CENTRE FOR INNOVATION IN
CAMPUS MENTAL HEALTH

Trauma-Informed Practice

Understanding trauma

A traumatic event can be defined as exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. These events are not all experienced the same way and can result in different emotional and physical responses in survivors. While these feelings are normal, some people have difficulty coping which can influence how they experience and navigate their physical and social environments.

Trauma itself is defined as an emotional response to a terrible event. It can be long-term reactions that can include unpredictable emotions, flashbacks, strained relationships, and physical symptoms like headaches or nausea.

While there are various theories about the effects of trauma as well as variability between individuals, the literature suggests that trauma can have a neurobiological impact on the function, structure, and biochemistry of the brain. For example, a well-researched issue related to experiences of trauma and Post-Traumatic Stress Disorder, or PTSD, is abnormal fear learning and memory. Often, this manifests as the brain overgeneralizing fear associations from the traumatic event to subsequent experiences where a threat is not present. To others, this can look like seemingly disproportionate behavioural or emotional reactions to an event. Other potential neurobiological impacts of trauma include hyperactivation of the amygdala, the emotional center of the brain, and under activation of prefrontal regions associated with emotional regulation. Although this is not an exhaustive list of the potential neurobiological impacts of trauma, these examples illustrate the deep impact that traumatic experiences can have on the brain and why it can be very difficult for individuals to control trauma-based behavioural responses. This is especially the case if they have not accessed any treatment and/or continue to exist in triggering environments.

Experiences of trauma can also result in physical issues. Survivors can exhibit chronic or acute symptoms such as, but not limited to:

- gastrointestinal issues
- changes in eating patterns
- headaches
- sleep disturbances
- muscle and body pains
- dizziness or disorientation

A survivor may experience panic attacks and physical discomfort as well as being unable to cope in certain triggering environments. The wear and tear on the body in response to repeated cycles of stress can also result in long-term mental health challenges, intensifying any existing trauma responses.

While most service providers are familiar with the term PTSD, there is less widespread knowledge surrounding the common trauma responses/ symptoms that are found outside of a formal PTSD diagnosis. It is important for service providers to be aware of these responses, as they can oftentimes affect building rapport in a working relationship.

Individuals who have experienced trauma may present in a variety of ways, however, there are commonalities found amongst them. The Substance Abuse and Mental Health Service Administration categorizes these responses into six broader categories: emotional, physical, cognitive, behavioural, social, and developmental.

From a service provider standpoint, we may notice in clients more frequent emotional dysregulation, and they may demonstrate "numbing", which is an absence of all emotions. This can be demonstrated by either frequently "over" reactions to emotional triggers, or "under" reactions. Somatization can occur as a common physical symptom, which is a tendency to express emotions through the physical body. This is demonstrated as frequent or constant complaints of physical ailments, with no biological causes. More commonly noticed, and identified as problematic, by service providers are the behavioural symptoms. One common example is avoidance. Individuals who have experienced trauma may use avoidance to limit any unpleasant feelings or memories resurfacing. This can often be observed in individuals who frequently miss appointments or avoid certain tasks/assignments despite being aware of the importance of them.

All of these trauma responses listed above can have a tendency to cause discord between a service provider and a service user if the provider does not understand that these are trauma responses, and not simply "behaviours".

It is also important to acknowledge that the biomedical and psychological understanding of trauma coexist with other cultural and/or spiritual definitions of trauma. Therefore, how trauma is defined and experienced will vary culturally.

What is Trauma-Informed Practice?

It is important to note that trauma-informed practices differ from trauma specific practices. Trauma specific practices are reserved for organizations or agencies that deal with the specific resolution of symptoms of trauma. This means that the interventions used will be targeted at treating the actual trauma, and associated symptoms. In trauma specific settings the service user will discuss the trauma event with a service provider explicitly trained in trauma-centered interventions.

