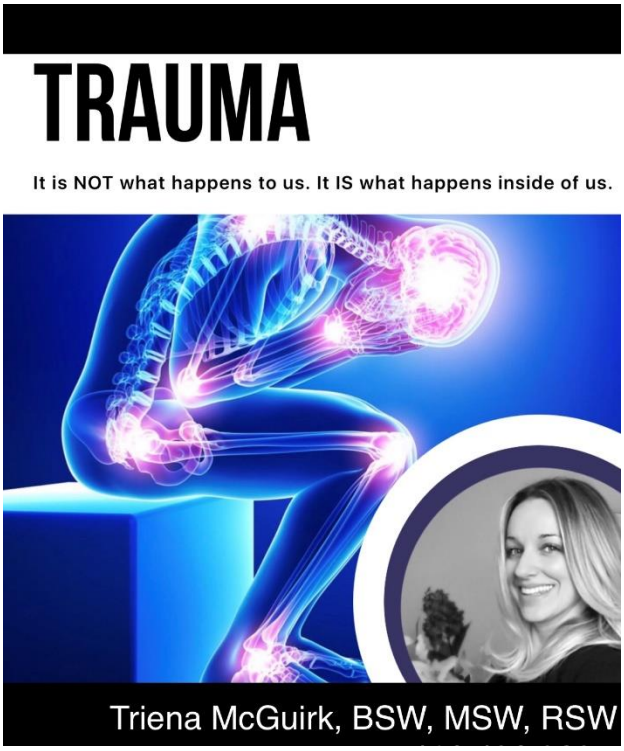

WHAT IS TRAUMA?

In 2017 when speaking at a two-day symposium on Compassionate Inquiry, Dr. Gabor Maté first brought attendees to the origin of the word 'trauma'. 'Trauma' is Greek for 'wound'. Dr. Maté shared a conceptualization of trauma as a flesh wound. Dr. Maté reviewed the healing process of the injury, to involve forming scar tissue around the injury, a scar forming, and contingent on the severity of the injury a loss of sensation and flexibility to the injured area. Dr. Maté explained that trauma is a loss of feeling, reduced adaptability, and increased defensiveness in response to life around us. Trauma is our response to a disturbing or distressing event. Trauma can manifest and masterfully maintain feelings of helplessness and can impact a person's capacity to feel the full range of their experiences and emotions. This is a human response and it does not discriminate. There are no objective criteria to evaluate what experiences are traumatic, it is the experience of the survivor. Trauma is a distressing and disturbing experience that can cause physical, emotional, spiritual or psychological harm. It is measured by a response, rather than a specific trigger.

THERE IS NO TRAUMATIC EVENT HIERARCHY.

The impact of trauma is contingent on the person and how the event is experienced by them. Many people experience various traumas in their lives in the form of divorce, legal trouble, financial instability, bullying, work conflict, etc. The potentially traumatic impact of these events tends to be minimized because these events are deemed a 'common', and they do not necessarily involve a life or body threatening outcome. Nonetheless, these life events have a profound capacity to impact our social-emotional well-being and ability to function. When multiple traumatic events coexist in a condensed period the impact on the induvial is compounded, in turn placing a person at risk for greater distress. Overt, or life or body threatening, traumatic events such as exposure to war, house fires, accidents, physical injury, physical assault, natural disasters, sexual assault, etc. are, generally, readily acknowledged as traumatic events, however, the impact of overt, traumatic events is also contingent on the individual experiencing them. The presence of 'common' traumatic events at the time of an 'overt' traumatic event occurring has the capacity for a cumulative effect that increases the impact on the individual, in turn intensifying the distress and dysregulation experienced. Two people can be exposed to the same traumatic event, however, the manner in which each person is impacted by the traumatic event can greatly differ person to person. **Trauma is NOT what happens to us. It IS what happens inside of us, in response to events that happen to us** (Maté (2008), (2003)).

FIGHT, FLIGHT & FREEZE RESPONSES.

