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A Primer on Trauma-Informed Practice in Refugee Law

GLEN CRANWELL*

This article is intended as a primer on trauma-informed practice for professionals working in the area of refugee law. Refugees and asylum seekers are amongst the most vulnerable groups in the community, and the process of seeking asylum itself can intensify stress. Trauma-informed practice is founded on 'safety first' and 'do no harm'. It reflects adherence to core principles, rather than a prescribed set of practices and procedures. The core principles of trauma-informed practice include safety, trust, choice, collaboration and empowerment. This article primarily focusses on professional applications of trauma-informed practice at an individual level. By taking steps to integrate these principles into interpersonal interactions with refugees and asylum seekers, professionals can better support their needs in the refugee law context.

I Introduction

Trauma is pervasive. It has been said that we are living in an 'age of trauma',[1] with research suggesting that experiencing events described as traumatic is more common than previously realised.[2] Even if we do not experience trauma directly, it has been argued that trauma should be 'everyone's business'.[3] We all need to know how to respond appropriately when we interact with people affected by trauma.

Refugees and asylum seekers are amongst the most vulnerable groups in the community. In Australia, it has been estimated that approximately half (48.7%) of refugees experience post-traumatic

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1 Simon Rosenbaum, 'The Age of Trauma', *Harvard Public Health* (Web Page, 30 September 2021) <https://harvardpublichealth.org/mental-health/the-age-of-trauma/>.

2 Dean Kirkpatrick et al, 'National Estimates of Exposure to Traumatic Events and PTSD Prevalence Using DSM-IV and DSM-V Criteria' (2013) 26(5) *Journal of Traumatic Stress* 537.

3 Cathy Kezelman and Pam Stavropolous, *Talking about Trauma: Guide to Everyday Conversations for the General Public* (Blue Knot Foundation, 2017) 6.

stress disorder (PTSD).[4] The impact of trauma on the brain may adversely affect memory functioning, raising particular challenges for asylum seekers in narrating their claims accurately,[5] which can negatively impact their credibility. The process of seeking asylum can also intensify stress.[6]

This article is intended as a primer on trauma-informed practice for professionals working in the area of refugee law. Trauma-informed practice can be implemented at various levels, from the individual, group, to whole-of-organisation level.[7] This article primarily focusses on applying trauma-informed practice at an individual level. It explores opportunities for incorporating trauma-informed practices into interpersonal interactions with refugees and asylum seekers. It also addresses the impact that secondary trauma can in turn have on professionals who work with refugees and asylum seekers.

The article draws on the best available evidence-based approaches, but the title uses the term 'primer' to identify that it is not intended to cover all aspects of the rapidly developing evidence-base on trauma. For readability, the term 'professional' is used flexibly to include lawyers, migration agents, decision-makers, support workers and volunteers.

II Nature of Trauma

Trauma is a complex concept with no universal definition. However, the most commonly referenced definition is from the US-based Substance Abuse and Mental Health Services Administration (SAMHSA):

> Individual trauma results from an *event*, or series of events, or set of circumstances that is *experienced* by an individual as physically or emotionally harmful or life threatening and that has lasting adverse *effects* on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[8]

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4 Mohammad Hamrah et al, 'The Prevalence and Correlates of Symptoms of Post-Traumatic Stress Disorder (PTSD) Among Resettled Afghan Refugees in a Regional Area of Australia' (2021) 30(6) *Journal of Mental Health* 674.

5 Diana Bogner, Jane Herlihy and Chris Brewin, 'Impact of Sexual Violence on Disclosure during Home Office Interviews' (2007) 191(1) *British Journal of Psychiatry* 75; Belinda Graham, Jane Herlihy and Chris Brewin, 'Overgeneral Memory in Asylum Seekers and Refugees' (2014) 45(3) *Journal of Behavioural Therapy and Experimental Psychology* 375.

6 Madeleine Silverstein et al, 'Continued Trauma: A Thematic Analysis of the Asylum-Seeking Experience Under the Migration Protection Protocols' (2021) 5(1) *Health Equity* 277.

7 See generally Helgi Maki et al (eds), *Trauma-Informed Law: A Primer for Lawyer Resilience and Healing* (American Bar Association, 2023).

