





# An Introduction to Trauma and Trauma Informed Practice Full Explainer Guide

Trauma Informed
Stoke-on-Trent and Staffordshire

TICS LTD
TRAUMA INFORMED CONSULTANCY SERVICES

# Contents

# What is Trauma?

Trauma is the multifaceted, difficult psychological and emotional response to a painfully and profoundly upsetting situation or series of situations. It is not just the event itself that defines trauma, but an individual's emotional experience of these events (Thomas, 2023). Trauma can result from various situations such as physical violence, sexual assault, emotional abuse, witnessing violence, being the victim of violent attacks either physically and/or psychologically, being involved in or witnessing accidents, or natural disasters (SAMHSA, 2023).

Trauma is pervasive and can prodigiously affect an individual's long-term health and life outcomes, as well as the community overall (Van der Kolk, 2003). Trauma can lead to changes in an individual's biology and behaviour across the life-course, affecting relationships both within and across generations (Dalvie & Daskalakis, 2021). Hence, trauma not only disrupts the lives of individuals but also affects the fabric of communities and society as a whole (Saul, 2022). The way a person deals with trauma is unique and multifaceted. The accessibility to resources and support greatly influences the impact that both protective factors and risk factors have on the severity of an individual's experience (NCTSN, 2024).

On a community level, those facing collective historical and structural violence will be more likely to be affected by trauma and its consequences (Li et al., 2023). Identifying the widespread, intensified impact of trauma on health and well-being is vital for all professionals and the systems/services they operate within. Efforts to prevent trauma and lessen its negative effects are key to improving community safety, reducing violence and working preventatively in both a physical and psychological health sense (Wilson, 2022). For those in the education and social work fields, the more knowledgeable we are about trauma and its effects, the more we can personalise our support to enhance outcomes and be in a position to both support and advocate for individuals who have experienced trauma.

## Types of Trauma

**Acute Trauma:** Results from a single incident
**Chronic Trauma:** Results from repeated and prolonged exposure to highly stressful events
**Complex Trauma:** Results from exposure to multiple traumatic events

# 6 Principles of Trauma Informed Practice

Implementing a trauma-informed approach requires an awareness of its existence, that we understand the role it plays, and adjust our approach and practice accordingly. If we embed this approach in meaningful ways the outcomes for those, we work with irrespective of trauma experiences, will be improved, by drawing on the principles of trauma informed practice (Center of Disease Control, 2020).

Now, you might be wondering where to start with this which is why the 6 trauma informed practice principles have been included which can help to guide your work. Check out the graphic below… how does it resonate with you? Do you recognise these principles within your current practice?

# Indicators

In case you haven't read the previous sections, trauma is a deeply personal experience which will affect every individual differently. It has the potential to present on a psychological, physical or emotional level with many individuals experiencing signs and symptoms across all three areas. It is common for those who have experienced trauma to report a reduction in their feelings around their safety and these effects can appear immediately after the initial situation or variable lengths of time afterwards. Please hold this in mind as you read this section.