The human brain is built to protect us. This is evident from the functions of our 'reptilian brain' that promote 'Fight', 'Flight' and 'Freeze' responses (Beaudoin (2014), Siegal (2010), van der Kolk (2015)). Our fight, flight, and freeze responses can be activated when we are in actual or a perceived threat of harm. Let's say you are in a house that is on fire, your reptilian brain kicks in to tell you to RUN, or engage 'flight' response, to keep you safe. Your brain then releases adrenaline (acts as a powerful stimulant) and cortisol (stress hormone) to give you the energetic boost to carry out this task. Our 'flight' response can be triggered when we are not in actual danger, which is a

perceived threat, such as when you are in a building and you hear a fire alarm. Your body can momentarily react the same way, startled, scarred, ready to respond, and an increased heart rate, however, the moment you hear "it was a drill" the thinking part of your brain activates you deduce that you are not in danger, and therefore do not have to run. When a person is impacted by trauma, their brain can send misleading signals that they need to protect themselves, engaging in 'fight', 'flight' or 'freeze' responses when they are not in danger. In turn, reducing capacity to feel safe on an ongoing basis, as non-threatening stimuli can be perceived as a threat ((Beaudoin (2014), Siegal (2010), van der Kolk (2015)).

PSYCHOLOGICAL RESPONSES to trauma vary across a spectrum and are significantly influenced by an individual's sociocultural history, and resiliency factors. Trauma can present itself in the emotional extremes of feeling too much (overwhelmed) or not feeling enough (numb). There is a tendency for family members and mental health professionals to assess levels of traumatic stress symptoms and the impact of trauma as less severe with regards to numbing. Anxiety, depression, post traumatic stress disorder, dissociative disorders, addiction issues, substance abuse, non-suicidal self injurious behaviour (NSSI), and suicidal ideations are amongst the most common psychological responses to trauma (Siegal (2010), Maté (2003). The period of emotional dysregulation for persons who are older and functioning well when a traumatic event occurs, is usually shorter lived. The behavioural manifestation of traumatic responses is not always considered 'negative', as some people find diligent, healthy, and creative pathways to cope with the overriding effect created by trauma, such as engaging in self-care, and becoming an advocate or support person for survivors of a familiar trauma. Responses to trauma can be highly adaptive and functional while simultaneously being maladaptive. An example of this would be an adult who is employed full time, is a member of various committees, cares for their family and has perfectionist standards for themselves within each realm. Outside observers often wonder how this is accomplished, as they cannot achieve this standard. The adaptative traumatic response for this person was to "keep busy, keep moving forward", which in turn fuelled their successes that were observable to others. What people couldn't see was that this person HAD to keep busy, as the dysregulation and palpable discomfort of sitting still was more than this person could bare. This is a form of a flight response.

HYPERAROUSAL is a common symptom that arises from traumatic experiences. Hyperarousal is also often referred to as hypervigilance. Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances or insomnia, muscle tension, and a lower threshold for startled responses. This can persist years after trauma occurs. Hyperarousal is also one of the primary diagnostic criteria for Post Traumatic Stress Disorder (PTSD) (Siegel (2010). Trauma rewires our biology and hyperarousal is a consequence of these biological changes. Self-protection is a function of hyperarousal after trauma, however, it can have the opposite effect as it can interfere with an individual's ability to take slow down, and appropriately assess and respond to a situation or stimuli, such as loud noises or sudden movements. To the non-trauma informed observer these behaviours are often categorized to be controlling, irrational or overprotective.

A family I worked with were involved in a horrific car accident leaving one family member hospitalized for months, and the other family members had brief hospitalizations for non-life-threatening injuries. The adult family member who returned home to care for the children after the accident started to experience heightened anxiety that presented itself as physical discomfort, tension and flashes of anger when friends or family members did not call or text to advise that they arrived at their destination safely, and it was starting to negatively impact relationships. The children in this family started to demonstrate regression behaviours, such as being scared to sleep alone, being afraid of the dark, and having separation anxiety from their well parent out of fear that something would happen to them when they were at school.