8 Substance Abuse and Mental Health Services Administration, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (SAMHSA, 2014) 7 (emphasis in original).

The three 'E's of the SAMHSA definition – event, experience and effects – provide a framework for understanding the impact of traumatic events on individuals.

A *Event*

The first 'E' represents the traumatic event itself. These events may include the actual or extreme threat of physical or psychological harm, or severe neglect for a child that imperils healthy development.[9]

Traumatic events may occur as a single occurrence or repeatedly over time. Trauma is often subdivided into two types:[10]

- *Type 1 trauma* refers to a single incident event which is sudden and unexpected. Examples of type 1 trauma events include rapes, assaults or serious accidents.
- *Type 2, or 'complex', trauma* goes beyond a single incident event, and refers to trauma which has been experienced over a length of time and is repeated. It is often part of an interpersonal relationship where someone might feel trapped emotionally or physically. Examples include childhood abuse and domestic abuse. Type 2 trauma can also be experienced in the context of war, torture and human trafficking.

The text revision of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) requires all conditions classified as 'trauma- and stressor-related disorders' to include exposure to a traumatic and stressful event as a diagnostic criterion.[11]

B *Experience*

The second 'E' refers to the individual's subjective experience of a traumatic event. Feelings of humiliation, guilt, shame, betrayal or silencing often shape the experience of these events.[12] How the event is experienced may be linked to a range of factors, including the individual's cultural beliefs, the availability of social supports or the developmental stage of the individual.[13]

For example, the original adverse childhood experience (ACE) study examined traumatic and adverse experiences reported in childhood and made clear the links between trauma and adversity and

[9] Ibid 8.

[10] NHS Education for Scotland, *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce* (NHS Education for Scotland, 2017) 8-9. See also Lenore Terr, 'Childhood Traumas: An Outline and Overview' (1991) 148(1) *American Journal of Psychiatry* 10.

[11] American Psychiatric Association, *Diagnostic and Statistical Manual on Mental Disorders* (American Psychiatric Publishing, 5th ed, text rev, 2022).

[12] SAMHSA (n 8) 8.

[13] Ibid.

longer-term health, mental health and social impacts.[14] In 2015, a study from Public Health Wales found that those who had experienced more than four ACEs were:[15]

- four times more likely to be high risk drinkers;
- six times more likely to have had or have caused unintended teenage pregnancy;
- six times more likely to smoke cigarettes or e-cigarettes;
- 11 times more likely to smoke cannabis;
- 14 times more likely to have been the victim of violence over the last 12 months;
- 15 times more likely to have committed violence against others over the last 12 months; and
- 20 times more likely to have been incarcerated.

C *Effects*

The third 'E' denotes the effects of trauma on an individual's functioning and well-being. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short- to long-term.[16]

When a person experiences a traumatic event or series of events, their brain automatically initiates the 'fight/flight/freeze response' to protect them from danger and threat. This is adaptive in the short term, allowing the person to respond in the way that is most likely to ensure survival – through fighting back, running away or staying extremely quiet and still. For a lot of people, when the threat has gone, their brain shifts back to its usual mode of functioning. However, trauma can cause some people to remain in a state of 'high alert' for a long time after the threat has gone.[17]

Critically, trauma can leave a person highly sensitive to subtle reminders of any previous traumatic experiences and relationships.[18] When experiencing a trauma response, the brain cannot tell the difference between the actual traumatic event and the memory of it, which can trigger intrusive trauma memories – a sense of it 'happening

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[14] Vincent Felitti et al, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study' (1998) 14(4) *American Journal of Preventative Medicine* 245.

[15] Public Health Wales NHS Trust, *Adverse Childhood Experiences and Their Impact on Health Harming Behaviours in the Welsh Adult Population* (Public Health Wales NHS Trust, 2015) 5.

[16] SAMHSA (n 8) 8.

[17] NHS Education for Scotland, *Transforming Psychological Trauma* (n 10) 11.

[18] NHS Education for Scotland, *Trauma Informed Justice: A Knowledge and Skills Framework for Working with Victims and Witnesses* (NHS Education for Scotland, 2023) 11.

again' accompanied by the same powerful feelings and sensations.[19] This is known as 're-traumatisation'.

