Relational Trauma and Traumawise Care: A Concise and Contemporary Overview

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April 5, 2018

Relational Trauma

In this section I offer a defensible definition of *relational trauma*, which views relational trauma as a form of victimization. This is followed by a framework for understanding how relational trauma impacts the *whole child.*

Relational Trauma as Victimization

Here is a short, valid, practical definition of *relational trauma*, adapted from D'Andrea et al. (2012, p. 188):

> [We use] the terms *victimization* or *interpersonal trauma* to refer to the range of maltreatment, interpersonal violence, abuse, assault, and neglect experiences encountered by children and adolescents, including familial physical, sexual, emotional abuse and incest; community-, peer-, and school-based assault, molestation, and severe bullying; severe physical, medical, and emotional neglect; witnessing domestic violence; as well as the impact of serious and pervasive disruptions in caregiving as a consequence of severe caregiver mental illness, substance abuse, criminal involvement, or abrupt separation or traumatic loss.

The Five B's of Relational Trauma

Relational trauma (*aka* complex developmental trauma) impacts the developing person in multiple, diverse, and complex ways (Perry et al., 1995; van der Kolk et al., 2005). One way to better understand the impact of relational trauma on the whole child is through the "Five B's:" Brain, Biology, Behavior, Beliefs, and Body.

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Brain The impact of relational trauma on the developing brain is now well documented (van der Kolk, 2014). A key aspect of this is the impact of traumatic experiences on the *amygdala,* which governs a person's response to fearful stimuli — especially the "fight, flight, or freeze" response. In children and youth who have experience relational trauma, the amygdala is both *hyper-sensitive* (highly sensitive to perceived threats based on past traumatic experiences) and *hyper-responsive* (highly reactive to perceived threats, leading to fight, flight, or freeze) (Diamond and Zoladz, 2016).

Biology Relational trauma not only impacts the brain, but impacts other systems connected to the brain, including the autonomic nervous system and the immune system. One way of seeing this systemic impact is through the *Adverse Childhoood Experiences (ACEs)* studies (Anda et al., 2006; Nakazawa, 2015), which demonstrate that among adults, ACEs (a) impact almost every aspect of physical and mental health, (b) have a cumulative effect so that more ACEs are associated with more health and mental health problems, and (c) are associated with with a toxic developmental cascade that can lead to disease and early death (Nusslock and Miller, 2016).

Behavior According to D'Andrea et al. (2012, p. 188), relational trauma places "... children and adolescents at risk of chronic and severe coexisting problems with emotion regulation, impulse control, attention and cognition, dissociation, interpersonal relationships, and attributions." In other words, relational trauma impacts almost every aspect of the developing person's behavior. Young people who have experienced relational trauma commonly receive multiple diagnoses (e.g., ADHD), none of which are related to the origins of their problematic behavior (van der Kolk, 2005; van der Kolk et al., 2005).

Beliefs Relational trauma also impacts our beliefs — our internal representations of the world, especially of the social world (Siegel, 2012). One way to see the impact of trauma on beliefs is through clinical research on the *Adult Attachment Interview (AAI).* According to Steele and Steele (2008, p. 20), these internal representations (beliefs) include "the apparatus of perception, memory, and affect guiding how we interpret the behaviors of others, the shaping of our sense of self, and ... the decisions we make defensively to exclude (from awareness) appraisals of the self or others."

Body We are just beginning to understand the impact of trauma on the body, although there are strong indications that succesful interventions must attend to the body, in a "bottom up" fashion (Perry, 2008b,a; van der Kolk, 2014). A number of interventions are being developed and tested based on these neurodevelopmental principles, including the use of sensory rooms, sensory-based occupational therapy, and the incorporation of sensory-motor strategies into trauma psychotherapy (Chalmers et al., 2012; Warner et al., 2013).

Traumawise Care

The "Five B's" help us to see how broadly relational trauma (victimization) impacts the developing person: Trauma impacts their Brain, Biology, Behavior, Beliefs, and Body. As a consequence of this developmental complexity, effective interventions must be designed with the Five B's in mind. One framework for understanding and creating effective interventions for children and youth is Howard Bath's "Three Pillars of Trauma-Informed Care," or "Three Pillars of Traumawise Care" (Bath, 2008, 2015).

Three Pillars of Traumawise Care

Here is a short, valid, practical definition of *trauma-informed care*, or *traumawise care*, adapted from Bath (2015, p. 6):

> The literature on trauma and resilience has produced long lists of risks and protective factors, but these can be distilled into a few fundamental principles — the *three pillars* for creating an environment that fosters healing and resilience:
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> 1. *Safety* entails an environment where one can feel secure, calm, and attend to normal developmental tasks. Maslow described safety needs as closely connected to survival, but also to higher level growth needs.
> 2. *Connections* involve trusting relationships with caring adults as weel as normative community supports such as sports teams, youth groups, and recreational programs. Building connections fosters resilience by meeting growth needs for *belonging* and *generosity.*
> 3. *Coping* enables the individual to meet life challenges as well as to manage emotions and impulses underlying traumatic stress. In resilience terms, successful coping strengthens growth needs for *mastery* and *independence.*

Implementing the Three Pillars

The three pillars themselves describe the content, or goals, of traumawise interventions for children and youth who have experienced relational trauma. However, implementation can be a major challenge, and it is worthwhile adding a few guidelines for implementation of traumawise care. Here are three guidelines for implementing the three pillars:

1. First, it is important to realize that "not all pillars are created equal." From developmental, behavioral, and psychological perspectives, *connections are primary.* It is through connections that children and youth (indeed, all humans) *feel safe* (Marvin et al., 2002; Hoffman et al., 2006). Further, it is through connections that children and youth (indeed, all

humans) learn to *self-regulate* (Feldman, 2007a,b). So, *connections* are primary, while *felt-safety* and *self-regulation* are secondary. Nevertheless, all three pillars are necessary for children and youth to heal and succeed.

2. Second, it is important to realize that children and youth are "hardwired to connect" (Commission on Children at Risk, 2003; Siegel, 2012). As youngsters, the primary connections are with parents, but as time passes, connections with peers, teachers and other adults, intimate partners, and one's own children increase in importance (Bronfenbrenner, 2005; Bronfenbrenner and Morris, 2006). This developmental progression suggests the importance of ecologies of caring, or *authoritative communities* (Commission on Children at Risk, 2003; Kline, 2008).

3. Third, it is important to realize that "ecologies of caring," or "authoritative communities," require a systems perspective on successful implementation of traumawise interventions. It is widely recognized in the field of implementation science that children, families, case workers, teachers, and therapists are embedded in larger systems, which provide crucial contexts for intervention efforts (Akin et al., 2017; O'Connor, 2007). These larger contexts are *complex systems,* and effective interventions will necessarily need to be based on concepts and practices that match this complexity (Burke et al., 2015; Stelk, 2006).

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