Trauma-Informed Editing Practice:

A Framework

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Acknowledgement of Country

I live and work on the land of the Dharawal people, and acknowledge and respect the traditional custodians of the ancestral lands from which I benefit – this land where mountains meet saltwater, this land that always was, and always will be, Australian First Nations' land. I acknowledge the story owners, holders, and tellers, and aim to play an active role in working towards building a nation that amplifies First Peoples' stories.

As an editor whose practice is informed by principles of trauma-informed care, I am committed to Transformational Ethical Story Telling, an anti-oppressive framework that aims to flip the story-telling balance of power, where each person's rights and needs – regardless of their race, ethnicity, language, age, gender, religion, sexual orientation, gender identity, gender expression, health, ability, economic status or background – must be respected.

In this thesis, I have chosen to use the term First Nations Australians. I understand that many of my primary and secondary sources use variations of the terms First Nations, Indigenous, and Aboriginal and Torres Strait Islanders interchangeably. I recognise that none of these terms are perfect and, within their imperfection, each carry nuanced residual forms of colonialism and power. With this in mind, the research conducted during this project was undertaken with integrity and respect, giving appropriate consideration to the needs of minority groups and vulnerable peoples.

Certification of Dissertation

I certify that the ideas, results, analyses, and conclusions reported in this dissertation are entirely my own effort, except where otherwise acknowledged. I also certify that the work is original and has not been previously submitted for any other award, except where otherwise acknowledged.

Abstract

Trauma-informed practice is a strengths-based framework that guides the service provisions of the Australian healthcare and education sectors. Based on Mental Health Australia's (2014) definition of trauma-informed care, the principles that underpin a trauma-informed approach to practice include safety, trustworthiness, opportunity for choice, collaboration, empowerment, and respect for diversity. While there is significant research on trauma-informed care and trauma-informed pedagogy in both national and international contexts, there is a dearth of literature on trauma-informed editing practice. Given that writing itself is a vehicle for processing and sharing traumatic experience, the lack of trauma-supported editing service provisions for writers and editors is concerning, with risks of harm to both the author and the editor if an adequate support framework is not in place.

Thus, this qualitative study reviews existing trauma-informed frameworks of Australian health and education organisations and conducts a field survey of Australian and New Zealand editors who self-identify as working, or having worked, with traumatic material or trauma survivors. This study acknowledges that the use of trauma-informed tools in a creative and communications industry that is so heavily populated by freelance or self-employed individuals will necessitate a cultural and philosophical shift and, as such, the findings from this research will inform the creation of a trauma-informed editing framework. This framework will provide editors with a set of trauma-informed guidelines for best practice. It is hoped that this framework will also provide professional development opportunities for qualified editors, as well as guide the development of editing curricula.

Keywords

Editing, editing practice, trauma, trauma-informed editing practice, trauma-informed pedagogy, trauma-informed creative practice, trauma-informed healthcare, reading resilience

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Introduction

Primum non nocere.

First, do no harm.

This common aphorism, which doubles as a moral injunction, is rife in popular renderings of medical practice, and is frequently attributed to the Hippocratic oath (Schmerling 2020). The principle of *primum non nocere*, historically implemented as nonmaleficence by the Western medical field (Varkey 2021), has increased in prevalence in recent years (Vibert 2022) as an ethical directive in other social agencies (CRS 2007; CSWA 2016; DFAT 2016 & 2018). Given the aphorism's new relevance to broader sociological applications, such as the 'Do No Harm Toolkit'[1] (DFAT 2016) and the Clinical Social Work Association's Code of Ethics (CSWA 2016), a clear definition of the principle's meaning and significance is still in construction; however, Charancle and Lucchi (2018) speculate that the moral instruction, *first, do no harm,* is commonly interpreted as the directive to 'avoid exposing [others] to additional risks', and, fundamentally, to 'mitigate potential negative effects [of one's actions] on the social fabric, the economy and the environment' (p. 9). Charancle and Lucchi's (2018) research suggests that this risk mitigation is achieved by taking a step away from the proposed social intervention to consider its broader implications on the individual and wider community.

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[1] The 'Do No Harm Toolkit' was developed in conjunction with the International Women's Development Agency and enables organisations to apply findings from the Do No Harm Research Project to their project design, implementation, and monitoring (DFAT 2016).

Indeed, in *The Subversive Copyeditor* (2016), Carol Fisher Saller reminds us that, as editors, it is 'a privilege to polish a manuscript without the tedium and agony of producing it' (p. 7). As editors, our relationship with an author can be combative or collaborative; we can pillage our way through a manuscript, or we can protect the author's voice, and promote it. Regardless of genre, form, or audience, our first goal should be – always – to do no harm (Fisher Saller 2016, p. 7). When editing traumatic material – whether it be traumatic content presented in fictional form or the traumatic experiences of an author – editors must be guided by this aphorism: *first, do no harm*. In other words, in our editing practices and processes, we must take care to not re-traumatise or lay blame. Rather, we must champion messages of resilience and recovery, and engage sensitively with authors, and responsibly approach problematic texts in a manner that protects our own wellbeing.

Best-practice editing – and editing that does no harm – must be shaped by directives and standards. Many highly developed, industrialised nations boast non-profit organisations that act as recognised authorities on editing and proofreading in their countries. The Australian and New Zealand authority for editors is the Institute of Professional Editors (IPEd). It exists to advance the profession of editing and to support and promote Australian and New Zealand editors, with membership open to individual editors, those with an interest in editing, publishing or a related field, students, and organisations that employ editors. Currently, neither the IPEd *Code of Conduct* (n.d.), nor the *Australian Standards for Editing Practice* (IPEd 2013) adopt a 'do no harm' (Kezelman 2014; Fisher Saller 2016; Charancle & Lucchi 2018) approach to service provision. Nor do they provide specific guidelines for trauma-informed editing practice. Examples of other recognised international organisations

include Britain's Chartered Institute of Editing and Proofreading (CIEP), the United States' ACES: The Society of Editing, and Editors Canada. A keyword search of their public websites reveals extremely limited recall for 'trauma', with CIEP and ACES producing no results. Editors Canada, on the other hand, yields a single result: a 2019 conference session titled 'Navigating Our Story: Distressing Content and Trauma Resiliency' (Cheung 2019). The absence of standards or directives on trauma-informed editing practice leaves the onus on the individual editor to navigate exposures to problematic texts and authors with trauma experiences, leading to potentially negative effects on editor and author wellbeing.

Research aims and objectives

Trauma-informed practice is a strengths-based framework that guides the service provisions of the Australian healthcare and education sectors. Based on Mental Health Australia's (2014) definition of trauma-informed care, the principles that underpin a trauma-informed framework include safety, respect for diversity, opportunity for choice, collaboration, trustworthiness, and empowerment (Kezelman 2014; SAMHSA 2014). These principles guide and inform this research in the development of a framework that aims to improve the accessibility, diversity and, most importantly, safety of editors and authors engaging in the transactional relationship of editing.

While there is significant research on both trauma-informed care (Center for Substance Abuse 2014; Reeves 2015; Bendall et al. 2021; RACGP 2022) and trauma-informed pedagogy (Thomas et al. 2019; Harrison 2020; Thompson & Carello 2022), there is a dearth of literature on trauma-informed editing practice. Given that writing itself is often a vehicle for

processing and sharing trauma experience, the lack of trauma-supported editing service provisions for writers and editors is concerning, with risks of harm to both the author and the editor if an adequate support framework is not in place (Carello & Butler 2013; McMahon & Lyall n.d.). To address this lacuna in scholarship, this 20,000-word traditional thesis seeks to answer the following research question:

Can established trauma-informed care principles guide the creation of a strengths-based framework that could be applied to Australian editing practice?

To answer this question, the project seeks to address the following sub-questions:

- *What is 'trauma-informed practice' in the editing context?*
- *How can trauma-informed principles be applied to the editor–author relationship?*
- *What established trauma-informed principles do editors believe to be most important in guiding their practice?*

To address the research question, this qualitative study reviews current trauma theory and assesses Australian healthcare and education trauma-informed practice frameworks before culminating in a field survey of Australian and New Zealand editors who self-identify as working, or having worked, with traumatic material or authors with histories of trauma. This two-phase project will identify thematic commonalities between existing trauma-informed care frameworks across sectors, and practising editors' knowledge, and implementation, of similar guiding principles. Compiled data will be investigated to propose simple and sustainable ways for editors to ethically approach traumatic material while protecting their personal and professional wellbeing. This study acknowledges that the implementation of

trauma-informed services in an industry that is so heavily populated by freelance or self-employed individuals will necessitate a cultural and philosophical shift and, as such, it is envisioned that the findings from this research will inform the development of a framework for trauma-informed editing practice that, with further research and development, can be presented to the Institute of Professional Editors (IPEd), the professional association for Australian and New Zealand editors.

Therefore, given the current dearth of formal research into trauma-informed editing practices, the benefits of this research are significant. It is envisioned that the affordances of a trauma-informed editing framework may include advances in practice knowledge, heightened editorial insight and understanding, and gains in expertise for individual editors. In a practical sense, it is hoped that this framework will provide opportunities for professional development in post-qualification editors, as well as inform future adaptations to editing and publishing curricula. However, it goes without saying that adapting a set of principles that originate in the healthcare sector to a creative arts/communication industry necessitates some degree of caution – editors are not qualified to act upon the clinical needs of trauma survivors. To this end, this research will remain transparent in its understanding of the limitations of trauma-informed practice versus a more clinical perspective of trauma-specific therapy (RACGP 2022), where complex trauma is seen to require additional knowledge and training in order to ensure a safe therapeutic process to recovery.

Literature Review

"One of the last frontiers of our society is the lack of realisation about the extent of trauma."

—Warwick Middleton (cited in Tobler 2011)

Trauma can be defined as physical or emotional harm that results in lasting adverse effects on an individual's functioning, including their physical, social, emotional, or spiritual well-being (SAMHSA 2014). Neurobiological research suggests that trauma – especially childhood trauma – affects the development and functioning of the brain, including the brain's physical structure (Anda, Felitti, & Bremner 2006; Nemeroff 2016).

Trauma can also cause adverse impacts on impulse control, executive functioning, and emotion-based activities (Toth et al. 2013; Cowell et al. 2015). In fact, many trauma survivors report increased incidence of anger (Chemtob et al. 1997), anxiety (Harness & Javankbakht 2021), and agitation (Iyadurai et al. 2019), including feelings of distress without periods of respite and intrusive recollections that continue despite a return to safety (Iyadurai et al. 2019). Long-term responses to traumatic exposure can include sleep disorders and fatigue, flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely (Center for Substance Abuse Treatment 2014).

Contemporary trauma theory provides a framework for conceptualising the effects of trauma on a survivor's functioning and behaviour. Where past theories held that a survivor's poor functioning signified a weak moral character (Goodman 2017), contemporary theories

of trauma regard survivors as psychologically and physically injured (Salovey & Sluyter 1997; Williams 2006; Bloom & Farragher 2011; van der Kolk 2014). Neurobiological research suggests that trauma – especially childhood trauma – affects the development and functioning of the brain, including its physical structure (Toth et al. 2013; Cowell et al. 2015). In this context, being trauma-informed is accepting that a person's behaviours, reactions, and responses may be symptoms of maladaptive coping with past trauma experiences, rather than indicative of the person themselves (Levenson 2014).

Having established that trauma can trigger both physiological and psychological changes to brain development, an individual's trauma response can be broken into two clear, but related, concepts: psychological trauma and behavioural trauma (Figley 1985, p. xix). Psychological trauma is defined by Figley (1985, p. xviii) as 'an emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm', whereas behavioural trauma is 'a set of conscious and unconscious actions and behaviours associated with dealing with the stresses of catastrophe and the period immediately afterwards' (p. xix). However, where Figley requires that an event be 'necessarily catastrophic, extraordinary and memorable' (p. xviii) in order to generate a traumatic stress reaction, contemporary trauma theorists such as van der Kolk (2006) and Scaer (2001) believe that, rather than the event needing to fit a certain preconceived measure, its potential for trauma is instead measured by the survivor's personal ability to deal with the stressor, as well as their previous exposure to trauma and

the prevalence of similar traumatic events within their family or community.[2] Thus, an individual's trauma response is better measured by their ability to act or respond appropriately at the time of the traumatic event (Scaer 2001).

Complex trauma

Complex trauma occurs when trauma survivors are exposed to chronic traumatisation through any number of instances, including remaining in an unsafe home; experiencing multiple or recurring traumatic events; or being exposed to ongoing internal and external (re)traumatisation via the reactions of family members or peers to trauma disclosure (van der Kolk 2005; Atkinson 2017), including the generation of feelings of guilt or shame or the ongoing perception of being unsafe (Blue Knot n.d.). This feeling of safety – or lack thereof – is key to understanding the ongoing effects of complex trauma, which can not only cause 'hyperarousal and hypervigilance in relation to external danger', but also 'the internal threat of being unable to self-regulate, self-organise, or draw upon relationships to regain self-integrity' (RACGP 2022). Therefore, given the work conducted to date on complex trauma, it is clear that, while not all individual experiences fit the psychiatric criteria for a traumatic event, exposure to multiple or prolonged events of this nature may trigger a traumatic stress disorder. These traumatic events most commonly relate to interpersonal

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[2] Building on established trauma theory, van der Kolk's research further explores the connection between trauma and wellbeing and finds that survivors of childhood trauma more frequently encounter difficulties developing and maintaining family, peer, and intimate relationships. As adulthood progresses, trauma survivors are at an increased risk of diseases related to lifestyle choices, such as cancer, heart disease, stroke, liver disease or diabetes, and are also more likely to be incarcerated during their lifetime (Atkinson et al. 2010, p. 293). As such, van der Kolk champions early detection of occurrences of childhood trauma, and early intervention in those who are childhood trauma survivors.

relationships, such as psychological maltreatment, neglect, and physical and/or sexual abuse (van der Kolk 2005), often beginning in childhood and extending over the course of an individual's life (Terr 1991; Giller 1999).

Retraumatisation

Retraumatisation is defined as the stress reaction that develops after either repeated exposures to traumatic events (Duckworth & Follette 2012) or the 'triggering or reactivation of traumatic stress symptoms' (Gildersleeve et al. forthcoming) through an event that mirrors experiences or emotions relating to previously experienced trauma. System-induced retraumatisation occurs when the procedures and services designed to protect survivors of trauma fail (Brain Training Australia n.d.).

Collective trauma

More than an individual's experience alone, trauma is also a sociocultural phenomenon where entire culture groups experience the effects of traumatic events. Intergenerational trauma, structural or historical trauma, and racial trauma are all forms of collective trauma (Andermahr 2015). Collective trauma can be further delineated into subsets: the intergenerational cycle of experiencing and perpetrating trauma affecting multiple generations of families or close social groups; the carrying of historical trauma down through time in the form of cultural norms; and racial or cultural trauma where experiences of trauma are ongoing and related directly to the positioning of an often minority cultural group (AIHW 2019; DeAngelis 2019; Hirschberger 2018).

Intergenerational trauma

Trauma, by nature, is a cause-and-effect phenomenon which, when left unaddressed, can result in a cycle of victimisation and perpetration, compounding within, and across, multiple generations (Healing Foundation 2013). Moreover, established neurobiological changes and maladaptive coping mechanisms can mean that childhood or young adulthood trauma culminates in the development of individual behavioural patterns that cause harm to family and community. Intergenerational trauma[3], in this sense, can be reinforced through 'parenting practice, behavioural problems, violence, harmful substance use and mental health issues' (Healing Foundation 2014). Notably, aspects of endemic intergenerational trauma often become normalised within families and communities, perpetuating the cycle of trauma and limiting the potential for assistance seeking (Atkinson & Atkinson 1999; Wilson 2016).

The result of intergenerational trauma is ingrained maladaptive coping mechanisms learned from individual experiences of trauma as well as collective social experiences of the same traumatic events (DeAngelis 2019; Hirschberger 2018). While the concept of intergenerational trauma is not limited to specific social groups, races, or socio-economic strata (Australians Together 2021), there is substantial evidence (Atkins, Nelson & Atkins 2010; Menzies 2019) that intergenerational trauma is most prevalent in disadvantaged and minority communities, quite possibly due to the 'combined effects of colonialisation (and

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[3] Secondary trauma is another facet of intergenerational trauma, whereby children or family members bear witness to traumatic events acted out upon parents or caregivers (Australians Together 2021).

the actions it legitimised)' (Atkins et al. 2010) and more contemporary – but equally problematic – policies, practices, and conventions of government, social services, and dominant culture.

Historical trauma

Historical trauma is defined as the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes as 'collective emotional and psychological injury … over the life span and across generations' (Muid 2006; Atkinson, Nelson & Atkinson 2010). Like the cyclical nature of intergenerational trauma, community networks play a significant role in the transmission of historical trauma across generations. Helen Milroy explains:

> The trans-generational effects of trauma occur via a variety of mechanisms including the impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from extended family, culture and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, the process of vicarious traumatisation where children witness the on-going effect of the original trauma... even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality. (2005, p. xxi)

Historical trauma can be clearly illustrated through large-scale events such as the Holocaust (Danieli 1985; Danieli 1989; Kellerman 2001); prosecution and diaspora (Aoki 2011; Antoniak 2020); war (Mohatt 2014); colonial violence and injustice (Smallwood et al. 2020); and government-endorsed displacement and discriminatory initiatives such as Australia and Canada's Stolen Generations (Healing Foundation 2014; Fast & Collin-Vezina 2010; Healing

Foundation 2019). These events have multigenerational effects upon minority cultural groups, and implications for the loss of language and cultural tradition.[4] Children exposed to unresolved and incomplete mourning generated by significant trauma are normalised to depression from birth and are more likely to experience poorer psychological and physiological health (van der Kolk 2014). For example, research conducted as early as 1988 (Solomon et al.) links depressive states of descendants of Holocaust survivors with their ancestors' Holocaust experiences. This complex trauma (re)experiencing frequently includes 'depression and suicidal ideation' as well as an innate obligation to share the collective pain, take responsibility for caring for survivor family members, and the 'compulsion to compensate for genocidal legacies' (Duran et al. 1998).

Trauma theory and Eurocentrism

Historically, trauma suffering and representation has been viewed through a Eurocentric social lens (Craps 2014). Where the *Macquarie Dictionary* (2022) defines Eurocentrism as 'of or relating to views, personal orientation, etc., which assume the primacy of European values and perspectives', this bland definition, although semantically correct, fails to address the true depth of the perception of trauma and trauma survivors. Indeed,

[4] Duran et al. (1998) write of the 'soul wound' in American First Nations as representative of historical trauma, where Indigenous peoples 'explained that present problems had their etiology in the traumatic events of the past, known as the "soul wound"' (Duran et al. 1998). This soul wound, and historical trauma in a broader sense, are more complex than a basic definition can cover; where unresolved trauma is 'multigenerational and cumulative over time,' extending 'beyond the life span' of the original event to encompass 'collective, cumulative psychic wounding ... across generations' (Duran et al. 1998) and contributing to the subsequent health problems of the community.