Maintaining hypervigilance to the threat over time can have adverse effects physiologically and psychologically. For some people, the effects of trauma will include the development of PTSD symptoms. According to the DSM-5-TR, PTSD may include the presence of:[20]

- recurrent, involuntary, and intrusive distressing memories of traumatic events;
- persistent avoidance of stimuli associated with traumatic events;
- negative alterations in cognitions and mood associated with traumatic events; and
- significant distress or impairment in social, occupational, or other important areas of functioning.

The effects of type 2 trauma are hypothesised to be significant and have been linked to individuals experiencing more severe psychopathologies than those exposed to type 1 trauma.[21] The term 'complex PTSD' has been proposed by Herman to include symptoms such as emotion regulation difficulties, alterations to consciousness, negative self-perception, chronic interpersonal difficulties and distorted perceptions of the perpetrator.[22]

III Trauma and Refugees

The definition of 'refugee' in s 5H of the *Migration Act 1958* (Cth) (the *Migration Act*) requires a non-citizen to have a 'well-founded fear of persecution'. Section 5J(4)(b) provides that persecution must involve serious harm to the non-citizen, with the following instances of serious harm being listed in subsection (5):

(a) a threat to the person's life or liberty;
(b) significant physical harassment of the person;
(c) significant physical ill-treatment of the person;
(d) significant economic hardship that threatens the person's capacity to subsist;
(e) denial of access to basic services, where the denial threatens the person's capacity to subsist;
(f) denial of capacity to earn a livelihood of any kind, where the denial threatens the person's capacity to subsist.

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19 Ibid.

20 American Psychiatric Association (n 11) 301-2.

21 Stephanie Lewis et al, 'Unravelling the Contribution of Complex Trauma to Psychopathology and Cognitive Deficits: A Cohort Study' (2021) 219(2) *British Journal of Psychiatry* 448.

22 Judith Herman, 'Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma' (1992) 5(3) *Journal of Traumatic Stress* 377; Judith Herman, *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror* (Basic Books, 1992).

Similarly, the definition of complementary protection in s 36(2)(aa) of the *Migration Act* involves a non-citizen having a 'real risk that [they] will suffer significant harm'. Section 36(2A) provides that a non-citizen will suffer significant harm if:

> (a) the non-citizen will be arbitrarily deprived of his or her life; or
> (b) the death penalty will be carried out on the non-citizen; or
> (c) the non-citizen will be subjected to torture; or
> (d) the non-citizen will be subjected to cruel or inhuman treatment or punishment; or
> (e) the non-citizen will be subjected to degrading treatment or punishment.

The reason for the high prevalence of trauma in refugee and asylum seeker populations is readily apparent from these definitions. As noted above, the process of seeking asylum itself can add further stress as many asylum seekers struggle with legitimate requirements to recall and talk about traumatic events.

Asylum seekers who are detained on arrival in Australia pursuant to s 189 of the *Migration Act* may experience further and more specific stress from the detention process and the detention centre environment, which may adversely affect their mental health status:

> Sources of stress include insecurity, loss of liberty, uncertainty regarding return to country of origin, social isolation, abuse from staff, riots, forceful removal, hunger strikes and self-harm. Depression and anxiety are common. Post-traumatic stress disorder is greatly underestimated and underdiagnosed.[23]

IV Trauma-Informed Practice

Trauma-informed practice is founded on the principles of 'safety first' and 'do no harm'. It does not re-traumatise or blame the victim, rather trauma survivors are seen as unique individuals who have managed abnormal situations to the best of their ability.[24] Trauma-informed practice shifts the focus from 'What's wrong with you?' to 'What happened to you?'

Trauma-informed practice is distinct from specialist services offering specific care, support and interventions for the consequences of trauma. The SAMHSA working concept reflects the international consensus around what trauma-informed practice looks like:

> A program, organisation or system that is trauma-informed *realises* the widespread impact of trauma and understands potential paths for recovery; *recognises* the signs and symptoms of trauma in clients, families, staff and

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23 Judicial Commission of New South Wales, *Trauma-Informed Courts: Guidance for Trauma-Informed Judicial Practices* (Judicial Commission of New South Wales, 2022) 18 (citations omitted).