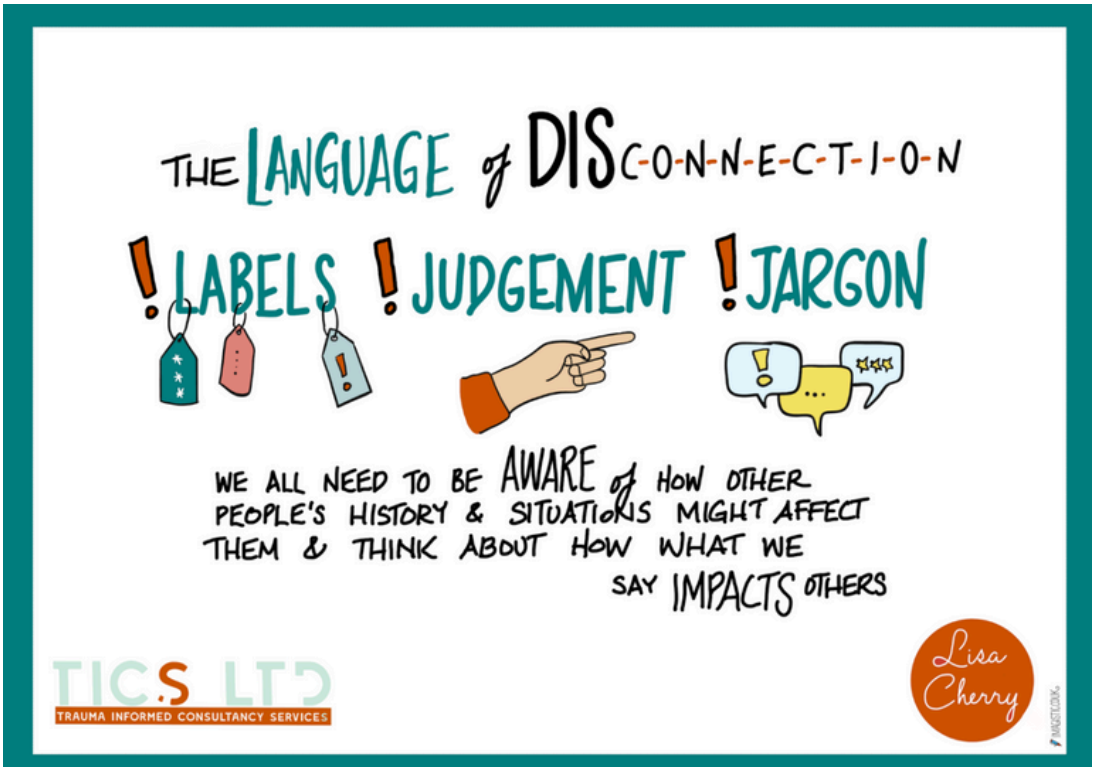
Below, we have listed some of the most commons signs and symptoms of trauma. However, it is crucial to hold in mind that every individual is unique in how trauma impacts them and the signs and symptoms they display. Furthermore, the period of onset and duration is also variable. These lists are not exhaustive but hopefully will contribute to an increased understanding and awareness of the far-reaching impacts of trauma which can affect the daily functioning of the individual.

This section has amalgamated the diagnostic criteria from DSM-5 (APA, 2013) and ICD-11 (WHO, 2019) to provide a holistic overview of the key characteristics of trauma. Diagnostically, there are several conditions trauma is referred to depending on the specific nature of presentation and duration of symptoms. Having an awareness of Post-Traumatic Stress Disorder (PTSD) and Complex Trauma is more than sufficient to shape a meaningful awareness. It is also noteworthy that an individual can be experiencing some of these symptoms and not have come forward for support meaning that they may not have a formal diagnosis or 'label.' This does not make their experience any less real and we must still consider how to best support. And the best bit? **If we get it right for those who have experienced trauma, we get it right for everybody!**

For clinicians, this section is intended to be a reminder of the diagnostic criteria available, but this should not be used as a substitute for the official manuals.

For non-clinicians, it is not within your responsibilities to make a diagnosis. However, having a comprehensive understanding is essential to enable you to provide effective support within your designated role and scope.

Despite the many uses of diagnostic labels and how these can often be necessary to access certain support options for individuals, we need to use language carefully particularly in our interactions with the individuals themselves.




## Post-Traumatic Stress Disorder

### Physical symptoms

*Please note, this is not intended to be an exhaustive list

- Increased blood pressure
- Increased heart rate
- Sleep Disturbances
- Tiredness/fatigue
- Feelings of nausea,
- Stiffness and aches
- Headache
- Muscular and joint pain
- Back Pain

### Emotional symptoms

*The emotional presentation is unique to the individual but common emotions are:

- Denial
- Fear
- Shock
- Anger
- Sadness
- Distrust
- Feelings of betrayal
- Guilt

- Shame
- Emotional Numbing

### Psychological symptoms

- Anxiety
- Depression,
- Reexperiencing and flashbacks
- Nightmares
- Diminished concentration
- Memory challenges
- Avoidance
- Social isolation
- Hyper-arousal (‘feeling on edge’ or not being able to settle)
- Easily startled

## Considerations regarding children

Younger children are often more likely to report physical sensations (Downey & Crummey, 2022). They may use play to express themselves and re-create a traumatic event(s) as a way of processing. We may also hear of children exhibiting ‘difficult behaviour,’ their attendance at school may decrease and they may struggle with the academic demands of school. Other children may present as more reserved or clingier than usual. There may be an increased need for approval from others. It is vitally important that we look beyond the external behavioural display and consider what the child might really be telling us, we can do this by creating a safe environment and being curious.

