CONCEPTUALISING CHILD ABUSE AND NEGLECT RELATED COMPLEX TRAUMA IN CHILDREN AND YOUNG PEOPLE: AN EXPLORATORY PILOT STUDY

DECEMBER 2022

Pursuit of Excellence in Responding to Child Abuse and Neglect, WA

ACKNOWLEDGEMENTS AND AUTHORS

This research was undertaken as part of a Lotterywest grant awarded to Parkerville Children and Youth Care Inc. (Parkerville CYC Inc) and the Australian Centre for Child Protection (ACCP) for the Pursuit of Excellence in Responding to Child Abuse and neglect (PERCAN) initiative.

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The project was led by Amanda Paton and Dr Sarah Cox who were primarily responsible for the conceptualisation, design, planning, and data collection of this project, as well as contributing significant content knowledge to the project, and contributing to the interpretation of the research data and writing and revision of this report. Dr Sarah Shihata was primarily responsible for drafting and revising significant parts of this report as well as contributing to planning, data collection, content knowledge and interpretation of the research data. Dr Eden Thain was primarily responsible for the analysis and interpretation of the research data as well as drafting and revising significant parts of this report and contributing methodological expertise.

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Pursuit of Excellence in Responding to Child Abuse and Neglect, WA

PURPOSE

This report formed part of a broader program of work for the Pursuit of Excellence in Responding to Child Abuse and Neglect (PERCAN) initiative. This report provides the findings of an exploratory pilot study designed to support understanding of child abuse and neglect related complex trauma by identifying prominent complex trauma symptoms and possible mechanisms contributing to the development and maintenance of complex trauma.

BACKGROUND

As part of a broader PERCAN program of work designed to complement the culturally governed, culturally led, and evidence informed co-design project (led by Chief Investigator Professor Vickie Hovane which sought to bring together western and cultural knowledge regarding healing of complex trauma), previous research and consultation were undertaken to identify appropriate western treatment models for child abuse and neglect related complex trauma. This work revealed that due to the complexity of presentation typically seen in clinical work (see case example below), there was no 'off-the-shelf' solution for complex trauma. Further, it was identified that there was variability in what clinicians and academics were terming 'complex trauma', and that children with complex presentations were often screened out of studies exploring efficacy of various trauma treatments. This led to further exploration of the construct of complex trauma, how it was defined, and how it was represented both within the literature and current diagnostic systems available in clinical practice, such as the International Classification of Diseases 11th Revision (ICD-11; World Health Organization [WHO], 2019) and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013). It became apparent that what was described in the literature and within diagnostic parameters (which are commonly used as the boundaries for inclusion and exclusion in treatment evaluations), did not encompass the full clinical picture based on the authors' own clinical experience working with this population. Therefore, before western treatment models for complex trauma could be considered, the conceptualisation of complex trauma needed clarification.

The below hypothetical case example of 'Carrey' has been developed by the authors to demonstrate the complexity of experience and symptomatology that develops and changes over time, a typical case with sadly an all-too-common journey and trajectory.

Carrey was born six weeks premature to her mother (Sally) and father (Ray) both 22 years old at the time. Carrey was Sally's second born child, her first being taken into care at birth, when Sally was just 16 years of age. Sally and Ray were in an 'on again off again' relationship that was at times described as emotionally and physically violent. Both parents had presented numerous times to police and health services with bruises, cuts, and other injuries, noting violence from the other. Carrey was exposed to amphetamines in utero which was believed to have contributed to her premature birth and early developmental delays. She was diagnosed early on by a paediatrician as having failure to thrive.

Sally and Ray spent much of Carrey's early years suffering from poor mental health, drug addiction, and transient housing. Sally was a child in care herself and reported that she has no positive family

connections. Ray, whilst not a child in care, explains that he moved a lot as a kid, never really connected with friends or schooling, and rarely speaks to his parents or siblings anymore.

From the age of two years, Carrey presented to health facilities with malnutrition, unexplained bruises, illnesses, and general poor health. Whilst some child protection concerns were raised, they did not meet the threshold for significant intervention. Sally and Ray went on to have two more children together before each re-partnered. Ray had another two children to other women, and Sally had a further two children also. Carrey therefore has two younger full siblings and five half siblings (one older and four younger). Neither Sally or Ray maintained regular employment given their poor mental health and drug use (which were largely untreated), and subsequently Carrey and her siblings regularly moved. At times, Carrey also accompanied Sally and some of her other siblings at short term refuges when violence in the home escalated.

Sally described Carrey as a very fussy baby that was difficult to sooth and feed. She also described what seemed to be experiences of post-natal depression, she found it difficult to bond with Carrey, admits to leaving her alone for hours in a room, and reports that the first few years were particularly bad between her and Ray (with regards to violence) and that they used a lot of drugs.

At age four when Carrey started kindergarten, teachers began reporting signs of significant neglect and potential physical harm. She had noticeably delayed speech, poor gross and fine motor skills, and did not interact well with her peers. She was repeatedly separated for rough and inappropriate play in the classroom and playground (including some sexualised play). Both parents were also noted to present to the school drug affected at times. On one occasion Sally picked up Carrey from school an hour late with significant bruises on her face and neck. The matter was reported, and some supports were provided. Carrey was briefly engaged with a psychologist via the school and had an assessment where she was diagnosed with Global Developmental Delay, and she was further sent to a paediatrician where an early diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) was queried.

As Carrey progressed in school, her behaviour and academic achievement continued to be problematic and delayed. Carrey was disruptive in class, displayed poor attention, and was performing well below her peers across all subject areas. Her grade three NAPLAN showed that she was reading and writing at a pre-primary level, and mathematics was lower still. Carrey was frequently caught punching and kicking other children and had been suspended twice for swearing and lashing out physically at teachers. This resulted in Carrey being physically restrained on several occasions for the safety of herself and other children. During this time, she continued to attend school with no lunch, dirty clothes, and without breakfast and general school supplies. Carrey would often steal and hoard other children's food and belongings at school which continued to add to her difficulties with peers. She was diagnosed with Oppositional Defiant Disorder (ODD) and confirmed as having ADHD. She was put on a behaviour support plan, a trial of medication, and provided some education assistant time and access to the Chaplain and school Psychologist with little positive effect.

Toward the end of grade three, there was a significant incident at school where she had touched a year one student on the vagina while in the toilets. The other child reported that this was a game that Carrey had played with other girls before as well. When approached about the behaviour by the school and where she had learnt this, Carrey stated that her older brother touched her that way when he came to visit. Further police and child protection involvement revealed that Carrey had been the victim of prolonged sexual abuse by her older brother for a three-year period during times when he stayed

over the house. In addition, Carrey also reported a very early incident when a friend of her mum and dad came to the house. Both experiences involved significant penetrative sexual abuse.

Unfortunately, when Sally was advised of the sexual abuse by her friend and eldest son, she didn't believe Carrey and responded inappropriately. At this time, Ray was facing unrelated drug and assault charges which would see him receive a prison sentence, so Carrey was placed in department care given ongoing concerns of neglect, physical abuse, exposure to violence, and failure to protect a child from harm. Carrey was placed in a temporary residential care home for a period of three months before being placed in foster care. While in this placement Carrey began attending therapy at a specialty clinic for children with an experience of child sexual abuse. She refused to speak about her sexual abuse experience with the therapist and was subsequently discharged being noted as not ready for therapy.

Despite this, Carrey remained in the foster care placement for 12 months and enjoyed some stability and engagement in regular therapeutic care and access to appropriate supports. She maintained some contact with her mother and siblings but refused to see her father while in jail. Contact with her mother was often sporadic, and her mental health and drug use deteriorated. Carrey's younger siblings were eventually also taken into care, with one sibling being placed with Carrey in the same foster care placement.

In grade five (now 10 years of age), Carrey displayed significant bursts of outward aggression towards her younger sister in the placement. Carrey was also struggling with nightmares, sleeplessness, and sporadically wetting the bed at night-time. During the day, she would swing from being easily excitable and bubbly to violent to herself and others. At times, Carrey engaged in cutting herself after verbal and physical altercations with her carers and sister. She was again referred to a therapist where she was described as being depressed and was sent to a psychiatrist for review. She was subsequently diagnosed with Depression and prescribed a low dose antidepressant alongside medication for her ADHD and ODD.

