Beyond Buzzwords: Trauma Therapy and the Mechanism of Healing

by

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Abstract

In Canada, many people will be exposed to a traumatic event at least once in their lives, some of whom will seek counselling to address any subsequent effects. Some clinicians report not feeling prepared to provide adequate care to clients seeking trauma treatment and can even re-traumatize people if not careful. To explore the ways that trauma can be treated, it is important to have a solid conceptualization of what trauma is. The mental health disorder called post-traumatic stress disorder was formalized in the DSM-III (American Psychiatric Association, 1980), but not all experiences of trauma will end up as a diagnosable disorder. Trauma exposure has been shown to cause both neurobiological and physiological effects. Options for treatment can be categorized into cognitive modalities, somatic modalities, and alternative approaches. There is evidence for a variety of trauma treatment methods (Hoppen et al., 2023), and it is recommended that further studies utilize different treatment modalities at the same time to explore the efficacy of a combined approach. Trauma is a deeply personal experience, which can affect people in a variety of ways, and thus healing will also take place through a variety of approaches. Because of the risk of potential re-traumatization, it is important for counsellors to be knowledgeable about trauma-informed practices and to be able to collaborate with clients to help meet their individual needs (Substance Abuse and Mental Health Services Administration, 2014).

Keywords: adverse childhood experience, cognitive therapy, complex post-traumatic stress disorder, historical trauma, post-traumatic stress disorder, trauma, trauma-informed, somatic therapy

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Chapter One: Introduction

Overview of the Topic

In Canada, while only 7.7% of adults will be diagnosed with post-traumatic stress disorder (PTSD) in their lifetimes, 64.4% of adults report exposure to at least one potentially psychologically traumatic event (PPTE; Public Health Agency of Canada, 2024). From the same report, statistics showed that the most prevalent of these PPTEs include transportation accidents, physical assaults, and illnesses or injuries that are life-threatening. Meanwhile, this same survey reported that among women, 16% have experienced a sexual assault and 24.3% have gone through an unwanted sexual experience. These statistics show that Canadians are experiencing traumatic events even if they either cannot access a healthcare provider that can provide them with a formal diagnosis of a trauma-related disorder, or if they do not necessarily meet the criteria for diagnosis but are still experiencing negative effects. Many of these Canadians will end up seeking counselling to address the effects of PTSD and PPTEs, as well as other clients who may be affected by related disorders that do not have current statistics tracking prevalence in the population. It is important for clinicians to have an understanding of how to recognize and identify trauma and its impacts on clients and how to treat it effectively to meet the needs of these clients. This paper will use terms such as trauma, PTSD, and complex post-traumatic stress disorder (CPTSD), which are often conceptualized differently based on professional background and perspective (Sternswärd et al., 2023). A consideration throughout the research will be how to define trauma and where and when to include information specific to trauma-related disorders.

Crucial to effective treatment is the quality of the relationship between the client and the therapist. Carl Rogers (1957) was one of the first to expound upon theories of person-centered therapy, including the importance of a therapeutic alliance founded on the clinician's

unconditional positive regard for the person sitting in front of them. To Rogers, this relationship was the key factor to creating conditions in which clients could grow and change. Subsequent research has confirmed Rogers' ideas about the correlation between therapeutic rapport and client change across a variety of client populations (Flückiger et al., 2018; Horvath & Symonds, 1991; Wampold, 2015). When interacting with clients presenting for trauma treatment, it is important that clinicians develop not only a strong rapport with their clients but also a robust understanding of trauma and its effects in order to avoid potential re-traumatization (S. Grossman et al., 2021).

The Canadian Centre for Addiction and Mental Health (n.d.) defines trauma as "the lasting emotional response that often results from living through a distressing event" (para. 1). Felitti et al. (1998) demonstrated that the negative impacts of these distressing events are amplified in younger populations, as it can directly affect brain and nervous system development. Further research demonstrates the negative effects of systemic traumas that can compound to further cause disruption and distress (Ames & Loebach, 2023). Regardless of age, it is crucial that individuals seeking help to address the effects of traumatic events are given appropriate care that does not expose them to the risk of potential re-traumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). Safety should always be the first priority for clinicians providing services to clients who have experienced a trauma (Herman, 1992). According to Lynch et al. (2025) who developed the sense of safety theoretical framework, some ways therapists can attend to client safety include following trauma-informed practices (as outlined by SAMHSA, 2014) and also by collaborating with clients, being aware of contextual factors, such as systemic barriers, that may be affecting clients, and by facilitating conversations about clients' own capacity to make good decisions for themselves.

Despite the prevalence of PPTEs in the general population, many clinicians do not feel adequately prepared to provide sufficient care to address the complex needs of trauma survivors, with or without an official diagnosis (Kumar et al., 2022). Unfortunately, actions such as minimizing or discrediting a client's story, ignoring emotional boundaries, or pathologizing symptoms of trauma (among other issues), can lead to situations where clients feel unsafe (SAMHSA, 2023). Based on this research and on SAMHSA's (2014) guidelines for trauma-informed practices, when a client is presenting with trauma related symptoms, counsellors should keep in mind that a major component of developing a strong therapeutic bond is having a clear understanding of what trauma is, how to implement trauma-informed care, and the ability to apply interventions from the field's current empirical understanding of the most effective treatment approaches (Berring et al., 2024). To better understand how to treat trauma, it would make sense that one would need to understand the specific effects of trauma and the mechanisms of healing through which various methods purport to help manage these symptoms. Many Canadians will experience some form of trauma in their lives that may be detrimental to their sense of wellbeing regardless of if they end up diagnosed with PTSD (Public Health Agency of Canada, 2024). As such, it is necessary that clinicians have an adequate understanding of what trauma is and how to treat it safely and effectively. This understanding will not only help clients on their healing journeys but will also help influence better overall public health outcomes (Nilaweera et al., 2023).

Purpose Statement

The intent of this capstone is to explore a comprehensive understanding of what constitutes trauma and how it can affect clients, regardless of diagnosis. It also seeks to amalgamate the field's current perception of the most effective, empirically supported treatment

approaches to better comprehend what constitutes “healing” when treating trauma. The hope is that broader awareness will help clinicians with building a foundation of trauma understanding, providing concrete ideas for future research or specific trainings to enhance the delivery of safe and effective trauma treatment. To do so, the history of trauma conceptualization and therapeutic methods will be considered, which will help lay the groundwork for a contemporary understanding of trauma and how the field arrived at its conclusions. The effects of trauma will also be explored in-depth to provide potential theories on mechanisms of trauma healing. To adequately assist with the healing process, it is important to understand the field’s findings on what specifically needs to be healed. Finally, based on any findings about trauma symptomology, a review of current treatment approaches will attempt to consolidate any links between the effects of trauma and potential mechanisms of healing.

Theoretical/Conceptual Framework

The conceptual framework used to approach this capstone will be through a trauma-informed lens; as such, safety, transparency, and empowerment will be key to undertaking this project (SAMHSA, 2014). The American SAMHSA was one of the first to develop a framework for trauma-informed care in 2014, which has been highly influential in the field of human services across different disciplines (i.e., medicine, social work, and nursing; Mahon, 2022). These practices include features such as having a solid foundation of knowledge about trauma and its effects, as well as guidelines for the prevention of re-traumatization by service providers (SAMHSA, 2014). Even though this project will not involve gathering data directly from participants, it is important to consider trauma-informed perspectives when researching and interpreting data to maintain a level of respect and empathy for those affected and as a way of emphasizing research findings that are congruent with trauma-informed practices. Trauma-

informed practices also bear in mind the wide spectrum of effects caused by trauma and seek to provide the same standard of care regardless of diagnosis (Purkey et al., 2018). Some of the findings in the literature review focus specifically on those diagnosed with PTSD, but a trauma-informed framework considers how to provide safe and effective care for all clients regardless of diagnosis.

When writing the project, a trauma-informed lens will avoid pathologizing client symptoms and will seek to frame trauma processing in a way that affirms clients and highlights their potential for growth and healing. An example of this would be using empowering language, such as the use of the word "survivor" rather than "victim" (Levy & Eckhaus, 2020).

It will also be important to hold space for diverse views of healing, as not everyone will reconcile their experiences of trauma the same way. When interacting with stories of trauma, many will look to redemption arcs such as the "Hero's Journey" that reframe traumatic narratives as avenues for growth (Jordan & Walker, 2022). While this perspective purports to empower survivors, it does not consider the ways that systemic and societal barriers can prevent people from healing in a feel-good, linear fashion (Delker, Salton, & McLean, 2020). One must consider how someone who has been affected by trauma may react when reading a research project about what can be a very sensitive topic and to not attempt to prescribe a uniform version of growth and healing to what is a very individual and personal situation. This research project will use a trauma-informed conceptual framework to deliver accessible and respectful findings in a way that aims to support growth and healing, as well as the diversity of what that can look like.

Contribution to the Field

This project is important because it delves deeper into an understanding of what trauma is and what the actual change process behind healing from trauma is. Even in this early stage of

research, there have been many articles that mention the words “trauma,” “processing,” and “healing” without giving the reader any definitions. As important as trauma and processing are, at times it can seem like the meaning of these words has been diluted by both clinicians and clients. This capstone aims to find overarching themes and connections in the literature that will lead to a more comprehensive understanding of both trauma and healing that clinicians can apply to a multitude of client presentations with or without necessitating a diagnosis. The literature review will consider the potential effects of trauma on both the brain and the body. Furthermore, it will consider the ways that research-backed modalities provide evidence for their efficacy. In essence, it seeks to understand what the literature says about how trauma can affect people and what the current evidence base supports to help participants deal with these effects. This project will also consider questions, such as: 1) Is healing just a reduction in symptoms? and 2) does the research reveal any other considerations for what healing can look like in clients seeking trauma treatment? The intent is to help provide clinicians, especially those just beginning their careers, with a more comprehensive knowledge base to improve the efficacy of treatment for clients seeking this type of support.

