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National Centre of Excellence
for Complex Trauma

TALKING ABOUT TRAUMA

GUIDE TO CONVERSATIONS AND SCREENING FOR HEALTH AND OTHER SERVICE PROVIDERS



BLUE KNOT FOUNDATION

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empowering recovery from childhood trauma

Talking about Trauma: Guide to Conversations and
Screening for Health and Other Service Providers

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*Talking about Trauma: Guide to Conversations and Screening
For Health and Other Service Providers*
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Blue Knot Foundation

Blue Knot Foundation is Australia's National Centre of Excellence for Complex Trauma, empowering recovery and building resilience for the five million adult Australians (1 in 4) with a lived experience of childhood trauma (including abuse), their families and communities.

Formed in 1995, Blue Knot Foundation provides a range of services including:

- specialist trauma counselling, information, support and referrals
- educational workshops for survivors and their family members, partners and loved ones
- professional development training for workers, professionals and organisations from diverse sectors
- group supervision
- consultancy
- resources including fact sheets, videos and website information at www.blueknot.org.au
- advocacy
- research

At the forefront of pioneering trauma-informed policy, practice, training and research, Blue Knot Foundation actively supported the work of the Royal Commission into Institutional Responses to Child Sexual Abuse and the people engaging with it.

In 2012, Blue Knot Foundation released *Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* www.blueknot.org.au/guidelines. These nationally and internationally acclaimed guidelines were a global first in setting the standards for clinical and organisational practice. In 2015, Blue Knot Foundation released an Economic Report, *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia* to present the economic case for providing appropriate trauma-informed services for adult survivors. This publication was followed in 2016 by *Trauma and the Law – Applying Trauma-informed Practice to Legal and Judicial Contexts*. In 2018-19 Blue Knot Foundation is releasing its *Talking about Trauma* series. This is the second publication in this series. The first was *Talking about Trauma – Guide to Everyday Conversations for the General Public* <https://www.blueknot.org.au/trauma-public>

For more information, visit www.blueknot.org.au. If you need help, information, support or referral, call Blue Knot Helpline on 1300 657 380 or email helpline@blueknot.org.au between 9am-5pm Monday to Sunday AEST/ADST.



Executive Summary

As a society we are becoming increasingly aware of the prevalence of trauma and its devastating impacts. But many people feel poorly equipped to have conversations with people they know or suspect have experienced trauma. Many segments of society do not know how to 'talk about trauma' including within families, among friends, and by the general public. This also applies to service-providers including health services, who frequently engage with traumatised people seeking support is concerning indeed.

Knowing how to 'talk about trauma' is essential to supporting traumatised people. It is also critical to establishing service systems which are 'trauma-informed' i.e. in which all professionals and personnel, regardless of qualification/s, occupation or skill base have a basic understanding of how overwhelming stress can affect the way we function as human beings and a working knowledge of how not to compound stress ('do no harm').

It is important to distinguish between 'treatment' in the formal clinical sense (which is provided by qualified health professionals) and non-clinical 'treatment'. The latter relates to empathic and respectful ways in which it is important to engage with and respond to people. The following information applies to the process of 'talking about trauma' for service providers, in the *non-clinical* sense. As such, it is relevant to all services, within and outside of the health sector, including those which don't provide any clinical treatment.

Research shows that positive relational experiences assist trauma recovery while negative social interactions impede it. Such interactions occur within diverse services, which can therefore play a major role in providing support for recovery from trauma. Non-clinical 'treatment', interacting in either positive or negative ways, can either assist or impede well-being. For this reason, *every type of service needs to know how to 'talk about trauma'*.

It is not difficult to acquire the necessary knowledge for 'talking about trauma'. No clinical training or specialist skills are needed. It simply requires a basic foundation of information about trauma; i.e. becoming 'trauma-informed'. When put into practice, this knowledge reduces the likelihood of stressful interactions and helps minimise the effects of prior traumas. Relating to one another in a trauma-informed way 'does no harm' and focusses on the way in which we treat each other as human beings. Services of all kinds can play a critical role in this regard.

The material provided is based on research presented in Blue Knot Foundation's (formerly known as ASCA) seminal document: *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* and more recent additional research. It presents the trauma-informed principles of *safety, trustworthiness, collaboration, choice and empowerment*, and infuses them into all conversations about trauma, with a particular focus on trauma that is interpersonal.

This guide is the second in a series on the topic of *Talking about Trauma* (the first is addressed to the general public). The series as a whole is intended to build the knowledge and skills of everyone in our community. Whether in a personal or professional capacity, we all need to engage in conversations about trauma. Building our capacity to 'talk about trauma' across the board will help create a trauma-informed society and improve our health as individuals and overall. This will also limit any regret related to 'not knowing', and not doing all we could to help our fellow citizens receive the support they need to recover. Services of all kinds can play a crucial role in this regard and the following information will assist them to do so.

Dr Cathy Kezelman AM and Pam Stavropoulos PhD

Blue Knot Foundation

Sydney, April 2018

INTRODUCTION: Why do all services need to be trauma-informed?

'It was once believed that [traumatic] events were uncommon. Traumatic events are extraordinary not because they occur rarely, but because they overwhelm the ordinary human adaptations to life'.
(Herman [1992] 1997:33)

'It is clear from many studies that interpersonal violence is more likely to have long-term consequences than natural disasters or accidents'.
(Bloom & Farragher, 2011:67)

New research, accumulating insights, and ongoing media coverage of human suffering mean that diverse sectors of society increasingly recognise the prevalence, devastating impacts and many forms of trauma. Trauma occurs globally, nationally, and interpersonally. *It is not just 'out there'; it is in our midst.*

People who experience the psychological and physical effects of trauma¹ access both mental and physical health services. Yet many health services are insufficiently aware of the impacts of trauma. *All health services of all types need to become trauma-informed.*

People who struggle with the impacts of trauma on their daily functioning, well-being and relationships also access diverse services **outside** the health sector. These services, too, need to become trauma-informed.

'Trauma' can be defined as overwhelming stress. Interpersonal trauma includes sexual abuse, physical and emotional abuse, community and family violence as well as neglect. All these forms of trauma are common. Many people also experience trauma through its intergenerational transmission from a parent who has their own unresolved trauma (which can come in many forms including mental illness, substance abuse or imprisonment). *Not all interpersonal trauma stems from abuse.*² Yet the trauma of abuse is sadly common.

We are also becoming aware of the *structural* and *systemic* contexts in which abuse of all kinds can flourish within our society. In Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse³ has increased awareness of the large number of victims of child sexual abuse in institutional 'care', and the gross neglect, physical cruelty and other violations which often accompany it. These alarmingly common traumas were not only perpetrated by individuals in isolation. They took place *within and across the full spectrum of 'mainstream' institutions.*⁴

There is growing awareness, too, of the scourge of domestic and family violence. Calls for action have been spearheaded by prominent former Australian of the Year, Rosie Batty, the Royal Commission into Family Violence in Victoria, and the White Ribbon campaign. This highlights the need for everyone – and especially service providers – to be aware of the risk and reality of trauma in diverse institutions, including that of the family.⁵ At the same time, we cannot ignore the trauma that stems from natural causes.

¹ For an introduction to the physical impacts of early life trauma, see Robin Karr-Morse, *Scared Sick* (New York: Basic Books, 2012).

² See, for example, Eric Hesse, Mary Main et al. 'Unresolved States Regarding Loss or Abuse Can Have 'Second Generation' Effects: Disorganization, Role Inversion, and Frightening Ideation in the Offspring of Traumatized Non-Maltreating Parents', ch.2 in Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma* (New York: Norton, 2003), pp.57-106.

³ See Warwick Middleton, Martin Dorahy et al 'The Australian Royal Commission into Institutional Responses to Child Sexual Abuse', *Australian and New Zealand Journal of Psychiatry* Vol.48 (1) 2014, pp.17-21, and Middleton et al. 'Institutional Abuse and Societal Silence: An Emerging Global Problem', *Australian and New Zealand Journal of Psychiatry*, ibid, pp.22-25.

⁴ See Warwick Middleton, Martin Dorahy et al 'The Australian Royal Commission into Institutional Responses to Child Sexual Abuse', *Australian and New Zealand Journal of Psychiatry* Vol.48 (1) 2014, pp.17-21, and Middleton et al. 'Institutional Abuse and Societal Silence: An Emerging Global Problem', *Australian and New Zealand Journal of Psychiatry*, ibid, pp.22-25.

⁵ Note that the context of the family was outside the remit of the Royal Commission.

When speaking of service providers, we mean all personnel involved in the service – i.e. frontline staff and specialists; professional and non-professional; irrespective of location, occupation or skill base.

Why do all service providers need to become trauma-informed? In Australia, millions of people of all ages are affected by trauma. They include our First Peoples, whose collective traumas span generations. Although trauma does not directly affect everyone, the many costs (psychological, physical, and financial) of its prevalence mean that we are all impacted indirectly. A credible estimate is that 1 in 4 Australian adults are living with the impacts of childhood trauma alone.⁶

Many people in our society live with the ongoing effects of past and present overwhelming stress. When they have not received the support to recover they are often left struggling with their health and well-being. Yet despite the vast numbers of people affected, many of those providing support working in health and other service – do not know how to ‘talk about trauma’.

This situation needs to change. All personnel working within and across services need to understand the impacts of trauma and take steps to reduce its incidence where possible. In addition, all personnel also need to know how to ‘talk about trauma’ in order to end the isolation and stigma which accompany it.

Given its prevalence and many forms, trauma cannot be seen by service providers as a ‘minority’ issue or as a solely ‘individual’ misfortune or affliction.

Rather it is a society-wide public health challenge⁷ about which all relevant personnel should be informed, concerned and responsive. Becoming trauma-informed – i.e. aware of the basic features of and facts about trauma – will enable service providers to *talk about trauma* and respond appropriately. Given the right support, people can and do recover from trauma (their trauma is resolved). Many people, however, have not recovered from their trauma (their trauma is not resolved).

A society in which large numbers of people remain affected by trauma cannot be healthy.

Increasing awareness of how common trauma is – and of its many guises – is a major step forward. There remains a gulf, however, between our awareness on the one hand and our knowledge of how to act on this awareness on the other. *Becoming ‘trauma-informed’ is the bridge between the two.*

Trauma is prevalent and has multiple adverse impacts on emotional and physical health, relationships, daily functioning and wellbeing. Its impacts involve many costs to individuals and society. This means that *the full spectrum of service delivery – i.e. from health to hospitality; from employment agencies to criminal justice; from the private and corporate sector to public services of all kinds* – need to become trauma-informed.

This publication aims to help *all* services know how to ‘talk about trauma’, to minimise its incidence, and to respond appropriately.

Because services are diverse, this is a big task. Yet services also have many commonalities, including a lack of awareness *about trauma* and knowledge of how to respond appropriately.

With some exceptions, this is also true of health services. While the paradigm of trauma-informed practice emerged from the mental health sector, many mental health services haven’t fully embedded trauma-informed principles within and across all levels and domains of their service. The same applies to physical health services.

⁶ Blue Knot Foundation, www.blueknot.org.au To read research about childhood trauma and its effects, see the Adverse Childhood Experiences ('ACE') study in the United States <http://www.americasangel.org/research/adverse-childhood-experiences-ace-study/>

⁷ Bessel van der Kolk, Posttraumatic Stress Disorder and the Nature of Trauma', in Soloman & Siegel, ed. *Healing Trauma* (New York: Norton, 2003) The prevalence of complex interpersonally generated trauma (see previous and subsequent discussion) upholds this perspective.

For this reason, we have included health services alongside other services within this single document. Health services are addressed in Part 3 Section A and other services in Part 3 Section B. Because trauma needs to be 'everyone's business' we have produced a separate publication for the general public.⁸ As the publications seek to address similar gaps in knowledge, there is some overlap in the foundational knowledge within these publications.

Part 1 of this document ('Trauma and Its Many Forms') comprises four chapters. Chapter 1 reviews and updates what is now known about trauma, and introduces the key role of dissociation. Chapter 2 discusses the differences between types of trauma, highlighting the distinction between 'single-incident' and 'complex' trauma. Chapter 3 addresses childhood trauma, and its ongoing effects on adult health and well-being if the underlying trauma is not resolved. Chapter 4 focuses on the many ways in which overwhelming stress adversely affects the brain and body. *All of this information is important for all service personnel.*

Part 2 ('Building the Foundations to Talk about Trauma') – builds on the underpinning knowledge presented in Part 1 and distils the core information needed to become 'trauma-informed' and to 'talk about trauma'. It also provides practical tips and strategies to implement trauma-informed practice.

Part 3 ('Having the Conversations') comprises two parts. Part A focuses on implementing trauma-informed principles within health services. Part B addresses their application within non-health services.

Part 4 ('Supporting Conversations and Screening') presents a range of material to assist a wide variety of services to 'talk about trauma'. It includes tips for conducting conversations and responses to 'What If?' questions. It also considers the important topic of screening for trauma and the many questions which need to be considered in relation to it. A grounding exercise, summary of key points for services, and a referral contact list are also provided.

⁸ Kezelman C., Stavropoulos P. *Talking about Trauma: Guide to Everyday Conversations for the General Public*: (Blue Knot Foundation, 2017). <https://www.blueknot.org.au/trauma-public>

PART 1: TRAUMA AND ITS MANY FORMS

1. *What is trauma? Process, experience and the role of dissociation*

'Trauma shocks the brain, stuns the mind, and freezes the body'
(Levine, 2015: xxi)

'There is more to trauma than PTSD'
(Shapiro, 2010: 11)

Trauma can be defined as the experience and effects of overwhelming stress. Trauma overwhelms a person's ability to cope when faced with threat, or when they believe there is a serious threat confronting them.

While life-threatening events are clearly traumatic, overwhelming stress can also occur in the absence of direct threats to survival.⁹

Trauma is a state of high arousal which interrupts connection ('integration') across a wide range of functioning.¹⁰ It disrupts the capacity for systems of the body to work together. This can negatively affect a person's physical and psychological health in many ways.

It is important to note the role of *perception*. Trauma is determined from the *perception* of threat rather than by the magnitude of the event/s. This means that it can arise from seemingly minor 'triggers'. This important point has many implications.

When we emphasise the *perception* of severe threat we can acknowledge that there are many sources of trauma to which there are a range of responses. While certain experiences would overwhelm almost anyone, we need to consider the context of the threat alongside the event/s.

A variety of events, situations and contexts can be experienced as traumatic.

These include natural disasters, accidents, betrayal in interpersonal relationships, and diverse forms of abuse.

There are important differences between diverse types of trauma.

The role of *perception* reveals why contrasting experiences can be traumatic, and why some experiences may be traumatic for some people and not for others. *Differences between people and context, such as a person's age, prior experience/s, and the extent and duration of the stress affect a person's capacity to respond.* So, too, do their resources, including their internal resources.

⁹ 'Trauma is not limited to surviving life-threatening experiences' (Louis Cozolino, *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*, New York: Norton, 2002, p.259).

¹⁰ Louis Cozolino, *The Neuroscience of Psychotherapy* (New York: Norton, 2002), p.270.

Trauma activates instinctive 'survival' responses.

This is another key point. The well-known trifecta of 'fight-flight-freeze' describes the key 'survival' responses activated by the perception of extreme and overwhelming threat.

It is important to understand that these responses are innate. They are biologically 'built in' and operate outside conscious awareness.

The instinctive nature of the 'fight-flight-freeze' 'survival' responses has important implications.

When responses are innate we do not intend them or deliberate over them. They simply 'cannot be helped'. This *may not be obvious in situations in which the 'trigger' to survival responses is not clear.*

If the initial trauma is not resolved and the person has not recovered, he/she can be repeatedly 'triggered' into survival responses by seemingly minor stressors. The person's reactions are often misunderstood and others may respond inappropriately.

Recovery from trauma does not relate to 'will power'. A traumatised person is often repeatedly triggered and cannot simply 'move on'.

'The passage of time does not cure trauma, nor does it diminish the intensity of flashbacks'.¹¹

It is not possible to 'reason' traumatised people out of feeling overwhelmed when their bodies are experiencing strong somatic (body-based) responses.

Past trauma defines the present as well as perceptions of the future:

'The trauma is a thing of the past, but your body keeps reacting as if you are still in imminent danger'.¹²

Recovery from trauma is not about 'will power' or 'deciding to move on'. The biological responses which are activated are innate.

Understanding this is a key component of becoming 'trauma-informed'.

'Fight', 'flight' and 'freeze' serve the critical biological purpose of survival. A person needs to be able to *instinctively mobilise a rapid, non-reflective response to maximise their chances of survival*. This is apparent in the presence of a large external threat, such as a natural disaster, physical assault, or major accident. *It is less obvious when the threat is not visible, triggered by seemingly minor stressors (factors which cause stress), and removed from the time of original trauma. People still affected by trauma experience continuing high sensitivity to seemingly minor stressors or 'triggers'.*

To the observer who does not know or remember this, a person may seem overly reactive for no apparent reason. It can be easy to misinterpret their reaction/s, and respond inappropriately in attitude and behaviour. This can compound the trauma and 're-traumatise' the person.

¹¹ Cozolino, *The Neuroscience of Psychotherapy*, p.265.

¹² van der Kolk, 2011:xxi). This affirms Judith Herman's earlier point that '[s]urvivors feel unsafe in their bodies' (Herman, *Trauma and Recovery* (Herman, 1997[1992]: 160).

Unfortunately, such inappropriate responses are common within the mental health system as well as outside it.¹³

The person experiencing the trauma and its effects may have not identified its source nor that they experienced trauma.

They may attribute their distress to other sources and/or blame themselves and those around them.

We all need to become trauma-informed so we can keep such dynamics in mind.

The process of trauma

What happens when a person faces being overwhelmed?

We can further understand the nature of trauma by paying attention to its *process*.

A key characteristic of trauma (regardless of its source and who experiences it) is that it activates divisions or 'splits' in the person's conscious experience (Howell & Itzkowitz, 2016: 35)

This requires us to define the term *dissociation*, a word which is increasingly common in the field of mental health but less well known outside it.

¹³ Recognition that '[t]rauma has often occurred in the service context itself' (Jennings, 2004:6) has been a major impetus for the paradigm of 'trauma-informed practice. See Ann Jennings (2004) 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'. Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States, 2004. For a disturbing report on retraumatisation within Australian health services, see Jane Davidson, (1997) *Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions*. NSW Department for Women and the NSW Health Department.

What we need to know about *dissociation* and why

We can all tell when someone is visibly distressed or 'hyper-aroused'. They may shake, sweat or have dilated pupils. People commonly become hyper-aroused when they feel overwhelmed. *It can be harder to identify the less visible trauma-related response of hypo-arousal, which can present as 'shutting down', 'zoning out' or being 'on autopilot'.*

Hypo-arousal, in contrast to hyper-arousal, is characteristic of the survival response of 'freeze'.¹⁴ The technical term is *dissociation*. Sometimes dissociation is obvious but more commonly it is hard to detect.

Dissociation is a complex response¹⁵ common to trauma. As dissociation can also occur in everyday situations e.g. daydreaming, 'highway hypnosis' or 'losing ourselves in a task' it can be seen as a spectrum, from mild to severe. Understanding the basic characteristics and function of dissociation is essential to being trauma-informed.

The divisions and 'splits' of experience which often characterise trauma relate to the process of dissociation:

'If the overwhelming traumatic event could not be taken in....it is dissociated. There is a split in experience. Experience that is too overwhelming to be assimilated will cause a division of experiencing and knowledge. Part of self-experience will be separated or split off from one another, and one part of ourselves will not know of other parts of ourselves...the result of trauma is dissociation' (Howell & Itzowitz, 2016: 35)

Dissociation fuelled by trauma commonly creates 'disconnects' between *thoughts, feelings, sensation and behaviour*.¹⁶

When a traumatised person dissociates they often can't function in a smooth, coherent, and integrated manner. *Trauma induces 'out-of-awareness' or dissociative divisions between key areas of activity and this prevents integrated functioning.*

The division or 'split' of experience in dissociation is the signature characteristic of trauma, regardless of its sources and varieties. It also accounts for the process of trauma.

'Thus, all of these kinds of trauma, seemingly massive, or ordinary, large, small, occurring in childhood or adulthood, while different and having different effects, cause some degree of dissociation' (Howell & Itzkowitz, 2016: 35)

¹⁴ Note that traumatised people often exhibit both types of response.

¹⁵ For example, while it is helpful to highlight the overt differences between hyper and hypo arousal, dissociative responses can manifest as hyperarousal in some instances.

¹⁶ As summarised and encapsulated in the BASK model (i.e. behaviour, affect, sensation and knowledge) developed by trauma therapist and researcher Bennet Braun in the late 1980s (Bennett G. Braun, M.D. 'The BASK Model of Dissociation', *Dissociation* 1:1, 1988, pp.4-23). Note that this formulation continues to be referenced by contemporary clinicians and researchers.

How do we experience trauma?

Trauma has been described in many ways. The analyst and philosopher Robert Stolorow summarises 'at least three important elements':¹⁷

BASIC EXPERIENCE OF TRAUMA

- Destruction of a sense of time in terms of past, present and future ('*The traumatic event is always now, and always impending*') (Orange, 2016:3)
- Creation of 'a profound sense of personal alienation' ('*in which the traumatized person... walks around as a ghost or a stranger, with a permanent sense of weirdness*').
- Destruction of the predictable foundation of everyday life which the non-traumatised person takes for granted ('*the familiar sense that others will be there in the morning, and so on*'). ibid

The above 'three important elements' of trauma highlight another critical point which can easily be missed.

Both the *traumatised person's relational context* and *the response they receive are relevant*.

The response to a traumatised person can crucially impact not only their experience of the trauma but their possibility of recovery as well.

In the absence of supportive and trauma-informed responses, a person's prior trauma can be compounded. A lack of understanding, empathy and support for their distress can also foster devastating secondary trauma.¹⁸

¹⁷ Donna M. Orange, citing Robert Stolorow, 2007, *Nourishing the Inner Life of Clinicians and Humanitarians: The Ethical Turn in Psychoanalysis* (New York: Routledge, 2016), p.3.

¹⁸ 'Trauma becomes intractable suffering in the absence of relational holding and even more so in the presence of relational contempt and devaluation' (Orange, *Nourishing the inner life of clinicians and humanitarians*, p.2)

TRAUMA:

- Is a state of high arousal that stems from the perception of severe threat (overwhelms a person's capacity to cope)
- Activates instinctive biologically based 'survival' responses of 'fight', 'flight' &/or 'freeze'
- If not resolved (recovered from) it can lead to high sensitivity to seemingly minor 'triggers'
- Disrupts interconnection ('integration') of key systems of the body and impairs health
- The *perception* of severe threat (rather than the 'size' of the event/s) makes the experience traumatic
- The biological basis of responses to being overwhelmed means the body reacts in the present even if the trauma is in the 'past' ('*your body keeps reacting as if you are still in imminent danger*'; van der Kolk, 2011:xxi)
- Because responses to trauma are innate and operate outside conscious awareness, recovery from trauma is not about 'will power', 'mind over matter' or trying to 'forget the past'
- Responses to traumatised people can be inappropriate if the above points are not understood and can lead to *re-traumatisation*
- Trauma of all kinds involves divisions or 'splits' in experience ('dissociation')
- Common dissociative divisions fuelled by trauma are 'disconnects' between *thoughts, feelings, sensation and behaviour*

2. 'Complex' trauma is different from 'single incident' trauma (PTSD)

'There is more to trauma than PTSD'

(Shapiro, 2010: 11)

All trauma shares common features, such as dysregulation of the body and adverse psychological, emotional, cognitive and behavioural impacts. These are ongoing if the trauma is not resolved or recovered from. However, there are important differences between *types* of trauma.

These differences are not always apparent or detected, even by otherwise highly qualified health professionals including in the mental health sector.¹⁹

The differences between 'single-incident' and 'complex' trauma need to be understood and have major implications, including for treatment.

'Single-incident' trauma (i.e. post-traumatic stress disorder; 'PTSD') is generated by 'one off' events, which may vary considerably. They include experience or witnessing accidents and emergencies, natural disasters, and single episodes of assault, physical or sexual. Such events can be deeply traumatic. Nevertheless, '[t]here is more to trauma than PTSD'.²⁰ *Complex* trauma includes far more than the defining features of single-incident PTSD (i.e. hyperarousal, avoidance, numbing, and intrusive thoughts).

'Complex' trauma is sometimes called 'relational' trauma, 'complex PTSD',²¹ and in relation to children, 'developmental' trauma.²² It is *cumulative, underlying, and often interpersonally generated*. The criteria for Post-Traumatic Stress Disorder²³ list a number of potentially traumatic adversities. But this classification is controversial as it doesn't encompass the wide spectrum of experiences which could be considered traumatic. It is also less applicable to children²⁴ than adults and not sufficiently attuned to the diverse impacts of extreme stress.

There is a large growing evidence base around both complex trauma and PTSD²⁵. Information about *complex* trauma, however, is generally not as well known, either within the health sector or outside it. There are several reasons for this. For example, complex trauma presents in many forms, receives diverse diagnoses, and does not currently have a 'stand-alone' diagnosis despite considerable support for this to occur.²⁶

¹⁹ This is due to a number of factors including the diverse ways in which complex trauma presents (where surface presentations can obscure underlying trauma), and absence of dedicated trauma training in the curricula of many health professions. Also despite the now substantial evidence base which attests to its distinctiveness (as well as areas of overlap with 'single-incident' PTSD) no free-standing diagnosis of complex trauma exists in standard diagnostic classifications utilised by psychologists and psychiatrists. Complex trauma does not appear as such in the *Diagnostic and Statistical Manual of Mental Disorders*, now in its fifth iteration, 'DSM-5'. There are indications it may be introduced in the upcoming iteration of the World Health Organization *International Classification of Diseases* (ICD).

²⁰ Robin Shapiro, *The Trauma Treatment Handbook* (New York: Norton, 2010), p.11.

²¹ The term 'complex PTSD' (CPTSD) was coined by American psychiatrist and feminist Judith Herman for inclusion in the DSM-IV, the iteration before the current DSM-5. For her more recent summary of the relationship of complex trauma to existing diagnostic classifications, see Judith L. Herman, 'Foreword' to Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, pp.xiii-xvii.

²² Bessel van der Kolk proposed a new diagnosis of 'Developmental Trauma Disorder' (DTD) for specific application to children who experience symptoms of complex traumatic stress (van der Kolk, 'Developmental trauma disorder: Towards a rational diagnosis for Chronically Traumatized Children; *Psychiatric Annals*, 2005, pp.1-18).

²³ i.e. in *The Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (Washington DC: American Psychiatric Association, 2013). The DSM is the most widely referenced manual of its kind in the US and is routinely used by psychiatrists and psychologists (though not by counsellors and psychotherapists). The other major diagnostic text is the *International Classification of Diseases* (ICD) published by the World Health Organization (which is referenced more widely than the DSM in the UK). We note some of the issues raised by the challenges of diagnosis in subsequent comments.

²⁴ A specific diagnosis for 'complex' trauma in children has been proposed by trauma specialist Bessel van der Kolk. Also see Molly McDonald MA, Cameo F. Borntrager PhD & Whitney Rostad MA, 'Measuring Trauma Considerations for Assessing Complex and Non-PTSD Criterion A Childhood Trauma', *Journal of Trauma & Dissociation*, 15:2, 2014, pp.184-203.

²⁵ For distillation of recurring themes of this growing evidence base, see *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (Sydney, 2012) <http://www.blueknot.org.au/guidelines>

²⁶ While supported by field trials and recommended by many, the CPTSD diagnosis was not included in DSM-IV (see Herman's account of possible reasons for this in her 'Foreword' to Courtois & Ford, *ibid*). While the DSM 5 does not include a distinct complex trauma classification, its inclusion of a new dissociative subtype of PTSD recognises that PTSD can be more complex than was initially considered.

'Over the past two decades, vast amounts of knowledge have accumulated about what we call 'complex trauma', a psychiatric condition that officially does not exist, but which possibly constitutes the most common set of psychological problems to drive human beings into psychiatric care'
(van der Kolk, in Courtois & Ford, 2009: 455)

The following quote from renowned trauma expert Bessel van der Kolk encapsulates the nature and significance of the differences between PTSD and complex trauma:

'When post-traumatic stress disorder (PTSD) first made it into the diagnostic manuals, we only focused on dramatic incidents like rapes, assaults, or accidents to explain the origins of the emotional breakdowns in our patients. Gradually, we came to understand that the most severe dysregulation occurred in people who, as children, lacked a consistent caregiver'
(van der Kolk, in Porges, 2011: xi-xii; emphasis added)

Van der Kolk also highlights that '*[e]motional abuse, loss of caregivers, inconsistency, and chronic misattunement showed up as the principal contributors to a large variety of psychiatric problems*'.²⁷

The effects of relational, interpersonally generated 'complex' trauma are far more extensive than those for 'single incident' PTSD.²⁸

It is important to differentiate the two main types of trauma: 'complex' and 'single incident' (PTSD)

'Single-incident' trauma, or post-traumatic stress disorder (PTSD) relates to 'one-off' events of various types. These include experiencing or witnessing single incidents of assault, natural disasters and accidents.

'Complex' trauma, by contrast, is cumulative, underlying, and often interpersonally generated (Courtois & Ford, 2009). It causes more far-reaching impacts on emotional and physical health (Courtois & Ford, ibid; van der Kolk & McFarlane, 1996).

²⁷ Bessel van der Kolk, 'Foreword' to Stephen Porges, *The Polyvagal Theory* (New York: Norton, 2011), pp.xi-xii, citing Dozier, Stovall, & Albus, 1999; Pianta, Egeland, & Adam, 1996.

²⁸ As noted in the introduction, for detailed discussion of both the shared and contrasting features of PTSD and 'complex' trauma, see ch.1 in Christine Courtois & Julian Ford, *Treating Complex Traumatic Stress Disorders* (New York: The Guilford Press, 2009), pp.13-30. Note that complex trauma also shows longer duration of symptoms, symptoms are often 'medically unexplained' MUS and are less responsive to standard treatment modalities. Hence complex trauma is often wrongly regarded as 'refractory' and 'treatment resistant'.

Complex trauma can seriously affect a person's ability to function, their sense of themselves, and their capacity to regulate their levels of arousal, emotions and behaviour. It impairs *self-conception and cohesion, sense of meaning, and capacity to relate to others as well as to manage or 'regulate' internal states.*²⁹

Unlike PTSD, *complex trauma disrupts a person's identity, and severely adversely affects* a person's relationship to themselves and others, as well as their capacity to experience and process emotion.

