

Trauma Responses and Coping Mechanisms

Dr Jessica Taylor

A trauma-informed approach to understanding human distress is a way we can explore the trauma responses without medicalising the person. Instead of seeing the trauma responses as mental illnesses, disorders and abnormal behaviours, a trauma informed approach sees the trauma responses as normal, rational and purposeful. Therefore, the trauma-informed approach to understanding ourselves opposes the medical model of mental health. Instead, the trauma-informed approach draws on the social model of mental health, which argues that we should look at the context, environment and situations to explore trauma.

The trauma-informed approach is anti-blaming and anti-stigma. It is not '*what is wrong with you?*', it is '*what happened to you? what did someone do to you?*'.

Medical Model Description of A Person

Barbara has a history of child sexual abuse. She has been diagnosed with anxiety disorder, personality disorder and does not engage well with our services. We have tried to support her to open up about what happened, but she refuses to engage. She does not build relationships well, and often refuses to trust new staff members or support workers. She has attachment issues and is not ready for support.

Trauma-Informed Description of A Person

Barbara was subjected to child sexual abuse. She is still very fearful and is struggling with trauma responses at the moment. She is not ready to talk to us about what happened yet, so instead we have supported her with other things she wanted to talk about. She is scared of new people and is not ready to trust any of us yet, this will take time and needs to be approached at her own pace when she is ready.

You may be able to see clearly that the medical model diagnoses Barbara with psychiatric disorders, complains about her lack of engagement and self-help. Whereas the trauma-informed model does not seek to medicalise Barbara and instead sees her behaviours as normal and rational.

What Is The Purpose of A Trauma Response?

All of our responses to trauma mean something important. They are not just symptoms of distress, they are responses we developed to help us to survive or process the trauma whilst it was happening and after it happened. Trauma responses mean something individual to each person. Two people might have flashbacks but might have them for different reasons and might experience them differently.

The purpose of all of our trauma responses is to warn us of danger and to make sure it does not happen to us again. For example, if after the sexual violence you found that you were left with a host of 'triggers', rather than seeing them as problematic or disordered, think of them as useful. Your brain is being triggered by those smells or sights or sounds or sensations to protect you from further harm. This was absolutely vital for us when we were prey in the wild. We needed to remember which events, animals, natural elements or experiences could kill or harm us. We remembered the feeling, sight, sound, smell or taste of impending danger so we could escape or protect ourselves.

Trauma triggers are doing the same thing. They are reminding us of factors that may protect us in future. For example, you may be left with triggers to people with a particular aftershave on, or cars of a particular colour and make, or the smell of cigarettes, or the taste of wine. These are important ways that our brain is trying to keep us safe.

What Is The Purpose of A Coping Mechanism?

Similar to trauma responses, all coping mechanisms have an important purpose. Coping mechanisms can be anything at all. Some of us might drink, take drugs, overeat, restrict food intake, self-harm, work too much, punish ourselves, overachieve, become perfectionists or even change something about ourselves to cope. Some research (Morrow and Smith, 1995; Eaton and Paterson-Young, 2018) suggests that all of our coping mechanisms really come down to two purposes:

- ❖ To keep ourselves from being overwhelmed with feelings and memories we cannot cope with
- ❖ To reduce our feelings of powerlessness, hopelessness and lack of control

This research is very important, because rather than perceiving our coping mechanisms to be mental illnesses or disorders, the research asks 'What is the purpose of this coping mechanism? What is it doing for this person?'

If a child who is trapped in abuse suddenly stops eating, we need to explore whether it is a coping mechanism or whether it is a way for the child to take back control of something in their life. Similarly, if an adult starts to drink to cope with the memories of the abuse, we have to explore whether the drinking and disinhibition or relaxation is reducing the feeling of being overwhelmed.

Perceiving and processing our thoughts, feelings and behaviours as either trauma responses or coping mechanisms for the trauma is a key part of adopting a trauma-informed approach to understanding ourselves. Coping mechanisms mean something. They perform a protective role for us, either physically or psychologically. Coping mechanisms are not because we are crazy, disordered or abnormal; they always serve an important purpose.

Often, coping mechanisms develop during the abuse or sexual traumas and can continue for many months or years after you escape abuse. For example, if you were abused for a long time by an unpredictable, aggressive person, one of your coping mechanisms may have been to become compliant, quiet and submissive. This may have worked many times to protect you from further violence or abuse, and then may become one of your coping mechanisms going forward. You may notice that you revert to this behaviour when people are being argumentative, confrontational or are becoming aggressive or loud around you.

Therefore, exploring where our coping mechanisms come from and when we first started using them can give us important insight into our thoughts, feelings and behaviours now.