Eurocentrism, as Çapan makes clear, is 'not a geographical question, but an epistemic one' (2018, p. 1).

Models of trauma theory have long failed to address trauma from a cross-cultural viewpoint, being unsuccessful on at least three counts. First, as Stef Craps explains in *Beyond Eurocentrism: Trauma theory in the global age* (2014), these models 'marginalize or ignore traumatic experiences of non-Western or minority cultures' (p. 46), with most trauma theories focusing on events that took place in Euro-American history, such as the Holocaust or 9/11. Through a Eurocentric lens, suffering is portrayed as a Western construct in which those 'others' who do not fit these perimeters are denied the right to express their trauma experiences as suffering. These constructions of 'Western' and 'other' create a differential distribution of grief and 'grievability' across cultures that is both material and perceptual in nature: 'those whose lives are not regarded as potentially grievable, and hence valuable, are made to bear the burden of starvation, underemployment, legal disenfranchisement, and differential expose to violence and death' (Butler 2009, p. 25).

Similarly, not all attempts to reconstruct trauma theory from a non-Western 'other' are appropriate. Cross-cultural encounters can display Eurocentric bias equally easily, demonstrating highly problematic witnessing across cultural boundaries (Craps 2014; Kankava 2013). Craps points out that this problematic interpretation is particularly evident in Caruth's (1996, pp. 26–59) examination of Alain Resnais's *Hiroshima mon amour* (1959), where Caruth fails to address the unilateral voice of the film – a French woman – with the story of Hiroshima, and the trauma experienced by the male Japanese characters, remaining

largely untold. Indeed, Craps claims that ‘Hiroshima is reduced to a stage on which the drama of a European woman’s struggle to come to terms with her personal trauma can be played out; the Japanese man is of interest primarily as a catalyst and facilitator of this process’ (p. 47). Thus, despite being a seminal theorist of contemporary literary trauma, Caruth fails to identify this asymmetric exchange and appropriation of Japanese suffering in order to articulate European trauma as anything other than a model example of cross-cultural witnessing. This blind spot illustrates how even the most well-meaning intentions might fail to recognise the trauma experience of the ‘other’.

Second, traditional models of trauma theory ‘tend to take for granted the universal validity of definitions of trauma and recovery that have developed out of the history of Western modernity,’ where ‘uncritical cross-cultural application of psychological concepts ... amounts to a form of cultural imperialism’ (Craps 2014, p. 48). Derek Summerfield (2004), in his exploration of cross-cultural perspectives on the medicalisation of human suffering, argues that psychiatric universalism amounts to knowledge imperialism, where colonial thinking acquiesced that there were different knowledges (Western versus ‘Other’) but maintained that First Nations’ knowledges were second-rate, leading to the creation of a dominant trauma model based on the cultural and political norms of the colonising party.

Importantly, Craps also criticises how such models can ‘often favour, or even prescribe, a modernist aesthetic of fragmentation and aporia as uniquely suited to the task of bearing witness to trauma’ (p. 46), suggesting that the notion that trauma can only be adequately represented ‘through the use of experimental, modernist textual strategies’ (Morrissey

2021) is an antiquated and Eurocentric notion. The anti-narrative, fragmented modernist form is frequently used by trauma theorists to justify their prepositions, listing similarities with the psychic experiences of trauma (Dewey 1990; Lifton & Mitchell 1995; Morrissey 2021); however, with modernistic approaches to art-making and writing being a specifically European cultural tradition, this notion risks establishing and upholding a particularly narrow trauma canon by mostly Western writers. This only serves to uphold the ongoing cycle of perpetuation of the structures that maintain existing inequalities. To remedy this, Luckhurst (2008) suggests revising assumptions about how literature bears witness to trauma, pointing out that the trauma-initiated crisis of representation creates as much narrative possibility as it does impossibility, reminding us that there is a 'wide diversity of high, middle and low cultural forms [that] have provided a repertoire of compelling ways to articulate that apparently paradoxical thing, the trauma narrative' (p. 83).

Therefore, to become more inclusive and culturally sensitive, contemporary literary trauma theory requires an acknowledgement of the experiences, sufferings, and grief of non-Western groups, on their own terms, rather than with forced connections between Western aesthetic form and political or ethical contexts. As Craps states, 'Trauma theory should take account of the specific social and historical contexts in which trauma narratives are produced and received, and be open and attentive to the diverse strategies of representation and resistance which these contexts invite or necessitate' (2014, p. 51). In this respect, it is important to note that the literature explored in this review has taken a very specific, Western, trajectory through trauma theory: historical trauma, as aforementioned, was explained by research into Holocaust survivors, and initial

understandings of literary trauma theory were framed in terms of modern versus postmodern restructured writing and appropriations as indicative of the artistic desire to somehow represent the unrepresentable.

Thus, with these biases in mind, this project endeavours to move beyond the Eurocentric approach to trauma theorising, replacing it instead with an emic–etic cross-cultural methodology that strives to avoid the biases that might be generated by an ethnocentric gauging of 'normal'. The editing recommendations developed are made with both the knowledge and acknowledgement that both editors and authors involved in the transaction of editing may be from non-Western, or minority, groups.

Trauma-informed practice

Trauma-informed[5] practice is generally conceived as practice that draws on six core principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and acknowledgement and appreciation of cultural, historical, and gender issues (Harris & Fallot 2001; SAMHSA 2014). This sociocultural model of care 'seeks to prevent retraumatisation and promote resilience through a skills-based approach to coping and capacity building' (Harris & Fallot 2001; SAMHSA 2014). Trauma-informed care practices recognise that trauma experiences are common, with many people

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[5] Quite the buzz-word, a simple Google search of 'trauma-informed' generates multiple hits: What are the 5 principles of trauma-informed care? What are the 4 concepts of trauma-informed care? What are the 6 principles of trauma-informed practice? And, most alarmingly, what are the 11 theories of trauma-informed practice? This rhizomatic mapping indicates a lack of cohesion across sectors and raises questions about how effective trauma-informed practice is, or how effective trauma-informed practice can be, when organisations are unable to agree upon a definition of what constitutes trauma-informed care.

having multiple adverse experiences across their lives (AIFS 2016) – an acknowledgement of both trauma prevalence and pervasiveness (SAMHSA 2014). These practices also accept that the impacts of trauma may be lifelong (NSW Health 2022) and felt both psychologically (SAMHSA 2014) and physically (Anda, Felitti, & Bremner 2006; Nemeroff 2016). The Australian Institute of Family Studies (AIFS) explains that, while being trauma-informed in clinical work is paramount, so too is recognising that trauma survivors have care needs beyond the clinical:

> In addition to evidence-based programs or clinical interventions that are specific to addressing trauma symptoms, such as trauma-focused cognitive behaviour therapy, there is a need for broader organisational- or service-level systems of care that respond to the needs of clients with a lived experience of trauma that go beyond a clinical response. (2016, p. 2)

The key tenet of trauma-informed care is to create a space of safety that does not retraumatise the survivor nor cause trauma for the care provider (Harris & Fallot 2001). This is achieved through viewing symptomatic behaviour as normal reactions to abnormal experiences (Evans & Coccoma 2014; van der Kolk 2014), implementing a screening process to flag the potentiality for trauma (Harris & Fallot 2001), seeing trauma-informed care practices as being an organisation-wide commitment to strengthen relationships between clients and practitioners (Leitch 2017), and enhancing personal safety through creating a sense of welcome and mutual respect (Elliott et al. 2005; Harris & Fallot 2001).

Despite the fact that many social agencies in Australia have sought to implement trauma-informed care in their service provisions, there has been little expansion or application of this model in other service-based industries, such as retail and banking. For organisations to

achieve sustainable change in service provision, there needs to be a substantial commitment in terms of resources, personnel, and time, which necessitates financial and structural change that is beyond the reach of many organisations (Atkinson 2010, p. 141). Granted, this difficulty is successfully navigated by Australian social welfare and trauma recovery programs such as the *Family Wellbeing* program (2017); the *Yarning Up on Trauma* education model (2008); and the *We Al-li Programs* (2019), all of which employ a 'train the trainer' model[6] of restructuring knowledge in order to achieve sustained community change over time. These programs focus as much on the development of worker and community strength, confidence, and skill building, as they do on overcoming the behaviours and attitudes that lead to dysfunctional communities (Frederico et al. 2010). As Atkinson et al. make clear:

> By establishing and equipping a core group of community members with the skills necessary to direct vulnerable individuals away from disruptive and damaging behaviour, substance and alcohol misuse and family violence and neglect, these programs are contributing to the development of safe, structured and stable Aboriginal communities (2010, p. 141).

More simply, by ensuring community leaders, care providers, educators, and custodians are actively engaging and educating their peers in trauma-aware practice, the implementation of trauma-informed frameworks becomes more sustainable in the longer term.

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[6] A 'train the trainers' model of information-sharing prepares training providers and educators with the skills and knowledge needed to effectively convey information, as well as with the knowledge that is intended to be conveyed. This creates a more sustainable and effective knowledge-sharing transaction (CDC 2019).

Trauma-informed healthcare in Australia

According to Australia's Mental Health Coordinating Council (MHCC), 'Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches' (2013, p. 1). As previously discussed, childhood trauma impacts brain and emotional development, leading to a range of psychological and physiological health issues in later life (van der Kolk 2005; 2014). Yet, despite established evidence for these claims (Anda, Felitti, & Bremner 2006; Toth et al. 2013; Cowell et al. 2015; Nemeroff 2016), trauma survivors are still exposed to stigma, discrimination, and systems of care that do not meet their basic needs (Schneider 2018; Schomerus et al. 2021). Trauma-informed guidelines provide a means for service providers, case workers, and healthcare professionals to be well-informed on trauma theory, as well as wary of past biases and system failures. For these professionals, being trauma-informed involves possessing an awareness of relationships, development, attachment, and physiology, as well as intra-psychic changes to sense of self and meaning (RACGP 2022). Subtle changes in affect, relational connection, and coherence of experience can disguise more significant feelings of overwhelm, dissociation, or hypo-arousal (Atkinson 2013).

In *Trauma-Informed Services and Trauma-Specific Care For Indigenous Australian Children* (2013), prominent Australian trauma policy writer, Judy Atkinson, suggests that a trauma-informed service: understands trauma and its impact on individuals, families, and communal groups; creates environments in which individuals feel physically and emotionally safe;

employs culturally competent staff and adopts practices that acknowledge and demonstrate respect for specific cultural backgrounds; supports victims/survivors of trauma to regain a sense of control over their daily lives and actively involves them in the healing journey; shares power and governance, including involving community members in the design and evaluation of programs; integrates and coordinates care to meet individuals' needs holistically; and supports safe relationship building as a means of promoting healing and recovery (p. 2). From this, it is clear that trauma is a whole-person and whole-community issue that requires a healthcare framework that negotiates how social determinants of health, environmental threats (including racism and other forms of injustice), and relationship dynamics are translated into health outcomes, including multimorbidity and medically unexplained symptoms (RACGP 2022).

Trauma-informed pedagogy in Australia

Trauma-informed practice in an educational context is a strength-based framework that promotes both an understanding and recognition of, and response to, the impact of trauma in the classroom (Quadara & Hunter 2016; Craig, cited in NSW Department of Education 2020). In 2020, the New South Wales (NSW) Department of Education released *Trauma-Informed Practice in Schools: An Explainer,* a document that outlines the following elements as being integral to trauma-informed care: understanding what trauma is; realising the impact of trauma on students' relationships, behaviours, and learning; recognising the signs and symptoms of trauma; responding to trauma by adapting policies, procedures, and practices in the classroom; identifying potential paths to success for students; and resisting

re-traumatising students (p. 4). These guidelines emphasise how educational staff can best support the learning, and recovery, of children and young people who have experienced trauma. However, these guidelines also clearly establish that the educator's role is not as therapist but rather as a place of safety for trauma-affected students. Trauma-informed practice in NSW schools is addressed as a whole-school approach 'with a focus on consistent, relationally-based and predicable strategies' to avoid students impacted by trauma being retraumatised or failing to reach their full potential (NSW Department of Education 2020).

Trauma-informed practice at the tertiary level

There is a growing appreciation of the need for trauma-informed frameworks to guide the delivery of tertiary and adult education, especially in courses that have adjunctive clinical practice or workforce placements, with evidence that exposure to trauma – directly or indirectly – during these clinical placements contributes to experiences of vicarious trauma in students (Bussey 2008; Butler & Carello 2014; Knight 2010). Indeed, building on Harris and Fallots' (2001) theory that safety is a key precept of being trauma informed, safety is also a 'necessary precondition to a learning-conducive environment ... especially true when teaching content that includes trauma' (Carello & Butler 2015, p. 264). Carello and Butler further outline the domains across which consideration must be given to issues of safety in the classroom, including the individual needs and identities of the students, the subject content and context, the requirements of assessment, the interactions between instructor and student, the classroom environment and, importantly, the instruction on and practice of

self-care (p. 269). It is important to note, however, that this striving for a 'safe' pedagogical setting is not comparable to the metaphorical 'safe place' discussed in Robert Boostrom's 1998 criticism of the term. Where Boostrum speculates that the desire for figurative safety in the classroom – creating a place of comfort where students 'want to be' (p. 401) – censors critical thinking, effective implementation of a trauma-informed teaching practice situates itself to 'remove possible barriers to learning, not to remove traumatic, sensitive or difficult material from the curriculum' (Carello & Butler 2014, p. 265). Certainly, a tertiary course covering post-colonial literature could not do so without acknowledging and addressing the trauma within the set texts or reading materials; however, it is here that responsible pedagogies – opposed to 'perilous pedagogies' (Carello & Butler 2014) – provide students with skill-building opportunities to develop resilience through reflexive practices (Gildersleeve et al. forthcoming; Koopman 2015; Seaboyer & Gildersleeve 2018), alongside content delivery.

Despite ongoing research in the domain of trauma-informed pedagogy, and abundant university course offerings addressing related theories, there has been a slow uptake of trauma-informed pedagogical frameworks at an organisational level across Australian tertiary institutions, with a broad search uncovering only one publicly available instance of a framework guiding campus teaching practices, at Griffith University in Queensland. This is particularly concerning given the Australian context of colonisation and Australian First Nations, as well as the trauma that may be experienced by international students attending Australian universities and colleges (Australian Human Rights Commission 2017; Fethi et al. 2022).

Reading resilience

Reading resilience refers to an individual's 'capacity to undertake and discuss the complex and demanding work of interpretation required by literary and rhetorical texts' (Douglas et al. 2015), a skill that requires reader self-efficacy and flexibility, as well as the employment of analytical techniques such as self-regulation, self-monitoring, and critical self-reflection. In a classroom setting, reading resilience is the ability to safely and responsibly engage with texts that may trigger retraumatisation or vicarious trauma. Carello and Butler address the potential for retraumatisation in their 2014 article, 'Potentially Perilous Pedagogies: Teaching Trauma Is Not the Same as Trauma-Informed Teaching', in which they discuss how retraumatisation – specifically the 'triggering or reactivation of trauma-related symptoms originating in earlier traumatic life events' (p. 156) – is a significant risk factor for students who are confronted with traumatic material or cues reminiscent of earlier adverse events. Importantly, retraumatisation can pertain to events not personally experienced by students, such as after viewing widespread media coverage of 9/11 (Kinzie et al. 2002), the 1995 Oklahoma bombings (Pfefferbaum et al. 1999; Pfefferbaum 2001) or coverage of natural disasters (Raphael & Harris 2014; Comer & Dick 2022). Vicarious traumatisation can occur when students are exposed to other individual or collective stories of loss or suffering (Pearlman & MacIan 1995). Further, students with past experiences of trauma may, like mental health professionals (Neumann & Gamble 1995; Pearlman & MacIan 1995; Saakvitne & Pearlman 1996), be more susceptible to experiencing retraumatisation.

In the Australian context, reading resilience is particularly important, given our history of colonial invasion and genocide, and ongoing disparity across political, social, and cultural spectrums (Leane 2010). There is a growing demand for curricula in Australian literary studies to better include the marginalised voices of Australia to enable students to cultivate a nuanced awareness of Australia's problematic history, moving past the 'resistance to hearing the history' (O'Dowd 2012, p. 105) and, instead, recognising the Australian canon as being assembled from a collection of diverse and ever-evolving texts on what it means to be Australian – an 'ideological edifice endlessly constructed and reconstructed' (Jeffery & Piccini 2020, p. 1) – particularly in terms of how this construction can erase the impact of colonialisation.

To be sure, this demand for change in curricula is occurring elsewhere in post/neocolonial populations (Luckett 2016). Maton (2014) writes of how structures of traditionally colonial education systems uphold the dominant culture, whereby these knowledge structures create a cultural conditioning of inherited curriculum. Indeed, to succeed, students operating within these systems must acquire a colonial gaze (Bernstein 2000), best acquired through 'strong sociality, a shared canon, and shared ways of interacting; crucially, this entails access to the shared cultural and linguistic resources that make this possible' (Luckett 2016, p. 416). Creating new curricula structures requires a 'decolonial gaze' (Escobar 2002), where there is explicit recognition of the 'violence of colonialism, the exploitation of extractive settler economies, the disfigurement of communities and culture' (Luckett 2016, p. 416) and how these acts have been concealed by grand colonial narratives. With the challenges of decolonialising the Australian curriculum necessitating the inclusion

of texts that 'directly contradict typical discourses of Australian history and culture' (Gildersleeve et al. forthcoming) and critical reflection that allows students to respond to, and process, 'trauma and the complex entanglements of language, identity and power' (O'Dowd 2012; Gildersleeve et al. forthcoming), there is increased opportunity for students to engage critically with texts that explore themes of colonialism and epistemic injustice – 'the dispossession of land and knowledge, testimonial exclusion and discounting, and even epistemicide itself' (Gildersleeve et al. forthcoming). This necessary engagement with problematic texts increases the potential for negative affect in students. These negative responses, which span discomfort and unease to denial and distress (O'Dowd 2012), heighten the need for a trauma-informed model of practice that builds reading resilience and which attends to the ethical demands of reading trauma narrative. Responsible reading of such texts includes, at minimum, an acknowledgement of both the confronting content itself, as well as the student's particular situation or circumstances, and, arguably, the option to 'opt-out'.[7]

With consideration of the historical, cultural, and personal ramifications of literary representations of trauma, it is prudent to assume that reading resilience – building the skills that allow for critical reading of texts that challenge or subvert the ideologies of the reader or that cause discomfort – is crucial for readers, and therefore editors, to safely and

[7] This, in itself, is controversial, with critics arguing that the opportunity to withdraw from a problematic or difficult engagement may not be possible, responsible or advisable in the workplace or life outside of the classroom (Gildersleeve et al. forthcoming). However, given that trauma-informed practice upholds self-determination as a major factor in safety (Center for Substance Abuse 2014b), providing the student or client the space to withdraw from the situation is essential.

respectfully approach traumatic material (Seaboyer & Gildersleeve 2018). This is especially significant where 'reflection, in response to such reading, might expose historical legacies of privilege and injustice, and thereby the fragility of identity, even for those – or perhaps especially for those – who belong to the dominant culture' (Gildersleeve et al. forthcoming). As posited by Carello and Butler (2014), 'exposure to traumatic narratives – particularly in circumstances in which the listener is highly empathic or trying to be (see Figley 2002) – can yield trauma-related symptoms in the listener' or the reader (Carello & Butler 2014, p. 156). Indeed, given that many current Australian editors would have completed education in the historically colonialised Australian curriculum, editing manuscripts challenging their social positioning with a (post/neo)colonialist Australia could be particularly problematic or uncomfortable.

