of response", and "effects on character") and their own fourth criterion of "pertaining to effectiveness, proportionality and balance" for judging the legitimacy of deployments of power, Watts, Fitzpatrick, and Johnsen (2018, 247) show that paternalistic interventions, if they prevent significant harms, are defensible. At the very least, tolerant approaches should be subject to the same scrutiny as interventionist ones (248). This article takes up this challenge by exploring the apparently softer approach of trauma-informed care from staffs' perspectives, and how it *feels* to perform it amidst a system in crisis (Blood et al. 2020).

In theory, a trauma-informed approach recognises the importance of training, supervision and support to protect the wellbeing and prevent the secondary traumatic stress (STS) of staff in contact with trauma (Menschner and Maul 2016; Sweeney et al. 2016). Suggested strategies include the provision of training to raise awareness of STS, opportunities for staff to explore their own trauma histories (which may include psychology support), reflective practice, and an organisational culture which values staffs' mental health (Menschner and Maul 2016). In practice, as literature on staffs' experiences is

limited, it remains difficult to conclude whether and how staff *feel* implementing trauma-informed care. While there is a growing body of work on the psychological impacts of working within an increasingly impoverished sector, consideration through the lens of emotional labour remains underexplored – and even less so within the additional contextual layer of trauma-informed care. While equally important, the literature prioritises service users' experiences, both of trauma and trauma-informed care, over staffs' (Edwards, Mullet, and Siller 2023; Olivet et al. 2010; Peters, Hobson, and Samuel 2022). Exceptions include Phipps et al. (2017) and Benson and Brennan (2018), both of which explore staffs' experiences of using psychological approaches with people experiencing homelessness. In both studies, psychological approaches were experienced positively by staff, empowering them to focus on client relationships rather than behaviour management. In Benson and Brennan (2018), staff reported that understanding what might lie behind clients' behaviour allowed them to work better and closer with them. Similarly, Phipps et al. (2017) cite the value of reflective practice, encouraging a different method of working with clients through increased awareness of psychological factors. However, as Phipps et al. (2017) caution, translating psychological approaches into practice is not always possible, especially in constrained economic climates. While emotion appears in both – for instance, staffs' distress at thinking about and encountering client trauma – neither use emotional labour as their conceptual framing, which is where this paper offers a unique lens.

Conceptualising Emotional Labour

Emotions are central to social lives, a focus that has been extensively explored in the social sciences. While Marxist scholars have critiqued the "emotional turn", categorising it alongside wider conceptual trends that focus on the "self" (Boltanski and Chiapello 2005), feminist theories conceptualise emotions not as possessions (or states) of an individual, but as relational dynamics and interactions *between* people (Ahmed 2004). What is often labelled as private is, in fact, rarely so (Hanisch [1969] 2006). Drawing on Foucault, Boler (1999) questions the supposedly private instances of feelings and reframes them as sites of social control.

Central to this emotional turn, and of importance to the paper's framework, is the concept of emotional labour. Work within this area has built on early definitions of emotional labour by Hochschild (1983, 7) as "the management of feeling". This has been explored in various guises, from flight attendants who suppress feelings of exhaustion and frustration to perform as cheerful (Hochschild 1983), to roles that require the suppression of emotion, or "emotional neutrality", such as GP receptionists (Ward and McMurray 2011) and call centre workers (Bunting 2004). Emotional labour has also been explored through a feminist perspective and extended to unpaid, invisible care work largely performed by women (Finch and Groves 1983).

Emotional labour places emphasis on the *effort* involved in such work. Studies note the "felt-display" gap in the emotions of employees when attempting to conform to organisational rules, noting a difference between genuine feeling and that which is outwardly performed (Schaubroeck and Jones 2000). Taking this further, the literature organises emotional labour along a typology of "surface acting", "deep acting" and "genuine acting" (Amissah, Blankson-Stiles-Ocran, and Mensah 2022). In surface acting, employees have

been found to display emotions considered desirable by employers, with little effect on actual feelings (Hochschild 1983). Deep acting involves employees adjusting their feelings in line with their performance (Spencer and Rupp 2009). At the other end of the spectrum, genuine acting requires little acting at all as employees expressed emotions match those felt (Amissah, Blankson-Stiles-Ocran, and Mensah 2022). Literature has explored the link between types of emotional labour and the experience of emotional exhaustion. It has been found that the wider the gap between displayed and felt emotion, the greater the risk of emotional exhaustion (Kim et al. 2012).

