

Integrating understanding of and care for trauma into general practice:

A fundamental aspect of quality whole person care



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Background

Everyday general practice can benefit from integrating understanding of and care for trauma into whole person care. This facilitates new understandings of how lived experience, relationships, culture and context affect complex physiology, disease formation and overall health.

Objective

This article explores a generalist understanding of how trauma interacts with health, including the biology of trauma and the clinical implications of trauma-informed care. It discusses the general practitioner's (GP's) role in integrating an understanding of and care for trauma into a universal precautions approach to everyday practice.

Discussion

Integrating an understanding of and care for trauma into everyday general practice supports GPs to provide both humane whole person care and high-quality biomedical care. It enables early intervention in disease formation, allows GPs to unravel complex presentations and provides a framework for safe, trustworthy, collaborative, empowering and culturally respectful care.

THE ORIGINAL MEANING of the Greek word 'trauma' is wound.¹ General practitioners (GPs) are exposed to the many types of potential wounds in our communities – historical, structural, physical, psychosocial, existential, cultural and environmental.² Definitions of 'trauma' in emergency medicine usually describe physical wounds, whereas psychiatric, legal and insurance definitions limit 'trauma' to physical life threats or sexual assault.³ These narrow definitions have delayed awareness in medicine of the complex and chronic impacts on health of a wider range of human experiences that threaten sense of safety and cause wounds.¹ Narrow definitions have obscured generalist pattern recognition and clinical awareness of the longitudinal physical impacts of chronic and unrelenting relational, social, psychological and cultural experiences of threat, including childhood maltreatment and domestic violence, colonisation, gender inequity, racism, entitlement, poverty and other social determinants of health.⁴

Understanding and caring for the impact of trauma on biology and biography is a fundamental part of whole person care.⁵ As GPs are already on the frontline using their clinical skills at the intersection of life, community and body, integrating new biological and psychotherapeutic understanding of trauma can benefit

everyday care.⁶ An understanding of trauma facilitates understanding of how subjective experience, relationships, culture, meaning and context affect physiology, neurobiology and immunology.⁷ This understanding, combined with GP pattern recognition skills, can help GPs to unravel complex presentations and processes of disease formation over time.⁸⁻¹⁰

A generalist view of trauma

Generalists need wide definitions of trauma that acknowledge the interconnected ways that threat affects the whole person. Descriptions of trauma from those working in child development, psychotherapy and psychophysiology are helpful. They describe the impact of arousal that overwhelms coping mechanisms, and the terror of physical or psychological invasion or aloneness.¹¹⁻¹⁵ These descriptions can help GPs to see trauma across the communities they serve and therefore to consider it in every patient. These definitions can also help GPs to question narrow psychiatric diagnostic frameworks that ignore lived experience, relationships and meaning. A widely used definition of trauma that aligns with the primary care view of health comes from the US Substance Abuse and Mental Health Services Administration:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being.^{16 (p. 7)}

Trauma can be caused by a *single incident*; for example, a car accident or a sexual assault. These often lead to acute stress reactions that can have ongoing consequences. More commonly, however, trauma is a chronic, ongoing experience during a child's development or within an adult intimate partnership, leading to *complex* impacts on emotional regulation, relational trust and perception of self and others.^{17,18} Trauma can also be a communal experience that can affect whole cultures and meaning-systems over time, in what some call 'intergenerational trauma' and Aboriginal elder Dr Richard Fejo names '*compound trauma*'.¹⁹ Understanding these layers of trauma can help GPs to look beyond psychiatric or 'post-traumatic' disorders that assume discrete traumatic events with a beginning and an end. Layers of trauma stretching from before birth to death are the reality for many people in our community, contributing to health disparities and explaining the impact of social determinants on health.

Integrating an understanding of trauma in healthcare can help GPs to make sense of symptoms currently considered unexplained; unravel the complex relationships between trauma and mental health issues including addictions or obsessions; and connect stress with physical health problems such as cardiovascular risk, asthma and eczema.²⁰⁻²³ It might also help to explain school refusal and risky behaviours and provide insights into why some patients seek care frequently whereas others delay seeking care.²⁴⁻²⁶ By acknowledging the impacts of trauma, health practitioners can help patients to understand how relationships, context, life story and other social determinants of health affect them personally.²⁷

Integrating a wide understanding of trauma into everyday practice allows GPs to see contextual, structural and communal determinants of health, as well as the complex

interactions of physical, interpersonal and intrapersonal experiences. Understanding trauma also allows practitioners to practice in a way that builds sense of safety and protects dignity, to attend to their own life experiences of trauma, to mitigate vicarious trauma from their work, and to make sense of moral injury from structural inequities and abuses in their workplace.²⁸ Box 1 outlines clearly what care underpinned by an understanding of trauma is and is not.