Carrey's behaviour and emotional dysregulation became such an issue, that her placement broke down and she was placed in a residential family group home with three other unrelated children of varying ages. Carrey's younger sister remained in the foster care placement and their contact slowly diminished over time. At about 12 years of age, Carrey and another older resident began absconding after school and at night. Incidents escalated with reports of Carrey trying alcohol and other drugs such as marijuana. She continued to engage in self-harming behaviour although this escalated to more controlled cutting outside periods of acute escalation and distress. She began cutting on her upper thighs and arms. As her mental health deteriorated, she reported periods of depressed mood, feelings of worthlessness, and helplessness. She was returned to the psychiatrist where it was noted that the antidepressants were no longer having positive effect and she was later prescribed antipsychotics as a trial to try and manage her fluctuating moods between severely depressed/self-harming and violent manic outbursts which led to significant conflict and safety concerns.

Carrey did not make the transition to high school well and during this time she failed to attend school regularly. When Carrey did attend school, she was disruptive to classmates and refused to engage in learning activities. She had repeated conflicts with peers and teachers that led to physical and verbal altercations.

Carrey remained in this placement until 13 years of age, when she was reunified with her mother (Sally) for a brief period. This unfortunately ended with her apprehension by police who were called to the

home in the middle of the night due to an altercation between Carrey and her mother. Sally reported that she couldn't manage Carrey's behaviour any longer, she wasn't attending school, was smoking marijuana, drinking alcohol, and was sneaking out at night. At this time, Carrey was confirmed as meeting the diagnostic criteria for Conduct Disorder (CD) due to the criminal level of her violent behaviours towards others.

Carrey was transferred to a youth residential care placement which was thought to be more suitable for her needs. This was a rotating roster model of care where young people were expected to be engaged in a day program. Given Carrey was not readily attending school this was a continued source of tension for the placement. She began a sexual relationship (perceived by her as such, despite limits of consent) with an older male in the residential unit, which staff reported as controlling and highly concerning. She continued to abscond, use drugs and alcohol, and engage in high-risk sexual behaviours.

At 15 years of age, Carrey reported to her therapist that while in her mother's care briefly (during the period of reunification), she was sexually assaulted by a family friend. She refused to discuss the incident further and did not want to report the matter to police. She reported significant ongoing distress related to this incident and the earlier sexual abuse by her older brother.

INTRODUCTION

Child Abuse and Neglect

Child abuse and neglect, including physical abuse, emotional abuse, sexual abuse, neglect, and exposure to intimate partner and family violence, is now recognised as a major public health and social welfare issue, globally (WHO, 2022). Child abuse and neglect is associated with actual, potential, or threatened harm to survival, development, health, or dignity and exists within the context of a relationship that encapsulates trust, responsibility, and power (WHO, 2022). While it is difficult to accurately quantify the global prevalence of child abuse and neglect due to differences in the way it is reported and recorded, as well as criteria applied by different child protection agencies in triaging reports of child abuse (Stoltenborgh et al., 2015), it was estimated in 2014 that up to 36% of children worldwide had experienced a form of child abuse and neglect (WHO, 2014).

In Australia, during 2020-2021, 531,884 notifications were received by Australian child protection departments, with 49,690 substantiations (54.7% emotional abuse including exposure to family and domestic violence; 21.4% neglect, 13.9% physical abuse, 9.7% sexual abuse, and 0.3% not stated; Australian Institute of Health and Welfare [AIHW], 2022). The average co-occurrence of substantiated abuse and neglect, by primary type of abuse and neglect, is 36.0% for emotional abuse, 30.4% for neglect, 22.4% for physical abuse, and 2.9% for sexual abuse (AIHW, 2022). It is important to note, however, that due to some jurisdictions being restricted to reporting on primary and secondary types of abuse and neglect only, this may be an underestimation.

In Western Australia specifically, 16,053 notifications were received by child protection during 2020-2021, with 4,274 substantiations. Of these, 58.2% substantiations were for emotional abuse

(incorporating children witnessing family and domestic violence), 22.1% for neglect, 10.7% for physical abuse, and 8.6% for sexual abuse (0.4% not stated; AIHW, 2022). Co-occurrence rates, by jurisdiction, are not available. Families known to Australian child protection systems are more likely to experience income and housing stress, parental mental health concerns, substance use problems, domestic violence, and reside in lower socioeconomic areas (AIHW, 2022). Australian Aboriginal and Torres Strait Islander children and families are significantly over-represented in Australia's child protection systems, compared to non-Indigenous children (AIHW, 2022). The reasons for this are complex and are connected to the legacy of forced removal policies, intergenerational effects of previous separations from culture and family, poor service design and delivery, a lack of understanding regarding cultural differences in child-rearing practices and family structures, and a higher likelihood of living in the lowest socioeconomic areas (AIHW, 2022; Human Rights and Equal Opportunity Commission, 1997).

As research continues to highlight the nature and extent of child abuse and neglect, increasing attention has been given to the associated short- and long-term consequences. These consequences are multifaceted with the clinical presentation, psychopathology outcomes, and adaptation patterns varying markedly depending on the exposure and nature of the traumatic event (Luxenburg et al., 2001).

Complex Trauma

Trauma can result from a range of experiences and refers to an event that overwhelms the ability to cope and the associated response to the event (Tarren-Sweeney, 2013). Within the context of trauma, exposure to acute and isolated traumatic events (e.g., severe accident or injury), tends to be associated with distinct and conditioned responses to trauma-related triggers whereas exposure to chronic forms of trauma, such as child abuse and neglect, tends to be associated with a more widespread and pervasive effect on functioning (Morelli & Villodas, 2022). Over recent decades, new concepts have been proposed to improve the way we understand chronic forms of trauma. Originating from Judith Herman's work (1992), 'complex trauma' is one of these available concepts.

Within the literature and clinical practice, there is a tendency for references to complex trauma to encapsulate a wide range of phenomena and be used interchangeably to describe the causes (e.g., exposure to traumatic events and abuse), experience of multiple incidents of different types of trauma, and the consequences of trauma (Cook et al., 2005; Wamser-Nanney, 2016). Although a comprehensive review of the slight variations in the way complex trauma is defined is beyond the scope of this report, there is general agreement that abuse and neglect related complex trauma in children exists within the context of abuse and neglect that is prolonged, repeated, interpersonal and relational in nature, and occurring during early periods of critical development (Cook et al., 2005; Herman, 1992; Morelli & Villodas, 2022; Spinazzola et al., 2018). There is also increasing recognition that complex trauma resulting from child abuse and neglect is often associated with problems across the lifespan, which in turn, poses a risk for additional trauma and a cumulative harmful impact on functioning (Cook et al., 2005). For example, child abuse and neglect related complex trauma is found

to heighten risk for impaired occupational, academic, and social functioning (e.g., involvement in the justice system; Ford, 2021).

The presentation of child abuse and neglect related complex trauma tends to reflect a diverse cluster of symptoms that manifest across different developmental stages and tends to have wide-ranging adverse effects in domains related to attachment, affect and behavioural regulation, cognitive functioning, dissociation, interpersonal dynamics, and self-concept as well as a significant impact on a person's worldview and perceptions and beliefs about others (D'Andrea et al., 2012; van der Kolk, 2005). Research indicates that early life exposure to interpersonal trauma and developmentally adverse events like child abuse and neglect may be associated with significant dysregulation in core biopsychosocial and neurodevelopmental systems and transdiagnostic processes (D'Andrea et al., 2012). In line with this, child abuse and neglect related complex trauma is found to impact transdiagnostic regulatory systems related to social information processing, emotional processing, and threat-related processing as well as the stress and arousal response (Flechsenhar et al., 2022). In addition, there are a breadth of symptoms which are found to be commonly associated with child abuse and neglect related complex trauma, including disrupted eating patterns (e.g., binge eating, hoarding food), sexualised behaviour, and issues related to toileting (e.g., enuresis, encopresis; Tarren-Sweeney, 2008, 2013). Despite this, capturing the full sequalae of complex trauma in the literature has so far been unsuccessful and the scope and heterogeneity of the presenting symptomology associated with complex trauma is not necessarily articulated in the current diagnostic systems (Tarren-Sweeney, 2008).