Like emotion, this paper sees emotional labour as inherently social and contextual (L. Lewis 2012). It situates the emotional labour of homelessness service staff in relation to a fractured homelessness system of which trauma-informed care is part. Little attention so far has been paid to new forms of emotional labour experienced in the context of homelessness services as a result of recent policy drives towards trauma-informed care (MHCLG 2020; NICE 2022). Before presenting findings, the paper outlines how the study was carried out, through an account and justification of the methods.

Methods

This article draws from findings from an internally funded qualitative research project undertaken by the lead author at Sheffield Hallam University between September 2021 and 2022. The study explored how trauma and trauma-informed care were understood and implemented by services working with people with experience of homelessness, based around three research questions: 1) how do practitioners understand a) trauma and b) trauma-informed care; 2) how do understandings of trauma and trauma-informed care translate into practice, and 3) what are the barriers and enablers to implementing trauma-informed care? (McCarthy 2022). The decision to focus on homelessness services was made, in part, due to the take-off of trauma-informed care – its increasing endorsement and implementation – across the sector within the last ten years (MHCLG 2020; NICE 2022), and the existing knowledge gaps around how it works in practice. While barriers and enablers have been explored elsewhere, evidence is limited and existing studies fall within social care (Galvin et al. 2021; Roberts et al. 2023) rather than housing studies.

The research followed a case study approach, in that it involved multiple perspectives rooted in a specific context (J. Lewis and McNaughton-Nicholls 2003). The context was a London borough[2] characterised by high homelessness and rough sleeping presentations alongside an endorsement of trauma-informed care. Homelessness provision in the borough comprises a mix of local authority services and commissioned voluntary sector organisations. At the time of fieldwork, the borough operated multiple outreach teams, including a general service and a specialist team working intensively with long-term rough sleepers. The rough sleeping pathway consisted of roughly ten services, spanning high-support 24-hour hostels, women-only accommodation, provision for couples, and move-on supported housing.

In-depth semi-structured interviews were conducted with 15 professionals from ten organisations working with people with experience of homelessness. To ensure a more holistic understanding of the implementation of trauma-informed care across the local authority, the study included professionals covering various roles and levels, from commissioning (1) and managerial (8), to frontline (6). Organisations covered local

government, domestic abuse and sexual violence services, supported housing providers, drug and alcohol services, and specialist psychology support, services which routinely engaged with people experiencing homelessness. Recruitment and interviewing started with a known contact in a commissioning role, from which more individuals were contacted. A snowballing approach was continued thereafter until it was felt that a broad range of stakeholders in the borough had been interviewed in the time available for the study. Prospective participants were approached via an invitation email with an overview of the research and a participant information sheet.

Participants were invited to take part in a remote interview via MS Teams which lasted between 45 and 60 minutes. Interviews were audio-recorded, using an encrypted Dictaphone, and all participants were emailed a consent form, which they signed and returned before the interview took place. Informed consent was checked again verbally at the time of interview. The semi-structured interview followed a topic guide with questions about practitioners' understandings of trauma and trauma-informed approaches; whether and how trauma-informed approaches are implemented in their service; barriers and enablers to implementation; how they are implemented differently for different groups; how practitioners are supported in working with people with experience of trauma; costs and benefits of working in a trauma-informed way; and key lessons and areas for improvement. Commissioners were asked about their view of the service landscape in the local authority; their understanding of existing services for different groups who have experienced trauma; and barriers and enablers to commissioning trauma-informed services. The case study interviews were supplemented by interviews with four professionals working in frontline, managerial and training roles across England with specific expertise in trauma and/or trauma-informed approaches. Experts were asked about their understandings of trauma and trauma-informed approaches in the context of homelessness practice. These interviews provided insight into the wider national context and consequently, further triangulation for the case study.

The study received ethical approval from Sheffield Hallam University Research Ethics Committee (ER38610001). While the study was considered relatively low risk, the main ethical challenge involved ensuring absolute anonymity given the small participant group and case study area, coupled with the use of snowball sampling to identify further interviewees. These points were communicated at the outset – both in the written consent form and information sheet, and verbally before the interview took place. Interview transcripts were reviewed, with any identifying information redacted, and returned to participants with the invitation to check the document for accuracy and anonymity and with the option to request further editing of their accounts.

