Alberta Health Services

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Trauma-Informed Care

Series Intro

This series consists of 7 self-study modules, each which can be completed in 30 minutes or less. A certificate of completion will be provided at the end of module seven when you have completed all of the modules in the series and the course evaluation.

We hope that these modules will help you better understand Trauma-Informed Care, including its rationale, guiding principles, and strategies for implementation.

Remember that learning about trauma can evoke strong emotions and memories in people who have experienced trauma themselves. Please pace yourself accordingly, respect your needs, and take necessary breaks.

NOTE: For consistency, these modules refer to individuals who have experienced trauma as trauma survivors. Not everyone who experiences trauma will relate to or identify with this label. It is important to ask each individual what wording and terminology they prefer.

Module 2 – Understanding Trauma

Welcome to Module 2 of the Trauma-Informed Care eLearning Series.

Learning Objectives:

By the end of this module, participants will be equipped to:

- Discuss the three components of the current Substance Abuse and Mental Health Services Administration (SAMHSA) definition of trauma
- Identify and give examples of the three types of trauma (acute, chronic, complex)
- Identify diagnoses directly associated with trauma (ASD, PTSD)
- Describe key concepts relating to the neurobiology of trauma
- Discuss findings and applications of Adverse Childhood Experiences (ACE) studies
- Demonstrate how Trauma-Informed Care (TIC) guiding principles can begin to move a person towards recovery

Definitions of Trauma

The word ‘trauma’ comes from the Greek word for ‘wound.’ It came into English language use in the 17th Century, and referred to physical wounds or injuries (Oxford English Dictionary, 2021).
Its use has steadily grown, particularly since the middle of the last century, and has come to encompass psychological trauma, those that we might call ‘wounds of the mind.’

The current edition of the Diagnostic and Statistical Manual of Mental Disorders definition of trauma requires the presence of “actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013). This first component noticeably restricts the understanding of trauma used for formal diagnoses of trauma-related disorders such as PTSD (Anushka Pai, 2017). For example, psychosocial stressors such as a prolonged illness or job loss would not qualify as a traumatic event under the DSM definition.

By contrast, the definition used by the Substance Abuse and Mental Health Services Administration (SAMHSA) is much broader than the psychiatric definition found in the DSM. According to SAMHSA, “Individual trauma results 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.” (The Colombo Plan and University of North Carolina - Chapel Hill, 2020).

With regards to Trauma-Informed Care, it would be wiser to adopt the broader definition, as not everyone who has experienced trauma meets the criteria for a DSM diagnosis. However, more people than we think have likely been overwhelmed by at least one event or situation in their lives that has had lasting consequences.

Both definitions have three components: (1) the presence of a potentially traumatic event, (2) exposure to the event (DSM), or the individual’s experience of the event (SAMHSA), and (3) symptoms of physical, mental, social, emotional, or spiritual distress appearing after the event.

Each of these components can help to assess for trauma.

1. The potentially traumatic event: objective characteristics. The usual who, what, when, where, and how facts are what embody these objective characteristics. Other characteristics of interest would be whether the event was expected or unexpected; and whether the event was experienced directly or indirectly.

2. The individual’s experience of the event: subjective characteristics. An individual’s interpretation of an event and their beliefs and assumptions about the world contributes to how they will process, react to, and cope with a traumatic event. Beliefs and assumptions are a person’s way of being in the world; they are determined by a wide range of social and individual factors. These factors are often referred to as Social Determinants of Health (SDOH) (Government of Canada, 2020). They combine in unique ways in each person’s life. SDOH include:

    - biology and genetics,
    - gender,
    - culture,
    - personal health practices,
    - social support networks,
    - social status,
    - social and physical environments,
    - child development,
    - education and literacy,
    - employment and working conditions,
    - living environments / conditions

Any combination can increase or decrease a person’s risk for experiencing events as traumatic. For example: living in poverty, having adverse childhood experiences, and lacking access to opportunities may significantly increase the chances of a person’s experiencing trauma. Social determinants also influence how well a person will recover from trauma. Having access to a strong and supportive social network or good personal health practices improves a person’s ability to address traumatic events and recover (The Colombo Plan and University of North Carolina - Chapel Hill, 2020).

3. Physical, mental, social, emotional, spiritual distress symptoms. These will be discussed in greater depth in the next module (‘Recognizing Trauma). Briefly, symptoms may include nightmares and difficulty sleeping, social withdrawal, emotional dysregulation such as fits of anger or general emotional lability, and loss of hope or faith in the future (The Colombo Plan and University of North Carolina - Chapel Hill, 2020).