Survivors of 'complex' trauma experience the same fear, helplessness and horror experienced by people with single-incident PTSD, *but with the additional legacy of adverse impacts on the self:*

*'In addition to hyperarousal and hypervigilance in relation to **external** danger, complex trauma poses for the person the **internal** threat of being unable to self-regulate, self-organize, or draw upon relationships to regain self-integrity'*
(Ford & Courtois, 2009:17)

Complex trauma involves '*a far more complex array of medical and psychiatric conditions and impediments*' than PTSD alone, which may be 'merely the tip of the iceberg'.³⁰

It is 'complex' because it places the person at risk not only for recurrent anxiety – which includes an increased risk of single-incident ['simple'] PTSD – but also for '*interruptions and breakdowns in the most fundamental outcomes of healthy psychobiological development*'.³¹

COMPLEX TRAUMA DISRUPTS A PERSON'S CAPACITY

- to regulate their bodily processes
- to develop a healthy identity and a coherent personality
- to attach securely and *be able to have healthy relationships*

Cook et al, 2005; van der Kolk, 2005, in Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, ibid, p.16.

Dynamics of interpersonal complex trauma: identity, shame, and the body

While threats to physical safety are traumatic, so too are psychological assaults within interpersonal relationships (with or without a physical threat). Such assaults can severely threaten a person's self-integrity; i.e. the state of being whole. They not only erode self-esteem, but can lead the person to experience intense negative attitudes to themselves. This includes *shame*, which is one of the most pervasive.

A person can experience a deep sense of shame when they are unable to self-regulate (manage their levels of arousal, emotional states and behaviour) and draw on relationships to regain their self-integrity: '*The feeling of shame is about our very selves – not about some bad thing we did or said but about what we are*'.³²

²⁹ 'Complex PTSD is involves alternations in views of the self and other' (Elizabeth Howell & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis* (New York: Routledge, p.37).

³⁰ David Emerson & Elizabeth Hopper, PhD, *Overcoming Trauma through Yoga: Reclaiming Your Body* (Berkeley, CA: North Atlantic, 2011), p.4.

³¹ Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, ibid, p.16.

³² Lewis B. Smedes, *Shame and Grace* (New York: HarperCollins, 1993), p.6. As Orange notes, '[R]ecent psychoanalytic studies of shame generally distinguish clearly between guilt for transgressions creating debt and/or feelings of guiltiness...and shame over one's very being in the eyes of others or one's own eyes (Kilborne, 1999; Lansky, 1994; Morrison, 1984; Orange, 2008; Wurmset, 1991' (Orange, *Nourishing the Inner Life of Clinicians and Humanitarians*, p.96).

People with complex interpersonal trauma often experience shame in relation to themselves and their very being (perception of 'a damaged self' (Courtois & Ford, 2009: 17). This is in addition to the fear and anxiety which can occur in either PTSD or complex trauma.

People with complex trauma histories often also have a problematic relationship to their body. A person who has been sexually abused, in particular, can view their body as alien, treacherous, contaminated, and/or detached from their self:

'Severe interpersonal trauma...often teaches people that their bodies are not safe, are not their own, or are a place of disgust and defilement of which to be ashamed. As a result, people often seek to flee from, or reject and abandon their bodies...the incest survivor may no longer wish to take ownership over his or her bodily self...Accordingly, consciously or unconsciously he or she rejects the bodily core, the most basic nature of him or herself' (Frewen & Lanius, 2015: 168)

The rejection of and 'separation' of one's 'self' from one's body sounds, and is, extreme. However, a person's body is a constant visible reminder of the interpersonal complex trauma they have experienced and its ongoing harmful impacts:

'If it is too painful to experience the world from inside one's body, self-identity can become organized outside the physical self.'³³

Inability to identify with, and feel comfortable within, one's body can also place the person at risk of suicide. This is because inhabiting one's body can literally feel unbearable.

What is it like to experience complex trauma? How does it 'feel' different from single-incident PTSD?

The contrasting experience of complex, as distinct from single-incident, trauma has been described as the difference between the feeling of losing one's *mind* (single-incident trauma) and losing *oneself* (complex trauma).

(Herman, 1992, 1997)

People with experiences of complex and single-incident trauma also vary in their initial attitudes to treatment.

People who present for treatment of single-incident PTSD often say they want to 'get back to the way [they were] before'.

Survivors of complex trauma rarely say this. Childhood trauma causes such a degree of self-disruption that those experiencing it often have no sense of having functioned well and cannot recall ever having felt healthy or happy.

People who have experienced complex trauma often struggle to say what they 'want' because they do not feel entitled to express their preference and sometimes cannot identify what it is. They also find it difficult to feel confident or joyous:

³³ Cozolino, *The Neuroscience of Psychotherapy*, p.267.

'In contrast to the traumatized person who has experienced a sense of safety and well-being prior to onset of the (single-incident) trauma, the survivor of complex trauma does not start with this advantage'.

(Shapiro, 2010)

Because complex trauma is *relational*, the *context in which it occurs is important*. Harm sustained in relationships needs to be healed *within* relationships which are healthy and unlike those in which their trauma occurred. This emphasises the need for healthy supports to assist recovery.

While many kinds of 'single-incident' trauma, including natural disasters and some accidents are comparatively impersonal, interpersonally generated complex trauma is *inherently relational*.

Unlike single incident trauma, *complex trauma frequently occurs within intimate care-giving relationships and often involves betrayal*.³⁴ It also involves dynamics of secrecy, shame, and power imbalance.

The difficulty many survivors experience in speaking about trauma has implications for the way to offer support. Complex trauma is especially difficult to disclose as it is relational. It *often occurs at the hands of individuals/groups well known to the person, to whom they may be related, with whom they may be intimate, and on whom they may be dependent e.g. child abuse*.

There is a high risk that people to whom trauma is disclosed will respond in an unfavourable, shaming, disbelieving and silencing way. This can lead to secondary trauma.

Even when a person wants to disclose and has the capacity to do so, they may choose not to because they fear a negative response.³⁵

It is especially hard to disclose experiences of complex trauma, as those receiving disclosures are often confronted, embarrassed, disbelieving or unsure of how to respond.

Such responses are less likely with single-incident trauma as the events tend to be impersonal. In fact, people so affected often say that even though their experience/s were awful, the response they received affirmed their faith in people (e.g. 'rallying of the community' after a bushfire).

In stark contrast, disclosure of *complex* trauma reveals ruptures and betrayal of interpersonal relationships which are harder to hear about.

³⁴ For clear explanation of betrayal, see Jennifer Freyd & Pamela Birrell, *Blind to Betrayal* (NJ: John Wiley, 2013).

³⁵ As some forms of trauma are pre-verbal and unconscious they cannot be disclosed verbally (see chapter 3). This is why people often don't disclose their child sexual abuse until well into adulthood, and sometimes not at all. They simply do not have the words.

'Trying to tell' (i.e. disclose) in a society which is not trauma-informed can reinforce rather than alleviate the isolation, secrecy and shame experienced by survivors of complex trauma. It can also compound their trauma.

The social and relational contexts of complex trauma mandate widespread trauma awareness within and across all health and other services. This is needed to dispel the silence, secrecy and stigma which foster interpersonal violations, to minimise the opportunities in which complex trauma flourishes, and to increase the likelihood that those directly and indirectly affected receive appropriate support.

DIFFERENCES BETWEEN 'COMPLEX' AND 'SINGLE INCIDENT' TRAUMA

'There is more to trauma than PTSD' (Shapiro, 2010:11).

- **'Single-incident'** trauma (i.e. posttraumatic stress disorder: PTSD) = being overwhelmed from 'one off' event/s (e.g. accident, natural disaster, single episode of assault)
- **'Complex' trauma** = cumulative, underlying, often interpersonally generated (*relational*)
- **Complex trauma is more common and more severe;** impacts not only basic functioning but self-connection and cohesion, capacity to relate to others, and sense of meaning (Courtois & Ford, 2009)
- **[T]he most severe dysregulation occur[s] in people who, as children, lacked a consistent care-giver** (van der Kolk, 2011:xii). Childhood trauma is complex trauma
- **'Single incident' trauma (PTSD):** like losing your *mind*; **'Complex' trauma:** like losing *yourself* (Herman [1994] 1997)
- **'Single incident' trauma:** to get back to 'how I was'; **'Complex' trauma:** may have no good memory of self
- **'Single incident' trauma:** usually easier to disclose; **'Complex' trauma:** strong dynamics of shame and secrecy. Multiple violations of care-giving/interpersonal relationship breach social 'norms' and 'duty of care' (e.g. childhood trauma/abuse) and are confronting to listeners
- In contrast to single-incident PTSD, people with complex trauma frequently experience the 'secondary' trauma of being silenced, criticised, judged and/or disbelieved in societies which are not yet 'trauma-informed'

Complex trauma across the life span

Overwhelmingly stressful experiences in childhood are more common, and have more diverse and enduring negative impacts on adult health than is commonly realised.

When complex trauma stems from overwhelming experiences *in childhood*, the adverse effects are particularly damaging:

'It stands to reason that the most devastating types of trauma are those that occur at the hands of caretakers'.³⁶

Childhood trauma is complex trauma and its effects are serious in many ways

Becoming trauma-informed requires a clear understanding of the *prevalence of childhood trauma*, its diverse forms and its devastating *impacts on adult as well as child health* (see the following chapter).

We also need to recognise that childhood trauma can occur *in the absence of abuse* and can be *transgenerational*.

Betrayal of trust and 'soul murder'

As a form of complex trauma, the trauma of *betrayal* merits specific reference.

Any betrayal of trust can be deeply traumatic, and especially when it occurs in contexts in which it should be *safe* to trust. This also clearly illustrates that '*[t]rauma is not limited to surviving life-threatening experiences*'.³⁷

American researcher Jennifer Freyd developed the concept of 'betrayal trauma' in response to controversies about the reliability of memory over two decades ago.³⁸ 'Betrayal trauma' involves complex processes and dynamics, as it focuses on social as well as psychological factors. Freyd's research led to 'a new scientific model of what constitutes trauma':

'Betrayal trauma theory has caused us to re-evaluate the concept of psychological trauma. Traditionally, psychological trauma was understood to be the result of terrorizing, life threatening events that cause extreme fear... Yet...an equally traumatizing aspect of the events is social betrayal'
(Freyd & Birrell, 2013: 56-57)

In the late 1980's, Edward Shengold MD³⁹ described the trauma of betrayal of trust as a form of 'soul murder'. While he has since updated the concept,⁴⁰ he notes that the term was used in the nineteenth century by Scandinavian playwrights August Strindberg and Henrik Ibsen.⁴¹ Ibsen described 'soul murder' as '*the destruction of the love of life in another human being*'.⁴²

³⁶ Cozolino, *The Neuroscience of Psychotherapy*, ibid, p.p.258.

³⁷ Cozolino, ibid, p.259.

³⁸ Laura S. Brown, *Cultural Competence in Trauma Therapy* (Washington, DC: American Psychological Association, 2009), p. 107.

³⁹ Leonard Shengold, MD *Soul Murder: The Effects of Childhood Abuse and Deprivation* (New Haven: Yale University Press, 1989).

⁴⁰ Shengold, *Soul Murder Revisited* (New Haven: Yale University Press, 1999; 2000).

⁴¹ Shengold, *Soul Murder Revisited*, ibid.

⁴² Shengold, *Soul Murder Revisited*, ibid.

'Soul murder' is a form of interpersonal trauma. It entails significant damage to self, identity, and relationships with others. This is because survival can come at the cost of subjugation (loss of control) of the spirit.

In Western liberal democracies which follow individualist 'norms', many people do not acknowledge the possibility that *groups* of people may be oppressed by '*the everyday attitudes of a well-intentioned liberal society*' (Young, 1991). The concept of oppression is alien to the view of liberal democracy and regarded as external to Western liberal societies (*ibid*).

Sociocultural trauma: insidious trauma and microaggression

'In the lives of many individuals who are members of target groups, daily existence is replete with reminders of the potential for traumatization and the absence of safety'

(Brown, 2009: 103)

'[B]etrayal...operates[s] in a larger context beyond interpersonal relationships'

(Freyd, 2013: 35)

American clinician Laura Brown draws attention to the concepts of 'insidious trauma' (Root, 1992) and 'microaggressions' (Sue, 2000). These terms describe experiences which are not necessarily traumatic themselves but 'can be traumatic in a subtle way'.⁴³

Because they occur 'in apparently banal ways', insidious trauma and microaggressions are often invisible to others. Even in democratic societies, some people are more welcome than others:

'Everyday racism, sexism, homophobia, classism, ableism, and so on...are the small but ever-present pulls of energy toward a survival level of consciousness, the reminders that someone, somewhere is trying to make you and people like you less welcome on the planet'

(Brown, ref. Essed. 1991. 2009: 103)

Insidious trauma and microaggressions are often *group based* rather than 'individual' traumas. Those outside the target, 'non-norm' or 'not mainstream' group/s often do not comprehend the discrimination which can stem from the ideology of individualism. While positive in many ways, focussing on 'the individual' can limit our ability to recognise the *social* and *relational* injustices experienced by whole *groups* of people who do not fit the stereotype of an 'individual':

⁴³ Brown, *Cultural Competence in Trauma Therapy*, p.103.

In Western liberal democracies which follow individualist 'norms', many people do not acknowledge the possibility that *groups* of people may be oppressed by '*the everyday attitudes of a well-intentioned liberal society*' (Young, 1991). The concept of oppression is alien to the view of liberal democracy and regarded as external to Western liberal societies (*ibid*)

Those who claim discrimination as part of a group are often told – directly or indirectly – that this is their 'individual' perception and that their objections are a matter of 'personal choice'.⁴⁴ This is despite the extensive documentation of successive government sponsored reports of systemic rights' violations in Western societies. There are frequent powerful personal accounts of the harm of group prejudice in so-called liberal democratic societies.⁴⁵

The ideology of liberal individualism which underpins Western societies obscures the reality of systemic and structural oppression within, as well as outside, Western societies.⁴⁶

We often rationalise discrimination and rights violations within Western societies as aberrant, the actions of 'bad apples', and/or as the product of 'the values of the time'. Paradoxically, the people involved are often seen to have 'meant well' and to have 'good intentions'.

In Australia, a number of inquiries, including Royal Commissions, have revealed the systemic rights' violations of diverse groups. Many such violations were officially authorised, culturally sanctioned, and routinely perpetrated *by and within the key institutions of 'mainstream' liberal 'democratic' society*.⁴⁷

A key point is the frequent 'invisibility' of bias, discrimination and prejudice to those who do not experience it.⁴⁸ While universal equality is a core principle of liberal ideology, relatively privileged residents of Western societies often discriminate unconsciously because of 'aversive' bias.⁴⁹

Trauma occurs socially as well as interpersonally. Oppression exists within as well as outside Western societies, can be highly traumatic, and can lead to dissociative responses: '*where oppression resides, dissociation is by necessity a constant companion*' (Sar, Middleton & Dorahy, 2013: 126)

⁴⁴ Iris Marion Young, *Justice and the Politics of Difference* (Princeton, NJ: University of Princeton Press, 1991). In contemporary Australia, this point can be illustrated with the 2016 controversy around Section 18C of the Australian Racial Discrimination Act. Section 18C defines it as unlawful to engage in offensive behaviour on the ground of race, colour, or national or ethnic origin if the act (a) 'is reasonably likely...to offend, insult, humiliate or intimidate another person or group of people' and (b) 'the act is done because of the race, colour or national or ethnic origin of the other person or of some or all of the people in the group'. Under a former Prime Ministership of Tony Abbot, it was proposed to repeal this section of the Act on the ground that it contravenes free speech. While the proposal was subsequently dropped, it was again revived and championed by many on the grounds that refusal to take offence to insults and humiliation is a personal decision and a matter of individual choice.

⁴⁵ For a powerful first-person account of ongoing experience of racism in Australian society, see Maxine Beneba Clarke, *The Hate Race: A Memoir* (Hachette, 2016).

⁴⁶ Young argues that the ideology of liberalism has never dealt well with the reality of group life, and that a bias against collective forms of identity (apparent at the inception of the 'Universal' Declaration of Human Rights) continues to discriminate against the many who do not have recourse to the status of 'individual' (Young, *Justice and the Politics of Difference*, pp.59-60). Note that the idea of the 'individual' dates to the particular context of eighteenth century Europe in which individual' rights could only be accessed by white middle class males (origins which many argue have continuing implications).

⁴⁷ Including the bureaucracy and administration, the education system, and the church. Previous inquiries and Royal Commissions have exposed the extent of the violations perpetrated against particular groups of people in Australia, including children, with respect to Aboriginal and Torres Strait Islander people ('Bringing them Home' Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families', Australian Human Rights Commission, 1997; Royal Commission into Aboriginal Deaths in Custody (1987-1991; note that the rate of Aboriginal deaths in custody is now higher than when the RC completed its findings) and Inquiry into Child Migrants from the United Kingdom, 2001; among others. Also see the published reports of the Royal Commission into Institutional Responses to Child Sexual Abuse.

⁴⁸ I.e. in the particular context in which it occurs; the diversity of grounds on which discrimination occurs e.g. ethnicity, gender, sexual orientation, age etc. means it is possible to be privileged in some respects but not others.

⁴⁹ For discussion of this concept, see Brown, *Cultural Competence in Trauma Therapy*, *ibid*.

For many people, trauma is neither solely a 'one off' single incident nor purely the product of interpersonal (e.g. intrafamilial) processes. Rather it is '*a frequent component of social and emotional environments in which daily life can become a series of encounters with threat*'.⁵⁰

The contemporary cultural and socio-political landscape is highly dynamic and conducive to many varieties of trauma. For example, terrorism is a form of trauma which does *not* discriminate.

VARIETIES OF TRAUMA AND THEIR CONTEXTS

- Experiencing betrayal can be deeply traumatic as the term 'soul murder' (Shengold, 1989; 2000) implies
- Betrayal occurs both interpersonally and 'in a larger context beyond interpersonal relationships' (Freyd, 2013: 35)
- At a sociocultural level, *insidious trauma* and *microaggression* occur in everyday contexts 'in apparently banal ways':
'[E]veryday racism, homophobia, classism, ableism, and so on...are the small but ever-present pulls of energy toward a survival level of consciousness'; Brown, 2009; ref. Root, 1992; Sue, 2000 & Essed, 1991)
- Discrimination is often 'invisible' to those who do not experience it and can be perpetrated unconsciously ('aversive bias', Brown, *ibid*)
- The individualist 'norms' of Western liberal democratic societies make it difficult to recognise *systemic* and *structural* oppression and the accompanying trauma

⁵⁰ Brown, *Cultural Competence in Trauma Therapy*, *ibid*, p.111.

Trauma is not only 'individual', physical and psychological; it is also social, cultural and political

'The worst traumatic states result... from human cruelty, often organised by schemes that seem unquestionable: slavery (Gump, 2010); discrimination, racism, sexism, childism (Young-Bruehl. 2012). These arrangements are often invisible to the participants in the systems, especially to those who benefit from them, but are nonetheless violent and leave transmitted [intergenerational] scars'(Orange 2016: 2)

The collective, as well as individual dimensions and contexts of trauma have many implications. One is that we cannot view the many relational contexts of complex interpersonal trauma solely in individualist terms. Another is that recovery from trauma is not only about clinical 'treatment' by health professions (which are also individualistic in orientation).⁵¹

Addressing trauma appropriately involves more than health professionals (both medical personnel and the 'psy' professions).

It also challenges the still dominant 'Western' paradigm of individualism.⁵²

⁵¹ While the individual needs to be prioritised in treatment settings, it is important to also emphasise the *context/s in which individuals are embedded*. Otherwise it perpetuates the characterisation of the professions culturally authorised to treat and minister to those whose wellbeing is compromised or who have a particular disorder. This is happening despite a growing focus on the importance of community/ies and awareness of social models of health. For example, even though psychology and counselling modalities acknowledge that human life is non-negotiable relational, they still follow narrowly individualistic frameworks. As one commentator points out, the 'default setting' of otherwise diverse counselling approaches is that of the bounded individual, despite frequent (and in some ways contradictory) emphasis on relationality - 'Many pressures incline us towards drafting an outline of the client as a private being, as someone who...has more or less stable boundaries, has a more or less internal locus of control...' (Mark Furlong, 'Calling the client as a relational being', *Psychotherapy in Australia* (Vol.19, No.3), 2013, p.69. As Furlong (*ibid*) goes on to remark, '*certain therapeutic traditions acknowledge an explicit relational aspect as a core principle, mindful that the established approaches (CBT, humanistic/third force, psychoanalytic traditions) recognise an autonomous, well-bordered self as the ideal...even if the practitioner has a relational, feminist or post-structural allegiance, the materiality and context of the therapeutic project invites the practitioner to act as if the client is bounded by their skin*' (*ibid*) In a different way, decontextualized individualism is very apparent in the conception of and emphasis on pathology in the context of biomedical discourse and treatment.

⁵² In Western liberal societies, 'violence' is often viewed as specific acts carried out by identified perpetrators (i.e. rather than as ongoing systemic violations which are generally less overt but increasingly destructive for large numbers of people). Slovenian psychoanalyst Slavoj Zizek outlines three forms of violence of which, he proposes, only the first is widely recognised within Western 'liberal democratic' societies: *subjective* (the most visible, 'performed by a clearly identifiable agent'), *symbolic* ('embodied in language and its forms') and *systemic* ('the often catastrophic consequences of the smooth functioning of our economic and political systems' (Slavoj Zizek, *Violence*, New York: Picador, 2008, pp.1-2). As numerous contemporary developments – from the Global Financial Crisis to new forms of global terrorism – disrupt the smooth operation of economic and political systems, it becomes harder to defend the 'official' ideology of liberal individualism, literally and figuratively.

The relational contexts of trauma are *systemic* and *structural* as well as interpersonal.

As the costs of unresolved trauma are society-wide, trauma needs to be seen as a 'whole of society' priority to which we all need to respond at a range of levels.

Power dynamics operate even in the 'micro' context of interpersonal relationships (as any breach of duty of care illustrates).⁵³

Complex trauma is enabled by structural factors and frequently stems from an imbalance of power.

The fact that people do not disclose because they fear the way people will respond underlines the importance of all of us becoming trauma-informed.

As the intergenerational transmission of trauma also reveals, individualist models and 'leaving it to professionals' is not enough. All personnel within health and other services – not only professionals – have a stake in recognising and responding appropriately to trauma.

⁵³ This is decisively illustrated with childhood trauma in its various forms; i.e. even when occurring outside of abuse, children are powerless as opposed to adults.

3. Child to Adult: the complexity of childhood trauma Varieties, prevalence, impacts on psychological AND physical health in adulthood

'I started routinely inquiring about childhood sexual abuse and was just flooded with acknowledgements of that...As we pursu[ed] that issue routinely ...we basically stumbled into other forms of child abuse and major household dysfunction' (Vincent Felitti, principal investigator of the Adverse Childhood Experiences [ACE] Study, 2011)

The adverse impacts of traumatic childhood experiences are well substantiated. But the effects on *physical* as well as psychological child AND adult health are less well known.⁵⁴ It is important to understand the nature of the many impacts as part of becoming 'trauma-informed'.

1. Childhood trauma includes but is not limited to abuse

The spectrum of experiences which overwhelm children is broader and more diverse than commonly realised.

'Abuse' occurs in a range of forms; e.g. *sexual, physical and emotional, as well as witnessing family violence*. It also includes *neglect*, which constitutes passive rather than active caregiver behaviour. The effects of neglect have been underestimated for this reason. But they are no less, and may in some ways be more, damaging to the developing child and the adult they become.⁵⁵

While abuse of all kinds is traumatic for children, there are more varieties of overwhelmingly stressful childhood experiences than abuse.

Being unable to connect safely with primary caregivers for whatever reason/s is overwhelming and traumatic for a child.

'Insecure attachment' develops when relational bonds with primary caregivers are not repaired. This can arise from non-abusive childhood experiences and negatively affects current and future well-being.⁵⁶

When we assume that childhood trauma only relates to abuse we also minimise its prevalence.

This information is confronting. It is also confronting for well-intentioned parents and caregivers who actively try to meet their child's needs to know that a child may experience events as traumatic in the absence of maltreatment.⁵⁷

⁵⁴ See, for example, Shonkoff et al 'The Lifelong Effects of Early Childhood Adversity and Toxic Stress', *American Academy of Pediatrics* (129 (1) 2012). As noted previously, it is important to be aware that experience of childhood trauma is not 'destiny' and that it is possible to recover (see Siegel, ibid, Courtois & Ford, ibid). The substantiated relationship between experience of childhood trauma and subsequent health problems is also discussed in Pts. 2, 3, 4 & 6 below.

⁵⁵ Neglect is a specific type of abuse because it invalidates the existence of the child. Indeed, a 'largely nonresponsive' family environment i.e. the context of abuse can be as detrimental to a child's development and constitute the trauma of abuse (Steven N. Gold, 'Contextual Therapy', ch.11 in Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, p.229). Also see Kirsten Weir, 'The lasting impact of neglect', American Psychological Association (Vol.45, No.6) 2014 <http://www.apa.org/monitor/2014/06/neglect.aspx>

⁵⁶ 'Attachment research has objectively demonstrated the crucial importance of the parent's focus on the child's subjective experience for the development of the child's well-being' (Siegel, 'An Interpersonal Neurobiology of Psychotherapy', ibid, p.6).

⁵⁷ Hesse, Main et al, 'Unresolved States Regarding Loss or Abuse Can Have 'Second Generation' Effects: Disorganization, Role Inversion, and Frightening Ideation in the Offspring of Traumatized Non-Maltreating Parents', ch.2 in Solomon & Siegel, ed., *Healing Trauma*, ibid, pp.57-106.

Research shows that when a parent or caregiver has unresolved trauma – often from their own childhood – they can transmit trauma to their child through impaired styles of relating or ‘disrupted attachment’.⁵⁸ *A child can therefore experience trauma outside of an abusive care-giving relationship.*

There are many reasons why parents and caregivers may not be able to provide optimal care of the children for whom they are responsible. As in all relationships, stress is normal in caregiving relationships and is not necessarily traumatic.

Yet ‘stress’ is different to being ‘overwhelmed’. While stress can cause ruptures in *any* relationship, the *repair* of ruptures which is critical in a caregiving relationship with a developing child.

Repairing ruptures in caregiving relationship/s protects against childhood trauma. Attending to and managing relational ruptures helps children learn to tolerate and metabolise stress.

*If relational repair does not take place, the child is less likely to learn to manage their internal states – i.e. ‘self-regulate’ - and will be at high risk of complex trauma.*⁵⁹

It is possible to *recover* from trauma related abuse or its inadvertent transmission by caregivers with unresolved trauma histories.⁶⁰

Research shows that when families can’t provide the conditions a child needs for normal development (which include *emotional and physical security, consistent affection, validation, support, guidance and promoting autonomy*) the child is ‘particularly vulnerable to abuse, by family members or by persons outside the family’.⁶¹

Studies also show that family environments which cannot provide the core conditions of healthy child development foster ‘long-term psychological problems, more substantial than those related to abuse’.⁶²

When an adult caregiver recovers from their trauma, this intercepts its transmission to their children.⁶³

2. Effects of childhood trauma are wide-ranging

Trauma, *especially in the early stages of brain development* affects and compromises multiple body systems.

‘[A]daptation to trauma, especially early in life, becomes a ‘state of mind, brain and body’ around which all subsequent experience organizes’.⁶⁴

It is important to be aware that ‘[m]ore and more problems of living are understood as being trauma generated,⁶⁵ and that ‘much of what used to be seen as neurosis is explained in terms of post-traumatic stress and dissociation’.⁶⁶

⁵⁸ Hesse et al, ‘Unresolved States Regarding Loss or Abuse Can Have ‘Second Generation’ Effects...’, *ibid*, p.:

⁵⁹ ‘[A]ttunement failures between parent and child always are, by definition, small-T traumas. If they are repetitive, fixed or rigid, there is no way to process the negative emotion that the trauma creates, and the effects become cumulative’ (Robert Neborsky, in Solomon & Siegel, *ibid*, p.290, referencing Kahn, 1963).

⁶⁰ Daniel J. Siegel, ‘An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma’, ch. 1 in Solomon & Siegel, ed. *Healing Trauma*, pp.1-56.

⁶¹ Gold, ‘Contextual Therapy’, *ibid*, p.230: ‘Growing up with emotionally distant, disinterested, or unpredictable family members prevent[s] the development of secure attachment’; ‘Inadequate familial structure and guidance [leads] to a wide range of deficits in social learning’ (Gold, *ibid*, p:229).

⁶² See Gold, *ibid*, p.230 (many references cited).

⁶³ Siegel, *ibid*, p.16.

⁶⁴ Cozolino, *The Neuroscience of Psychotherapy*, pp. 258-259.

⁶⁵ Elizabeth Howell, *The Dissociative Mind* (New York: Routledge, 2005), p.ix.

⁶⁶ *ibid*

Because children depend on adult caregivers for survival, overwhelming experiences have the most impact in childhood. During the early stages of development, children are highly vulnerable to multiple adverse impacts across the full spectrum of functioning:

'The single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma, and the more severe and prolonged the trauma, the more severe are the psychological and physical health consequences'.⁶⁷

The phrase 'trauma-related' is used to describe conditions, problems and disorders involving trauma. **'Trauma-related' may be the key common denominator of otherwise diverse physical and psychological health problems stemming from overwhelming experiences:**

'The malformation of ...interdependent systems results in many disorders that spring from extreme early stress';⁶⁸

'Compulsive disorders related to eating or gambling, and somatization disorders in which emotions are converted into physical symptoms, can all be understood in this way. PTSD, borderline personality disorder, and self-harm can all reflect complex adaptation to early trauma'.⁶⁹

3. Childhood trauma affects both emotional and physical health

Multiple systems of the body are interconnected. This means that the adverse impacts of childhood trauma affect psychological AND physical health. The greater the severity and duration of childhood trauma *'the more severe are the psychological and physical health consequences'*. Yet 'mind' and 'body' have long been considered as separate in Western culture, including within the professions. Many still don't fully appreciate the implications of their interconnectedness.

The language, conceptualisation, and classifications we use, especially around diagnosis, are blocks to us acknowledging this. The practice of medicine in Western societies has traditionally focussed on the physical body, while the 'psy' professions of psychology, psychiatry and psychotherapy, focus on 'mental health'. *This split, misconception and division of labour has left trauma and its impacts compartmentalised.* As psychological trauma (i.e. as distinct from physical head injury) is regarded as 'in the mind', traumatised people are referred solely to psychologists, psychiatrists and psychotherapists.

Current clinical and neuroscientific research shows that we urgently need to 'bring the body back' to trauma treatment.⁷⁰ This is conveyed in the phrase 'bottom up and top down'.⁷¹

The 'psy' professions have traditionally been 'top down', privileging the spoken word (e.g. psychotherapy as 'the talking cure'). This means that we need to supplement and adapt these treatment approaches.⁷² We also need to focus on the physical pathways of trauma and its impacts.

Overwhelming childhood experiences compromise the hormonal, endocrine and immune systems, and other body systems.⁷³ Because chronic conditions evolve slowly, these connections are often not recognised:

⁶⁷ Warwick Middleton, 'Foreword', *The Last Frontier*, ibid, p.x.