In a trauma-informed practice, the service providers are expected to be knowledgeable surrounding the impact trauma may have on individuals, outside of the diagnosis of PTSD. These service providers will not be treating the trauma, or the trauma symptoms, but are expected to remain aware of and sensitive to these responses as they proceed with their service delivery. There are four main principles of trauma-informed practice. These consist of:

1. Normalizing and validating clients' experiences and feelings
2. Supporting clients in understanding how their past trauma will hold such emotional impacts for them
3. Empowering clients to learn to better manage symptoms and engage in a positive life
4. Helping clients understand how current challenges are impacted by past trauma

By adopting trauma-informed practice as described above, service providers are prepared to provide a safe, empowering space for a wide array of experiences of trauma. Especially when it comes to survivors of sexual violence, there is sometimes a tendency to focus on common triggers within this group. While there may be some utility to understanding specific common triggers, this can also lead to making assumptions about the individuals that you are supporting. Some individuals that you work with may have traumas and triggers related to situations or things that you think are benign. Others may have additional traumas outside of their experiences of sexual violence. While we cannot possibly come into our work knowing every single trauma, possible trigger, or fully understanding every individual's perspective, trauma-informed practice helps us to be sensitive, non-judgemental, and empowering when supporting individuals.

Implementation

The following checklist can help you establish trauma-informed practices in your own office:

- ○ Acknowledge the causes of trauma without probing the client for details
- ○ Maintain a non-judgemental position about the ways that the client has been coping
- ○ Allow the client to have control over the process, soliciting feedback often
- ○ Provide clear information and consistent expectations about your services and programs
- ○ Validate the client's trauma responses
- ○ Provide the client with many opportunities to practice making choices for themselves
- ○ Recognize the ways that sexual violence intersects with other systems of oppression
- ○ Develop tools to soothe and ground the client in the case of triggers or flashbacks
- ○ Maintain your own nervous system when interacting with the client by grounding yourself when possible
- ○ Do not touch the client without warning and permission
- ○ Use a client's correct gender pronouns, and be open to changes in how a survivor may identify or ask to be referred
- ○ Minimize any power differences between yourself and the client where possible
- ○ Recognize the client's strengths and gifts
- ○ Encourage clients to bring a support person with them to appointments, but do not pressure them to do so
- ○ Provide space for the client to express themselves openly
- ○ Allow the client the option to speak their first language where possible
- ○ Conduct an audit of your office to minimize the chances of re-traumatization for the client
- ○ Refer to trauma specific services where necessary

Self-Care for Service Providers

Empathic strain, also referred to as vicarious trauma, secondary traumatic stress, compassion fatigue, and critical incident stress, is the exposure to graphic details of other's traumatic experiences and to the post-traumatic stress symptoms of those persons, which impacts the listener over time. Symptoms of trauma may arise in an individual even though they have not directly experienced the traumatic event. Those who may experience empathic strain can include but are not limited to counsellors, support people, therapists, and helpers and can occur from such experiences as listening to individual clients recount their victimization; looking at videos of violence; reviewing case files; and hearing about or responding to the aftermath of violence and other traumatic events day after day. For more information on empathic strain, see **CICMH's empathic strain infosheet.**

As has been discussed in the Sexual Violence Response toolkit, intersectionality and understanding the influence of systemic forms of oppression in sexual violence response work is crucial. However, this discussion is also important in how we conceptualize "self-care" as individuals who are striving to create trauma-informed spaces. Mainstream wellness culture is not exempt from the influence of the capitalist, colonial society that we live in. Often, conventional self-care campaigns highlight individualistic, consumer-based activities such as enjoying luxurious bath products or purchasing an expensive fitness membership. This isn't to say that there is anything inherently wrong with enjoying these activities if they are accessible to you, but self-care does not have to be a commodity and it can also have a community component. In fact, the movement of "self-care" into the broader population outside of medicine was mobilized by 1960s civil rights activists in the Black Panther Party to encourage care for individuals and the collective.

This form of self-care is sometimes referred to as "radical self-care" and this concept has been discussed by figures like Angela Davis as well as Audre Lorde in her essay, "Uses of the Erotic: The Erotic as Power." While non-commodified, community-inclusive self-care has and continues to hold particular meaning for equity-deserving groups and activist communities, this type of self-care can be taken up by anyone. The key is recognizing that self-care can be anything that allows you to cultivate a meaningful relationship with yourself and your community. In practice, this can mean many things such as sharing a meal with friends, contributing to mutual aid, connecting with nature, or truly doing "nothing" without attempting to explain or justify it. Rest does not need to be "earned" or seen as a strategy to be more productive later. Importantly, if you are in a leadership position, it may be worth asking yourself how you can promote self-care as both a personal and communal act within your workplace and how this can translate into your work supporting survivors.

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