## Comorbidities (other related mental health difficulties)

The symptoms of PTSD and CPTSD can overlap other areas. Whilst this guide cannot explore each of these areas, we have included links to wider reading at the end if this which may benefit you in your role.

For more information: Qassem, T., Aly-ElGabry, D., Alzarouni, A. (2021). Psychiatric Co-Morbidities in Post-Traumatic Stress Disorder: Detailed Findings from the Adult Psychiatric Morbidity Survey in the English Population. Psychiatric Quarterly, 92, 321–330.

## What is Complex Post-Traumatic Stress Disorder (C-PTSD)?

C-PTSD is a specific condition which stems from repeated, prolonged experience of trauma or multiple traumas. For example, long term exposure to abuse or domestic violence where the individual may have felt that they could not escape or the options to escape were literally restricted. The feelings of entrapment can then give rise to a myriad of symptoms.

### Physical symptoms:

- Chronic fatigue which does not improve with rest
- Aches and pains which cannot be attributed to other causes
- Digestive problems including Irritable Bowel Syndrome (IBS)
- Heightened senses
- Compromised immunity e.g. greater susceptibility to infection
- Sleep difficulties e.g. nightmare, waking terrors, insomnia

### Emotional symptoms:

- Dysregulation e.g. controlling emotions can be challenging
- Sometimes sudden and intense emotional experiences
- Challenges expressing emotions (flat affect)
- A prolonged sad or depressed state, anxiety and fear are common
- Feelings of hopelessness
- Managing anger can be difficult
- Shamefulness/Guilt which may seem disproportionate for a certain circumstance
- Feeling distant or separated from others

### Psychological symptoms:

- Flashbacks and intrusive thoughts. This might look like revisiting/reliving traumatic events in a way that is beyond the control of the individual
- Avoidance e.g. of locations, others, activities which cause triggering of memories
- Diminished feelings of self-worth
- Negative self-perception
- Worthlessness
- Difficulties around managing relationships and socialising
- A lack of feelings of safety even in unthreatening, benign situations
- Attention and concentration difficulties
- Challenges in engaging in conversations about the future including goal planning
- An increased risk of self-harm including using substance abuse

## How is C-PTSD different to PTSD?

From looking through the symptom overviews, you will have likely noticed the overlap in symptoms between C-PTSD and PTSD. So, how are they different? It is true to say that both conditions do share many similarities, and stem from similar causes. However, it is worth noting that those with C-PTSD may require additional support where possible. This is because the causes, whilst similar to PTSD, will have been prolonged. Here is an example of an adult who experienced adversity growing up to illustrate C-PTSD.

## Case Example

Alex, a 35-year-old, was raised in a household marked by severe domestic violence. Witness to the physical and emotional abuse of one parent by the other from an early age, Alex grew up in an environment where safety and security were unknown. The violence was not only physical but also emotional, including verbal assaults and threats. This prolonged exposure to trauma throughout Alex's developmental years laid the groundwork for Complex Post-Traumatic Stress Disorder (C-PTSD).

### Presentation

Alex sought therapy due to persistent feelings of low mood, anxiety, and an overwhelming sense of worthlessness. Alex described difficulties in forming close relationships, citing an inherent distrust in others and a fear of betrayal. Alex often found themselves experiencing flashbacks to violent episodes from their childhood, especially during moments of stress, distress or confrontation, leading to severe emotional distress and panic attacks.

Physically, Alex struggled with chronic fatigue and unexplained aches and pains, which no medical treatment seemed to alleviate. Sleep was fragmented, haunted by nightmares that left Alex waking in terror. Despite a deep desire for connection, Alex felt emotionally numb, detached from both themselves, others and the world around them.

### Diagnosis

Through a detailed and comprehensive assessment, a clinical psychologist diagnosed Alex with C-PTSD. The diagnosis was based on the chronic exposure to traumatic events, the range and severity of symptoms, and the impact these symptoms had on Alex's functioning.

### Key symptoms included:

- Emotional dysregulation, marked by intense episodes of anger and sadness.
- Persistent feelings of shame and guilt, deeply tied to the violence witnessed and experienced.
- Intrusive thoughts and flashbacks to traumatic events.
- Efforts to avoid triggers that might evoke memories of trauma.
- A profound sense of isolation and mistrust in relationships.
- Somatic symptoms, such as chronic pain and sleep disturbances, with no identifiable medical cause.