Data were analysed following the traditions of reflexive thematic analysis (Braun and Clarke 2006, 2019). Practically, this took the form of reading and re-reading transcripts and manually coding the data. The analysis was conducted by a single researcher (the lead author), consistent with the principles of reflexive thematic analysis, in which coding is treated as an interpretative, creative, and situated process (Braun and Clarke 2021). Codes were a mixture of surface-level and conceptual meanings (Braun and Clarke 2019). Analysis took place at multiple points and on multiple levels. Naturally, the interviews deviated and turned to experiences not determined by the topic guide or anticipated by the researcher. Hence, the specific focus of this article is, in part, grounded in the experience of homelessness workers. Broader findings from the study are explored

elsewhere (McCarthy 2022). While the final project report (McCarthy 2022) required a narrowing down of codes based on the study's research questions – and interpretation through a more applied, social policy lens – the writing of this article entailed returning to the data to perform a deeper, more specific analysis through a different conceptual framework ("emotional labour"). Drawing on versions of revised grounded theory, data were neither "forced" into the conceptual framework nor was the conceptual framework ignored completely (Glaser and Strauss 1967). Rather, theories acted as "skeletons" to which the "flesh" of the empirical data was added (Kelle 2007, 149).

This study has several limitations which should be acknowledged. Recruitment was limited to professionals working within a single London borough, and while this site was selected for its particularity, the sample size and geographical specificity mean the data reflect experiences embedded in this local policy context. The method of sampling participants, as a starting point, through the commissioner may have also resulted in some self-selection bias.

Generalisability is often not the point of case study research; rather the value lies in the depth it provides (Eckstein 1975; Flyvbjerg 2006). Nevertheless, it is important to situate the findings within broader structural trends. Austerity has actively shrunk the capacity of local government in Britain across the board (Gray and Barford 2018; Peck 2012). The term "traumatised system" was coined in relation to ten years of commissioning trends in UK homelessness services (Blood et al. 2020, 3). Trauma-informed care has also seen growth internationally, suggesting relevance of this work across a range of national and international settings (FEANTSA 2017).

The next sections explore the study's two main themes, reflecting on how practitioners upheld trauma-informed care within the constraints of the system: 1) how they maintained empathy; and 2) how they contained emotion, in part, as a self-preservation attempt.

Findings

Keeping Up the Empathy

In their ongoing work with clients, practitioners described their approach as being empathic, flexible, persistent, hopeful, reliable, patient, moving at the client's own pace and being client-led in terms of goals and actions. Being able to maintain empathy and tolerance all the time, especially when working in a fractured system and encountering difficult behaviours daily inevitably took its toll on workers, and several spoke of it "dragging" them out of trauma-informed care. The chaos of the working environment made it difficult for practitioners to find the headspace to practice a trauma-informed approach continuously.

> The level of practitioner skill that is needed to retain a trauma-informed lens when you're working in your spit and sawdust, salt of the earth but absolutely wonderful homeless[ness] service, whether it's a night shelter, a day centre, a more transient type of homeless[ness] service say, the chaos that comes with that drags practitioners out of a trauma-informed approach. (Expert 1)

Working in proximity to trauma took its toll. Secondary traumatic stress is increasingly acknowledged as affecting staff in the homelessness sector (Homeless Link 2023;

Pearlman and Saakvitne 1995), but here, the effects were described as more existential, or harder to pin down, than any previous studies have managed to capture. This suggestion is in line with work that has attempted to broaden the definition of trauma beyond its clinical roots (Pain 2021).

> I always try and communicate that if you're working in proximity to trauma, and again this is that stuff that doesn't quite get picked up in the clinical sort of stuff. Is there something that happens, something subconscious? It's not easily defined, it's not easy, but to be in proximity to someone who's been really hurt will impact you on a deeper level. (Participant 8, frontline)

Trauma-informed care is about making sure everyone in a space feels safe, including staff (OHID 2022). However, in the homelessness services in this study, this ideal was frequently unmet. One practitioner highlighted the difficulty of adhering to trauma-informed care in the face of abusive behaviour, particularly when staffs' sense of safety was compromised.