Reflexivity and Positionality Statement

My social location is that of a Caucasian cisgender female who grew up on the traditional territory of the Secwepemc people in British Columbia and who currently resides on Treaty 7 land in Banff, Alberta. My curiosity about the subject of trauma arose during my time as a volunteer with the Distress Centre in Calgary, as well as when I was a supportive counsellor for survivors of domestic and sexual violence at YWCA Banff. In both roles, I interacted frequently with people who had experienced various forms of trauma, but neither role was clinical in nature. I was able to build a solid foundation of supportive skills, but I was not yet at a place in my

career where I had the necessary training or skills to help address the clinical effects of traumatic experiences.

Though both of those roles are necessary in Canadian society for helping facilitate access to tangible resources like food supports and a safe place to sleep, I became more curious about how I might work with these clients moving forward into a clinical role. Social safety nets can help facilitate access to safe places to stay and basic necessities, but I wanted to be at a place in my career where I had the skills to go beyond just supporting clients with their day-to-day needs and to be able to delve deeper into helping survivors achieve more longer-lasting peace and stability in life. Mental health outcomes can affect tangible matters such as food security (Jensen et al., 2023) and stable housing (Aubry et al., 2016), so it seemed that being able to address mental health would be helpful for bridging the gap between stabilization during a crisis and achieving more overall stability in the long-term. Many clients presenting for support at places like domestic violence shelters have complicated trauma histories (Dekel et al., 2019), and addressing trauma from a mental health standpoint would only help with achieving stability in other areas of life.

As I moved into a clinical practicum, I was now on the other side of this mysterious healing process, and I had clients coming to me and sharing that they felt like they had trauma that they wanted to heal or "process." During these intake interviews, I found that I had not really come across any singular clinical definitions of these concepts, and I also got the sense that clients did not necessarily know either. Given that as a practicum student I was not in a position to offer a formal assessment for something like PTSD, it also seemed that knowing how trauma can affect clients regardless of diagnosis would be imperative to my practice.

Not only did I want to have more understanding for my overall practice, I was also curious about where clients might be hearing these terms and how they could come to our first meetings (and for many, their first experiences with counselling in general) and be so confident in their language around these terms and what they wanted out of therapy. Much of this project is inspired by wanting to help my clients "process" or "heal" from their "trauma," which requires a deep understanding of what exactly trauma is versus what clients think trauma is and where they might be getting that information. I also wanted to see if I could find any sort of definitive answer to the question of what it might mean to truly heal.

I must also recognize that when it comes to trauma and being able to achieve mental and physical stability, there are various systemic barriers in place that keep people caught in negative cycles. I have experienced my own traumas, but I have also had supports such as access to healthcare and mental health resources, healthy relationships, and stable housing. For instance, I do not have to experience the effects of systemic racism or poverty that can prevent access to necessities for my basic needs. I do not want to make it seem like healing from trauma is an easy thing to do or that once someone is "healed" all challenges and problems dissipate. Systemic barriers to care can also prevent many people from moving forward. In this role, it is important to attend to our clients' stated therapeutic goals but also to continually look for ways to remove systemic barriers and to advocate for accessible mental health care and basic necessities of life for everyone. Based on my previous professional experiences, I would argue that they are intrinsically interconnected.

Definition of Terms

Adverse childhood experience (ACE): Various negative experiences before the age of 18, such as abuse or neglect (including witnessing these events without having experienced them firsthand)

that can have long-term physiological and psychological impacts on those affected (Felitti et al., 1998).

Cognitive therapy: An approach to therapy that seeks to help clients make a change in their cognitions in order to facilitate behavioural change (Beck et al., 1979).

Complex post-traumatic stress disorder (CPTSD): A mental health diagnosis in the *International Statistical Classification of Diseases and Related Health Problems* (11th ed.; *ICD-11*; World Health Organization [WHO], 2019) but not in the most current version of the *DSM*. This diagnosis is applicable to someone who has experienced repeated and prolonged trauma exposure. Core symptoms are similar to PTSD, but also encompass more profound effects on identity, beliefs, and relationships that can occur after recurrent traumatic events (WHO, 2019).

Historical Trauma: Cumulative trauma and unresolved grief that occurs across multiple generations in groups that have experienced cultural traumas such as slavery or genocide (Brave Heart, 1998).

Post-traumatic stress disorder (PTSD): A mental health diagnosis for someone experiencing symptoms such as intrusive thoughts, negative cognitions, and/or hyper- or hypoarousal after experiencing or witnessing death (or threatened death), injury, or sexual violence. Symptoms must be present for at least one month and be debilitating to overall functioning (American Psychiatric Association, 2013).

Somatic therapy: An approach to therapy that seeks to help clients connect with their bodily awareness and sensations to facilitate a shift in overall wellbeing or a release of stored emotion (van der Kolk, 2014).

Trauma: A distressing or overwhelming experience that can have negative long-term cognitive and somatic effects. Trauma on its own is not diagnosable in the same way that a disorder like PTSD can be formally diagnosed; rather, it is a subjective experience of harm (Boals, 2018).

Outline of Capstone Project Chapters

Chapter one has laid the groundwork for the literature review section of the project. It has highlighted the background research that introduces the topic and explored the theoretical framework that will guide the research. It has also examined the author's positionality in relation to the subject of trauma and trauma treatment, and it has defined some important terms to know before moving into the literature review.

Chapter two encompasses the literature review that will provide an in-depth exploration of trauma conceptualization and treatment. It will begin with a look into the history of a clinical conceptualization and definition of trauma and PTSD, as well as more recent advancements in the field's understanding of trauma. It will also include an exploration of how this information is disseminated and communicated to and amongst the public. The next section will explore the cognitive and physiological effects of traumatic experiences. Lastly, the review will detail cognitive, somatic, and alternative and multicultural approaches to trauma treatment, seeking to make connections between the effects of trauma and the ways that various modalities seek to help clients address these effects.

Lastly, chapter three will consolidate the learnings from the literature review. Gaps in the literature will be acknowledged, and recommendations for future research and clinical practices that may enhance the field's understanding of the topic will be put forth. The chapter will conclude with a summary of personal learnings, revisiting positionality and detailing any new insights.

Chapter Two: Literature Review

History of Trauma Understanding

Largely confined to the fields of medicine and psychology throughout the 20th century, trauma concepts and language have now been disseminated to the general public, and many clients come to session with their own established vocabulary. Many clients are getting their understanding of what trauma is from social media such as TikTok, where the hashtag #TraumaTok has been viewed upwards of five billion times (O'Connor et al., 2024). This understanding is a startling change from the way trauma was initially conceptualized in the early stages of modern psychotherapy.

It was only near the end of the 19th century that professionals began to consider different theories of trauma. At that time, it was mainly called by the name "hysteria" for women and "neurosis" for men (Busch & McNamara, 2020). One of the first people to note an early concept of trauma was a doctor by the name of John Erichsen. In the 1860s, he explored how trauma affected the victims of railway accidents, although he attributed the symptoms displayed by survivors to either shock or spinal damage (Leys, 2000). In the early stages of trauma theory, the mind was not considered to be wounded, only the body. However, pioneering psychiatrists and psychoanalysts such as Pierre Janet and Sigmund Freud, largely influenced by the effects of WWI on returning soldiers, began to explore the emotional and psychological toll that distressing and shocking events could have on the human mind.

Janet's early ideas referred to trauma as "emotional accidents"—a state in which someone who had been subject to a particularly frightening experience was now unable to integrate it into their overall worldview (Busch & McNamara, 2020). These fragmented memories were somehow stored differently than typical memories and were not available to be

retrieved. Meanwhile, Freud also viewed trauma through the lens of fear, noting how soldiers coming home from WWI appeared to suffer from some terrible neuroses attributed to the distressing experiences of war (Picht, 2022). Though he most likely did not coin the term himself, in 1915 physician Charles Myers was the first to use the term "shell shock" in a published medical journal (Rees, 2020). These were some of the early notions of trauma theory in written work, as professionals in the realm of both the physiological and the psychological began to take note of how undoubtedly and irrevocably the surviving soldiers of WWI were changed by the horrors to which they had borne witness.

WWII brought with it fresh understandings of trauma as it related to soldiers and wartime. It was during this time that psychiatrist Abram Kardiner (1941) published his work *The Traumatic Neuroses of War* on combat-related trauma, cataloguing such symptoms as shock and terror, delirium, and sensory disturbances. In this same work, Kardiner also acknowledged the existence of traumatic neuroses stemming from events outside of the context of war. However, it would be wartime again that would push the issue beyond the annals of medical and psychiatric journals and into a broader understanding. Motivated by the symptoms of soldiers returning from the Vietnam War, a diagnosis called post-traumatic stress disorder (PTSD) was added to the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) in 1980 (van der Kolk, 2014). Finally, decades after the pioneers of modern psychology had first begun to explore the effects of trauma on soldiers, the collection of symptoms now had a name and an official diagnosis.

Since then, the concept of PTSD has expanded to encompass not just soldiers but anyone who has had direct or indirect exposure to an event that could be considered distressing, accompanied by symptoms similar to what Kardiner researched in the 1940s. Building upon

early assessments of symptomatology, the most current version of the *DSM* includes such symptoms as intrusive thoughts (e.g., nightmares, flashbacks, dissociation, etc.), avoidance of trauma-related stimuli, negative cognitions (including perception of self and the world) and mood (feelings of fear and/or anger), and increased arousal and reactivity, all of which must be present for a duration of at least one month (American Psychiatric Association, 2013). Now, instead of being brushed aside by disaffected physicians as in the case of female hysteria that was most likely actually a trauma response (Leys, 2000), PTSD is a well-documented diagnosis in medical and psychological literature. Not every client who is experiencing negative effects after a traumatic experience will meet a formal diagnosis, and not every client will even want or need a formal diagnosis, but when planning treatment, it is helpful to be able to differentiate trauma-related disorders.