Trauma-informed practice in the Australian creative arts

Along with an increased awareness of the impacts of colonialisation on curricula, there has been calls for better representation of minority groups and supressed voices in the Australian creative arts (Marcatilli 2021). The 2020 'Towards Equity: A Research Overview of Diversity in Australia's Arts and Cultural Sector' report (Australia Council for the Arts), while originally developed to provide an overview of the state of diversity in the arts sector[8] for

[8] The report addressed eight key demographics: First Nations Australians, people with cultural and linguistic diversity (CALD), people with disability, gender identity, LGBTIQ+ people, regional, rural and remote Australia, children and young people, and older people. People with disability made up 18% of the population in 2016, but only 9% of the arts sector workforce and, worse still, only 3% of people in leadership roles identified as living with disability. First Nations Australians made up around 3% of the population in 2016, and only 1% of the arts sector workforce. However, they made up 4.2% of artists in Australia and received around 7% of Australia Council grants. At least 12% of those working in leadership roles in the sector identified as Aboriginal and/or Torres Strait Islander. However, even where representation is

funding purposes, established that Australia's diverse identities are significantly under-represented in the arts. To remedy this, there are a number of independent organisations and government bodies currently developing processes and practices to heighten the engagement of minority groups in the arts sector.

Our Race, for instance, is a social enterprise with an emphasis on the redemptive and restorative nature of storytelling in a culturally diverse social environment. *Our Race* seeks to flip the prevailing power imbalance – that is, decolonialise the act of storytelling – by developing and sharing tools that enable artists to direct their own art-making in a way that prioritises cultural knowledge and safety. Although the organisation's approach embraces the wellbeing of the individual, they encourage the challenging of broader colonial narratives by replacing these narratives with counterstories, through the democratisation of information and the building of capacity in under-represented artists. Their framework is based on the intersectional tenets of Transformative Ethical Story Telling, which provides spaces for 'more voices to be heard, without the compromising conditions generally placed on our marginalised groups' (Our Race 2022). While these concepts are not explicitly trauma-informed, and they do not publicly announce a trauma-informed framework guiding their actions, the engagement of Our Race with our First Nations Australians occurs in a

essentially equal—as is the case with the distribution of men and women in the arts workforce—this has not necessarily led to equity. For example, women who work in the sector earn 25% less than men (the overall gender pay gap is 14%), while women artists earn on average 30% less than men.

state of autonomy, recognising the ongoing deleterious effects of colonialisation on the artistic practices of our oldest story tellers.

In fact, there are a number of Australian government-run arts organisations currently charged with addressing the lacuna in representation of First Nations creatives, people with diverse cultural and language backgrounds, and people with diverse abilities, including access for audiences belonging to these groups. These organisations include the federally run Australia Council for the Arts, the state-run CreateNSW, CreativeVIC, ArtsACT, Arts Queensland, and Arts NT, as well as creative arts support under premier and local government banners for South and Western Australia.

Nevertheless, there remains a lack of explicit engagement with trauma-informed practice, despite a large proportion of Australian creatives having a background that predisposes them to experiences of individual or historical/intergenerational trauma (Australia Council for the Arts 2020). The absence of trauma-informed care in high-risk creative populations mirrors the same lack of trauma-informed guidance for sustainable and ethical editing practice, which further reiterates the need for ongoing research and development across service industries outside of the health and education sectors.

Literary trauma theory

Given the capacity for the human lifetime to include some degree or extent of traumatic experience, it is not unreasonable to see referential implications in art, music, and literature. Literary trauma theory seeks to identify the implicit referencing of trauma within

texts by engaging with their shared literary devices, strategies, and characteristics. In 'trauma texts', these elements can include intertextuality, repetition, fragmentation, and language manipulation, all of which are employed to create meaning, or to make sense of, a world that is 'deeply absurd and dangerous' (Lifton & Mitchell 1995, p. 335). In fact, there is evidence to suggest that whole waves of literary creation came about in response to the experience and inheritance of collective trauma. In postmodern fiction published after the Hiroshima and Nagasaki bombings, for example, there is increased reference to bombs and bombing, nuclear warfare and fall-out, bunkers, armed forces, and New World Orders (Lifton & Mitchell 1995). Similarly, there was a recognisable wave of postmodern fiction written in the aftermath of the Cold War and during the US political upheavals of 1960s, 1970s, and 1980s (Dewey 1990). More recently, Morrissey predicts a similar release of new fiction in the aftermath of the COVID-19 pandemic, representing the associated fear, isolation, loss caused by the virus, including lockdowns and other political measures, coinciding with the political upheavals of the 2019–2022 period. Morrissey (2021) explains:

> The year 2020 and the earliest weeks of 2021 have supplied ample opportunities for cultural trauma (the Covid-19 pandemic and its mass deaths, a surge in hate groups and subsequent hate crimes, the takeover of the US Capitol by pro-Trump insurrectionists, and President Trump's second impeachment, etc.). I anticipate that these events will shape the work of writers, artists, and every sort of creative person for years and even decades to come, in all likelihood compelling a resurgence of a postmodern-esque voice in literature. (p. 3)

By the end of 2020, there was a prevalence of 'lockdown literature' (Nielson Report 2020), with subject matter reflecting the precarious nature of the time. In the aftermath of the world's first year of the COVID-19 pandemic, book sales in the United States reflected an increasing demand for apocalyptic science fiction and romance subgenres, as well non-

fiction self-help and social justice titles (Merry & Johnson 2020). Indeed, the necessary measures and precautions employed to control the spread of COVID-19 inevitably resulted in an increase in social isolation, loneliness, and stress, and a concurrent increase in the consumption of pornography, with marked trends in pandemic-themed offerings (Zattoni et al. 2020).

In other words, art-makers and audiences generated and consumed art in response to the challenges of the global pandemic. As such, while it was initially posited that postmodern writers were rebelling against the linguistic and artistic conformities of modernist sensibilities (Bellamy 1974; Coover 1989), a more cogent explanation, as offered by Morrissey, could be that they are using language as a tool for sense-making in response to the collective traumas of the modern world. As Morrissey reiterates, 'the trauma of the nuclear age, experienced by the entirety of Western culture, affected the psyches of these writers in a way that resulted in postmodern literary style—a style reflecting the traumatized voice' (2021, p. 3).

Historically, trauma theory is marked by contradiction and contention, with both psychologists and literary theorists alike sifting through multiple definitions of trauma and its legacies and effects on individuals, communities, and cultures. Contemporary theories of literary trauma go further, to place the behaviour-response of a trauma experience in a social context, where the 'value attached to an experience is influenced by a variety of individual and cultural factors that change over time' (Balaev 2014, p. i). Balaev further explains that 'a single conceptualisation of trauma will likely never fit the multiple and often

contradictory representations of trauma in literature because texts cultivate a wide variety of values that reveal individual and cultural understandings of the self, memory, and society' (p. 8). Like the cross-cultural model of analysis, this understanding of literary trauma moves beyond a restrictive analysis into a framework that recognises trauma's varying representations and manifestations. This departure from a more classical model allows for the forming of a variety of conclusions on the influence of trauma on language – and language on trauma – leaving us with 'a repertoire of compelling stories about the enigmas of identity, memory and selfhood that have saturated Western cultural life' (Luckhurst 2008, p. 80).

As a pioneer of contemporary literary trauma, Cathy Caruth, in her seminal work, *Unclaimed Experience: Trauma, Narrative, and History* (1996), takes a poststructural approach to trauma, defining it as a problem of the unconscious – inherently unsolvable – and illuminating of the contradictions between experience and language, where trauma is a recurring sense of absence that cleaves linguistic determination and leaves, instead, ambiguous referential expression and aporia (Balaev 2008, p. 1). Rather than facilely attempting to elucidate the psychiatry of trauma, Caruth investigates the complex ways that 'knowing and not-knowing are entangled in the language of trauma' (1996, p. 4), where all texts – whether they present trauma theory as an individual or collective experience, or implicitly or explicitly address a traumatic experience – seek to engage a 'a central problem of listening, of knowing, and of representing that emerges from the actual experience of the crisis' (Caruth 1996, p. 5). Indeed, if the Freudian concept of trauma as a non-assimilated event is considered, Caruth's theories suggest that language, and literature, are used to

both transmit and theorise around an event in a way that 'simultaneously defies and demands our witness … a language that defies, even as it claims, our understanding' (1996, p. 5). In this model of trauma, history is understood to be inherently traumatic – an 'overwhelming experience that resists integration and expression' (Craps 2020, p. 45).

Despite the extensive reach of literature on trauma theory, literary representations of trauma, and trauma-informed practices, an exhaustive search has established that there are few – if any – studies pertaining to the application of these theories to editing practice. A broad search of non-academic websites has indicated just two related sources. First, an Australian editor, Renée Otmar, offers a year-long program, *Cultivating a Trauma-Informed Approach to Editing Practice,* to provide professional supervision and support for practising editors. Second, a Canadian editor, Iva Cheung, offers a webinar on trauma-informed editing through the FOLD Academy. Neither of these offerings appear to be evidenced-based, nor do they deliver a set of parameters that could be translated into a guiding framework.

Thus, to remedy this important gap in practice and to address the corresponding lacuna in literature, this project identifies commonalities of trauma-informed principles across the Australian health and education sectors to formulate clear definitions of trauma and trauma-informed practice before subsequently developing a set of trauma-informed principles that can be applied to the editing context. These principles have been developed into a set of recommendations that will be presented to IPEd for adoption. It is envisioned that these recommendations will allow editors to safely and responsibly navigate potential

secondary and vicarious trauma, as well as emotional labour, compassion fatigue, and disclosure response (Blue Knot n.d.).

Methodology

In Australia, trauma-informed principles have guided healthcare and education practice from the late 1980s onwards (Center for Substance Abuse Treatment 2014; Thomas et al. 2019), with principles evolving and permeating peripheral fields, such as arts advocacy and trauma-related research. Despite this, the centrality of trauma and, by extension, the need for trauma-informed practice, remains unexplored in the editing context, specifically in terms of how trauma-informed principles can be integrated and applied in everyday practice. To address this gap, this study conducts a qualitative investigation of the development and implementation of trauma-informed principles in Australian healthcare and education, alongside a survey of both trauma and trauma-informed practice in the Australian and New Zealand editing profession.

Mixed-methods approach

Taking lead from *The SAGE Handbook of Qualitative Research* (Denzin & Lincoln 2018), in which Denzin and Lincoln argue that ‘qualitative research, as a set of interpretive activities, privileges no single methodological practice over another’ (p. 12), this study prioritises a mixed-methods approach, with data collected through two primary tools: (i) a survey of existing trauma-informed practice frameworks currently in place in the Australian

healthcare and education sectors; and (ii) an online survey of self-identified practising editors from the Antipodes.

Researcher authority

Just as a constructionist approach to analysis recognises the placement of participants within social structures, so too must the researcher acknowledge their 'own theoretical positions and values in relation to qualitative research' (Braun & Clarke 2006, p. 7). There are three generic activities that define the act of qualitative research: ontology, epistemology, and methodology (Denzin & Lincoln 2018, p. 16). These three aspects require a blend of research methods to be considered in combination, and the qualitative researcher must recognise their own interaction with their research, and how their gender, personal history, biography, social class, race, and ethnicity shapes their interpretation of data (Denzin & Lincoln 2018, p. 19). With this in mind, I recognise that my ontological and epistemological beliefs influence my research and acknowledge that, as a practising Australian editor, I have been at least partly motivated to conduct this research through my own observance and insights around shortcomings in trauma-informed editing practice and scholarship. I am also aware that I conduct this research from a position of white privilege in a country where both historical and contemporary acts of aggression towards, and subjugation of, our First Nations peoples have engendered individual, cultural, and generational traumas. While my research within this cultural space is limited to observation and interpretation rather than any formal belongingness, I endeavour to acknowledge that my research is both informed and guided by my own trauma history.

Data collection

The data collection process of this research took a two-fold qualitative approach.

In **Phase 1**, the researcher collated publicly available trauma-informed care recommendations, principles, frameworks, and guidelines adopted across the Australian healthcare and education sectors before using thematic analysis to identify a common set of trauma-informed principles in an attempt to offer a more definitive answer to the question: *what is trauma-informed practice?*

In order to ensure contemporaneous data were gathered for this phase of the study, the trauma-informed frameworks and recommendations that were surveyed must have been (i) published in English; (ii) produced in the past decade (2012–2022); and (iii) published or produced by an Australian organisation. The constraints of time in this study necessitated the search for frameworks and recommendations to be restricted to those produced for, or by, Australian organisations.[9] Due to limited results located in the scoping searches conducted in academic databases such as InformIT and EBSCOhost, Boolean searches were conducted that combined the three areas of interest: (1) trauma; (2) trauma-informed frameworks or guidelines; and (3) best practice in the relevant sector (healthcare and education). Despite this limitation, an effort was made to collect a broad sample of trauma-

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[9] However, to broaden the reach of the survey conducted in Phase 2 of the data collection, editors from both Australia and New Zealand were invited to participate – this was facilitated by the membership database of the Institute of Professional Editors, which represents members from both countries. Given the similarities in culture, and the use of IPEd's *Standards of Editing Practice* in a New Zealand context, it is assumed that outcomes of this study may be extrapolated to a New Zealand setting.

informed frameworks and recommendations; therefore, those within the healthcare sector included publications belonging to both general medical practice and social welfare services, while education data included publications from both the primary and secondary school years, as well as tertiary institutions. No results were found from searches with 'early childhood education' parameters, despite additional email contact being made with a number of Australian early childhood education providers. Thus, this category of education was excluded from the research. Importantly, there were no results found for arts-based social enterprises and/or organisations acting within Australia's creative industries. While this parameter was included to better situate data within the scope of editing, the decision was made to refrain from expanding the search to offshore organisations lest the results be confounded. A total of four frameworks were selected to be surveyed on the basis of their accessibility, contemporaneity, and variety. Appendix A lists the four organisations that were surveyed in this phase.

In **Phase 2**, the researcher conducted an online survey of practising Australian and New Zealand editors. The survey was designed to examine the scope and extent of the editors' professional encounters with either traumatic content or trauma-affected authors. The survey asked respondents to (1) identify and rank, in order of importance, the trauma-informed principles that they believe to be most important in guiding their practice; and (2) to share examples of author-editor situations or scenarios where trauma-informed principles were applied, or could have been applied, to improve editing practice. In addition, the survey included open-ended questions that invited the participants to (3) share any emotional responses, reactive behaviours, or associations triggered by these encounters.

The survey also investigated the participants' knowledge of trauma theory and trauma-informed principles. In this way, the online survey was designed to answer the research sub-questions: *What established trauma-informed principles do editors believe to be most important in guiding their practice? How can trauma-informed principles be applied to the editor–author relationship?*

The online survey, which was hosted through the University of Southern Queensland's official survey platform, LimeSurvey, was distributed via social media networking groups on Facebook and LinkedIn and through the researcher's professional contact email lists. In addition, permission was granted to have the survey circulated via the Australian and New Zealand member database of the Institute of Professional Editors (IPEd). Appendix B provides a copy of the survey questions, which are arranged thematically in three sections: Part 1, Part 2, and Part 3.

- **Part 1** of the survey included three demographic questions that allowed for the exclusion of participants who did not meet the inclusion criteria: (i) must be practising as an editor; (ii) must be located in Australia or New Zealand; and (iii) must be over the age of 18, negating concerns around the disclosure and reporting of the abuse of a minor.
- **Part 2** of the online survey included 16 questions that gathered qualitative data on the professional practices of Australian and New Zealand editors in regard to their previous experiences with traumatic material; with authors who identify as trauma survivors and/or disclose trauma during the editing process; with incidents of

retraumatisation; and with experiences of vicarious traumatisation. These questions were open-ended in order to generate rich responses that allowed for in-depth analysis and to avoid confounding such data with bias. In the second section of Part 2, the survey collated quantitative data on the incidence of traumatic content and trauma disclosure in the participants' editing practice in order to investigate the importance of trauma-informed practice in an editor's daily work.

- **Part 3** included four questions that collected demographic data on participants to situate the findings within particular groups of practising editors, allowing for an appreciation of any outliers in the dataset and a more nuanced understanding of the relationship between editor demographics and editing experience.

As aforementioned, the survey was distributed across multiple social media platforms, with 50 participants returning completed surveys and 54 participants returning partially completed responses. These partially completed responses were excluded from the data pool. Additionally, the inclusion criteria required that the participant be a currently practising editor. Therefore, two participants who indicated 'no' to the question 'Are you a practising editor?' were excluded from the data pool. There was sufficient response from the remaining 48 participants in this survey to build a dataset that allowed for the identification of emerging themes and the validation of claims.

Data analysis

The data collected from the survey of existing trauma-informed practice frameworks was analysed using reflexive thematic analysis that searched for themes across the surveyed

frameworks, assigning these into categories, which were then compared to identify patterns of meaning across the dataset. These patterns were refined to determine a simplified set of trauma-informed guidelines that are both achievable and applicable to editing practice.

Common meanings and patterns within the data were coded and then grouped into themes and sub-themes, from which a narrative – supported by the coded evidence – was used to provide validity to the claims of this study. Interpretation of data, especially the construction of codes, was supported by the study's theoretical lens, which intersects contemporary trauma theory with theories of literary trauma and reading resilience, using a cross-cultural emic–etic methodology to investigate how this research can be meaningful to different cultural groups within Australia.

Combining this theoretical framework with constructionist thematic analysis, per the approach of Braun and Clarke (2006), allowed for a richly detailed and complex account of the collected data. This constructionist approach upholds that experience and interpretation do not occur in isolation but are, instead, socially produced and reproduced (Burr 1995). Under this framework, thematic analysis seeks to 'theorise the socio-cultural contexts and structural conditions' (Braun & Clarke 2006, p. 14) that enable the individual accounts that are gathered during the data collection process.