⁶⁸ Cozolino, ibid, p.267.

⁶⁹ Cozolino, ibid, citing Saxe et al., 1994; van der Kolk et al., 1996, pp.267-268.

⁷⁰ 'The body, for a host of reasons, has been left out of the 'talking cure' (Ogden, *Trauma and the Body*, p.xxvii).

⁷¹ In psychotherapy the phrase 'bottom up and top down' refers to an approach which addresses the lower brain stem 'arousal' responses, the mammalian 'emotional' brain, and cognitive capacity (where the latter relates to the 'higher' brain functioning of the prefrontal cortex - the 'top' - to which standard 'talk' therapies have traditionally been directed). As van der Kolk underlines, '[N]either CBT nor psychodynamic therapeutic techniques pay much attention to...physical sensations and preprogrammed physical action patterns' (despite the centrality of these to the experience and treatment of trauma; van der Kolk, 'Foreword' to Pat Ogden et al. *Trauma and the Body* New York: Norton, 2006, p.xxii). Hence the current call for effective trauma therapy to be 'bottom up' as well as 'top down'; i.e. addressed to the range of dimensions which parallel and correlate with different areas of brain and body functioning.

⁷² See Ogden et al. *Trauma and the Body*, and *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*.

⁷³ See Robin Karr-Morse, *Scared Sick: The Role of Childhood Trauma in Adult Disease* (New York: Basic Books, 2012).

'Because most chronic disease builds slowly and does not manifest until later, diagnoses are typically disconnected from their early developmental roots'.⁷⁴

A number of publications are now exploring and substantiating the serious physical, as well as psychological, impairments associated with trauma in general and childhood trauma in particular.⁷⁵

4. Childhood trauma is prevalent

The Adverse Childhood Experiences (ACE) Study is a major prospective and ongoing longitudinal study in the United States.⁷⁶ It provides the clearest most compelling evidence of the prevalence of childhood trauma and its relationship to adult ill-health.

The ACE Study involves over 17,000 participants with an average age of 53, who are predominantly white middle-class, and don't have obvious markers of social disadvantage.

Overwhelming childhood experiences were common within this large socially privileged cohort who experienced substantial harm to their psychological and physical health decades later.

The landmark findings of the ACE Study show that overwhelming childhood experiences are 'vastly more common than recognized or acknowledged' and that they powerfully impact both mental and physical health 'a half-century later'.⁷⁷

ACE Study participants were instructed to indicate, from a diverse range of experiences, which categories of childhood experience related to them. As well as the more familiar categories of sexual, emotional and physical abuse, they included growing up with *family violence, in a household in which a family member had a mental illness, had spent time in prison, and/or had a substance abuse problem*.⁷⁸

Participants in the ACE Study were assigned a point for each of 10 types of 'adverse childhood experience'. The higher the score, the greater the risk of physical and psychological ill health in adulthood.

The results were extraordinary. *Only a third had an ACE score of 0. 1 in 6 had 4 or more, and 1 in 9 had more than 5.* And as the score for each category was 1 irrespective of the number of times an overwhelming experience in each category occurred, the level of accumulated childhood trauma of participants is certainly higher.

The data of the ACE Study has yielded additional rich information. For example, it showed that if any one category of adverse experience was reported, *there was an 87% likelihood that at least one additional category was registered.*⁷⁹

Strong proportional correlations were found between the number of ACE categories or the overall ACE score and adverse health impacts later in life across a variety of markers.

⁷⁴ Karr-Morse, ibid, pp. ix-x.

⁷⁵ Note, for example, recent research that '[t]hose with complex PTSD have roughly double the rate of fibromyalgia, chronic fatigue, and disorders of musculoskeletal, digestive, circulatory, endocrine and immune systems' (Seng, Clark et al. 2006). Also see Victoria Banyard, Valerie Edwards, & Kathleen Kendall-Tackett, ed. *Trauma and Physical Health: Understanding the effects of extreme stress and of psychological harm* (New York: Routledge, 2009).

⁷⁶ Vincent J. Felitti, Robert F. Anda et. al. (1998) 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine*. 14 (4), 1998, pp.245-258. Note that the ACE Study continues to generate publications and widespread conversations and initiatives <http://www.acestudy.org/index.html>

⁷⁷ Vincent J. Felitti, 'The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead', *The Permanente Journal* (Vol. 6, No.1, 2002), p.45.

⁷⁸ Additional categories have also since been proposed. See David Finkelhor PhD et al. 'Improving the Adverse Childhood Experiences Study Scale', *Journal American Medical Association Pediatrics*. 2013;167(1):70-75

⁷⁹ Felitti, (2011: 78).

These include depression, addiction and suicide. As the lead investigators of the study underlined, '*[r]elationships of this magnitude are rare in epidemiology*'.⁸⁰

The ACE study established without doubt the variety of adverse childhood experiences, their prevalence and their serious long-term physical and psychological health impacts in adulthood. This knowledge needs to be widely disseminated for society to become 'trauma-informed'.

The fact that its participants were predominantly white middle-class, socially advantaged and college educated also explodes a lingering stereotype.

Contrary to widespread belief, the prevalence of childhood trauma is not confined to socioeconomic status, particular families, or 'at risk' groups. Rather, it is society-wide.⁸¹

While we all know that sexual, emotional and physical abuse constitute experiences of trauma, many people don't know that *caregivers who don't maltreat their children but who have unresolved trauma histories from their own childhoods can unwittingly transmit trauma to their children*.⁸² In this way, transmitted trauma becomes transgenerational (see pt. 7 below).

Abuse, in all its forms, is also far more prevalent in 'developed' postmodern societies than we want to believe. *This includes within and across the full spectrum of social institutions.*⁸³

⁸⁰ Felitti. & Anda, (2010) 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare'. Ch. 8 in Lanius. R.A., Vermetten, E. & C. Pain, *The Impact of Early Life Trauma on Health and Disease* (Cambridge University Press, 2010), p.82.

⁸¹ And prevalent within what Ozturk & Sar have termed 'the apparently normal family' (Erdinc Ozturk PhD & Vedat Sar, MD, 'The Apparently Normal Family: A Contemporary Agent of Transgenerational Trauma and Dissociation', *Journal of Trauma Practice* (Vol.4, Issue 3-4, 2006), pp.287-303.

⁸² See Erik Hesse, Mary Main et al. 'Unresolved States Regarding Loss or Abuse Can Have 'Second Generation' Effects: Disorganization, Role Inversion, and Frightening Ideation in the Offspring of Traumatized, Non-Maltreating Parents, ch. 2 in Solomon & Siegel, *Healing Trauma* ibid, pp.57-106, and Ozturk & Sar, 'The Apparently Normal Family', ibid.

⁸³ At global as well as national levels; see Vedat Sar, Warwick Middleton & Martin Dorahy, 'Individual and Societal Oppression: Global Perspectives on Dissociative Disorders' (July 5, 2014). Available at SSRN: <http://ssrn.com/abstract=2462797>

5. Childhood trauma increases risk of psychosis

A history of childhood trauma is '*[t]he single most significant predictor*' of subsequent contact with the mental health system.⁸⁴ Complex trauma receives diverse psychiatric diagnoses because it presents in many forms, with severe, wide-ranging and comorbid symptoms⁸⁵.

The extensive impacts of complex trauma mean that *comorbidity (i.e. coexistence of more than a single symptom or condition) is the norm rather than the exception*. For example, coexisting depression and anxiety is common. While not all childhood trauma leads to psychosis, and not all psychosis is trauma-related, we are revising our understanding of psychopathology as we better recognise the vulnerability of the developing brain to stress.⁸⁶

Psychosis features poor reality-testing and inability to distinguish the internal from the external: '*[i]t is exactly this distinction that trauma disrupts*'.⁸⁷

'Childhood trauma is a well-documented potential risk factor for psychosis'.⁸⁸

Presentations related to trauma can also be *confused with psychosis, including within the mental health system*.⁸⁹ This costly error further underlines the urgent need for health personnel in particular, but all services, to become trauma-informed.

Both outside and within the mental health system 'hearing voices' is often regarded as a sign of craziness. In the mental health system, it is routinely seen as a symptom of psychosis and diagnosed as schizophrenia. Yet 'hearing voices' can also be a sign of trauma:⁹⁰

'Some traumatized children hear voices commanding them to fight back or voices consoling them with comforting words....[L]acking consistent parental guidance and support, children adapt by providing themselves with the soothing or protection that they so desperately need'.⁹¹

⁸⁴ Middleton, 'Foreword' to *The Last Frontier*, ibid: x): 'Numerous studies demonstrate that around two thirds of both inpatients and outpatients in the mental health system have a history of childhood sexual and/or physical abuse. When emotional abuse and neglect are added to the mix, the percentage experiencing *some form of adverse traumatic childhood* becomes even higher' (ibid)

⁸⁵ Which is the ground on which the CPTSD (Complex PTSD) diagnosis was initially proposed by Judith Herman: '*Rather than a simple list of symptoms, it [i.e. CPTSD rather than 'simple' PTSD] is a coherent formulation of the consequences of prolonged and repeated trauma*' (Herman, 2009: xiii). For a first person account of experience of the mental health system in which complex trauma attracts diverse diagnoses, see Tamara Stillwell, 'Foreword', *The Last Frontier*, ibid, p.viii.

⁸⁶ Howell, *The Dissociative Mind*, p. ix.

⁸⁷ Ibid.

⁸⁸ Monica Aas et al, 'A history of childhood trauma is associated with slower improvement rates: Findings from a one-year follow-up study of patients with a first-episode psychosis' *BMC Psychiatry*, 2016; also see Maia Szalavitz, 'How Child Abuse Primes the Brain for Future Mental Illness', *Time*, 15 February 2012. As Aas et al discuss, a recent large-scale meta-analysis 'concluded that childhood trauma is strongly linked to an increased risk of developing a psychotic disorder... A recent study of individuals at a high risk of psychosis also showed that a history of childhood sexual abuse increased the transition rate to psychosis from two to four times ...while others have found that childhood trauma increases the likelihood of a specific admixture of affective-, anxiety- and psychotic symptoms that cut across traditional diagnostic boundaries of mood disorders and schizophrenia...' (ibid; additional cited references deleted). This suggests, as Aas et al go on to note, 'reasonably consistent evidence that childhood trauma is associated with an increased risk of developing a severe mental disorder in adulthood across clinical features, including positive symptoms, anxiety and suicidal behaviours' (ibid) <http://bmcpshiatry.biomedcentral.com/articles/10.1186/s12888-016-0827-4>

Similarly, Varese et al concur that 'childhood adversity is strongly associated with increased risk for psychosis' (*Schizophrenia Bulletin*, 2012); as do Barker et al, 'There is now a well-established link between childhood maltreatment and psychosis' (*British Journal of Psychiatry*, 2015).

Aas et al (ibid); note that '[c]hildhood physical and sexual abuse are by far the most studied subtypes of childhood trauma in relation to severe mental illness, with fewer studies investigating associations with emotional abuse and neglect... Including emotional abuse and neglect are important, as recent studies indicate these as important aspects of childhood trauma in both schizophrenia and bipolar disorders...' <http://bmcpshiatry.biomedcentral.com/articles/10.1186/s12888-016-0827-4>;

⁸⁹ 'A number of studies have shown that DDs [Dissociative Disorders] are often misdiagnosed as psychotic disorders and such patients may suffer iatrogenic worsening of their disorders due to years of misdiagnosis and mistreatment' (Spiegel, Loewenstein et al, 2011:829). This is despite the fact that the appropriate screening tools 'show that DDs can be distinguished from psychotic disorders (and other disorders) with excellent discriminant validity' (ibid).

⁹⁰ As noted above, trauma and psychosis can also co-exist. The point being made here is that 'voice hearing' is not of itself a symptom of psychosis.

⁹¹ Joyanna Silberg, *The Child Survivor* (New York: Routledge, 2013), p.xiii.

The *potentially adaptive purpose* served by ‘hearing voices’ challenges the ‘standard’ diagnosis of psychosis for both children and adults. It also highlights the extraordinary capacity of the mind – including the developing minds of young children⁹² – to respond protectively to extreme stress and the perception of threat.⁹³

Traumatised children often cannot ‘fight’ or ‘flee’.⁹⁴ The same applies to adults. This can activate the ‘freeze’ response which also paves the way for dissociation – the risk of subsequent dissociative disorders if the trauma is not resolved.

6. Childhood trauma generates the need for coping strategies, which, if the trauma is not resolved, can become ‘symptoms’ of ill-health in adulthood

‘It’s hard to get enough of something that almost works’

Vincent Felitti, Principal Investigator, Adverse Childhood Experiences (ACE) Study.

‘The problem is the solution’ (ibid)

As already outlined, perception of extreme threat generates powerful innate responses in the brain and body. The responses of ‘fight’, ‘flight’ and ‘freeze’ help protect the child from being overwhelmed and maximise their chances of survival.

Coping strategies also help a person with unresolved trauma to manage the physiological and psychological effects of the dysregulation which arises.

In childhood trauma the ‘freeze’ response is common. This is because young children, in particular, are disempowered around adults and less able to ‘fight’ or ‘flee’.⁹⁵ But children, like adults, develop *coping strategies* to protect them from being overwhelmed. Such coping strategies are often creative and effective *in the short to medium term*.

One of the major findings of the Adverse Childhood Experiences (ACE) Study is:

the relationship between childhood coping strategies and the development of the ‘symptoms’ of impaired well-being and ill health later in life if the underlying trauma is not resolved.⁹⁶

The phrase ***‘the problem is the solution’*** - coined by lead investigator of the ACE Study, Dr Vincent Felitti – describes this relationship.

People who experience trauma will look for ways to manage the psychological and physiological disruption which trauma causes. Some of the methods ‘chosen’ may seem to be and are risky, and may damage health in the longer term.

⁹² In this context, reference should be made to Dissociative Identity Disorder (DID) which is associated with childhood trauma. A key characteristic of DID is multiple self-states ('parts'). This is not a psychotic disorder but is frequently and wrongly regarded and treated as such. See Dorahy et al, 'Dissociative Identity Disorder: An empirical overview', *Australian and New Zealand Journal of Psychiatry*, Vol. 48 (5) 2014, pp. 402 – 417; & Brand et al. 'Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' *Harvard Review of Psychiatry*, Vol.24, Issue.4, July-August 2016, pp. 257-270.

⁹³ I.e. Although protective and adaptive in the first instance; if the initial and underlying trauma is not resolved, the defence will negatively impact well-being over time (see pt.6).

⁹⁴ 'Young survivors of early trauma.... often rely on dissociative strategies to cope with the dilemmas in their world. They use automatic programs such as rage, retreat, or regression that help them avoid authentic emotional engagement' (Silberg, ibid, pp. xiii-xiv).

⁹⁵ Which presents as withdrawal, ‘shut down’ and appearance of ‘spaciness’; adults who can help and society more generally need to be ‘trauma-informed’ and recognise this less obvious trauma response, which is widely misunderstood.

⁹⁶ I.e. recovered from, which anecdotally and through clinical and neuroscientific research shows is possible (see previous and subsequent comments).

Traumatised children, like adults, try to reduce their overwhelming stress when it occurs and in the short term. This often threatens long-term health.

It is critical for all service providers to understand this if we are to become 'trauma-informed'.

It is well-known that distressed people 'self-medicate'. But people also adopt methods other than use of 'illicit substances' to help them feel better. We need to appreciate the deeper implications of these methods so we can respond appropriately, interpersonally, and 'in treatment'.

Service personnel which are not trauma-informed often misunderstand, judge, and punish 'self-harming' behaviour (which can range from 'cutting' and drug use to overwork and extreme sports).⁹⁷

The health threat of addiction alone is costly in various ways for those directly affected and for society as a whole. The ACE Study clarifies that drug **addiction depends on experiences rather than being substance dependent⁹⁸** (i.e. *the greatest predictor of adult illicit drug use is unresolved adverse childhood events*).

The powerful findings of the ACE Study ('[r]elationships of this magnitude are rare in epidemiology')⁹⁹ confirm that **people adopt diverse long term health risk behaviours to reduce the likelihood they will be overwhelmed in the short term.**

Additionally, in the context of childhood trauma, such behaviours stem from strategies which the child used to protect themselves and which were originally adaptive.

The relationship between childhood coping mechanisms and adult health problems is more complex than we can explore here. But simply recognising this relationship is central to becoming trauma-informed.

⁹⁷ Of course not all instances of overwork and extreme sport are trauma-related.

⁹⁸ Felitti, 2010; 2011, *ibid*.

⁹⁹ Felitti & Anda, 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare', *ibid*, p.82.

7. Childhood trauma is transgenerational

'[R]esearch over the past few years has not only chronicled the existence of [intergenerational trauma] but has demonstrated some of the epigenetic, molecular, and biochemical mechanisms responsible for such transmission'(Levine, 2015: 161)

Adult caregivers who are dysregulated find it difficult to meet their child's needs, in particular their emotional needs. As a result, they transmit their own impaired styles of relating via 'disrupted attachment' relationships.¹⁰⁰

Transgenerational trauma is also broader than the context of 'the family' and impaired interpersonal and caregiving relationships.¹⁰¹

The Royal Commission into Institutional Responses to Child Sexual Abuse exposed the ***systemic, structural, and institutional transmission*** of child sexual abuse in *social institutions*.

The situation of indigenous peoples, who are themselves diverse, provides a contrasting context for the transmission of intergenerational trauma.

For Aboriginal and Torres Strait Islander people, transgenerational trauma extends well beyond the 'micro' contexts of the interpersonal and the familial.

The 'historical' and ongoing effects of colonialism, dispossession, racism and 'the Stolen Generation' comprise the basis of intergenerational transmission of trauma for Australia's indigenous peoples.¹⁰²

While transgenerational trauma occurs throughout society, it affects particular groups of 'individuals' in society more than others (see discussion in the previous chapter).

¹⁰⁰ Hesse, Main et al, 'Unresolved States Regarding Loss or Abuse Can Have 'Second Generation Effects', ibid; Ozturk & Sar, 'The Apparently Normal Family', ibid. As Siegel points out, '[a]dult attachment studies...suggest that parents' own subjective internal coherence, or how they have 'made sense' of their lives, is best predicts whether their child will develop a secure attachment. These research findings highlight the importance of internal and interpersonal subjective states in the development of well-being' (Siegel, 'An Interpersonal Neurobiology of Psychotherapy, ibid, p.6).

¹⁰¹ See, for example, Rachel Yehuda, 'How Trauma and Resilience Cross Generations', 30 July 2015

<http://www.onbeing.org/program/rachel-yehuda-how-trauma-and-resilience-cross-generations/7786>

¹⁰² The vast discrepancy in mortality rates of indigenous and non-indigenous Australians is one of many markers which attest to this. On the nature, causes and impacts of trauma in the context of indigenous Australians, see Judy Atkinson, *Trauma Trails, Recreating Song Lines: The Transgenerational Effects of Trauma in Indigenous Australia* (Melbourne: Spinifex Press, 2002).

8. Recovery from trauma (including complex early life trauma) is possible

The possibility of recovery, including from childhood trauma, is high.¹⁰³ This is despite the devastating scope, stakes and impacts of trauma across a range of functioning.

Neuroplasticity (the capacity of the brain to change in structure and function due to experiences) means that neural growth can occur across the lifespan.

The brain is now seen as 'social' because of the central role *experience* plays in neural development; *the brain is built over time and is capable of change.*¹⁰⁴

Recovery from traumatic experience is a process, the degrees and extent of which depend on many factors.¹⁰⁵

People need support which addresses both the social and relational contexts of interpersonal trauma.

The social dimensions of recovery from trauma also mandate that all service providers as well as the whole of society become trauma-informed.

¹⁰³ Siegel, 'An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', ibid.

¹⁰⁴ Norman Doidge, *The Brain that Changes Itself*; Louis Cozolino, *The Neuroscience of Psychotherapy* and see the following chapter.

¹⁰⁵ Courtois & Ford, *Treating Complex Traumatic Stress Disorders*.

'CHILD TO ADULT' (SUMMARY)

THE COMPLEX TRAUMA OF OVERWHELMING CHILDHOOD EXPERIENCES & ITS IMPACTS ON ADULT HEALTH

'It stands to reason that the most devastating types of trauma are those that occur at the hands of caretakers' (Cozolino, 2002:258).

CHILDHOOD TRAUMA:

- is more prevalent, more diverse, and its impacts on adult health last longer than is recognised
- **Comes in many forms (*is not limited to abuse*)**
- Affects both emotional **AND** physical health
- **Leads to many 'trauma-related' health problems**
- Is a risk factor for psychosis
- **Parents/care-givers with unresolved trauma histories can unintentionally transmit trauma to their children via impaired styles of relating ('disrupted attachment')**
- Is transgenerational
- **Generates coping strategies which can become 'symptoms' of adult ill health if the trauma is not resolved** (ACE Study, 1998, 2010)
- **Long term** 'health risk behaviours' of traumatised people provide **short term** relief for physiological and emotional distress ('problem is the solution'; (ACE Study, ibid)
- Can be **recovered from** (neuroplasticity; effects of positive experiences/trauma-informed therapy/social support

4. 'Basic brain stuff': Essential knowledge about trauma and the brain

'The brain is neither predetermined nor unchanging, but is rather an organ of adaptation' (Cozolino, 2002: xv)

How does overwhelming stress impact the brain and body?

The brain is not static in structure and function, but is continually *shaped by experiences*. Our brains are not 'hard-wired', as previously believed, but rather *neuroplastic*.¹⁰⁶

Research establishes that *neurons are activated by experiences*, 'especially those involving emotional relationships'.¹⁰⁷ It is not simply a matter of 'nature OR nurture'. Our genetic potential is realised in relation to our *experience of our environment*.

Our relational and social interactions activate our neural networks and become 'a physical reality in the brain'¹⁰⁸ ('[i]n a very real sense, the sociocultural environment becomes physically structured in the brains of individuals').¹⁰⁹

The brain IS social in the sense that it responds to the social experiences which shape it.¹¹⁰ It is not an isolated constellation of neurons within each independent individual. Rather it is receptive to - and its structure and functions are dependent upon – relational experiences. This is a 'mixed blessing'.

The good news is that neural growth and change can continue across the lifespan. Clinical and neuroscientific research indicate that we need to be more optimistic about the possibility of recovery from even severely damaging experiences.¹¹¹

The bad news is that the brain is vulnerable to damaging as well as positive relational experiences.

This highlights the critical need for positive relational experiences to forge optimal neural connections to foster healthy development and functioning.

Positive experiences of relationship do not only promote good connections with others. They also assist optimal brain functioning and enhance our ability to manage our own stress levels:

'Interactions with loved ones are our major stress-modulating mechanism' (Perry & Szalavitz, 2006:89-90).

This applies across the life cycle; we are always interdependent and we never cease to be so.

¹⁰⁶ Norman Doidge, *The Brain Changes Itself* (New York: Viking, 2017)

¹⁰⁷ Marion F. Solomon & Daniel J. Siegel, Prefatory note, *Healing Trauma: Attachment, Mind, Body and Brain* (New York: Norton, 2003).

¹⁰⁸ Richard Castillo, *Culture and Mental Illness* (Pacific Grove, CA: Brooks/Cole, 1997), p.268.

¹⁰⁹ Castillo, ibid (emphasis added).

¹¹⁰ See 'The Interpersonal Sculpting of the Social Brain', ch.9 in Louis Cozolino, *The Neuroscience of Psychotherapy* (New York: Norton 2002), pp.172-214.

¹¹¹ 'Today we have the clinical insights to repair deeply embedded and disrupted neural networks...It is an exciting time for the practice of psychotherapy' (Robert J. Neborsky, 'A Clinical Model for the Comprehensive Treatment of Trauma Using an Affect Experiencing-Attachment Theory Approach', in Solomon & Siegel, *Healing Trauma*, ibid, p.319. As another clinician and researcher affirms, '[o]ur understanding of the neurobiology of attachment and trauma is unfolding with increasing pace. Now, our understanding of the neurobiology of healing has to catch up so that the therapeutic interventions by which the suffering of trauma and disorganized attachment are relieved can continue to grow in precision and effectiveness' (Diana Fosha, Siegel & Solomon, ibid, p.276).

Relational experiences in *early life* are particularly important. This is because children are highly dependent. *The brain is especially vulnerable to stress when it undergoes critical growth periods.*¹¹²

Infancy and early life is the period in which our relationships with primary caregivers foster our capacity to self-regulate.

When early caregiving relationships are not nurturing, we do not develop the foundation to tolerate and process stress.

This, in turn, leads to a raft of developmental challenges. It also explains the damaging legacy of early caregiving which is not optimal (i.e. even in the absence of trauma).

If we develop the capacity to manage ('regulate') our internal states in childhood, subsequent life stress is less likely to damage our well-being.

This ability depends heavily on the quality of our early caregiving relationships: *the capacity to self-soothe and self-regulate develops - or not - in the context of early care-giving relationships.*¹¹³

If we have received 'good enough' caregiving,¹¹⁴ we will be well placed to cope with the many challenges of adulthood.

If we have not been so lucky, and have not learned to regulate our internal states,¹¹⁵ we can *learn to do so later in life as neuroplasticity enables the necessary changes in brain structure and function.*

Inadequate nurturing in early life makes us more vulnerable to even mild forms of stress. But neuroplasticity across the life cycle¹¹⁶ means that *early experiences are not destiny.*

NEUROPLASTICITY: THE 'SOCIAL' BRAIN

- Experience of relationships is necessary for neurons to activate (*'neurons that fire together, wire together'; 'the social brain'*)
- Positive experiences of relating assist brain functioning and well-being (*we are relational and interdependent beings*)
- The capacity to manage stress and internal states ('self-regulate') develops in the context of early caregiving relationships
- Severe overwhelming stress disrupts neural connections, leads to rigidity, and limits our ability to respond to new experiences (hence needs to be resolved)
- When we have not learned to tolerate stress ('self-regulate') in childhood we can develop this ability later in life due to *neuroplasticity* (i.e. the brain is not 'hard wired' but changes in structure and function with ongoing experiences)

¹¹² See Cozolino, 'The Interpersonal Sculpting of the Social Brain', ch.9. in Cozolino, *The Neuroscience of Psychotherapy*, ibid.

¹¹³ Cozolino, 'The Interpersonal Sculpting of the Social Brain', ibid.

¹¹⁴ The concept of 'good enough' parenting derives from the work of British psychotherapist Donald Winnicott (1896-1971) and remains widely referenced in current counselling and psychotherapeutic literature. 'Good enough' parenting (and relationships) exist/s when the inevitable ruptures of human relating are accompanied by *relational repair*. For a valuable introduction to the importance of repair of relational ruptures (which is critical in early caregiving relationships but remains important in subsequent adult relationships) and of the underpinning neurobiology, see Daniel J. Siegel, *Mindsight* (New York: Random House, 2009).

¹¹⁵ i.e. via empathic attunement of the caregiver to the child's needs. For a detailed account of the process by which this takes place, see Allan Schore, *Affect Dysregulation and Disorders of the Self* (New York: Norton, 2003) and Cozolino, 'The Interpersonal Sculpting of the Social Brain', ibid.

¹¹⁶ Doidge, *The Brain that Changes Itself*, ibid.

When experience is overwhelming: the neurobiology of trauma

The areas of the brain that are devoted to self-awareness (the medial prefrontal cortex) and body awareness (the insula) often are shrunk in people with chronic PTSD – the body/mind/brain has learned to shut itself down

(van der Kolk in Levine, 2015: xv)

Trauma is biochemically encoded in the brain in a variety of ways
(Cozolino, ibid: 258)

Diverse fields of research are helping us understand the many effects of stress, including severe stress, on human functioning.¹¹⁷

Trauma is severe and overwhelming and of a different order to 'normal life stress'.

Neuroscience shows how trauma becomes 'biochemically encoded' in the brain, and changes the way neurotransmitters operate.¹¹⁸ The changed neurological activity corresponds to 'long-term behavioural and psychological alterations':¹¹⁹

'Trauma produces a wide variety of homeostatic dysregulations that interfere with all realms of personal and interpersonal functioning'.¹²⁰

In short, trauma disrupts neural networks that should operate in a connected or 'integrated' way. It impairs integration and restricts the capacity to respond flexibly.

Becoming 'trauma-informed' requires basic knowledge of how stress impacts the brain, and the ways in which trauma disrupts flexible integrated neural functioning.

'Bottom up' and 'top down': key domains of the brain

The basic structure of the brain can be summarised as three major areas:¹²¹

- (1) the *brain stem* (the 'oldest', 'reptilian' part of the brain which controls states of arousal including 'survival' responses)
- (2) the *limbic region* (the 'mammalian' area in the centre of the brain which includes the amygdala and hippocampus (the limbic 'system') which evolved next and which coordinates 'a wide range of mental processes such as working out meaning, processing social signals, and activating emotion' (Siegel, 2012: A1-45)
- (3) the *cortex* (which allows a person to reflect; i.e. cognition and thinking, which developed last)

¹¹⁷ 'The field of mental health is in a tremendously exciting period of growth and conceptual reorganization. Independent findings from a variety of scientific endeavours are converging in an interdisciplinary view of the mind and mental well-being' (Solomon & Siegel, Prefatory note, ibid).

¹¹⁸ Cozolino, *The Neuroscience of Psychotherapy*, ibid, p.258.

¹¹⁹ Cozolino, ibid, p. 262.

¹²⁰ Cozolino, ibid, p.258 (multiple sources cited).

¹²¹ Hence reference to 'the triune brain'. For a clear account of these three domains of the brain, see Siegel, *Mindsight*, ibid, pp.14-22.

This description also represents the way in which the brain has developed.¹²²

The *brain stem 'arousal' region – which developed first – represents 'bottom up', 'lower' brain functioning.*

The cortex, which enables thinking and reflection, evolved last ('top down') is described as 'higher' brain functioning).

Trauma activates the subcortical ('lower') brain stem region first. Overwhelming stress – 'bottom up' – significantly disables the thinking and reflective capacity of cortical ('higher') level functioning.

This simple and basic understanding is essential to safe and effective trauma treatment.

Traditional modalities of the 'psy' professions have focussed on cognitive 'top down' treatment approaches, ignoring 'bottom up' 'lower' brain stem responses.¹²³

Neuroscientifically informed approaches to trauma treatment are 'bottom up' AND 'top down'. This is because trauma impacts *all dimensions* of brain and body activity.¹²⁴

'Hand model' of the brain: Daniel J. Siegel

American researcher and clinician Dr Daniel J. Siegel has developed a simple visual representation of the brain, called the 'hand' model. You can watch a demonstration of the hand model of the brain on YouTube at the following link: <https://www.youtube.com/watch?v=gm9CIJ74Oxw>

The 'hand model' of the brain is a simple and effective way of introducing the three basic areas of the brain (i.e. *brain stem, limbic system* and *prefrontal cortex*) and what happens in and to the brain when a person is under stress.