Clinically we can think of trauma in terms of times when there are not enough resources to emotionally process an event or series of events. Resources can refer to several things. For example, time could be one of these resources: soldiers

carrying out orders in the middle of combat often do not have enough time to feel or think about the myriad emotions they may be feeling, such as fear, anger, or helplessness. Young children do not have the emotional maturity to understand or process the confusion of big emotions that accompany an abusive situation. Many who are experiencing some form of oppression do not have an adequate support network to help them cope.

Types of Trauma

We can think of traumatic events as falling under three general types (The Colombo Plan and University of North Carolina - Chapel Hill, 2020):

1. Acute trauma: refers to a single incident of relatively short duration. An example would be a motor vehicle accident.

2. Chronic trauma: refers to multiple traumatic events which can be diverse but are repeated and/or frequently experienced over an extended period. An example of this would be various forms of domestic violence (physical, verbal) throughout a relationship.

3. Complex trauma refers to chronic trauma that began or took place often before age 5, or more broadly during periods of attachment and relational growth; and perpetrated by trust figures. Examples would be childhood physical, sexual, or emotional abuse; and often historical or intergenerational trauma. (For more information on a social/ecological framework for understanding trauma, see Module 3, Recognizing Trauma).

It is also useful to consider whether traumatic events are naturally caused (e.g., flood, earthquake, hurricane) or involve human agency (e.g., war, terrorist acts).

When the human agency is involved, we might consider whether actions were intentional (e.g., loss of friends or social support due to an optional job transfer) or unintentional (loss of friends or social support due to escape from a war zone).

In general, the prognosis for recovery improves when the traumatic event is experienced as unintentional as opposed to intentional when human agency is involved; and likewise when the event is experienced as naturally caused as opposed to events implicating human agency (The Colombo Plan and University of North Carolina - Chapel Hill, 2020).

Notes on Types of Trauma

We have outlined the general types of trauma (acute, chronic, complex) because it is the simplest way to make sense of more complicated trauma typologies, some of which we will discuss here. The general types are also useful in terms of the initial assessment of treatment needs.

However, it is helpful to also be familiar with other ways that chronic and complex trauma have been conceptualized and classified to best help our clients.

Types of Chronic Trauma

As mentioned previously, chronic trauma refers to multiple traumatic events which can be diverse but are repeated and/or frequently experienced over an extended period. We can fine-tune our conceptualization of particular types of chronic trauma by considering the following possibilities:

- **Domestic Violence**
  Domestic violence, sometimes known as family violence or intimate partner violence, is characterized by harmful behaviour between family members and intimate partners, and often takes place in the home. Even when not experienced directly, domestic violence can affect everyone in the home and even those who are close to the family, such as caregivers and family friends. They may see or hear violent incidents, or witness the aftermath of a violent incident (Center for Substance Abuse Treatment, 2014).

  For more information on types of domestic violence, see Wheels - Domestic Abuse Intervention Programs (theduluthmodel.org)

- **Interpersonal Trauma**

Interpersonal trauma involves actions undertaken with the intent to hurt, harm, or take advantage of another. This may occur within the context of domestic violence, but may also occur amongst people who are mere acquaintances. Interpersonal trauma most often refers to actions that betray trust, whether or not there is physical violence involved. Some examples might be bullying, and repetitive lying or deceiving (Centre for Substance Abuse Treatment, 2014).

- **System-Oriented Trauma**
  System-oriented trauma occurs when services that are meant to help people unintentionally cause trauma or retraumatization. Sometimes maneuvering through an unfamiliar system can be overwhelming and trigger feelings of helplessness and isolation akin to a traumatic experience. Some examples include: lack of privacy in medical health settings or poorly explained invasive medical procedures; minimizing or discounting reports of bullying within a school system, or the use of seclusion or restraint in mental health settings (Centre for Substance Abuse Treatment, 2014).

Types of Complex Trauma

Recall that complex trauma refers to chronic trauma that began or took place during significant developmental periods and was perpetrated by trust figures. There are many ways that such trauma could be perpetrated, some of which we discuss here.

- **Developmental Trauma**
  Developmental trauma is likely what we tend to think about most when we think about complex trauma – reactions to harmful events that occur during a person's developing years. However, the concept of developmental trauma includes all developing years: infancy, childhood, adolescence, and even young adulthood. Experiencing psychological trauma in childhood is linked to the development of risk factors for both social well-being and physical health. A discussion on Adverse Childhood Experiences (ACEs) will follow later in this module (BC Provincial Mental Health and Substance Use Planning Council, 2013).

- **Trauma at the Community Level**
  There is a class of complex trauma that focuses on traumatizing events engulfing whole communities: that is, the unit of analysis is not the individual but a group of people bound together by a common history, identity, or culture. These are important to keep in mind because a person can be affected by these events to the extent that the individual identifies with the community. Also, we know that trauma survivors are at higher risk for more trauma because any given traumatic event may take place against the backdrop of trauma at the community level (see the social/ecological framework for trauma in Module 3, Recognizing Trauma) (Center for Substance Abuse Treatment, 2014).

