1. The majority of people who access human services have undergone many overwhelming life experiences, interpersonal violence and adversity (Bloom & Farragher, 2011; Jennings, 2004). Most clients of the community services sector, as well as the mental health sector, have trauma histories.

2. Current organisation of service-delivery does not reflect the prevalence of trauma within the community. This has led to calls for implementation of a new paradigm – Trauma-Informed Care & Practice (TICP). ‘Trauma-informed’ practice requires comprehensive change to existing ways of operating, and would apply across the full spectrum of human service-delivery.

3. Trauma-informed practice recognises that many problems, disorders and conditions are trauma-related. It rests on awareness of the impacts of trauma (as distinct from directly treating it) and emphasises a ‘do no harm’ approach. It aims to avoid the re-traumatisation which frequently takes place within the very services to which traumatised people are referred and from which they seek assistance (‘Trauma has often occurred in the service context itself’; Jennings, 2004:6).

4. Trauma is a state of high arousal which stems from the overwhelming of coping mechanisms in response to extreme stress (Cozolino, 2002; van der Kolk, 2003). We are innately equipped with ‘survival’ responses (‘fight’, ‘flight’ and ‘freeze’) which are activated by the perception of threat. Such responses are normal and initially protective. They only become pathological if traumatic experience is not resolved after the precipitating event/s.

5. The effects of unresolved trauma are pervasive, and impair a wide range of functioning. Trauma radically restricts the capacity to respond flexibly to daily stress and life challenges. If trauma is not resolved people cannot ‘move on’.

6. ‘Complex’ trauma is cumulative, repetitive and interpersonally generated. It differs from, and is more common than, ‘single-incident’ trauma or PTSD (‘There is more to trauma than PTSD’; Shapiro, 2010:11). A major type of complex trauma is child abuse in all its forms.
7. Unresolved trauma has life-long impacts and affects the next generation. *Parents do not need to be actively abusive for their children to be adversely affected* (Hesse, Main et al, In Solomon & Siegel, 2003). But trauma *can* be resolved, and its transmission to the next generation can be avoided (Siegel, 2003).

8. The relationship between overwhelming childhood experiences and emotional and physical health problems in adulthood is now clearly established (Felitti, Anda et al, 1998). *Childhood coping mechanisms* become adult *symptoms* of ill health if overwhelming stress experienced in childhood is not resolved (ibid) This suggests the need for *many symptoms and challenging behaviours to be reappraised as responses to trauma*. Focus should be not on what is *wrong* with a person, but on what has *happened to* the person (Bloom, 2011; Fallot & Harris, 2009: Jennings, 2004).

9. It is now known that the structure of the brain changes in response to experience (*neuroplasticity*). Early interactions with caregivers are crucial in initial ‘sculpting’ of the brain (Schore, 2003; Cozolino, 2002) and intimate relationships ‘are our major stress-modulating mechanism’ (Perry, 2006:90): ‘*Resilient children are made, not born*’ (ibid, p.38).

10. When a child is threatened, two circuits in the brain are activated simultaneously and are *incompatible* (Siegel, 2012:21-10) Caught in the ‘biological paradox’ between the ‘survival reflex’ and the ‘attachment circuit’, *the internal world of the child collapses* (ibid) The trauma of child abuse leads to movement from a ‘learning brain’ to a ‘survival brain’ (Ford, 2009:35).

11. The responses of traumatised children include problems with *emotional regulation, relationships, attention and reasoning under stress*. Such responses are frequently misinterpreted (‘*Troubled children are in some kind of pain – and pain makes people irritable, anxious and aggressive*’; Perry, 2006:244, 55). While the setting of boundaries is important, consistent care, rather than punishment, is required (‘*Just because a child is older does not mean a punitive approach is more appropriate or effective*’; Perry, 2006: 244)

12. *Dissociative* responses to extreme stress (‘spacing out’) are also common in infants and children (Siegel, 2012:21-11; Perry, 2006:49). This is because young children are rarely able to ‘fight’ or ‘flee’ when faced with threat. Both *visible agitation* (hyperarousal) and *emotional blunting* (hypoarousal) are trauma responses.

13. Experience of relationships registers in the brain, and is crucial to both resolution of trauma and general well-being (Siegel, 2009; Doidge, 2007). *Positive*
relational experiences have great healing potential, while negative relational experiences compound emotional and psychological problems.

14. Because healing is relational, positive experiences need to occur within services and organisational settings which are accessed by people with trauma histories. Trauma-informed service-delivery requires sensitivity to diverse coping strategies, recognition that both agitation and withdrawal are signs of distress, and that challenging behaviour in general may be trauma-related.

15. Basic knowledge of the brain allows us to understand the effects of negative experiences on our level of functioning. Such understanding can increase empathy with clients, as well as self-compassion for our own compromised functioning when we are stressed and ‘not at our best’ (Siegel, 2012). The brain comprises three regions when depicted ‘vertically’ from top to bottom – the cortex (thinking, concepts, reflection), limbic area (emotions & evaluation) and brain stem (controls states of arousal, including ‘survival’ responses). See Siegel’s ‘hand model’ of the brain http://www.youtube.com/watch?v=DD-lfP1FBFk

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

16. Key principles of trauma-informed practice are safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). These principles should be embedded at all levels of service-delivery in relation to all activities. This is because they assist the positive relational experiences which research shows are necessary both for resolution of trauma and for general well-being. Service-delivery which is trauma-informed is ‘win-win!’

17. Your own awareness, conduct and self-care has major implications for your interactions with clients (Bloom, 2006:2) Personal well-being is a prerequisite for service-delivery which is trauma-informed. The well-being of staff and volunteers (which has both individual and organisational components) fosters empathy, reduces the risk of vicarious trauma, and decreases the likelihood of negative interactions which are destabilising to clients. Safe, courteous and respectful interactions are not only more mutually rewarding, but actively assist the process of trauma recovery.

18. In implementing the key principles of safety, trustworthiness, choice, collaboration and empowerment, trauma-informed practice focuses not only on what the service offers, but on the way in which it is provided. How you provide services – not just what you do – is crucial to operating in a trauma-informed way!
REFERENCES


Jennings, A. (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.