In the 'hand model', the different parts of a person's hand represent each of these three regions. Everyone's brain develops with the bottom region forming first and the top region, last.
Hold your hand upright with palm facing outward:

- The wrist represents the brain stem (*i.e. the part which controls a person's level of arousal and which developed first*).

The palm with thumb folded over it represents the limbic system (*the 'emotional' part of the brain which developed next*).

- The fingers (folded down to cover the thumb and palm) represent the *cortex* or cognitive ('thinking/reflective') part of the brain which evolved last.

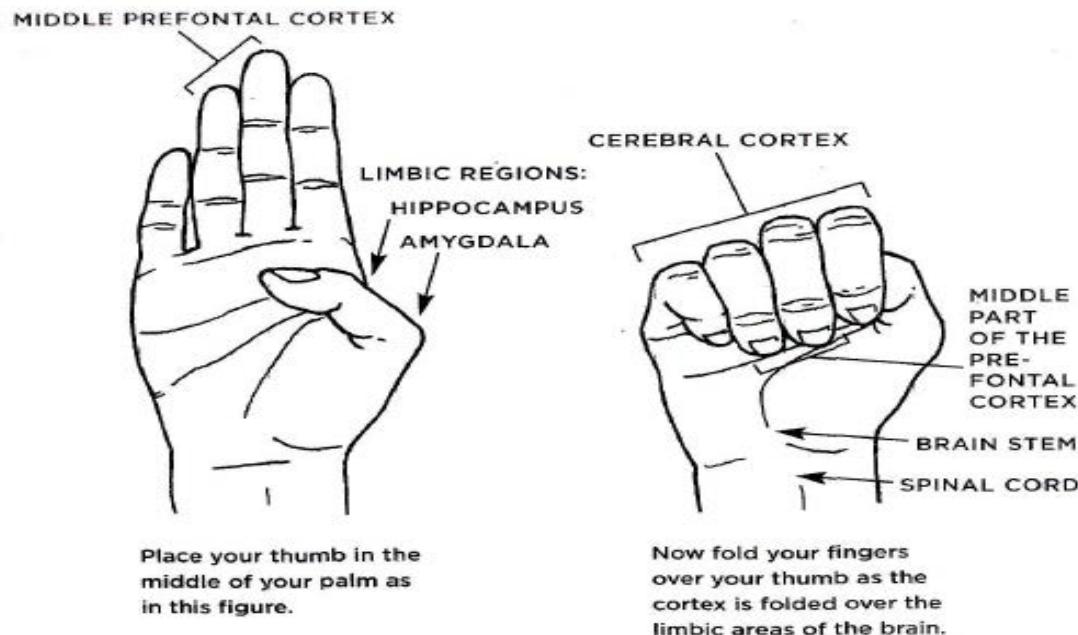
¹²² Siegel, *Mindsight*, ibid.

¹²³ As Pat Ogden, Bessel van der Kolk and others point out, traditional psychotherapeutic approaches believe 'that change occurs through a process of narrative expression and formulation in a 'top down' manner' (Ogden et al *Trauma and the Body* (New York: Norton), p. xxviii. This is a common feature of diverse counselling and psychotherapeutic modalities (e.g. cognitive and insight-based); also see van der Kolk, ibid, and Diana Fosha in Solomon & Siegel, *Healing Trauma*, ibid, pp.229-230.

¹²⁴ Hence the need for 'the addition of 'bottom up' interventions that address the repetitive, unbidden *physical* sensations, movement inhibitions, and somatosensory intrusions characteristic of unresolved trauma' (Ogden et al, ibid: xxix). Effective treatment of trauma needs to be 'bottom up' as well as 'top down' and involve all dimensions of the person; body as well as mind and emotions (Fosha, 2003; van der Kolk, 2003; Ogden, 2006).

The simple shift of moving your fingers upright and away from your palm (so that your thumb and palm are exposed) represents how severe stress can cause us to ‘flip our lid’.

Stress activates our arousal ('survival') responses – represented by the upright wrist – and ‘knocks out’ our capacity to think and reflect (i.e. cortical activity represented by fingers).



Daniel J. Siegel, *Mindsight* (Scribe, Melbourne, 2010), p.15.

Under stress, the ‘lower’ brain stem responses predominate, and impair our ability to be calm, reflect and respond flexibly.

‘When we are calm it is easy to live in our cortex, using the highest capacities of our brains [to reflect]. But if something...intrudes on our thoughts...we become more vigilant and concrete, shifting the balance of our brain activity to subcortical areas to heighten our senses in order to detect threats’.¹²⁵

‘As we move up the arousal continuum towards fear... we necessarily rely on lower and faster brain regions. In complete panic...our responses are reflexive and under virtually no conscious control’.¹²⁶

Dan Siegel’s ‘hand model’ of the brain simply but eloquently represents stress as a continuum with which we can all identify.

We have all experienced stress without trauma. Even minor stress distracts us and affects our concentration.

¹²⁵ Bruce Perry & Maia Szalavitz, *The Boy Who Was Raised as a Dog: What Traumatized Children Can Teach Us about Loss, Love, and Healing* (Basic Books: New York, 2006), p.49.

¹²⁶ Perry & Szalavitz, *ibid*.

This makes it easy to understand how extreme stress such as trauma and ‘complete panic’ can seriously affect our ability to think, learn, and plan. We can also understand how recurrent, prolonged, overwhelming stress can sabotage the ability to live a healthy life.

‘Integration’ (or flexible connection between the various capacities and functions of the brain) is the hallmark of well-being. It is also the goal of effective trauma treatment:

‘At a very minimum, integrating the brain involves linking the activity of these three regions’.¹²⁷

The connectedness of the brain stem, limbic system and prefrontal cortex ('bottom up and top down') is called ‘vertical integration’.

We also need ‘horizontal integration’ of the left ('thinking') hemisphere of the brain with the right ('feeling') part.¹²⁸

If we lack integration at these levels – i.e. both ‘horizontal’ and ‘vertical’ – we become dysregulated and unable to function flexibly. This means that we find it difficult to cope with stress and to have harmonious relationships.

When key areas of the brain ‘shut down’ under extreme stress, we lose the capacity to reflect.

Unresolved trauma comes at a significant cost. This is because *‘the same brain areas that convey pain and distress are also responsible for transmitting feelings of joy, pleasure, purpose, and relational connection’*.¹²⁹

The ‘shut down’ (dissociative) response to trauma limits ‘bad’ feelings. But if the trauma is not resolved, the corresponding cost is that we can’t experience ‘good’ feelings either.

¹²⁷ Siegel, *Mindsight*, ibid, p. 15.

¹²⁸ Ibid. For elaboration of the ‘left’ and ‘right’ brain hemispheres and the need for ‘horizontal’ ('bilateral') integration between them, see ‘Half a Brain in Hiding: Balancing Left and Right’, ch.6 in Siegel, *Mindsight*, ibid, pp.102-119. Note that the above comments on the key areas of the brain are cursory; for a detailed and authoritative account of the brain and its workings, see ‘The Divided Brain, Part 1 in Iain McGilchrist, *The Master and his Emissary* (New Haven: Yale University Press, 2009), pp.15-237.

¹²⁹ Bessel van der Kolk, ‘Foreword’, Peter Levine, *Trauma and Memory* (Berkeley, CA: North Atlantic Books, 2015) p.xv.

IMPACTS OF STRESS ON THE BRAIN

BASIC STRUCTURE OF THE BRAIN:

- *brain stem* (the ‘oldest’, ‘reptilian’ part which controls states of arousal including ‘survival’ responses)
- *limbic region* (the ‘mammalian’ area in the centre of the brain which evolved next and which coordinates assessing meaning, processes social signals, and activates emotion.) (Siegel, 2009)
- *cortex* (allows reflective capacity; i.e. cognition and thinking; developed last)
- The brain evolved ‘bottom up’; understanding both the ‘bottom up’ and ‘top down’ regions and their functions is important for well-being
- Healthy functioning requires *integration* (i.e. coordination and connection) which is both ‘vertical’ ('top down and bottom up') and ‘horizontal’ (between ‘left’ and ‘right’ brain hemispheres) (Siegel, 2009)
- Stress activates the *subcortical* ('lower') brain stem region and impairs the ‘higher’ brain capacity to think and reflect
- The ‘hand model of the brain’ (Siegel, 2009) provides a simple depiction of this process
- The overwhelming stress of trauma becomes ‘biochemically encoded’ in the brain and if not resolved (recovered from) has many adverse health impacts

Neurology of early life trauma

Adult and child onset trauma affect the brain and subsequent functioning differently:

'Because of the importance of a context of safety and bonding in the early construction of the brain, childhood trauma compromises core neural networks'.¹³⁰

'[T]he earlier, more severe, and more prolonged the trauma, the more negative and far reaching the effects':¹³¹

'[T]he brains of traumatized children are affected both structurally and chemically by the effects of enduring stress. Multiple areas of function are compromised, and disconnection and dysregulation is the result'.¹³²

Trauma disrupts integration of areas of the brain which are still being formed, i.e. *vertically* between 'higher' and 'lower' spheres, and *horizontally* between 'left' and 'right' hemispheres.¹³³

Harvard researcher Martin Teicher has established that child maltreatment *alters the trajectory of development of the brain* in specific ways according to the type of maltreatment and the age of the child.¹³⁴

Childhood trauma disrupts a child's neural development and their developmental trajectory and has adverse impacts on adolescent and adult health as well.

Early life trauma which has implications for adolescent and adult functioning is correlated with:

Changes in the corpus callosum¹³⁵ (the fibres which link the right and left hemispheres).¹³⁶

Deficits in the hippocampus (the sea-horse shaped part of the brain in which memory is consolidated or coded).¹³⁷

Activation of the amygdala (the 'smoke detector' of the brain which assesses social cues and activates emotion including the perception of threat). Trauma sensitises the amygdala which means that lower levels of stimuli can trigger conditioned fear responses.¹³⁸

Prefrontal cortex ('higher' brain centres are very vulnerable to the effects of traumatic stress.¹³⁹ The capacity to think is impaired and children's ability to *learn* can be compromised (shift from a 'learning' to a 'survival' brain).¹⁴⁰

¹³⁰ Cozolino, *The Neuroscience of Psychotherapy*, ibid, p.258.

¹³¹ Cozolino, citing many sources, ibid, p.257.

¹³² Joyanna Silberg, *The Child Survivor* (New York: Routledge, 2013), p.15.

¹³³ Silberg, ibid, p.15.

¹³⁴ Max Teicher et al. 'Sticks and Stones and Hurtful Words: Relative Effects of Various Form of Childhood Maltreatment', *American Journal of Psychiatry* (163, 2006), pp. 993-1000, and see Silberg, *The Child Survivor*, pp.9-13.

¹³⁵ For helpful explanation of various relevant terms including those which describe the different areas of the brain, see 'Annotated Index', in Siegel, *Pocket Guide to Interpersonal Neurobiology*, ibid, pp.A1-1-A1-85.

¹³⁶ Note that verbal abuse of young people by peers can alter the brain in this way (Teicher et al, 'Sticks and Stones and Hurtful Words... ibid.

¹³⁷ The impact of trauma causes excessive production of the hormone cortisol.

¹³⁸ Silberg, *The Child Survivor*, p.10.

¹³⁹ Silberg, ibid.

¹⁴⁰ Julian Ford, 'Neurobiological and Developmental Research: Clinical Implications', in Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, ibid, p.32.

What happens in the brain of an overwhelmed child?

'When a child is threatened, there are two circuits in the brain that are activated simultaneously, and that are incompatible' (Siegel, 2012:21-4)

'One message – a feeling of terror induced from the parent's behavior – activates two circuits that create opposite actions to go away from and go toward the same person' (ibid)

When a child's primary caregiving relationship is not nurturing, the child is caught in a 'biological paradox' between the 'survival reflex' and the 'attachment circuit'.¹⁴¹

Because the child needs to attach to their caregiver to survive, s/he tries to connect.¹⁴² But if the child perceives that connection is threatening, s/he can be overwhelmed:

This applies whether the parent/caregiver **frightens** the child or is **frightened by** the parent in some way (e.g. parent may be non-maltreating as previous discussion). The latter is common when the care-giver has an unresolved trauma history.¹⁴³

It is important to recall that impaired caregiving can be addressed. Adults can recover from unresolved trauma, and when they do their trauma is no longer passed onto the child and thus to the next generation.¹⁴⁴

If the adult caregiver has not recovered from their trauma, and repeated ruptures in the caregiving relationship are not repaired, the child will be overwhelmed by stress and traumatised:

'Inside the child is an unresolvable war between two impulses, and the internal world of the child collapses'.¹⁴⁵

The right brain hemisphere and the formation of self

Experience with early caregivers is crucial to emotional development as well as to physical survival.¹⁴⁶

A child needs attuned caregiving to help them learn to relate to others, **develop their self**, learn to metabolise stress, manage internal states and 'self-regulate'.

This requires the development of the '*right*' brain hemisphere, which in contrast to the '*left*' is dominant in the early years of life.¹⁴⁷

The '*right*' hemisphere, which is linked to pre-verbal experience, is critical to developing a continuous coherent sense of self, the ability to self-regulate and recognise other people's emotional states. Developing empathy ensures healthy identification with others and is 'centrally involved in the control of vital functions supporting survival'.¹⁴⁸

¹⁴¹ Siegel, *Pocket Guide to Interpersonal Neurobiology*, ibid, p.21-10.

¹⁴² John Bowlby, *A Secure Base* (London: Routledge [1988] 2005).

¹⁴³ Hesse, Main et al, 'Unresolved States Regarding Loss or Abuse can have 'Second Generation Effects', ibid.

¹⁴⁴ Siegel, 'An Interpersonal Neurobiology...'. Ibid. and see comments in the previous chapter.

¹⁴⁵ Siegel, *Pocket Guide to Interpersonal Neurobiology* (New York: Norton, 2012), p.21-10.

¹⁴⁶ 'Attachment research has objectively demonstrated the crucial importance of the parent's focus on the child's subjective experience for the development of the child's well-being', Siegel, 'An Interpersonal Neurobiology...', p.6.

¹⁴⁷ Cozolino, 'The Interpersonal Sculpting of the Social Brain', ibid; Schore, *Affect Dysregulation and Disorders of the Self*, ibid.

¹⁴⁸ Schore, *Affect Dysregulation and Disorders of the Self*, ibid, p.86, emphasis added.

The dysregulating effects of trauma are especially damaging when they are experienced in early caregiving relationships. This is because during this period, the right hemisphere is 'under construction'.

Helping a child interact and connect is central to their development. When caregivers do not 'mirror' or 'model' an infant in an attuned way, it limits *the child's ability to connect with others and with themselves*:

'[a]ttunement failures between parent and child always are, by definition, small-T traumas. If they are repetitive, fixed or rigid, there is no way to process the negative emotion that the trauma creates, and the effects become cumulative'.¹⁴⁹

If a child cannot achieve the *internal equilibrium* they need to be healthy and manage basic stress, s/he will experience cumulative developmental trauma and seek *external sources to mediate it*.¹⁵⁰

As discussed in the previous chapter:

'[A]daptation to trauma, especially early in life, becomes a 'state of mind, brain and body' around which all subsequent experience organizes'.¹⁵¹

¹⁴⁹ Neborsky, referencing Kahn, 1963, 'A Clinical Model for the Comprehensive Treatment of Trauma', *ibid*, p. 290.

¹⁵⁰ Neborsky, *ibid*, pp.286-287.

¹⁵¹ Cozolino, *The Neuroscience of Psychotherapy*, pp. 258-259).

CHILDHOOD TRAUMA, THE BRAIN AND HEALTH IMPACTS

- The need of children to attach to a caregiver drives their impulse to connect. This is necessary for survival. If the child perceives their connection to a caregiver as threatening, for any reason the child can be overwhelmed
- When a child perceives a parent/ caregiver to be threatening for any reason, incompatible neural circuits (i.e. to go towards and move away) are activated simultaneously (Siegel, 2012) '*Inside the child is an unresolvable war between the two impulses, and the internal world of the child collapses*', (*ibid*)
- The right brain hemisphere is dominant in the early years of life and 'centrally involved in the control of vital functions supporting survival' (Schore, 2003; Cozolino, 2002)
- Deficits in the development of the right hemisphere from impaired caregiving and childhood trauma lead not only to negative 'effects' but impair the development of the *self* and disrupt the developmental trajectory
- '*The insecurely attached person must constantly recruit other sources of comfort within and/or outside the self for comfort. These are in the form of defences or addictions...Illness of one kind or another results*' (Neborsky, 2003:286-7; Felitti, Anda et al, 1998; 2010)

Dissociation and the brain

'Exciting strides have begun to reveal the neurobiology of dissociation'

(Brand, 2012:394)

As noted in chapter 1, trauma invokes a process of *dissociation* in which a split or division of experience occurs as a protective 'survival' response to being overwhelmed. Rather than confront the perception of extreme and unbearable threat, the innate ability of the mind to disconnect and detach from potentially overwhelming input serves clear survival purposes.

While it is easier to recognise the signs of distress and overwhelm when someone is visibly agitated (e.g. shaking, sweating, dilated pupils), dissociative responses (the 'shut down' of hypoarousal) are not easily 'seen'. *The signs of dissociative overwhelm are much more subtle*. Trauma-related dissociative responses are frequently undetected, ignored, and misinterpreted. *If they remain unrecognised*, service providers can doubt their significance, prevalence, and even existence.

For this reason, it is important to be aware that:

Neurological research has established the relationship between dissociative experience and distinctive activity in the brain¹⁵² i.e. 'dissociation is accompanied by altered activation of brain structures...involved in regulating awareness of bodily states, arousal, and emotions':¹⁵³

[N]euroimaging studies provide concrete, theoretically consistent evidence that dissociation exists¹⁵⁴

'Shut down' as a survival response to being overwhelmed is often confused with sadness or depression. It is also dismissed (as in why doesn't the person just 'snap out of it?') and even punished (e.g. regarded as disinterest, deliberate withdrawal, and conscious refusal to engage).

'The responses of traumatized children [and also adults] are often misinterpreted'.¹⁵⁵

Becoming trauma-informed requires understanding that both hypoarousal and hyperarousal can be responses to trauma.

Neuroscientific research findings provide important insight into the neurobiology of trauma. Children who are traumatically overwhelmed in primary care-giving relationships can experience rapid neural shifts. These occur because of the need to 'alternate so quickly and frequently among emerging defensive and daily life action systems'.¹⁵⁶

As noted earlier, childhood trauma ignites the contradictory impulse to move towards and away from the frightening/frightened caregiver. 'Incompatible neural circuits' are activated simultaneously.¹⁵⁷ *This can profoundly impact a child's (and subsequent adult's) inner world development.*¹⁵⁸

¹⁵² Ruth Lanius, Eric Vermetten et al, 'Emotion Modulation in PTSD: Clinical and Neurobiological Evidence for a Dissociative Subtype', *American Journal of Psychiatry*, 167 (6) 2010: 640-647. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3226703/>

Also see Lanius, Paul Frewen, et al. 'Fear conditioning and early life vulnerabilities: two distinct pathways of emotional dysregulation and brain dysfunction in PTSD', *European Journal of Psychotraumatology*, 1:10, 2010.

¹⁵³ Bethany Brand, 'What We Know and What We Need to Learn About the Treatment of Dissociative Disorders', *Journal of Trauma & Dissociation*, 13:4, 2012, p.395.

¹⁵⁴ Brand, 'What We Know and What We Need to Learn', ibid

¹⁵⁵ Perry, *The Boy Who Was Raised as a Dog*, ibid, p.55.

¹⁵⁶ van der Hart et al, *The Haunted Mind*, ibid, p.78.

¹⁵⁷ Siegel as above and as per the previous quote; i.e. van der Hart et al, *The Haunted Mind*, p.78.

¹⁵⁸ 'Problems with affect-regulation have pervasive effects on the development of mind and brain and lead to significant increases in the utilization of medical, correctional, social, and mental health services' (van der Kolk, 2011: xii).

The brain reflexively organises around dissociation to preserve the attachment bond (even if it is toxic) on which a vulnerable child depends. This leads to compartmentalisation of experience.¹⁵⁹

The dissociative divisions which result can cause sudden shifts in personality ‘parts’ and self-states. These may appear chaotic – particularly in adulthood if the underlying trauma is not resolved. Yet they *make sense in the context from which they arose*.¹⁶⁰

DIVISION, DISSOCIATION AND THE BRAIN

- Dissociation (disconnection from immediate experience) occurs in mild everyday forms and is part of normal personality structure (Bromberg, 2001; Butler, 2004)
- As a protective, ‘survival’ response (*‘the escape when there is no escape’*; Putnam, 1992) it correlates with freeze and ‘shut down’ and is ‘part of our standard response to trauma’ (Steinberg & Schnall, 2003:32)
- In contrast to the visible agitation of hyperarousal, signs of the hypoarousal of dissociative overwhelm are subtle, harder to recognise, and easily misinterpreted.
- Dissociation correlates with distinctive activity in the brain (Lanius, Vermetten et al, 2010; Brand, 2012)
- Dissociative divisions and compartmentalisation of ‘parts’ of experience can be more complex and numerous according to the severity of the trauma and the context in which it occurs
- The most complex dissociative splits stem from radically impaired early care-giving relationships (*‘fragmentation becomes the central principle of personality organization’*; Herman, 1997:107; van der Hart et al, 2006) in which traumatic overwhelm simultaneously activates neural circuits that are incompatible (Siegel, 2012)

¹⁵⁹ ‘An environment of trauma and impaired caregiving elicits overwhelming negative affect consequently the brain selects and reinforces pathways that encourage avoidance of affect and associated traumatic content’ (Silberg, *The Child Survivor*, p. 22).

¹⁶⁰ This also attests to shows the extraordinary capacity of the human mind under stress to preserve survival by unconsciously privileging ‘continuity over coherence’ (Bromberg, *ibid*). In early life trauma, severe overwhelm is correlated with Dissociative Identity Disorder (DID), with the generation of multiple self-states: ‘If, early in life, the developmentally normal illusion of self-unity cannot safely be maintained when the psyche-soma is flooded by input that the child is unable to process symbolically, a configuration of ‘on-call’ self-states is gradually constructed...’ (Bromberg, *Standing in the Spaces* [1998] 2001: 200). Note that ‘The dissociation must be preserved, *sometimes at any cost*, to prevent the return of unbearably traumatic self-experience’ (*ibid*: 180; emphasis added).

Trauma and memory

Trauma also affects memory. Current neuroscientific and other research confirm that memory is not a single entity. It comprises different subsystems in which different types of memory are stored in different parts of the brain.¹⁶¹ 'Traumatic memory' is a different type of memory from that of conscious ('explicit') recall.

There are two main types of memory: *explicit* (conscious) memory and *implicit* (relatively unconscious) memory. These two memory systems serve separate functions and are mediated by different neuroanatomical structures.¹⁶² *Explicit*, conscious memories are generally verbally accessible (i.e. facts, information, and consciously recollected experience ('I remember when...')). By contrast, *implicit* memories are often *situational*ly accessible and triggered by environmental prompts (e.g. a fragrance, sight, or sound). Implicit memories are also 'primarily organized around emotions and/or skills, or 'procedures' (i.e. that is the things the body does automatically').¹⁶³

The 'behavioural reactions'¹⁶⁴ of *implicit, procedural memory* are 'bottom up', i.e. they derive from the subcortical area of the brain which evolved first. Implicit, somatic memory (e.g. 'the smells and tastes and sounds of home and parents')¹⁶⁵ occurs early in life before we develop the ability to think. By contrast, development of the hippocampus in the second year of life enables *explicit* conscious memory.¹⁶⁶ By this time we have already absorbed considerable sensory input. This does not simply 'disappear' when we begin to verbalise and become capable of conscious thought and recall: '*all aspects of the self are forms of implicit memory stored in neural networks that organise emotion, sensation, and behaviour*'.¹⁶⁷

Traumatic memories are an intense and devastating form of *implicit* memory. High levels of cortisol released during extreme stress affect the function of the hippocampus and impede consolidation of explicit memory. Extreme stress also activates the amygdala and the release of adrenaline, which heightens and intensifies *implicit* memory:¹⁶⁸ '*Flashbacks, intrusive bodily sensations... and images of traumatic events that 'seem to come out of nowhere' are all elements of this blocked explicit/enhanced implicit processing*'.¹⁶⁹

Trauma impedes the processing of experience into explicit, conscious memory. Instead it is recollection is via automatic actions and reactions, visceral sensations, and/or visual images such as flashbacks and nightmares:¹⁷⁰ '*the imprints of trauma are stored, not as narratives about bad things that happened...in the past, but as physical sensations that are experienced as immediate life threats – right now*'.¹⁷¹

Current neuroscientific research confirms that trauma is experienced in the body (i.e. subcortically): ('[s]tarting with the earlier students of traumatic stress and continuing with the most recent neuroscience research, scientists have noted a critical relationship between bodily action and memory').¹⁷² It also confirms that traumatic memory is often *re-enacted* via behaviours which 'don't make sense' when detached from the overwhelming experience/s which precipitated them.

¹⁶¹ For a concise and authoritative account of the impacts of trauma in the context of the various types of memory, see Peter Levine, *Trauma and Memory: Brain and Body in the Search for the Living Past* (Berkeley, CA: North Atlantic Books, 2015).

¹⁶² Levine, *Trauma and Memory*, p.15.

¹⁶³ Levine, *Trauma and Memory*, p.21.

¹⁶⁴ Daniel J. Siegel, *Pocket Guide to Interpersonal Neurobiology* (New York: Norton, 2012), p.30-3.

¹⁶⁵ Siegel, *Mindsight*, pp.149-50.

¹⁶⁶ Siegel, *Pocket Guide to Interpersonal Neurobiology*, p.30-2.

¹⁶⁷ Cozolino, *The Neuroscience of Psychotherapy*, p.233.

¹⁶⁸ Siegel, *Mindsight*, p.157. As Cozolino (*ibid*, p.271) likewise points out, '[a]ctivation of the amygdala (and the related physiological and biological changes) is at the heart of the modulation of emotional and traumatic memory (Cahill & McGaugh, 1998). The release of norepinephrine during the stress response seems to heighten the activation of the amygdala, thus reinforcing and intensifying memories for traumatic events (McGaugh, 1990)'.

¹⁶⁹ Siegel, *Pocket Guide to Interpersonal Neurobiology*, 30-5.

¹⁷⁰ Van der Kolk citing Janet, 'Foreword', in Levine, *Trauma and Memory*, p.xi.

¹⁷¹ Bessel van der Kolk, 'Foreword', Levine, *Trauma and Memory*, p.xi-xii.

¹⁷² (van der Kolk, 'Foreword', in Levine, *Trauma and Memory*, *ibid*, xiii; emphasis added).

These findings have major implications for clinical and non-clinical treatment. People with unresolved trauma can be easily triggered by seemingly minor cues. It is important to understand more about memory to avoid pathologising and/or blaming a person who is not consciously aware of what is happening, and is experiencing a traumatic re-enactment. It is helpful to be empathic and gently assist them to lower their levels of arousal.

*To find out more please go to Blue Knot Foundation publication *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance for Trauma**

<https://www.blueknot.org.au/ABOUT-US/Our-Documents/Publications/memory-and-trauma> as well as Factsheets on Memory <https://www.blueknot.org.au/Resources/Fact-Sheets/Memory-factsheets>

DIFFERENT TYPES OF MEMORY (I.E. EXPLICIT AND IMPLICIT) AND THE NATURE OF TRAUMATIC MEMORY

- Memory is not a single entity all of which can be recalled at will. Complex neural networks are associated with *different types of memory* (explicit and implicit) and stored in different areas of the brain
- *Explicit* memory is conscious while *implicit* memory is largely unconscious. Implicit memories (of which traumatic memory is an intense variety) '*are primarily organised around emotions and/or skills or 'procedures' – things that the body does automatically'* (Levine, 2015:21)
- Conscious (explicit) recall depends on development of the hippocampus in the second year of life. *We develop implicit memory before we develop explicit memory*
- Trauma (i.e. overwhelming stress) impedes the function of the hippocampus which is necessary for consolidation of explicit memory recall. Traumatic memories are implicit, stored as physical sensations, and '*tend to arise as fragmented splinters of inchoate and indigestible sensations, emotions, images, smells, tastes, thoughts...*' (Levine, 2015:7)
- The relationship between repetitive problematic behaviour (which can be easily triggered by seemingly minor cues) and unresolved trauma needs to be understood by all primary care practitioners and providers. Gentle assistance to lower the arousal level of the patient (which may present as hyper- or hypo-arousal) is necessary

Current knowledge of neuroplasticity and the capacity of the brain to change its structure and function in experiences of relationship is important to inform service responses.

Positive relational experiences assist neural integration which is necessary not only for the healing of trauma but also for general psychological well-being.¹⁷³

Basic information about 'brain stuff' is also essential to service settings, systems and all personnel becoming 'trauma informed'.

¹⁷³ Siegel, 'An Interpersonal Neurobiology of Psychotherapy'; Cozolino, *The Neuroscience of Psychotherapy*, ibid; 2002; Doidge, *The Brain that Changes Itself*, ibid.

PART 2: BUILDING THE FOUNDATIONS TO TALK ABOUT TRAUMA

Starting and responding to conversations: introducing the trauma-informed principles

Safety Trustworthiness Choice Collaboration Empowerment

[Fallot & Harris, 2009]

The above principles are important for us all. If we're lucky, we take them for granted. People who experience either single incident or complex interpersonal trauma *do not* take these principles for granted. Another person/s has violated their basic sense of safety, right to be respected, or ability to make choices.



These principles can inform the basis for every one of our interactions and *it is important that they are applied by service providers of all kinds*.

Doing so is not only supportive. It leads to interactions which minimise tension, upset, and distress. When services incorporate these principles as part of their daily operation, and are sensitive to a person's life path, experience and background (including cultural, gender, religious and other orientations as well) 'difficult' interactions can become easier. This is because the person with whom you are talking is less likely to experience additional trauma (become re-traumatised).

The safer a person feels, the more likely they are to fully or partially reveal their interpersonal trauma and make us aware of their need for support.

Applying the trauma-informed principles is important whether service providers are *starting* interactions and conversations with clients or *responding* to them. It is especially important if it is known or suspected that a person may be experiencing interpersonal trauma.

*Look for ways to bring **SAFETY, TRUST, CHOICE, COLLABORATION** and **EMPOWERMENT** into all interactions and conversations.*

'Talking about trauma' is easier if trauma-informed principles are applied at all times.

Helping a person feel safe assists 'the conversations which need to be had' with people known or suspected to experience interpersonal trauma.

Many people with experiences of trauma do not disclose their trauma, even to health professionals. They have often been discouraged from disclosing, as children and as adults. Some fear they will not be believed, will be blamed, or even punished for speaking out.

While it is not surprising that traumatised people don't often disclose to personnel in *non-health services*, it is concerning that the same can apply in health services (*i.e. even when the service relates directly to a person's health*). In addition, health personnel and providers rarely ask about or screen for trauma (see subsequent discussion).