Data storage, participant confidentiality, and ethical research

Ethical clearance for this project was granted by the University of Southern Queensland's Human Research Ethics Committee (Appendix A), and the complete list of survey questions,

as provided to the respondents, is available in Appendix B. The respondents provided informed consent to participate (see Appendix B) and anonymity was guaranteed in the reporting of findings. Throughout the research process, data was stored on a secure, password-protected computer in a locked home office, with additional data copies also stored on UniSQ's Research Data Bank (ReDBank). Although participant information remained anonymous throughout the data collection process, some direct quotations have been used in the reporting of results. These quotations are not attributable to an identifiable individual.

The potential for risk of psychological harm to the participants or the research team is amplified in this study by the nature of the research – trauma – but is also somewhat mediated by the fact that this preliminary research sought editors as participants rather than editors who were themselves trauma survivors. To mitigate the risk of psychological harm to both the participants and the researchers, informed consent for data-gathering and details on anonymity and data storage was explicit. Additionally, all surveys and information sheets included information on accessing psychological referral services.

Limitations of methodological approach

The online survey, as the data collection tool deployed in this study, was selected because it is an inexpensive method of reaching a broad array of participants in a short timeframe (Llieva et al. 2002; Andrade 2020) – essential given the research was conducted in a single academic year, without an expense budget. However, there are a number of limitations and biases that can occur when using an online survey, especially one that requires participants

to both self-select and self-report, and when investigating problematic themes such as trauma. According to the SAGE *Encyclopaedia of Research Methods* (Lavrakas 2008), self-selection bias occurs when respondents are required to volunteer to participate in a survey, to the extent that 'respondents' propensity for participating in the study is correlated with the substantive topic the researchers are trying to study' (p. 809). This can create a pool of participants who do not wholly represent the target population (Wright 2005; Andrade 2020). With this in mind, it was expected that responses from participants were more forthcoming from those with a history of trauma and from those who have engaged with traumatic material in the past.

Similarly, self-report also includes some limitations. Most notably, since 'respondents are asked to report directly on their own behaviors, beliefs, attitudes, or intentions' (Lavrakas 2008, p. 805), this can bias the results. Other limitations of self-report include the potential for deliberate or unintentional dishonesty, whereby a participant purposefully chooses a more socially acceptable response. Other limitations include a lack of insight preventing the participant from answering accurately, as well as variations in question interpretation (Farnsworth 2019; Nikolopoulou 2022). These limitations were considered throughout the interpretating process and are addressed in the conclusion.

Findings 1: Field Survey of Existing Trauma-Informed Frameworks

The two datasets collected for this project were analysed separately using thematic analysis techniques to derive common motifs, and to quantify the understanding of trauma theory

and trauma-informed principles in the work of Australian and New Zealand editors. The first dataset was used for the development of a trauma-informed framework that may be applied to editing practice, grounded in a comprehensive assessment of trauma theory and existing research in trauma-informed practice. The second dataset allowed for the quantification of traumatic content, trauma-affected authors, and experiences of vicarious trauma or retraumatisation by the editor in the execution of editing. This second dataset also provided a qualitative observation of editors' understandings of the breadth and depth of trauma theory and trauma-informed practices, as well as an overview of the tools that editors use to avoid, navigate, or recuperate from these encounters.

The first phase of data collection relied heavily on publicly available trauma-informed guidelines or frameworks. These included publications from Australian healthcare and education organisations. Given the reduced scope of this project, there was a need to limit the quantity of reviewed publications and, thus, the decision was made to select the two most comprehensive items from each category (healthcare and education). These particular frameworks and guidelines were deemed most comprehensive, and applicable to the aims of this study, for three reasons. First, given that Australian and New Zealand editors are expected to have limited clinical psychological or health knowledge, frameworks or guidelines that presented non-clinical practical implementations of established trauma-informed principles were sought. It was hoped that this would increase the potential for the successful transference of these principles to an editing context. Second, it was identified in the second phase of data gathering (the online survey of practising editors) that self-care was an important aspect of managing the effects of editing traumatic material. Thus,

frameworks or guidelines that explicitly addressed self-care measures for the service provider were prioritised over those that did not address these criteria. Third, due to the large number of frameworks and guidelines available in both the health and education sectors, those with similar content were excluded. Variety between service providers – for example, mental health services and general practitioners, or primary school and tertiary education organisations – was sought to increase the breadth of data.

With this in mind, the following publications were selected for review:

- *Practice Guidelines for Clinical Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* (2012), Blue Knot Foundation; and,
    - *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019), Blue Knot Foundation[10]
- *Abuse and Violence: Working with our Patients in General Practice* (2022), Royal Australian College of General Practitioners
- *Trauma-Informed Practice in Schools: An Explainer* (2020), New South Wales Department of Education
- *Trauma-Informed Tertiary Learning and Teaching Practice Framework* (2020), Griffith University

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[10] These two Blue Knot Foundation frameworks – the original published in 2012, and its updated version published in 2019 – were read in conjunction. Note that the updated version does not include guidelines for service delivery. Instead, it refers the reader to the earlier guidelines via a hyperlink (Blue Knot Foundation 2019, p. 31). Due to the importance of trauma-informed service delivery to this study, the decision was made to include both items in the review.

While this study acknowledges that, traditionally, ‘guidelines’ refer to a collection of recommendations for operational actions that may improve service delivery (Spector 2019), while a ‘framework’ is a top-down approach to a conceptual structure that sets out policies within an organisation (Spector 2019), in the interests of increasing accessibility to a broad data pool, the terminologies of ‘guidelines’ and ‘framework’ were considered synonymous during the data gathering process.

Trauma-informed principles in Australian healthcare

Practice Guidelines for Clinical Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery (2012), Blue Knot Foundation

Practice Guidelines for Clinical Treatment of Complex Trauma (2019), Blue Knot Foundation[11]

The Blue Knot Foundation is the National Centre of Excellence for Complex Trauma. Originally founded in 2015 as Adults Surviving Child Abuse (ASCA), the Centre was initially established as a volunteer-run organisation that provided peer support to people with trauma histories, including providing referral services and information hubs. Rebranded in 2016, Blue Knot Foundation now works closely with medical, psychological, and social

[11] These two Blue Knot Foundation frameworks – the original published in 2012, and its updated version published in 2019 – were read in conjunction. Note that the updated version does not include guidelines for service delivery, instead, it refers the reader to the earlier guidelines via a hyperlink (see p.31). Due to the importance of trauma-informed service delivery to this study, the decision was made to include both items in the review.

services to develop and maintain both clinical and best practice guidelines for the care of complex trauma survivors across multiple disciplines. Additionally, the Centre offers workshops and educational resources and materials for both clinicians and non-clinicians to expand their understandings of complex trauma. In 2012, Blue Knot released the first edition of the *Practice Guidelines for the Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery*. These nationally recognised guidelines were a global first in setting the standards for trauma-specific and trauma-informed organisational practice (Kezelman & Stravropoulos 2019, p. 21). Despite both the clinical and organisational guidelines having been updated for counsellors and therapists, and separately for specific organisations since, the 2012 guidelines have remained the framework upon which new guidelines developed by the Blue Knot Foundation are based (Kezelman & Stravropoulos 2019, p. 31). It is partly due to the framework's currency in the adoption and development of new trauma-informed guidelines in the healthcare sector that this document has been chosen for inclusion in the Phase 1 data collection of this study.

The *Practice Guidelines for Clinical Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* (2012) works to provide both overt practice guidelines alongside theoretical studies that guide trauma-informed provisions. Claims are evidence-based, with citations included. The qualifications of the authors – an advisory team comprised of professionals from multiple service industries, as well as survivors – are stated, and quotes supporting the need for this document are included. Structurally, the guidelines (Part I of the document) are divided into two chapters. The first chapter, 'Practice Guidelines for Treatment of Complex Trauma (Clinical)', deals explicitly with the clinical treatment of

complex trauma survivors, which is somewhat outside of the scope of this project. However, the second chapter – 'Practice Guidelines for Trauma-Informed Care and Service Delivery (Organisational)' provides guidelines on how service industries – in this case healthcare providers – can modify policies, procedures, and provisions to become holistically trauma-informed in their daily operations. It is this second part of the document that is most relevant to the creation of a set of trauma-informed guidelines for editing practice.

The clinical guidelines included in 'Practice Guidelines for Treatment of Complex Trauma (Clinical)', while outside of the scope of implementation by a non-health professional, are underpinned by trauma-informed principles. Clinicians are encouraged to facilitate client safety; promote affect-regulation as foundational to recovery; recognise the impacts of trauma on functioning; and understand – and adapt to – how trauma shapes cognitive development, emotional expression, and social behaviour (Kezelman & Stravropoulos 2012, pp. 4–5). Congruent to established trauma theory, which posits individuals' responses to traumatic events are diverse (Figley 1985; Scaer 2001; van der Kolk 2006), this chapter advocates that psychotherapeutic approaches need to be adapted for the individual, and that trauma has many psychological and physical representations in the patient (Kezelman & Stravropoulos 2012, p. 6). Clinicians are reminded that not all therapy approaches or providers will be a suitable fit for all trauma survivors (2012, p. 7).

More applicable to the objectives of this study, and thus investigated in greater depth, are the guidelines addressed in the second chapter: 'Practice Guidelines for Trauma-Informed Care and Service Delivery (Organisational)'. In order to reflect both the diversity of material

relevant to trauma-informed practice, and the diversity of organisational and service settings to which it can be applied, the structure of this chapter is divided into two sub-chapters: 'Philosophy and Vision' and 'Mapping to Practice'. 'Philosophy and Vision' establishes the core principles upon which the trauma-informed care recommendations are based and promotes the formation of service charters of trauma-informed care. This philosophical approach encompasses organisational commitments and cultural modifications, and acts as the 'hopes and dreams' of an ideal trauma-informed practice approach (Kezelman & Stravropoulos 2012, p. 10). Conversely, 'Mapping to Practice' establishes concrete actions that can be undertaken by organisations in order to move towards a more trauma-informed service provision, such as revising policies and procedures to incorporate trauma-informed principles, involving consumers in all systems, articulating and upholding trauma-informed rights, promoting education on trauma-informed practices, identifying funding needs and opportunities, and promoting coordination between and among different stakeholders to incorporate a life-span perspective on both trauma and trauma-informed provisions (Kezelman & Stravropoulos 2012, p. 12).

The fundamental causatum of these guidelines is the need for service providers to recognise the now considerable research evidencing trauma prevalence in Australian society, as well as the established relationship between unresolved childhood trauma and a wide range of psychological and physical health problems. Additionally, the Blue Knot Foundation endorses a holistic understanding of the transgenerational impacts of trauma, and the diversity of presentation among trauma survivors (Kezelman & Stravropoulos 2012, p. 13). The Centre asks that service provision articulates explicit commitments to a recovery-

oriented adoption of the core trauma-informed principles, arguing that the adoption of these principles will necessitate a major shift from 'pre-trauma-informed eras of service delivery' (2012, p. 14), and especially a shift from approaching trauma-maladaptive behaviour from a symptoms-based model of care to a strengths-based model of skills acquisition. Ann Jennings, author of 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', a 2004 report into trauma-informed care, is quoted within this section of the guidelines, with directions for organisations to understand that:

> Without such a shift in both perspective and practice, the dictum to 'Do no harm' is compromised, recipients of mental health services are hurt and re-traumatised, recovery and healing are prevented, and the transformation of mental health care … will remain a vision with no substance in reality. (Jennings, cited in Kezelman & Stravropoulos 2012, p. 14)

By promoting a practical application of the philosophies underpinning trauma-informed care, the *Practice Guidelines for Clinical Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* (2012) suggest not only making changes at a policy level, but also insisting on both educating current employees on trauma-informed care principles and establishing whether potential employees (at the interview stage) have existing knowledge of trauma-informed care. Policies, and therefore employees, should respect diversity in culture, gender, ethnicity, age, disability, and socio-economic status, and policies should be developed in accordance with the principles of trauma-informed care. Organisations should have appropriate mechanisms in place for compliance and quality assurance, and policies should be reviewed on a regular basis (Kezelman & Stravropoulos 2012, p. 17).

Abuse and Violence: Working with our Patients in General Practice (2022)*,* Royal Australian College of General Practitioners

A primary objective of this research was to ensure data was collected from a broad variety of sources, so that a diversity of applications of trauma-informed principles may guide the formation of a framework that could be applied to an editing context. In light of this, the second set of trauma-informed care guidelines surveyed in the health sector were *Abuse and Violence: Working with our Patients in General Practice* (RACGP 2022). This White Book, released by the Royal Australian College of General Practitioners (RACGP), is in its fifth iteration and exists as a fractional component of a larger collection of clinical guidelines. The *Abuse and Violence* (2022) guidelines address the impacts and effects of family violence across the whole life course (opposed to only child abuse) and is explicit in stating that it does not make provisions for those exposed to violence and trauma through global conflict zones, refugee camps, or asylum-seeker detention centres (RACGP 2022, p.7). Instead, the White Book concentrates on the more prevalent form of interpersonal violence – that of violence against women by someone they know (RACGP 2022, p. 8).[12] In particular, this document addresses specific populations, including patients with disabilities, those from culturally and linguistically diverse (CALD) populations, and those who identify as Australian First Nations, all of whom may be subjected to a higher prevalence of violence and abuse (ABS 2017). The RACGP (2022) stresses the importance of acknowledging the complex and

[12] In recognising that interpersonal violence occurs against all genders, the RACGP now endeavours to use the term 'victim' in its publications, rather than 'woman' or 'women' (RACGP 2022, p.7).

cumulative way in which the effects of multiple forms of discrimination (for example, racism, sexism, and classism) combine, overlap, or intersect, especially in the experiences of marginalised individuals or groups. As the guidelines make clear, 'trauma- and violence-informed care enacts policies and practices that recognise the connections between violence, trauma, negative health outcomes and behaviours' (RACGP 2022, p. 9), which increases the opportunity for safe and resilient care giving and care receiving in trauma settings.

Structurally, the document is divided into chapters, with only one chapter dedicated to the implementation of trauma-informed care principles in general practice. The bulk of the document is focused on defining interpersonal abuse and violence; identifying markers that may allow a care provider to identify familial violence; providing suggestions for effective acute care; and making provisions for efficiently referring the patient to the most suitable care providers (RACGP 2022). Given that, to achieve the objectives of this study, the (i) data collected from this White Book must be transferrable to an editing context, and (ii) the limitations of the editing context prevent editors from acting on clinical needs of patients with histories of trauma experience, this review focused on the chapter: 'Trauma and Violence-Informed Care'. This chapter is divided into two sub-chapters: 'Trauma-Informed Care in General Practice', and 'Keeping the Health Professional Safe and Healthy: Clinician Support and Self Care', both of which pertain directly to the practical execution of established trauma-informed principles and the implementation of self-care practices by the service provider.

‘Trauma-Informed Care in General Practice’ first establishes definitions of trauma in the context of Australian general practice. This sub-chapter endorses the concept of ‘trauma’ as being semantically rich, and advocates for general practitioners to see their patients – and their experiences and manifestations of trauma – as equally diverse (RACGP 2022, p. 91). This perception of the diverse manifestations of trauma aligns itself with established trauma theory (Kezelman & Stravropoulos 2019), which regards trauma as both a whole-person experience and a whole-person legacy:

> Trauma-informed approaches facilitate a coherent, whole-person framework that understands how social determinants of health, environmental threats (including racism and other forms of injustice) and relationship dynamics are translated into health outcomes, including multimorbidity and medically unexplained symptoms. (RACGP 2022, p. 91)

Importantly, and again in congruence with trauma theory (Anda, Felitti, & Bremner 2006; Nemeroff 2016), the guidelines promote an understanding of trauma as having impacts on both physiological and cognitive health:

> GPs are also uniquely positioned to attend to the physical element of trauma-informed care. As well as direct injury to the body, chronic impacts of trauma leave a legacy of physiological arousal, changes in autonomic tone and consciousness, stress modulation, and adaptive changes in neural architecture and connectivity. As the body attempts to adapt to threat or perceived threat, especially when it is repeated (the process of allostasis), endocrine and cellular dysregulation, known as allostatic overload, contribute to long-term ill-health. This is directly relevant to understanding somatisation, chronic pain, inflammatory disorders, a range of other physical and mental health impacts, and unexplained symptoms. (RACGP 2022, p. 91)

In this way, the sub-chapter aligns itself with the trauma-informed principles established by the Blue Knot Foundation. These core values include safety, trustworthiness, choice,

collaboration, and empowerment.[13] The implementation of these principles in a general practice setting is designed to facilitate pattern recognition and treatment priorities, and to foster skill-building in individual general practitioners by re-imagining the established principles to allow for more practical application. These practical applications include the clinician prioritising both physical safety and client perception of safety, fostering a capacity to self-sooth physiological arousal, validating both person and perceptions, collaborating with the client and with other services to empower both the client and the care team, and connecting and remaining involved with ongoing care aims (RACGP 2022, p. 93). These established principles are expanded upon by the RACGP, with detailed steps that can be implemented by the general practitioner to create a holistic trauma-informed care plan. For example:

> In the consulting room, in dialogue, GPs can also use what Fisher[14] calls 'empathic interrupting' to manage storytelling intensity and content – intentionally slowing down, shifting the focus, narrowing attention or changing the topic all help the speaker manage their levels of arousal and distress. Bottom-up tools are useful for all forms of distress, including pain. (p. 95)

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[13] It is notable that the Blue Knot Foundation does not list 'respect for diversity' as a key principle, despite addressing this requirement in their *Practice Guidelines for Clinical Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* (2012, see p. 17). This current study draws trauma-informed principles from the Substance Abuse and Mental Health Services Administration (SAMHSA, see: https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884).

[14] Fisher, J 2014, 'Transforming trauma-related shame and self-loathing', *Overcoming trauma-related shame and self-loathing conference*, Brisbane: Delphi Institute.

As demonstrated above, providing practical examples of how trauma-informed principles can be implemented allows for a shift from a conceptual understanding of trauma-informed care to a more concrete and authentic understanding of trauma-informed practice.