Diagnostic Challenges

Complex trauma has been implicated in a wide-range of psychopathology, for example, research demonstrates that the impact of complex trauma is pervasive and is significantly associated with both internalising psychopathology (e.g., disorders represented by anxiety and depressed affect) and externalising psychopathology (e.g., disorders represented by interpersonal conflict, aggression, disruptive behaviour, and difficulties with impulse-control; Schmid et al., 2013), as well as personality disorders, substance misuse, and other mental health concerns (e.g., psychosis; Gardner et al., 2019; Halpern et al., 2018). However, contention in the diagnostic literature surrounds what constitutes complex trauma, with the conceptualisation of complex trauma being theoretical in nature rather than a formal diagnosis with an agreed upon symptom profile. D'Andrea et al. (2012) argue that the multifaceted cluster of symptoms associated with complex trauma cannot be accounted for by a single current psychological diagnosis. For example, it has been argued that diagnostic criteria for Posttraumatic Stress Disorder (PTSD) in the DSM-5 tends to be too narrow (particularly for children and adolescents) and does not adequately consider the pervasive and developmental effect of chronic child abuse and neglect, including interpersonal conflict, disrupted attachment, psychological and emotional harm, and neglect (Ford, 2021; Morelli & Villodas, 2022). As such, multiple diagnoses and comorbidity are considered the norm (D'Andrea et al., 2012). Other common DSM diagnoses administered to children who have experienced abuse and neglect include Depression, Anxiety, Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder,

Disinhibited Social Engagement Disorder, and Reactive Attachment Disorder (Tarren-Sweeney, 2008). Aside from the DSM, Complex PTSD has been included in the ICD-11. Complex PTSD refers to symptomology resulting directly from complex trauma (e.g., affect regulation problems, negative cognitive distortions about self and feelings of shame and guilt, and difficulties maintaining relationships and feeling close; Maercker et al., 2022). Although research has provided support for the diagnosis of Complex PTSD in adult populations (Brewin et al., 2017), there is a paucity of research regarding Complex PTSD in children and adolescents (Haselgruber et al., 2019; Maercker et al., 2022).

Based on criticisms and concerns regarding the narrow definition of PTSD and issues related to multiple diagnoses, van der Kolk (2005) consequently proposed a diagnosis of Developmental Trauma Disorder. The proposed Developmental Trauma Disorder was developed to extend PTSD by encapsulating the interpersonal victimisation, widespread dysregulation, developmental impact, and neurobiological, cognitive, emotional, psychosocial, and behavioural sequelae associated with complex trauma (van der Kolk, 2005). van der Kolk et al. (2022) suggest that the proposed Developmental Trauma Disorder may be best represented as a syndrome distinct from PTSD. Of note, despite proponents of Developmental Trauma Disorder, a formal diagnosis of Developmental Trauma Disorder has not been included in the DSM to date (Weems et al., 2021).

Although diagnostic classifications provide a standardised language, given the significant symptom overlap between the many possible diagnoses for children who have experienced abuse and neglect, issues related to multiple and differential diagnoses frequently occur. Research suggests that although these common diagnoses may reflect an element of the presenting symptoms, they do not capture the extent and severity of the impact of child abuse and neglect and the core factors underlying complex trauma, including the self-regulatory and relational deficits (Ford, 2021; Morelli & Villodas, 2022). Further, Cuthbert and Insel (2013) posit that categorical diagnostic criteria tends to be associated with reduced symptom specificity, and a loss of heterogeneity within symptom presentation. As such, clinicians may not readily consider the broader spectrum of symptomology that is not articulated within extant diagnostic categories (Luxenberg et al., 2001). Administering multiple diagnoses or misdiagnosis therefore tends to underestimate the impact of complex trauma (Leenarts et al., 2012; Lindauer, 2012). Further, misdiagnosis or multiple diagnoses can be associated with a plethora of issues, including (but not limited to) the stigma associated with mental health concerns, maintenance of self-blame and maladaptive schemas, and a lack of tailored intervention approaches (e.g., application of behavioural management principles which may exacerbate symptoms rather than a trauma-focused and targeted approach; Morelli & Villodas, 2022). When considering the challenges that exist within diagnostic categories, it is also important to acknowledge that there is a lack of evidence about the current diagnostic systems and associated symptom profiles and their appropriateness and adequacy for understanding complex trauma in Aboriginal and Torres Strait Islander people.

The above diagnostic issues align with persistent criticisms of mental health approaches that do not account for, allow for, or accommodate the varied context of Indigenous Peoples or other minority groups. Critiques from Indigenous and Feminist scholarship highlight that the diagnosis approach,

aiming to bring symptoms together as ratified clusters, is done so with white-western and patriarchal lenses, which do not account for the on-the-ground power, threats, and meaning-making of the people often at the mercy of these systems, especially poorer women of colour (Dudgeon & Walker, 2015; Gee et al., 2014; Guerin, 2021; Johnstone & Boyle, 2018). Therefore, ignorance of real contexts can result in the inappropriate application of diagnostic systems (e.g., Indigenous Australians being diagnosed with borderline personality disorder while the bulk of identity disruptions can be traced back to contexts of colonisation and the stolen generation; Fromene et al. 2014; Fromene & Guerin, 2014). While it is acknowledged that recent efforts have been made to give greater attention to culture, racism, and discrimination in the DSM-5-TR (American Psychiatric Association, 2022), the above parallel patterns of critique invite questions about how researchers and clinicians use, work with, or resist these trends within the diagnostic systems.

A Symptoms-based Approach

There is increasing awareness that the consequences of complex trauma (and inadequately addressed complex trauma) are profound across the individual, familial, societal, and wider macrosystem level, and as such, the importance of effective therapeutic intervention remains despite the current definitional and diagnostic impasse. Yet, given the ongoing issues related to definitions and diagnosis, there is a lack of fit for purpose and culturally safe therapeutic options for children presenting with abuse and neglect related complex trauma. Thus, a symptoms-based approach that is independent of a stand-alone definition or diagnosis may be warranted. This is in accordance with the International Society for Traumatic Stress Studies (ISTSS) which suggests interventions be client-focused, flexible, components and phased-based, and targeted specifically to symptoms (Cloitre et al., 2012). In line with this, Ford (2021) posits that increased specificity in characterising target symptoms and the mechanisms of treatment may be required to support posttraumatic growth and facilitate adaptive functioning. Conceptualising complex trauma based on a symptoms-based approach provides a framework that not only encompasses the multifaceted symptom clusters but is also sensitive to the aetiology of complex trauma. Further, adopting a symptoms-based approach provides an opportunity to build upon and fine tune existing evidence-based therapeutic approaches.

THE CURRENT STUDY

Aims

There are two broad aims of this exploratory pilot study:

1. Adopt a dimensional and symptoms-based approach to the conceptualisation and formulation of children with abuse and neglect related complex trauma.

2. Increase understanding of the development and maintenance of child abuse and neglect related complex trauma and what makes it unique from other forms of trauma.

Research Questions

Informed by the broad aims of this study, this research was guided by the following research questions.

From an experienced clinical perspective:

1. What symptoms and/or constructs do children and young people with a background of child abuse and neglect experience/present with?

2. How do these symptoms compare with current diagnostic criteria and are they reflected holistically in any one diagnostic tool?

3. Can these symptoms be grouped into symptom clusters/categories?

4. What makes complex trauma from child abuse and neglect distinct from other types of trauma?

5. What factors influence the development of complex trauma in children and young people who have experienced child abuse and neglect?

6. What mechanisms serve to maintain complex trauma presentations into adulthood for some children and young people who have experienced child abuse and neglect?

METHOD

Participants

Potential participants were recruited using a purposive sampling and snowball sampling technique. The inclusion criteria for this study were that participants be above 18 years of age, reside in Australia, and have practice experience in the area of child abuse and neglect and/or complex trauma from child abuse and neglect. Of the 27 individuals invited to participate in this study, 17 expressed an interest (response rate of 63%), with three unable to attend the scheduled focus group session times. Four participants scheduled to attend the focus group discussions were unable to attend on the day, resulting in ten participants.