This creates a self-reinforcing loop of lost opportunities with the very services which could help clients who have experienced trauma.

It cannot be assumed that a client's trauma will be recognised in health or other services.

For this reason, the general principles for initiating and responding to conversations with people with trauma histories *apply to health and other service providers as well as to the general public.*

As traumatised people engage frequently with health and other services, all personnel in all services need to learn to interact in trauma-informed ways.

It is important to plan conversations with people who have experienced trauma. In some cases, the person may start a conversation to disclose their trauma. Because many people are understandably reluctant to disclose, however, it is more likely that service-providers will need to *initiate* such conversations.

It is important to consider how to help the person feel safe during such a conversation. This can be done by implementing the trauma-informed principles.

Basic knowledge of how to engage appropriately is needed regardless of whether a conversation/interaction is being started or responded to.

Services need to know how to engage with and support people who are experiencing interpersonal trauma or struggling with its impacts. If staff 'don't know what to do' they will continue to ignore and miss signs of distress.

Learning how to have trauma-informed conversations also fosters health more broadly. This is because *the positive social interactions that help people to recover from trauma also improve general well-being.*

Trauma-informed principles can and should be applied in all communication and interactions, not only when 'talking about trauma'.

Knowing the core trauma-informed principles is one thing. Applying them in conversations, and particularly challenging conversations, initially takes effort.

Because trauma-informed principles seem so basic they are often taken for granted. The assumptions we make around applying them put them at risk of being compromised frequently. We need to actively safeguard the principles to avoid potentially disastrous consequences for traumatised people.

Service delivery is fast-paced. Basic courtesies and care can be compromised both intentionally and unintentionally. This is especially damaging for trauma survivors who have already been violated.

As basic as trauma-informed principles seem and are, applying them in conversations in the context of service delivery may at first seem challenging.

When we are more familiar with trauma-informed principles, we can apply them in our everyday interactions and conversations, including with people who experience the impacts of interpersonal trauma.

Application of trauma-informed principles and tips

The following definitions of the five trauma-informed principles will help diverse service personnel to understand their application. We have also provided some questions to help implementing the principles in conversations.

The recommendations and tips are particularly important for all conversations with traumatised people as well as those who are distressed.

Sometimes trauma and other forms of distress are not obvious. The signs can be subtle. Some people 'over function'. While appearing to enjoy a certain quality of life, they never allow themselves to slow down and rest.

This is another reason why all service personnel and providers need to communicate using the five trauma-informed principles at all times.

GUIDING PRINCIPLE: Safety first, second and third!

PRINCIPLE 1 - SAFETY

We all need to feel safe and secure. If a person who has an experience of interpersonal trauma doesn't feel safe, they are unlikely to have a conversation about their situation.

Both emotional and physical safety are important.

Service personnel and providers need to pay attention to the physical space – location, building/room – in which conversations take place. They also need to consider a person's *emotional* space, much of which is non-verbal (i.e. not communicated in words). Anything that can be done to help a person feel more comfortable is useful. Various aspects of the possible interaction – many of which may normally be taken for granted – also need to be considered.

You need to find a safe context in which to speak. This includes both the *physical* (Is there any risk of being overheard?) and *emotional space* (Does the context for this conversation build feelings of comfort?)

If you are not the one who has started the conversation (e.g. a work colleague suddenly reveals their experience of family violence) you will not be able to create and ensure the safest environment possible. If we can, we all try to 'choose our moment' to reveal a painful experience. Sometimes, however, we may be so distressed that we are oblivious to our surroundings.

*It is important to establish a person's basic physical safety (i.e. *distance from immediate physical harm*) and emotional safety (i.e. *let the person know you are willing to be with them and hear what they have to say*).*

If a person does reveal their experience to you, take immediate steps to ensure their basic physical safety within the context of the service. Also attend to their emotional safety. This might overlap with physical safety (e.g. '*how about we sit and talk quietly away from the reception desk?*').

You can obviously pay more attention to safety if you are not 'taken by surprise'. But *even if you are approached unexpectedly, it is important to foster the minimal conditions of basic physical and emotional safety.*

Being sensitive to what isn't said (non-verbal aspects) in any interaction helps the person feel safe and makes for trauma-informed conversations.

The word 'conversation' implies that only spoken language is significant. But in 'talking about trauma' *the non-verbal aspects of communication are critical*.

What you convey through non-verbal communication is as important as your words. If your non-verbal communication is effective, you will help people who experience interpersonal trauma feel safer.

Even in the context of busy service-delivery, you can show people you are focused on them and on what they are telling you when you listen and tune into them. Not looking away or interrupting helps a person feel it is safe to speak with you.

'Not knowing what to say' can be a positive. Sometimes words don't help when responding to deep distress. It's okay to say 'I don't know what to say'.

When you listen compassionately, tune in, you are present and express your support through your non-verbal communication, you will help the person feel safe. Having 'trauma-informed' conversations can be easier than we think.

The most reassuring support you can offer is to simply be with the person. Don't try to 'fill the space with words', which often 'falls flat'. Words imply that you know what the person is experiencing when you don't. This can make them feel less safe.

Of course words can also be important. Total silence can invalidate the person and make them feel less safe.

If a person tells you they are still experiencing abuse or a violent relationship, it is important to do what you can to help them find appropriate support (see Referral Services and Contacts p126).

It is important to understand the stress response to apply the trauma-informed principle of safety. This puts you in touch with the person's level of stress, and helps you support them to lower their level of arousal if this becomes necessary.

To be able to help others, you also need to be in touch with and manage your own stress levels. ('First fasten your own oxygen mask'). See the tips below to help you manage your own stress levels and to help you help others.

People who have experienced interpersonal trauma are often more sensitive to events which can trigger stress, and which can seem minor to others. They are also more likely to experience further trauma (i.e. retraumatisation) in interactions which are not trauma-informed.

Tips to help a person who has experienced interpersonal trauma feel safe when you are having a conversation with them:

1 (a) PHYSICAL SAFETY

- Is the physical/geographical space in which you are having the conversation safe?
Is it away from busy roads if outside or in a room in which you are unlikely to be interrupted if you are inside?
- Have you asked the person if there is anything you can do to make the conversation space more comfortable?
Many factors, some which we might not know about, can lead to stress reactions. For example, some people might be triggered by a particular visual cue
- Will the person be physically safe after – as well as during – the conversation?
This applies not only to the situation to which they are returning but to their general levels of arousal. You may need to help them with a basic Grounding Exercise, see page 156

1 (b) EMOTIONAL SAFETY

- ‘Choose your time’: if you are initiating the conversation, have you selected a time at which the person is likely to be receptive?
- Does your non-verbal communication show that you are supportive, focused and listening in a way which is tuned into the person? Maintaining eye contact which is *consistent but not fixed* is important. *Take care not to look distracted.*
- Are you alert to possible signs of stress in the person’s body?
This can include dilated pupils or changes in skin colour. The person may be twisting a tissue or take long pauses.
- Do you encourage the person to take their time and take short breaks if they need to?
If the conversation is long you could return to it after a short break.
- Will the person be emotionally safe after, as well as during the conversation? Are you able to help them to lower their level of arousal if necessary? (see Grounding Exercise p.156)

PRINCIPLE 2 – TRUSTWORTHINESS

Sharing personal information can feel risky. This is especially when the information has to do with trauma that occurs in relationships.

[T]he social context in which people disclose affects the process itself...a process that is highly dependent on the reactions of others'

(Freyd & Birrell, 2013:126)

Being betrayed, or what we call ‘betrayal trauma’¹⁷⁴, can make it much harder for a person to speak about their trauma to anyone else. It is important to make the contexts in which disclosure takes place as reassuring to the person as possible.

¹⁷⁴ Jennifer Freyd & Pamela Birrell, *Blind to Betrayal: Why We Fool Ourselves We Aren’t Being Fooled* (NJ: John Wiley & Sons, 2013).

Because interpersonal trauma violates trust, we cannot expect people who have experienced it to trust other people easily. Even in therapy and counselling, trust can sometimes take years to develop.

Service personnel and providers can foster trustworthiness by applying the other trauma-informed values of *safety, choice, collaboration* and *empowerment*.

When starting a conversation with someone known or suspected to experience interpersonal trauma, take a gentle low-key approach which does not seem to have ‘an agenda’. This does not mean, however, that you should ‘pussyfoot around’, or that you can’t directly communicate your concern.

When a person who has experienced trauma feels physically and emotionally safe, and realises that nothing will be done ‘to’ them or imposed ‘on’ them, they are more likely to begin to trust people again.

If a person feels helpless and can’t remove themselves from a debilitating, abusive, or otherwise distressing relationship, they may welcome you starting the conversation. On the other hand, the person may also reject your overtures (see ‘*What if...?*’ Questions which arise).

We recommend a ‘softly, softly’ approach which incorporates all of the trauma-informed principles. This is important when you are speaking with a person whose capacity – as well as their desire to trust may have been massively disrupted by interpersonal trauma.

If the person has ‘reached out’ themselves, they might be particularly receptive, making for an easier interaction. Even so, we still advise a ‘softly, softly’ approach.

Tips to build trust in conversations with a person who has experienced interpersonal trauma:

YOU CAN BUILD TRUST IF YOU:

- Are always attentive to physical and emotional safety
- Always tune in to the person’s level of comfort and ask them whether/how you might improve it
- Pay ongoing attention to your and their non-verbal communication
Is the person showing signs of stress? Are you encouraging them and being supportive?
- Take a gentle approach that does not convey ‘an agenda’
- Listen in the right way; do not interrupt the person unless there is an issue with their level of arousal (see ‘the window of tolerance’ below)
- Ask the person how they are feeling after (as well as during) the conversation. Be ready to help them with ‘grounding’ if/as necessary (see page 156)

PRINCIPLE 3 - CHOICE

How often do we perceive ourselves actively exercise choice in our lives? Even in the absence of trauma, the many pressures of everyday life can leave many of us feeling as if we are simply 'doing what we have to do'. So just imagine how trauma accentuates this!

When we think about it, however, most of us make small choices (such as whether to catch up with friends this month or next). Because they are small, they may not seem like 'a big deal'. But small choices do assist us to feel better.

Actively inviting people to express their preferences around when and where you should meet, and how they would like to make contact, can make a big difference if making choices has not been an option previously.

Trauma removes a person's ability to exercise choice. Thus it is critical to provide choices, however small, to people who experience interpersonal trauma.

The more you 'build in' small choices around these conversations the more supportive and effective the conversation is likely to be.

As people who experience interpersonal trauma are often not used to having choices, we need to be careful not to overwhelm them person with the *number* of choices. When we 'build in choice', however small, to interactions with people who experience interpersonal trauma, we help empower them.

Tips to increase options and choices in a conversation with a person who has experienced interpersonal trauma (questions for consideration).

ENABLING CHOICE

When you are starting a conversation with a person you know or suspect may be experiencing interpersonal trauma, give them choice/s around the conversation.

- Within your service context, how can you give the person greater choice about the way the conversation is held and develops?
- In what other way/s can you give the person other choices, even if they are small?
- How can responding to, rather than starting, the conversation affect the extent to which you can foster choices for the person?

PRINCIPLE 4 – COLLABORATION

Everyone wants a say in things that affect them. This is a basic human desire which is reflected in the fourth trauma-informed principle of *collaboration*. This principle underlines the difference between 'doing something *with*' someone rather than doing something 'to' or 'for' them.

It is important to collaborate with people who experience interpersonal trauma, and to offer them as much opportunity for input as possible. This key point can sometimes be overlooked as it might not seem logical.

Because interpersonal trauma is debilitating and disabling, we might assume those affected might want us to make decisions, do things for them, and take things 'out of their hands'. But while this may at times be welcome and even necessary, we need to ensure that we provide support, rather than 'taking over' altogether.

*People do not lose all their abilities because they experience interpersonal trauma.
The sheer fact of their survival may attest to their strengths and capabilities.*

As mental health worker and client Tamara Stillwell states, 'more often than not the [person] will rise to fill that adult role'.¹⁷⁵

Just because a person has experienced deep distress as a child or adult, we should not assume that they cannot collaborate or should be treated like a child.

The exception is if the person is at risk to their own safety or the safety of someone else. At such a time, it may be important to intervene and engage more active forms of assistance (see '*What if...?*' Questions which arise). In all other circumstances, we recommend a collaborative approach to all conversations and interactions with people who experience interpersonal trauma. It is likely to be both welcomed and accepted.

Tips to help us collaborate in conversations with people who experience interpersonal trauma:

COLLABORATION MEANS:

- 'Doing something *with*' a person rather than doing something '*for*' or '*to*' them
- Not assuming that the person can't act on their behalf or engage in decisions and actions which affect them
- Recognising when additional assistance may be necessary
- Recognising we engage more effectively with people when we cooperate with them
- Acting in a spirit of cooperation whenever and as much as we can

¹⁷⁵ 'Foreword by Tamara Stillwell', *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, 2012, p.viii.

PRINCIPLE 5 - EMPOWERMENT

Interpersonal trauma often occurs in situations of a *power imbalance* in relationships. Interpersonal trauma is also *enabled* by power imbalance. People who experience interpersonal trauma often have little or no power over a long period of time. *Acquiring or restoring a sense of personal power is key to the process of healing.*

It is important not to assume that a person who has been disempowered is incompetent or unable to take steps towards being empowered.

Tamara Stillwell's testimony is again relevant:

'People with complex trauma will often respond better... when they are empowered in ways that are unique to them, and [we] should not underestimate [their] ability to be very useful and active in their own treatment' (Stillwell, ibid)

We recommend an optimistic approach with people who experience interpersonal trauma that will foster their ability and capacity to act.

Even in situations in which there is an urgent and immediate need for support (such as for direct intervention in fleeing a violent partner), it is more effective to empower the person's abilities rather than to assume their passivity.

Tips to maximise empowerment in conversations with people who experience interpersonal trauma:

TOWARDS EMPOWERMENT:

- Understand that interpersonal trauma often stems from and fosters *disempowerment*, and that taking steps to feeling more empowered is essential to healing
- Recognise that *the way in which* a conversation is arranged and conducted can contribute to a sense of empowerment
- Recognise that trauma which occurs in relationships erodes self-esteem and a person's sense of their own abilities. It is important to identify ways to make your interactions respectful, democratic and inclusive
- As far as possible, seek the person's preferences around the logistics of your conversation and try to meet them in a collaborative way

Essential knowledge to becoming trauma-informed*

* assists conversation and interactions with people known or suspected to experience the impacts of trauma.

(1) UNDERSTAND THE IMPACTS OF STRESS ON THE BRAIN

Under stress, we can lose our ability to be calm, reflect and respond flexibly (see 'Effects of stress on the brain')

(2) SIGNS OF TRAUMA CAN TAKE DIFFERENT FORMS

Trauma responses include both:

Hyperarousal (obvious agitation; e.g. shaking, sweating, raised voice)

AND

Hypoarousal (e.g. glazed eyes; 'zoning out'; 'shut down'; can be harder to detect)

(3) SIMPLE WAYS TO LOWER AROUSAL CAN RESTORE SAFETY

We can learn to do this for ourselves and others.

It allows the person to return to a place where they can tolerate their feelings (see 'The window of Tolerance'). It also minimises the risk of being overwhelmed from both hyper- and hypo-arousal.

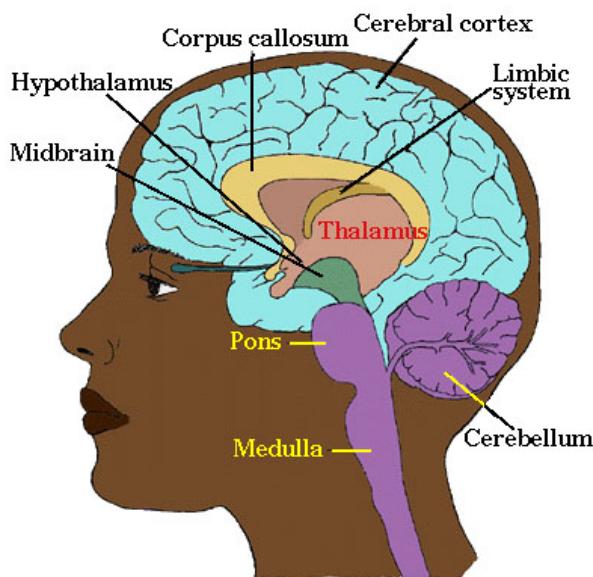
(4) CHALLENGING RESPONSES AND BEHAVIOURS CAN BE DEFENCES AGAINST STRESS

Traumatised people develop coping strategies to protect them from being overwhelmed. When we understand this, we can consider what may have 'happened to' a person rather than what is 'wrong' with a person.

(5) THE 'WAY IN WHICH' WE INTERACT WITH A TRAUMATISED PERSON NOT JUST 'WHAT' WE SAY AND DO - IS IMPORTANT

It can also either increase or decrease a person's stress levels. This shows the importance of knowing how to interact in a trauma-informed way, not make things worse, and 'do no harm'.

Effects of stress on the brain



Brain Stem: Basic survival response, states of arousal; automatic

Limbic: Emotion (fear), evaluation, unconscious

Cerebral Cortex: thinking, concepts, reflection, conscious

Under conditions of stress, our 'lower' brain stem responses become dominant ('bottom up') and we are less able to be calm, reflect and respond flexibly.

Trauma activates the 'lower' brain stem region (the area below the cortex).

Conditions of stress affect our 'higher' brain functioning (*cortical; our ability to think*). When stress is overwhelming (i.e. traumatic) the impacts are especially severe.

'When we are calm it is easy to live in our cortex, using the highest capacities of our brains [to reflect] But if something...intrudes on our thoughts...we become more vigilant and concrete, shifting the balance of our brain activity to subcortical areas...' (Perry, 2006:49)

'As we move up the arousal continuum towards fear... we necessarily rely on lower and faster brain regions. In complete panic...our responses are reflexive and under virtually no conscious control.' (ibid)

Understanding the stress response

HYPER AROUSAL

- Increased heart rate
- Increased rate of breathing
- Blood flows from the arms and legs to organs and major muscle groups
- Tension in the person's muscles
- Hypervigilance i.e. being on guard (for threat)
- Problems with the digestive system
- Disturbance of sleep and energy levels

HYPO AROUSAL

- Having feeling of being 'shut down' or 'cut off'
- Avoidant – avoiding places, events, feelings
- Withdrawn
- Loss of humour, motivation, pleasure and connection with others
- Disturbance of sleep and energy levels

Tips to reduce distress

HYPER AROUSAL

- Recognise being hyper-aroused is a distress/fear response
- Validate their response ('I can see you are...')
- Support the person to feel safe
- Turn the person's focus to their current task/need
- Support gentle ways for the person to release some energy
- Help the person to feel grounded, and feel settled in their body (e.g. feet firmly on the floor; some stretches)

HYPO AROUSAL

- Recognise being hypo-aroused is a distress/fear response
- Support the person to feel safe
- Provide an opportunity for the person to express their current needs without pressuring them to do so
- Pay attention to the physical space (*more or less proximity to others?*)
- Help the person to become aware of their current surroundings and to tune into their senses
- Encourage the person to move a little, change their posture/position or practice a familiar ritual or rhythm. Emphasis should be on movement rather than sensation for hypoaroused states.
- Direct attention outward (e.g. noticing objects in the room) rather than inward.

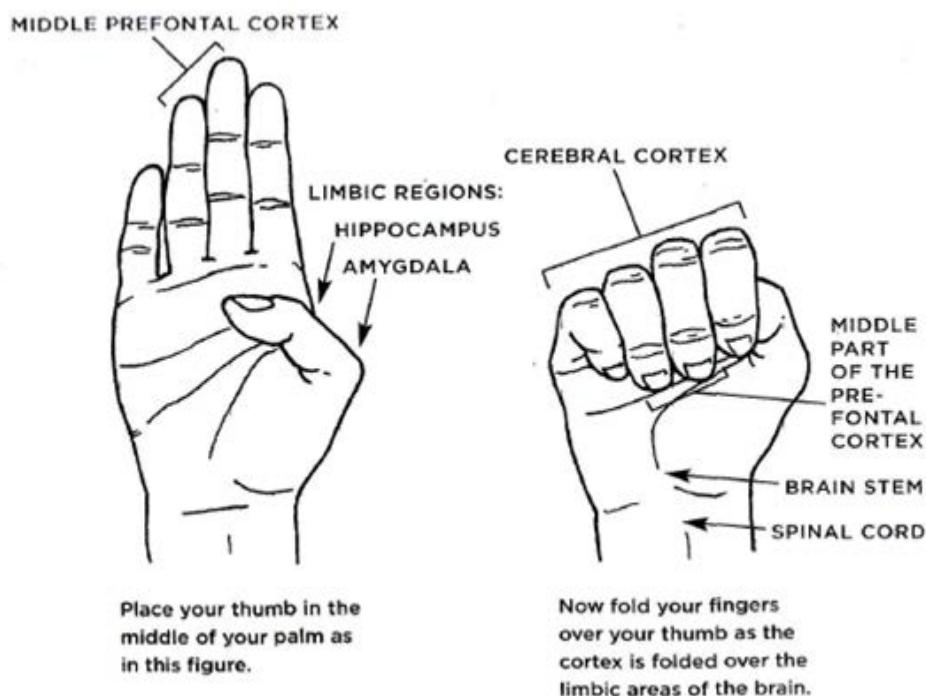
Hand model of the brain

(Daniel J. Siegel, 2009) You can watch a demonstration of the hand model on YouTube.
<https://www.youtube.com/watch?v=gmgCIJ74Oxw>

The 'hand model' of the brain is a simple and effective way of introducing the three basic areas of the brain (i.e. brain stem, limbic system and prefrontal cortex). It is also helpful to understand of what happens in and to the brain when a person is under stress. In the 'hand model', the different parts of a person's hand represent each of these three regions. Everyone's brain develops with the bottom region forming first and the top region, last.

Hold your hand upright with palm facing outward. The wrist represents the brain stem (the part which controls a person's level of arousal and which developed first). The palm with thumb folded over it represents the limbic system (the 'emotional' part of the brain which developed next). The fingers (folded down to cover the thumb and palm) represent the cortex or cognitive ('thinking/reflective') part of the brain which evolved last.

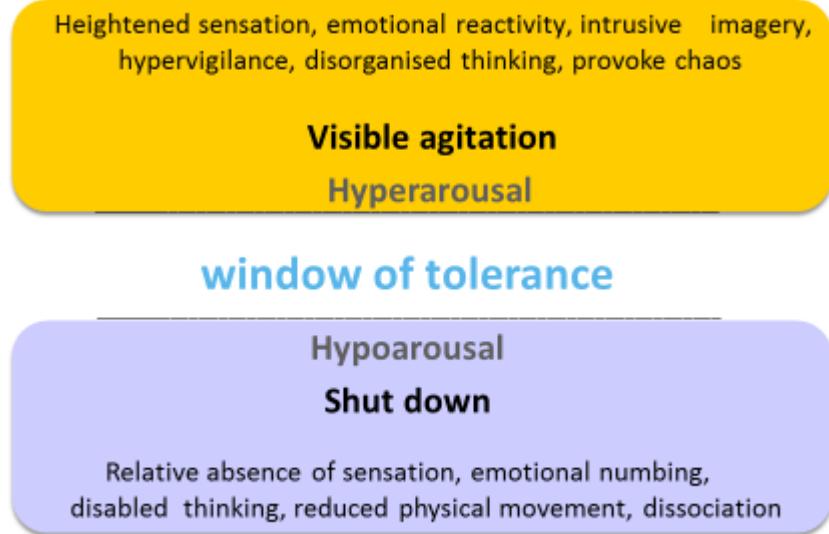
The simple shift of moving your fingers upright and away from your palm (so that your thumb and palm are exposed) represents how severe stress can cause us to 'flip our lid'. Stress activates our arousal ('survival') responses – represented by the upright wrist – and 'knocks out' our capacity to think and reflect:



The window of tolerance

The 'window of tolerance' is the state in which we can tolerate our feelings without becoming stressed, distressed, and overwhelmed.

We need to be in this state (also called the 'optimal arousal zone') to maintain our well-being. If we stray outside of this zone and become hyper- or hypo-aroused, we have exceeded our level of tolerance and need to return to the 'window of tolerance' state.



window of tolerance

Hypoarousal
Shut down

Relative absence of sensation, emotional numbing,
disabled thinking, reduced physical movement, dissociation

(Ogden, Minton and Pain, 2006:27)

5

We can monitor our own stress levels if we consider 'what part of the brain' we are in at any particular time.

*If we are distressed and/or fearful, we will be in the 'lower' (subcortical) part of the brain. We need to return to the 'higher' functioning part (cortical) to be calm and be able to respond flexibly. *See Tips to reduce distress.*

People who experience the impacts of interpersonal trauma can be easily 'triggered' by stress and can find themselves outside of the 'window of tolerance'.

By interacting in a trauma-informed way we can assist them – and ourselves - to stay within 'the window of tolerance'.

We also need to know how to assist people to **RETURN** to the 'window of tolerance' if they stray outside it (i.e. if they become either hyper- or hypo-aroused).

*See Tips to reduce distress and Hand Model of the brain.

Dimensions of safety: personal, interpersonal, environmental

DIFFERENT CONTEXTS OF SAFETY

People who experience the impacts of interpersonal trauma can feel unsafe:

- In their bodies (*unable to control/predict their thoughts and emotions*)
= INTRAPERSONAL safety
- In their interactions with others = INTERPERSONAL safety
- In their surroundings (*the present can trigger the past*) =
ENVIRONMENTAL safety
- In systems and institutions = SYSTEMIC safety

SUPPORTING PERSONAL SAFETY

Positive interactions help people who are traumatised AND increase a person's general well-being.

- *What do you do to feel safe within yourself?*
- *Is there anything I can do to help you feel safer right now?*

SUPPORTING ENVIRONMENTAL SAFETY

- Where would you like to sit/stand/walk?
Is there anywhere here that you think might feel safer?
- Is there anything about this place/room that concerns you?
Is there somewhere else you'd like to be right now?

SUPPORTING *INTERPERSONAL SAFETY*

Safe interactions have 'boundaries' which are:

- Negotiated by agreement with both parties where possible (*if you are initiating a conversation with someone you know or suspect experiences interpersonal trauma, seek and honour their preference for the time and location of the conversation if possible*)
- Reliable and predictable (but not rigid) where possible

QUESTIONS WHICH CAN INCREASE SENSE OF SAFETY:

- Do you feel I'm understanding what you're saying?
Can I check that I've understood you?
- Is there something particular you need from me right now?
How can I best support you right now?
- Is there anyone you would like me to contact or would like to be here right now?

PART 3: HAVING THE CONVERSATION/S

You are now aware of:

- trauma-informed principles
- the effects of stress on the brain and body
- basic ways to reduce stress
- the importance of the way in which interactions take place
- tips for addressing common questions around interactions with people who may experience trauma

This means you are ready for conversations with people you know or suspect may experience the impacts of interpersonal trauma who present to your service.

The context of any conversation is also important. It will be impacted, among other things, by your role, the nature of the services, needs of the client and your relationship with your client (or lack thereof). Attention to these variables will assist in making the conversation as effective and productive as possible.

A. For health professionals and health service providers

Interpersonal single incident and cumulative 'complex' trauma are both common; they also occur in many forms. They can have numerous adverse impacts on a person's health, especially when the trauma occurred in childhood and even when the original events occurred a long time ago. This means that large numbers of traumatised people access diverse health services and/or engage with health professionals in different ways.

'Health professionals' comprise a broad group of people with contrasting occupations, qualifications, and skill sets. Members of the general public often assume that people whose health has been damaged by trauma will contact health professional, who are qualified in this area and 'know about trauma'. This, however, is often not the case.

The reality is that many otherwise well qualified, experienced, committed, and competent health professionals are not 'trauma-informed'. The topic of trauma, especially complex trauma is still not specifically addressed in many relevant training curricula.

Research confirms that most people who access the mental health system have histories, rather than 'single incidents', of interpersonal trauma¹⁷⁶ (i.e. complex trauma with its '*far more complex array of medical and psychiatric conditions and impediments*' than those for PTSD alone).¹⁷⁷ Because complex trauma impacts *physical* as well as psychological functioning,¹⁷⁸ people with trauma also access health services other than those of mental health.

Because complex underlying trauma affects so many areas of functioning, and receives diverse diagnoses, health professionals - even when highly qualified and experienced – often do not identify that their clients may be experiencing its impacts.

If health professionals are not trauma-informed, and are not consistently aware of the possibility of underlying trauma, they will not detect or appropriately treat it. They are also unlikely to 'talk about trauma' in contexts where such conversations are necessary.

¹⁷⁶ 'It]he majority of people who seek treatment for trauma-related problems have histories of multiple traumas' (Bessel van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', ch.4 in Marion Solomon & Dan Siegel, ed. *Healing Trauma* (New York: Norton, 2003, p.172; emphasis added).

¹⁷⁷ And where the latter may be 'merely the tip of the iceberg' David Emerson & Elizabeth Hopper, PhD, *Overcoming Trauma through Yoga: Reclaiming Your Body* (Berkeley, CA: North Atlantic, 2011), p.4. As van der Kolk & McFarlane (1996:15-16) point out, 'the PTSD diagnosis does not begin to describe the complexity of how people react to overwhelming experiences...Focusing solely on PTSD to describe what victims suffer from does not do justice to the complexity of what actually ails them' (cited in Paul Frewin & Ruth Lanius, *Healing the Traumatized Self* (New York: Norton, 2015, p.239).

¹⁷⁸ See, for example, Victoria Banyard et al, ed. *Trauma and Physical Health* (London: Routledge, 2009) & Robin Karr-Morse, *Scared Sick* (New York: Basic Books, 2012).

Engaging with clients

If we have but one closing message...it would be that healing and recovery are possible.

(Frewen & Lanius, *Healing the Traumatized Self*, 2015, p. 318)

Health professionals of all types know it is important to relate positively to clients.

Part of any positive interaction is to convey the message that recovery is possible, and provide hope and optimism about the prospects for healing.

All health professionals should know and adhere to the trauma-informed principles in their daily practice. Yet the evidence shows that many health professionals have not fully implemented these principles as yet.¹⁷⁹

Research shows that health services do not routinely follow trauma-informed principles, and that clients have been re-traumatised by and within the health services to which they have turned for assistance:
'Trauma has often occurred in the service context itself'

(Jennings, 2004:6)

Traumatising interactions can occur within health services and involve both health professionals¹⁸⁰ and non-professional staff. Such interactions are not solely the product of 'systemic' failures.

When health professionals focus solely on clinical treatment, they sometimes do not relate to and engage with their clients holistically.

A key feature of trauma-informed practice is ***the way in which a service is offered rather than what it entails alone (i.e. the whole context of a service is important, outside of clinical treatment).*** This implies an expanded concept of what constitutes 'treatment'.