24 Cathy Kezelman, 'Trauma Informed Practice', *Mental Health Australia* (Web Page, 4 February 2021) <https://mhaustralia.org/general/trauma-informed-practice>.

> others involved in the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatisation.*[25]

Realise, recognise, respond and resist are known as the four 'R's of trauma-informed practice.

A *Realise*

The first 'R' is to realise the prevalence of traumatic experiences. Michultka coined the term 'triple trauma paradigm' to describe the stressors and traumatic exposures that many refugees and asylum seekers endure.[26] The term refers to 'a chronological interaction of three distinct traumatic periods':[27]

1. the trauma of the country of origin;
2. the trauma of the escape/journey of immigration; and
3. the trauma of the relocation process.

Traumatic experiences that a refugee may encounter prior to and during migrating from their country of origin include:

- Violence directed at themselves, their families and others around them.
- Witnessing killings, rapes and other physical assaults, often inflicted on members of their families and neighbours.
- Living in a state of fear prior to leaving their country.
- An arduous and dangerous journey to leave the country. This may involve leaving behind family members that cannot make the journey or losing family members along the way due to death, violence or separation because of chaos.[28]

As well as pre-migration trauma, refugees and asylum seekers often face a multitude of systemic, personal and social difficulties associated with integrating into Australian society. The chronicity of these difficulties often exacerbates the effects of pre-migration trauma. Some of the types of difficulties that may be experienced include:

- language barriers;
- obtaining stable housing;
- financial hardship;
- acquiring employment;
- difficulties in accessing help and assistance;
- encountering forms of institutional racism and discrimination;

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25 SAMHSA (n 8) 9 (emphasis in original).

26 Denis Michultka, 'Mental Health Issues in New Immigrant Communities' in Fernando Chang-Muy and Elaine Congress (eds), *Social Work with Immigrants and Refugees: Legal Issues, Clinical Skills and Advocacy* (Springer, 2009) 135.

27 Ibid 145-6.

28 Trauma and Grief Network, 'Refugees and Asylum Seekers: Supporting Recovery from Trauma' *Trauma and Grief Network* (Information Sheet, 2014) 1-2.

- feelings of loss of home, family and other connections; and
- acculturative stressors.[29]

The triple trauma paradigm helps to explain the unique stress that refugees and asylum seekers undergo, and why it is not 'over' upon arrival in Australia.

B *Recognise*

The second 'R' relates to the ability to recognise the effects of traumatic experiences. Recognising trauma-related symptoms empowers professionals to respond early when a refugee or asylum seeker is experiencing a trauma response. Trauma-related symptoms can be identified through observation, as well as in conversation.[30]

One helpful metaphor when working with refugees and asylum seekers is the 'window of tolerance'. This term was initially developed in neuroscience by Siegel.[31] As represented in Figure 1, each of us has a window of tolerance in which various intensities of emotional arousal can be comfortably processed. This window of tolerance has an upper and a lower boundary. Above the upper boundary is a zone of 'hyperarousal', and below the lower boundary is a zone of 'hypoarousal'.

Figure 1
Window of Tolerance [32]

Hyperarousal heightened sensation; emotional reactivity; hypervigilance; intrusive imagery; disorganised thinking
Window of tolerance
Hypoarousal relative absence of sensation; emotional numbing; disabled thinking; reduced physical movement

When a person's level of arousal moves beyond the boundaries of their window of tolerance, their thinking and behaviour can become disrupted:

> In states of mind beyond the window of tolerance, the prefrontally mediated capacity for response flexibility is temporarily shut down. The 'higher

29 The Bugmy Bar Book Project Committee, *The Bugmy Bar Book* (Web Page) <https://bugmybarbook.org.au/> Refugee Background 2 (citations omitted).

30 Network of Alcohol and other Drug Agencies, *Trauma-Informed Practices for Responding to Difficult Situations* (Network of Alcohol and Other Drug Agencies, 2022) 19.

31 Daniel Siegel, *The Developing Mind* (Guilford, 2nd ed, 2012) 281.

32 Adapted from Pat Ogden, Kekuni Minton and Clare Pain, *Trauma and the Body: A Sensorimotor Approach to Psychotherapy* (Norton, 2006) 27.