The biology of trauma

An understanding of the physiological impact of trauma can inform how GPs consider the formation of disease, including everyday complex and chronic presentations. This is directly relevant to the general practice focus on prevention and public health, and can increase recognition of and responses to personal and systemic abuses of power and injustice where people live, learn and work.¹

When a person experiences intense or long-term threat without supportive relationships – especially during important developmental stages – their physiological ability to adapt (called 'allostasis') can become overwhelmed.²⁹⁻³² This overwhelm is a dynamic process known as 'allostatic overload'. Emerging research links this to multisystem physiological dysregulation³³ and increased risk of morbidity and mortality.³⁴⁻³⁶

One allostatic mechanism is the stress response system.³⁷ Early stress research identified stress (including positive stress that causes growth – 'eustress') as a physical state affected by 'stressors'.³⁸ 'Stressors' include anything internally (eg dysregulated mitosis, despair or grief) or externally (eg sun exposure, unstable housing or childhood adversity) that causes the body to experience 'stress' requiring adaptation.¹

The term 'toxic stress' is defined by the Harvard Center on the Developing Child as the physical impact on a child of:

*frequent, prolonged adversity such as physical or emotional abuse, chronic neglect, caregiver substance abuse, exposure to violence, climate driven extreme weather events ... and/or the accumulated burdens of family economic hardship – without supportive relationships to buffer against stress.*³⁹

As outlined in Figure 1, stress research has highlighted the role of relationships in health, naming 'tolerable stress' where the presence of a supportive caregiver facilitates adaptive coping and a sense of control, mitigating the impact of stressors on brain architecture and lifelong health.^{7,30,40-52} In the absence of this protective factor, toxic stress in childhood can disrupt multiple biological systems, as outlined in Table 1. This 'biological signature'^{30 (p. E238)} confers lifelong risk for physical and mental health disorders.³⁰

Overarching principles of trauma-informed care

Early internationally recognised principles of trauma-informed care highlighted the importance of safety, collaboration, choice,

Box 1. What care underpinned by an understanding of trauma is and is not

What care underpinned by an understanding of trauma is:

- A facilitator of whole person care.
- A universal precautions approach to working with all patients, regardless of what is known of their personal history.
- A whole person approach to health that integrates life experience, relationships and meaning into clinical decision making.
- A culturally respectful approach that stays aware of violation and neglect in community structures, processes and history.
- A strengths-based and healing-oriented awareness of resources and processes that facilitate respect, healing, recovery and post-traumatic growth.
- An approach to suffering in all people, including vicarious trauma of healthcare practitioners.

What care underpinned by an understanding of trauma is not:

- A narrow psychiatric diagnostic approach.
- A legal insurance assessment process.
- A psychological therapy technique.
- Digging up people's past to 'process' it.
- Diagnosis that pathologises normal responses.
- Something only 'vulnerable' people need.
- Justifying inexcusable behaviour.
- Individualising societal issues.

empowerment and trustworthiness.⁵³ Further principles of peer support; voice and choice; and cultural, historical and gender issues have since been clarified.¹⁶ The framework of trauma- and violence-informed care adds

an explicit acknowledgement of the ongoing impacts of structural and historical sources of trauma and inequity.⁴ These build on Dr Judith Herman's original (and enduring) clinical model of care,⁵⁴ which describes

three key stages of healing from trauma: (1) establishing safety; (2) remembrance and mourning; and (3) reconnecting with everyday life.

The term safety, used in the context of trauma, is more than physical safety or prevention of medical harm. It is a broad whole person experience of sensing that you are physically, emotionally and socially safe in this context, with these people and with your own memories, sense of self and ways of making meaning of the world.²⁸

The framework for the understanding of and care for trauma outlined in Figure 2 in this paper draws on other key documents relevant to the field. These include:

- An Australian national strategic position paper and recommendations by the National Trauma-Informed Care and Practice Advisory Working Group.⁵⁵
- The Royal Australian College of General Practitioners' (RACGP's) White Book chapter on trauma-informed care, which highlights the need to care for both events and processes that wound.⁵⁶
- The Sense of Safety Theoretical Framework, which names healing-oriented

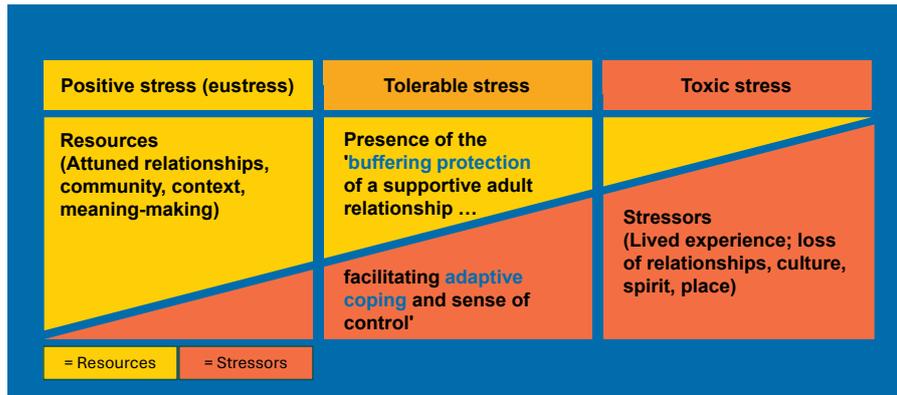


Figure 1. Biological stress reactions to the complex interplay of resources and stressors. Resources are in yellow; stressors are in orange.