As mentioned previously, of particular concern to this study is RACGP's guidelines on general practitioner wellbeing and self-care practices when working with patients with trauma histories. This work stresses the value of staying healthy and safe when working with families experiencing violence and abuse, and encourages reflecting on personal practices, seeking support from peers, and working as a part of a wider team in situations that can trigger compassion fatigue, burnout, or vicarious traumatisation. Core components of the guidelines delivered in this sub-chapter include acknowledging that healthcare providers will be required to care for people who inflict abuse and violence as well as for those to whom it is happening; that it is important to be aware of the early signs of compassion fatigue, burnout, and vicarious trauma; that healthcare professionals need to have both a personal and professional management plan that addresses these feelings; and that these plans should include increased social connectedness, team collaboration, and professional support such as therapy, as well as ongoing professional development with the intention of improving trauma-specific practice (RACGP 2022). For example, health professionals are encouraged to 'recognise their own limitations and those of their practice or organisation and ask for professional support appropriately' (RACGP 2022, p. 114) since shared responsibility in a patient-centred team is likely to be more successful when treating patients with trauma histories (RACGP 2022).

Finally, a notable aspect of the RACGP's trauma-informed care guidelines is that the College differentiates between trauma-informed care and trauma-specific therapy – an important consideration in the development of a framework for editing practice since editors are unlikely to have the healthcare background required for clinical diagnosis or treatment. Indeed, the White Book states, 'It is important to note that providing trauma-informed care is different from providing trauma-specific therapy with people who have experienced trauma, especially complex trauma. Therapy requires additional knowledge and training to ensure a safe therapeutic alliance and the processes needed to support recovery' (2022, p. 92). Thus, it is important that any trauma-informed framework for editing practice does not exceed the scope of support appropriate to the editor's remit and qualifications.

Trauma-informed principles in Australian education

Trauma-informed practices are becoming more prevalent in educational policy (Harris 2017). Such policies recognise that children's development – both academic and social – can be affected by their trauma experiences (DeCandia et al. 2014; Tucci & Mitchell 2015; Harris 2017; Perry & Szalavitz 2017). Thus, the first of the surveyed trauma-informed guidelines in the Australian education context was taken from a primary and secondary school setting: New South Wales (NSW) Department of Education's (2020) *Trauma-Informed Practice in Schools: An Explainer.* To offset this, the other framework selected for analysis was from a tertiary setting: Griffith University's (2020) *Trauma-Informed Tertiary Learning and Teaching Practice Framework*. Interestingly, there are no publicly available trauma-informed frameworks for the early childhood setting.

Trauma-Informed Practice in Schools: An Explainer (2020), New South Wales Department of Education

Released in 2020, the *Trauma-Informed Practice in Schools: An Explainer* (NSW Department of Education 2020), was designed to complement the NSW Department of Education trauma-informed practice professional learning course that was in its pilot stage at the time of release.[15] Like the trauma-informed frameworks surveyed above, the explainer provides definitions of trauma, including simple, complex, and collective traumas, all of which have ongoing effects on the behaviours of both students and parents, with these effects often felt through multiple generations (2020 p. 2). In addition to its definitional work, the explainer provides information to educators and school staff regarding five key components: the prevalence of developmental trauma among NSW children; how school staff can recognise behaviours related to trauma; what constitutes trauma-informed practice; what strategies schools can implement to support students with trauma histories; and how schools can care for staff who are supporting students impacted by trauma. The document is liberal in its provision of evidence-based citations, and encourages readers to expand their understanding of trauma-informed practice in an educational context by additional reading of suggested texts, such as break-out boxes. For example: 'For more information on the neuroscience of trauma and its effects on children, see Bruce Perry and Maia Szalavitz 2017, *The boy who was raised as a dog,* Basic Books, New York' (NSW Department of Education

[15] Unfortunately, no further information was forthcoming on the outcomes of this professional learning course when the researcher contacted the NSW Department of Education Disability Strategy Implementation team.

2020, p. 3), and ‘For a complete list of possible indicators of trauma for each age group from 0-18 years, see Victoria State Government 2012, *Child development and trauma: Best interests case practice model and specialist practice resource*, Department of Human Services’ (NSW Department of Education 2020, p. 4). The benefits of including supplementary resources such as these include encouraging further learning, increasing motivation and engagement with the information, and providing additional support.

In contrast to the other surveyed documents, the explainer does not explicitly claim to follow the established Blue Knot Foundation or Substance Abuse and Mental Health Services (SAMHSA) principles of trauma-informed practice. Instead, it claims that, in an educational context, trauma-informed care is a framework that allows educators to ‘recognise and respond effectively to the impact of trauma on students’ (NSW Department of Education 2020, p. 4), and that elements of this approach include understanding what trauma is, realising the impact of said trauma on the behaviours, relationships, and learning achievements of students, recognising the signs and symptoms of trauma in students, and responding to these with adapted policies, procedures, and practices. Additionally, the NSW Department of Education claims to maintain a commitment to adapting teaching strategies to avoid the retraumatisation of students. It accepts that there is no one-size-fits-all approach for successful implementation of trauma-informed practice in NSW schools, and suggests that prioritising physical and emotional safety for students is pivotal (NSW Department of Education 2020, p .5). Additionally, the guidelines advocate for the implementation of interrelated strategies, such as enforcing a respect for diversity and working on building positive relationships focused on trustworthiness and consistency.

Student empowerment may be fostered through strengths-based skills building, which the NSW Department of Education claims goes a long way towards developing a whole-school approach ‘with a focus on consistent, relationally based and predictable strategies’ (2020, p. 5). It is here, in these practical implementations, that there is reference to more robust trauma-informed principles of safety, respect for diversity, empowerment, and trustworthiness. However, despite these principles being enshrined in policy, it is not always so that this is what eventuates in practice (see Berger et al. 2008).

In addition, the Department’s guidelines stress the importance of ongoing professional development as vital to the successful implementation of trauma-informed practice, submitting that ‘professional learning can help school staff recognise the signs of trauma, respond appropriately, and know when to refer students for mental health support’ (2020, p. 5). Indeed, it is noteworthy that these guidelines are explicit in their directions for teachers, staff, and school leadership teams to always engage professional specialist support rather than asking them to play therapist:

> It is important to note that trauma-informed practice is not about asking teachers, school-based staff or leaders to be therapists, but rather to support them to teach with an understanding of the impacts of trauma and in ways that can help students feel safe. Teachers, school-based staff and school leadership teams should always engage professional specialist support when required. (NSW Department of Education 2020, p. 5)

The intention is for school staff to support students with an understanding of the impacts of trauma and to conduct the learning–teaching transactional relationship in a manner that makes the student feel safe. This is particularly pertinent to trauma-informed principles in an editing context, and will be unequivocally stated in the developed framework.

Trauma-Informed Tertiary Learning and Teaching Practice Framework (2020), Griffith University

Griffith University's trauma-informed framework consists of two working documents: a 'Quick Reference Guide' (28 pages) and an expanded 'Trauma-Informed Tertiary Learning and Teaching Practice Framework' (52 pages). The intended audience is presumably both academic and administration professionals employed by the university. As the framework makes clear, 'The *Trauma-Informed Tertiary Learning and Teaching Practice Framework* was developed for teaching academics ... to better understand and respond to the needs of students in the classroom, on practicum, and in online courses, some of whom may have their own trauma histories, and to students in general who may experience program and course content as distressing' (Tsantefski et al. 2020, p. 6).

Unlike other surveyed frameworks, Griffith's 'Quick Reference Guide' increases access to the framework's core principles for academic and professional staff who are time-poor. This abridged version of the framework contains an explanation of the trauma-informed principles underpinning the university's learning and teaching framework. The condensed document also includes explanations of how interdependent tertiary learning components, including student characteristics and behaviours, educator behaviour, course content and assessment requirements, classroom and field placement characteristics, and general educational policies, are underpinned by the framework. Additionally, there is information on both employee self-care and collective-care, which includes care for colleagues and students at both the faculty and organisational level (Tsantefski et al. 2020, p. 22).

In addition, both the 'Quick Reference Guide' and the unabridged framework include a glossary of terms that are commonly used in trauma-informed practice. Such terms include, for example, broad definitions of common types of trauma, such as complex, secondary, and vicarious trauma, as well as burnout and compassion fatigue. While this list is not exhaustive, the glossary improves both comprehension and accessibility, and thus a similar glossary will be incorporated into the development of the trauma-informed framework for editing practice. The extended document, understandably, expands on the principles established within the 'Quick Guide', with more robust definitions, practical applications for the teaching–learning context, and information on the evidence base that underpins trauma-informed principles.

In contrast to the other surveyed documents, the *Trauma-Informed Tertiary Learning and Teaching Practice Framework* encourages the tertiary instructor to consider their own social positioning and how this might be reflected in their interactions with students and peers. A trauma-informed approach to teaching requires not just a certain level of content awareness, but also a level of self-awareness built from self-reflexivity (Tsantefski et al. 2020, p. 26). This self-reflexivity assists 'the educator to understand how their own worldview, experiences, and perceptions impacts on student–teacher interactions' (2020, p. 15) and the effects this may have on student outcomes. The framework proposes that educators consider 'the personal characteristics that define their social position and privilege, for example: ethnicity; age; socio-economic status; education history; gender; sexuality; (dis)ability status; marital status; and parental status' (2020, p. 15) and how these characteristics privilege or disadvantage. Additionally, the framework encourages educators

to give thought to how their discipline frames trauma – whether this framing is binary in nature (that is, ‘this is trauma’ versus ‘this is not trauma’), and how this ‘impacts the lens with which the educator views students, student behaviour, and student learning’ (Tsantefski et al. 2020, p. 15).

In addition to reflexive teaching strategies, the framework provides guidance on behaviour and classroom strategies that may allow for better alignment with the trauma-informed practice principles. These include adherence to a code of contact that promotes respect and confidentiality, but also how to manage disclosures of trauma in a manner that validates the victim without increasing the potential for vicarious traumatisation in peers – a guideline that corresponds with the primary principle of safety. For example, ‘while “use of self” is highly valued in some professions, including social work, students with trauma histories may overly disclose in class and deeply affect educators and peers alike. In such an instance, the educator has a responsibility to ... steer the session plan gently back to the educational goals’ (Tsantefski et al. 2020, p. 32), a strategy which can assist all students to engage meaningfully and safely.

Interestingly, there is an increased focus on such safety within Griffith’s framework and, unlike other frameworks surveyed for this study, the university’s framework includes consideration of student and staff physical safety as paramount to upholding a trauma-informed teaching–learning environment. The framework stipulates, for example, that ‘physical and emotional safety is ... a prime consideration in a trauma-informed learning and teaching environment [and] educators and field supervisors are responsible for the

classroom setting' (Tsantefski et al. 2020, p. 19). Examples of managing the classroom setting and local built environment include ensuring walkways and parking areas are well lit; that directions to buildings of safety (such as reception) are clear; that university spaces are comfortable and welcoming; and that restrooms are easily accessible and gender-neutral. Moreover, Tsantefski et al. (2020) encourage the provision of additional designated supportive spaces on campus, such as women's rooms or low-stimulus areas.

Indeed, as can be seen from the sample of trauma-informed guidelines and frameworks surveyed here, the core principles of trauma-informed practice – safety, trustworthiness, opportunity for choice, collaboration, respect for diversity, and empowerment – are central to the development of trauma-informed guidelines, both clinical and service-provision in nature. While there is a clear need for the definitions and weighting of these core principles to be tailored to specific service contexts – in this instance, editing – if comprehensively implemented they may affect a major cultural and philosophical shift in the functioning of services beyond the context of healthcare and education. Despite this, caution must be taken in the development of a trauma-informed editing framework, with consideration given not only to the scope and accessibility of such a document, but perhaps more importantly, to the limitations of editor training.

Findings 2: Field Survey of Practising Editors

The second phase of data collection for this study involved an online survey distributed to practising editors via the social media platforms of Facebook, Instagram, and LinkedIn, as well as via an email to the Institute of Professional Editors (IPEd) member database. This

survey served two purposes. First, the survey gathered quantifiable data on the participant demographics, their formal study (if any) of trauma-informed care, their frequency of engaging with traumatic material or trauma disclosures, their opinions on the value of trauma-informed principles in editing practice, and their willingness to incorporate further learning on trauma-informed practices in future professional development. Second, the survey gathered qualitative data on editors' interpretations of the meaning of 'trauma' and 'trauma-informed practice principles', and their feelings and attempts at self-care when exposed to trauma narratives or disclosures. Importantly, the survey provided an opportunity for editors to rank the six principles of trauma-informed practice (safety, collaboration, respect for diversity, empowerment, opportunity for choice, and trustworthiness) in perceived importance, with specific consideration to the editing context.

Participant demographics

The participant group consisted of 48 respondents[16], of which 39 identified as members of IPEd (81.25%). The division of IPEd membership was 10 accredited members, 17 professional members, 10 associate members, one honorary life member, and one student member. There were four respondents who were not members of IPEd, and four participants who did not provide a response to this optional question. This imbalance in membership versus non-membership may be explained through the channels of

[16] There was a total of 106 returned surveys, with four not fulfilling the criteria for involvement in the study and 54 not having progressed beyond the first page of the survey. Participant ID numbers relate to their original response registration.

recruitment (an email to the IPEd member database and advertisement of the survey on an IPEd-associated Facebook group). Thus, further thought must be given to how this over-representation of IPEd membership in the participant pool affects the data due to the potential for bias to appear in the results; however, positive associations of this engagement with IPEd include conceivable pathways for distribution of the trauma-informed editing framework at a future date.

Of the 48 participants, there were a variety of editor 'types', with many respondents indicating that they undertake multiple types of editing. Of the total responses to the question 'What type of editing do you undertake?', keeping in mind that many editors identified more than one option, the breakdown of editors, by type, included 21 fiction editors (18.9%), 33 non-fiction editors (29.7%), 24 academic editors (21.6%), 15 trade editors (13.5%), and 18 (16.2%) other. Interestingly, there was a high proportion of editing types other than fiction compared to the frequency of encountering traumatic material, which may suggest that non-fiction has a high incidence of trauma reporting, such as in the case of memoir or biography. Of the 21 participants who indicated that they perform fiction editing, 18 (85.7%) indicated that they also perform non-fiction editing. Employment types further revealed that 36 (69.2%) respondents were employed on a freelance basis – alarmingly, this was in contrast to zero respondents being employed at a traditional publishing organisation. While this, again, may be indicative of a sampling bias, it also may have ramifications in terms of future distribution of the trauma-informed framework for editing practice or engagement of this framework in policy creation at these organisations. Seven participants (13.5%) work at a non-publishing organisation undertaking editing

responsibilities, while 17.3% of respondents are employed as ‘other’. While these numbers are statistically low, it remains important that consideration of these more niche departments of editing practice is given when designing and distributing the framework. Most respondents reported that their highest level of education was at a postgraduate level (70.8% at honours level or above), which has implications for the level of education where pedagogical implementation might be best utilised. Further investigation would need to be performed to determine the availability of undergraduate versus postgraduate editing education programs before evidenced claims on the most appropriate distribution channels can be made.

Trauma exposure/engagement

Significantly, responses to the questions ‘What types of traumatic material have you worked on in the past?’ and ‘As an editor, how did you feel when working with an author who disclosed personal trauma?’ indicated that engagement with traumatic works was common among the participant group, with 87.5% of participants indicating that they have encountered traumatic material and 60.4% indicating they have experienced disclosure of trauma by an author. Similarly, eight participants (16.6%) indicated that they, themselves, were trauma survivors. Given the sensitive nature of trauma experience, it is likely that not all editors with personal histories of trauma have disclosed this, especially given the survey did not explicitly request this information. Thus, this potential for authors to have trauma histories remains an important consideration for the development and implementation of a

framework for trauma-informed editing practice, as editors' personal trauma experiences may increase the likelihood for retraumatisation when encountering traumatic material.

Editors' previous learning on trauma-informed principles

Overwhelmingly, this quantitative analysis also determined that few editors from the participant group had engaged in formal learning on trauma-informed care practices, with 38 (79.2%) indicating that they had not undertaken any formal learning on trauma-informed care, and just 7 (14.6%) indicating that they had participated in formal learning on the topic. In contrast, 27 (56.3%) participants indicated that they had engaged in informal learning on the principles of trauma-informed care; however, the free-response comment box revealed a wide range of interpretation of what this informal learning encompassed. For example, in response to the question 'Have you engaged in any informal learning on trauma-informed practices?', Participant 6 stated 'Yes, I have read blog posts' and Participant 29 wrote 'Watching people use trigger warnings in online groups and other forums is helpful'. Overall, the lack of formal learning about trauma may suggest a scarcity of learning opportunities in both early-editor education programs and the professional development programs on offer, reaffirming the value of the desired pedagogical outcomes of this study. This is supported by revelations that 34 (70.8%) participants would engage in future trauma-informed learning if it were made available.

Moreover, 38 (79.2%) participants indicated that they would implement trauma-informed principles in their editing practice if guidance on these principles from an editing context was available. Just 9 (18.8%) participants indicated that they were unsure if they would

implement the guidelines, with zero respondents indicating that they would definitively not implement a trauma-informed framework. Of the three participants (6.2%) who indicated they would not engage in further trauma-informed learning, only one had engaged in any form of formal or informal learning (ethics education for a doctoral degree). Despite this, all three participants indicated they would consider implementing, or would implement, trauma-informed guidelines in their editing practice if these guidelines were made available. In response to the question, 'Do you think trauma-informed practice is important for editors?', 83.4% (40 from 48 responses) responded 'yes', and 14.6% (7 from 48 responses) responded 'unsure'. Only one participant declined to answer this question. It is remarkable, and relevant to the aims of this study, that all participants – bar one failure to respond – agreed that trauma informed practice is important for editors.

Trauma awareness amongst Australian and New Zealand Editors

The qualitative data collected in this survey was rich and expressive and, in the first instance, painted a thorough picture of the wide variety of interpretations of the concept of trauma itself. The broad understandings of trauma theory relayed by the participants – some of them misguided – support the hypothesis that Australian and New Zealand editors remain under-educated on the scope and extent of trauma, not only in their practice but in society at large. When asked 'What is your understanding of trauma?', Participant 33 responded simply 'injury', and Participant 68 responded 'from Greek for "wound"'. Despite these simplified perspectives, overarchingly, the interpretation of trauma was of an event,

or series of events, experienced by an individual, that had immediate and acute effects. As the following participants explain:

> Trauma is an experience which triggers our fight or flight response and which can cause that response to stay switched on long after the event. (Participant 97)
>
> I understand [trauma] as a form of psychological or physical injury following experience of violence, abuse, neglect, a distressing event or a physical accident. (Participant 71)
>
> An adverse experience that goes beyond everyday misfortunes. It can be physical, psychological, or emotional (or a combination). (Participant 32)

Interestingly, there were a number of respondents who indicated a basic understanding of trauma theory, in that trauma can affect cognitive function and behaviour patterns as well as having an ongoing impact on functioning (Anda, Felitti, & Bremner 2006; Nemeroff 2016).