As healing from interpersonal trauma occurs in relationship, the wider relational context in which healing takes place is also important. It is vital to engage with the client in a trauma-informed manner in all respects of engagement, including its context.

¹⁷⁹ Recognition that '[t]rauma has often occurred in the service context itself' (Jennings, 2004:6) has been a major impetus for development of the paradigm of 'trauma informed practice. See Ann Jennings (2004) 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'. Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States, 2004. For a disturbing report on retraumatisation within Australian health services, see Jane Davidson, (1997) *Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions*. NSW Department for Women and the NSW Health Department.

¹⁸⁰ 'Many patients have been retraumatized by therapists who had inadequate understanding and skills to treat complex trauma-related problems...' (van der Hart et al, *The Haunted Self*, 2006, p.224)

Health professionals who do not value *the context* of formal treatment and *the way in which it is administered, including formal AND informal client engagement* – may provide a professional service which is not trauma-informed.

This is regardless of the other merits of the service: '*Without such a shift [towards trauma-informed practice] even the most 'evidence-based' treatment approaches may be compromised*' (Jennings, 2004).

Most health professionals and other health service personnel try to treat their clients in a manner which is respectful, courteous, and upholds their dignity. Yet the many demands of service delivery however can undermine this. *Civility and respect, important to us all are critical for those who experience the impacts of trauma*. These crucial values are more likely to be eroded when services themselves experience stress, which can include insufficient funding and challenging bureaucratic requirements.

When clients present with 'difficult' behaviours (as is common with unresolved trauma) a stressed health professional or staff member is more likely to regard the *client* as difficult, rather than the experiences and challenges with which they present.

We can all become tired and distracted. At times we can also feel overloaded. When either of these occur, however, we are less likely to connect well with our patients/clients.

It is important to always remember the importance of respectful interaction for good professional practice. Practitioner/client interactions are likely to be less than optimal if the context and way in which the service is offered are not perceived as equally important as the nature of the service.

For clients who struggle with the impacts of unresolved trauma, even seemingly minor interpersonal stressors experienced in an interaction with a health professional or other staff member can reinforce prior negative experiences of relationship and negatively impact the professional service they receive.

*The very act of seeking help can trigger a person who is traumatised.*¹⁸¹ This is because it can throw them back to times in which they felt threatened, vulnerable, unsafe and/or were betrayed. Many become highly sensitised to subtleties of verbal and non-verbal communication which may be perceived as invalidating. *Regardless of their role*, it is important for health service personnel to be mindful of this and to stay sensitive and attuned to their clients at all times.

¹⁸¹ Fallot, R. & Harris, M., 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol' (Washington, DC: Community Connections), 2009. Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems', ibid, Sandra Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: OUP, 2011).

Some clients will withdraw from a service if they feel the practitioner or other staff member is distracted or dismissive. A non-trauma informed response might wrongly regard this client response as 'non-compliance' or 'resistance'.

It is important to attune to *the way you engage with your clients*. Health professionals and other health service personnel also need to attune to their own well-being ('first fit your own oxygen mask').

It is not possible for a health practitioner or worker who is struggling with their own well-being to consistently engage empathically with clients with difficult behaviours related to trauma ('Your own awareness, conduct and self-care has major implications for your interactions with clients' Bloom, 2006:2)

The wider service culture and policies need to become trauma-informed as well, to benefit clients and staff alike.

Trauma-informed principles such as 'collaboration' and 'empowerment' are not simply aspirational values. They need to be *actively embedded within health service culture to include ALL the ways in which ALL personnel engage with and respond to clients*.

Doing so requires practitioner and staff *self-care*. This should be enabled by the health services themselves. Implementing trauma-informed practice will facilitate and assist its quality assurance.¹⁸² The benefits of starting the journey are wide-ranging. For example, the reality of 'vicarious trauma'¹⁸³ alerts us to the stresses *for service providers*, including managers, staff and volunteers who work with distressed people.

¹⁸² See the second set of *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (2012) <http://www.blueknot.org.au/guidelines>

¹⁸³ Vicarious trauma is defined as '*the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them*' (Pearlman, & Caringi, 'Living and Working Self-Reflectively to Address Vicarious Trauma', ch.10 in Courtois & Ford, ed., *Treating Complex Traumatic Stress Disorders* (New York: The Guilford Press, 2009), pp.202-203.

**ALL HEALTH PROFESSIONALS AND SERVICE PERSONNEL* SHOULD BE
TRAUMA-INFORMED BECAUSE:**

* i.e. irrespective of occupation, skill base, place of work and level of experience.

- 'Treatment' does not relate solely to formal clinical modalities and practice. It also relates to *the way in which* health professionals and other personnel engage with *clients* and *the context in which clients access health services*.
- Positive experiences of relationship – which include *positive experiences of health service delivery* – assist general health and well-being as well as trauma recovery.
- For the many clients who struggle with the impacts of unresolved trauma, even seemingly minor interpersonal stressors experienced in interactions with a health professional or staff member can reinforce prior negative relational experiences and impede the effectiveness of the service.
- Retraumatisation of patients/clients is likely if trauma-informed principles are not implemented ('[t]rauma has often occurred in the service context itself'; Jennings, 2004, ibid: p.6).
- If the *way* the professional or staff member engages with the client, and the *context, both formal and informal* – *in which* they provide the service is not trauma-informed, neither the service nor the service provider is trauma-informed (and '*even the most 'evidence-based' treatment approaches may be compromised*'; Jennings, 2004).

***PRINCIPLES OF TRAUMA INFORMED-ENGAGEMENT: RECOMMENDATIONS FOR ALL
HEALTH SERVICE PERSONNEL***

Trauma-informed engagement:

- Applies to all mental and physical health professionals (from counsellors, social workers, psychologists and psychiatrists to remedial massage therapists and physiotherapists) as well as to all health service personnel
- Seeks to not compound existing problems and 'do no harm'
- Concerns *the way in which* interactions take place (i.e. the 'how' of engaging; not just 'what' the service is)
- Ensures the service is provided in a *safe physical and emotional context*
- Recognises the high prevalence of unresolved trauma, the impacts of stress on the brain and body, the relationship between 'symptoms' and coping strategies, and the potential for 'triggering'
- Minimises the potential for client destabilisation by embedding the principles of *safety, trustworthiness, choice, collaboration & empowerment* into all interactions

Tips for applying:

- Attune to both verbal & non-verbal communication
- Attune to client comfort levels
- Honour client preferences where possible
- Discreetly monitor stress levels and help return to the 'window of tolerance' if necessary (see above) *Note that if this 'optimal arousal zone' is exceeded – e.g. if the client becomes either visibly agitated or 'spaced out' and 'shut down' – the therapeutic potential of the service will be lost*

At all times:

- Client behaviour should be regarded as *adaptive attempts to cope* with life experiences (i.e. what *has happened* to the person rather than what is 'wrong' with the person)
- Interaction and intervention should be respectful, empathic and non-escalating (*fosters client confidence, resourcing and skill-building*)
- Clients should remain within, and be assisted to return to, the 'optimal arousal zone' in which they can tolerate feeling if they need to (i.e. 'window of tolerance')
If a client exceeds their stress tolerance, the interaction/service will stop being therapeutic and could be re-traumatising
- It is important to convey optimism – both directly and indirectly – about the possibility of recovery to clients/patients

Sample conversations

Daily health service delivery – of whatever type – presents multiple opportunities to 'talk about trauma' with clients who may need support but who do not disclose their trauma because doing so does not feel safe. Such opportunities are often overlooked by staff who tend to 'leave it to clinicians' and who are unsure of how to engage around what is regarded as a 'difficult' topic. The following are illustrations of how such conversations might be conducted.

IMPORTANT NOTE

The following illustrations relate to situations in which it is either known or suspected* that a person may experience** interpersonal trauma

*While 'knowing' and 'suspecting' are different, the challenge of 'knowing' (i.e. due to the dynamics of trauma in relationships e.g. secrecy, power imbalances, what counts as evidence, and the dynamics of memory) means that the issues involved in conversations and interactions are similar

**'May experience' applies to both prior and ongoing interpersonal trauma, both of which can cause concern. The sample conversations below relate to both contexts.

SAMPLE CONVERSATION 1:

A client is initially chatty and seems relaxed when she arrives in reception for her appointment. As she conveys basic personal information she seems to become fearful for no apparent reason.

Client (hesitating) 'I'm sorry – what did you say?'

Staff member: 'I was just asking for your address for our records'.

Client: 'Um – yes. I'm not sure. I'm not sure that I...'

Staff member: 'It's our standard procedure. Your details will be confidential'.

Client: 'Yes but – I don't know if I can – Is it really necessary? Actually I really don't think I have time for the appointment today'.

Staff member: 'I can see you are a little uneasy. Why don't we sit down over there (points to a quiet corner of the waiting room) have a drink of water, and just take a moment?'

A staff member who is concerned about the client's sudden change of demeanour – but who isn't confident or doesn't know how to act on that concern – might be tempted simply to agree that the client should come back another day. Basic trauma awareness, however, alerts us to the possibility of trauma, and opportunities to safely engage the client about whether concern about trauma is warranted. Also see 'Tips to reduce distress' in Part 2, 'What If?' in Part 4, and 'Referral Services and Contacts' in Part 4.

SAMPLE CONVERSATION 2:

At his second physio appointment, a client suddenly becomes teary before immediately apologising for his 'over-reaction'.

Client: 'Sorry mate. I don't know where that came from. Probably just need some time off work but it's hard to arrange that right now'.

Physio: 'Sign of the times! But sometimes we can also be dealing with life stuff and work stress is not the whole story'.

Client: 'Oh I'll be ok'.

Physio: 'Are you sure there's not something you might need to talk about? Because sometimes we can minimise what's really going on for us. It's not a sign of weakness to talk about it; we all need support. Is there someone you can talk to if you need to?'

As a physical, rather than psychological, practitioner, physiotherapists and other physical health personnel are primarily focused on the body. But mind and body are intimately connected. Irrespective of their qualification and skill base (or lack thereof) diverse health service personnel and providers do not need to be psychologists or counsellors to express concern for the emotional well-being of their clients.

Once again, basic grounding in trauma-informed principles will help all such personnel to 'talk about trauma' in circumstances in which it may be warranted, and to engage in conversations which are needed.

B. For all service providers

'I work in reception at an employment agency and some of our clients get really stressed'.

(Rebecca, 25)

'As the manager of a catering firm, I need my staff to be on top of things and to engage well with clients. Stress comes with the territory but the stress levels of some people are off the chart. Dealing with staff challenges is one of the most difficult parts of my job'.

(Rick, 37)

'I'm a first responder and while I'm very experienced, direct contact with distressed people takes its toll. I haven't slept well in years'

(Steve, 48)

Interpersonal trauma is common. Those who have experienced it in childhood often experience multiple adverse impacts across diverse areas of functioning.

People who have experienced interpersonal traumas access many different types of services, all of which need to become trauma-informed.

Introducing and implementing trauma-informed practice across *the full spectrum of human services* may seem a 'tall order'. But while comprehensive change takes time, *there are also immediate measures we can take*.

As in the health sector, the benefits of starting the journey are wide-ranging. *Service providers*, including managers, staff and volunteers experience stress as well as their clients, and trauma-informed conversations and interactions can mitigate the risk that stress may intensify.

Trauma-informed engagement is protective not only for traumatised people. It is also protective for the diverse service-providers and personnel with whom they come into contact.

The prevalence of interpersonal trauma also means that many people *employed by* and *within* a wide range of diverse services have experienced their own trauma.

i.e. *it is not only 'clients' who may have trauma histories but some of the staff who provide services as well.*

This underlines the importance of all workplaces becoming trauma-informed.

Comprehensive trauma-informed practice has widespread benefits across all services because ***trauma-informed practice assists well-being even in the absence of trauma.***

As well as fostering the neural connections which trauma disrupts, positive experiences of relationships reduce stress and enhance general health.

Engaging in a trauma-informed way in *all* our interactions – *i.e. regardless of whether the people with whom we engage have a known trauma history* – assists overall health and well-being.

EXAMPLES OF SERVICES AND WORKPLACES WHICH NEED TO BE TRAUMA-INFORMED:

- *government departments*
- *non-government organisations*
- *small business*
- *policing and criminal justice*
- *education*
- *hospitality* *i.e. ALL services; society-wide*

A TRAUMA-INFORMED SERVICE:

- Commits to the core principles of **safety, trustworthiness, choice, collaboration, empowerment** (Fallot & Harris, 2009:3).
- Recognises that experience of relationships and environment (both positive and negative) **affects brain structure, functioning and well-being**.
- Fosters positive relational experiences – **including experience of services** – to assist the connection ('integration') of neural pathways.
- Acts on the knowledge that integration is the hallmark of well-being, as well as necessary for the healing of trauma.

TRAUMA-INFORMED SERVICES ARE A 'WIN WIN' FOR ALL PARTIES

- *Stress experienced by staff negatively impacts clients*
- *Staff sensitivities can be ignited in interactions with clients (particularly if staff have their own trauma histories)*
- *'a program cannot be safe for clients unless it is simultaneously safe for staff and administrators'* (Bloom, 2006:2)

RELATING IN A TRAUMA-INFORMED WAY MEANS:

engaging and interacting with all clients, regardless of the service type - according to the core trauma-informed principles:

SAFETY, TRUSTWORTHINESS, CHOICE, COLLABORATION, EMPOWERMENT

Both simple and challenging

The trauma-informed way of relating is consistent with how most of us *already* believe we interact with others. In this way it is a simple extension of our preferred way of conducting ourselves.

Many services and workplaces, however, are not conducive to consistently implementing such principles. Some workplaces actually work against them.

Many services and workplaces have constraints of time, budget, and staff levels.

Unfortunately, such challenges can negatively impact interactions with clients even when the service is met.

Recall the trauma-informed principle that *the way in which* a service is provided – i.e. not just *what* the service is – is important.

Also recall that a safe and collaborative *manner* and *context* of service delivery is not an optional or incidental extra if the service is to be trauma-informed.

Both dimensions need to be operative.

The greater the pressure and constraints on staff (i.e. despite best intentions and even if the constraints are unavoidable) the greater the likelihood that trauma-informed engagement and communication will be compromised.

The result is increased stress levels for all parties.

All of us can find stress debilitating. *But for people with unresolved trauma histories,* additional stress can be incapacitating and re-traumatising.

Basic trauma awareness (i.e. being trauma-informed) means being aware that people who experience interpersonal trauma can be vulnerable to seemingly minor 'triggers'.

Minimising stressful communication and interactions, when using a trauma-informed approach, benefits both clients and staff.

It can also *prevent* minor tensions which can accumulate over time and become overwhelming.

Stress breeds stress and trauma-informed services and workplaces are a key part of the antidote.

Service diversity

Trauma-informed principles need to be adapted to the context/s of *diverse services and workplaces*.

The situation of a first responder to crisis is very different from that of the catering manager which is in turn different from that of the receptionist in an employment agency.

The context of, for example, a black letter law practice or the stock exchange will be very different from that of a not-for-profit, small business, or sole provider.

Some services and workplaces are competitive, territorial and even adversarial.

Service commonality

All services and workplaces engage with people in different ways and in different capacities. As interpersonal trauma is so prevalent, all workplaces engage, knowingly or unknowingly, with people who experience the impacts of complex trauma.

Because stress is increasingly a feature of *all* workplaces, both clients AND staff of diverse services can benefit from trauma- informed practice.

Sample conversations

A situation which commonly arises in the daily course of provision of diverse services is the client who is 'difficult' deal with. This could manifest in a number of ways, including irritability, withdrawal, and high sensitivity to minor stressors ('triggers'). The ensuing conversation could also evolve in a number of ways (or even break down completely).

Whether or not the client has experienced prior trauma, applying trauma-informed principles will help reduce arousal (and the likelihood of retraumatisation if prior trauma exists).

The first conversation contrasts two different responses to the same client by a staff member at reception (i.e. a context which is similar across a wide range of services). The client may appear vague and unco-operative, but may well be experiencing the impacts of trauma. The first response is NOT trauma – informed and the second IS. Note the contrast between application of trauma-informed principles in conversation and failure to implement them for the client and also the worker.

The second conversation illustrates how concern for the well-being of a client might be communicated by the service-provider with whom they are interacting.

CONVERSATION 1

(interaction with a client at reception; applicable to a wide range of services)

(*NON-TRAUMA INFORMED)

Client (*looking flustered and unhappy as they approach reception*): 'I have an appointment at 2.00 pm'.

Staff member (*sitting at a keyboard and just off the phone*): 'Your name?'

Client: [says their name]

Staff member: 'Who is your appointment with?'

Client: 'Um – I'm not really sure. Am I meant to know that? I may have been told when I made the appointment but I can't remember'.

Staff member (*somewhat impatiently*): 'You would have been told. Try to think. It makes it difficult for everybody if you don't know the name of the person you've come to see'.

Client (*increasingly flustered and visibly upset*): 'I don't think I can – Isn't it in your appointment book? I really don't know. Maybe I should come back another time'.

Staff member (*not exactly rudely but with an edge of dismissiveness*): 'Why don't you take a seat over there and I'll try to sort it out'.

The above conversation – replicated countless times daily across a wide range of services – may seem innocuous. But if the client's 'vagueness' is trauma-related (i.e. they may have difficulty with memory and focusing) the response of the person at reception could be experienced as shaming, invalidating and infantilizing. Contrast it with this trauma-informed response to the same client in the same situation:

(*TRAUMA-INFORMED)

(i.e. the same interaction from a trauma-informed perspective)

Client (*looking flustered and unhappy as s/he approaches reception*): 'I have an appointment at 2.00 pm'.

Staff member (*sitting at a keyboard and just off the phone*): 'Welcome. Can I have your name?'

Client: [says their name]

Staff member: 'Do you know the name of the person your appointment is with?'

Client: 'Um – I'm not really sure. Am I meant to know that? I may have been told when I made the appointment but I can't remember'.

Staff member (*warmly and reassuringly*): 'You probably would have been but we can all forget names. Do you need a moment to think about it?'

Client (*arousal level decreases as tries to focus on remembering*): 'I don't think I can – Isn't it in your appointment book? I really don't know. Maybe I should come back another time'.

Staff member (*again warmly and reassuringly*): 'No that's fine. The appointment will be listed in the book and I'll be able to find out who you'll be seeing and where you need to go. Do you want to take a seat over there? Help yourself to water if you'd like to, and the bathroom is just to your left. Let me know if you need anything; the wait shouldn't be long.'

Note how, in contrast to the *non-trauma informed* response, the above response is soothing, normalising, and validating. As such, it is likely to be reassuring for the flustered client and will help lower their arousal level. It is also likely to smooth the interaction for the staff member, who may also be stressed and who can avoid 'buying into' (and potentially escalating) their own stress level as well as that of the client.

CONVERSATION 2:

(expressing concern about the well-being of a client who appears stressed and who may experience the impacts of trauma)

Stella, a 44 year-old café manager, is concerned about a client who was a regular who loved to chat, but who now stops to buy coffee less frequently and who increasingly looks exhausted and sad. While gaining the sense that the client may have problems at home, Stella's first thought is that she doesn't want to intrude, that it is 'none of her business', and that the client may not welcome her overtures. Aware, however, of the prevalence of trauma and family violence, she decides to initiate a conversation with the client to express her concerns.

Stella: 'I thought you might have given up coffee! Either that or my standards are slipping. You haven't stopped by for a couple of weeks'.

Client: (*uncomfortably*) 'Oh, has it been that long? The days seem to fly by so quickly'.

Stella: 'I can't argue with that! But you used to be a regular. And often you'd drink it here rather than ordering it to go. Can you do that today? We could sit down for a few minutes and have a chat'.

Client: 'Well, I don't know...'.

Stella: 'It wouldn't take long. See it's ready already!'

[With some hesitation, the client agrees to sit down with her coffee at one of the tables and allows Stella to join her].

Stella (*knowing they have little time and needing to 'cut to the chase'*): 'We've spoken several times in the past but I realise I don't know your name'.

Client: 'It's Fiona'.

Stella: 'Nice to formally meet you, Fiona! I enjoyed chatting with you when you used to come by more frequently. I hope you don't mind me asking, but is everything ok?'

Client: (*immediately*) 'What makes you say that? Everything's fine'.

Stella: 'Oh just that you haven't been in for a while and you look a little run down. Are you sure you're ok? Sometimes it can be hard to cope with things and we need a little extra support. I was just wanting to check that all is ok with you and that you have the right support if there's something you're struggling with'.

Client: (*becoming teary*) 'That's nice of you. Actually I am dealing with quite a lot at the moment. I do have a lot on my mind right now...'

Note how 'the ice is broken' by Stella's empathic inquiry. Her normalising choice of language ('*Sometimes it can be hard to cope with things and we need a little extra support...*') is also likely to reassure the client by not putting her 'on the spot'.

Also note Stella's gentle follow up question ('*Are you sure you're okay?*'). This provides the client with an opportunity to revise her initial defensive reaction ('*What makes you say that? Everything's fine*'). When asked how we are by others – including and especially when we are not feeling good – our first response can be automatic and should not necessarily be taken at face value. Respectfully 'asking a second time' allows the opportunity for the person to reconsider their initial response, and – as in this case, to potentially revise it.

In the context of service delivery – *irrespective of the nature of the service* – initiating and responding to conversations with clients (and/or co-workers) about whose well-being we are concerned is relatively straightforward when resting on foundational knowledge about trauma and based on trauma-informed principles (as outlined in Part 2; also see '*What If?*' in Part 4). *All personnel of all types of service-delivery need to become comfortable to conduct and respond to such conversations.*

Individual and systemic

Regardless of the nature of the service, introducing and implementing trauma-informed principles needs to occur both *individual* and *organisational/systemic* levels. Personnel/employees need to be supported in trauma-informed practice by service *policies, cultures and systems*.

The *organisational, systemic, and structural* changes diverse services and settings need to make to become trauma informed ('bottom up' and 'top down') require major changes to existing ways of operating:

'Changes to a trauma-informed organizational service system environment will be experienced by all involved as a profound cultural shift in which [clients] and their...behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently'.¹⁸⁴

The systemic changes needed can be gradual and step-wise as the process is complex. Services are advised to consult and obtain support regarding the various steps and levels the process involves.¹⁸⁵

Yet many aspects of trauma-informed interactions with clients can occur immediately. (see 'Small changes can make a big difference' below).

Key questions to consider

How might an experience of trauma:

- (1) affect client attitudes to, and interactions with, *your organisation's services*?
- (2) affect a client's attitudes to, and interactions with, *you as a worker in your role*?
- (3) the ways in which *you interact with, and respond to, clients*?

- What does ***your organisation*** need to do to improve its interactions with, and service delivery to, clients?
- What do ***you*** need to do to improve your interactions with, and service delivery to, clients?

Key point to recall:

Positive relational experiences promote well-being; they not only make interaction more pleasant but actively assist healing.

Trauma-informed relating – *and organisation of diverse human services to promote this at individual, policy, systems and cultural levels* - is 'win-win' for everyone.

¹⁸⁴ Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma Specific Services', p.15.

¹⁸⁵ Blue Knot Foundation offers trainings and consultancies in this area.

Trauma sensitivity is 'win-win'!

- Goal is 'sensitization to trauma-related dynamics and avoidance of re-traumatization' (Fallot & Harris, 2009:16).
- Staff well-being – which involves both *self-care* and *organisational support* – is an indicator of *client* well-being:

'[I]t is] the shared responsibility of staff and administrators to become 'trauma sensitive' to the ways in which past and present overwhelming experiences impact individual performance, leadership style, and group performance' (Bloom, 2006:2).

Small changes can make a big difference

- The capacity of positive interactions to be *soothing and validating* – even in competitive work cultures and in the most routine aspects of relating – should not be underestimated.
- This applies to all of us, and *especially to those with trauma histories*.

Think of a challenging interaction you have experienced with a client

- How does regarding the prior experience of the client as 'difficult' (rather than the client) alter your reading of the interaction?
- How might you handle such an interaction differently in light of a trauma-informed perspective?

Tips for conversations (Summary)

GUIDING PRINCIPLES:

Safety Trustworthiness Choice Collaboration Empowerment

- **Safety first'** This is the most important point to remember and follow, and also the foundational principle of being trauma-informed
- '**Safety' applies to: physical, geographical space** (e.g. the building and room; the 'place' in which you are speaking)
AND
emotional space i.e. atmosphere and comfort levels, your own and those of the person to whom you are speaking
- Consider the nature of your relationship to the person you are concerned about and its possible implications for your conversation

How might the nature of your relationship affect:

- a) *their perceived and actual physical and emotional safety?*
 - b) *your sense of safety in speaking with them?*
 - c) *your and their comfort levels?*
- Ask yourself 'How, in light of my relationship, or lack of relationship, with this person can I apply the core trauma-informed principles? What steps can I take to help the conversation go well?'

NB: An effective conversation depends on both the physical and emotional safety of the way in which it is conducted and the context in which it takes place.

- 'Choose your moment' if you are initiating the contact
- Honour the person's preferences regarding the time, location for the conversation etc. if you can
- Your approach and style should be empathic at all times
- Attune into their verbal and non-verbal communication
- Consider what may *have happened to* the person rather than what is 'wrong' with them
- Recognise that a person's 'problematic' behaviours and responses may be their attempts to protect themselves and to cope with stress
- Listen to and validate the person (don't 'talk over' them or contradict them)
- Recognise the signs of stress (which may take the form of visible agitation, such as accelerated pace, raised voice OR silence, glazed expression and 'shut down'). Gently help them return to the window of tolerance if their stress levels become high

-
- If the person initially says they are 'okay' but you are still concerned, you can gently ask a second time as the first response may be automatic. Do not persist if the person is reluctant or insistent
 - Don't give advice unless you are asked for it (e.g. avoid saying '*Have you tried...?*')
 - Inquire about who the person might contact for support. Provide contact numbers for any relevant services or where to find them if necessary (See the Referral Services and Contacts)
 - Ensure the person does not leave the conversation in a distressed state

Remember that *the way in which* you interact with the person (and not just *what* you say/do) is important for their safety. Being able to recognise the signs of stress and being able to help them with lowering their arousal if you need to (see 'Understanding the stress response' and 'Tips to reduce distress') builds confidence and is mutually protective).

PART 4: SUPPORTING CONVERSATIONS AND SCREENING

Screening (questions to consider; includes guide, sample and tools)

Why screen universally for trauma in...health services? Exposure to trauma is common. In many surveys, more than half of respondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders.

Trauma-Informed Care in Behavioral Health¹⁸⁶ Services
NCBI Bookshelf www.ncbi.nlm.nih.gov/books/NBK207188/

[F]or the most part, the issue of trauma is simply screened out organizationally and systemically'.

Bloom & Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (NY: OUP, 2011), p.224

The high prevalence and adverse health impacts of unresolved 'complex' trauma in the general population provides sufficient grounds for the introduction of routine universal trauma screening into and across all health settings, services and facilities. This is because the prevalence and debilitating psychological, physical, social, and financial¹⁸⁷ costs of unresolved trauma to those directly affected and to society as a whole are enormous. While screening within health services should be universal, the choice of screening tool however will be determined by the context of the health service.

It needs to be noted that trauma screening is also applicable to some *non-health* services, depending on context. The decision of whether to screen at all within *non-health* services will be particular to each service context. So, too, will the choice of screening tool if it is decided to introduce screening within a specific service context. Given the variations in services, it is beyond the scope of this document to address trauma screening in diverse services. Nevertheless, some general principles presented in this section in relation to health services will be instructive.

While the quotations at the beginning of this section relate to the United States, trauma screening does not occur commonly within Australian health services including in contexts such as psychiatric facilities, in which one might expect it.

A recent Melbourne study found that the majority of patients admitted to a psychiatric ward are not asked whether they have experienced trauma, and that only 3% of patients had a specific description of their trauma recorded in their file.¹⁸⁸ Yet when patients were asked about prior trauma, 83% reported abuse trauma relative to only 17% who did not.¹⁸⁹

¹⁸⁶ The above quote (cited from a US publication on which the current document draws references 'behavioral' health services (i.e. the nomenclature favoured in the discourse of health policy in the United States). The points made in relation to trauma and trauma-informed practice, however, are applicable to the Australian context. Despite substantial differences between the two countries in the landscape of health service delivery there is considerable overlap between the two contexts in terms of the prevalence of trauma and the lack of priority accorded to it.

¹⁸⁷ See, for example, *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia: an economic report for Adults Surviving Child Abuse 2015*.

¹⁸⁸ 'Trauma histories go unrecorded' *Psychiatric Update* (19 February 2016) <http://www.6minutes.com.au/psychiatryupdate/latest-news/trauma-histories-go-unrecorded>

¹⁸⁹ 'Trauma histories go unrecorded', ibid.

The fact that trauma screening is *not common* in health settings - let alone routine - also highlights the *disincentives* for its widespread introduction. These *disincentives need to be carefully addressed for trauma screening to be effective and widespread*. The claim of the second of the above quotes i.e. that trauma may be actively screened *out* raises important questions.

The Melbourne study suggests possible reasons why trauma screening is not common practice:

Mental health clinicians avoided screening for trauma '*because they don't feel competent to do so, or they feel unable to follow up with appropriate management if they uncover a history of trauma, leading to avoidance of the whole issue*'.

'Trauma histories go unrecorded'

<http://www.6minutes.com.au/psychiatryupdate/latest-news/trauma-histories-go-unrecorded>

This study also underlines that not 'screening for trauma' is problematic, despite legitimate reasons for not screening.¹⁹⁰

¹⁹⁰ 'There is a need for clinician retraining, a trauma-informed care model, and the incorporation of mandatory inquiry in best practice guidelines to generate a shift in culture in the delivery of mental health care services', 'Trauma histories go unrecorded', ibid.

Addressing the disincentives: for 'screening for trauma' in health settings

'It is not necessarily easy or obvious to identify an individual who has survived trauma without screening... The two main barriers to the evaluation of trauma and its related disorders in...health settings are clients not reporting trauma and providers overlooking trauma and its effects. (NCBI Bookshelf; ibid, 8/17).

We need to first identify the reasons that trauma is 'overlooked' by health professionals and services more broadly. These range from a subconscious need to avoid confronting the unpalatable, to an individual or collective concern about the capacity to appropriately address any trauma revealed.

Disincentives to screen for trauma: health professionals and services

The following chart details some of the common grounds why health professionals and services may not screen for trauma:

WHY HEALTH PROFESSIONALS/SERVICES MAY NOT SCREEN FOR TRAUMA:

- *They underestimate the impact of trauma on physical and mental health*
- *Relevant questions are not part of the standard intake procedure*
- *They lack knowledge about how to respond to any information received*
- *They are concerned that clients/patients may be upset*
- *They believe that treatment should focus solely on presenting symptoms rather than their possible origin*
- *They are concerned that a treatment may be required which they can't provide*
- *They believe that any substance abuse issues should be treated prior to the treatment of other issues*
- *There is not enough time to assess and explore trauma histories or symptoms.*
- *Practitioners, other staff members, and administrators may have their own untreated trauma-related symptoms*

(Points drawn from 'Screening and Assessment – Trauma-Informed Care in Behavioural Health Services', NCBI Bookshelf, 9/17)

Disincentives to screen for trauma: clients

'[S]ome clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the occurrence of traumatic events' (NCBI Bookshelf; ibid, 8/17).