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Table 1. Biological systems disrupted by stressors

System	Mechanism	Health impact
Neurologic; neuroendocrine	<ul style="list-style-type: none"> • Autonomic dysregulation of sympathetic-adrenal-medullary and hypothalamic-pituitary-adrenal axes • Altered reactivity and size of the amygdala • Hippocampal neurotoxicity • Reward-processing dysregulation 	<ul style="list-style-type: none"> • Heighted or blunted stress sensitivity: difficulty modulating, sustaining or dampening stress response • Increased fear responsiveness, impulsivity, aggression • Impaired executive function with poorer planning, decision making, impulse control and emotion regulation • Difficulty with learning and memory • Increased risky behaviours and risk of addiction
Immunologic; inflammatory	<ul style="list-style-type: none"> • Increased inflammatory markers, especially Th2 response, inhibition of anti-inflammatory pathways, gut dysbiosis 	<ul style="list-style-type: none"> • Increased risk of infection, autoimmune disorders, cancers, chronic inflammation and cardiometabolic disorders
Endocrine; metabolic	<ul style="list-style-type: none"> • Changes in growth, thyroid and pubertal hormone axes • Changes in leptin, ghrelin, lipid and glucose metabolism and other metabolic pathways 	<ul style="list-style-type: none"> • Changes in growth, development, basal metabolism and pubertal events • Increased risk of overweight, obesity, cardiometabolic disorders and insulin resistance
Epigenetic; genetic	<ul style="list-style-type: none"> • Sustained changes to the way that DNA is read and transcribed • Telomere erosion, altered cell replication and premature cell death 	<ul style="list-style-type: none"> • Mediates all aspects of the toxic stress response • Increase risk for disease, cancer and early mortality

Adapted from Bhushan D, Kotz K, McCall J, et al; Office of the California Surgeon General. Roadmap for resilience: The California Surgeon General's report on adverse childhood experiences, toxic stress, and health. Office of the California Surgeon General, 2020. doi: 10.48019/PEAM8812, with permission from the Office of the California Surgeon General.

approaches to the whole person including key processes that build sense of safety.^{1,28}

- The recovery and post-traumatic growth literature, which names the importance of connection, hope, identity, meaning and empowerment.^{57,58}
- A paper describing healing relationships in primary care (which highlights valuing each person, managing clinician power in a way that benefits the patient and abiding [staying with] the person on the journey of healing).⁵⁹
- The construct of trauma-transformative practice described by the Australian Childhood Foundation.⁵

Trauma-informed care in the consulting room

In the consultation room, it is important to remember that understanding and caring for trauma is a universal precautions approach to working with all patients, regardless of presentation or what is known about their personal history.¹⁶ Trauma can be present across the community, not just in patients with medically unexplained symptoms, mental health presentations, substance abuse or other complex presentations. Patients may or may not choose to share their experiences of trauma with their GPs. Disclosure of prior trauma is not the goal of caring for trauma.

Clinical care can be guided by the overarching principles outlined in Figure 2 and below.

GPs can *maintain systemic awareness* of the prevalence and historical, structural and personal impact of trauma on both survivors and perpetrators of harm. Being tuned in to the impact of colonisation and resulting harmful social practices is an important element of this systemic awareness. Having a strong awareness of both the prevalence of trauma and the many ways in which it can affect patients' health can allow GPs to be attuned to the indicators of possible underlying trauma and integrate that into clinical decision making.^{4,60}

GPs can also *build sense of safety* in every interaction – prioritising each person's physical, relational and emotional safety.^{4,54,61} This overarching task uses communication skills such as pacing, tone of voice, empathy and emotion regulation. It also requires developing an understanding of what stressors or threats a person is experiencing and what strengths, resources and new skills build sense of safety in a person's life.¹ All staff members can contribute to ensuring the physical or online clinic is welcoming and accessible to all patients and is a place that offers safe care. This includes individual practice and clinic policies and procedures, facilitation of longer appointments as needed, as well as respectful and flexible intake and booking processes. Some patients with experiences of trauma might find keeping booked appointments difficult for a number of reasons, including the neurodevelopmental impacts of trauma and, for some, ongoing high levels of stressors in their daily lives. Clinic-wide responses that are non-judgemental can support patients to overcome barriers to attendance.