> That's always a challenge for services; how do you balance being trauma-informed with someone that is being extremely abusive? It's all very well understanding and recognising where their trauma comes from and acknowledging and trying to work with that, but equally if you've got someone that's being verbally and physically abusive it's a hard one. (Participant 5, managerial)

Practitioners described what they saw as their occasional lapses in performance as an inevitable aspect of human nature. While this perspective reflects a level of acceptance, it also conveyed an apologetic tone. Nearly all practitioners identified these challenges as fundamentally opposed to the principles of trauma-informed care. They expressed concern that even brief lapses in empathy or patience, revealing their human imperfections, were perceived as a failure to uphold standards. To some extent, this implied perfectionist interpretations of trauma-informed care, seeing it as an ideal to be reached rather than a learning process.

> At the end of the day, we're all only human [. . .] sometimes I think it's very difficult to be trauma-informed and compassionate and be very unconditional and everything else when you're faced with a wall of abuse. (Participant 5, managerial)

Workers also had to bear the emotional burden of how their changes in tone or performance might impact clients. As Participant 7 infers, even on bad days, when "you've got ten people shouting at you all day", or with "someone who [is] picking at everything", feeling your patience slipping is something that needs to be worked on.

> I saw someone recently who was just picking at everything I said, and I could feel myself losing patience so I guess just having that humanity, or being human about it and going "I can't do this anymore" and just absorbing that and that's okay and then working out how to mitigate that happening again so that people aren't getting negative responses from you. I don't know if they picked up on my frustration but I was certainly picking up on it. (Participant 7, managerial)

These emotions often came about, or were intensified, because of the state of the wider system: a lack of (secure) funding, staffing shortages and increasing complexity of client need within the homelessness sector (Blood et al. 2020). The wider context in which homelessness services are embedded – a commissioner described local statutory services as being "on their knees" – detracted from a sense of safety for staff. The insecurity of

funding, not knowing if a service would continue into the next year, was highlighted as a particular issue.

> I just think if services don't feel safe in terms of how long they're going to be funded [. . .] that can seep into . . . but also just the time it might take to engage people or for you to actually see the outcomes. I do recognise there's the reality of commissioners only having so much money and this is where I think it goes back to the politics and being like the different people in government and how much funding is given to homelessness services or other services. (Participant 12, frontline)

A lack of resources resulted in staff spending much of their time responding to crises, making it difficult for them to adhere to trauma-informed care principles. In such circumstances, practitioners felt like they were unintentionally neglecting or not caring for clients. This was seen to result from not only a lack of time but a lack of headspace; that after dealing with crisis after crisis, practitioners ran out of emotional capacity to engage with a client more creatively and emphatically.

> Because of the lack of resource and that greatness of the need, I think there's often a feeling that - not by anyone's fault - but I hear people do experience, that re-experiencing of being left in neglect and not being cared for and not being understood and not be able to get their needs met just because of the sheer number of residents with multiple needs and the number of staff who have to prioritise crises or other practical things like that. And that happens quite a lot. (Participant 10, frontline)

> There's three of them on shift and then there's 80 clients and they want to do this key work session or they want to take the client out for a coffee or to the museum or just get them engaged in the community again, which I think can be so powerful, but they just haven't got the time because this has popped up or there's a crisis. Yeah, there just doesn't feel like there's enough resource. And again, that might feed into almost neglecting clients a bit sometimes, not because we want to do that, but just because there's not enough time or headspace in the day. (Participant 12, frontline)

Tact and Timing: The Attempt to Contain Emotions

Practising trauma-informed care was also about attempting to contain emotions (Hochschild 1983). Often this was predicated on the almost counterintuitive act of not responding to crises immediately but reflecting on the best course of action and waiting for the right moment; "tact and timing", as one practitioner termed it.

> That tact and the timing of conversations, that's all experience. I mean someone shouting in the hallway, you can go out and deal with it or you can think wait, wait a minute. Wait, wait, wait. Go in for that right moment. (Participant 13, managerial)

> A really big part of it is the reflective component of just taking a step back and thinking what am I missing, why am I doing this, what's going on in this system, how am I, how is the client? And sometimes I think when systems get traumatised, we stop that kind of mentalising or thinking, and we just go into like "my god, we need to call the police". (Participant 12, frontline)

Performing trauma-informed care within a fractured system required a delicate balance of feeling enough but not too much, walking an emotional tightrope of empathy. It was expected that workers possess and exercise a range of interpersonal skills to be able to

engage well with clients but not feel so much that it affects their ability to work due to burnout. As one practitioner put it, "you can't be ripped open, but you need to be open enough" (Participant 8).