The ten participants were professionals with experience working within the child protection system, clinical practice specialising in the trauma sector, and/or demonstrated knowledge of children and young people who have experienced trauma from abuse and neglect (clinical psychologist n = 4, forensic psychologist n = 1, psychiatrist n = 1, clinical psychologist and academic n = 1, professor n = 1, occupational therapist n = 1, and general manager for a therapeutic service n = 1). Five participants were currently working in non-government organisations, two in government organisations, two were self-employed, and one was working across both government and non-government organisations. In their current roles, participants had between one and more than 21 years' experience. Overall length

of professional experience for participants ranged from three years to over 21 years, with the majority having 13 or more years' experience overall (60%). Participants were aged between 25-29 years and 65-69 years. The majority of the sample identified as a woman or female (90%; 10% man or male) and most identified as having a non-Aboriginal Australian cultural background (80%; 10% British; 10% Netherlands). All participants resided in Australia, with three each in the states of Western Australia and South Australia (30% each), two in Queensland (20%), and one each in the Australian Capital Territory and Victoria (10% each).

Study Design

This research used a qualitative exploratory expert focus group design. The approach allows for an array of information to be collected with the agreement or disagreement between participants to provide a level of confirmability and trustworthiness to the data. Through this process, facilitator knowledge can also be injected where more direction is needed, otherwise gaps and prompts can be largely based on participant input over researcher input, again adding to the quality of the data collected.

Data Collection

This research was approved by the Human Research Ethics Committee (HREC) of the University of South Australia (204999). Purposive and snowball sampling techniques were used, with potential participants recruited based on the broader professional networks and contacts of the research team. Potential participants were sent an email invitation which included an information sheet about the research project. Participants who expressed interest in the study were then provided with a link (hosted by Qualtrics) which directed them to read the information statement and to complete an online consent form and provide demographic information. If participants had not completed the online consent form prior to the commencement of the focus group session, verbal consent was also obtained, and participants were asked to complete the online consent and demographic questions after the session. The focus groups were conducted over four weeks, in November 2022 and December 2022. The focus groups were conducted via videoconference using Microsoft Teams.

The focus groups were conducted for approximately one-and-a-half to two hours depending on the number of participants present and the collaborative nature of discussion. The audio-visual recording and live transcription functions on Microsoft Teams were used to automatically transcribe the group discussion. The use of the recording and the transcription function enabled the facilitators to be attuned, present, and focused on the group discussion. The recording function was also used for the purpose of checking the accuracy of the transcription and enabled the research team to ensure that the utterances of participants were accurately reported.

The structure of the focus group discussion was in line with development of a focus group protocol which was designed to aid consistency across the groups. Each focus group discussion included provision of informed consent (where not already provided through the online consent form), welcome and introductions, a brief background summary of the research project and data collection,

discussion regarding the research questions, and conclusions. The focus groups consisted of one primary facilitator (AP; consistent across all groups) and a co-facilitator (SC or SS), and a minimum of two and maximum of four participants across groups, which ensured that each participant had the opportunity to share their thoughts, ideas, and opinions and collaboratively engage in the discussion.

Data Analysis

The main analyst (ET) was provided with the focus group transcripts. The analyst then anonymised the transcripts and removed identifiable details. Names and identifiers were replaced with codes (e.g., Participant 1.1 to indicate focus group 1 and first participant to speak, or [place of work] where needed). In this process the Qualtrics survey attributes (e.g., profession and length of time in that profession) were anonymised and tied to these markers in NVivo as cases. All transcripts were imported into NVivo and a mixture of deductive codes – based on team discussions and previous knowledge of complex trauma – and inductive codes – open/eclectic coding processes deriving meaning units from the transcripts (Saldaña, 2021) – were used to organise the data.

The Reflexive Thematic Analysis (Braun & Clarke, 2021) below is based on the preliminary analysis at the end of 'coding pass 1'. This summarises the core overt themes as generated by the analyst. It is common practice that a second or more 'coding passes' are completed to confirm that the codes and themes are uniform throughout the data though this was not completed at the time of this report. The three themes were generated using the research questions as a foundation, with the codes and concepts found in the group discussions. As per Braun and Clarke's (2021) guidance for Reflexive Thematic Analysis there was consistent reflexive noting and discussion between the analyst and the research team as to reason, feelings, and reactions to the codes and to seek uniform agreement between the different reflexive positions of the research team. It is worth noting that the main analyst is not a clinician with direct experience of treating complex trauma; this is seen as a strength for analysis as they approached the coding in an open/naïve way while the rest of the team have clinical experience with the topic.

The quotes below are presented in an 'intelligible' verbatim style. This means that some repeated words, missed words, or pauses have been removed or included to allow the quotes to flow in an intelligible manner whereas a strictly verbatim style may not allow for understanding without utterances before, after and from interjections from other speakers.

RESULTS

Three broad themes were generated using the Reflexive Thematic Analysis (Braun & Clarke, 2021). These themes are broadly conceptual answers to the research questions though this section will conclude with answers to the research questions more directly. The three themes weave in-between one another and are not exclusive in process or kind.

Theme 1: All symptoms are valid, and all symptoms are possible (RQ1)

There were many symptoms and clinically significant constructs named in the presentation of complex trauma (see Table 1). While there were many symptoms provided their inclusion was accompanied by comments explaining the difficulty of generalising or narrowing complex trauma down to a simplified presentation of symptoms or constructs.

Participant 1.1: It's hard to make generalisations because it's so individualized, but for a lot of kids a trigger will happen, and sometimes that will be obvious.

Participant 2.1: Like it can look really variable, when I supervise others, I generally describe the, you know, the symptoms that you can see with complex trauma as being a little like the flu. Like there are 1000 things you could present with, and everybody can present with them a little bit differently… [I've been] in clinical psychology for such a long time. Complex trauma is like shifting sand like it can, it just, it can be really dynamic and look really different. Yeah, and you wouldn't want kids missed, I guess.

Participant 3.2: I think the conversation today, but actually thinking about each of these parts, really highlights the fact that what we have in place at the moment is really insufficient and that makes what is already really complex work, I think even harder when there isn't a clear. [It is] very confusing if we're confused.

Participant 4.1: You also, it's easier just to think like, okay, what do I need to do? But they're all unique. But they're also not all unique. And the more you work with these kids, I think the more you see the same thing over and over again, the more easy it becomes to say, okay, this is where we need to go. To fix it or to, you know, to heal from that.

Despite the difficulty in narrowing down, and the ultimately vast array of symptoms and constructs, there was still relatively similar discussions in the four focus groups indicating that this array is agreed upon. It may seem that this answer is not overly helpful for the research question, given the array of symptoms is so varied (see Figure 2 below); yet this reinforces ideas present in the literature (D'Andrea et al., 2012; Tarren-Sweeney, 2013; van der Kolk, 2005).

Furthermore, while there was a lot of difficult symptoms, their variation, and their housing constructs discussed, there were few concrete examples to accompany many of these concepts (Table 1).