> mode' of integrative processing has been replaced by a 'lower mode' of reflexive responding. The integrative function of emotion, in which self-regulation permits a flexibly adaptive interaction with the environment, is suspended.[33]

For people who have experienced trauma, it can be difficult to stay in their window of tolerance. Murray and El-Leithy suggest that 'if trauma memories are activated too strongly, they can overwhelm our client's ability to think clearly, verbalise, and update their thoughts and feelings'.[34]

The Administrative Appeals Tribunal's *Guidelines on Vulnerable Persons* sets out the following trauma symptoms which may influence an asylum seeker's ability to participate during an interview or hearing:

- Poor attention, poor concentration and distractibility which may be the result of intrusive recollection of events, generalised fear and emotional arousal, or depression. Anger and hostility … may occur which are the result of over-reactivity to reminders of traumatic experiences, poor control of emotions, sensitivity to feeling that one is not believed, protection against shame and guilt, anxiety and distrust of people in authority.
- Memory difficulties which can manifest as extremely vivid recollection of some details alongside amnesia for other detail. This may lead to apparent inconsistencies and/or inability to present a chronologically intact account. These difficulties may be the result of … intrusive recollection of events, generalised fear, avoidance or depression, protection against shame and guilt.
- Hesitancy to disclose due to fear of reliving experiences, shame, guilt, or anger about having to prove experiences of violence or injustice.
- Emotional distress due to intrusive memories/images of traumatic experiences, grief, shame or guilt.[35]

C *Respond*

The third 'R' concerns responding in ways that adapt to the effect of trauma and support recovery. Responding to trauma is not the same as treating it, which requires specialised training, qualifications and experience.

The first and best source of what may be causing distress, and what may help to reduce it, is the refugee or asylum seeker themselves. In conversation, professionals can consider asking trauma-specific questions such as:[36]

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[33] Siegel (n 31) 283.

[34] Hannah Murray and Sharif El-Leithy, *Working with Complexity in PTSD: A Cognitive Therapy Approach* (Routledge, 2022).

[35] Administrative Appeals Tribunal, *Guidelines on Vulnerable Persons* (Administrative Appeals Tribunal, 2018) 20-1. See also *Lehrmann v Network Ten Pty Ltd* [2024] FCA 369, [117] (Lee J).

[36] Network of Alcohol and Other Drug Agencies (n 30) 19.

- 'Are there any situations that you find overwhelming or triggering?'
- 'What is the best way for me to support you if you become distressed?'
- 'What are strategies that you have used in the past that you have found helpful?'

When working with asylum seekers in interview or hearing settings, the *Guidelines on Vulnerable Persons* also provides the following strategies to assist asylum seekers who have suffered traumatic events:

- Encourage the applicant to bring a friend or relative … to support them if it is known that the impairments are likely to manifest in an interview situation.
- Explain to the person that it may be necessary to ask questions about 'difficult' or 'upsetting' past experiences during the hearing. Assure the person that the questions will be limited to those that are necessary for the review process.
- Assist the applicant to locate traumatic events in time by not relying only on chronology and dates, but by asking about other contextual events – for example, about how old the applicant was at the time or what their social and familial role was, what was happening in the applicant's family at the time, or what significant local events occurred around that time.
- If the person shows that they are distressed or very angry ask if he or she wants to continue or have a break.
- Don't expect the person to display emotion when recounting traumatic experiences. Emotional detachment is a symptom of PTSD and/or functions as a coping mechanism.
- Explain the process, outline the possible outcomes, specify what other specific information is needed.
- Acknowledge distress without judgment.
- Show that you want to understand why the person is distressed.
- Where appropriate link the person to community support groups or mental health professionals who have experience with victims of trauma ...[37]

Further, consideration can be given to requesting departmental officers or tribunal members of a particular gender, or for an interpreter of a particular gender to be used.[38]

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[37] Administrative Appeals Tribunal (n 35) 21.
[38] Ibid.