GPs can consistently *validate the person and their perceptions*, protecting dignity in every consultation. This involves actively listening to the patient's perspective, prioritising their voice and culture, spending time validating and holding space, offering and respecting choices about their care, and encouraging shared decision making.^{60,62} This can help patients to feel worthy of care.

GPs can hone their capacity to *tune in to the body* in a way that remains aware of the long-term impacts of trauma on physical health and allows moment-by-moment



Figure 2. Overarching principles for integrating understanding of and care for trauma into everyday practice.

Reproduced from Lynch JM. Biology and biography intertwined: The science of trauma-informed care. Presentation at Medical Learning Journeys Conference, Hamilton Island, Queensland, 3 May 2025. Sense of Safety Project, 2025, with permission from Lynch JM, Director of the Sense of Safety Project.

awareness of the person's sense of safety. GPs can use overt consent processes, as well as medical rituals of care, distraction and attuned humour, to help to calm distress.^{57,63} Raising awareness of the impacts of trauma on physical health can also help patients to make connections and understand their own symptoms.

GPs can *facilitate genuine choice* in the management of information, confidentiality, consent and clinical decision making. Integrating understanding of trauma into care requires an awareness of the inherent power dynamics in the clinician-patient relationship and the ways clinical interactions can inadvertently evoke shame, fear and flashbacks to patients' prior experiences of interpersonal trauma and abuse. Collaboration and choice are important aspects of supporting patients to rebuild their sense of agency, empowerment and control over their lives.^{53,16} Enacting these principles in practice includes offering overt processes of consent and shared decision making with patients (eg inviting their review of referral letters and shared decision making). Patients might also have had many betrayals of trust in the past or might currently be in danger. Strict attention to confidentiality is therefore critical; for example, not asking a patient to give their address details in front of the waiting room. Facilitating genuine choice also includes supporting patients to feel safe during all physical examinations.⁶⁰ Explaining the examination and why it is recommended and requesting consent for each step beforehand can help patients feel more in control. Providing privacy, offering choices, allowing a support person and reminding patients that they can pause, adjust or stop the exam at any time also contributes to each person's sense of autonomy.

GPs can *be healing oriented* by maintaining therapeutic relationships and guiding patients on pathways towards healing in their community that align with CHIME (Connection, Hope, Identity, Meaning and Empowerment).⁵⁸ This aligns with GP priorities of continuity of care through long-term therapeutic relationships. Providing patients with a safe, reliable and stable clinical relationship within clear and appropriate boundaries can offer therapeutic value and healing in itself.¹ The Sense of Safety Theoretical Framework also offers

clear guidance on goals of care that are strengths-based and healing oriented.²⁸

This approach to clinical practice aligns closely with the generalist lens that prioritises whole person care as an essential aspect of quality general practice.⁶⁴ It also reflects the voices of survivors of domestic violence

who have described their expectations that healthcare providers will offer them CARE (Choice and control, Action and advocacy, Recognition and understanding, and Emotional connection).⁶⁵ Each of these expectations is an essential element of quality general practice care (Box 2).

Box 2. Cases

Case 1: Integrating trauma-informed care into preventive care (key principles are in brackets)

Layla, patient aged 42 years, attends for a script for her contraceptive pill. You realise that she did not attend after her routine cervical screening reminder. She has no symptoms or history of concern. When you suggest she has the screening done, she explains that she finds the examination too embarrassing and has been putting it off. She seems reluctant to expand on why she does not want to be examined. You discuss the option of a self-collected test as an alternative. She accepts this and is grateful that she is able to do the sampling herself (Facilitate genuine choice). While she is collecting the sample, you check her records, scanning for physical side effects of chronic stressors, such as headache, insomnia, elevated cholesterol, waist/hip ratio, C-reactive protein, asthma, eczema and autoimmune disease (Tune into the body). When she returns with the sample, you validate her choice and reflect on the fact that many women prefer to self-collect for many reasons, including embarrassment or past issues (Validate the person and their perceptions). You then ask her if she would be comfortable telling you if there is any reason she finds examination uncomfortable (Build sense of safety). She discloses a past history of sexual trauma. You listen carefully to what she shares, acknowledge and validate her experience and thank her for sharing the information, letting her know that this can play an important part in her health. You check in about how safe she feels and whether she has received support previously, and you offer resources including 24-hour counselling support numbers. Layla is happy to accept the resources, and you reassure her that general practice is the right place to seek further help, offering another appointment to explore what this might look like and instilling some hope that healing is possible (Be healing oriented).

Case 2: Integrating trauma-informed care in the whole of clinic

As a general practitioner, you receive a discharge letter from a hospital explaining that one of your patients, a mother of two aged 26 years, left the emergency department (ED) against medical advice after presenting with pelvic pain and bleeding as she was not prepared to wait to be examined by the doctor. She was advised to follow up with you as she had not had a full assessment.