"Concept Creep" and the Evolving Language of Trauma

Just as a clinical understanding of trauma has changed with further attention and research, so too has public perception of trauma shifted throughout the years. Early conceptualizations of trauma viewed it through the lens of the physical, with the word itself coming from the Greek word for "wound" (Haslam, 2016). As previously established, a clinical exploration of trauma was mainly motivated by the effects of war on soldiers, culminating in the inclusion of PTSD as an official diagnosis in the *DSM-III* in the 1980s. Since then, the language and public perception around trauma has morphed beyond PTSD and extended into broader social and cultural consciousness via a term called "concept creep."

According to Haslam et al. (2021), concept creep is a term that represents the way that harm-related concepts, such as addiction and bullying, have expanded their definitions to cover a wider range of experiences. No longer limited to returning soldiers, or even other events such as

rape or assault that are typically agreed upon by general society as being shocking and terrifying to experience, the public perception of trauma has been "semantically overstretched" (Busch & McNamara, 2020, p. 324) to include any negative event that can cause pain or frustration.

The general public is currently talking about and interacting with the concept of trauma. Social media hashtags such as #TraumaTok and #racialtrauma receive billions of views, many of them recounting explicit traumas such as racialized police violence (Hung et al., 2023). However, as stigma has lessened around trauma and popular cultural movements such as #MeToo have empowered more people to share their personal stories (Delker, Salton, McLean, & Syed, 2020), it is important to consider how potential clients are conceptualizing trauma when they present for counselling.

Social movements can provide avenues for interpersonal connection amongst survivors and powerful steps forward towards collective healing (Strauss Swanson & Szymanski, 2020). However, concept creep has made it so that while more people are talking openly about trauma, the events they are describing as traumatic are declining in severity. The fact that conversations about trauma and mental health are becoming less stigmatized in society is important and can help push people to seek treatment when needed. However, as the meaning of the word "trauma" is diluted to include stressors that are merely irritating or frustrating and not catastrophic to the human psyche, clients who have experienced traumas with more debilitating effects may find their pain to be minimized and trivialized (Baes et al., 2023). As well, even though many people are publicly engaging with trauma concepts, especially on social media, most of them are young, female, and Caucasian, and very few have professional knowledge of trauma or even recommendations for trauma management (O'Connor et al., 2024). Public perception is shifting, and although it is a positive that outlets like social media can allow for greater public discourse

surrounding mental health and trauma, it is important that the people engaging in these conversations keep in mind the clinical definitions and symptoms that differentiate PTSD from a more general experience of trauma and the various ways that the effects can manifest across cultures and demographics. If more people are aware of the different effects of trauma, it is hoped that people will feel empowered to seek professional help when necessary.

Cultural Variations of Trauma

Typically, clinical conversations around trauma revolved around a Westernized, postcolonial concept, but there are other viewpoints to consider, including how people and cultures outside of this narrow lens may also interact with the idea of trauma. Even before the modern (and again, Westernized and postcolonial) age of psychotherapy, ideas about mental health and treatment were approached differently depending on one's cultural context and geographic location. Before there was the clinician's office or hospital ward, there were healers and shamans, and even clergymen, all trying to make sense of the unknown and unseen, typically through the lens of the supernatural (Mullan, 2023).

Many cultures throughout history have incorporated the spiritual world into an understanding of mental health. Trauma, while not explicitly named or understood, was often interpreted as a spirit or a demon, or perhaps even a witch (Mullan, 2023). Unlike a Westernized worldview that sought to burn witches at the stake and cast out demons, interactions with these mystical spirits were not always considered to be negative events in certain populations. While the average North American would probably be treated to an inpatient psychiatric unit stay and a prescription for antipsychotics if they found themselves experiencing hallucinations, certain Indigenous cultures view these types of communications as a positive way of interacting with the spirit world (Gould et al., 2021).

Despite the positive perspective from certain Indigenous groups, cultures outside of the postcolonial psychodynamic model that was spreading in Europe and North America did have ideas about the downsides of mental illness and the severity of trauma. For example, the Kickapoo people of Oklahoma do not have a word for trauma in the Kickapoo language but were able to roughly translate it as something bad that happened to someone, or something that a person would want to be healed from (Keyes et al., 2024). Other populations across the globe have attempted to describe trauma in their own ways, such as *babskat*, which means "broken courage" in Cambodia, or *noro*, which means "spiritual contamination" in Sierra Leone (Rechsteiner et al., 2020). Clearly, humanity in general has been able to distinguish when someone is facing negative emotional and psychological symptoms from a traumatic experience, although there are a variety of possibilities for why someone might experience those symptoms.

As globalization has spread Westernized ideas about psychotherapy across the earth, different countries have had to wrestle with if and how to integrate them into their own cultural contexts. Indigenous cultures have had to add trauma from colonization to their understanding of the wounds that can affect the psyche. The psychological consequences of loss of one's lands and culture across generations is now known clinically as historical or generational trauma (Brave Heart, 1995, as cited in Hartmann et al., 2019). Meanwhile in Algeria, a region of the world that has also been shaped by violence, traditional cultural understandings of trauma have been influenced by organizations like Doctors Without Borders who disseminate a Westernized version of diagnosing and treating PTSD (Henry, 2023). Throughout history and around the world, different cultures have attempted to recognize and understand mental illness and trauma in their own way. However, despite areas with strong traditional and cultural understandings of

trauma, many of these concepts have now been integrated with a Westernized, clinical framework of PTSD.

Recent Developments in Trauma Understanding

In recent years, the landscape of trauma has continued to evolve, most notably regarding trauma-informed frameworks of care, and the development of the CPTSD diagnosis. Trauma-informed care is not exclusive to the treatment of trauma, but rather it is a broad framework that seeks to provide a consistent understanding of the effects of trauma that can be applied to any and all clients (Cook et al., 2023). One of the first and most influential set of guidelines for trauma-informed practice was published by SAMHSA in 2014. SAMHSA identified four basic guidelines for trauma-informed practice: that all providers understand how trauma affects people, that all providers can recognize when someone has been affected by trauma, that all providers are confident in their ability to provide trauma-informed care, and that all providers will actively avoid re-traumatizing anyone receiving services (Cook et al., 2023). Although new and different frameworks have since been published by various global agencies, all providers of trauma-informed care agree on the basic principles of creating an environment that is safe for clients to heal and where they will feel empowered during care (Holmes et al., 2023). Trauma-informed practice guidelines have also emphasized the importance of culturally responsive treatment approaches (SAMHSA, 2014).

Although PTSD was formally codified in the *DSM* in the 1980s, CPTSD was not given a formal diagnostic criteria until its inclusion in the WHO's (2019) *ICD-11*. At current, CPTSD is not included in the *DSM*, highlighting that even as an understanding of trauma and trauma-related disorders has expanded to include new diagnoses and definitions, it can also be conceptualized differently based on one's social and geographical location. Compared to a

typical PTSD diagnosis that is more applicable to a singular traumatic event such as a car accident, CPTSD considers the potential pathology of prolonged and repeated exposure to traumas, such as abuse in childhood (Hyland et al., 2021). The symptomology expanded to include not just the more well-known effects of PTSD such as hyperarousal and flashbacks but also symptoms such as negative beliefs about the self, relational difficulties due to disorganization of the self, and affect dysregulation (Møller et al., 2020) CPTSD provides a deeper understanding of how repeated trauma exposure can cause pathological changes in not just arousal and emotional regulation but also in one's sense of self and the people and world around them.

Neurobiology of Trauma

The literature is robust with evidence for the myriad ways that trauma can change the brain, and a brief summary to assist clinicians with effective treatment planning follows. Across a typical lifespan, the brain will undergo normal changes to the structure of the brain (Bremner, 2006), but the following section will elaborate on a few of the essential structural changes to the brain after trauma.

Experiencing something significantly traumatic such as sexual assault or childhood neglect can affect brain structure, including in the corpus callosum, and various studies have investigated the effects of trauma on this area of the brain. The corpus callosum is a bundle of white matter nerve fibers that connects the left and right hemispheres of the brain and allows them to communicate (Jinkins et al., 1989). Damage to or congenital deformities of the corpus callosum have been noted to affect executive functioning skills (Mangum et al., 2021), including memory (Delvenne, 2024). Graziano et al. (2021) found that compared to a control group, adult women who had experienced interpersonal violence had higher instances of fractional anisotropy

in the corpus callosum, meaning that brain imaging showed a lack of structural integrity in that region when compared to those who had not had traumatic experiences. Other studies investigating traumatized individuals found a link between higher self-reported symptoms of PTSD and brain imaging showing higher instances of fractional anisotropy (Weis et al., 2021).

Another area of the brain that can be affected by trauma is the amygdala, a small structure in the brain that has a big role to play when it comes to learning, especially fear conditioning and emotional processing (Frick et al., 2022). This part of the brain helps people figure out the appropriate emotional responses to various people and situations they may come across. When studied, researchers have been able to link experiences of trauma with changes to the amygdala. When young people who had experienced trauma were compared with a control group, Sambuco et al. (2020) found a reduced amount of blood-oxygen-level dependent activity in the amygdala when viewing emotionally stimulating images compared to more neutral ones. In essence, compared to the controls, the amygdala in a traumatized brain showed a lower emotional response, which might also help explain why those with PTSD often face comorbidities with depression and anxiety. On the other hand, rather than causing an emotional dampening, trauma can also sometimes result in a heightened fear response. When veterans with PTSD were shown combat-related imagery, researchers saw a distinct uptick in activity in the amygdala, resulting in a state of hyperarousal (Feola et al., 2023). When trauma affects the amygdala's ability to process emotions, especially those related to fear, it can lead to either a diminished ability to feel emotions, or it can do the opposite and cause someone to feel overly emotional and unable to regulate their fear response.