D *Resist*

The fourth 'R' is for resisting re-traumatisation. Each time a refugee or asylum seeker is asked to give an account of traumatic events, there is a significant risk of re-traumatisation.[39]

In the context of the process of seeking asylum, it is necessary to recognise that there is the unavoidable risk of re-traumatisation that comes with the requirement to re-tell horrifying trauma content.[40] There are also limits on the adaptations possible while following the rules of procedural fairness and the codes of procedure in the *Migration Act*.[41]

The NHS Education for Scotland's *Trauma Informed Justice: A Knowledge and Skills Framework for Working with Victims and Witnesses* offers the following guidelines to minimise the risk of re-traumatisation:

- minimising the number of times a witness is asked to recount traumatic events
- maximising their sense of trust and safety by ensuring predictability where possible, and that it is to the same consistent person with whom they have built a trusting relationship
- predictability and planning
- avoidance of feeling under pressure or rushed
- avoiding overwhelming distress while discussing trauma
- empathic, validating and professional responses
- introducing elements of choice and control where appropriate and explaining where this may not be possible eg the location of the court or due to the rules of evidence and procedure[42]

V Core Principles

Trauma-informed practice reflects adherence to core principles, rather than a prescribed set of practices and procedures.[43] The core principles of trauma-informed practice include safety, trust, choice, collaboration and empowerment. These five principles have been adapted from SAMHSA[44] and reflect 'the direct opposite conditions of persons who have experienced traumatic events'.[45] There is an overlap with the

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[39] NHS Education for Scotland, *Trauma Informed Justice* (n 18), 52.

[40] Ibid 18.

[41] See *Migration Act 1958* (Cth) pt 2 div 3 sub-div AB, pt 5 div 5 and pt 7 div 4.

[42] NHS Education for Scotland, *Trauma Informed Justice* (n 18) 52.

[43] SAMHSA (n 8) 10.

[44] Ibid. See also Cathy Kezelman and Pam Stavropoulos, *'The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (Blue Knot Foundation, 2012); Roger Fallot and Maxine Harris, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Learning Protocol* (Community Connections, 2009).

[45] Travis Hales, Nancy Kusmaul and Thomas Nochajski, 'Exploring the Dimensionality of Trauma-Informed Care: Implications for Theory and Practice' (2017) 41(3) *Human Service Organizations: Management, Leadership & Governance* 317, 318.

therapeutic jurisprudence principles of voice, validation, respect and self-determination,[46] and trauma-informed practice complements the application of therapeutic jurisprudence techniques.[47]

The core principles of safety, trust, choice, collaboration and empowerment are elaborated on below:[48]

- *Safety* relates to both physical and psychological safety. Physical safety considerations include ensuring the room is sufficiently private without unnecessary interruptions. Psychological safety depends upon a working relationship in which refugees and asylum seekers experience validation, understanding and support.
- *Trust* requires professionals to set and manage realistic and predictable relationship boundaries, protect confidentiality (to the extent that is possible) and maintain open and honest communication. Simply put, this means following through on what they say they are going to do.
- Refugees and asylum seekers are the experts on their own lives, and professionals should offer as much *choice* and control over processes as possible. This requires adherence to key legal and ethical duties: choice is only possible where someone is presented with full information.[49]
- *Collaboration* requires consistently communicating a sense of 'doing with' rather than 'doing to' or 'doing for' refugees and asylum seekers. Collaboration reinforces choice and empowerment.
- The working relationship itself should be *empowering*, making sure refugees and asylum seekers understand their rights and are able to fully engage with them. Research supports the idea that when refugees and asylum seekers achieve greater mastery over their lives, symptoms of trauma reduce.[50]

Examples of ways in which professionals can implement the core principles of safety, trust, choice, collaboration and empowerment are provided in Table 1.

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[46] See generally Glen Cranwell, 'Therapeutic Jurisprudence and Mediation: Natural Partners in Dispute Resolution' (2023) 32(3) *Australasian Dispute Resolution Journal* 185, 189-191.

[47] Katherine McLachlan, 'Same, Same or Different? Is Trauma-Informed Sentencing a Form of Therapeutic Jurisprudence?' (2021) 25(1) *European Journal of Current Legal Issues* 1.

[48] Ibid 6; Maki et al (n 7) 169-70.

[49] See, eg, *Barristers' Conduct Rules* (Queensland Bar Association, 23 February 2018) rule 39; *Australian Solicitor Conduct Rules* (Law Council of Australia, November 2023) rule 7.1; *Code of Conduct for Registered Migration Agents* (Department of Immigration and Border Protection, 18 April 2017) para 2.7.