### Taking a collaborative approach

A multi-agency approach played a crucial role in supporting Alex's journey toward recovery from Complex Post-Traumatic Stress Disorder (C-PTSD), providing a comprehensive support system that addressed not just psychological needs but also social, medical, and practical aspects of recovery. This integrated approach ensured that various facets of Alex's life were considered and supported, enhancing the effectiveness of treatment and providing a safety net of resources and professionals dedicated to Alex's well-being.

### Collaboration among healthcare providers professions?

Alex's treatment involved effective joined up support between mental health professionals, including a psychologist, a psychiatrist, and a general practitioner. The psychologist focused on psychotherapy, employing techniques such as TF-CBT and EMDR, while the psychiatrist managed any necessary medications to help regulate mood and anxiety symptoms. The general practitioner monitored Alex's physical health, addressing somatic symptoms, and ensuring that their overall health was supported.

### Support groups and community services

Participation in a support group for survivors of domestic violence, facilitated through a community mental health service, provided Alex with peer support. This group helped Alex feel less isolated, offering a sense of community belonging and understanding that was pivotal in their healing process. Community services also offered psycho educational workshops on building healthy relationships and self-care practices, crucial elements in Alex's journey toward regaining trust in others and themselves.

### Social services and legal assistance

Social services played a pivotal role, especially in the early stages of Alex's recovery, by providing access to housing support and legal advice. Safe housing was critical for Alex, offering a stable, secure and safe environment away from past traumas. Legal assistance was also provided to help Alex navigate restraining orders and understand their rights, which was essential for their sense of security and autonomy.

### Employment and educational support

Career counselling and educational support services helped Alex explore new job opportunities and educational pathways. This assistance was vital in rebuilding Alex's life and self-esteem, providing a sense of purpose and direction that had been lost to the many years of trauma. Vocational training and resume-building workshops helped Alex gain new skills and confidence to re-enter the workforce.

### Ongoing coordination and communication

Central to the success of the multi-agency approach was the ongoing coordination and communication among the involved parties. Case managers ensured that information was shared (with Alex's consent) among healthcare providers, social services, and support groups, facilitating a cohesive plan that addressed Alex's needs holistically. Regular meetings and updates between agencies helped adjust the support plan as Alex's needs evolved, ensuring that the provided services remained effective and responsive.

### Outcome

After two years of consistent therapy and support, Alex reported significant improvements in their quality of life. While the memories and impact of the trauma remained, Alex developed effective strategies for managing symptoms and emotional responses. Relationships began to feel safer, and Alex reported moments of genuine connection and joy that had seemed unattainable before treatment. The journey was ongoing, but Alex now had tools and support systems in place to navigate the challenges that arose from living with C-PTSD.

Alex's case highlights the complex nature of C-PTSD stemming from prolonged exposure to violence and the importance of a comprehensive, trauma-informed approach to treatment. It is important in our roles to convey hope and optimism and that Recovery is possible with the right support and therapeutic interventions, allowing individuals to reclaim their lives from the shadows of trauma.

# How Does Trauma and Experiences of Adversity Impact on Child Development?

Having a base line knowledge of neurobiology helps us to understand the impact of adversity on a child's development (Racine et al., 2020). Situations which relate to poverty and abuse are just two examples of adversities which have now been found to change the brains' structure. The really powerful thing about relationships and connections that nurture and respond to the needs of a child is they can both prevent and undo some of the biological changes through early identification and supportive, compassionate understanding. Furthermore, it is critical that we appreciate that the brain undergoes the majority of its changes and development during the initial years of life. This period is crucial in human development, as adversities can potentially lead to an excessive production of cortisol (the stress hormone). Elevated and prolonged levels of cortisol can disrupt the brain's circuitry (Wolf & Schnurr, 2016).

When a child's brain is in survival mode, dealing with the effects of chronic stress, we may note psychological differences which can include (but are certainly not limited to):

- Attention difficulties
- Reduced memory retention for their age
- Not meeting age-related expectations at school
- Emotional dysregulation
- Attachment difficulties including forming and keeping friendships
- An increased risk of substance use across the life course
- High risk behaviours which may can lead to a higher risk of committing a criminal offence

### Biologically

- Signs of malnutrition, undernutrition or overeating
- Delayed/reduced growth
- Compromised immunity
- Increasing reporting of somatic symptoms such as stomach aches, headaches and other pains which do not seem to be related to a physical illness can be expressions of stress.