Table 1. Number of Examples given per symptom or construct mentioned

Symptom	No of Examples Provided
1 : Absence of 'Basic Skills'	1
2 : Avoidance or Suppression or Masking	1
3 : Biological or Innate Traits	-
4 : Biological Change	0
5 : Innate	0
6 : Locus of Control	0
7 : Pleasure Drive	0
8 : Resilience	0
9 : Survival Mechanism or Instinct	0
10 : Neuro or Brain Issues	0
11 : Cognitive	-
12 : Beliefs (errors)	0
13 : Cognitive Deficit (memory)	0
14 : Distorted Thinking	1
15 : Executive Functioning	0
16 : Sensory Processing Issues	0
17 : Developmental Issues	0
18 : Age Dependent Behaviour	2
19 : Educational Troubles	2
20 : Externalising and Internalising	-
21 : Absent or Dissociated or Withdrawal	1
22 : Aggression or Explosive	1
23 : Avoidance of Triggers	0
24 : Disinhibition	0
25 : Harm	-
26 : Others	2
27 : Self	2
28 : People Pleasing	1
29 : Flashbacks	0
30 : Food Behaviour	1
31 : Identity or Sense of self	1

32 : Learnt Behaviour	0
33 : Neglect	2
34 : Personality	0
35 : Play	0
36 : Regulation	5
37 : Emotion	-
38 : Guilt	1
39 : Shame	0
40 : Worthlessness	0
41 : Relational	2
42 : Attachment	1
43 : Risk Averse or Taking	0
44 : Sense of Safety	0
45 : Triggers	3
46 : Threats	0
47 : Sexual Behaviour	0
48 : Sleep issues	1
Total (examples / symptoms with examples)	**31 / 19**

Overall, there are so many different presentations to complex trauma but within that variation there was a message that focusing solely on the presentation at a particular point in time was not always correct. Rather, varying and changing symptomology is not only common but should be expected given the cycles that complex trauma, and the systems around it, create. As in the case study of Carrey introduced at the beginning of this report, there is often a significant variation of symptoms that appear over time that impact across a range of functional and developmental domains. For example, Carrey first presented in early childhood with self-regulation difficulties, inattention in the classroom, difficulty engaging with peers, aggressive behaviours towards others that were both physical and verbal, and later in development she displayed sleep disturbance, sexualised behaviour, and various self-harming behaviours.

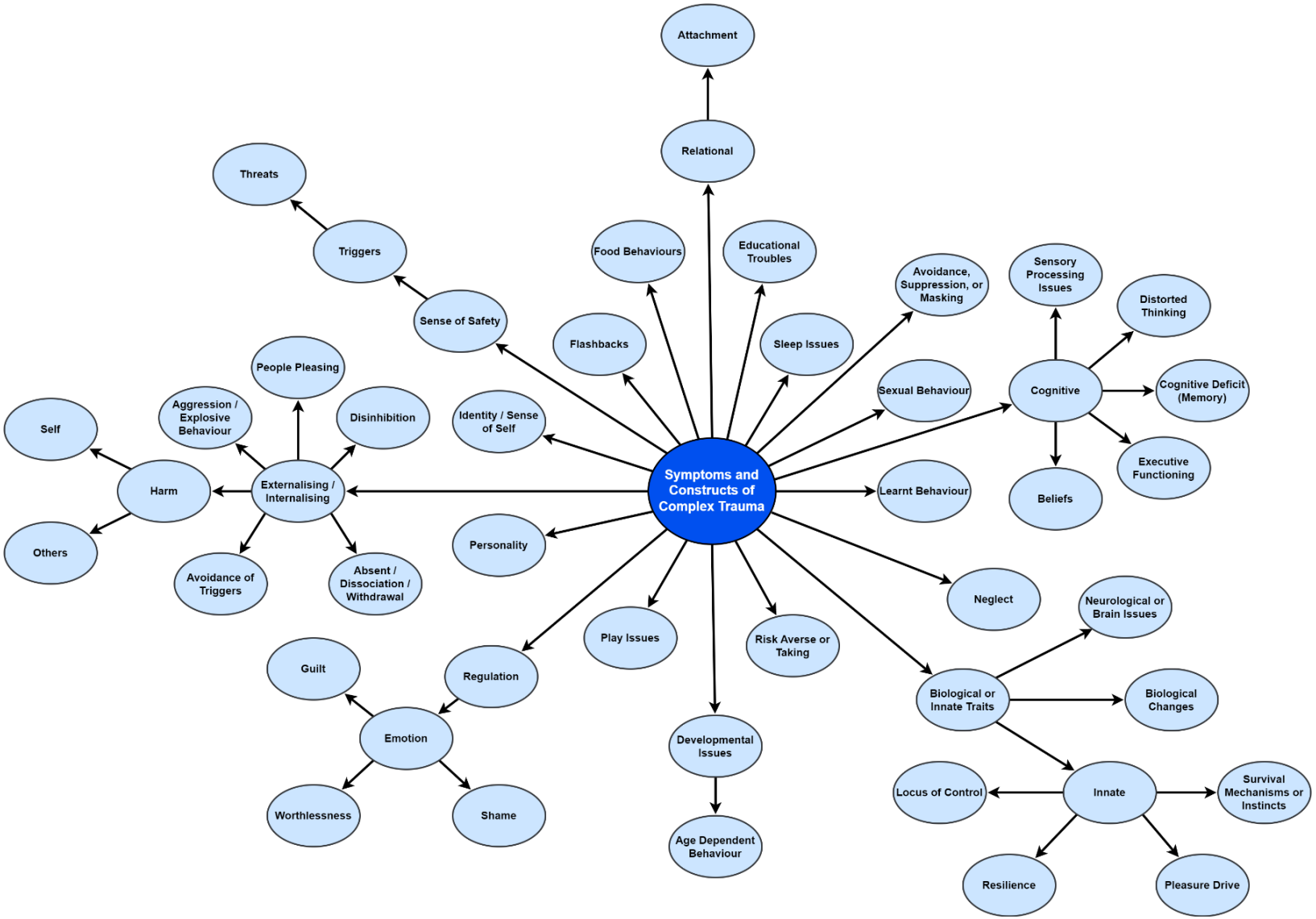

Figure 2. Array of symptoms and constructs mentioned as presenting with complex trauma

Theme 2: The cycle of complex trauma (RQ 4, 5, 6)

When differentiating between trauma and complex trauma, there were a few interesting though complicating considerations raised in the focus groups. These included: comparison between other types of trauma; whether to focus on impact or experience; changes in experience through the lifespan; and the cycle of complex trauma through the lifespan.

Comparison between other types of trauma (RQ 4)

Within the discussions, other types of trauma were contrasted or compared by the participants. This included differentiating between the common instigation of complex trauma – often sexual abuse or neglect – compared to natural disaster or medical trauma as instances (though admitting they could also be pervasive). More profound was the inclusion of development and relational trauma which both directly related to the cycle of complex trauma as described amongst all focus groups (see below).

Importantly there were many comments that, due to a lack of definition for complex trauma, developmental and relational trauma overlapped conceptually for some expert practitioners, directly stating that they believed they were interchangeable:

Facilitator 1: Do you think this concept of complex trauma and developmental trauma do you think they one in the same or do you think there's a distinction?

Participant 1.1: I thought that [they] were the same, but genuinely thought the concepts were interchangeable…

…

Participant 1.2: I feel like developmental trauma is always complex, but complex trauma isn't always developmental.

This idea was present throughout focus groups:

Participant 3.1: You know, we all use different, you know, complex trauma, developmental trauma. I think we're all. You know, meaning the same thing. But there is such variability within that.

The similarity issue has follow-on effects though, including when the term complex trauma is used but potentially different concepts are ultimately at play, despite expertise.

Participant 4.2 But they're not generally accepted across professionals to mean the same sorts of things. And that's where I think it gets complicated. So, if I said complex trauma in a report, and Bessel van der Kolk said complex trauma and the local psychiatrist say complex trauma; I'm not sure we're even all talking about the same thing. And we're probably not.

Furthermore, linking the experience of abuse or neglect with the resultant behaviours and therefore the disorders presented with issues. That potential confusion between result and experience is commented on rather starkly as just 'made up':

Participant 4.1: Complex trauma refers to what you have experienced, whereas complex PTSD refers to the result of that. And developmental trauma disorder is the result of complex trauma and then there's chronic trauma and relational trauma. So relational, personally is complex. No one knows. It's just made-up, yeah.

Within this there were attempts to separate the idea of complex trauma from single instances of trauma for example in medical or natural disaster events:

Participant 3.2: Umm, you know if someone else. If someone experiences another type of trauma, like this is probably not a great example, but like a natural disaster or something like there's an endpoint to that or there's like a point where things may begin to return, back to what feels like a normal level, but for children who experience complex trauma at this is ongoing, no endpoint.

Participant 4.2: Yeah, I mean, I'm not sure what I mean can you have complex trauma without the attachment stuff? Umm, maybe it's not complex, but if you're left with simple is it, what does that mean? It seems it is simple trauma, if it's not complex, but having 20 medical operations and whatever, that's not simple either.