On reviewing her file, you note this patient, Maria, has a history of childhood trauma, intimate partner violence and sexual assault (Maintain systemic awareness). You call her and organise a long consultation, explaining why it is important for her to see you. Her notes indicate that she is often late for appointments, so you add her at the end of a list and explain to your reception staff that if she is late for her appointment, you will still see her (Validate the person and their perceptions). When she presents, the reception staff help her to feel welcome and comfortable and give her regular updates on the expected wait times for you (Build sense of safety). In the consult room, she discusses her symptoms and discloses that she left the ED as she thought the examination would be done by a male doctor and she did not want this to occur. You spend time listening to her, explain why an examination is recommended and explore her concerns and how she would like to proceed (Facilitate genuine choice). With her consent, you are able to complete her assessment and examination by pacing the process, offering a chaperone, reminding her that she can ask for the examination to be adjusted or stopped at any time, ensuring her privacy and enabling her to listen to music on her phone during the examination (Build sense of safety). With her agreement, you set up regular follow-up appointments. Over time, you are able to build a strong, collaborative, trusting relationship and a shared understanding of how useful more specific trauma counselling could be for her wellbeing (Be healing oriented). You carefully pace conversations and tone of voice to gently invite her to consider her next steps with your support (Tune in to the body).

Trauma-informed care for the clinician

GPs are people with their own personal life experiences, including experiences of trauma, often at higher rates than the general population.⁶⁶ They are also often exposed to trauma in patients' lives, regularly seeing suffering in their community. In the current climate of neglect of primary care funding, GPs can also experience wounding from the structures and funding models they work within. Like other caring professions, it is important to have clinical supervision from skilled facilitators to reflect on the intense and painful, as well as joyful and fulfilling, aspects of practice. Seeking personal therapy and making life routines that include creativity, connection and meaning are also ways to care for our own trauma and mitigate vicarious trauma. There is a useful section in the RACGP White Book on vicarious trauma with resources for GPs.⁵⁶

Conclusion

Trauma that affects health is very common in our community. It has an impact at the complex intersection of lived experience, relationships, context, culture, meaning and biology. Integrating an understanding of, and care for, trauma in general practice offers new ways to understand disease formation and integrate social determinants of health into clinical decision making and approaches to care. Understanding the impact of trauma can also decode previously confusing or unexplained presentations. Understanding trauma enables clinicians to prioritise safety and collaborative respect in every consultation, to refer appropriately and to hold hope for healing despite ongoing systemic and structural processes that traumatise our community. Integrating an understanding of trauma into everyday general practice is part of good-quality whole person care.

Key points

- Integrating an understanding of, and care for, trauma into general practice is a universal precautions approach to working with all patients, regardless of what is known of their personal history.
- Generalist whole person care that considers both biology and biography

in each consultation requires an understanding of the prevalence and impact of trauma across the lifespan.

- Understanding the impact of trauma embeds a new way of conceptualising disease formation and health disparities at the intersection of physiology, lived experiences, relationships, meaning, culture and context.
- Integrating an understanding of trauma into whole person care enables everyday clinical decision making that considers social determinants of health, biography and biology.
- Providing patients with a safe, reliable and stable clinical relationship within clear and appropriate boundaries is therapeutic and healing oriented.

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Competing interests: None.

Funding: JL is employed as a clinical consultant to the Domestic, Family, and Sexual Violence Local Link team at the Brisbane South Primary Health Network. Although the Australian Government helped fund this research, it has not reviewed the content and is not responsible for any injury, loss or damage however arising from the use or reliance on the information provided herein. MS has received funding for her higher degree under the Australian Government's Research Training Program.

Provenance and peer review: Commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

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References

1. Lynch JM. A whole person approach to wellbeing: Building sense of safety. Routledge, 2021.
2. Wathen CN, Schmitt B, MacGregor JCD. Measuring trauma- (and violence-) informed care: A scoping review.

Trauma Violence Abuse 2023;24(1):261-77. doi: 10.1177/15248380211029399.