- **Historical Trauma**
  Historical trauma refers to reactions to widespread and severe events that affect a large group of people over a lifespan or at times even beyond (cf. intergenerational trauma). Examples would be colonialism (forcible removal of a people's autonomy, possible destruction of culture and language), genocide, slavery, and war (BC Provincial Mental Health and Substance Use Planning Council, 2013).

- **Intergenerational Trauma**
  Intergenerational trauma is an aspect of Historical trauma and describes the psychological and/or emotional effects that can be experienced by people who have a long-term connection to trauma survivors. Memories of the trauma and the sometimes inadequate coping strategies of trauma survivors are passed from one generation to the next. These memories and ways of coping are reportedly transmitted from caregiver to child, who often also transmit this legacy of trauma to subsequent generations unless healing processes are supported and allowed to take place (BC Provincial Mental Health and Substance Use Planning Council, 2013). For example, intergenerational trauma has been used as a causal narrative to interpret negative social impacts amongst Indigenous people in Canada relating to colonization (Hatala, 2016)

- **Cultural Trauma**
  Culture is considered to be the norms, characteristics, attitudes, and collective knowledge of a particular group. Cultural trauma is a community's reaction to events that challenge and may even seek to destroy its culture. Culture is an important part of the way people define themselves and helps create a sense of belonging and

meaning in the world. Loss of culture can compromise the ability of a group of people to avail themselves of opportunities and fully participate in society (Center for Substance Abuse Treatment, 2014).

DSM-5 Diagnoses Directly Associated with Trauma

According to DSM-5, two types of disorders, both of which can be quite debilitating, may be diagnosed after trauma by a qualified professional. (American Psychiatric Association, 2013) Clients who have a diagnosable disorder would benefit from more specialized, trauma-specific treatment.

- **Acute Stress Disorder (ASD)** is a normal response to a highly stressful situation. Situations may include facing death, serious injury or sexual violation. ASD occurs as a result of one specific event rather than the experience of long-term or chronic exposure to trauma. ASD symptoms include being emotionally 'numb', having distressing memories of the event, flashbacks, problems with sleep and concentration, angry outbursts, and an exaggerated startle response. Symptoms appear 2 days to 4 weeks after the event and usually resolve by 4 weeks (American Psychiatric Association, 2013).

- **Posttraumatic Stress Disorder (PTSD)** is the most commonly diagnosed trauma-related disorder. Symptoms fall into four classes: (1) re-experiencing (intrusive memories, flashbacks, nightmares); (2) avoidance of internal and external reminders of the event; (3) cognitive and emotional dysregulation; (4) hypervigilance and reactivity. A major distinction between ASD and PTSD is those symptoms of PTSD last longer than four months (American Psychiatric Association, 2013).

It is worth noting that people are resilient, and the disorders are not as common as we might think, given the prevalence of traumatic events. Fewer than 10% of the population will develop PTSD even though over 70% will experience at least one traumatic event in their lifetime (Canadian Psychological Association, n.d.).

Neurobiology of Trauma

Psychological trauma overwhelms a person's capacity to cope, not just psychologically, but biologically. Advances in neuroscience have increased our understanding of what happens in the brain and body when experiencing trauma reactions. We react as a whole being and now understand that psychological trauma is also a neurobiological trauma (Harvard Health Publishing, 2020). Some key concepts are implicated in the whole-body response to traumatic events:

- **Flight, Fight or Freeze**
  In a traumatic situation, multiple organs and systems engage to create a response to the threat in the environment and prepare us to survive the threat. This is called the "Fight, Flight, or Freeze Response" because it helps us to pay attention (freeze), and either fight off the threat or flee to safety. It is worth noting, however, that the 'freeze' response may also signal an overwhelmed system which detracts from being able to pay attention. With the 'fight' and 'flight' responses, a group of stress hormones are released upon signals from the brain and physiological responses may result, including increased heart rate, faster breathing, tension in muscles, and sweating (Harvard Health Publishing, 2020).

  Physiological responses to trauma can be varied and even hard to identify. The response can be short-term or long-term, depending on how a person experiences the event. Most physiological responses are unconscious, and quite often a person experiencing trauma may not know what they are feeling or why. They may perceive threats where there are none, their body responds accordingly, and a state of physiological balance may be hard to achieve. This dysregulation in the brain and body systems maintains mental, emotional, and physical distress (Harvard Health Publishing, 2020).