Another example, a woman who was fleeing a violent partner reported that she had great difficulty sleeping, would vigilantly and repeatedly ensure that all locks on doors and windows in her home

were engaged and wake at night fearful that she had left one unlocked, and would get up and check all windows and doors again prior to going back to bed. It was also observed that when someone would raise their voice this woman would cower and wrap her arms around her chest (seated fetal position to protect self) and become silent and unable to engage. This hyperarousal response can be classified as a cognitive error. Cognitive errors are the misinterpreting of a situation as dangerous because it resembles, even remotely, a situation from a previous trauma (i.e. being spoken to in a raised voice, prompts a memory of abuse that occurred when the perpetrator of abuse raised their voice). This woman also reported that being in the community was uncomfortable. When she had go to a restaurant she ensured she was seated in a location where the entrance was visible (not at her back) and she was aware of the emergency exits at all times, in case her abuser arrived or something happened in that environment she could flee to protect herself. This pattern went on for years. These are some examples of how hyperarousal from trauma can manifest itself in our lives.

HYPOAROUSAL is also commonly experienced by persons impacted by trauma, and often this presentation is undetected initially by clinicians, or support persons, as hypo arousal is an internal process. Hyperarousal may occur when we are engaged in a heightened state of hyperarousal, when a person's body and brain become overwhelmed by the emotional pain of their trauma, and they can enter a downward spiral into hypoarousal. Hypoarousal is commonly referred to as shutting down, a depressed affect, numbing, or disassociating. Our brains shift between hyperarousal and hypoarousal as a form of self preservation. Hypoarousal may make people lethargic, or want to sleep all of the time, it can impact their appetite and digestion and creates a barrier for people to experience the full range of their emotions. When I was working with a youth, who was 12 years of age, prior to being aware of the multiple compounding traumas in their early life, they spoke of always being tired and that they would sleep for 3-5 hours after school daily. This youth also shared that when their family was celebrating Christmas they felt flat, and could not reach the joy around them that was clearly being experienced by others. The youth described being subject to insensitive statements by multiple family members about their sitting quietly, on their own, in the corner of the room, which resulted in the youth removing themselves from that environment to go to a bedroom to cry alone, not understanding why they were not happy because nothing bad happened that day. That is trauma manifesting itself as hypoarousal. Other persons I have worked with have described hypoarousal as feeling as though they were going crazy, not feeling right, they are messed up, and not feeling okay. Statements such as these can serve as flags of concern for us to be curious about. It is important to unpack these feelings and discover effective strategies to help people make shifts in this capacity. Clinicians well versed in trauma informed modalities can be of assistance at a therapeutic level in this regard, but any person can support in this capacity. When attending the 2015 conference on Interpersonal Neurobiology and Therapeutic Practices, in Toronto, Dr. Dan Siegel was the keynote speaker on day one of three. When speaking on this matter, he shared a simple strategy to support persons impacted by trauma, that anyone can employ, "name it to tame it". Despite your training or expertise, we are all human and connection is the essence of the human experience. When we notice a trauma response in ourselves or others naming what we observe or sense, opens the pathways for understanding of a person's perspective in addition to be validating. When we take the time to stop and notice, this can be a powerful tool to connect, co-regulate, ground, and move forward. Sometimes we may notice a person's energy being low and they are withdrawn, name it by saying "I noticed you seem withdrawn today, do you want to talk about what is happening for you?". Often, in any given moment we pick up on an energetic shift for people, and this too is a point of inquiry. In working with a woman who was fleeing violence I asked what I perceived to be an innocuous question not related to the violence, and upon asking this question the energy coming from this woman changed, it down spiralled immediately, it was palpable. We all have the capacity to perceive energetic shifts, and when we do, we can "name it to tame it" (Siegal) to open dialogue, give support and inform our practice. In this instance I simply stated "I feel something shifted or changed for you. Did something happen for you when I asked that question?". In response the woman shared why this innocuous question

activated her, brought her back to a traumatic event, which in turn provided helpful insight on how to best support her.