3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5). American Psychiatric Association, 2013.
4. Wathen CN, Varcoe C. Trauma- & Violence-Informed Care (TVIC): A tool for health and social service organizations and providers. Equip Health Care, 2021. Available at <https://equiphealthcare.ca/files/2021/05/GTV-EQUIP-Tool-TVIC-Spring2021.pdf> [Accessed 28 March 2025].
5. Reeve J, Dowrick CF, Freeman GK, et al. Examining the practice of generalist expertise: A qualitative study identifying constraints and solutions. *JRSM Short Rep* 2013;4(12):2042533313510155. doi: 10.1177/2042533313510155.
6. Mitchell J, Tucci J. From trauma informed to trauma transformative: Core dimensions for practice, organization and community change. In: Tucci J, Mitchell J, Porges SW, Tronick EC, editors. The handbook of trauma-transformative practice: Emerging therapeutic frameworks for supporting individuals, families or communities impacted by abuse and violence. Kingsley Publishers, 2024; p. 444.
7. Lynch JM, Kirkengen AL. Biology and experience intertwined: Trauma, neglect and physical health. In: Benjamin R, Haliburn J, King S, editors. Humanising mental health care in Australia: A guide to trauma-informed approaches. Routledge Taylor and Francis Group, 2019; p. 195-207. doi: 10.4324/9780429021923-15.
8. Ladds E. Exploring the GP-patient relationship: A historical narration. *Med Humanit* 2025;51(1): 112-22. doi: 10.1136/medhum-2024-012916.
9. Heath I. How medicine has exploited rationality at the expense of humanity: An essay by Iona Heath. *BMJ* 2016;355:i5705. doi: 10.1136/bmj.i5705.
10. Lynch JM, Klieve-Longman J, McLindon E, Cullen P, Giles F, Hegarty K. Coercive control: Recognising relational patterns that impact patient wellbeing. *Aust J Gen Pract* 2025;54(12):855-59. doi: 10.31128/AJGP-02-25-7576.
11. Porges SW. The Polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation. WW Norton & Company, 2011.
12. Porges SW. Polyvagal theory: A biobehavioral journey to sociality. *Compr Psychoneuroendocrinol* 2021;7:100069. doi: 10.1016/j.cpnec.2021.100069.
13. Berthelot N, Ensink K, Bernazzani O, Normandin L, Luyten P, Fonagy P. Intergenerational transmission of attachment in abused and neglected mothers: The role of trauma-specific reflective functioning. *Infant Ment Health J* 2015;36(2):200-12. doi: 10.1002/imhj.21499.
14. Fonagy P, Campbell C, Luyten P. Attachment, mentalizing and trauma: Then (1992) and now (2022). *Brain Sci* 2023;13(3):459. doi: 10.3390/brainsci13030459.
15. Cozolino L. The neuroscience of psychotherapy. Building and rebuilding the human brain. WW Norton & Co, 2002.
16. Huang LN, Flatlow R, Biggs T, et al. SAMHSA's working concept of trauma and guidance for trauma-informed approach. Substance Abuse and Mental Health Services Administration, 2012. Available at <https://library.samhsa.gov/sites/default/files/sma14-4884.pdf> [Accessed 28 March 2025].
17. Australian Institute for Health and Welfare (AIHW). Australia's children. AIHW, Australian Government, 2020. Available at www.aihw.gov.au/getmedia/6af928d6-692e-4449-b915-cf2ca946982f/