The hippocampus, which among other functions is implicated in the operation of verbal declarative memory, is highly correlated to stress-induced structural changes (Bremner, 2006). In

populations that have experienced trauma, the hippocampus has been shown to display significant reductions in the volume of grey matter present (Rokita et al., 2020). Grey matter in the brain is necessary for cognitive functioning, and its absence is linked to cognitive decline (Zhu et al., 2021). The hippocampus is also associated with processing emotions (Szymkowicz et al., 2016). The resulting effects of structural changes to the hippocampus due to trauma can result in memory challenges and difficulty regulating emotions. Damage to the hippocampus could also be a clue as to why some trauma survivors experience fragmented memories and a feeling of being stuck in the past (Bremner, 2006).

Although there are many other areas of the brain that can be affected by trauma, the last area of consideration will be the prefrontal cortex. This part of the brain contributes to higher order cognitive functions such as problem solving, judging, planning, and making decisions, all encompassed under the umbrella term of executive functioning (Khandekar et al., 2023). A meta-analysis that considered the link between PTSD and hypoactivation of the prefrontal cortex showed a strong relationship between the two, meaning that it is quite common for those who have suffered a trauma to also have difficulty processing stimuli in the rewards center of the brain, leading to a loss of the ability to feel pleasure (Manthey et al., 2021). Another way that trauma can affect the brain is through increasing levels of inflammation (Danese et al., 2007). When studied, a group of women with a PTSD diagnosis was found to have higher inflammatory biomarkers that correlated with a reduced level of functional connectivity in the prefrontal cortex (Mehta et al., 2020). However, sometimes trauma can have the opposite effect in the structure of the brain. The prefrontal cortex in a traumatized brain has also been linked to hyperactivity, which can end up with survivors locked into a fear state because they have trouble with accurate threat processing, even in memory (Kredlow et al., 2022).

The above research is a broad overview of one of the most complicated organs of the human body. There are many more ways that various structures in the brain are affected by trauma, but it is hoped that a brief sketch of some of the ways that trauma can change the brain will be helpful for a neurobiological explanation for some of the symptoms of PTSD. Trauma can affect the brain's fear response and its ability to process emotions and threats. This response can make survivors feel constantly unsafe and on edge, making them more prone to emotional outbursts or hyper-reactivity. Sometimes the effects of trauma on the brain can cause hypoactivity and a loss of neurons and connections, meaning that survivors suffer from anhedonia, loss of emotion, and a dangerous lack of fear. It can also affect executive functioning, meaning that many people who have experienced trauma have trouble planning and completing daily life tasks, and it also affects how memories are encoded and stored, leading to either flashbacks and feeling stuck in the past, or fragmentation and dissociation from the memories.

Another consideration when it comes to the neurobiology of trauma is the developmental stage at which someone experiences a trauma. Adverse childhood experiences (ACEs) can have a significant impact on healthy brain development, affecting a variety of brain structures and circuitry, causing lack of integration of the self and a persistent stress response (Parish-Plass, 2021). Imagine all of the previously described injuries of the brain that can result from trauma and then place them into a brain that never had the chance to finish developing in a healthy way. Although every instance of trauma deserves the proper validation and support required to promote healing and growth, children are particularly vulnerable to the effects of trauma due to the fact that these experiences are then integrated into their overall neurobiological development (Campbell, 2022). What are children who have never felt safe learning about themselves and about the world around them? How are these experiences altering the trajectory of their entire

lives? When working with trauma, clinicians should consider the age at which trauma occurred in order to have a better understanding of how their clients may have been affected neurobiologically. Because of the impact traumatic experiences can have on development, it is helpful that evolving conceptualizations of trauma such as CPTSD include considerations of repeated trauma exposures over time.

Physiology of Trauma

Unfortunately, it is not just the brain that can be affected and damaged by trauma. Trauma also invokes a physiological response and can have lasting impacts on physical health. Although the brain and the body are connected and there is almost certainly a relationship between structural changes in the brain due to trauma and physiological effects, this section will consider some of the ways that the body responds to trauma exposure. Again, this overview will be brief as it is meant to underscore some of the most salient physiological responses and not an in-depth consideration of every possible physiological symptom.

One of the effects of trauma that stood out in the literature was on the cardiovascular system. PTSD is a strong risk factor for instances of cardiovascular disease (CVD; J. Chen et al., 2024). For a long time, the mechanism underlying this connection was unknown, but researchers have a few different theories. When J. Chen et al. (2024) studied the relationship between PTSD and CVD, they found that two specific symptom clusters of PTSD were associated with CVD: hyperarousal and re-experiencing. These symptom clusters can lead to heightened physiological arousal and an elevated stress response, both of which are implicated in CVD (Krantz et al., 2022). Considering Mehta et al.'s (2020) study on levels of inflammation in the traumatized brain, inflammation does not exist in a vacuum, and elevated levels will affect both the brain and the body. Chronic inflammation affects the entire system, with connections to insomnia and an

elevated resting heart rate, which is also a risk factor for CVD (Meinhausen et al., 2022). Another potential reason for the connection between PTSD and CVD is that researchers have found a link between PTSD and a reduced Heather Index, which is a measurement of the heart's ability to pump blood efficiently (Sheikh et al., 2023). Over time, trauma-induced chronic stress and hyperarousal can affect the cardiovascular system in a variety of ways, whether overtly in the form of the body's ability to pump blood, or more subtly in the slow, continuous damage related to insomnia.

CVD symptoms are very specific and measurable in the body, but not all somatic symptoms have a clear effect in trauma survivors. Many people who have experienced a trauma exhibit a wide variety of somatic symptoms, including gastrointestinal and/or pseudoneurological (Chang et al., 2025). The gut microbiome has long been considered the "second brain" (Terry et al., 2022), so it makes sense that mental health issues, including those stemming from traumatic experiences, could manifest themselves as gastrointestinal symptoms. Sadly, many survivors of trauma find themselves burdened with inexplicable pain that does not fall under any specific category or area of the body. When evaluated for a wide variety of symptoms, including depression and anxiety, American veterans were also measured to be at higher pain levels than a typical global baseline (Bernstein et al., 2022). While it is certainly possible that those who have served in combat roles may experience pain from injuries sustained during their service, veterans are not the only population that has reported pain after experiencing a trauma. Similar reports of chronic pain have been found in survivors of sexual assault (Dodd et al., 2021), racism (Hood et al., 2023), and domestic violence (Ford-Gilboe et al., 2023). As well, looking at the issue from a different point of view, research has also demonstrated a link between people seeking treatment for chronic pain and instances of PTSD

(Bartel et al., 2020; Siqveland et al., 2017). Somatic symptoms can be very specific, or they can be widespread throughout the body, and it is important to consider the bodily experience of trauma effects along with the psychological.

There are several reasons to support the notion that trauma affects the body in so many ways. One reason could be the way trauma affects the nervous system. In traumatized individuals, elevated fear levels can lead to both hypo- and hyperarousal of the sympathetic and parasympathetic nervous systems (Sumner et al., 2020). People find themselves stuck in "fight or flight" mode as their nervous system becomes dysregulated, leading to many potential chronic physical symptoms. Similar to how early life traumas have a significant effect on cognitive development, children exposed to trauma have also been found to have significant disruptions in nervous system efficacy and regulation (Campbell, 2022). The effects of trauma can also result in a cycle of unhealthy coping mechanisms that can have a negative effect on physical health, such as reaching for higher fat foods that can cause weight gain (Fogelman et al., 2022) or abusing alcohol (Jones, 2017).

Overall, trauma can have a variety of effects on both the brain and the body, and all of these effects are closely interconnected. Some studies have looked specifically at those with a diagnosis of PTSD, but not all, and one does not need a diagnosis to experience some of these effects. They can also be mediated by genetics, attachment wounds, systemic barriers, and/or supports and coping skills. There is no one single effect of trauma exposure, and every symptom of trauma should be considered within the overall context of the client's life. However, just as there are many different ways that traumatic events can affect the brain and body, there are also many different ways to approach trauma treatment.

Types of Trauma Treatments

Cognitive Approaches to Trauma Treatment

Considered to be the most effective approaches for trauma and PTSD, cognitive therapies are some of the most well-researched and widely applied treatment models for helping clients process and heal from trauma (Hundt et al., 2020). These models include cognitive behavioural therapy (CBT), trauma-focused CBT (TF-CBT), and cognitive processing therapy (CPT). Although not considered explicitly cognitive approaches, exposure therapy and eye movement desensitization and reprocessing (EMDR) are derived from cognitive theories and will be included in this section as well. Cognitive approaches emphasize the role of the maladaptive cognitions resulting from trauma and provide avenues through which clients can shift their thinking around the trauma and reduce symptomology. Meanwhile, EMDR focuses on bilateral stimulation that allows clients to reprocess traumatic memories that can then be successfully integrated into the system (Landin-Romero et al., 2018). An explicitly cognitive approach considers the changing of posttraumatic cognitions that are maladaptive to be the key mechanism for healing from trauma (Kangaslampi & Peltonen, 2022), with similar therapies such as EMDR focusing more specifically on desensitizing and consolidating traumatic memories.

Many trauma survivors experience cognitive distortions about the self and about the world around them. It would appear that identifying and reframing maladaptive cognitions about self, including feelings of shame that a traumatic event happened or blaming oneself for the event, are effective for clients seeking trauma treatment (Stein et al., 2024). For example, Gómez et al. (2019) found that the most significant relationship between PTSD and trauma-related appraisals were ones that related to the self, such as “I am a weak person.” Effective treatments would then target the specific self-related cognition over other cognitions about the situation. To

be more specific about what types of self-related thoughts contribute to post-traumatic distress, DePrince et al. (2010) sorted trauma appraisals into six different categories of cognition: alienation, anger, betrayal, fear, self-blame, and shame. By challenging these maladaptive thoughts and replacing them with thoughts that are more nuanced towards the self and the situation, researchers have been able to facilitate progress in those seeking treatment.