PHYSIOLOGICAL RESPONSES to trauma include, but are not limited to, chronic pain, auto-immune disorders, chronic illness, gastrointestinal issues, headaches, migraines, nausea, dizziness, and disturbed sleep. Research into the biology of trauma is a burgeoning area of exploration that is innately dismissed in our western culture. The body holds on to our traumatizing experiences and this has implications for mental and physical health (Maté (2003), van der Kolk (2015)). If a person experienced Adverse Childhood Experiences (ACEs), such as abuse, neglect, violence in the home and other traumas that affect brain development, a high ACE;s score increases a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseases and other physical illnesses, mental heath issues, substance-related disorders, and impairment in other life areas (Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Marks, J. S. (1998)). These traumas interact and compound the impact of later traumas experienced in that person's life, in turn increasing their risk for a variety of physiological ailments (Maté (2003), Maté (2010), van der Kolk (2015), Doidge (2015), Anda, Schulman, Felitti, Croft (2010, Barile, Edwards, Dhingra, Thompson, 2014).

SENSORY CONNECTION TO A TRAUMATIC event is commonly reported by persons who have been traumatized. Trauma is recorded through all our senses, may it be sight, touch, smell, sound, or taste and these recordings of a traumatic event have the capacity to transport the person who has been traumatized back to the traumatic event without provocation or consistent antecedent. There are times when persons impacted by trauma cannot connect their sensory activations (more commonly known as 'triggers') to the trauma they endured, however, many persons can make this connection, and through the support of clinical interventions they reduce the impact of their reactivity to these stimuli (Levine (2015). When working with an adult who was a survivor of childhood sexual abuse they would periodically report going about their day and being derailed by the random unanticipated taste of the abuse manifesting in their present, and it taking them back to the act of the sexual abuse they endured as a child. An adult male reported that it took him years to overcome the fear he felt when he saw a leather belt with a metal buckle, as the sight of such a belt prompted memories of physical abuse he endured as a child, when he was repeatedly thrashed with a leather belt. An man in his 60's reported that when hearing wood break the sound transported him to the memory of his tail bone cracking upon impact with this father's steel toe boot when he was kick ed as a teen for not moving fast enough. A survivor of intimate partner abuse reported not being able to tolerate the smell of a particular cologne, as it was the cologne worn by her abuser, and when she smelled that cologne her anxiety immediately increased, her body tensed and she was brought back to the abuse she endured. It is not uncommon for persons who have been traumatized to be deemed as unreliable witnesses, as they have challenges recalling events in a linear or chronological order, they will have gaps in their recall, or new information from the traumatic event may never surface or surface years later. Systems tend to discredit people who have been traumatized because of this, however, the fragmentation of memories associated with traumatic event is the brain's way of compartmentalizing and protecting the person from the overwhelming impact of the trauma (Levine (2015)).

HOW TO SUPPORT PERSONS WHO HAVE BEEN TRAUMATIZED is knowledge of importance for all people, regardless of profession, as trauma is a shared human experience. There are a variety of modalities, such as but not limited to, desensitization therapy, Cognitive Behavioural Therapy (CBT), hypnosis, exposure therapy, Eye Movement Desensitization and Reprocessing (EMDR), Somatic Experiencing therapy, Sensorimotor Psychotherapy, mindfulness, craniosacral therapy, trauma-sensitive yoga, art therapy, pharmaceuticals, and acupuncture, that persons who have experienced trauma can access, however, therapy is most effective when it is self-determined. To be trauma informed we must first look in the mirror, and reflect on the trauma's we have experienced, and the impact of that trauma on