> Trauma is an experience of negative stress (a single event or ongoing events) which overwhelms the nervous system. It's experienced by all animals; the nervous system goes into protective responses e.g. flight/fight/freeze. If the nervous system isn't in a supportive environment where it can recover, and discharge the stress of the experience, the trauma results in changes to the brain and body. In people this is usually observed as hypervigilance, flashbacks, fear, physical symptoms, depression (etc) – symptoms of nervous system dysregulation. (Participant 94)
>
> A physiological and psychological response to an adverse event that significantly impacts functioning. (Participant 66)
>
> I understand trauma to be the result of a bad experience. The trauma causes symptoms that affect the person's daily life. (Participant 6)
>
> Events witnessed or experienced leaving psychological scarring that impairs ability to act. (Participant 20)
>
> An event or experience that a person finds difficult to go through, for various reasons, which also often leaves a physical or emotional (or both) legacy. (Participant 61)

Indeed, this understanding of trauma as having a lasting legacy (NSW Health 2022) was frequently mentioned by the participants, as evidenced in the below responses to Question 4.

> Trauma is sudden injury that comes about through a lived experience. If not resolved, the short term impacts of trauma, especially psychological, may result in long-lasting impacts that are more difficult to manage. (Participant 79)

> I understand trauma to be a condition experienced by an individual, or groups of individuals, based on direct experience of terrifying events. This experience, or experiences, have a profound, and often prolonged, negative effect on that person's or group's sense of wellbeing and, on occasion, on their ability to function healthily. (Participant 85)

Articulated far less frequently was an understanding of more complex (and less acute) forms of trauma, such as collective, intergenerational, or historical trauma, with only two respondents referring to trauma in these terms.

> As an Aboriginal editor, my understanding of trauma occurs on multiple levels. Emotionally, I understand [my] trauma as a psychological reaction to writing that positions my culture in a negative way. I cry, grit my teeth, clench my fists, have self-harming thoughts, doubt my sanity, fear encountering bad writing about Aboriginal people, and minimise genuine involvement with non-Aboriginal people … I understand trauma at a family level in discrimination from accessing the ordinary rights that non-Aboriginal Australians take for granted, such as social systems that reflect their cultural values … I understand trauma at the societal level when Aboriginal people have to fight so hard for justice every day, even in the editing profession where non-Aboriginal people control the profession. However, that is changing too with more companies and writers searching for Aboriginal people to review their work. (Participant 70)

> I understand that trauma can be intergenerational, in that trauma experienced by children can also affect their children. (Participant 35)

This minimal reference to the more pervasive traumas that are present in our social systems may indicate a lack of awareness or understanding in the participant body of these more

complex trauma forms. This lack of insight into privilege from collective or cultural trauma is common among members of the dominant culture in a post/neo-colonial society, where the 'conflict over competing cultural priorities occurs in the context of unequal power and status relations between groups, with the result that dominant cultures are largely inclined to actively suppress minority cultural group practices and meanings' (Halloran 2004, p. 4), leading to a collective helplessness in the minority culture and resulting in maladaptive coping practices that become endemic to a culture, 'increasing the likelihood that cultural trauma and its effects are carried forth into successive generations' (2004, p. 4). Certainly, evidence supports the cyclical nature of complex trauma, where the Center for Substance Abuse Treatment (2004) articulates that those individuals who have experienced repeated, chronic, or multiple traumas have an increased likelihood of both trauma symptoms, and pronounced consequences of such symptoms, including substance abuse, mental illness, and health problems, all of which compound trauma experience.

Editor frequency of exposure to traumatic material

While the quantifiable data indicates a high frequency of editor exposure to traumatic material, with 87.5% of participants reporting regular trauma exposure, qualitative analysis of the participants' long-form answers to Question 13 indicates similar, or shared, understandings of what is perceived as 'traumatic material'. Overwhelmingly, participants reported exposure to narratives of rape, domestic abuse and neglect, drug use, mental health struggles, violence, and war experiences as the most common types of trauma

narratives encountered. In response to Question 13, which asked, ‘What types of traumatic material have you worked on in the past?’, the following participants responded:

> I work on memoir so a fair bit. Sexual and domestic abuse, controlling relationships, pregnancy loss, severe mental illness and psychosis, neglectful families, institutional abuse ... Lots more I can’t think of right now. (Participant 4)
>
> I edit material on refugees, incarceration, criminal justice (including violent crimes and homicide), out-of-home care, sexual assault, and family violence. (Participant 100)
>
> I’ve worked with different people on memoirs that deal with grief (eg, death of parents, death of a child from a drug overdose) and, recently, worked with a client who wrote about her experiences of living through Cyclone Tracy as young naval recruit (and what she witnessed) and has long-term PTSD. (Participant 27)
>
> A memoir recounting childhood abuse (sexual, physical, and emotional) and neglect (emotional and physical). A book about the illness, medical maltreatment, and eventual death of a child, written by a healthcare practitioner involved in the case. A memoir by a young sex worker recounting very graphic sex scenes (including violent group sex and rape), trafficking, emotional and physical abuse and emotional neglect. (Participant 71)

Similarly, half of the respondents reported that they regularly encountered traumatic material in their editing of both academic and corporate texts, which suggests that trauma exposure is not limited to fiction and creative non-fiction genres.

> [I have edited] academic papers by social workers dealing with the range of issues that social workers deal with – domestic violence, child abuse, children in care, mental illness. These are just some of the common topics dealt with. (Participant 78)
>
> [I have edited] guidance to managers and health practitioners on response to potentially traumatic events ... (Participant 47)
>
> I edit material on refugees, incarceration, criminal justice (including violent crimes and homicide), out-of-home care, sexual assault, and family violence. (Participant 100)

Curiously, there appears to be less reference to fictionalised recounts of trauma in response to the question ‘What types of traumatic material have you worked on in the past?’, with

only two respondents reporting exposure to traumatic narratives in fiction form. It is noteworthy that one of these two respondents encountered this traumatic narrative as a fictionalised version of sexual abuse that had been experienced by the author (Participant 32). This raises questions about whether a trauma recount that is truly fictionalised in nature – that is, a made-up event – is less likely to result in vicarious traumatisation compared to a fictionalised recount of an actual traumatic incident, especially one experienced by the author.

In contrast, Participant 88 – who also recalls exposure to traumatic content through fiction editing – details their experience and feelings around what they perceive to be gratuitous material in fiction. When asked, 'What types of traumatic material have you worked with in the past?', Participant 88 responded:

> Lots of novels involving sexual violence; I feel like there are a lot of weirdos out there that write gratuitous material. There was one novel involving an African American woman being raped by a bunch of white men in masks; when they removed their masks, she expressed gratitude that they would even consider her, 'an ugly black woman'. I felt as though this author was playing out a fantasy and had to have a pretty frank discussion with him that nearly resulted in me not even being paid for the work. (Participant 88)

Certainly, some readers may recoil at reading descriptive scenes of rape or violence, and this reaction raises questions around whether the inclusion of traumatic content is purely gratuitous or if it serves a deeper purpose as a literary device. One argument is that the inclusion of traumatic material functions as a means to navigate problematic ethical content. Gildersleeve et al. address this in their forthcoming article, 'Reading, Reflection, and Resilience in the Study of Australian Literature', in which they claim that the inclusion of

traumatic events, such as rape, violence, or death, is ‘rarely gratuitous; often, traumatic material is a necessary response to the events of the narrative and its contexts’ and that it may, indeed, operate as a ‘type of poetic justice’ (p. 4). That is, the narrative requires a certain level of trauma to effectively present the problematic themes it attempts to address. While this argument is outside the scope of this study, this particular participant’s responses to the survey reinforces the need for editors to be able to engage skills that allow them to safely and effectively negotiate these instances, both in terms of their personal exposure to the traumatic material and in navigating issues around explicit content versus ethical publishing decisions.

While all expected text types (fiction, non-fiction, creative non-fiction, academic, and corporate) were reported to have the potential for including traumatic themes and content, the genre of memoir was by far the most statistically significant, with the word ‘memoir’ mentioned a total of 44 times by 18 participants. Additionally, in response to the question ‘As an editor, how did you feel when working with an author who disclosed personal trauma?’, over half of the respondents (54.2%) reported disclosures of personal trauma by an author in the process of editing a memoir or autobiographical manuscript. Two important conclusions can be drawn from this finding: first, memoir has an increased potential for exposing editors to traumatic material; and second, memoir has an increased potential for editors to encounter authors with histories of trauma. Further research would be required in order to draw conclusions as to whether authors with trauma histories are more likely to record these narratives in memoir, or if memoir, as a genre, has a higher incidence of traumatic content overall.

Memoir is not the only non-fiction text type that has increased potential for containing traumatic content or traumatic themes. One Australian First Nations participant edits non-fiction and academic texts. They report that 'in general, almost every academic journal article about Aboriginal people is filled with trauma statistics (death, disease, and disadvantage)' (Participant 70). This is the sole participant to explicitly[17] address trauma exposure linked to the Australian (post/neo)colonial identity. The survey did not ask demographic questions around cultural identity, so the percentage of respondents identifying as Australian First Nations is unquantifiable. Despite this, it is notable that the only respondent to address issues of historical and ongoing trauma experienced by Australian First Nations identifies as such themselves. This participant expands on the pervasiveness of trauma in their daily editing practice as an editor of both non-fiction and academic work:

> Every piece of writing that I edit is traumatic material. Every day I edit material that is based on historical records, to academic statistics of trauma, to writing that is just plain ill-informed (e.g., people still use the acronym 'ATSI'). (Participant 70)

Therefore, a comprehensive understanding of the effects of cultural trauma on Australian First Nations may be necessary in order to engage in editing processes from a trauma-informed perspective. While outside the scope of this initial study, there exists opportunity

[17] In response to Question 13, 'What types of traumatic material have you worked with in the past?', Participant 66 responds 'First Nations work', but does not elaborate as to content, genre, or text type.

for the involvement of a cultural safety specialist in the refining of the proposed framework for trauma-informed editing practice.

Editor frequency of encounters with authors who identify as trauma survivors

Of the 48 participants who completed the survey, 60.4% chose to provide additional detail about particular occasions when authors disclosed they were trauma survivors. The nature and extent of these disclosures was varied, and included, for example, revealing war crimes, health problems, violence, and sexual abuse. For some editors, this disclosure resulted in a decision to not proceed with the editing arrangement due to feeling ill-equipped to manage both their wellbeing as an editor, and the wellbeing of their author client. As one participant explains after learning of a family friend's experience of sexual assault:

> ... I didn't realise she'd been abused until she approached me about the book 25 years later and explained what it was about. It was an initial enquiry, and she was interested in my editing help but mentioned the abuse content with understanding that the material might be emotionally challenging to edit and I may not want to ... I tried to be supportive and compassionate. I told her that she was very brave to write about the abuse and that she'd put an awful lot of time into the writing, so well done. That from an editing perspective it would take some time to hone the story, and that I'd be happy to recommend other editors as I was too busy at the time, but that I hoped she stuck with her project as it could potentially be a very healing overall process and helpful to others, but she would need to do lots of self-care throughout. (Participant 53)

Other participants, however, indicated that they had adopted approaches in author management that allowed them to address the disclosure in terms of how it impacted on the development of the manuscript. One participant explains that 'A Stolen Generations survivor revealed sexual abuse by a school teacher about halfway through the editing of her memoir ... the author and I worked with the words that she could find to describe the

experiences until we came up with a passage that expressed what she wanted to say' (Participant 25). Similarly, Participant 4 describes how they work to assist the author to convey meaning in their texts, 'As I work on memoir, [disclosure] is a fairly regular occurrence. Sometimes I express that I'm sorry that a particular thing happened to them, but most of my care for the writer goes into sensitively addressing things in the edit, with a focus on helping the writer get across what they are hoping while also being mindful of the reader'. This refocusing of attention on the aims of the text may assist with the creation of boundaries in the author-editor role by prioritising the original objectives of the relationship – effective editing – where, indeed, more detailed narrative development may be the driving force behind some instances of disclosure of traumatic histories by authors.

As demonstrated in the comments above, sensitively addressing and responding to trauma disclosure is a key concern of editors. Other common priorities that arose in response to Questions 17–19, which deal with author disclosure of trauma and editor responses to such disclosures, included editors recognising that they were not mental health professionals and thus must work only within the limitations of their qualifications. As Participants 88 and 59 explain:

> I was aware that I must tread carefully to avoid reopening old wounds and increasing [the author's] trauma. I never questioned the truthfulness of their accounts, and if they appeared as though they were getting upset during our discussions, I suggested that we reconvene at another time. It's hard because I'm not a mental health specialist. Yes, I have edited accounts of traumatic experiences. I try to focus on what I know: editing. I endeavour to keep discussions focused on the manuscript and 'keep to my lane'. (Participant 88)

> Early on, I wasn't very self-aware about my limitations, and I became overwhelmed and dropped a memoir project. This wasn't good for me or the author. I reflected on this

> outcome and determined to be more honest and more mitigative, in the future. At the time, I felt overwhelmed and numb ... flooded, I guess. I also felt resentful of the author's expectations that I support her by listening a lot when she 'dumped' emotionally. This was time consuming and upsetting, and made me feel very stressed because I was only charging for editing time not talk-time. These days I charge a consultancy rate for talk-time and I am gently assertive about keeping the text central to those conversations. (Participant 59)

Editors' reports of experiencing burnout, overwhelm, vicarious traumatisation, or retraumatisation

When asked about their feelings when editing works containing traumatic material, 34 participants (70.8%) responded that they felt varying degrees of distress and depression. Participant 63 explains, 'Unfortunately, if I'm having any sorts of difficulties with the editing, especially when the material itself is distressing ... I can get quickly quite depressed; that is, I start to feel real symptoms of depression. I feel powerless to deal with the situation ...'. In fact, several respondents expressed feelings of inadequacy, frustration, and exacerbated stress, all of which are associated with burnout and the cumulative nature of work-related stress (see, for example, Figley 2002; Newell & MacNeil 2010; Stamm 2010).

> I've also edited non-fiction books about survivors of sexual violence, and it can be very hard to distance yourself, especially when you're working with the author on multiple edits. I frequently felt inadequate and had to keep reminding myself to focus on the words on the page, not her experiences. (Participant 88)

> The first [manuscript] left me with nightmares for around three months. I found that I couldn't focus and eventually had to take a couple of weeks off work ... I was really stressed throughout the editing process ... (Participant 88)

While compassion fatigue was not mentioned in response to any of the questions – raising questions around participants' fluency with this key characteristic of secondary traumatic

stress – participants did recount feelings of emotional exhaustion, indicating the taxing nature of editing traumatic material. As one participant explains, ‘It was tiring and stretching. I no longer edit trauma memoirs due to the delicate and taxing nature of the work’ (Participant 59). Interestingly, this decision to ‘opt-out’ of editing traumatic material is a recurring theme in the participants’ responses, with 12 (25%) editors deciding to avoid editing similar traumatic material in the future. One participant, for example, has made a deliberate decision to not edit material that may trigger their own history of trauma, while another would rather avoid traumatic content or trauma disclosures altogether. Other editors expanded on their decision to limit their work with traumatic content in order to prioritise their own wellbeing:

> I didn’t edit [the manuscript], but skim reading it was upsetting for me. Although I’m not a survivor myself, the details were disturbing, and I didn’t wish to take on the job for that reason. I’m quite sensitive, so I’m careful about what jobs I take on. (Participant 53)

> There are certain topics I’ve decided that I don’t want to work with anymore because they are too triggering for my own mental health. (Participant 4)

> I don’t edit trauma memoirs or creative works for inexperienced authors any more. It takes time to develop a healthy approach to managing trauma and an editor is not a therapist. (Participant 59)

While opting out of editing traumatic material is an editor’s prerogative, and far more easily managed when working in a freelance capacity, the option to do so is not always possible (such as in the case of employment), nor is it always in the best interests of editors or their clients. This common indication of avoiding editing traumatic material due to the emotional load of the practice further reinforces the overarching hypothesis of this study: Australian editing practice needs a framework to guide editors through the processes of safely and

ethically editing traumatic material or working with authors who have personal trauma histories. Indeed, there is an incongruence between the editor's responsibility to provide a service and their equal right to withdraw such service when confronted with trauma. Insight into this incongruence is demonstrated in participants' compassion for authors of traumatic material, and their belief that it is important for these authors to have access to editing services despite (1) the increased psychological load of editing trauma narratives, and (2) the heightened possibility of difficulties arising within the editor–author relationship due to the symptomatic manifestations of trauma and its impacts. Participant 31 explains, for example, that they feel 'justified in supporting people who often are silenced by their trauma to gain a voice and to share their experiences with the world', while Participant 57 remains committed to editing traumatic material because 'it is important for … those with lived experience of trauma to be published'. Indeed, giving voice to trauma survivors is an ongoing theme throughout the participant responses, especially for those participants with their own trauma histories.

> I would work with traumatic material again. Having cPTSD [complex post-traumatic stress disorder] myself, I am mindful of what readers would like to know and understand about the thoughts, actions, and feelings of the person(s) involved. It helps to bring understanding to the world of non-traumatised people. (Participant 5)

This ongoing commitment to editing traumatic material and/or working with authors who are survivors of trauma, as articulated by 15 participants (31.3%), raises important questions about the role that reading resilience plays in maintaining the editor wellbeing. In fact, one participant addresses the concept of reading resilience in terms of skills learnt from their parents, both of whom worked as tertiary educators:

> [My feelings were] complex ... My parents were English literature teachers/academics, so I learnt how to analyse text as text and distance myself, I suppose. And material that is not generally regarded as 'traumatic' can be difficult to work with if it is strongly against one's own value system. (Participant 68)

Despite a professional lens (in this case) endorsing the editor's commitment to editing traumatic material or working with authors who have histories of trauma, there are numerous recounts by participants that highlight the potential for vicarious traumatisation, with 27 participants (56.3%) reporting symptoms of vicarious trauma. One participant explained, for example, that 'At times the material triggered my own trauma' (Participant 57), while another disclosed that '[Editing traumatic material] can feel overwhelming at times and can trigger my depressive symptoms. I may feel sadness, helplessness, anger' (Participant 13). One editor was particularly insightful into how their editing of difficult/sensitive subject matter addressing the trauma experienced by East Timorese peoples in the 1990s and early 2000s led to significant feelings of vicarious traumatisation.