Much of the knowledge we have about "Adverse Childhood Experiences" comes originally from the ACE Study by Felitti, et al., (1998). It demonstrated extensive episodes of various forms of trauma. These included children who had experienced the main types of abuse, neglect, challenging family lives including domestic violence, paternal imprisonment and more. The study did only focus on a white middle class research sample, but its applications are still very useful. 63.9% of endured at least one category of ACE, and 12.5% had faced four or more categories.

Roberts et al., (2011) explored the racial disparities in PTSD prevalence, exposure to trauma, and patterns of seeking treatment across White, Black, Hispanic, and Asian populations in the US. Despite this study being the US, the sample was impressive at 34,653 adults from various racial backgrounds (58.2% White, 18.4% Hispanic, 19.0% Black, 2.8% Asian). The findings demonstrated that Black individuals were more likely to have been exposed to childhood maltreatment including domestic violence with a higher likelihood of developing PTSD. However, White individuals were more regularly exposed to trauma.

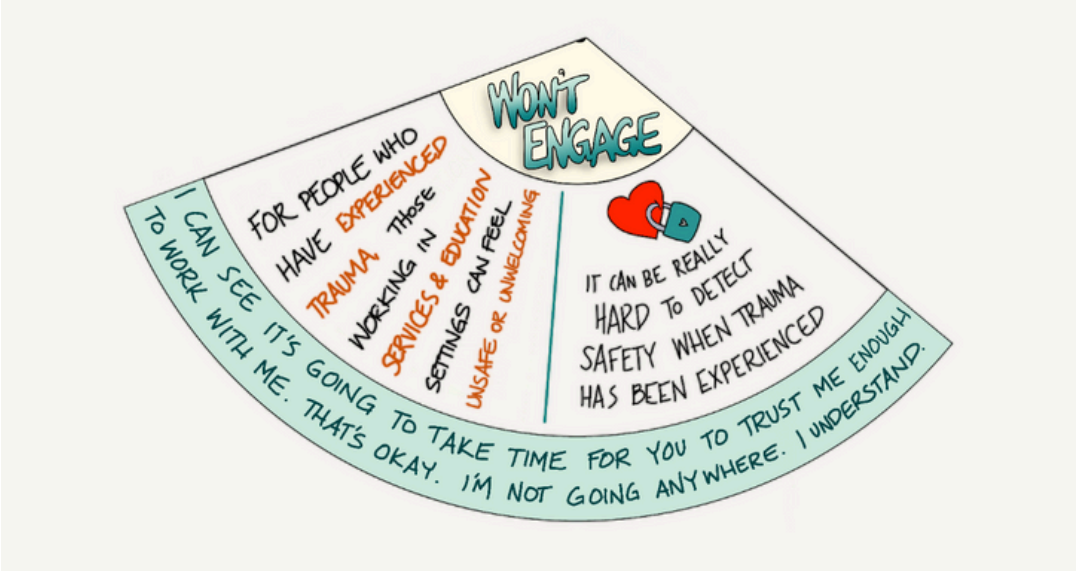
This highlights the importance of holding in mind that any steps we take professionally to support children or indeed adults who have experienced trauma must consider the full context, backgrounds, demographics and ensure we embed tailored approaches.

# How to Approach a Child with Suspected Trauma

The encouraging aspect is that the brain is plastic and can adapt. Every positive experience or interaction a child has contributes to the ongoing process of rewiring, gradually leading to a brain less inclined towards fear as its default response. It's essential to bear in mind that trauma or fear responses can manifest in various forms, such as anger, sadness, hyperactivity, or fear which may lead to the child shutting down (Bartlett et al., 2017).

In states of heightened alertness (which can look different for every child), the primary focus should be on creating a safe environment and fostering a calm and supportive atmosphere to help support a child to feel safe, calm and supported. Trauma can manifest in diverse ways, and it is unproductive to attribute blame. Our central concern should be the well-being of the child (Cummings et al., 2017).