There are various approaches that focus on challenging these cognitive distortions that fall within the parameters of cognitive therapy. Stein et al. (2024) engaged study participants in writing letters to themselves. Some letters were intended to help clients reflect on maladaptive cognitions and adjust unrealistic assumptions by asking clients to imagine they were writing a letter to a friend who had undergone the same trauma. They would ask reflective questions such as, “What evidence and counterevidence is there that your friend is responsible for what happened?” (p. 5), and counsellors would provide written feedback to participants. A specific TF-CBT approach also challenges maladaptive post-traumatic cognitions, albeit with a more standardized framework. TF-CBT therapy typically encompasses three distinct phases: establishing rapport and teaching coping skills, narrating and reframing the trauma, and consolidating new cognitions and practicing applying them outside of therapy (Molero-Zafra et al., 2022). A core component of TF-CBT is the applied learning and in vivo experiencing. It will not do to simply tell one’s story in therapy and expect all symptoms to resolve. Clients must be able to go beyond discussing new cognitive appraisals of self and be able to actually implement these re-appraisals in real life situations and relationships (Cohen et al., 2017). Researchers have found a TF-CBT approach to be effective in both youth (Peters et al., 2021) and adult client cases (Kangaslampi & Peltonen, 2022).

CPT, an offshoot of CBT, also works to assist clients in challenging post-traumatic maladaptive cognitions. From a CPT perspective, the root of the maladaptive cognitions and subsequent post-traumatic stress symptoms (PTSS) are a survivor's cognitive schemas that have become incompatible with the reality of the trauma they have experienced. To heal, clients must alter their cognitive schemas to fit with the new information their traumatic experiences have taught them, a process known as "accommodation" (König et al., 2021). In folks who have experienced a trauma, many cope by altering their cognitions to a dysfunctional degree of rigidity and negativity about themselves and about their futures, referred to as "stuck points" (Marques et al., 2016). They may also integrate their cognitions about the trauma into their self-schemas, leading to guilt and shame. Throughout the healing process, it is important that one's cognitions are able to return to a sense of balance about life and the world; for example, "I now know that bad things can happen to me, but I am still able to feel safe" (König et al., 2021). Clients are taught how to identify maladaptive cognitions about themselves and about the traumatic event(s), while verbally working to challenge the cognitions with a therapist using Socratic questioning (Sloan et al., 2022). Clients may also work to re-appraise their maladaptive cognitions through the use of progressive worksheets and written exercises. Early CPT protocols always included a written component, but research showed similar outcomes without the written exercises, so more recent models view them as optional (Resick et al., 2008).

Although not entirely cognitive, exposure therapies and EMDR are more cognitive in scope than physiological as they still attend more to the brain's experience of trauma more than the body. In exposure therapy, the fear structures (such as the amygdala) in the brain are intentionally activated so that clients can learn to experience the fear without suffering through the actual traumatic event. This activation provides opportunity for the brain to input new

information about the trauma, allowing it to re-process the associated memories and threat level in a way that is more accurate to the client's present circumstances (McLean & Foa, 2011). One way to facilitate this approach to therapy is through written exposure therapy, which allows clients to follow writing prompts for exploring their traumatic memories in the absence of what would most likely be quite questionable in vivo exposure scenarios (Sloan et al., 2022).

Lastly, this section will consider EMDR therapy and how effective it is for clients presenting with symptoms of trauma and PTSD. EMDR operates under the assumptions of the adaptive information processing model, which posits that the brain is always working to assimilate new experiences and information in a way that supports one's wellbeing (Shapiro & Laliotis, 2011). EMDR works by desensitizing the client to traumatic memories, paving the way for the brain to continue its natural process of assimilation that was disrupted by a traumatic event (Kaptan et al., 2023). However, unlike strictly cognitive approaches, EMDR incorporates bilateral attention stimulation, body scans, and a focus on the bodily sensations of the targeted traumatic memories as well as the maladaptive cognitions (Molero-Zafra et al., 2022). An EMDR approach, while not explicitly cognitive, has been shown to reduce symptoms of PTSD across various populations and demographics, and it has a vast array of empirical evidence for its effectiveness in treating trauma (L. Chen et al., 2015).

There are many different techniques for treating trauma using a cognitive approach. Based on empirical evidence, cognitive approaches such as TF-CBT are considered the gold standard for psychotherapeutic treatment of trauma. Similarly, exposure and EMDR therapies have shown effective results in treating trauma. The approaches discussed above view the mechanism of trauma healing as having to do with maladaptive cognitions stemming from exposure to a traumatic event. In some approaches, such as TF-CBT and CPT, the maladaptive

cognitions are about the self, such as feeling weak or feeling a sense of shame. They can also be negative beliefs about the world at large or about one's future and ability to feel happy and safe again. Meanwhile, treatments such as exposure therapies view the underlying problem as more related to the brain's fear response, and the work focuses on installing new cognitions and broadening the window of tolerance around specific triggers and memories. In all cognitive approaches, there is a shared belief that trauma can cause maladaptive cognitions that result in dysfunctional and disruptive behaviours in clients. However, they also all emphasize the neuroplasticity of the brain and the ability to process trauma through adapting, assimilating, and re-examining the negative and often untrue cognitions and feelings about the self and about the traumatic events. Whether it is through talking, writing, exposure, or EMDR, the brain is seen as capable of re-assessing and re-evaluating the traumatic memories and cognitions in a way that promotes growth and healing.

Somatic Approaches to Trauma Treatment

Despite the empirical success of cognitive approaches to trauma, this project will consider somatic and body-based approaches as well. Not every client will have the ability or desire to sit through cognitive talk therapies. Although they are effective, they can often be distressing to clients and can exacerbate symptoms before providing relief (Lancaster et al., 2020). As well, the physiology of trauma shows how the body is involved in trauma symptomology and must also be considered in trauma treatment. Somatic approaches such as sensorimotor psychotherapy, somatic experiencing, and polyvagal therapy emphasize the bodily sensations resulting from trauma and the body's role in promoting overall healing. They do this by addressing the body's way of storing traumatic memories through a more "bottom-up" approach, rather than the "top-down" approach of cognitive therapies (van der Kolk, 2014). The

mechanism of healing is about the process of being able to self-regulate arousal in the context of traumatic memories and triggers.

In somatic approaches such as somatic experiencing, it is theorized that PTSS results after trauma renders the nervous system unable to complete its fight or flight response and is instead trapped in a freeze state that results in enduring physiological and psychological symptoms (Kuhfuß et al., 2021). Rather than focusing on maladaptive cognitions, clients rely on their bodily sensations, aiming to recognize when the body is in a state of hyperarousal and differentiating between comfortable and uncomfortable physical sensations (Andersen et al., 2020). In a similar way to how cognitive approaches seek to re-evaluate and replace cognitive distortions around traumatic memories, somatic experiencing gives the body a chance to replace uncomfortable and adverse physiological sensations with new interoceptive experiences (Payne et al., 2015). This change occurs through a program that monitors clients' physical responses such as breathing and working to identify and tolerate what is felt in the body (Andersen et al., 2018).

Similar to somatic experiencing, sensorimotor psychotherapy invites clients to mindfully explore their physical experiences, while also expanding their window of tolerance relating to physical sensations that correspond with traumatic memories. The experiential, sensorimotor aspect of therapy works in tandem with an aspect of emotional processing (Ogden & Minton, 2000). Unlike somatic experiencing, sensorimotor psychotherapy emphasizes childhood traumas and the way that repeated exposure to traumas at a young age encodes itself into a child's ability to feel safe in the world and in their own body (Classen et al., 2021). Classen et al. (2021) trialed breathing exercises and activities designed to expand somatic language and awareness and found it to be beneficial for clients presenting with complex trauma. They also explored the concept of

"savouring" progress and identifying physical evidence of growth such as feeling able to take a deeper breath than before. Other trials showed evidence of the method's ability to help clients with their levels of mind-body connection and their ability to self-soothe during states of hyperarousal (Langmuir et al., 2012).

Another somatic approach is polyvagal theory, which is interested more specifically in the nervous system's response to trauma. A polyvagal lens purports that traumatic memories can subconsciously activate the autonomic nervous system, more specifically a component of the autonomic nervous system called the vagus nerve (Ryland et al., 2022). *Poly* means many, and *vagal* means relating to the vagus nerve, so polyvagal theory focuses on the relationship between the brain and the body's responses to stimuli as interpreted by the autonomic nervous system regarding behaviours relevant to trauma such as threat assessment and stress responses (Haeyen, 2024). The body is thought to move between different stages of fight, flight, or freeze, with the ideal state being one of safety and relaxation known as the ventral vagal complex (VVC; Porges, 2001). In a traumatized system, the body is continuing to signal to the brain that there is danger, and the nervous system is unable to move to the VVC. Thus, treatment focuses on recognizing and conceptualizing what it feels like to be in different states and providing strategies for returning to the VVC (Blanning, 2024).

Relative to cognitive theories which focus on changing one's thoughts around trauma, somatic theories emphasize the role the body plays in holding onto and releasing trauma. The mechanism of change is to soothe the nervous system and limit physical states of hyperarousal. When the body is relaxed, it will signal to the brain to relax also, promoting healing and allowing for more confidence and control in emotional regulation. Similar to cognitive approaches, somatic approaches still highlight the importance of targeting trauma-related responses, but the

interest lies in body-based symptoms of trauma exposure. There are some criticisms of the scientific basis for somatic therapies (P. Grossman, 2023); however, in situations where cognitive approaches are intolerable to clients, somatic therapies are a potential alternative treatment. As well, given that the physiology and the neurobiology of trauma are interrelated, van der Kolk's (2014) "bottom up" approach of somatic treatment can certainly fit within the wider context of trauma symptomology and treatment.

Alternative Approaches to Trauma Treatment

There is hesitation in describing the following treatments as "alternative," as it would be remiss to imply that these approaches are somehow "less than" or not as effective as the previously described cognitive and somatic therapies. In fact, there is plenty of evidence in the coming section that shows how these types of alternative treatments can be just as, if not more, effective than traditional psychotherapy modalities. In placing these treatment approaches in their own separate category, it is done solely to differentiate between therapeutic modalities rooted in Westernized psychotherapies, and therapeutic modalities that have been around far longer and have their roots in ancestral, cultural knowledge.