> [I was] traumatised by the work I was doing, although I did not have the words for this at the time. [I] got into the habit of drinking a lot (binge drinking). At least one episode where I had a waking dream where it was as if I had been taken over by one of the victims of rape in the book. Timorese people helped and comforted me plus I had family around who were helpful, plus my 'family' of Australian activists, others of whom were going through vicarious trauma themselves (though we didn't know it).
>
> I didn't have another fall into vicarious trauma until 2019 when the combination of COVID-19 and the books I had been editing/writing with the author-clients put me into a stressed state, and it was only when I went to the IPEd conference in 2019 that I learned what 'vicarious trauma' is and learned some tools to cope with it. Still, I did suffer vicariously from the Vietnam memoir (violent images from the war via his memories) and it affected me quite badly, and took me about a year to recover my mental health. (Participant 96)

As established in this study's literature review, vicarious traumatisation can manifest as increased stress, distress, discomfort, sadness, overwhelm, increased emotional intensity, or

fatigue (Figley 2002). Indeed, trauma more broadly, as Participant 85 explains, ‘can lie in wait, ready to ambush you when you least expect. It never seems to go away’. This powerful analogy succinctly articulates the insidious and compounding nature of trauma when not mediated through judicious use of self-care practices and the setting of boundaries.

Methods of self-care implemented by editors

Self-care is an important aspect of managing the negative effects of editing traumatic material or engaging with authors with trauma experience in order to ameliorate the threat of vicarious traumatisation. In Section 3 of the survey, editors were asked about their self-care practices in order to develop an understanding of the current scope of editor self-care and the specific areas where additional improvements may be made. The majority of respondents (62.5%) reported implementing self-care techniques to manage stress generated by editing traumatic content. Overwhelmingly, editors reported that they needed to take ‘time out’ or time away from the editing job, breaking it down into smaller, more manageable, chunks:

> Really, only putting the work aside for a period of time worked to manage these feelings. With other people’s work this is not necessarily practical as deadlines loom. (Participant 86)

> I take regular breaks (Pomodoro timer), work on other projects in between. (Participant 52)

> Recently, when I was very distressed about a thesis ... I ended up talking to my sister [who] convinced me to stop [editing] and take the evening off. I think I watched a movie or something like that. When I came back to the thesis the next day I was better able to cope with it. (Participant 63)

> Time is often a luxury for freelancers but I prioritise my well-being, taking breaks to process distressing content. (Participant 48)

A significant number of editors (60%), however, also reported feeling ill-equipped to implement self-care practices. In response to the question, 'Did you engage in any self-care practices during the editing process to manage these feelings?', one respondent answered, 'Not really. I don't have time for that. And I'm not very good at self-care at the best of times' (Participant 63). Others (27%) reported that they did not engage in self-care practices at all, or if they did, it was through the process of discussing the difficult material with colleagues, friends, or family members. While this constitutes a sharing of the load, and may have been beneficial for the editor, it potentially indicates a lack of awareness about the vicarious effects of 'passing the trauma baton' to another, equally underqualified, person (Miller 2021).

Interestingly, only seven editors (14.6%) demonstrated significant insight into both the effects of editing traumatic material on their mental health, and the importance of employing strategies that ameliorate these negative effects. These deeper insights came from editors who work in healthcare related fields, have histories of personal trauma, or extensive experience editing trauma narratives. Participant 88, for example, discloses previous vicarious traumatisation before explaining, '[I] now have a series of practices I implement when working with certain content, particularly content involving sexual violence or child abuse. I think its [sic] important to be aware of the potential impact of trauma'. Similarly, other editors recognise the importance of actively anticipating their mental health needs when editing traumatic material:

> [My editing of] systemic trauma such as mental health evaluations and associated reporting puts the onus on me to similarly manage my own wellbeing. I need to be proactive, self-aware, and gentle to myself in this kind of work. I have to pay attention to how I'm really going and communicate my needs and limitations. (Participant 59)

> As someone living with a significant post-traumatic condition, I practice self-care routinely in all my work engagements as much as possible. I have also learned to somewhat separate myself in teaching/critical mode, which has a protective function. (Participant 28)

Other coping strategies reported by participants include engaging in leisure activities (35%), escaping into nature (18.7%), and practising acts of 'emotional release' (31.2%) such as screaming, journaling, or engaging in intense exercise. Participant 58, presumably a New Zealand-based editor, recalls 'a friend taking me into the bush after the Dunedin cops came ... and I did some crying and screaming in there for a few minutes. It helped'. Other participants describe using leisure activities as acts of self-care:

> Having spent many years listening to stories of survivors of often horrific abuse, and realising how insidious and widespread abuse is …, I have developed self-care practices such as long walks in the bush, reading fiction, [or] discussing the topic with others without revealing anything about any material that I am working on. (Participant 82)

> [I engage in] regular breaks outdoors and extra attention to bodily needs. (Participant 18)

Interestingly, only a small proportion of editors (12.5%) report engaging the services of qualified mental health professionals in order to amend the impacts of editing traumatic material, as explained by Participant 70: 'Psychologists are a regular part of my response to editing and writing because they help me process my response and teach me new things about coping with trauma'. Of particular note here is the participant's understanding that their mental health professional can provide them with the skills needed to cope with trauma, rather than merely acting as an outlet for emotional stress after vicarious

traumatisation has occurred. Participant 96, who has a long history of editing traumatic material from East Timor, now has regular counselling sessions. They explain:

> In early 2021 I commenced regular counselling sessions with a psychologist (every 2-3 months) and this year I have increased that support to about once a month, to help me not only cope with editing or working with traumatic material in future but just to deal with my past experiences that include (but are not limited to) vicarious trauma through my editing work. This is extremely helpful. (Participant 96)

Interestingly, one participant demonstrated significant insight into practical steps that can be taken to carefully navigate the relationship between editor and trauma-effected author, including setting boundaries and referring the author on to more qualified mental health practitioners. These steps, as identified by the participant, include:

- Invoicing for talk-time to discourage the client from using me as a proxy therapist
- Making clear recommendations for appropriate therapeutic mechanisms for the client
- Clearly negotiating project scope and goals
- Checking in regularly about how the editing process is going (Participant 59)

This unprompted addition to the data draws attention to the importance of pre-emptively reducing the emotional labour of trauma disclosure, and thus encourages consideration of how practical steps can be implemented *before* issues arise in the editing process.

Another method of approaching traumatic material and working with authors with trauma histories is reframing the interaction as an opportunity for the editor to give a personal contribution to their community, a strategy that aligns with a strengths-based approach to practice.

> For me, the writing and editing is part of empowerment and healing. I'm making a small contribution [and] I will continue to work in a way that supports dignity, compassion, and respect. (Participant 49)

> [As an Aboriginal editor of material containing trauma felt by Australian First Nations, I also] work with positive and empowering non-Aboriginal people because they give me faith that justice can be achieved. I write and research about cultural safety because that is a form of empowerment that is immensely enjoyable. (Participant 70)

> I am privileged to have people trust me in this way. It is difficult to read and to work with, however it is important and must be done. (Participant 20)

> I see myself as a supportive conduit - there to help the person say what they want to say. For many, writing is empowering and I can support the writing process. I'm a warm, sympathetic listener, but nothing more. (Participant 49)

As mentioned previously, several participants (12.5%) disclosed their own status as trauma survivors. This personal experience is likely to be implicated in their feelings about, and responses to, editing narratives of trauma or working with authors with trauma histories. This unique context is reflected in a number of comments about editors' own emotional journeys when editing traumatic content as trauma survivors themselves:

> It was very difficult talking about some of the passages, writing them, reviewing them, reading them out before publication. Sometimes I was completely fine, and sometimes I was overcome. It was totally unpredictable when the tears might come. I identified 'trigger' words, which plunged me back into the painful past. I was very pleased with myself when I read a conference paper a few days ago based on my memoir, trigger words included, and I didn't waver. Trauma can lie in wait, ready to ambush you when you least expect. It never seems to go away. (Participant 85)

Notably, editors with personal trauma histories were more likely to report self-care techniques that went beyond the more stereotypical responses of 'I go for a walk' or 'I take a break from work'. Participant 13, for example, articulates that recognising when they need to take a break from editing traumatic material is key to managing wellbeing, as is regular

psychotherapy. Other participants with histories of trauma employ a multitude of self-care practices. Participant 70 details the variety of techniques they use to minimise vicarious traumatisation, as well as how these self-care techniques make them feel:

> I keep fit because the endorphins from exercise are just a wonderful feeling of happiness. I drink wine when I'm too sad. I call colleagues to discuss complex issues. I read stories about resilience and survival of Aboriginal people because they give me strength. I talk to my talisman, a trophy from my grandmother, as a way to channel her spirit. (Participant 70)

Editors' perceived value of trauma-informed principles for editing practice

Crucially, the overwhelming majority of participants (83.3%) acknowledged the need for more practice-specific guidance when working with both traumatic material and authors with trauma histories. In their responses, these editors demonstrate an understanding of the pervasiveness of trauma and an awareness of the value of the editor in realising publication of stories authored by writers with trauma experiences. One participant recognises that this is particularly important when editing work about Australian First Nations people, where 'in editing writing about Aboriginal people, trauma-informed practice is essential because words are powerful and can influence thoughts, attitudes, values and behaviours about Aboriginal society' (Participant 70). Another participant recognises that 'writers are already vulnerable when they hand their work over to us' and that 'those who have experienced and are sharing about their trauma need to feel safe with us and our approach' (Participant 4). Such comments directly address the trauma-informed principle of safety: 'we can help [authors] to feel supported, respected, and part of a team that has their needs and feelings in mind (Participant 4).

Conversely, few participants expressed valid concerns about the increased expectations on them to be trauma-fluent, citing both time restrictions and financial concerns as limiting factors, as well as a lack of the qualifications needed to address the more clinical needs of trauma survivors:

> Well, there are a lot of things we have to deal with, and trauma-informed practice wouldn't be too high on my list. However, if I could learn more about it without expending too much time or money, I'd be very interested. (Participant 63)

> I think it is a mistake to impose a term like 'trauma-informed', developed in the health sphere, onto a profession such as editing ... while editors can be sensitive in their approach to working with authors who have experienced trauma and in their editing of works (e.g. memoir), unless they undertake specific training in trauma-informed practices, they should not claim to be doing it. (Participant 31)

These issues around both the scope of the editing role, and the duty of care of an editor when engaging with trauma survivors, remains a particular concern in this research project. As such, these concerns are addressed in detail in the Discussions chapter.

Established trauma-informed principles currently guiding editing practice

Overwhelmingly, participants felt that trauma-informed practice was important for editors. In Question 8, participants were asked to rank the six established trauma-informed principles – safety, trustworthiness, collaboration, respect for diversity, empowerment, and opportunity for choice (Kezelman 2014) – in order of importance with regards to their editing practice. When this data was collated across the dataset, the trauma-informed principle of safety was established as the most important of the principles in an editing context, with 62.5% of participants nominating this principle as paramount. Safety is certainly a basic human need and, as a trauma-informed principle, it is a multi-faceted issue

that requires specific attention to the physical editing environment, as well as giving attention to emotional and psychological wellbeing. Safety is particularly important for trauma survivors, as they ‘cannot teach themselves how to be safe and stable because they have no baseline, no meaningful experience of what the words “safe” or “stable” mean’ (Fisher 1999, p.1). In a trauma-informed context, a practical manifestation of safety is being consistent in behaviours, responsibilities, expectations, communications, and boundaries – indeed, safety is perhaps best described as removing the element of surprise from the editing relationship. The principle of safety – and its grounding in consistency – is related closely to the principle of trustworthiness, which was ranked as the second most relevant trauma-informed principle for editing practice (56%). The principle rated the least important was the principle of collaboration (43.8% of respondents ranked this principle last), which may reflect the solitary nature of the editing role, or an unawareness of how engaging other professionals can assist in managing the effects of encountering traumatic material or authors with histories of trauma.

Thus, the ranking of trauma-informed principles by practising editors is an important aspect of this data collection as it can assist in prioritising how trauma-informed principles are addressed in the *Proposed Framework for Editing Practice*, with the intention being that the framework is most suited to the daily editing processes of Australian and New Zealand editors. However, this project acknowledges that, with the illustrated limited scope of participants’ understanding of trauma theory and established trauma-informed principles seen in earlier segments of the survey, there also exists the potential for a broader definition of these six principles, which may, in turn, lead to confluence of meaning. Despite

this, and given the universal nature of trauma, and its prevalence, it is also possible that the proposed framework for trauma-informed editing practice will have a broader application for editors in general.

Discussion

In order to gather data from what is, essentially, a multi-disciplinary theory, this research reviewed existing trauma-informed frameworks and principles currently implemented in Australian healthcare and education sectors, and conducted a survey of practising editors from the Antipodes. Data was analysed and conclusions drawn from common themes in order to develop a framework that may inform and direct adaptations to future editing and publishing curricula, as well as provide opportunities for professional development in post-qualification editors. The need for this framework was validated through the collection, analysis, and interpretation of both quantitative and qualitative data regarding the incidence of editor engagement with traumatic material and/or authors who identify as trauma survivors.

The overarching question that this study aimed to answer was:

Can established trauma-informed care principles guide the creation of a strengths-based framework that could be applied to Australian editing practice?

To answer this question, the project addressed the following sub-questions:

- *What is 'trauma-informed practice' in the editing context?*
- *How can trauma-informed principles be applied to the editor–author relationship?*

- *What established trauma-informed principles do editors believe to be most important in guiding their practice?*

Overwhelmingly, the quantitative data collated in the Phase 2 data collection supports the hypothesis that exposure to traumatic material, narratives of trauma, and/or authorial disclosures of trauma is a commonplace occurrence in the editing profession. This exposure is compounded by a lack of formal or informal learning on trauma-informed principles. Additionally, the predominantly positive response to a framework that could guide a safer approach to editing traumatic material, or assist in a more ethical negotiation of the relationship between the editor and the author with a history of trauma, reinforces the need for a trauma-informed discipline-specific framework to be available by contemporary editors, especially those editors who work with, or are regularly exposed to, traumatic content or material.

In the second phase of data collection, the qualitative data that was analysed uncovered a limited awareness of the more pervasive traumas present in Australian society, with limited reference, for example, to collective, intergenerational, and historical traumas. Collective trauma in Australian communities may present through shared experiences of natural disasters, such as the 1999–2020 bushfire season (Smith & Burkle 2020) and the multiple floods experienced by the east coast in 2021 and 2022 respectively. Moreover, there is evidence that human responses to natural disasters parallels those responses articulated by Australian First Nations in the context of colonisation and its sequelae (Krieg 2009). The cause-and-effect phenomenon of intergenerational trauma results in a cycle of victimisation

and perpetration, compounding within, and across, multiple generations (Healing Foundation 2013) and perpetuating the cycle of trauma itself (Atkinson & Atkinson 1999; Wilson 2016). In this study, the participants' lack of awareness about these different trauma types, and the cross-over between them, raises more broader concerns about a possible failure on the editor's part to recognise trauma signs and symptoms in an author, as well as the potential for reduced sensitivity around difficult or sensitive themes in the authors' respective narratives. It is hoped this risk may be ameliorated by ensuring that the developed framework includes definitions of trauma beyond the individual or acute trauma experience. Certainly, references to these trauma types are prevalent in the guidelines surveyed in the first phase of data collection for this study.

To be trauma-informed in the editing context, then, requires an understanding of the ways in which traumatic experiences have shaped the lives, perceptions, and behaviour patterns of the individuals involved, and to actively apply that understanding to the provision of editing practice in a manner that accommodates the needs of trauma survivors while simultaneously promoting healing and recovery. Trauma-informed editing practice also incorporates the process of designing systems that protect the wellbeing of the editor, minimising the risk of vicarious traumatisation and compassion fatigue. A trauma-informed care framework, in general, is built upon six fundamental principles consonant with such protective measures. These are: safety, respect for diversity, opportunity for choice, collaboration, trustworthiness, and empowerment. Arguably, each principle is of equal value, but for the sake of mapping these principles to the editing context, the participants in this study were asked to rank the principles in order of perceived importance to editing. As

established in the Findings 2 chapter, there is the potential for a range of understandings about what each of these principles represent, which has the potential to hinder effective implementation in editing processes and editor–author interactions. To combat this, the proposed framework includes both semantic definitions and practical examples of these principles as they are executed in an editing context. Certainly, this dual approach to defining these trauma-informed principles attempts to bridge the gap between theory and praxis, with this research thus making a salient contribution to the potential wellbeing of editors and authors alike.

As established at the beginning of this thesis, trauma-informed practice was originally instituted as a directive in healthcare and has subsequently been used to promote more ethical provisions across a range of social services. Understandably, the transition from clinical practice to a non-clinical setting has required some adjustment to the context and application of the trauma-informed principles. Certainly, one participant in this study even raised concerns about the appropriateness of the term ‘trauma-informed practice’ in an editing context:

> I think it is a mistake to impose a term like ‘trauma-informed’, developed in the health sphere, onto a profession such as editing. I have worked extensively in public health, research and ethics, and in editing and training editors, and through this work I have concluded that while editors can be sensitive in their approach to working with authors who have experienced trauma and in their editing of works (e.g. memoir), unless they undertake specific training in trauma-informed practices, they should not claim to be doing it. Therefore, in my work and in my training of editors I use the term ‘trauma-sensitive’ in reference to editing, book coaching and other work with authors. (Participant 31)

While this participant raises a valid concern, the objective of this research is to pave the way for existing editors to broaden their understanding of trauma-informed practices through professional development, and for future editors to be explicitly educated in these practices through the implementation of the framework in the design and delivery of editing pedagogy. Furthermore, there is a real possibility that the tendency to label something as '-sensitive' has the potential to minimise the important and immediate action that must be taken to address the effects of trauma in the wider community (see Desautels 2021; UNFPA 2021). To be sure, being 'trauma-sensitive' trumps being 'trauma-unaware', and so it may be that being trauma-sensitive is the best we can hope for in terms of mid-career editors re-educating, especially due to limitations in cost or time. With additional research, and practical validation of the framework in action, new editor education programs may include trauma theory, reading resilience, and trauma-informed practices as core learning objectives, to raise a new generation of editors who are aware that trauma is more than just assault, violence, or neglect but instead is something that also encompasses historical and collective traumas perpetuated by the very social structures we work within. It is the researcher's hope that the framework assists editors to safely and effectively engage with both trauma narratives and survivors while recognising that certain behaviours can be pathophysiological responses to trauma experience. Moreover, the key principles of trauma-informed practice – safety, respect for diversity, opportunity for choice, collaboration, trustworthiness, and empowerment – are not inherently medical or clinical concepts and can be applied quite readily to the author–editor relationship. Indeed, editing by its very nature, takes place in an important part of our social fabric – where writing is the

physical manifestation of our history-keeping. That said, to alleviate the risk identified by this participant's concerns, and to align with other non-healthcare iterations of trauma-informed guidelines, the proposed framework will include explicit direction for editors to act only within the scope of their editing role when encountering authors with trauma histories. These directions will include seeking information on referral services, as well as clear and explicit guidelines around how to refer and when.