Understanding that a child's responses may resemble those of a younger child, owing to a delay in brain development caused by trauma, can foster a more compassionate and forgiving perspective regardless of the setting or service the child is presenting at, whatever our remit, we must think on a ‘safety first’ basis, establish their trust, and prioritise their well-being. This can be achieved through a supportive and healing environment as indicated below:



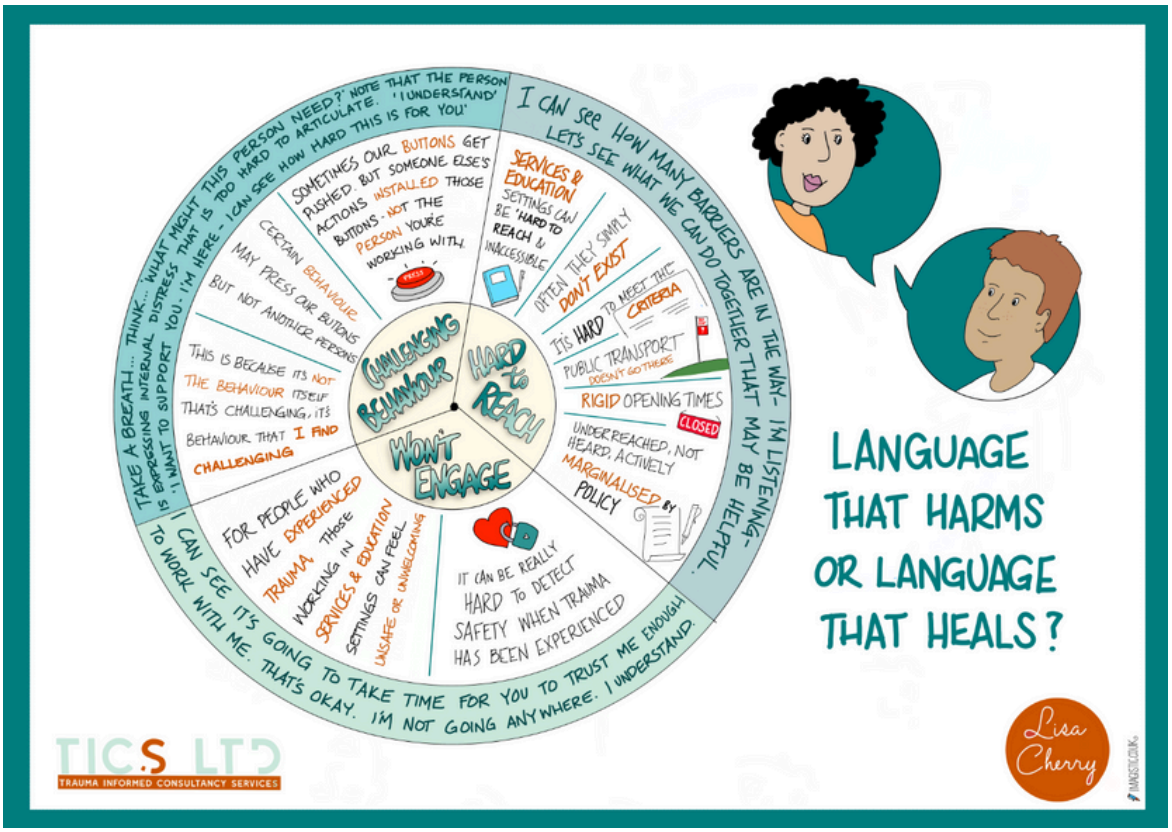
**Trust:** Across all sectors, this may look like being open and transparent with the child such as anticipating next steps and what to expect, taking time if the situations allows, to break the ice and help the child to feel more comfortable in your company. With younger children, toys/art supplies can be useful to provide distraction during difficult conversations.

Another way to build trust and establish an appropriate, nurturing relationship is to validate and acknowledge what they are feeling /what they have experienced. You might be the first person in the child's life to do this! Or they may have not felt listened to or heard by an adult previously.

Being as concrete as possible also mitigates against misunderstandings which can undermine any relationship. For example, rather than "your uncle has gone to sleep/is no longer with us," "your uncle has died." Adapt for the age of the child and circumstance but concrete is almost always better. Using drawings when a child is explaining something can help to provide clarity too.

Some suggested prompts are:

- "It's really understandable that you're feeling X"
- "I can see that you are upset/angry. How can I help?"
- "That must have been hard"
- "You aren't alone now"
- "I hear you"



**Give choices:** Carefully consider where it is possible to give the child choices in your interactions with them. This will look very different depending on the setting/service you work in.

You may want to set aside time to assess as a team what you currently do as a service to offer child/ren choice.

Some children find it difficult to sit in a room with adult/s and would find it more comfortable to 'walk and talk'.

Do you have resources available for example a child may want to use pictures to express their feelings?