- aihw-cws-69_australias_children_print-report.pdf?v=20230921161957&inline=true [Accessed 28 March 2025].
18. Spinazzola J, Ford JD, Zucker M, et al. Survey evaluates: Complex trauma exposure, outcome, and intervention among children and adolescents. *Psychiatr Ann* 2005;35(5):433–39. doi: 10.3928/00485713-20050501-09.
 19. Lynch JM. The ALIVE National writer-in-residence program. ALIVE National Centre for Mental Health Research Translation, 2024. Available at https://static1.squarespace.com/static/5dd65fcf476e6268dc6f6601/t/672c41f22b4ee8696b9901a4/1730953721292/Writer+in+Residence+ALIVE_2024.pdf [Accessed 28 March 2025].
 20. Wright RJ. Trauma-informed research and care for difficult-to-control asthma: The time is now! *J Allergy Clin Immunol Pract* 2021;9(12):4310–11. doi: 10.1016/j.jaip.2021.09.027.
 21. Konkoly Thege B, Horwood L, Slater L, Tan MC, Hodgins DC, Wild TC. Relationship between interpersonal trauma exposure and addictive behaviors: A systematic review. *BMC Psychiatry* 2017;17(1):164. doi: 10.1186/s12888-017-1323-1.
 22. Sumner JA, Cleveland S, Chen T, Gradus JL. Psychological and biological mechanisms linking trauma with cardiovascular disease risk. *Transl Psychiatry* 2023;13(1):25. doi: 10.1038/s41398-023-02330-8.
 23. Roelofs K, Spinhoven P. Trauma and medically unexplained symptoms towards an integration of cognitive and neuro-biological accounts. *Clin Psychol Rev* 2007;27(7):798–820. doi: 10.1016/j.cpr.2007.07.004.
 24. Ulaş S, Seğer İ. A systematic review of school refusal. *Curr Psychol* 2024;43(21):19407–22. doi: 10.1007/s12144-024-05742-x.
 25. Laceulle OM, Rentfrow J, Lamb ME, Alisic E. General risk or individual vulnerability? Individual differences in young adults' health risk behaviour after childhood trauma. *Pers Individ Dif* 2019;142:288–94. doi: 10.1016/j.paid.2018.09.017.
 26. Glaser JP, van Os J, Portegijs PJ, Myin-Germeyns I. Childhood trauma and emotional reactivity to daily life stress in adult frequent attenders of general practitioners. *J Psychosom Med* 2006;61(2):229–36. doi: 10.1016/j.jpsychores.2006.04.014.
 27. Magruder KM, McLaughlin KA, Elmore Borbon DL. Trauma is a public health issue. *Eur J Psychotraumatol* 2017;8(1):1375338. doi: 10.1080/20008198.2017.1375338.
 28. Lynch JM, Stange KC, Dowrick C, et al. The sense of safety theoretical framework: A trauma-informed and healing-oriented approach for whole person care. *Front Psychol* 2025;15:1441493. doi: 10.3389/fpsyg.2024.1441493.
 29. Butler EA, Randall AK. Emotional coregulation in close relationships. *Emot Rev* 2013;5(2):202–10. doi: 10.1177/1754073912451630.
 30. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 2012;129(1):e232–46. doi: 10.1542/peds.2011-2663.
 31. Gouin JP, Kiecolt-Glaser JK. The impact of psychological stress on wound healing: Methods and mechanisms. *Immunol Allergy Clin North Am* 2011;31(1):81–93. doi: 10.1016/j.jiac.2010.09.010.
 32. McEwen BS, Wingfield JC. The concept of allostasis in biology and biomedicine. *Horm Behav* 2003;43(1):2–15. doi: 10.1016/S0018-506X(02)00024-7.
 33. Wiley JF, Gruenewald TL, Karlamangla AS, Seeman TE. Modeling multisystem physiological dysregulation. *Psychosom Med* 2016;78(3):290–301. doi: 10.1097/PSY.0000000000000288.
 34. Fava GA, McEwen BS, Guidi J, Gostoli S, Offidani E, Sonino N. Clinical characterization of allostatic overload. *Psychoneuroendocrinology* 2019; 108:94–101. doi: 10.1016/j.psyneuen.2019.05.028.
 35. Juster RP, Bizik G, Picard M, et al. A transdisciplinary perspective of chronic stress in relation to psychopathology throughout life span development. *Dev Psychopathol* 2011;23(3):725–76. doi: 10.1017/S0954579411000289.
 36. Juster RP, McEwen BS, Lupien SJ. Allostatic load biomarkers of chronic stress and impact on health and cognition. *Neurosci Biobehav Rev* 2010;35(1):2–16. doi: 10.1016/j.neubiorev.2009.10.002.
 37. Juster RP, Misiak B. Advancing the allostatic load model: From theory to therapy. Elsevier, 2023; p. 106289.
 38. Selye H. The general adaptation syndrome and the diseases of adaptation. *J Clin Endocrinol Metab* 1946;6(2):117–230. doi: 10.1210/jcem-6-2-117.
 39. Harvard University, Center for the Developing Child. Toxic stress – Key concepts. Center on the Developing Child, [date unknown]. Available at <https://developingchild.harvard.edu/key-concept/toxic-stress> [Accessed 21 April 2025].
 40. Shonkoff J, Boyce W, Cameron J, et al. Excessive stress disrupts the architecture of the developing brain. Working Paper 3 Updated edition. National Scientific Council on the Developing Child, Center on the Developing Child at Harvard University, 2014. Available at https://developingchild.harvard.edu/wp-content/uploads/2024/10/Stress_Disrupts_Architecture_Developing_Brain-1.pdf [Accessed 14 May 2025].
 41. Schore AN. Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Ment Health J* 2001;22(1–2):7–66. doi: 10.1002/1097-0355(200101/04)22:1<7::AID-IMHJ2>3.0.CO;2-N.
 42. Fagundes CP, Glaser R, Kiecolt-Glaser JK. Stressful early life experiences and immune dysregulation across the lifespan. *Brain Behav Immun* 2013;27(1):8–12. doi: 10.1016/j.bbi.2012.06.014.