[50] Kenneth Carswell, Pennie Blackburn and Chris Barker, 'The Relationship Between Trauma, Post-Migration Problems and the Psychological Well-Being of Refugees and Asylum Seekers' (2011) 57(2) *International Journal of Social Psychiatry* 107.

Table 1
Examples of Core Principles in Practice

Core principle	Examples of ways for professionals to implement in practice
Safety	• Recognise cues or signs that the refugee or asylum seeker is moving out of their window of tolerance. • Respond to a disclosure of traumatic events professionally and with empathy, validation and compassion. • Pay attention to the refugee or asylum seeker's basic welfare and comfort needs.[51]
Trust	• Demonstrate patience and a calm presence, providing ample time and opportunity to build rapport. • Clearly explain the professional's role and revisit this as appropriate to ensure that the refugee or asylum seeker has properly understood the boundaries of the relationship. • Outline any limits to confidentiality that may exist at the initial contact. • Keep regular communication with the refugee or asylum seeker regarding what is going to happen and when, anticipating when there may be long delays during the process.[52]
Choice	• Seek informed consent for relevant steps and disclosures. • Ensure that the refugee or asylum seeker is aware of the choices they can make at each stage and the short and long-term legal implications of their choices, helping them make informed decisions that do not bring unexpected consequences. • Provide the refugee or asylum seeker with information as to what formal and informal supports are available, reminding them that they have a choice over when and with whom they engage.[53]
Collaboration	• Consider any processes which may be potentially re-traumatising for the refugee or asylum seeker and support them to develop strategies to cope with this in advance of the process taking place.[54]
Empowerment	• Explain in plain language any legal terms or procedures which may be difficult to make sense of to ensure the refugee or asylum seeker understands the process and what is being communicated.

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51 NHS Education for Scotland, *Trauma Informed Justice* (n 18) 202-3.
52 Ibid.
53 Ibid 202-4.
54 Ibid 204.

Core principle	Examples of ways for professionals to implement in practice
	• Clearly communicate the refugee or asylum seeker's rights at each stage of the process so that they do not feel coerced into making any specific decision. • Provide realistic expectations about timescales to make the process as predictable as possible.[55]

VI Secondary Trauma

Studies of professionals who work with survivors of trauma reveal that they might themselves experience 'secondary trauma'. The term was coined by Figley to describe a constellation of symptoms resulting from indirect exposure to traumatic material.[56] Secondary traumatic stress (STS) is related to the phenomenon of PTSD, with symptoms mirroring those of PTSD. However, unlike PTSD, STS can develop in the absence of direct exposure to trauma. Essentially, 'the primary exposure to traumatic events by one person becomes the traumatising event for the second person'.[57] Although they refer to distinct conditions, the terms STS, vicarious trauma and compassion fatigue are often used interchangeably to describe the cumulative effect that working with trauma survivors has on professionals.[58]

While acknowledging the overlap with the symptoms of PTSD, *The Johns Hopkins Guide to Psychological First Aid* nonetheless offers the following list of warning signs that a professional might be experiencing the effects of STS:

- Feelings of emotional depletion or exhaustion
- Neglecting physical, emotional, and spiritual needs
- Diminished quiet time to reflect and replenish oneself
- Feeling unappreciated
- Diminished ability to be empathetic
- Decreased sense of purpose and accomplishment
- Decreased concentration …
- Irritability
- Insomnia
- Cynicism
- Increased substance abuse

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55 Ibid 203-4.

56 Charles Figley, 'Coping with Stressors on the Home Front' (1993) 49(4) *Journal of Social Issues* 51; Charles Figley, 'Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview' in Charles Figley, *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who Treat the Traumatized* (Routledge, 1995) 1.

57 Richard Harrison and Marvin Westwood, 'Preventing Vicarious Traumatization of Mental Health Therapists: Identifying Protective Practices' (2009) 46(2) *Psychotherapy Theory, Research, Practice, Training* 203, 204.

58 See, eg, Joy Osofsky, Frank Putnam and Cindy Lederman, 'How to Maintain Emotional Health when Working with Trauma' (2008) 59(4) *Juvenile and Family Court* 92.