Psychedelic-assisted therapies are currently being studied for treatment of PTSD with hopes of having these hallucinatory substances becoming more widely available and accessible. The most common drugs used in therapy are psilocybin (magic mushrooms), 3,4-methylenodloxymethamphetanine (MDMA), and lysergic acid diethylamide (LSD; Davis et al., 2020). These substances are able to affect the brain's serotonin receptors to promote altered states of cognition, emotion, and perception (Rose, 2024). Unlike cognitive or somatic therapies that have more empirical evidence and explanations for how they work, psychedelic therapies still pose many questions for researchers. In trials, study participants have reported being able to

access and process traumatic memories without experiencing debilitating and progress-halting anxiety, but the specific mechanism behind this phenomenon is still unknown (Gravitz, 2022). Another effect that could play a role in the mechanism of healing is the drugs' ability to help clients increase their psychological flexibility and being able to shift their thinking around their traumas (Davis et al., 2021). Future research will continue to explore psychedelic drugs and their mediating effects on trauma symptomology when used in conjunction with clinical counselling.

If one had to categorize psychedelic-assisted therapy for trauma, it would most likely fall under the umbrella of exposure therapy, with the drug somehow facilitating the ability to access traumatic memories in the imagination. However, similar to cognitive approaches that can cause distressing effects during treatment, some participants in clinical trials of psychedelic-assisted therapy have reported negative experiences and exacerbated symptoms (Modlin et al., 2024). Another heretofore explored aspect of trauma is the spiritual realm and a holistic viewpoint of healing that is rooted outside of the empiricism of academia. Although currently considered à la mode in the world of Westernized research, alternative therapies such as psychedelics have been in use across various cultures for thousands of years. Plants such as psilocybin-containing mushrooms and ayahuasca had many uses, most notably to connect with the sacred or the divine, often thought to be brought about from connection with spirits within the plant itself (Goldpaugh, 2022). What modern psychological research sometimes misses is the importance of holistic health and the existence of states of wonder and healing that cannot be conceptualized solely via data.

Indigenous cultures have historically had a firm grasp on holistic healing and wellness practices encompassing the individual but also society as a collective, the spiritual realm, and the natural environment. In examining general trends across global contexts of Indigeneity, it is with

the caveat that there are countless Indigenous nations and groups with their own unique practices, languages, and beliefs. However, it is important to consider Indigenous ways of healing as globally, these groups experience disproportionally high rates of mental health issues, including PTSD (Tanta-Quidgeon et al., 2024). Indigenous peoples are also at risk of traumatic symptoms from overarching historical and intergenerational traumas (Brave Heart, 1998), but just as Indigenous peoples experience collective traumas, they can also experience collective societal and cultural healing in a way that Westernized therapies based on theories of a singular mind cannot facilitate (Captari & Worthington, 2024).

It is difficult for Westernized academic systems to work with Indigenous ways of knowing and healing because they often include a spiritual aspect that is unable to be measured in a traditional empirical sense (Lavallée, 2009). Even within the narrow lens of postcolonial evidence-based treatment, there is still a considerable amount of research that points to the importance of spirituality when recovering from trauma (Captari & Worthington, 2024). Evidence also shows the power of connection to culture and family in treating trauma in Indigenous clients (Burrage et al., 2022). One Indigenous healer shared their belief that humans exist “within a complex, interdependent relational network consisting of other humans, other-than-human beings, and elements of the environment” (Tanta-Quidgeon et al., 2024, p. 535), a belief that encompasses a holistic worldview of health and healing.

It is dangerous to assume that all treatment approaches must show empirical evidence in scholarly, peer-reviewed journals, as traditional methods of healing exist outside of the medicalized and Westernized paradigm of mental health and treatment, and they have existed before the current paradigm was even created. There are Indigenous scholars who have been able to bridge the gap between the traditional and the academic, giving data and numbers to an

essence that cannot quite be quantified. Dempster-Rivett et al. (2022) were able to identify common themes of healing trauma amongst Māori study participants. These themes included spiritual connection, a sense of belonging, and being a symbol of strength in the community. Symbols like the Medicine Wheel are viewed as important by many different Indigenous groups, showing the importance of four different dimensions of health: the spirit, the mind, the body, and the heart (Schick et al., 2021). Unlike other approaches that have more specific mechanisms of healing, Indigenous ways of healing take a more holistic look at what it means to heal from trauma.

The land and a connection to the natural environment is also an important aspect of Indigenous approaches. For example, Coast Salish groups collaborated with the University of Washington to create a wellness curriculum that incorporates the canoe, a vessel that is both a practical need for living next to the ocean, but that is also a powerful cultural symbol (Richardson et al., 2022). In another example, the United Houma Nation of what is now known as Louisiana and Choctaw scientists co-created a land-based healing pilot study that invited participants to re-connect with their ancestral lands and explore narratives about what knowledge the land and their ancestors shared with them and how it could be applied to their daily lives and healing journeys (Johnson-Jennings et al., 2020). Land-based healing can look like sustainably harnessing the natural tools that the land provides (going back to the discussion about psilocybin), or it can mean simply being mindfully present on the land and connecting to the natural environment. Both practices can be powerful tools for both individual and collective healing from trauma.

Although difficult to categorize and quantify, alternative approaches to trauma treatment are valid, especially when colonized cultures are able to utilize their long-used healing methods

in a contemporary context. Alternative treatments like these often incorporate a more holistic approach to healing, rather than targeting just the brain or just the body. They also incorporate ideas about the spiritual realm, collective and cultural healing, and a connection to the natural environment. While it would be inappropriate for non-Indigenous clinicians to use these treatment approaches, clinicians should consider how alternative (i.e., traditional, cultural) approaches can be incorporated in a safe and culturally-appropriate manner, as they can often be significant components in clients' healing journeys.

Chapter Three: Discussion and Recommendations

Revisiting Project Goals and Research Questions

The purpose of this project was to explore trauma and its effects, as well as to better understand trauma healing and mechanisms that may contribute to this. It was also a goal to develop a clearer conceptualization of trauma, not just by being able to illustrate it in today's language, but by learning about how a historical clinical understanding has shaped the field's approach to treatment, inclusive of both specific diagnoses and non-pathological generalizations. This project was undertaken with the hope of providing clinicians with a more comprehensive understanding of how to treat trauma, especially given that a high proportion of Canadians will experience a traumatic event in their lifetime (Public Health Agency of Canada, 2024). Overall, the literature review provided this project with some of the necessary insights to better conceptualize trauma and understand trauma healing, as well as highlighted some gaps in the literature for consideration in future research and applied practices.

Key Findings

Some of the major themes that were represented in the literature included the significant impact of traumatic experiences on both the brain and the body, common mechanisms of healing

derived from different treatment approaches, and the importance of being open to holistic and unquantifiable methods of healing due to the very individual nature of trauma and recovery. Although there is plenty of room for nuance, the literature review highlighted that there are many different effects that can occur as a result of experiencing a traumatic event, and just as many different ways to approach healing.

Effects of Trauma and Clarity of Definitions

When attempting to understand the effects of trauma, the literature clearly suggests that it has a real effect on both the brain and the body (van der Kolk, 2014). Many studies found evidence of structural changes in the brain after trauma, such as higher instances of fractional anisotropy in the corpus callosum (Graziano et al., 2021) and reductions in grey matter volume in the hippocampus (Rokita et al., 2020). These structural changes after trauma can potentially contribute to some of the symptoms of trauma, such as hyperarousal and difficulty regulating emotions (American Psychiatric Association, 2013), due to damage in areas of the brain that function to help process emotions and regulate a fear response. The reduction of functional connectivity in the prefrontal cortex after trauma (Mehta et al., 2020) is also important to consider when attempting to understand the effects of trauma. Executive functioning skills become more difficult in instances of damage to the prefrontal cortex, which could also impact trauma symptoms like difficulties with managing emotions or being able to control impulsive behaviours (Selemon et al., 2019).

The literature review also highlighted the physiology of trauma and the impact that these experiences can have on the body. These impacts can affect mortality, such as a higher risk of cardiovascular disease (J. Chen et al., 2024) and can also affect one's day-to-day experience in their body, such as chronic pain (Dodd et al., 2021). Other possible somatic effects can also

include insomnia (Meinhausen et al., 2022), digestive issues (Chang et al., 2025), and chronic inflammation (Mehta et al., 2020). It is not just trauma exposure itself that can directly cause some of these physical symptoms but also the compounded effects of chronic stress and maladaptive coping mechanisms, such as excessive drinking (Jones, 2017). Furthermore, many of these somatic symptoms presenting in the body can also be attributed to dysregulation of the sympathetic and parasympathetic nervous systems (Sumner et al., 2020).

The literature also suggests the age at which a traumatic event occurs is a significant factor that can determine the severity of trauma symptoms later on in adulthood (Parish-Plass, 2021). As the brain and the nervous system attempt to learn and develop in a healthy way, setting the stage for overall positive mental and physical health outcomes throughout the lifespan, the impact of trauma or ACEs can cause a serious disruption in typical development (Campbell, 2022). This interruption can lead to complications in both childhood and later in life; therefore, it potentially alters the trajectory of someone's life due to trauma sustained during sensitive times in development. When working with clients presenting for trauma treatment, clinicians should consider not just the events they are describing but the context within which the events occurred. Additionally, practitioners should consider the individual's overall history and family of origin, evaluating for other potential trauma exposures and seeking to place their history within an overarching narrative relative to the age of first exposure (Parish-Plass, 2021).

When attempting to sum up the learnings about trauma into a non-pathological definition, the results of the literature review suggest that trauma is the very individual manifestation of the negative effects of distressing events, which can have tangible consequences on both the brain and the body. Sometimes experiencing trauma can result in a formal diagnosis of a disorder such

as PTSD, but trauma itself is not a diagnosis. By better understanding the possible outcomes after trauma exposure, clinicians can provide more effective care to those seeking treatment.