Complex trauma could, however, be separated from these other types of trauma by the presentation with multiple instances or cases of abuse or pervasive neglect.

Participant 4.2: Well, I think they get used by different people to mean similar things. And I think at some point we really need to identify are they the same or are they different? And I mean complex trauma. At a sort of vague, general level means that someone had multiple traumas over time, sort of thing as opposed to developmental trauma where it it's really implied that it had traumatic things, but it's particularly family-based things.

Ultimately, it seems that complex trauma is not a separate concept, construct, or tool for these professionals, but rather other elements of complex trauma are considered where these other traumas may be present or are essentially part of the generation or maintenance of complex trauma itself. In the case study of Carrey, there is a clear pattern of child abuse and neglect experiences that begin prior to birth (with exposure to parental substance misuse and family domestic violence in-utero), and such experiences continue with compounding effect throughout her childhood. As highlighted in the case study, Carrey experiences neglect, multiple sexual abuse experiences, exposure to family violence, and prolonged emotional and psychological abuse via repeated system issues including inconsistent caregivers, invalidating responses, and ruptures in her attachment

relationships, all leading to a broad range of symptoms. Both these experiences and Carrey's presentation would likely be explained in the same way by our participants but may be labelled with different names such as development trauma disorder, complex trauma, and relational trauma.

Focus on impact or experience (RQ 5)

For several of the participants, the instigating factor played a large role in determining if something was complex trauma or not. Similarly other factors including age, meaning making, the multiplicity of trauma, and the pervasive severity or multidimensional effects were key to understanding complex trauma. This resonates with a quote above suggesting the variation comes from whether practitioners focus on the trauma experience or the resultant behaviours and effects of the trauma.

There were several elements that arose in the discussion about what may be key to the development of complex trauma compared to other types of trauma. For example, being the (perceived or real) target of abuse.

> Participant 2.1: Often it's because they've been targeted within the abuse, or they've borne the brunt of it. You know, either by their perception or in reality.

Otherwise, it seemed important that trauma was occurring at a key developmental stage which lends itself to being pervasive – as a defining feature of complex trauma. As illustrated in the case example, the different types of abuse that Carrey experienced occurred at multiple critical developmental stages (i.e., pre-birth, early childhood, and pre-adolescence).

> Participant 1.2: I agree with Participant 1.1 in that I still see it as developmental in some capacity, but I do think there's a distinction between, because it's developmental in the way that you know and when we're teenagers we learn so much about the world and our place in it. And if we're experiencing a period of trauma there, I think she's right in that you know that that looks very different to experiencing that period of trauma at 30 or 40. But I do think there's a distinction between that kind of foundational met needs stuff and it occurring when you're 16.

Meaning making was also a consideration for impact or experience and could potentially explain why some children and young people experience the same events but do not experience the same outcome in the form of behavioural presentation of complex trauma. In the case study, Carrey and her younger sister would likely have experienced many of the same adverse events while living with their parents and prior to entering care, but it is possible that they may not present with the same profile of symptoms or internalising and externalising behaviours. Further, Carrey, who was older than her sister, seemed to internalise these experiences and develop a sense of defectiveness with herself, that she was not deserving of or able to be loved by caregivers – leading to difficulty within her foster care placement and relationships with others.

Participant 3.3: [explaining that a client didn't know what happened to her was wrong until she saw counter reference points with friends]…then the symptomology came out because she had made sense of her experiences in a different way than she had made sense of them before. So, I wonder how much that meaning making process contributes to the development of what we would say, see, as a cluster of symptoms for complex trauma.

Instability and unpredictability of the relationships that are involved in and around the trauma were highlighted as a common context for compounding complex trauma.

Participant 2.1: Thinking like somebody who might be exposed to some really terrible instances of abuse, but there is stability in their life, at least it's predictable. They can come up with ways of coping with that crap existence versus someone who's got really crappy experiences happening to them, but everything's out of control and there's no predictability and there's no routine, even if it's crappy routine, [someone without it] is probably likely to be worse off in terms of how they end up.

The importance of having positive relationships to buffer the trauma and short circuit issues before they develop into complex trauma was also highlighted.

Participant 1.2: And within that, I think the presence of other safe adults is really, really important. So, you know, Mum may be crap. But Auntie is fantastic, and I think we underestimate the importance of those other kind of safe people around our kids to kind of modulate the impacts of that trauma.

These varied factors were the aspects that practitioners in the focus groups highlighted most as those that define the complex trauma experience, despite the varied presentation. Ultimately there was a balance between the idea that complex trauma is defined by its initial instigation factors – be it the abuse type, amount, or timing – and the follow-on impacts of these experiences – be it changing meaning of experiences or sources of support. This leaves this analysis to a point where complex trauma is both the experience of traumas which are complex in their events but also is the complexity in the pervasiveness and multidimensional effects of that trauma even if it alone does not seem overly complex.

Changes through the lifespan (RQ 6)

Clinicians were also keen to point out that there is no expectation that the presentation of complex trauma is the same through the lifespan. Some of the clinicians pointed out the raw ability and opportunity for different aged individuals to behave in certain ways, and how coping strategies develop and adapt over time:

Participant 3.3: Across the, you know kind of developmental stages in that way. I kind of think the behaviours that we see would be

developmentally appropriate for someone in distress at that particular developmental stage. So, an infant, can't you know, run away from home like an adolescent. All they can do is become distressed or shut down.

Participant 4.1: And OK, you can't. I can't really like generalise that. But in teenagers ... young kids, you see, there's some of those play out in play or with other kids. Like how? The trauma has affected them or what they remember their memories. They can't put it in words, so they put it in in actions and with teenagers, yeah, I see a lot of that as well, where they act out in their relationships with other teenagers or with adults. They just act out what has been done to them, but they have a lot more experience in managing the trauma symptoms, so the older they get, the more avoidance, the more they kind of find ways to deal with it.

In other cases, the behaviour is more likely to change because the triggers for negative reaction change throughout the lifespan – indicating the bidirectional relationship between contextual and personal experience.

Participant 3.2: I'm certainly going ebbs and flows; I think certainly I've seen around different like key developmental points. You know, I think often you know, it's particularly for children who might have experienced sexual abuse. You know, the idea of engaging in intimate relationships, all these other experiences that they might have throughout life often. Yeah, there might be functioning OK, but then those experiences retrigger some of their, the symptoms that they've experienced before, so I think also the types of relationships that they're engaging in on a day-to-day basis can reinforce some of those beliefs.

Some core aspects are so persistent and pervasive they can follow people throughout all the stages of their life ultimately hampering development throughout the lifespan:

Participant 4.2: Yeah, but it's also lifespan. I mean, having been a psychologist in these systems now for 35ish years. I saw kids in juvenile justice when they were naughty boys. They then graduate, I saw them in the adult system when they were dangerous men. Then I've seen them in family court or, as parents, protection when they were hopeless parents, when I've seen him in family court, where they're now in their 40s and then they're not so bad that they're care and protection anymore, but they're, there's still, you know, generating because of their personality dysfunction, warfare, and this trail of trauma through their life.

One presentation of this throughout the lifespan was the lack of trust from others due to those issues with safety and relationships early on in life, compounding into self-fulfilling tendencies to avoid relationships with others.

> Participant 2.2: [They] don't feel like others can be trusted and relied upon, and then if they've had multiple experiences of that, whether it's in the initial abuse experience or just further vulnerability and in their friendship for their first relationship, they potentially are vulnerable to further harm. And then they get this kind of, piling on affect almost all of their experiences and in relationships and feeling that others can't be trusted. And the way often, if they have learned to cope in a maladaptive way that might push others away or not lead to potentially healthy relationships. Then it just creates further experiences that concern those beliefs that others can't be trusted.

The case of Carrey is a classic example of this ever-changing presentation of children who experience complex trauma. As she matured throughout the years, the impact of her abuse experiences changed, she responded to the world around her and the people in it in different ways. As demonstrated in the case study, Carrey's capacity for understanding and meaning making shifted as she aged and entered different developmental stages, and in turn, the way she perceived herself and relationships with others also changed, having subsequent impacts on her behaviour both internally and externally.