Are Trauma Responses A Form of Mental Health Issue?

The trauma-informed approach would argue that trauma responses are not a mental health issue. Instead, we choose to see trauma responses and coping mechanisms as healthy, normal, rational, expected and justified.

For example, it is **healthy** to be fearful and scared of abuse and memories of the abuse. It is **normal** to be traumatised by sexual violence. It is **rational** to fear it happening to you again and to change your behaviours to protect yourself. It is **expected** that you will have trauma responses after sexual and domestic violence. Your responses to trauma and your coping mechanisms are **justified** because what you have lived through was traumatic.

With this approach, trauma-informed theorists and practitioners do not perceive victims of abuse to be mentally ill, disordered or abnormal. They campaign against the medicalisation and pathologisation of adults and children who have been abused. Instead, they argue for trauma therapies, long term support and humanistic, holistic ways of supporting people without classifying them with mental illnesses they do not have.

This is still a controversial way of working. The world is dominated by medical models of mental health in which professionals and the public are regularly told that mental health issues are due to brain chemistry, neuropsychology and imbalances. People are encouraged to go to medical professionals and seek medication for their traumas, with many people placed on waiting lists for support for months or years. However, there are now many more psychologists, therapists, social workers and counsellors who are beginning to understand the trauma-informed approach and now campaign to stop the oppression and medicalisation of traumatised people. VictimFocus is committed to a trauma-informed way of working which focuses on the human, and not on the labels. Hence this resource.

How Do People Respond Or React To Abuse And Trauma When It Is Happening To Them?

Everyone is different. However, practitioners and academics tend to talk about five adrenal responses that we have when we are threatened with serious danger. Our brains tend to perceive lots of different forms of abuse as serious danger. However, some of us will not have a trauma response during abuse if we have been effectively groomed to believe that the abuser loves us or that we love the abuser. This means that for some of us, we could be neglected, oppressed or abused for long periods of time and not necessarily show any trauma responses until we are much older and have started to process what that person did to us.

For that reason, use the five F's with caution. Not everyone will experience them. Not everyone will have one set trauma response, either. In fact, most of us will be able to recall times when we have responded to different traumas in different ways. It is a myth that we have one particular trauma response which is 'hard-wired' into our brains. We are much more complex than that.

The Five F's of Trauma

Fight: This trauma response is where we try to argue, fight, shout, push, kick, punch, swear, bite or any other response to being abused. It is a very rare form of trauma response in interpersonal violence. However, it is still seen by many as the 'first' trauma response, and so we are expected by society to have fought our attackers. Unfortunately, many of us have also been socialised to believe this myth too, which means we can often feel guilty or confused when we cannot explain or understand why we did not fight back.

Flight: This trauma response is where we try to avoid, escape or get away from the abuser or the abuse. We may try to do this in many different ways and does not mean we have to 'run' to have a flight response. Some people have flight responses they cannot act on, such as thoughts and feelings that tell you to 'get out' or 'leave', when you become aware you are in danger. Similar to 'fight', this response to trauma is rare. Most people do not escape a sexual assault or rape.

Freeze: This trauma response is the most common. For example, 70% of us will 'freeze' during a rape or sexual assault (Moller et al., 2017; Eaton, 2019). A freeze response is one in which we feel as though we cannot move, cannot talk, cannot fight the person off or do anything to protect ourselves. People who freeze often do so to limit further harm from the perpetrator. However, this trauma responses often induces feelings of guilt because people feel as though they should have fought back.

Friend: This trauma response is where we try to talk or appease the abuser. Lots of us use this approach, especially those of us in long term abusive situations with parents, carers, partners or ex-partners. It is common for people who have a friend response to trauma to try to bargain with the abuser, to calm them down, to agree to one sex act but to ask not to be hurt, or to agree to something to protect someone else (including kids or family members).

Flop: This trauma response is argued to be a reaction to such high levels of cortisol (stress hormone) in the blood that our body shuts down non-essential muscles and body parts to keep us alive. This causes us to sort of 'flop', which some people describe as feeling like going limp, fainting, passing out or feeling like 'a rag doll'.

Whilst this list of trauma responses is helpful, remember that everyone is an individual and we were all abused or harmed in different situations. This means our responses will all have been diverse and purposeful at the time. It also means that you will not have one set trauma response that you always did or always do. Your brain will respond differently based on what is likely to be the safest response at the time. For those of you with multiple perpetrators who harmed you, you might notice that you were more likely to try to talk one of them down, but there might have been one that was so violent and dangerous that you were more likely to freeze until it was over. This is completely normal and very common.

For more information about trauma responses, coping mechanisms or victim blaming, please visit www.victimfocus.org.uk or contact Jessica on jessica@victimfocus.org.uk