- Relationship difficulties[59]

Developing STS is a well-recognised risk of working with trauma survivors,[60] including refugees and asylum seekers. Follette, Polusny and Milbeck identified several unhelpful coping strategies employed by professionals including increased alcohol use, withdrawal and avoidance.[61] Therefore, much of the literature-base places emphasis on professionals being proactive in mitigating and managing the effects of secondary trauma. The 'ABC' of self-care – awareness, balance and connection – recommends that professionals:[62]

- build *awareness* of the impact of trauma exposure and monitor for signs so they can seek help early;
- strive for a *balance* of roles and workload within their work, and between work and other areas of their life; and
- develop a *connection* to colleagues, to family/friends and to something larger, whatever that means for the individual. Intentionally engaging in practices that reconnect professionals to their beliefs, values and ethics is an important part of cultivating meaning and feeling sustained in their work.

Despite the emphasis on self-care strategies, it cannot be solely a professional's responsibility to look after their own well-being. Supervisory support and co-worker support have been found to be organisational protective factors against STS.[63] Specifically, an organisational climate that validates and normalises professionals' responses mitigates the risk of STS, while one that is perceived as unsupportive increases it.[64] Considering this, ameliorating STS is an organisational responsibility as much as an individual one. The provision of supervision structures and effective working relationships are key parts of a supportive organisational culture.[65]

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[59] George Everly and Jeffrey Lating, *The Johns Hopkins Guide to Psychological First Aid* (John Hopkins University Press, 2nd ed, 2022) 250-1.

[60] Roman Cieslak et al, 'A Meta-Analysis of the Relationship Between Job Burnout and Secondary Traumatic Stress Among Workers with Indirect Exposure to Trauma' (2014) 11(1) *Psychological Services* 75.

[61] Victoria Follette, Melissa Polusny and Kathleen Milbeck, 'Mental Health and Law Enforcement Professionals: Trauma History, Psychological Symptoms, and Impact of Providing Services to Child Sexual Abuse Survivors' (1994) 25(3) *Professional Psychology: Research and Practice* 275.

[62] Adapted from Karen Saakvitne and Laurie Pearlman, *Transforming the Pain: A Workbook on Vicarious Traumatization for Helping Professionals who Work with Traumatized Clients* (Norton, 1996).

[63] Jennifer Hensel et al, 'Meta-Analysis of Risk Factors for Secondary Traumatic Stress in Therapeutic Work with Trauma Victims' (2015) 28(2) *Journal of Traumatic Stress* 83.

[64] Rebecca Brockhouse et al, 'Vicarious Exposure to Trauma and Growth in Therapists: The Moderating Effects of Sense of Coherence, Organizational Support, and Empathy' 24(6) *Journal of Traumatic Stress* 735.

[65] Hensel (n 63); Ginny Sprang et al, 'Psychometric Properties of the Secondary Traumatic Stress-Informed Organizational Assessment' 23(2) *Traumatology* 65.

VII Conclusion

This article has provided a primer on trauma-informed practice for professionals who work with refugees and asylum seekers. By taking steps to integrate these principles into their daily work, professionals can better support the needs of refugees and asylum seekers. As reworded for the refugee law setting, the *Knowledge and Skills Framework for Working with Victims and Witnesses* sets out the following desired outcomes of trauma-informed practice:[66]

- create environments in which the impacts of trauma are understood, and that reduce traumatic stress engendered by the immigration process;
- support the recovery of refugees and asylum seekers affected by trauma by providing them with a different experience of relationships, one that offers them safety, trust, choice, collaboration and empowerment; and
- minimise the barriers to engaging with the migration system that refugees and asylum seekers affected by trauma can experience when memories and associated feelings of trauma are triggered by aspects of the process.

Working with refugees and asylum seekers is deeply rewarding but at the same time very challenging. Hearing the difficulties that refugees and asylum seekers have endured can have an impact on professional wellbeing if self-care strategies are not in place and used. While not the focus this article, learning to recognise symptoms of secondary trauma is also crucial.[67]

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[66] NHS Education for Scotland, *Trauma Informed Justice* (n 18) 13.

[67] See further Helen Bowskill, 'Emotion at Work: Acknowledging and Dealing with the Cumulative Trauma and Stress of your Role as a QCAT Member or Adjudicator' (Presentation to Queensland Civil and Administrative Tribunal, 11 March 2022).