The cycle of complex trauma (RQ 5, 6)

Throughout all the focus groups a consistent notion arose and was agreed upon – the cycle of complex trauma. Essentially a key aspect of complex trauma is that it is not singular, and it is pervasive but what does it pervade? Below is the explanation of such a cycle (Figure 3).

The cycle starts with early but often multiple or pervasive trauma experiences, these are often punctuated by the absence, neglect, or inability of key relational figures (i.e., parents and/ or other caregivers) to be present as attachment figures for appropriate regulation to occur (other-, co- and self-regulation). These disruptions that occur within the attachment relationships is evident in the case example of Carrey whereby her mother experienced challenges with feeding, soothing, and bonding with Carrey in her early years. Without these skills and this knowledge, or the continuing context of these issues, both abuse and neglect, there is little for children to understand as counter reference points, and few (if any) positive examples in their life to understand what should be expected or what they can ask for to assist them in their emotional life and to meet their needs. This cycle of complex trauma is apparent in the case study of Carrey, as her journey almost exactly maps that which was explained in the focus groups.

> Participant 1.2: Path is the wrong word, but you know what I'm trying to say. Like there, there's those, you know, personal factors, but I think there's huge, huge systemic issues

with reinforcing trauma and adding cumulative harm to these kids, who have already experienced so much.

Participant 2.2: You know, we're talking about how some children, for whatever reason, learn to cope with those experiences with internalising versus externalising and then how they cope, it then, umm influences how they interact with the world and others as they grow up and with other caregivers and with people at school and society around them. And I feel like when those symptoms that they start to develop don't fit nicely within society and what is expected of them, it's even more likely to get that cycle effect. So, we just talked about because, umm, it further breaks relationships and can cause further harm.

The lack of counter reference points, places to learn alternative ways of being from, were commented as central to complex trauma being recognised:

Participant 3.3: And that there's not kind of a stable base to start from saying the world is a safe place. What children have learned from a very young age, sometimes from the very first experiences, is the world is not a safe place. And I don't have anyone to talk to about that or to help me feel safe. For me, I think that's what's at the kind of centre of the difference between trauma and complex trauma.

These clinicians acknowledge the unfortunate realities many of us are aware of, that the systems of protection are often also sources of continuing issues for these children and young people due to further attachment and regulation issues from rotational and transient relationships:

Participant 3.1: And then if they're not in foster care and they're in residential care, they're really in strife because they're having to relate to, you know, rotational carers.

Participant 3.3: That's right, who use language that demonstrate to them or reinforce to them over and over that they're not there to be in relationship. They're here on a shift. They're working, you know, all those sorts of things.

Participant 4.2: The whole nature of our welfare system is just appalling in terms of, if you look at it from a trauma model, you on one hand, yes, you get rid of the risk of harm, but you do it by risking attachment, harm, you take them away from the people who love them, put them with a bunch of well-meaning strangers. And then in the system you put them in short term care. But that short term care. I can't keep him long term, so you're going to end up with at least three different lots of attachment. The family, which was dysfunctional, not healthy, the short-term care and in a long-term care, at a minimum. And so, we've now created a, yeah, we're compounding the trauma. Now, I'm

> not saying, you can't, "you could simply just leave them in the environment". But these are the factors which then make this so complicated.

The drawbacks of the protection systems are illustrated in the case example whereby Carrey's symptoms progressively worsened as she began her journey as a child in care. Carrey experienced multiple relational ruptures, placement breakdowns, and subsequent changes in placements which further compounded her core schemas and beliefs and experiences of defectiveness, worthlessness, and lack of connection to others. Further, Carrey was subject to abuse in these environments reinforcing that the world is unsafe, and others are likely to fail to care and protect her at best, and at worst will actively harm her.

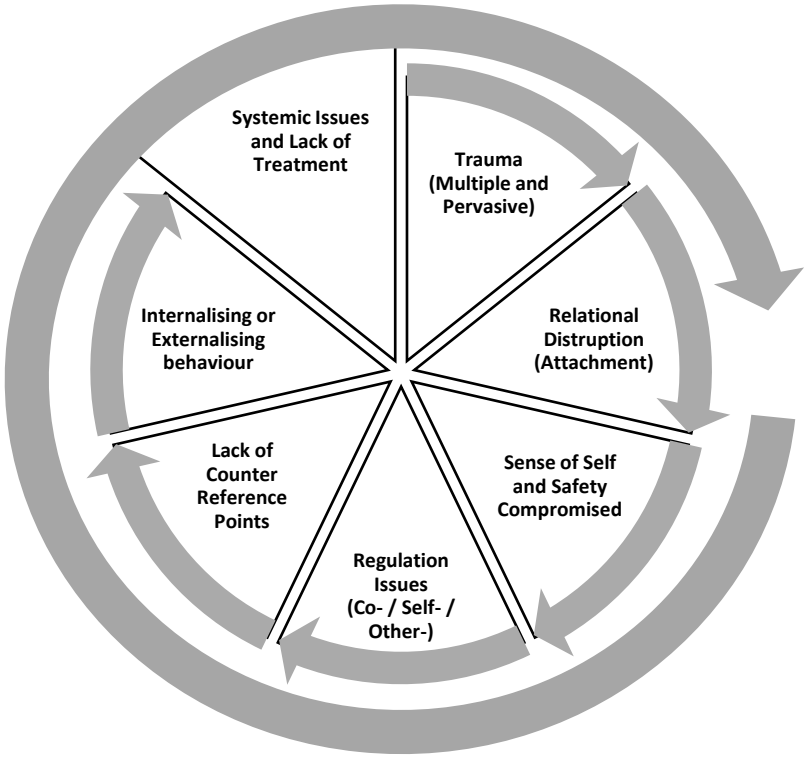

Figure 3. The cycle of complex trauma symptoms and constructs

Theme 3: No one box for complex trauma (RQ 2, 3)

A large portion of the focus group discussions were dedicated to the discussion of current, former, and future diagnostic criteria for the understanding and the treatment of complex trauma. Throughout the discussions, one consistent notion was repeated and became the core of the theme – that complex trauma, to date, fits no one simple box for diagnosis and that no criteria these professionals have seen thus far includes the right content to capture the complexity described.

Participant 4.1: … If you look at the presentations and adults and adults that need help and that and get a diagnosis, the majority of them have trauma and we have nothing really; like the DSM is symptom based. It's a checklist of symptoms, so that doesn't really fit with this. I find it even unhelpful cause there's now like a tendency to, you know, there's more knowledge about PTSD, but then when you don't meet the criteria, you don't get treatment.

Unfortunately, the benefits of diagnosis were also reported to be imposed rather than particularly about the presentation or the issues that clients have. It seemed for this sample, diagnosis was more about ensuring that clients were able to gain compensation, funding, or access to treatment even if the diagnosis was not entirely accurate.

Participant 1.2: You know things that teachers are scared before they even meet the kid because they've got this rap sheet of 17 different diagnosis of intermittent explosive disorder, ADHD. Yeah. And I think that that's really problematic, but my flip argument to that is that. That's how they get funding.

Participant 2.1: I try not to diagnose in my work where and you know, unless I need to, and I think in my criminal injuries work that is, that is one of the main places that I provide diagnosis because it serves a function in terms of getting that individual compensation and I always find that part of the report pretty tricky.

Participant 3.1: But there is such variability within that that I think then it opens the door for or let's call it ASD [Autism Spectrum Disorder] because then we'll get the NDIS [National Disability Insurance Scheme] package that we won't get if we mention the word trauma which is a terrible position to be in, I think, because you know all we've talked about today is there is something different about trauma within care giving.

Participant 4.2: Because again, the whole thing of diagnosing, I hate diagnosis but what I, the problem I see, one of the problems I see with the model, of the DSM criteria, [they] fit fairly well for somebody who goes along and has a really nasty episode of something. So, if your life is pretty good and you're in a life-threatening situation and it triggers, you know arousal symptoms and avoidance symptoms, you're fine [in terms of meeting diagnostic criteria].