In practical terms, this meant that practitioners working under trauma-informed care needed to put in place boundaries when supporting clients. Practitioners spoke of how trauma-informed care was often misunderstood as being "boundary-less" when, in fact, boundaries were understood to benefit both clients and staff. A lack of boundaries was even seen as having the potential to re-traumatise if it reminded clients of a disordered past. Determining the extent of boundaries was also a balancing act. While too many boundaries may detract from other tenets of trauma-informed care – choice and empowerment – too few would risk chaos and an absence of safety.

> There's just this lack of a nuanced understanding of what being trauma informed actually is. One way you need to give people allowances, but in another way, if you do that in a way that isn't boundaried, then you re-traumatise people 'cause it reminds them of that time in their life. (Expert 2)

While workers managed their emotions as a protective measure for both themselves and their clients within the framework of trauma-informed care, this approach had a darker side, which experts identified as potentially leading to harmful consequences. For staff to feel safe, trauma-informed care requires access to support systems – reflective practice, counselling and therapeutic debriefs – and a culture that encourages their use. However, there was a sense among participants that while support mechanisms were available in their organisations, some staff members avoided them, possibly due to fear of being perceived as failing at their jobs. A stark example is provided in the following quote:

> I was eating my lunch next to a couple of support workers the other day and they were like "had to resuscitate [name] last night". And I was like, "what?" And they're like, "yeah, [name] was clinically dead for half an hour. And we had to resuscitate him and get the defibrillator out". And I was like "are you OK?" And then they were like "yeah, it's just part of the work, isn't it?" And I was like, no, no. But I almost sensed this reluctance in them admitting that they've been affected by it because they seemed almost like a bit scared I might judge them. (Expert 2)

Framing the traumatic incident of performing CPR and resuscitating a client as "part of the work", suggests a stoic normalization of extreme events and an almost culture-wide practice of suppressing emotion. Other similar responses described by participants included the adoption of a "gallows humour", becoming "hardened", and building up defences. As Participant 8 alludes below, there remain unanswered questions around "what it means to be in trauma all the time", concerning the longer-term effects on workers who continually suppress and carry significant emotional burdens without healthy outlets. While literature recommends trauma-informed care to prevent trauma transmission between clients and staff (Figley 1995), there was a suggestion that it was more complex here. Not only was there evidence of secondary traumatic stress exhibited by staff as direct trauma survivors – the strategies employed by staff described in this section are akin to the emotional numbing of survivors (Pearlman and Saakvitne 1995) – but an implication that trauma was being passed on, not just between clients and staff but throughout the system itself.

> There's so many other parts where it's recognised it's a bit of a shit job and you've got gallows humour, but actually there's huge issues for individuals within that work, but then for society itself because it's not . . . you're creating an abusive system. (Participant 8, frontline)

This returns full circle to Blood et al.'s (2020, 3) "traumatised" homelessness system. The sector is indeed fractured by over a decade of austerity. But so too is it shaped by the cumulative trauma of those who work in proximity to trauma survivors and how that leaks into the wider system.

Conclusion

Little attention has been given to new forms of emotional labour in the homelessness sector. This is the first study to explore how professionals in the homelessness sector manage their own emotions amidst the complexities of a fractured homelessness system. This article makes an innovative contribution by drawing on empirical material with staff to show how service delivery in a sub-optimal system demands levels and forms of emotional labour incongruent with the principles of trauma-informed care (Elliott et al. 2005; Fallot and Harris 2001, 2006). By applying the concept of emotional labour to the practice of trauma-informed care in homelessness services, it highlights the disconnect between expectations and what can reasonably be performed in a fractured system. Focusing attention on *emotional* labour has foregrounded the often-hidden work practitioners undertake to maintain trauma-informed care under systemic constraints.