our perceptions, actions and interactions with others. If we are activated (triggered), by a client, family member, stranger, or situation it is important that we sit with that activated sensation, and self reflect, in an attempt ascertain the origin of this engrained response, as it can have unfavourable implications for ourselves and others. This is challenging to do on our own, therefore professional guidance is supported to assist in this 'unpacking'. When supporting persons who have experienced trauma it is important to create psychologically and physically safe spaces. Take time to hear a person's story and **get curious!** Professionals can invite persons they work with to inform what a safe place for them entails (i.e. shuttled meetings, seating arrangements, tone, allowing moments of silence, non-verbal signals that a break is needed etc.). Trauma is illogical and it unique to each person. Invite conversations that promote compassionate exploration, attentive listening, and most importantly promote and **support connection**. It is essential to observe and not interpret, be curious, provide validation (to the person's perspective and subjective experience), do not judge, do not challenge, do not reassure any distress away, coach and mentor and assist in generating solutions. **Attunement** is fundamental as it promotes growth and assists in co-regulation. The Still Face experiment by Dr. Edward Tronick (easily found on YouTube) demonstrates co-regulation between an infant and their mother. While this concept is presented through a child developmental lens, the concept remains true for all persons. Our verbal, non-verbal, and emotive reactions are palpable and important to understand as they impact the way we interact with others and how those interactions are received and perceived. When supporting a person who is experiencing dysregulation, we can support them by being calm, present and grounded, in turn promoting co-regulation. **Relationships are key!** Trauma violates a person's capacity to feel safe, therefore connection and nurturance, primal human needs, serve as the foundation for any helping relationship with a person who has experienced trauma; establishing this should be the priority within your role. There is no magic, one size fits all answer on how to best support persons impacted by trauma. What I have learned is this, **allow people to be the experts of their own lives,** often the details we "need" for our helping roles will come from hearing people's stories. **LISTEN**. Listen to listen, don't listen to respond or formulate your plan of support, and finally practice humility as you are not going to have all the answers.

REFERENCES

BOOKS

Beaudoin, Marie Nathalie (2014), Boosting ALL Children's Social Emotional Brain Power: Life Transforming Activities, USA, Corwin

Doidge, Norman (2015), The Brain's Way of Healing: Remarkable Stories of Discoveries and Recoveries from the Frontiers of Neuroplasticity, USA, Penguin Books

Levine. Peter A. (2015), Trauma and Memory Brain and Body in a Search of the Living Past: A Practical Guide to Understanding and Working with Traumatic Memory, Berkeley, California, USA, North Atlantic Books

Maté, Gabor (2003), When the body says no: The costs of hidden stress, Toronto, Ontario, Canada, Vintage Canada

Maté, Gabor (2008), In the Realm of Hungry Ghosts: Close encounters with addiction, Toronto, Ontario, Canada, Vintage Canada

Siegal, Daniel J. (2006), Trauma and the Brain: A Sensorimotor Approach, New York, NY, USA, W.W. Norton & Company Inc.

Siegal, Daniel J. (2010), Mindsight: The New Science of Personal Transformation, New York, NY, USA, Bantam Books

Siegal, Daniel J. (2012), Pocket Guide to Interpersonal Neurobiology: An Integrative Handbook of the Mind, New York, NY, USW, W.W. Norton & Company Inc.

Segal ZV, Williams JMG, Teasdale JD (2002), Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. New York, USW, Guilford Press

van der Kolk M.D., Bessel (2015), The Body Keeps Score: Brain, Mind and Body, USA, Penguin Books

ARTICLES

Anda R, Tietjen G, Schulman E, Felitti V, Croft J. (2010), Adverse childhood experiences and frequent headaches in adults, *Headache.* 2010;50(9):1473-81.

Barile, JP, Edwards, VJ ., Dhingra, SS., Thompson WW., (2014) Associations among county-level social determinants of health, child maltreatment, and emotional support on health-related quality of life in adulthood external icon. *Psychol Violence*. Oct.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258.

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Triena McGuirk, BSW, MSW, RSW
Clinician
www.familyfundamental.com
email: triena@familyfundamental.com