Allow children to bring comfort items from home, like a favourite toy or blanket, to create a familiar and soothing environment.

Offer a variety of distraction tools or activities (e.g., toys, books, videos) and let the child choose what they find most engaging during waiting times

Involve children in service design and delivery.

**Behaviour as communication:** We may be met with resistance from a child or be working with a child that has been defined as 'naughty' or 'unruly.' For a child who has not been provided with opportunities to talk about their feelings and experiences, or who may not yet have the verbal skills/vocabulary to express themselves, they can show us through their behaviour (Sweeney et al., 2018).

| Instead of | Try thinking |
|---|---|
| What is wrong with you? | What happened to you? |
| This child has challenging behaviour | I'm finding this behaviour challenging |
| Attention seeking | Connection needing |
| They do this to me every time they're here | What is it about this space that feels unsafe? |
| They choose to behave this way | What are they communicating that I'm not understanding and what can I do to change it? |

## Re-establish a sense of safety

Don't underestimate the power of creating a safe and sensitive environment no matter how short or long our interaction with a child is. Anything that we can do to minimise the impact of sights, sounds, sensations that might be triggering for a child in our setting can be helpful. Examples could include:

- In a health care setting this might look like carefully planning any necessary physical contact and communicating this with the child before touching them. Or, forewarning the child that they might hear X sound and what it means.
- In a police station, we could, where practically possible, interview a child in a quiet room where we can minimise exposure to things like shouting.
- In a school, increase the predictability of the environment and wherever possible be providing a calming area if a child becomes emotionally dysregulated and requires a safe, quiet, nurturing space.
- As adults it is important that we are aware of our own emotions and the importance of remaining calm and not externalising our own distress when we are hearing from the child; The importance of both formal and informal supervision can support in establishing greater psychological safety for those that we work with, and this will help within our practice.

As adults it is important that we are aware of our own emotions and the importance of remaining calm and not externalising our own distress when we are hearing from the child; The importance of both formal and informal supervision can support in establishing greater psychological safety for those that we work with, and this will help within our practice.

**Providing a culture of meeting needs:** Embedding a culture of meeting need, is fundamental in becoming Trauma-Informed. When we ask those affected by conflict, what they need, rather than want, we develop accountability and reflection. Services need to create an ethos and environment built around trust and forgiveness. Restorative Processes are not without consequences. We need to manage potential conflict and be open to taking account when things don't go as we hoped or planned and create an environment of psychological safety where individuals feel able to express their dissatisfaction. Processes need to be in place where we are held accountable and all staff understand the effect our actions can have on others and through reflection and learning opportunities, with the aim to minimise the likelihood of further harm being repeated and re-traumatisation.

# Importance of Joint Working

It is important to hold in mind that there is so much that we can do when adopting a trauma informed approach in the work that we do and through recognising and acknowledging that those that we work with bring with them their own unique experiences (Olafson et al., 2016).

Applying a trauma-informed lens when working with adults acknowledges the enduring effects of past trauma on mental and emotional health.

For children, who are often more vulnerable and less equipped to articulate their emotions, a trauma-informed approach fosters an environment of understanding and empathy. This approach acknowledges the potential impact of adverse childhood experiences on a child's development, behaviour, and overall mental health. The power of creating a safe and supportive space, that fosters a sense of belonging can help children navigate their emotions, build resilience, and establish healthier coping mechanisms.

# Glossary of Terms

| Term | Definition |
|---|---|
| **Trauma Aware** | Having an understanding of what trauma is and how it effects people. |
| **Trauma Sensitivity** | Trauma Sensitivity pertains to the creation of a secure and considerate setting, allowing individuals who have survived trauma to foster compassionate connections, manage their emotions and behaviours, and that promotes their overall well-being. |
| **Trauma Informed** | Trauma-informed refers to a service or setting which uses interventions that are based on the recognition that trauma exposure can influence an individual's neurological, biological, psychological, and social development. It is separate to specific trauma services such as psychological therapies and draws on the understanding that all settings should and can be trauma informed. |
| **Trauma Responsive** | Trauma is recognised and addressed and effective support mechanisms are put in place for those that need it which promote resilience and heighten protective factors. |
| **Adversity** | Adversity is used to explain the difficult situations and experiences a person has lived through |
| **Re-Traumatisation** | Re-traumatisation occurs when an individual who has experience trauma faces people, places, events, situations, or environments that trigger the re-experiencing of past trauma. |

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