 43. Tomasdottir MO, Sigurdsson JA, Petursson H, et al. Self reported childhood difficulties, adult multimorbidity and allostatic load. A cross-sectional analysis of the Norwegian HUNT study. *PLoS One* 2015;10(6):e0130591. doi: 10.1371/journal.pone.0130591.
 44. Shaughnessy DT, McAllister K, Worth L, et al. Mitochondria, energetics, epigenetics, and cellular responses to stress. *Environ Health Perspect* 2014;122(12):1271–78. doi: 10.1289/ehp.1408418.
 45. Picard M, Juster RP, McEwen BS. Mitochondrial allostatic load puts the 'gluc' back in glucocorticoids. *Nat Rev Endocrinol* 2014;10(5):303–10. doi: 10.1038/nrendo.2014.22.
 46. Uchino BN, Cacioppo JT, Kiecolt-Glaser JK. The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. *Psychol Bull* 1996;119(3):488–531. doi: 10.1037/0033-2909.119.3.488.
 47. Eisenberger NI, Master SL, Inagaki TK, et al. Attachment figures activate a safety signal-related neural region and reduce pain experience. *Proc Natl Acad Sci USA* 2011;108(28):11721–26. doi: 10.1073/pnas.1108239108.
 48. Slavich GM, Way BM, Eisenberger NI, Taylor SE. Neural sensitivity to social rejection is associated with inflammatory responses to social stress. *Proc Natl Acad Sci USA* 2010;107(33):14817–22. doi: 10.1073/pnas.1009164107.
 49. Kirsch P, Esslinger C, Chen Q, et al. Oxytocin modulates neural circuitry for social cognition and fear in humans. *J Neurosci* 2005;25(49):11489–93. doi: 10.1523/JNEUROSCI.3984-05.2005.
 50. Valtorta NK, Kanaan M, Gilbody S, Ronzi S, Hanratty B. Loneliness and social isolation as risk factors for coronary heart disease and stroke: Systematic review and meta-analysis of longitudinal observational studies. *Heart* 2016;102(13):1009–16. doi: 10.1136/heartjnl-2015-308790.
 51. Gouin JP, Carter CS, Pournajafi-Nazarloo H, et al. Marital behavior, oxytocin, vasopressin, and wound healing. *Psychoneuroendocrinology* 2010;35(7):1082–90. doi: 10.1016/j.psyneuen.2010.01.009.
 52. Uchino BN, Trettervik R, Kent de Grey RG, Cronan S, Hogan J, Baucom BRW. Social support, social integration, and inflammatory cytokines: A meta-analysis. *Health Psychol* 2018;37(5):462–71. doi: 10.1037/hea0000594.
 53. Kezelman C, Stavropoulos P. 'The Last Frontier': Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. BlueKnot Foundation, 2012. Available at <https://blueknot.org.au/product/practice-guidelines-for-treatment-of-complex-trauma-and-trauma-informed-care-and-service-delivery-digital-download> [Accessed 14 May 2025].
 54. Herman JL. Trauma and recovery: The aftermath of violence – from domestic abuse to political terror. Pandora (an imprint of HarperCollins Publishers), 2015.
 55. Bateman J, Henderson C, Kezelman C. Trauma-informed care and practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group. Mental Health Coordinating Council (MHCC), 2013. Available at https://mhcc.org.au/wp-content/uploads/2018/05/ticp_awg_position_paper_v_44_final_07_11_13-1.pdf [Accessed 14 May 2025].
 56. Lynch JM. Trauma-informed care in general practice. The White Book Abuse and Violence. The Royal Australian College of General Practitioners, 2021. Available at www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice [Accessed 20 October 2025].
 57. Calhoun LG, Tedeschi RG, editors. Handbook of posttraumatic growth. Research and practice. Lawrence Erlbaum Associates, 2006.
 58. Hurst R, Carson J, Shahama A, Kay H, Nabb C, Prescott J. Remarkable recoveries: An interpretation of recovery narratives using the CHIME model. *Ment Health Soc Incl* 2022;26(2):175–90. doi: 10.1108/MHSI-01-2022-0001.
 59. Scott JG, Cohen D, Diccio-Bloom B, Miller WL, Stange KC, Crabtree BF. Understanding healing relationships in primary care. *Ann Fam Med* 2008;6(4):315–22. doi: 10.1370/afm.860.
 60. Bulford E, Baloch S, Neil J, Hegarty K. Primary healthcare practitioners' perspectives on trauma-informed primary care: A systematic review. *BMC Prim Care* 2024;25(1):336. doi: 10.1186/s12875-024-02573-4.

61. Courtois CA, Ford JD. Treating complex traumatic stress disorders: An evidence-based guide. Guilford Press New York, 2009.
62. Brooks M, Barclay L, Hooker C. Trauma-informed care in general practice: Findings from a women's health centre evaluation. *Aust J Gen Pract* 2018;47(6):370-75. doi: 10.31128/AJGP-11-17-4406.
63. Lynch JM, Thomas HR, Askew DA, Sturman N. Holding the complex whole: Generalist philosophy, priorities and practice that facilitate whole-person care. *Aust J Gen Pract* 2023;52(7):428-33. doi: 10.31128/AJGP-01-23-6686.
64. Lynch JM, van Driel M, Meredith P, et al. The Craft of Generalism clinical skills and attitudes for whole person care. *J Eval Clin Pract* 2022;28(6):1187-94. doi: 10.1111/jep.13624.
65. Tarzia L, Bohren MA, Cameron J, et al. Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open* 2020;10(11):e041339. doi: 10.1136/bmjopen-2020-041339.
66. McLindon E, Humphreys C, Hegarty K. "It happens to clinicians too": An Australian prevalence study of intimate partner and family violence against health professionals. *BMC Womens Health* 2018;18(1):113. doi: 10.1186/s12905-018-0588-y.