- **Prolonged Stress and the Stress Response**
  Repeated and chronic activation of the stress response causes wears and tear on the body and the mind. Chronic prolonged stress has been linked to many problematic health outcomes, including

cardiovascular, metabolic, immune, and nervous system problems (The Colombo Plan and University of North Carolina - Chapel Hill, 2020). It also causes brain changes that may contribute to anxiety, depression, and addiction.

When a prolonged stress response to repeated traumatic events occurs in childhood, it can have even more serious implications. Early exposure to trauma is harmful to a developing brain and body. The following video highlights effects of possible complex trauma termed 'toxic stress.' How Brains are Built: The Core Story of Brain Development - YouTube

Adverse Childhood Experiences

The term 'Adverse Childhood Experiences' (ACEs) refers to harmful experiences that happen during a person's developing years – infancy, childhood, adolescence and even young adulthood. These events can be acute (e.g., a single exposure to an episode of domestic violence), chronic (e.g., lack of adequate nutrition throughout pre-school years), or complex (e.g., being raised by parents with substance use issues). Since many of these adverse events begin in the childhood home and involve parents and other trusted caregivers, ACEs often indicate complex trauma (The Colombo Plan and University of North Carolina - Chapel Hill, 2020).

The ACE Study (Felitti, 1998), was designed to assess the links between various adverse conditions in childhood and physical and mental health status in later life. The ten specific adverse conditions included in the study were: abuse (emotional, physical, or sexual); neglect (physical or emotional); and household dysfunction (mental illness in the home, violence against mother, divorce, household members abusing substances, or a relative being incarcerated)

Results of the original study showed, and have since been replicated (Waite, 2020), that experiencing trauma in childhood is directly correlated to risk factors for health and social well-being. ACEs harm neurological, endocrine and immune systems, increasing a person's risk of physical, mental, and substance use disorders. Moreover, ACEs increase the risk of having more trauma events across the life span.

Moving towards Recovery with Trauma-Informed Care (TIC)

Using the guiding principles of TIC outlined below, how would you approach the following case study? How would you demonstrate each principle with specific questions, suggestions, or practices?

- Awareness
- Looking at trauma through the eyes of each individual
- Safety and trust
- Choice and collaboration
- Focus on strengths
- Empowerment – recovery is possible

Case Study

Marlies, 35yo mother of twin girls, presenting with depression and anxiety. Immigrated to Canada five years ago as a newlywed from Eastern Europe to join my husband's family, originally from the same country, who had settled in Calgary. The entire family (parents-in-law, older brother-in-law and wife, younger sister-in-law who is single) live in a three-bedroom house and work together in the family business. At first, Marlies enjoyed this arrangement as it kept her from feeling too lonely; although the relationships were not always easy as her in-laws tended to be critical of her. When Marlies and her husband started their own family, they moved into the basement, which was a larger space but was not separated from the main house. They continued to share the use of the kitchen and the laundry (which was in the basement) and had meals with the extended family.

Marlies grew more and more despondent, finding it increasingly difficult to care for her daughters or to participate in home life. Her in-laws have become even more critical and complain that she is lazy and anti-social. Even her husband says he doesn't understand her, as he thinks she should be happy to have family support always available, to not have to be responsible for every meal and to just enjoy the babies. Recently she has been having a hard time controlling her emotions. She is often sad when she thinks she should be happy, and angry and resentful when she thinks she should be grateful.

[Possible questions, suggestions, practices:]

- **Awareness**
  - What were some of the things that changed with the move to Canada? Does Marlies think some of those changes would have happened even if she had stayed in her home country?
- **Looking at trauma through the eyes of each individual**
  - Gathering history and information about the current living situation would help assess the resources Marlies has at their disposal when faced with emotional challenges involved in marriage, immigration, and childbirth.
- **Safety and trust**
  - Introduce self with name, training, and role in the unit; what the goals of the session would be; with what kinds of information and resources might Marlies expect to leave the session
  - Begin and end sessions on time to provide secure boundaries and a sense of predictability and control
- **Choice and collaboration**
  - Frame questions respectfully; make suggestions as opposed to giving directives (e.g., 'do you think it would be helpful to have your husband come in for a few minutes?' vs 'let's have your husband in so I can get some collateral information')
  - Check to see if an idea is workable, and negotiate until it is (e.g., 'one of the things we've talked about is the possibility of having more privacy … who does it make sense to chat with about that?' or 'can you see yourself having a conversation about privacy with anyone in your household?')
- **Focus on strengths**
  - Inquire about past accomplishments, or character traits that the client looks upon as positive
  - Include questions about support network: who is around; who could be around, such as community resources, church, etc
- **Empowerment – recovery is possible**
  - Offer help in addressing issues herself: 'How would you address the privacy issue in your home?' 'Is that something I can help you with here?'
  - Offer suggestions in terms of motivating interpersonal resources: 'Who would you ask to help you with ensuring more privacy?'

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