Findings reveal the extent of emotional labour required for workers to keep up the empathy, or to maintain trauma-informed care, in the face of regular crises, chaotic environments and increasing client need. As a result of the complex decision-making processes that come with performing empathy in trauma-informed care models, staff found themselves walking an empathy tightrope, a tricky act of needing to "feel enough but not too much". Inevitably, they sometimes lost their balance. This meant that some of the principles of trauma-informed care, in particular safety, were absent at times for staff as well as clients (Edwards, Mullet, and Siller 2023; Olivet et al. 2010; Peters, Hobson, and Samuel 2022).

While there were hints that some staff recognised that much of the fault lies with the wider system – and how in more recent years it has been gradually eroded – there was also evidence that systematic shortcomings were internalised and absorbed personally; the sense of guilt when practitioners felt they had let the mask slip and were unintentionally neglecting or not caring for clients. Applying emotional labour in a different setting, this article has identified particular manifestations of emotional exhaustion. Previous literature on emotional labour has found that the wider the gap between displayed and felt emotion, the greater the risk of emotional exhaustion (Kim et al. 2012). Here, it was when that gap narrowed – when emotion could not be contained in stressful scenarios – that practitioners felt the emotional burden of having failed to meet the expectations of trauma-informed care. This reveals a form of emotional labour that is deeply shaped by systemic precarity, offering a new lens on how structural failings are felt at the level of frontline practice.

Staff went to great lengths to contain their emotions, engaging in more boundaried working and pausing in order to deeply consider how to approach a situation before

reacting at all. Rather than a difference between genuine feeling and that which is outwardly performed (Schaubroeck and Jones 2000), the emotional labour in this case was in the attempt to suppress the display of emotion completely. In some ways, this seemed like an attempt at self-preservation. In other, more dangerous ways – especially if staff did not take up psychology support or reflective practice – it suggested a normalisation of traumatic events and a stoic acceptance that they are part of the job role. This finding is similar to work in the field on stress and burnout, and how practitioners keep feelings of distress to themselves in case they are interpreted as a sign of weakness (Lenzi et al. 2021).

What lessons do findings provide for ongoing implementation of trauma-informed care in homelessness and related services now? While the principles of trauma-informed care are indeed worth striving for (MHCLG 2020), it is difficult to imagine how they can be fully achieved in the context of an austerity-stripped public sector, either in the UK or similar international contexts (FEANTSA 2017). Smith and Monteux (2023) make this point in relation to social care: it would be difficult to implement new models of care in the current conditions of, for example, high levels of staff turnover and recruitment difficulties. This paper argues for policy to prioritise addressing the structural deficits that undermine the functioning of a trauma-informed homelessness sector. Our findings reinforce the need for explicit endorsement of trauma-informed care within homelessness strategies, backed by financial support to make these commitments meaningful. Echoing recent developments in Scotland, a national training programme and roadmap to a trauma-informed workforce across all sectors would bolster these commitments (Scottish Government 2023). At an organisational level, mandatory core training and reflective practice, alongside active promotion of the principles of trauma-informed care, may help embed and normalise a trauma-informed culture and reduce the sense that practitioners must individually absorb the emotional labour of performing trauma-informed care in a fractured system themselves.

There are several directions future research could take. This study could be scaled up to explore the practice of trauma-informed care across different local contexts, identifying strategies that most effectively support staff wellbeing. Evaluating the impact of national training programmes, such as Scottish Government's (2023) roadmap, would provide further evidence to guide the implementation of trauma-informed care. Finally, there is a need for more research on trauma-informed care in general, further interrogating the realities of practice in the homelessness sector and beyond.

Notes

1. Harris and Fallot (2001) define a trauma-informed approach as being two-fold: 1) it requires services to have an awareness that clients may have experienced trauma; and 2) the former provides a framework through which services are designed and delivered, i.e. in a way that appreciates the impact that trauma has on survivors. Trauma is broadly understood across the literature as resulting "from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA 2014, 7).
2. Details of the exact local authority are not revealed in this article to protect participants' anonymity.

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For the purpose of open access, the author has applied a Creative Commons Attribution (CC BY) licence to any Author Accepted Manuscript version of this paper arising from this submission.

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Statement of Novelty

We believe the paper's contribution is twofold: first, it provides much-needed empirical knowledge about the implementation of trauma-informed models; second, in contributing a new conceptualisation of trauma-informed care, it discloses the ways in which endorsement of the model in the homelessness sector demands forms of highly precarious emotional labour. This conceptual framing is applicable to other disciplines and sectors coming to terms with the model.

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