Clients are understandably reluctant to disclose prior traumatic experience given the risks, stakes, and potential consequences of disclosure.¹⁹¹ Such reluctance is self-protective. Reasons for not disclosing range from fear of retribution by perpetrators to the possibility of unempathic responses and not being believed.

Some people may not regard their prior overwhelming experience/s as traumatic. Others may not consciously recall it/them or are unable to verbalise it/them. Traumatic memory is very different to conscious 'autobiographical' memory.¹⁹² Additionally, if the trauma was experienced in early childhood it may be pre-verbal, which explains the subsequent difficulty in expressing it in words.

It makes sense that many people are not motivated to disclose or are ambivalent to do so, even when they are fully aware of their trauma and could articulate it in words.

It is important to work with this reality in the appropriate trauma-informed manner, rather than rationalising the reasons for not screening for trauma.

Foundational knowledge for being trauma-informed – and specifically around the 'dynamics of disclosure' – provides the basis for safe and effective trauma screening.

The following chart details some of the common reasons why client/s are reluctant and/or unable to disclose their trauma to health personnel:

¹⁹¹ For elucidation of the 'politics' of disclosure of childhood trauma in general and childhood sexual abuse in particular, see Freyd & Birrell, *Blind to Betrayal* (NJ: John Wiley & Sons, 2013), pp.122-129.

¹⁹² See, for example, Peter Levine, PhD *Trauma and Memory: Brain and Body in a Search for the Living Past* (Berkeley, CA: North Atlantic Books, 2015).

WHY CLIENTS MAY NOT DISCLOSE THEIR PRIOR TRAUMA TO HEALTH PERSONNEL/SERVICES

- ***They fear for their emotional and/or physical safety, either immediate and/or subsequent.***
- ***They may not trust the person/service or fear that they will be judged.*** People who have experienced complex interpersonal trauma often struggle to trust. Health personnel and services often do not understand this or underestimate it. If clients have only just met the person and may not see them again, they may be less inclined to disclose to them
- ***They may be feeling distressed and ashamed***
- ***The client may not view their experience as traumatic*** (i.e. client does not identify with the word/s 'trauma' and/or 'abuse')
- ***The client might not consciously recall*** the trauma (*the nature of traumatic memory is distinct from conscious, 'autobiographical' memory; see Levine, 2015, ibid*)
- ***The client might respond to any inquiry about their trauma by 'spacing out', 'glazing over' or 'shutting down'*** (i.e. trauma may trigger hypo arousal (dissociation) preventing the person from focusing sufficiently to respond)
- ***'Loyalty to the perpetrator/s'***
Though counterintuitive to many, some people have mixed feelings towards or even idealise their perpetrator/s. This happens especially in care-giving or romantic relationship/s in which there are unequal power dynamics (Freyd & Birrell, 2013). Childhood trauma affects strong attachment dynamics, especially if the perpetrator is a parent or primary caregiver

The combination of reasons for health professionals/other service personnel and clients to be reluctant to screen for trauma might suggest that the exercise is misguided.

In fact, identification of these reasons informs criteria for safe and effective trauma screening.

Meeting the obstacles: towards effective trauma screening

'[H]ow screening is conducted can be as important as the actual information gathered'.

Trauma-Informed Care in Behavioral Health Services (NCBI Bookshelf 2/17)

A grounding in the principles of a trauma-informed approach immediately resolves many of the pitfalls of screening for trauma.

We need to pay attention to the 'how' as well as the 'what' (i.e. to *the way in* which screening is administered, not just the content of the screening tool). We also need to attune to what *has happened to* the person rather than what is 'wrong' with the person, and to the *emotional as well as physical safety* of the client at all times.

When we actively embed the core principles of safety, trustworthiness, choice, collaboration and empowerment into all aspects of the screening process we safeguard the client. This lowers the client's arousal levels, and minimises the potential for stress, 'triggering' and retraumatisation.

This also makes the exercise less problematic for everyone.

Who would administer screening?

'Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process...Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them'.

NCBI Bookshelf, 3/17

Basic trauma screening is about *detecting the existence of* prior trauma, not treating it. Any screening tool needs to be carefully designed and relatively straightforward to administer.

The administration of trauma screening should not need specialist knowledge. But it does require:

- 'trauma awareness' (i.e. being trauma-informed)
- grounding in the core trauma-informed principles
- an ability to recognise signs of stress
- a basic capacity to assist with lowering of arousal if necessary

All staff – irrespective of their position, seniority, skill base, and level of experience – should be fully trauma-informed.

This requires basic training in the implementation of trauma-informed practice and the individual and collective capacity to maintain it:

'[A]ll individuals who administer screenings, regardless of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained'.

NCBI Bookshelf 15/17 www.ncbi.nlm.nih.gov/books/NBK207188/

The core trauma-informed principles are simple. But service cultures need to be attentive to embed them *at all levels* of service delivery (i.e. formal and informal, 'bottom up and top down').

Staff who administer trauma screening need to have the requisite foundational knowledge and be alert to *their manner of engagement* with clients.

Adhering to the following recommendations will assist the introduction and administration of trauma screening in health service settings.

GUIDING AND NON-NEGOTIABLE PRINCIPLE:

Physical and emotional safety must be prioritised in all aspects of the process of trauma screening.

SENSITISING TO SCREENING: GUIDE TO TRAUMA SCREENING IN HEALTH SERVICE SETTINGS

- **Embed the core trauma-informed principles of safety, trustworthiness, choice, collaboration and empowerment into all aspects of the process**
- **Ensure the emotional and physical safety of the context in which the screening will occur (e.g. expecting that clients will simply complete a form on arrival and at reception is not trauma-informed)**
- **Basic screening is for prior/current traumatic experience (as distinct from trauma-related 'symptoms')**
'If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present' (NCBI Bookshelf 2/17)
- **Method/format of screening may vary**
(e.g. self-inventory checklist, questionnaire, interview and/or a combination of modes according to service, policy, and other factors) (*'Initial information should be gathered in a way that is minimally intrusive yet clear. Brief questionnaires can be less threatening to clients than face-to-face interviews, but interviews should be an integral part of any screening and assessment process'* (NCBI Bookshelf 14/17) & see 'What Kind of Screening Tool?' below)
- **Inquire ABOUT not INTO the trauma**
Avoid eliciting of detail. The purpose of the screening is to identify any prior or current traumatic experience, NOT to delve into the details (which is inappropriate and could be re-traumatising the client)
- **Explain and demystify**
'The client should understand the screening process, why the specific questions are important and that he or she may choose to delay a response or to not answer a question at all' (NCBI Bookshelf, 2/17) (as per trauma-informed principles of choice, collaboration and empowerment)
- **Take care with words**
Language used, both in the screening tool and in introducing/explaining it, should be direct but sensitive (i.e. should convey that the traumatic experience can be acknowledged in a safe manner and context)
- **Both content and process should be paced**
'Fools rush in': 'Initial questions about trauma should be general and gradual' (NCBI Bookshelf, 5/17)
- **Screening should not take place at a time when clients are substantially under the influence of drugs or alcohol**
Active alcohol/substance use should not automatically be a bar to trauma screening if the client is undergoing treatment for withdrawal (N.B. that there are contrasting perspectives on this).
- **Difference between screening and assessment**
Assessment/s follow a positive trauma screen as they indicate the need for further action to gauge the nature and degree of its impacts. ('Assessment determines the nature and extent of the client's problems'). Assessments should not be 'one off' but rather recur throughout treatment (NCBI Bookshelf, 3/17; 4/17)

A clinical assessment is more extensive and sometimes more intrusive than basic screening. Personnel need a level of expertise to respond to and manage client reactions, especially if they involve compromised functioning: 'Qualifications for conducting assessments and clinical interviews are more rigorous than for screening' (NCBI Bookshelf, 3/17)

- **Risk factors for suicidality**

Many health professionals recommend screening for suicide risk when screening for trauma. Yet suicide risk assessments have also become controversial because a large percentage of mental health patients categorised as at high risk did not complete suicide while a high proportion of those assessed to be low risk did ('The meta-analysis of 37 studies on the link between suicide classification and mortality...found there was no reliable way to measure suicide risk and no scientific progress had been made in 50 years' (Alexander, 2016). The study also found that '[c]omplex methods of risk assessment that considered multiple factors were not superior to those which measured a single risk factor' (ibid)

While some health professionals recommend direct questions around suicidal thoughts and intent, including these on an initial trauma screen can be problematic. Questions such as 'have you ever had suicidal thoughts, had intention to commit suicide, or made a suicide attempt? Do you have any of those feelings now? Have you had any such feelings recently?' (NCBI Bookshelf, 16/17) should be carefully integrated into the screening process if included at all. There is a range of suicide assessments available to help you decide whether to include such questions:

- *Other possible questions are 'Do you struggle with urges of wanting to do something harmful to yourself?'*
- *'Would you be interested in referral to a clinician who could follow up on issues related to these questions for further assessment and/or counselling?'*
- **Attunement to diversity** (gender, ethnicity, socio-economic status, etc.) '*[H]ealth service providers must approach screening and assessment processes with the influences of culture, ethnicity, and race firmly in mind'; 'Screening and assessment should be conducted in the client's preferred language by trained staff members who speak the language or by professional translators familiar with treatment jargon'; 'Instruments that are not normed for the population are likely to contain cultural biases and produce misleading results' (NCBI Bookshelf, 12/17; 10/17; 12/17)*
- **Importance of 'what happens next'**
i.e. how the results of screening are assessed and addressed (i) with the client, and (ii) by, within, and if necessary beyond, the context/organisation/practice in which screening is conducted: '*Screening procedures should always define the steps to take after a positive or negative screening'; 'Screening is only as good as the actions taken afterward to address a positive screen' (NCBI Bookshelf, 3/17; 14/17)*

A positive screen does not indicate a disorder (NCBI Bookshelf, 2/17) In fact the language of 'disorder' can itself be pathologising. Nor does the presence of trauma symptoms indicate their severity (assessment is needed for this): '*Positive screens only indicate that assessment or further evaluation is warranted, and negative screens do not necessarily mean that an individual doesn't have symptoms that warrant intervention' (ibid).* The trauma-informed paradigm is different to standard biomedical approaches in regarding 'symptoms' as the outgrowth of attempts to cope with overwhelming stress (ACE Study, 1998; 2010; *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, 2012).

WHAT KIND OF SCREENING TOOL SHOULD BE USED?

The mechanism and format of screening for trauma in health settings varies. This also applies to *non-health service* settings in which it may be indicated. As noted in pt 4 above, because basic initial information gathering should be as non-intrusive as possible, '*[b]rief questionnaires can be less threatening to clients than face to face interviews*' (NCBI Bookshelf, 14/7). But brief questionnaires elicit limited information. As was also noted in pt 4 above, '*interviews should be an integral part of any screening and assessment process*' (*ibid*).

It is important to be clear and direct but also sensitive to the language you used and the way in which all questions, both verbal and written, are paraphrased and paced.

There may be some tension between talking about trauma (i.e. conveying that the topic of trauma CAN be raised and addressed) and the way this happens (a sensitive but normalising style is recommended). This, too, has implications for the appropriate format for trauma screening.

There is a distinction between basic screening for the *existence* of prior or current trauma and for that of its *impacts* or 'symptoms', which would generally follow.

In any case,

'One instrument is unlikely to meet all screening or assessment needs or to determine the existence and full extent of trauma symptoms and traumatic experiences' (NCBI Bookshelf, 13/7).

This justifies the use of a number and/or mix of screening components and formats (e.g. *self-inventory checklist, questionnaire, interview and/or a combination of modes*). This choice will vary according to the service, policy, and other factors.

There are now many instruments for trauma screening available (see below). It is important to consider all the factors before choosing between them and to understand the difference between standardised and non-standardised measures.

Tools which emphasise traumatic 'events' are likely to be more relevant to single-incident PTSD than to complex interpersonal trauma from childhood.

'Checklist' type questions are not likely to capture a client's subjective experience (as occurs particularly with complex trauma and impairments of self and identity.) This is harder to elicit via quantifiable markers and observable 'symptoms'.

The *context* in which screening takes place is critical, as is its immediate, short, as well as medium to longer term aftermath (i.e. 'what happens next?').

Even if the screening tool lacks a significant qualitative and interview component, trauma-informed practice mandates at a minimum, a brief immediate 'check in' with clients about their experience of the screening.

Note that this is distinct from the time a client may subsequently spend with a clinician in relation to their responses

This is distinct from the time a client may subsequently spend with a clinician in relation to their responses. Follow up with a clinician, or appropriate service personnel should always be collaborative. Not only does this deepen clinical understanding, but it also demonstrates the clinician's or relevant staff member's concern and sensitivity for the client's past and current experience.

Orienting to screening tools

Many instruments are available to screen for trauma if it is decided to do so. The choice of a tool is determined by the service context and its attendant purpose. This section is not intended to be comprehensive or directive. Rather the aim is to provide an overview of some of the options to enable informed consideration with respect to identifying the need for screening in the first instance, and appropriateness of a tool or process in the relevant service context.

It is also important to remember the difference between *screening* and *assessment*, as these processes are sometimes conflated.

For a brief overview of the difference between screening and assessment see:
<http://www.nctsnet.org/resources/topics/trauma-informed-screening-assessment>

The type of screen, whether it is a self-assessment and if not, who will administer it, are also relevant. It is important to understand the distinction between standardised and non-standardised measures (i.e. those which comply with psychometric criteria and those which don't). Non-standardised instruments do not necessarily lack quality but relate to the qualification of personnel who can administer them.

Assessments in health services generally follow a positive screen. They are more extensive, potentially more intrusive, and require a degree of clinical expertise which is not needed by staff who administer screening (but who should always be trauma-informed): '*Qualifications for conducting assessments and clinical interviews are more rigorous than for screening*' (NCBI Bookshelf, 3/17).

A helpful article regarding assessment is:

Christine Courtois, 'Complex Trauma, Complex Reactions: Assessment and Treatment', *Psychotherapy: Theory, Research, Practice* (Vol.41, No.4, 2004), pp.412-425.

Self-assessment screening tools

- *The ACE Score Calculator*, based on the original scoring criteria of the Adverse Childhood Experiences Study allows individuals to calculate their own ACE Scores
<https://acestoohigh.com/got-your-ace-score/>
- Childhood Trauma Questionnaire (CTQ) <http://www.midss.org/sites/default/files/trauma.pdf>
- Stressful Life Events Screening Questionnaire <http://library.niwap.org/wp-content/uploads/2015/StressfulLifeEvents.pdf>
- Tools for self-assessment of PTSD, dissociation and dissociative disorders can be found here: <http://traumadissociation.com/questionnaires>
- Traumatic experiences checklist (*a self-report measure addressing potentially traumatising events*) can be found here: <http://www.enijenhuis.nl/tec>

The following are self-assessment measures for dissociation:

- Steinberg depersonalisation measure:
<http://www.strangerinthemirror.com/questionnaire.html>
- Shutdown dissociative scale: <http://traumadissociation.com/shut-d.html>
- Dissociative Experiences Scale, a screening test for Dissociative Identity Disorder can be found here: https://pcsearle.com/screening/screen_des.html

Administered screening tools

It is important to consider the factors which are relevant to selecting an appropriate screening tool. This link provides access to a US resource which incorporates comprehensive discussion about the importance of trauma-informed screening and assessment within behavioural health services (mental health and substance abuse) as opposed to screening for complex trauma itself:

- 'Choosing Instruments' in 'Trauma-Informed Care in Behavioral Health Services NCBI Bookshelf 13/17 www.ncbi.nlm.nih.gov/books/NBK207188/' for more information.
- A comprehensive list of trauma exposure measures can be found here:
<https://www.ptsd.va.gov/professional/assessment/te-measures/index.asp>
- PTSD Screening and Assessment
- Information about assessment for single trauma exposure and PTSD in adults can be found here: <http://www.ptsd.va.gov/PTSD/professional/assessment/overview/index.asp>
- This section looks at adult PTSD interviews:
<https://www.ptsd.va.gov/professional/assessment/adult-int/index.asp>
- Adult self-report scales can be found here:
<https://www.ptsd.va.gov/professional/assessment/adult-sr/index.asp>
- This section looks at DSM 5 measures including for the dissociative subtype of PTSD:
https://www.ptsd.va.gov/professional/assessment/DSM_5_Validated_Measures.asp
- PTSD screening instruments can be found here:
<https://www.ptsd.va.gov/professional/assessment/screens/index.asp>

Screening for complex trauma

Screening for complex (cumulative, underlying, interpersonally generated) trauma is not the same as screening for 'single incident' trauma. For complex trauma, it is important to use an instrument which does not confine its focus to specific 'events', but which can potentially indicate the more extensive impairments (e.g. regarding identity and self-conception) associated with complex trauma.

The Adverse Childhood Experiences (ACE) scale from the US is a very credible screening tool for diverse forms of prior interpersonal childhood trauma. The ACE scale is easy to administer and complete; respondents simply allocate a point for each type of adverse experience/household dysfunction they have undergone and the points for the 10 items are added to arrive at the ACE Score.

Of course the context in which the screen is completed and the subsequent follow up should be fully trauma-informed:

The Adverse Childhood Experiences Study: the ACE Score www.acestudy.org and <http://www.acestudy.org/the-ace-score.html>

Also see:

- Childhood Trauma Questionnaire (CTQ) <http://www.midss.org/sites/default/files/trauma.pdf>
 - The Mental Health Professionals' Network (MHPN) webinar provides helpful insights into screening for complex trauma:
 - 'Recognising, Screening and Assessing Complex Trauma'
<https://www.mhpn.org.au/WebinarRecording/55/Recognising,-Screening-and-Assessing-Complex-Trauma#.V2lDR49OLVI>
 - A non-exhaustive list of tools to assess complex trauma can be found here:
<http://www.nctsnet.org/trauma-types/complex-trauma/standardized-measures-assess-complex-trauma>
 - Assessment of dissociative disorders
 - Structured assessment interviews
 - Dissociative disorders interview schedule (DDIS): <http://www.rossinst.com/downloads/DDIS-DSM-5.pdf>
 - Structured clinical interview for DSM -IV Dissociative Disorders (SCID-5)
<https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5>
 - Assessment Measures of Dissociation
 - Multidimensional Inventory of Dissociation (MID):
<http://www.bainbridgepsychology.com/screening-assessment/mid/>
 - Multiscale Dissociation Inventory (MDI): <http://s1097954.instanturl.net/multiscale-dissociation-inventory-mdi/>
- Screening for somatoform dissociation (*asks about different physical symptoms or body experiences which may have been experienced either briefly or for a longer time*): <http://www.enijenhuis.nl/sdq/>

SAMPLE SCREEN

The following is a 'mixed method' sample of a basic non-standardised screening tool for trauma. A dedicated qualitative or interview component should be included early in the client presentation although not necessarily at the first contact point (not that either are included here).

This sample has been provided to support health professionals and other health or relevant service personnel to consider the kinds of questions which might help them to ascertain prior and current trauma in the lives of their clients. It is also to encourage practitioners and service providers to consider the form and content of trauma screening appropriate to the context/s in which they work and to the service/s they offer.

Note that this sample screen does not overtly seek information about prior trauma and it is likely to be easier for many clients for that reason. For example, q.4 ('Have you had any particularly painful experiences in your life? i.e. that took time to recover from or maybe you are not fully recovered from) is a normalising question. The experience of pain is a part of life, but 'particularly' painful experiences from which it took a long time to recover - or from which the person has not yet recovered - would potentially indicate trauma.

Also note that the word 'trauma' is not used in this sample screen as many people may not see their experiences in this light. Neither is the word 'abuse' for the same reason. Inquiring about 'abuse' is also potentially triggering, re-traumatising, and should be avoided in a screening instrument on the additional ground that experiences of abuse are extremely difficult to talk about. The client would anticipate that they would subsequently be asked to elaborate, and the trauma-informed principle of *trustworthiness* is unlikely to be in place early in client engagement.

Responses which indicate that a lack support and coping strategies (or has strategies which could be problematic), has prior problems with drugs and alcohol, frequent experience of guilt, and views themselves as 'not okay' would all potentially indicate trauma. This applies to any one of these responses and especially if they occur together.

Health professionals and relevant service providers are strongly encouraged to engage with Blue Knot Foundation which can assist, advise, and support further in this regard.

SAMPLE OF A NON-STANDARDISED TRAUMA SCREEN FOR HEALTH SERVICES

N.B. Elements of this trauma screen are also applicable to other relevant services.

Please circle your responses to the following questions:

[GENERAL PHYSICAL AND EMOTIONAL WELL BEING]

1. How would you describe your overall *physical* health?

Good _____ Ok _____ Poor _____

2. How would you describe your overall *emotional* health?

Good _____ Ok _____ Poor _____

3. Have you had any experiences which may have affected your health?

Yes _____ Maybe _____ No _____ Don't know _____

4. Have you had any particularly painful experiences in your life?

(i.e. that took you time to recover from or you may not be fully recovered from)

Yes _____ Maybe _____ No _____ Don't know _____

[COPING & SUPPORT]

5. Do you have ways of helping yourself feel better when you're upset?

Yes _____ No _____

If yes, do they work 'in the moment' but sometimes cause problems for you later on?

Yes _____ Maybe _____ No _____ Don't know _____

6. Do you think people who know you can tell if you're upset?

Yes _____ Maybe _____ No _____ Don't know _____

7. Was there someone you could go to if you were upset when you were a child?

Yes _____ No _____

8. Is there someone you can speak to now if you're upset?

Yes _____ No _____

If yes, do you have regular contact with this person? (i.e. not only when you're upset)

Yes _____ No _____

9. Do you experience, or have you ever experienced, depression?

Yes _____ Maybe _____ No _____ Don't know _____

10. Do you experience, or have you ever experienced, anxiety?

Yes _____ Maybe _____ No _____ Don't know _____

11. Do you ever feel spaced out, shut down or unreal?

Yes _____ Maybe _____ No _____ Don't know _____
If yes, how often?

Sometimes _____ Frequently _____ Much of the time _____

12. Have you ever had a problem with alcohol or drugs of any kind?

(i.e. include prescription medication as well as non-prescription drugs)

Yes _____ Maybe _____ No _____ Don't know _____

[CURRENT ATTITUDES AND BEHAVIOURS]

13. Which of the following statements best describes your views about sharing problems and asking for support?

- (a) The support of others is vital and I have no problem either asking for support or offering it
 - (b) I find it easier to offer support than to ask for it
 - (c) I need and ask for support more often than I am able to give it
 - (d) I tend not to ask for support and I'm ok with that
 - (e) I tend not to ask for support and wish I found it easier to do so
 - (f) Seeking support seems like a weakness to me
-

14. Do you agree it is possible to be alone without feeling lonely?

Yes _____ Maybe _____ No _____ Don't know _____

15. Which of the following statements best applies to you?

- (a) I generally feel lonely when I'm alone
 - (b) I can be alone without feeling lonely
-

16. Do you agree it is possible to feel alone in the company of others?

Yes _____ Maybe _____ No _____ Don't know _____

17. Which of the following statements best applies to you?

- (a) I sometimes feel alone when I'm with people I don't know
 - (b) I sometimes feel alone when I'm with people I know
-

18. Which of the following statements best describes your overall attitude to yourself and others?

- (a) 'I'm okay and other people are okay too'
 - (b) 'I'm okay and others are not okay'
 - (c) 'I'm not okay and others are okay'
 - (d) 'I'm not okay and others aren't either' (Adapted from Harris (1969; 2004) *I'm Ok, You're OK*)
-

19. How often do you feel guilty?

Not much _____ Frequently _____ All the time _____

20. Which of the following statements best describes your view of yourself?

- (a) Generally stable with the normal 'ups and downs'
 - (b) Generally stable but sometimes reactive when stressed
 - (c) Fairly stable but very reactive when stressed
 - (d) My moods seem to shift a lot for no obvious reason
 - (e) I don't have a stable view of myself
-

'What if...?' Questions which arise

The following questions are common when thinking about how to engage in conversation with someone you know or suspect may experience interpersonal trauma. While *knowing* and *suspecting* are two different things, the information below will be helpful in both circumstances. Your relationship to the person is also important (e.g. type of service you are providing, whether contact with them is prior or ongoing, whether you are starting or responding to the conversation, etc).

The specifics of different service settings and of applying trauma-informed principles in particular situations and contexts may require adaptation as appropriate.

The questions below address initial 'off-the-cuff' concerns you may have about holding these 'difficult' conversations. As the responses indicate, and even in busy and diverse service settings, applying trauma-informed principles can make these conversations easier than you might expect.

(1) *Is it really a good idea to express my concerns to a person I know or suspect may experience interpersonal trauma? If I don't know them well, might it be awkward or intrusive?*

It *is* a good idea to discuss your concerns with a person you believe may experience interpersonal trauma. If you are concerned about a child and there is a threat of harm and abuse you may also need to report it (see 'Referral Services and Contacts' at the end of this document).

Having a *foundation of trauma-informed principles* can make the conversation relatively straightforward and affirming for both parties. In fact, the *way in which* you engage in any significant conversation can be reassuring and foster confidence. This applies for *you* as the service provider/worker as well as for the person to whom you speak.

It is normal to feel apprehensive about raising and/or responding to such a challenging topic. Sensitivity to the *way in which* you approach and conduct the conversation (i.e. rather than fixating only on its content) increases the likelihood that it will proceed and go well. When you are coming from a trauma-informed perspective, the person is likely to respond positively.

Trauma-informed principles simply need to be put into practice. They do not require special expertise and hopefully are an extension of how you already communicate.

(2) *If I can't help someone myself, should I just leave it?*

No. If you suspect a person is experiencing trauma, and are concerned they may not have enough support, you should share your concerns either directly with them or with someone who can speak to them. If we do nothing, we become bystanders and pass up an important opportunity to make a real difference.

It is normal to not want to become personally involved in another person's issue. It is also normal to feel inadequate to the task. Yet talking about trauma does not require you to 'do' a lot, much less to 'solve' the situation. Not wanting to 'become involved' means losing important opportunities to help.

It is often sufficient simply to express a concern about a person's well-being (which could be of great assistance in itself). Depending on the person's response, additional action may or may not be necessary, and should only be undertaken if and as required.

If you are still reluctant to speak directly with a person you know or suspect is experiencing interpersonal trauma, and you believe they are isolated and don't have enough support, please share your concerns with someone who can speak with them. Letting a trustworthy other know of your concerns is both trauma-informed and the right thing to do.

(3) *What if a person tells me they are experiencing family violence?*

Your basic conversation will not change with the type of interpersonal trauma, or whether you are approaching someone or they are approaching you. If the person feels you are listening to what they say, you are providing a major form of support.

Good listening, without distraction or interruption, can really validate a person's experience. Our culture undervalues listening because it is often wrongly viewed as the opposite of 'action'. Perhaps we should reverse the familiar advice of '*don't just stand there – do something!*' to '*don't just do something – stand there!*' (i.e. and *listen*).

Often we don't want advice, and especially not action, which has not been properly considered (which often makes things worse). Often we simply want to *be heard*, which also applies whether trauma is present or not. It is important to focus on the person, on what they are telling you, and to listen carefully. It is also important not to jump to any conclusion or action other than to provide a supportive and validating presence.

Sometimes action may be required (i.e. when supportive listening and validation are not enough in the circumstances). Depending on the nature of the conversation or disclosure, urgent action may also be necessary. But it is important to *inquire about existing supports, and about the type and level of support the person can access on a regular basis*.

Sometimes you may sense that support is lacking or non-existent. The person may also not know of any relevant services, or may ask you to direct them to help. There are specialist support services for particular varieties of interpersonal trauma (e.g. sexual assault, family violence, adult survivors of childhood trauma). See the final pages of this document for a list of support services which may assist and provide the relevant contact details as needed.

(4) *What if I can't cope with what the person is telling me?*

A trauma-informed approach is *protective for all parties*. This includes both the person who experiences the impacts of trauma and those with whom they speak.

Applying the principles of *safety, trustworthiness, choice, collaboration* and *empowerment* radically reduces the possibility that any party will be overwhelmed. When we are alert to the signs of being overwhelmed in ourselves and others, we can steer the interaction in ways to avoid it in the first place (i.e. 'safety first').

As noted in pt. 3 above, all you may need to do is focus on the person without being distracted, gently ask whether they are okay, and listen in a supportive way. *Not being able to cope with what you hear will hopefully not be an issue at all.*

It is possible, however, that the person will reveal details which may be disturbing, as the topic of interpersonal trauma is unsettling by itself. This is why it was hard to talk about in the first place. If we want people who have experienced trauma to receive the right help, we need ways to engage in potentially difficult conversations.

To ensure the necessary conversations are as safe as possible for all parties, the following additional recommendations need to be implemented:

- **Avoid and discourage any focus on distressing detail** i.e. re the specifics of interpersonal violence and abuse.

When we express our concern for another person's well-being (regardless of whether they or we started the conversation) it does not mean 'let's talk about everything terrible that's happened to you'. The person usually doesn't want to or is unable to do so anyway. If they do begin to relate distressing details of their experience, you need to gently steer them away from doing so. This trauma-informed response serves their interests as well as yours.

You are not providing a counselling session. Discussing distressing detail in the absence of appropriate support does not help anyone's well-being. If the person seems determined to reveal distressing and potentially overwhelming details of their experience (i.e. distressing either to you or to them) we suggest the following replies:

'I'm so sorry this has happened/is happening to you. It seems as though you need a place where you can discuss your experience.'

'The safest place to do that would be with an experienced counsellor or therapist. Can I help you find who you could talk to?'

If the person you are speaking with conveys the gist of their experience (i.e. the general nature of it without 'drilling down') you won't need to say anything like this. You don't want to seem as if you are 'fobbing them off', particularly as they have probably been silenced before (and being silenced is painful).

If the person starts to provide details which are distressing *for either of you*, gently stop them before they continue and present them with other options. For example, call the Blue Knot Helpline 1300 657 380 to speak with a trauma therapist who can also provide contact details of trauma-informed therapists and services for ongoing support.

It is also important to be aware of the impacts of stress, as stress may arise during the conversation. Tuning in to signs of stress, and knowing how to assist someone to lower their arousal level (i.e. so they don't become overwhelmed) is essential to being trauma-informed.

See 'Effects of stress on the brain'; 'Stress response', 'Tips to reduce stress', 'Hand model of the brain' and 'the Window of Tolerance' (in Part 2 of this document) which will assist.