Mechanisms of Healing

When considering any potential mechanisms in trauma healing, it would appear that a cognitive approach works by allowing clients to re-assess maladaptive cognitions surrounding the traumatic event(s) and integrating these cognitions in a way that promotes healing. Some of these cognitive distortions are about the world itself, such as reducing feelings of debilitating fear when coming across trauma triggers (König et al., 2021). It would also appear that there is a strong relationship between PTSD symptoms and cognitive appraisals of the self in relation to the event, such as feeling weak or ashamed (Gómez et al., 2019). Though there are multiple cognitive modalities that can help clients challenge a variety of maladaptive cognitions, common across a general cognitive approach was a newfound sense of healing when clients were able to feel empowered and to allow themselves to release guilt, shame, and blame in relation their traumatic experiences (DePrince et al., 2010).

Emerging from the literature, a potential mechanism of trauma healing from a somatic approach would appear to be helping clients calm the nervous system. In response to trauma, the nervous system can become trapped in a state of hyper- or hypoarousal, and a somatic approach that helps the nervous system and body relax can signal to the brain to relax also. As such, reducing this state of arousal through somatic strategies would lead to shifts in symptoms of trauma. Unlike the cognitive approach and maladaptive cognitions, somatic modalities emphasize paying attention to bodily sensations and widening the window of tolerance before experiencing distress (Andersen et al., 2020). Training the body to recognize new interoceptive

experiences is key to moving past uncomfortable physical sensations and symptoms of trauma (Andersen et al., 2020).

As well, more traditional or cultural approaches can be helpful for facilitating growth and healing, such as the use of psychedelics (Davis et al., 2021) or the integration of traditional Indigenous cultural knowledge and connection with one's community (Johnson-Jennings et al., 2020). Unfortunately, it can be difficult to gather concrete data on the efficacy of some of these non-Westernized approaches because many of the people using these methods are doing so in the role of an elder or healer, and not as a clinician or researcher (Lavallée, 2009). In approaches that harness traditional Indigenous teachings about healing, there is also not one singular mechanism that emerges from the literature but an overall pattern of holistic approaches and a deep sense of healing that can come from engaging in one's cultural practices. Some of these approaches are steeped in story and symbolism (Richardson et al., 2022) or may personify aspects of the natural world (Tanta-Quidgeon et al., 2024). Overall, it is important to consider how a client's cultural background can aid them on their healing journey, not just because of the potential positive outcomes from a holistic approach to wellbeing, but also due to the possibility of collective healing that can be shared between members of the same cultural group (Captari & Worthington, 2024).

Generally, in considering both trauma symptomology and treatment, the literature review supported the individual and unique nature of how trauma can present and how clients can find new ways to move forward. Although there are common patterns parsed from a review of trauma symptoms, other contextual and mitigating factors will likely affect each client and their experiences differently, sometimes leading to a trauma-related diagnosis, and sometimes not. Though symptoms have been separated mainly into either the body or the brain, people interpret

the world through both lenses and from the myriads of interconnected responses within the human system (Maggio et al., 2022). Additionally, the evidence of change can be seen across multiple modalities and approaches. Some specific modalities have been presented in the previous chapter, but there are many other potential modalities not included in this review and thus the potential for other mechanisms of healing not covered within the scope of this project. In attempting to find common themes within the literature, this review also highlights how personal traumatic experiences and healing can be.

Appreciations Within Current Knowledge

Some appreciations found within the current knowledge around trauma are the wealth of research providing evidence for effective trauma treatment using accessible, foundational modalities, and the growing body of Indigenous-led and multicultural research. Although there is also a growing body of evidence around current popular approaches, such as EMDR for trauma (Onofri, 2023), many of these modalities require very specific knowledge obtained from expensive trainings. While new research and interventions can be exciting for both scholars and clinicians, it is also gratifying to see that accessible approaches such as TF-CBT and CPT are still considered to be the prevailing frameworks for trauma treatment, with the largest body of evidence in their favour (Hundt et al., 2020). Similarly, when it comes to a somatic approach, interested practitioners can sign up for more specialized and expensive trainings in specific modalities, but interventions such as grounding exercises and breathing techniques are both cost-effective and user-friendly.

It is also heartening to see that there is a growing body of evidence for cultural and traditional healing approaches, hybrid treatments, and holistic paths to wellness, especially from Indigenous scholars. Although there is a conversation to be had about the tension between

cultural traditions and institutionalized education, as well as the various barriers preventing Indigenous folks from accessing both higher education and formal counselling, it would appear that a broad network of Indigenous researchers and clinicians are working to bridge these gaps in knowledge and care in order to better serve their own people. The literature review highlights the individual nature of trauma treatment, and this is especially pertinent when considering those from backgrounds outside of a Eurocentric purview.

Limitations in the Literature

Despite providing a foundation on which to build one's knowledge of trauma, the literature review also points out some limitations in the current understanding. One of the most glaring of these limitations is the lack of diversity in the research. Most participants are from Eurocentric contexts, with studies being conducted in Westernized institutions that have historically reinforced colonial narratives of truth and the value of peer-reviewed data over cultural knowledge. Although some Indigenous scholars have been able challenge this divide by conducting empirical research on their own cultures within the boundaries of formalized education systems, it raises concerns about the systemic barriers non-Western scholars face if they want to have their traditional practices legitimized. On the other hand, within colonial systems, data can be a powerful tool when pursuing advocacy and change, and it would be remiss if formal institutions in North America were to not prioritize Indigenous-led research in future.

This gap also raises questions about systemic barriers preventing both researchers and potential clients from exploring different approaches to trauma healing and accessing appropriate care. Many marginalized communities face limitations such as lack of funding, geographical constraints such as communities located in rural areas, and cultural reasons for not wanting to

participate in research or treatment offered by Westernized institutions and practitioners (Goetz et al., 2023). These barriers can also make it difficult for folks in those communities who are interested in higher education to be able to gain admittance to these institutions (Cameron et al., 2024). Additionally, cultural mistrust can occur in cases where clinicians without proper training in trauma-informed and culturally competent practices have attempted to force their own version of what psychological healing can look like onto clients from other cultures, at times actively re-traumatizing them and further alienating them from access to care (Gone, 2010).

Indigenous clinicians and researchers have the unique position of being able to help their own people on their journeys of trauma healing due to their intrinsic knowledge of cultural healing and their lived experiences within their communities. This knowledge can translate to much-needed data on what works and can facilitate access to safe and effective care. Continuing to find a balance between the need for more Indigenous scholars and clinicians in the field and the inherent value of traditional practices based on centuries of lived experiences will determine the future of the profession's ability to dismantle systemic barriers and cultural stigmas around trauma treatment.

One final note about the limitations of diversity is that the literature review and subsequent gaps focused mainly on Indigenous issues, especially given the complicated history of Indigenous peoples in postcolonial Canada and the need for safe and accessible trauma counselling within these communities. However, other marginalized groups such as the queer community, immigrant populations, persons with different abilities, and the neurodivergent community are also at a higher risk of experiencing traumatic events (Matheson et al., 2019), and health outcomes within these communities can also suffer from significant gaps in the literature and systemic barriers to care.

Recommendations for Future Research and Practices

Based on the literature review, some recommendations for future research and practice have arisen. These include expanding research and access to holistic and cultural approaches to healing and the duty of non-Indigenous clinicians to advocate on behalf of their Indigenous colleagues and clients, expanding understanding of the ways that trauma can present outside of a formal diagnosis while also continuing to ensure clarification of the language used, and the potential of the role of self-compassion in existing trauma treatment frameworks.

Diversifying the Professional Landscape

Based on what has already been discussed with regards to limitations in the literature and in the field overall, it is recommended that academic institutions continue to diversify their programs, both when it comes to practical training programs for clinicians and when it comes to Indigenous-led research projects. Universities looking to recruit more students from marginalized populations should examine their admissions processes to ensure that these communities are not shut out of these institutions due to systemic barriers, such as finances or geographic location, and should address potential challenges that may prevent these students from successfully completing their programs. Some recommendations from Blanchet Garneau et al. (2021) suggest that partnering directly with Indigenous communities and educators, such as by hiring advisors specifically for Indigenous students and providing mentorship opportunities between Indigenous educators and learners, could help with increasing the number of students able to successfully complete clinical programs and research projects. Looking to the future, this systemic change would mean that there would be more Indigenous counsellors in the field available to provide culturally appropriate care in their own communities.

Regarding the overall lack of Indigenous clinicians and the dangers that non-Indigenous counsellors can pose when it comes to potentially re-traumatizing Indigenous clients (Gone, 2010), it is also important that non-Indigenous allies advocate on behalf of their Indigenous colleagues and clients. Because of systemic power imbalances, it may be that non-Indigenous professionals in academic and clinical realms have the responsibility to create space for Indigenous voices and expertise where there currently is none. When it comes to client work, non-Indigenous practitioners should also ensure that they are knowledgeable about the history of Indigenous peoples in Canada and how this may affect mental health, and that they are working collaboratively with Indigenous practitioners to provide safe and effective treatment for clients from a variety of cultural backgrounds (Bowden et al., 2017).

When it comes to future research that can help with bridging gaps in the field's understanding of trauma treatment that are not related to specific cultures, it is recommended that future studies explore the efficacy of integrative and holistic treatment programs. Much of the data in the literature review concentrated on singular modalities applied one at a time, and it could be useful to develop research studies that incorporate both cognitive and somatic approaches simultaneously. Although clinicians are typically adept at providing interventions from an integrative lens (Zarbo et al., 2016), there is currently not much research specifically focusing on the treatment outcomes when incorporating both bottom-up and top-down approaches to trauma. Considering that the literature review found evidence for the efficacy of both approaches in treating trauma, it is theorized that combining some of these interventions may lead to even more favourable outcomes. Other researchers have noticed this gap in the literature as well, with Zoromba et al. (2024) arguing for the importance of trauma research that explores holistic approaches and integrates individual and cultural factors into current

frameworks. It would seem pertinent to research holistic programs specifically in group settings as well as to expand upon some of the literature review's findings about communal and societal healing (Captari & Worthington, 2024).