In addition to uncovering a limited awareness of the more pervasive traumas present in Australian society, and validating the need for a trauma-informed framework to guide editing practice, this study established that reading resilience, a pedagogical theory of skills-building that allows for the critical reading of texts that challenge or subvert the ideologies of the reader or that cause discomfort, could also be of particular use in the editing of traumatic works. Likewise, this study confirmed that reading resilience appears to be underrepresented in both formal and informal editor education programs. With consideration of the historical, cultural, and personal ramifications of literary representations of trauma, it is prudent to assume that reading resilience is crucial for readers, and therefore editors, in order for both to safely and respectfully approach traumatic material (Seaboyer & Gildersleeve 2018). The skill of reading resilience is particularly important in the Australian context, where 'reflection, in response to such reading, might expose historical legacies of privilege and injustice, and thereby the fragility of identity, even for those – or perhaps especially for those – who belong to the dominant culture' (Gildersleeve et al. forthcoming). Indeed, given that many current Australian editors would have completed education in the historically colonialised Australian curriculum,

editing manuscripts that challenging this ideology could be particularly problematic or uncomfortable. Therefore, this study confirms the need for additional research to investigate the role of reading resilience in editing praxis, with consideration given to how established theories of reading resilience in the Australian tertiary literary studies classroom may be applied to Australian tertiary editing pedagogy design more broadly.

Where the survey of practising Australian and New Zealand editors (Phase 2 data collection) validated the need for guidance around approaching editing traumatic material and negotiating editing relationships with authors who have trauma histories, the Phase 1 data collection has established conditions that have guided the development of the framework for trauma-informed editing practice. These conditions include:

- Establish a definition of trauma, including collective, generational, and historical trauma.
- Establish the principles of trauma-informed practice, namely safety, respect for diversity, opportunity for choice, collaboration, trustworthiness, and empowerment.
- Provide practical strategies for how editors can implement trauma-informed principles in their daily practice.
- Encourage ongoing professional development for editors, including the opportunity for knowledge growth in trauma-informed theories and practices.
- Define the limitations of the editor in terms of identifying, diagnosing, and treating trauma symptoms, and direct editors to refer instances beyond these

limitations to the appropriate mental health professionals. Where possible, provide a list of possible organisations and their contact details to assist with such referrals.

- Promote self-care and collective-care as practical methods for preventing overload, compassion fatigue, vicarious traumatisation, and retraumatisation.
- Ensure the framework is accessible, appropriately sized, and contains easy-to-read breakout boxes with important information summaries.

The draft *Proposed Framework for Trauma-Informed Editing Practice* is available in Appendix C. At the time of submission, the framework reflects the most recent research and practice knowledge available nationally. Given that the project continues to unfold, it is envisaged that the framework will remain a live document, and that future iterations will continue to incorporate the latest knowledge from an evolving evidence base.

Conclusion

Despite significant research on both trauma-informed care (Center for Substance Abuse 2014; Reeves 2015; Bendall et al. 2021; RACGP 2022) and trauma-informed pedagogy (Thomas et al. 2019; Harrison 2020; Thompson & Carello 2022), the literature review undertaken as the preliminary investigation for this study determined that there is a dearth of research into trauma-informed editing practice. This study has also established that writing itself is often a vehicle for processing and sharing trauma experiences, with a statistically significant portion of participants recalling exposure to traumatic material, traumatic narratives, or disclosures of trauma in the execution of their editorial roles. In

addition, the synthesised data clearly establishes that there is scope within non-fiction and academic texts to represent or reinforce traumatic themes and content, especially when associated with Australian First Nations storytellers and stories. This corroborated lack of guidance around the provision of a trauma-supported editing service for writers and editors is concerning, with the potential for risk of harm to both author and editor if an adequate support framework is not in place. To address this lacuna in research, this project identified commonalities in trauma-informed principles in Australian healthcare and education policies and applied these to editing practice. In order to answer the primary research question – *Can established trauma-informed care principles guide the creation of a strength-based framework that could be applied to Australian editing practice?* – this study investigated the *perceived meanings of trauma-informed practice in an editing context*, considered *how trauma-informed principles can be applied to the editor–author relationship*, and established *which trauma-informed principles editors believe to be the most important in guiding their practice*.

Based on qualitative and quantitative analysis of the participant data, it can be concluded that there is a high incidence of Australian and New Zealand editors encountering traumatic material or traumatic narratives, or of experiencing trauma disclosures by authors. It can also be concluded that many editors have insufficient training and education in trauma theory and trauma-informed practice, potentially preventing them from safely engaging with both traumatic material and traumatised authors. It is also clear that in the editing profession there is a broad appreciation of what constitutes trauma; however, within this broad definition, there remains a tendency to misperceive trauma as an individual

encounter of physical violence, neglect, or sexual abuse. With the exception of those participants with a background in trauma theory, few editors made reference to the generational, collective or historical traumas that could impact post-/neo-colonial Australian writing and editing communities. The results indicate a genuine need for early editor education programs, and mid-career editor professional development offerings, to meet this shortfall in knowledge on the broad reach of potential trauma and its implications for author and editor wellbeing.

Alongside this confirmation of the necessity of a trauma-informed framework that can guide editing practice for Australian editors, this study scrutinised publicly available guidelines and frameworks designed to guide the implementation of trauma-informed principles in the Australian healthcare and education sectors. This in-depth analysis allowed for the identification of common features, themes, principles, and methods of application, which has resulted in the generation of an editing-specific trauma-informed framework. Although this framework is in its infancy and is as yet unverified through implementation and testing, the framework has been developed with the intention of raising awareness of trauma prevalence, and providing uncomplicated consideration to how the framework could be implemented in daily practice in order to improve the accessibility, diversity and, most importantly, safety of authors and editors engaging in the transactional relationship of editing.

To better understand the implications of these results, future studies could examine the associations between theories of reading resilience and trauma-informed editing practice,

with a focus on how reading resilience skills might assist editors in avoiding vicarious traumatisation when encountering trauma narratives. This research could consider the value of reading resilience as a core learning objective in the early-editor education classroom versus the efficacy of this concept being offered as an optional professional development course for mid-career editors. Additional research may also examine the relationship, if any, between editors with trauma histories and their ability to edit traumatic material without experiencing retraumatisation. Finally, future research could also investigate the efficacy of specific models of self-care.

Finally, given the limited scope of this 12-month dissertation, further research is needed to determine the validity of the proposed framework in practical contexts, as well as how the framework influences the relationship between editors and authors with trauma histories. It is hoped that future studies will confirm and extend the value of this framework, as well as enrich both the content of the framework and the conclusions that can be reached. Given that new research will continue to uncover ongoing learnings on trauma-informed care principles and how these principles can improve practice in an editing context, it is envisaged that the proposed framework will remain a living document, with future iterations striving to incorporate the latest knowledge from an evolving evidence base. At time of publication, the framework reflects the most recent research and practice knowledge available.

In conclusion, this research clearly illustrates the need for a trauma-informed framework to guide editing practice. However, this research also raises the question of how this

framework could be best distributed to currently practising editors, and to new students who are beginning their journey towards entering the editing profession. Thus, it is suggested that establishing and embracing a more robust, interdisciplinary research agenda with the specific purpose of integrating these findings within early editor education programs is the first step towards engaging editors in trauma-informed practice.

As established in the introduction to this study, editors must, when editing traumatic material, be guided by the aphorism: *first, do no harm*. Indeed, this maxim has shaped the passage of research across the breadth of this study, with deliberate actions taken to minimise the potential for retraumatisation of participants and collaborators. As a researcher, and in the design and implementation of the proposed trauma-informed guidelines, I am compelled to champion messages of resilience and recovery to both editors and authors and, in engaging sensitively and responsibly, I commit to: *first, do no harm.*

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Appendices

Appendix A: UniSQ Human Research Ethics Approval

Camilla Cripps

[RIMS] USQ HRE Application - H22REA199 - Expedited review outcome -Approved
1 message

human.Ethics@usq.edu.au <human.Ethics@usq.edu.au> Wed, Sep 14, 2022 at 3:20 PM
To:
Cc:

Dear Camilla

I am pleased to confirm your Human Research Ethics (HRE) application has now been reviewed by the University's Expedited Review process. As your research proposal has been deemed to meet the requirements of the National Statement on Ethical Conduct in Human Research (2007),
ethical approval is granted as follows:

USQ HREC ID: H22REA199
Project title: Trauma-Informed Editing Practice: A Framework
Approval date: 14/09/2022
Expiry date: 14/09/2025
USQ HREC status: Approved

The standard conditions of this approval are:

a) responsibly conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal;.

(b) advise the University (email:ResearchIntegrity@usq.edu.au) immediately of any complaint pertaining to the conduct of the research or any other issues in relation to the project which may warrant review of the ethical approval of the project;

(c) promptly report any adverse events or unexpected outcomes to the University (email: ResearchIntegrity@usq.edu.au) and take prompt action to deal with any unexpected risks;

(d) make submission for any amendments to the project and obtain approval prior to implementing such changes;

(e) provide a progress 'milestone report' when requested and at least for every year of approval.

(f) provide a final 'milestone report' when the project is complete;

(g) promptly advise the University if the project has been discontinued, using a final 'milestone report'.

The additional conditionals of approval for this project are:

(a) Nil.

Please note that failure to comply with the conditions of this approval or requirements of the Australian Code for the Responsible Conduct of Research, 2018, and the National Statement on Ethical Conduct in Human Research, 2007 may result in withdrawal of approval for the project.
Congratulations on your ethical approval! Wishing you all the best for success!

If you have any questions or concerns, please don't hesitate to make contact with an Ethics Officer.

Kind regards

Human Research Ethics

University of Southern Queensland
Toowoomba – Queensland – 4350 – Australia
Email: human.ethics@usq.edu.au

This email (including any attached files) is confidential and is

for the intended recipient(s) only. If you received this email by

Appendix B: Online survey used in Phase 2 data collection

Trauma-informed editing practice: A framework

UniSQ HREC Approval number: H22REA199

Description

Trauma-informed practice is a strengths-based framework that guides the service provisions of the Australian healthcare and education sectors. While there is significant research on trauma-informed care and trauma-informed pedagogy, there is a dearth of literature on trauma-informed editing practice. Given that writing itself is often a vehicle for processing and sharing personal trauma, the lack of trauma-supported editing service provisions for trauma survivors is concerning, with risks of harm to both the author and the editor if an adequate support framework is not in place.

This qualitative study conducts a field survey of Australian and New Zealand editors who self-identify as working, or having worked, with traumatic material or survivors of trauma. The findings from this research informs the creation of a framework for trauma-informed editing practice that will inform and direct adaptations to future editing and publishing curricula, as well as provide opportunities for professional development in post-qualification editors.

This project is being undertaken as part of a Masters of Editing and Publishing through the University of Southern Queensland.

Participation

Your participation will involve completion of an online questionnaire that will take approximately 40 minutes of your time. Questions will include 'What types of traumatic material have you worked with in the past?', 'Have you engaged in any formal learning on trauma-informed practices?' and 'What is your understanding of trauma?'

Your participation in this project is entirely voluntary. If you do not wish to take part, you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project prior to submitting the questionnaire. Due to the anonymous submission process, you will be unable to withdraw data collected about yourself after you have participated in the questionnaire as your data will be unable to be identified.

Your decision whether you take part, do not take part, or take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland.

Expected benefits

It is expected that this project will not directly benefit you; however, the availability of a trauma-informed framework to guide future editing practice has the potential to benefit you through improved client-editor relationships, improved publishing outcomes and improved wellbeing through the implementation of self-care when editing traumatic material or working with authors with trauma experiences.

Risks

In participating in the questionnaire, there are no anticipated risks beyond normal day-to-day living However, sometimes thinking about the sorts of issues raised in the questionnaire can create some uncomfortable or distressing feelings. If you need to talk to someone about this immediately, please contact USQ Student Support on (07) 4631 2372.

You may also wish to consider consulting:

- your General Practitioner (GP) for additional support

- Lifeline 13 11 14 or crisis support chat https://www.lifeline.org.au/get-help/online-services/crisis-chat

- Beyond Blue either via phone on 1 300 22 46 36 or real time chat https://www.beyondblue.org.au/get-support/get-immediate-support

- UniSQ Psychology and Counselling Clinics: Toowoomba Clinic +61 7 4631 1763 or Ipswich Clinic +61 7 3812 6163 (clinics are open to the general public and provide low-cost services by provisionally registered psychologists who are postgraduate students undertaking advanced study in psychology at UniSQ: https://www.usq.edu.au/hes/school-of-psychology-and-counselling/psychology-and-counselling-clinics)

Privacy and confidentiality

All comments and responses are confidential unless required by law. The names of individual persons are not required in any of the responses. Your data may be made available for future research purposes (for similar projects only) but the data will be stored as non-identifiable. If you would like to access a summary of results, please contact the principal investigator (details at the bottom of this form). Any data collected as a part of this project will be stored securely, as per University of Southern Queensland's Research Data and Primary Materials Management Procedure.

Consent to participate

Clicking on the 'Submit' button at the conclusion of the questionnaire is accepted as an indication of your consent to participate in this project.

Questions

Please refer to the Research team contact details at the bottom of the form to have any questions answered or to request further information about this project.

Concerns or complaints

If you have any concerns or complaints about the ethical conduct of the project, you may contact the University of Southern Queensland, Manager of Research Integrity and Ethics on +61 7 4631 1839 or email researchintegrity@usq.edu.au. The Manager of Research Integrity and Ethics is not connected with the research project and can address your concern in an unbiased manner.

Research team contact details

Principal Investigator

Camilla Cripps

School of Creative Arts

Faculty of Business, Education, Law, and Arts

University of Southern Queensland

Thank you for taking the time to help with this research project. Please keep this document for your information.

There are 23 questions in this survey.

Eligibility details

This section of the questionnaire gathers information about your eligibility to participate in this survey.

How old are you?

*

❶ Choose one of the following answers
Please choose **only one** of the following:

◯ 0 - 17
◯ 18 - 29
◯ 30 - 39
◯ 40 - 49
◯ 50 - 59
◯ 60 - 69
◯ 70 - 79
◯ 80 or over

Are you a practicing editor? *

❶ Choose one of the following answers
Please choose **only one** of the following:

- Yes
- No

Do you work as an editor in Australia or New Zealand? *

❶ Choose one of the following answers
Please choose **only one** of the following:

- Australia
- New Zealand
- Other

Knowledge of Trauma-informed principles

This section of the questionnaire gathers information about your knowledge of trauma-informed practice.

What is your understanding of trauma?

Please write your answer here:

What types of trauma are there and what do you understand them to mean?

Please write your answer here:

As an editor, what does it mean to be trauma-informed?

Please write your answer here:

Do you think trauma-informed practice is important for editors? Please explain your answer

❗ Choose one of the following answers

Please choose **only one** of the following:

- ◯ Yes
- ◯ No
- ◯ Unsure

Make a comment on your choice here:

The core principles of trauma-informed practice are safety, trustworthiness, opportunity for choice, collaboration, empowerment, and respect for diversity (Mental Health Australia 2014). Please rank these in order of your understanding of their importance in the editor–author relationship.

❶ All your answers must be different and you must rank in order.

❶ Please select at most 6 answers

Please number each box in order of preference from 1 to 6

[ ] opportunity for choice

[ ] empowerment

[ ] collaboration

[ ] respect for diversity

[ ] safety

[ ] trustworthiness

Have you engaged in any formal learning on trauma-informed practices?

If you answered 'yes' to this question, please provide details.

❗ Choose one of the following answers
Please choose **only one** of the following:

- ◯ Yes
- ◯ No
- ◯ Unsure

Make a comment on your choice here:

Have you engaged in any informal learning on trauma-informed practices?

If you answer 'yes' to this question, please provide details.

❶ Choose one of the following answers
Please choose **only one** of the following:

- Yes
- No
- Unsure

Make a comment on your choice here:

Would you be interested in engaging in further learning on trauma-informed editing practices?

❶ Choose one of the following answers
Please choose **only one** of the following:

- Yes
- No
- Unsure

If trauma-informed guidelines for editing were available, would you incorporate these into your editing practice?

❶ Choose one of the following answers
Please choose **only one** of the following:

- ◯ Yes
- ◯ No
- ◯ Unsure

Trauma Encounters and Frequency

This section of the questionnaire gathers information about how often you encounter traumatic material in your editing practice and your techniques for managing your well-being during the editing process.

What types of traumatic material have you worked with in the past?

Please write your answer here:

How did you feel during the editing process?

Please write your answer here:

Did you engage in any self-care practices during the editing process to manage these feelings? What, if any?

Please write your answer here:

How do you feel now when reflecting on the process of working with traumatic material?

Please write your answer here:

Disclosure of trauma

This section of the questionnaire gathers information about authors disclosing trauma and your techniques for managing your well-being during the editing process.

As an editor, how did you feel when working with an author who disclosed personal trauma? How did you manage the disclosure? Did their manuscript include accounts of their traumatic experience?

Please write your answer here:

If comfortable, please describe a specific experience of disclosure and how the relationship with the author was managed.

Please write your answer here:

How do you feel now when reflecting on the process of working with an author who disclosed personal trauma?

Please write your answer here:

Demographics

Before you go, if you are comfortable, please tell us more about yourself.

If you are a member of IPEd, what level membership do you hold?

❶ Choose one of the following answers
Please choose **only one** of the following:

- ◯ Student
- ◯ Associate
- ◯ Professional
- ◯ Accredited
- ◯ Honorary Life Member
- ◯ Not a member

What type of editing do you do?

❶ Check all that apply
Please choose **all** that apply:

- ☐ Fiction
- ☐ Non-fiction
- ☐ Academic
- ☐ Trade
- ☐ Other

Which of the following best describes your employment status?

❶ Check all that apply
Please choose **all** that apply:

- ☐ Freelancer
- ☐ Employed by a publishing company
- ☐ Employed by a non-publishing company in a role with editing responsibilities
- ☐ Other

What is the highest level of education you have attained?

❶ Choose one of the following answers
Please choose **only one** of the following:

- ◯ Year 10
- ◯ Year 12 / Higher School Certificate equivalent
- ◯ Diploma / Advanced Diploma / Associate Degree
- ◯ Bachelor Degree
- ◯ Bachelor Degree with Honours / Graduate Certificate / Graduate Diploma
- ◯ Master Degree
- ◯ Doctoral Degree / PhD

Thank you kindly for taking the time to help with this research.

04.10.2022 – 10:38

Submit your survey.
Thank you for completing this survey.

Appendix C: List of organisations included in Phase 1 data collection

Practice Guidelines for Clinical Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery (2012), Blue Knot Foundation

Abuse and Violence: Working with our Patients in General Practice (2022), Royal Australian College of General Practitioners

Trauma-Informed Practice in Schools: An Explainer (2020), New South Wales Department of Education

Trauma-Informed Tertiary Learning and Teaching Practice Framework (2020), Griffith University

Appendix C: Proposed Trauma-Informed Framework for Editing Practice