Keeping the level of stress manageable helps everyone. If you become aware that you or the person with whom you are speaking is becoming distressed, gently intervene to allow the person to return to a tolerable level of arousal. The state in which people can tolerate stress without becoming anxious is called the 'window of tolerance'). See graphic in Part 2 for further explanation and tips.

It doesn't help anyone to become or stay distressed. The distress of one person can also have a negative impact on those around them.

You will need to understand the stress response so you can monitor that everyone's stress levels remain at a tolerable level (e.g. 'hand model of the brain'; see Part 2).

A person's high arousal levels are not always obvious. People who are hyperaroused *are* visibly agitated. They may speak faster, have a red face, dilated pupils, and a raised voice. The signs of hypoarousal are less obvious. They may include a glazed expression, 'spacing out', and 'shutdown'.

When you are focused on *what* is being said (i.e. the *content* of a conversation) it is easy to miss the more subtle signs of distress, which often relate to *the way in which* the interaction occurs.

Being able to 'tune in' to your feeling states and body responses - and those of the person with whom you are speaking - and also 'step in' to help everyone feel safe if it becomes necessary, is a vital trauma-informed safeguard. This applies for all service personnel as well as for the clients with whom they engage. Also see 'Stress Response' and 'Tips for reducing stress' in Part 2 of this document.

(5) *What if the person rejects my concern outright?*

The person may dismiss your concerns even if you are expressing them in a fully trauma-informed manner.

This does not necessarily mean that your concern is misplaced (although it might be). The person may be feeling set upon and overwhelmed and may struggle to respond to even a gentle inquiry. They may even be hostile.

Being trauma-informed means being aware of the impacts of stress on the body and brain. It also means that you understand that people with experiences of interpersonal trauma have had their trust violated and may treat even your well-meant conversation with suspicion.

A defensive reaction may 'make sense' in light of the person's prior experience. That doesn't mean you won't feel uncomfortable. If the person rejects your concerns – even, and especially, if they do so abruptly and are agitated – it is advisable to apologise to them.

This is different from a person calmly letting you know that there is no cause for concern, and can leave you feeling unsettled. If you still *believe there is a basis for your concern* you may decide to try a second time.

Obviously, 'asking a second time' if you were rebuffed the first, makes *the way in which* you ask critical. If your concern was flatly rejected, and especially if you are told to 'but out', it is important not to ignore the person's prior objections by simply repeating yourself. This would not only be rude, but likely inflame an already tense situation.

The following would be a trauma-informed response in this circumstance:

'I'm really sorry if I've upset you. I know you didn't ask for this conversation. If everything really is fine, that's great and I can leave and not bother you again.'

'But I know that sometimes if things aren't good it can be hard to open up about them. And that sometimes our first response doesn't actually reflect how things really are for us.'

'So I hope you don't mind if I just ask you again, because I'd hate to leave you like this if you're dealing with some heavy duty stuff in your life'.

Offering to follow up at a time which is convenient for the person (which would also allow them time to reflect and avoid being ‘taken by surprise’) could also be advisable if you feel able to do this.

If you have expressed your concern in a trauma-informed manner, and the person has become annoyed or ‘shut down’, it is possible that their dismissal of your concern is indeed trauma-related and that there are grounds for your continuing concern.

For this reason, *respectfully ‘asking a second time’ is trauma-informed*. If your concern is dismissed a second time, you should not persevere. It would be good, however, to advise a third party who is trusted by the person if you are still concerned about their well-being.

(6) *What if I suspect someone may be experiencing interpersonal trauma, I approach them with my concerns, and it turns out I’m mistaken?*

If, on speaking with the person, you feel reassured that your concern has been misplaced, that’s a good outcome! And if you have engaged in a trauma-informed conversation you probably haven’t offended them.

Bear in mind, though, that the longstanding ‘risks of telling’ can make people appear okay when they’re not (even if they insist that they are). So ‘check in with yourself’, to see if you really do feel you were mistaken. If something doesn’t ‘ring true’, you may want to consider the situation further (see pts 3 and 5 above).

(7) *What if the person I am speaking to becomes angry or upset?*

Interpersonal trauma causes people to feel and be distressed. The very idea of it upsets many people. So it is not surprising that a conversation about the possibility of trauma can trigger strong emotions.

It is time to end an era in which we ‘don’t know how to talk about’ trauma, so people can feel less isolated and are able to access support.

Being trauma-informed helps us to know what to do if the person to whom we are speaking becomes angry or upset. In such situations, we need to know how to help a person lower their level of arousal (as per return to the ‘window of tolerance’; see the graphic in Part 2).

People can be upset for a whole range of reasons. See Part 2 for tips and suggestions for lowering arousal when anyone (including yourself) becomes stressed.

Anger can be more challenging. But even though many of us are uncomfortable in the presence of anger, we can learn appropriate ways to deal with it. Unless we do so we will avoid having the conversations we need to have.

The following tips for understanding and responding to anger will help:

If a person you know or suspect is experiencing interpersonal trauma becomes angry:

- It should not surprise you in light of what their experiences may have been

- It does not mean you made a mistake to raise your concerns when you did
If your conversation was trauma-informed, their anger is unlikely to be about you
- It does not mean you should immediately terminate the conversation.

Responding to anger in a conversation with a person who may experience interpersonal trauma:

- acknowledge their anger and express your concern for their distress. *Do not tell them to 'calm down', which has the opposite effect for many people!*
- tell them you are sorry they are upset. *This is not the same as accepting responsibility for 'causing' their upset*
- tell them it was not your intention to annoy them (*does not mean that you are taking responsibility for their anger*)
- don't take their anger personally. *If you are interacting in a trauma-informed manner it is probably not about you*
- apologise if you believe you should (e.g. '*I'm sorry if I came across as intrusive*')
- assist the person to return to the 'window of tolerance' if possible (see Part 2)
- suggest that you take a short break ('*How about we pause for a bit?*')
- provide them with some reassurance that it is 'okay to be angry'. Let them know that you're 'still there', and 'not going anywhere' unless they tell you they would prefer to end the conversation

If this is their immediate response, 'ask a second time' because their first response may be a reactive one. Do not, however, ask a third time if they decline the second. You might phrase the second time question as 'Are you sure? Because I know when I'm angry my first response is just to pull up stumps'.

If it's not possible for the conversation to proceed:

- ensure the person is safe. *Avoid leaving them in an angry state if you can. Also try to ascertain what they plan to do next, as it may not be advisable for them to be alone. Ask them if there is anyone they would like you to call*
- ask them if there's anything you can do to help them feel better (This does not include complying with *unreasonable requests*)
- Repeat that you are upset they are distressed. Let them know you hope you will be able to speak with them at another time (*only say this if you are comfortable to do this*)

Look after your own well-being at all times

Ideally you will be able to 'weather' an expression of anger because you will be trauma-informed.

It is important to acknowledge and validate a person's right to be angry. If you feel able to do so, tell them you are 'still there' despite it. This will likely be a different response than they are used to from prior painful experiences. In previous relationships, they may have had people cut-off from them or leave them feeling abandoned.

You will be able to do this if you can move yourself from feeling intimidated and use the '*thinking' part of your brain* (see '*Hand model of the brain*').

Some people may become momentarily angry in any conversations which feed into prior negative interactions. Normalising these reactions - and validating that people with experiences of trauma have every right to feel angry - can be very valuable. It can also help soothe discomfort for both of you. Remember it is always important to look after safety *including your own*.

(8) *What if the person insists there's nothing wrong but I don't buy it?*

If you still feel concerned despite being reassured there is 'nothing wrong', trust your intuition. If you don't feel the person is okay despite them saying otherwise, you may well be right.

It is difficult for people who experience interpersonal trauma to access help, and trust that it is safe to do so. The trauma-informed response is to 'ask a second time' (as per pt 3 above) and to indicate your availability and willingness (if you are) 'if [they] ever want to talk'. Also see previous points 3, 5 & 6.

(9) *What if I fear the person is returning to an unsafe situation?*

You need to distinguish between your *general concern for the person's safety* and any *immediate risk*. In situations of *immediate risk*, you need to act urgently to address any safety concerns as needed (see pt 10 below).

The foundational principle of 'safety first' also means you need to do what you can to ensure the person is safe *immediately after the conversation as well as during it*. This applies even if the person did not show any distress.

Any reference to interpersonal trauma, however well received, can unsettle a person. Do not assume that the person is fine to return to 'business as usual' even if it seems there was no real concern or if they appear to be fine. In this case, the simple query 'are you okay?' may be all that is necessary.

If, however, the person is returning to an untenable living space (either one they have told you about or one you suspect) you do need to follow up with trustworthy support people and/or any services which may be necessary. See 'Contact and Referrals' at the end of this document.

(10) *What if I feel the person is at immediate risk of harm?*

Many people who experience interpersonal trauma function highly in some regards. Many have also developed coping strategies (even if some of these are problematic) to protect them from what challenges them. While a person may need to escape or move on from a situation which seems unbearable to an outsider, they may not be in imminent danger.

The 'crisis team' (i.e. a service which can be called if people are in serious distress and/or at high immediate risk of harm) should be called if necessary (see 'Referral Services and Contacts'). It is reassuring to know this service exists. Mostly, it may not be necessary for you to access it. Contacting 'the crisis team' prematurely may be unwise, potentially traumatising, and 'overkill'.

If you are aware of how to assist a distressed person to lower their arousal level (see 'Stress Response' and tips) this may be all that is necessary. What may seem to be a crisis can often be appropriately managed when responses are trauma-informed.

In circumstances of distress, also try to ensure the person has other supports, and that they know who to contact if they need help. *The conversation with you might help the person begin to identify the supports that they need.*

If, on the other hand, you believe the person to be at immediate risk, you need to do whatever you can to help them stay alive. When you can negotiate with the person directly, the trauma-informed principle of *collaboration* suggests you should work with them to identify what steps you should take.

If you can't negotiate with the person, are unable to assist them to lower their arousal, believe them to be at immediate risk and don't know who to call, contact a crisis team, hospital, or dial 000 *even if the person does not wish you to do so*. Collaboration is not always possible and serious risk of immediate harm should always be acted upon.

(11) *What if the person tells me about their interpersonal trauma but wants me to promise that I won't tell anyone?*

A person who acknowledges their experiences of interpersonal trauma may try to swear you to secrecy. They may have all sorts of reasons for doing so, regardless of whether you know them or whether you are a 'concerned stranger'.

If you are the first person they have told, they may panic that their 'secret is out'. They may feel high anxiety after disclosing their trauma, even if they are also glad and relieved that someone knows. Research confirms that a person's responses to their own disclosure can be mixed.¹⁹³

It is generally unwise to agree 'not to tell anyone else'. But you need to take care in communicating this to the person (who may regard it as a betrayal). Care also needs to be taken when conveying to appropriate others the information you are given. In some cases, there may be dire repercussions of disclosure, and fears of the 'secret being out' may be realistic. *If this is the case, you will need to take extreme caution around sharing the information you have obtained.*

Trauma in relationships flourishes under conditions of secrecy. It is not healthy for your own well-being (regardless of any ongoing relationship with the person or not) to 'hold their secret' yourself.

When others learn what is happening, and appropriate supports are in place, the person may feel less trapped.

We advise a gentle conversation around the need for trustworthy supports, which enlists the person's preferences around who and what these should be.

In some cases, the person will be able to collaborate on ideas about form/s of support. But this will not always be the case. In some cases, they may be willing and able to call support services themselves if this is necessary. In others cases, they may not be, or may not be informed about such services (see 'Referral Services and Contacts').

¹⁹³ See Freyd & Birrell, *Blind to Betrayal*, ibid, pp.122-129.

If the person knows you are aware they are distressed, *part of them will welcome your support around their distress even though another part of them may not.*

A trauma-informed perspective allows you to understand such ambivalence, *because it makes perfect sense under the circumstances*. It also helps you to gently but clearly let the person know that someone other than you should be informed. You may advise the person to call Blue Knot Helpline (1300 657 380). You can also call this number yourself if you need help in safely handling the aftermath of the conversation.

Tips for Conversations (Summary)

GUIDING PRINCIPLES:

Safety Trustworthiness Choice Collaboration Empowerment

- **'Safety first'** This is the most important point to remember and follow, and also the foundational principle of being trauma-informed
- **'Safety' applies to: physical, geographical space** (e.g. the building and room; the 'place' in which you are speaking)
AND
emotional space i.e. atmosphere and comfort levels, your own and those of the person to whom you are speaking
- Consider the nature of your relationship to the person you are concerned about and its possible implications for your conversation.

How might the nature of your relationship affect:

- d) *their perceived and actual physical and emotional safety?*
 - e) *your sense of safety in speaking with them?*
 - f) *your and their comfort levels?*
- Ask yourself 'How, in light of my relationship, or lack of relationship, with this person can I apply the core trauma-informed principles? What steps can I take to help the conversation go well?'

NB: An effective conversation depends on both the physical and emotional safety of the way in which it is conducted and the context in which it takes place.

- 'Choose your moment' if you are initiating the contact
- Honour the person's preferences regarding the time, location for the conversation etc. if you can.
- Your approach and style should be empathic at all times
- Attune to their verbal and non-verbal communication
- Consider what may *have happened to* the person rather than what is 'wrong' with them
- Recognise that a person's 'problematic' behaviours and responses may be their attempts to protect themselves and to cope with stress
- Listen to and validate the person (don't 'talk over' them or contradict them)
- Recognise the signs of stress (which may take the form of visible agitation, such as accelerated pace, raised voice OR silence, glazed expression and 'shut down'). Gently help them return to the 'window of tolerance' (see Part 2 of this document) if their stress levels become high

-
- If the person initially says they are 'okay' but you are still concerned, you can gently ask a second time as the first response may be automatic. Do not persist if the person is reluctant/insistent.
 - Don't give advice unless you are asked for it (e.g. avoid saying '*Have you tried...?*')
 - Inquire about who the person might contact for support. Provide them with the contact numbers for any relevant services or where to find them if necessary (See 'Referral Services and Contacts' below)
 - Ensure the person does not leave the conversation in a distressed state:

Remember that *the way in which* you interact with the person (and not just *what* you say/do) is important for their safety. Being able to recognize the signs of stress and being able to help them with lowering their arousal if you need to (see Part 2) builds confidence and is mutually protective.

Core principles for conversations (summary)

CORE PRINCIPLES FOR STARTING OR RESPONDING TO CONVERSATIONS WITH PEOPLE WHO HAVE EXPERIENCED INTERPERSONAL TRAUMA

'Safety first' – all aspects of the circumstances in which the conversation takes place should be safe.

- Choose the time and place for the conversation if you can
Try to minimise the possibility of any distraction or of anything taking attention away from the main issue. Find a space which is 'private' and assure that the conversation will be kept confidential
- Engage in quality listening
Listen carefully to what the person is saying, and connect to their words while you keep monitoring how comfortable they are with the conversation
- Avoid going into too much detail
Too much detail may cause the person to become overwhelmed
- Recognise the signs of a person becoming distressed or stressed. *These can vary from hyper-arousal (i.e. the person is visibly agitated) to hypo-arousal (i.e. the person is 'spacing out' or 'shutting down'). Learn how you can help them and do help them if they want or need you to (see 'Tips to reduce distress' in Part 2)*
- Validate what the person is saying
Be a supportive witness to what the person is telling you. This is not the same as knowing 'exactly what happened'
- Provide the person with follow up support
Help the person take the next step by identifying trustworthy people or recommending professional support if they want or need you to e.g. Blue Knot Helpline 1300 657 380

Tips for applying trauma-informed principles (summary)

SAFETY *Tips to help a person who has experienced interpersonal trauma feel safe when you are having a conversation with them:*

1 (a) PHYSICAL SAFETY

- Is the physical/geographical space in which you are having the conversation safe?
Is it away from busy roads if outside or in a room in which you are unlikely to be interrupted if you are inside?
- Have you asked the person if there is anything you can do to make the conversation space more comfortable?
- *Many factors, some which we are unable to predict, can lead to stress reactions. For example, some people might be triggered by a particular visual cue.*
- Will the person be physically safe after – as well as during – the conversation?
This applies not only to the situation to which they are returning but to their general levels of arousal. You may need to help them with a basic grounding exercise (see p.156)

1 (b) EMOTIONAL SAFETY

- * ‘Choose your time’: if you are initiating the conversation, have you selected a time at which the person is likely to be receptive?
- Does your non-verbal communication show that you are supportive, focused and listening in a way which is tuned into the person?
Maintaining eye contact, consistent but not fixed, is important. Take care not to look distracted.
- Are you alert to possible signs of stress in the person’s body?
This can include dilated pupils or changes in skin colour. The person may be twisting a tissue or take long pauses.
- Do you encourage the person to take their time and take short breaks if they need to?
If the conversation is long you could return to it after a short break.
- Will the person be emotionally safe after, as well as during the conversation? Are you able to help them to lower their level of arousal if necessary?

TRUSTWORTHINESS *Tips to build trust in a conversation with a person who has experienced interpersonal trauma:*

YOU CAN BUILD TRUST IF YOU:

- Are always attentive to physical and emotional safety
- Always tune in to the person's level of comfort and ask them whether/how you might improve it
- Pay ongoing attention to your and their non-verbal communication
Is the person showing signs of stress? Are you being sufficiently supportive?
- Take a gentle approach which does not convey 'an agenda'
- Listen in the right way; do not interrupt the person unless there is an issue with their level of arousal (in which case assist them to return to the 'window of tolerance'; see Part 2)
- Ask the person how they are feeling after (as well as during) the conversation. Be ready to help them with 'grounding' if/as necessary (see Grounding Exercise on p.125)

CHOICE *Tips to increase options and choices in a conversation with a person who has experienced interpersonal trauma (questions for consideration)*

ENABLING CHOICE

- When you are starting a conversation with a person you know or suspect may be experiencing interpersonal trauma, provide choice/s around the conversation
- Has the person chosen the logistical details of the proposed conversation, including the date, time and venue? Or have you discussed your decisions with them?
- How can you give the person greater choice about the way the conversation is held and develops?
- In what other way/s can you give the person other choices, even if they are small?
- How can responding to, rather than starting, the conversation affect the extent to which you can foster choices for the person?

COLLABORATION *Tips to help us collaborate in conversations with people who experience interpersonal trauma*

COLLABORATION MEANS:

- 'Doing something *with*' a person rather than doing something '*for*' or '*to*' a person
- Not assuming that the person can't act on their behalf or engage in decisions and actions which affect them
- Recognising when additional assistance may be necessary
- Recognising we engage more effectively with people when we cooperate with them
- Acting in a spirit of cooperation whenever and as much as we can

EMPOWERMENT *Tips to maximise empowerment in conversations with people who experience interpersonal trauma*

TOWARDS EMPOWERMENT:

- Understand that interpersonal trauma often stems from and fosters disempowerment, and that taking steps to feeling more empowered is essential to healing
- Recognise that the way in which a conversation is arranged and conducted can contribute to a sense of empowerment
- Recognise that trauma which occurs in relationships erodes self-esteem and a person's sense of their own abilities. It is important to identify ways to make your interactions respectful, democratic and inclusive
- As far as possible, seek the person's preferences around the logistics of your conversation and try to meet them in a collaborative way

BECOMING 'TRAUMA INFORMED': SUMMARY FOR SERVICES

We can all learn to become informed about trauma, and act on this awareness. While the paradigm of 'trauma-informed practice' developed within the mental health sector, its core principles are *applicable in all services, interpersonal contexts, and society-wide*.

Becoming trauma-informed, and putting its basic principles into practice, lowers stress levels and reduces the likelihood that people who have experienced trauma will be overwhelmed. It also assists interactions in general, and is 'win-win' for everyone.

TRAUMA INFORMED PRACTICE:

- Rests on the foundational principle of 'do no harm'
- Does not require clinical knowledge and is not 'treatment'
- Understands the effects of stress on the brain and body
- Considers what *has happened to* the person (not what is 'wrong' with the person)
- Regards 'symptoms' as outgrowths of *coping strategies*
- Is sensitive to client comfort levels and to *THE WAY IN WHICH* a service is delivered (not just *WHAT* the service is)
- Works with (rather than 'doing to') the client

CORE TRAUMA INFORMED PRINCIPLES (*embed service-wide*)

SAFETY (*emotional as well as physical; e.g. are the physical space, reception, and intake procedures welcoming?*)

TRUST (*is your service sensitive to client needs at all levels of contact? How does the service consistently convey its reliability?*)

CHOICE (*does your service provide choice to clients at all levels at which it is appropriate and possible to do so? In what ways?*)

COLLABORATION (*does your service consistently communicate to clients a sense of 'doing with' rather than 'to?' How?*)

EMPOWERMENT (*is empowering clients an ongoing goal of your service? How is this goal enabled by service systems, programs and processes?*)

RESPECT FOR DIVERSITY (*Does your service convey and enact respect for client diversity in all its forms? In what ways?*)

GROUNDING EXERCISES

Part of being trauma-informed is knowing how to help a person who becomes overwhelmed by stress (i.e. assisting them back to the 'Window of tolerance'). A simple 'grounding' exercise can help them do this.

There is no 'one size fits all' exercise that will work for everyone. You may find the following suggestions useful:

- Suggest that the person takes a 'rest' break in which they stretch or walk around for a minute or two
- Encourage the person to gently stamp their feet on the ground/floor
- Suggest that the person takes some long, slow breaths (*if doing this makes them more agitated rather than soothing them, you can suggest they try one of the physical movements above*)

IF A PERSON BECOMES VISIBLY AGITATED (hyperaroused; e.g. sweats, face changes colour, pupils dilate, voice is raised, pace of speech accelerates):

- Make the above suggestions (i.e. rest break; movement; focus on breathing more slowly)
- Suggest the person focuses on a calming image (i.e. this needs to be a relaxing image for them; some people do not like waterfalls!)
- Ask what you can do to help

IF A PERSON 'ZONES OUT' (hypoaroused; eyes glaze, on automatic pilot, 'shut down'):

- Suggest that the person takes a short break (*if their attention has wandered and doesn't quickly return, don't keep going as if nothing has happened*)
- Voices can help people regulate: speak calmly and slowly to help bring the person back to an awareness of where they are ('I am xx; it's Tuesday morning; we're sitting in a café...')
- Assure the person they are safe (*taking care to ensure that they are*)
- Suggest a simple stretch (*the focus should be on an external movement rather than on an inner sensation*)
- Ask if the person can name 3 objects that they can see in the room (*this engages the person and helps them focus their attention on something outside of them*)
- If the person is sitting down, suggest that they stand up for a moment (*and stand up with them*)
- Engage one or more of the person's '5 senses' (i.e. sight, smell, sound, touch, taste; *the feel of a velvet cushion; the smell of coffee beans, the taste of a peppermint lolly*)

REFERRAL SERVICES AND CONTACTS

Emergency Service	Service Name	Phone	24 x 7	Website
EMERGENCY	Emergency Services Australia's primary national emergency number. For life threatening or time critical emergencies only	000	✓	
CRISIS SUPPORT	Lifeline Telephone crisis support; crisis support chat	13 11 14	✓	www.lifeline.org.au
SUICIDE	Suicide Call Back Service Counselling for people 15 years and over who are suicidal, caring for someone who is suicidal, bereaved by suicide, or a health professional providing suicide-related support	1300 659 467		www.suicidecallbackservice.org.au
MENTAL HEALTH CRISIS SUPPORT	All major public hospitals (and some private hospitals) have an emergency department, where people can receive emergency help for mental health conditions. If you or someone you know are feeling suicidal, have thoughts of harming others or are acutely unwell you can visit your local emergency department and get help from a doctor or health professional who is specially trained in mental health.		✓	www.mindhealthconnect.org.au/australian-mental-health-services

Service Type	Service Name	Phone	24 x 7	Website
AGED CARE	myagedcare Information and referrals for elderly people seeking home and community care (HACC) services at home; residential aged care; respite for carers	1800 200 422	✓	www.myagedcare.gov.au
CHILDHOOD TRAUMA	Blue Knot Foundation Telephone counselling support for adult survivors of childhood trauma and abuse, their partners, family and friends, health professionals and anyone in the workplace working with people who have experienced childhood trauma	1300 657 380	✓	www.blueknot.org.au
CHILD ABUSE PREVENTION	Child Abuse Prevention Service Family Support and prevention of abuse to children and young people	1800 688 099		www.childabuseprevention.com.au
DEPRESSION & ANXIETY	beyondblue Depression and anxiety support and referrals Also have a widely used online forum with thousands of supportive posts as well as chat services	1300 224 636	✓	www.beyondblue.org.au
DRUG & ALCOHOL ABUSE	VICTORIA ONLY: DirectLine Confidential alcohol & drug counselling and referral in Victoria	1800 888 236		www.directline.org.au
EATING DISORDERS	Butterfly Foundation Supporting Australians in the prevention and treatment of eating disorders and body image issues	1800 334 673		www.thebutterflyfoundation.org.au

Service Type	Service Name	Phone	24 x7	Website
FORGOTTEN AUSTRALIANS	Find & Connect Support Services Provide referrals to counselling and other relevant services; obtaining records; tracing family members	1800 161 109		www.findandconnect.gov.au
GAMBLING	Gamblers Helpline Support for anyone affected by gambling	1800 858 858		www.gamblinghelponline.org.au
LGBTI	QLife Nationally-oriented counselling and referral service for people who are lesbian, gay, bisexual, trans, and/or intersex (LGBTI)	1800 184 527		www qlife org au
MEDICATIONS	Medicines Line Information about prescription, over-the-counter and complementary medicines	1300 633 424		www nps org au/contact-us/medicines-line
MEN	MensLine Australia Telephone and online support and information service for Australian men.	1300 789 978	✓	www.mensline.org.au

Service Type	Service Name	Phone	24 x7	Website
MENTAL HEALTH INFORMATION	SANE Helpline Information about symptoms and treatments related to mental illness, where to go for support, help for carers, and how to look after yourself NSW ONLY Mental Health Line Puts you in touch with your local mental health service QLD ONLY 13 HEALTH assessment, referral, advice, and hospital and community health centre contact details WA ONLY Mental Health Emergency Response Line Provide assessment and specialist intervention for people experiencing a mental health emergency SA ONLY Mental Health Triage Provide advice and information in a mental health emergency TAS ONLY Mental Health Services Helpline Mental health assessment and intervention for persons in need	1800 187 263 1800 011 511 13 43 25 84 Metro callers 1300 555 788 Peel callers 1800 676 822 13 14 65 1800 332 388	✓ ✓ ✓ ✓ ✓ ✓ ✓	www.sane.org/helpline www.health.nsw.gov.au/mentalhealth www.qld.gov.au/health/contacts/advice/13health www.mentalhealth.wa.gov.au/getting_help/Emergency_help/emergency_mherl www.sahealth.sa.gov.au/wps/wcm/connect/public+content/SA+Health+Internet/Health+services/Mental+health+services/ www.dhhs.tas.gov.au/mentalhealth

Service Type	Service Name	Phone	24 x7	Website
ACT ONLY Mental Health Triage Service Assessment and treatment of mentally ill people in crisis situations		1800 629 354	✓	www.health.act.gov.au/our-services/mental-health
NT ONLY Mental Health Line Emergency help or support for anyone experiencing a mental health crisis or for those concerned about another person's mental health		1800 682 288	✓	http://health.nt.gov.au/Mental_Health/NT_Mental_Health_Access_Team
MISCARRIAGE STILLBIRTH & NEWBORN DEATH	SANDS Provide support, information and education to anyone affected by the death of a baby before, during or shortly after birth	1300 072 637	✓	www.sands.org.au
OVERDOSE or SUSPECTED POISONING	Poisons Information Centre Information about overdose and medication errors	13 11 26		www.poisonsinfo.nsw.gov.au
PARENTING	Parentline NSW Information and support for parents and carers of children 0 to 18 years. Parentline ACT Information and support for parents and carers of children aged 0 to 18 years. Parentline VIC Parentline provides a statewide telephone counselling service to parents and carers of children aged birth to 18 years.	1300 130 052 (02) 6287 3833 13 22 89		www.parentline.org.au www.parentlineact.org.au www.education.vic.gov.au/about/contact/Pages/parentline

Service Name	Service Type	Phone	24 x7	Website
	<p>Parentline QLD & NT For parents of carers in Queensland and the Northern Territory for support.</p> <p>Parentline SA The Parent Helpline is a telephone information service for parents in South Australia.</p> <p>Parentline WA The Parenting WA Line provides telephone information, support and referrals to parents, carers grandparents, foster carers and families who are taking care of a child or children aged from pre-birth to 18 years.</p> <p>Parentline TAS The Parent Line is available at any time to assist parents, of children 0-5 years, with stressful parenting issues and concerns.</p>	1300 301 300 1300 364 100 1800 654 432 1300 808 178		www.parentline.com.au www.parenting.sa.gov.au/helpline.htm www.dlgc.wa.gov.au/AdviseSupport/Pages/Parenting-WA-Line www.dhs.tas.gov.au/service_information/children_and_families/parentline
PERINATAL SUPPORT (PRE AND POST BIRTH)	PANDA (Perinatal Anxiety & Depression Australia) Specialist national perinatal mental health telephone counselling service	1300 726 306		www.panda.org.au

Service Name	Service Type	Phone	24 x7	Website
LEGAL ADVICE – INSTITUTIONAL CHILD SEXUAL ABUSE	knowmore Knowmore is an independent service giving free legal advice to assist survivors of institutional child sexual abuse by providing them with information and advice about the justice or redress options that may be available to them.	1800 605 762		www.knowmore.org.au
SAFETY PLANNING	beyondblue safety planning app Can download the app or create this online. Supportive way to help someone with risk management helping focus on what works for them		✓	www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning
SEXUAL ASSAULT – CRISIS COUNSELLING (sexual assault)	Rape & Domestic Violence Services Australia Counselling for anyone in Australia who has experienced rape or sexual assault and their non-offending supporters	1800 424 017	✓	www.rape-dvservices.org.au
SEXUAL ASSAULT (young people and children)	Bravehearts Information support and therapeutic services for children and young people, and adults and non-offending family members affected by child sexual assault	1800 272 831		www.bravehearts.org.au

Service Name	Service Type	Phone	24 x7	Website
SEXUAL ASSAULT, DOMESTIC & FAMILY VIOLENCE	1800 RESPECT National counselling helpline, information and support for people experiencing sexual assault or domestic and family violence	1800 737 732	✓	www.180orespect.org.au
TORTURE & TRAUMA	Forum of Australian Services for Survival of Torture and Trauma (FASSTT) Survivors of torture and trauma: refugees and "refugee-like backgrounds"	07 3391 6677		www.fasstt.org.au
YOUNG PEOPLE & CHILDREN	Kids Helpline Support for people aged 5-25 years. Web services for 5-12, 13-25 as well as parents and carers.	1800 55 1800	✓	www.kidshelp.com.au
YOUNG PEOPLE & CHILDREN AFFECTED BY ABUSE; PARENTS	Australian Childhood Foundation Trauma counselling community education & training. Trauma recovery teams work throughout Australia including regional and remote areas	1800 176 453		www.childhood.org.au

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