Expanding Understanding of Trauma Symptomology

As the clinical understanding of trauma has shifted throughout the years, including establishing and expanding to include a formal diagnosis with clearly defined criteria in the *DSM* and the *ICD*, it is recommended that research and practice continue to explore the impact of various trauma symptoms on survivors. For example, symptomology tends to concentrate on mood and arousal (American Psychiatric Association, 2013), but the literature review also highlights the ways that structural changes in the brain can affect executive functioning (Mangum et al., 2021). As discussed in chapter one, trauma can affect day-to-day functioning when it comes to things like being able to maintain stable housing and food security (Jensen et al., 2023). These effects are further compounded by ACEs and their consequences on development (Parish-Plass, 2021). Future research could look specifically into the link between trauma and executive functioning to better understand the tangible impacts of trauma on basic life tasks and how this may present in clients seeking trauma treatment. Furthermore, with the way that trauma effects can also include physical symptoms such as cardiovascular disease and digestive issues, it is recommended that counsellors also inquire about prior medical evaluations to rule out physical issues that may be mimicking symptoms related to mental health. Just as the field's conceptualization of trauma has shifted with time, it is recommended that research and practice continue to evaluate and explore other potential symptoms of trauma that may affect clients.

Because treatment and conceptualization can shift depending on one's professional background and their different interactions with what they believe to be trauma (Hoppen et al., 2023), and because many clinicians feel like they are not adequately prepared to treat trauma (Kumar et al., 2022), it is also recommended that clinicians continue to expand their understanding of the effects of trauma as well as the distinction between various trauma-related disorders. Not everyone who has experienced a trauma will need an official diagnosis to receive treatment (and not all clinical counsellors are even qualified to diagnose), but considering that different diagnoses can sometimes respond with more favourable outcomes depending on the specific treatment (Bohus et al., 2020), it is recommended that clinicians continually increase their knowledge of the various potential manifestations of trauma. Given that some clients may also be coming to sessions with varying understandings of trauma, such as those who are getting their information from #TraumaTok (Hung et al., 2023), accurate definitions of trauma and trauma-related disorders can help clinicians with clarifying psychoeducation for clients. Somewhat conversely, it is also recommended that an effective clinical approach includes trauma-informed practices regardless of any specific pathology or diagnosis.

Exploring the Role of Self-Compassion in Treatment

The final recommendation drawn from the literature is with regards to exploring cognitive approaches and the importance of self-concept in relation to traumatic events. The evidence suggested that when clients were able to release feelings of guilt, shame, and blame in relation to their traumatic experiences, this seemed significant in helping resolve trauma symptoms and providing clients with an empowering foundation with which to move forward (DePrince et al., 2010). This finding aligns with Neff and Germer's (2022) research that

highlights the importance of showing oneself kindness as a way of reducing symptomology across a wide range of clinical disorders.

Therefore, it is recommended that future research specifically explores the link between self-kindness and shifting self-perception in relation to trauma as a way of better understanding how this may function as a potential mechanism of healing. Research could also explore ways to integrate self-compassion into somatic and holistic treatment approaches to further expand potential trauma toolkits for counsellors. Self-compassion aligns with trauma-informed principles as it is empowering to clients and can provide them with an increased sense of both internal and external safety (SAMHSA, 2014). It would perhaps be worthwhile to further research how self-compassion can be used in trauma treatment across a range of modalities and populations.

Reflections on Personal Learning

Over the span of the months that it has taken me to complete this project, my understanding of the effects of trauma and clinical treatment approaches has been able to grow as I have dedicated many hours to both researching the topic and expanding my practice during my practicum. It has been very gratifying to be able to apply my learnings in clinical practice, especially given that many of my clients have presented with complex trauma histories. It has highlighted for me the importance of having comprehensive knowledge of trauma and its effects and further underscored my desire to specialize in traumatology as a clinical niche. However, as mentioned in the opening chapter, the statistics have shown that trauma is pervasive in Canadian society (Public Health Agency of Canada, 2024) and as such, it is likely that every counsellor will brush up against the effects of trauma in their caseload at some point.

Trauma Treatment and Self-Compassion

One aspect of this research that has particularly resonated with me has been the way that a better understanding of the effects of trauma has helped me to provide clients with psychoeducation on why they may find themselves struggling, which has in turn led them to a greater understanding and ability to offer themselves compassion and kindness. The interest in and recommendations for research on self-compassion came as a surprise, perhaps influenced by the real-life ways I was able to apply self-compassion work in clients presenting for trauma treatment. As evidenced by DePrince et al. (2010) and Gómez et al. (2019), shifting one's self-concept in relation to a traumatic event is one way that a cognitive approach can help alleviate symptoms of PTSD. For example, some clients who have been really hard on themselves for still finding themselves struggling with symptoms like flashbacks, despite the fact that the traumatic events occurred years in the past, have seemed to find it a relief when I have been able to explain things like the way that traumatic memories can get stuck due to structural changes to the brain, making it difficult to integrate and move on from these overwhelming experiences. In my experience with clients so far, being able to provide an explanation for how trauma does not necessarily just "go away" with time can help with understanding why symptoms may linger even after a long time. In turn, this explanation can help clients practice self-compassion as they experience cognitive shifts towards releasing guilt and blame or feelings of being weak. For many clients, it has been evident that they are continually blaming themselves for not healing from their traumas in a timely or expected manner. Being able to provide some sort of explanation of why a lot of their symptoms are actually not their fault has seemed to have gone a long way towards helping clients rebuild a healthy self-concept that both empowers them to change but also allows them to give themselves a little bit of grace in the meantime.

I have also noticed significant shifts in clients when we have focused on self-concept rather than diving into what happened to them and trying to change how they feel about their trauma. The reality is that these experiences are considered traumatic for a reason because they are distressing, overwhelming, and indescribably painful. In my own practice, it has seemed that being able to acknowledge and sit with this reality rather than trying to change it has been a source of relief for clients as well. Being able to facilitate self-compassion in clients, such as inviting them to write a letter to themselves, practice affirmations, or explore what they might say to a friend or loved one who has gone through the same event (Germer & Neff, 2019), has resulted in some incredibly profound release of guilt and self-blame.

The Individuality of Trauma

This project also highlighted for me the individual and personal nature of trauma healing. There are many ways that trauma can manifest in both individual and collective systems and just as many potential ways to heal. Sometimes these individual symptoms may present in a way that meets a criterion for a trauma-related disorder, but not always. Trauma itself, while often semantically intertwined with PTSD and other related disorders, is its own individual concept encompassing more subjective and wider-ranging experiences of harm. This broader conceptualization of trauma does not mean that undiagnosable or undiagnosed clients presenting for trauma treatment should not receive the same level of trauma-informed care to address self-reported symptoms. I have actively worked to ensure that my practice is collaborative, prioritizes the goals of my clients, and meets their individual needs based on their own multifaceted personal contexts.

At times this project has also been incredibly overwhelming. I knew going into the literature review that there would be endless amounts of information to understand and attempt

to organize into something semi-coherent. Although I do feel much more knowledgeable about the topic, I will also be the first to admit that I have only just begun to scratch the surface. There are many foundational texts referenced in this project, but there are still so many works from incredible writers and teachers that I have not yet had the chance to read. My interest in traumatology, while endlessly helpful for my practice, has in some ways made my life more complicated as I now have an ever-growing list of books, trainings, and webinars to explore. As well, when considering the gaps in the research, it has also highlighted future professional directions, such as moving into research on holistic treatment programs that incorporate a wider range of interventions, or perhaps a better understanding of the mechanism of trauma healing through self-compassion. It has also made clear the continued need to invest my time and energy into trauma-informed and Indigenous-led trainings, as well as more tangible advocacy on behalf of these initiatives and those pertaining to other marginalized communities. Although this project is nearing its end, I am finding myself re-energized at the realization that this is also only just the beginning of what I hope is a long and impactful career.

Conclusion

This project was undertaken with the purpose of gaining a more comprehensive understanding of what trauma is and how it can affect survivors, as well as a better understanding of potential ways to help clients heal. First, the history of trauma conceptualization and treatment was explored, from early ideas about how war affected soldiers, to the current understanding (and perhaps misunderstanding) of trauma within the general public. Associated reasons, such as concept creep and the influence of social media were explored. The effects were categorized into neurobiological and physiological. The second chapter also contained a review of some of the main treatment approaches, which were categorized as either

cognitive, somatic, or alternative, which typically meant traditional cultural practices that may not necessarily have as much empirical evidence as other approaches. Limitations have focused mainly on the lack of diversity in trauma research, as well as the tension between the validity of cultural practices and the importance of empirical evidence.

Recommendations have included future research directions that can help continue to bridge this gap between holistic and cultural ways of healing and the rigidity of Westernized academia, as well as research expanding on other potential mechanisms of healing. These expanded approaches could consider explicitly holistic approaches that intentionally combine multiple modalities, the possibilities of group work, and tools that can facilitate self-compassion for trauma treatment related to self-concept. Recommendations for clinical practice have focused on the importance of working within trauma-informed and culturally competent frameworks for all clients seeking treatment regardless of diagnosis, as well as the need for allied counsellors to advocate for and amplify marginalized voices within the field.

Overall, trauma has proven to be difficult to conceptualize in just one way, as it carries with it a diverse array of potential symptoms and corresponding treatments. It is its own concept, and a singular one at that, but one with many interconnected interpretations and connotations depending on individual and societal experiences. Amidst the ambiguity that can cloud one's understanding, a unifying insight that emerges throughout the literature is the resilience of survivors and the ability of the brain and the nervous system to heal. This healing will look different for everyone based on various contextual factors, such as cultural background and age of first exposure to trauma. While counselling for trauma treatment may not be accessible to everyone due to systemic barriers, the research shows that with a collaborative, respectful, and

empowering approach that suits the diverse individual needs of the client, the human capacity for healing and growth after trauma is undeniable.

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