The presentation of entrenched complex trauma issues was consistently commented on as changing throughout the lifespan and changing depending on external and contextual factors (further commentary about complex trauma through the lifespan is mentioned above, see Theme 2).

Participant 4.2: Because the trauma, the complex trauma is going to emerge as personality disorder, and you don't actually see it until their teen years. So, you get these kids who are, there's a, if you like, the traumas derailed their personality development.

As shown with the case study of Carrey, the issue of diagnosis and the lifespan was pointedly described in the focus groups as the nature of diagnosis shifts so drastically through time. The focus group members highlighted that common diagnoses follow along the line of Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), Autism Spectrum Disorder and commonly in adolescents start to present as emergent personality issues through to the development of substance use issues and personality disorders (e.g., borderline personality disorder).

Participant 1.2: And the other one that comes to mind, as well as a lot of the current diagnosis that we can, you know like if we think something like borderline [personality disorder] or emerging borderline or opposition defiance disorder or you know a lot of these diagnosis that we are clutching at straws to fit our kids into have massively stigmatized kind of [experience in the system].

Participant 4.1: They can have any diagnosis that you can think of because it can look like ADHD. It can be both. It can look like autism; it can be both. It can look like an eating disorder, and they can use substances.

At the same time, sometimes the diagnostic criteria were too narrow, and the child may not fit into any box while displaying many different issues.

Participant 2.1: You know, running with this idea of having clusters and stuff that you know, I know with, you look at other, other disorders, like you know, Autism or ADHD and things like that. And you'll get, you get children and young people who clearly are presenting with things that are representative of that issue, but because they don't quite meet some kind of part of a cluster or category; it's wiped and it's not a thing for them. And so, I think there is a danger in, like, if it was, if we were using things like this for diagnosis, that if a child didn't meet one particular bit, or you had whoever was doing the assessment was not skilled enough to recognize bits of what that child was presenting with as representing a certain part, that child would fall through the cracks.

Consistently the reality of complex trauma is opposed to the functional imposition of welfare, protection, and compensatory systems. Presentations may not be direct and are rather reports by teachers, parents, or other caregivers; if a behaviour is not dysfunctional or disruptive for them a child could fall between the cracks. Such cases were those that internalise and suppress symptoms while still having attachment or other regulative emotional issues. These individuals may even present with

worsened symptomology through therapy as their suppression of these problems and related behaviours are overcome. In the case example, Carrey only begins to share some of her inner symptoms as she engages in therapeutic intervention, but at this point her inner symptoms manifest into self-harming behaviours as well. It is possible that as a child engages in therapy and learns ways to connect with and express their emotions and thoughts within a safe, open, and non-judgemental relationship they are able to stop avoiding their internal world of distress and share it with the external world including those individuals around them.

Participant 2.1: The kids who internalised are often they're the ones that you miss quite easily. Teachers won't pick up on it because they're really quiet and they don't cause trouble. You know, parents often don't pick up on it because you know they're so busy with their own lives that you know, if the child isn't actively, you know, bringing the house down with drama.

Participant 4.1: A lot of the young people that I work with also feel that in as "No, no, no, no, no, I feel fine, not a problem", so then when you, after treatment they score higher [on symptom ratings]… they also become more aware of their feelings so they can be like feeling. I say feeling more, so, also scoring higher.

The clinicians did find that understanding trauma through constructs and symptoms – including diagnoses – could be helpful for treatment.

Participant 2.1: And the diagnosis isn't my focus. And my focus is reducing that symptoms to optimize their functioning.

Participant 4.1: Yeah, I would. I would say yes, we need those criteria because to be able to say, okay, this person needs that kind of treatment, and that person needs that kind of treatment.

Unfortunately, as featured in the cycle of complex trauma symptoms and constructs above (see Figure 3), there are systemic problems that compound issues around treatment and around diagnosis or the classification of trauma. Foremost were consistent comments about the lack of real support that is given by the systems in place for children's protection. These include that complex trauma which often presents with attachment issues or disrupted relationships is compounded by welfare systems in which children and young people are with rotational and transient workers that they may not be able to build relationships with, as well as a lack of therapeutic options or knowledge in these spaces.

Participant 3.1: Unfortunately, you know, we see that in children in care. They do get really abused in. Yeah. Yeah. In a range of settings and. And you know, and is that because, you know, we have made no attempt? Yeah. I mean, I think it's just so complicated because obviously I'm seeing the worst of the worst in the sense that, you know?

When labels are used and can render appropriate treatments there is the pervasive issue of the stigma and misunderstanding often created by these labels:

Participant 1.2: You know things that teachers are scared before they even meet the kid because they've got this rap sheet of 17 different diagnosis of intermittent explosive disorder, ADHD. yeah. And I think that that's really problematic, but my flip argument to that is that. That's how they get funding.

Participant 4.1: I think for these kids we need diagnostic criteria to provide them with the treatment they need, and I would rather look at it that way than saying this is your label and that's your identity now cause a lot of kids that are diagnosed with something that it then becomes their identity like borderline personality or whatever.

The issue of stigma can occur without the formal labels though given that the behavioural presentation of the impacts of complex trauma often are primarily the reactions of other people to what they now see as complex trauma.

Participant 1.2: Yeah, it's now that because he's this trauma kid and his behaviour that he's displaying that is even remotely kind of. I hate it, it's not even sexual, like, like anything that's remotely even the slightest bit, because he's this trauma kid. It's now a harmful sexual behaviour. So, it's like where we take that too far and start pigeonholing these kids based on this understanding of their trauma history.

Participant 3.3: The problem for children who've experienced trauma is all of the adults around them trying to make sense of what essentially is a cluster of behavioural presentations that are challenging for adults.

The participants often responded to these issues of diagnosis with alternatives to the current system. What was mentioned reverberates with current international trends that are critical of diagnostics (e.g., Britain; Johnstone & Boyle, 2018). Some of their alternatives included transdiagnostic approaches including a dimensional model distinguishing threat-based experiences (e.g., physical abuse) from deprivation-based experiences (e.g., neglect; Mclaughlin et al., 2014)

Participant 3.4: And I don't know whether anybody has really tried to sit down and match those to a case of a child that has experienced, and I think we, you know, I personally am very persuaded by the dimensional model that we have to differentiate threat from deprivation. And so, if we if we take that as a starting point sequela of extreme deprivation versus extreme threat, and that then I'm thinking like, well, what is complex trauma anyway? So, I'm really just all I'm throwing in is a is a whole

series of kind of messy thinking because that's sort of where my thinking is at the moment it's confused by trying to integrate.

The participants were also critical of the internal or dispositional attribution that disorders and diagnosis often create. These children were exposed to chronic abuse and neglect and react to it. Resonating with the systemic and often oppressive nature of diagnosis mentioned in the introduction, clinicians were keen to highlight that the children and their behaviour were not really the problem but rather they were responding to a problematic care situation with the tools and opportunities they had at their disposal:

Participant 3.3: I like the idea of a complex trauma diagnosis because it locates the problem outside the child as something that's been done to them. And this is kind of the consequence of what's occurred…

Participant 3.1: … should we be thinking about a chronic maltreatment diagnosis rather than, you know? So, identifying the aetiology which then, you know, you can then describe symptoms under rather than trying to describe symptoms that we fit into something because the common denominator, if you like, is the harm, whether that be, as Participant 3.4 spoke about, you know, neglect or threats.

These points, from all focus groups, casts the researcher team's suspected criticism of current diagnostics in an even harsher light than was expected. The outcome of such pervasive critique is that we may need to rethink current approaches to complex trauma presentations and complex trauma treatment.

Participant 3.1: I would, I would agree. I think we're at our current system is incredibly inept, inadequate.

The way forward here seems to be focusing down on the presentation of the array of complex trauma symptoms and having a better understanding of how real-world cases are worked on as issues with a real person and the components of treatment that are effective. It is difficult to conceptualise with this data how we would measure effectiveness given we cannot communicate concretely what complex trauma is for it to be treated.

Research question answers summarised

Below are some summarised comments to each of the research questions from this preliminary analysis of the focus groups with expert practitioners.

1. *What symptoms and/or constructs do children and young people with a background of child abuse and neglect experience/present with?*

The symptoms and/or constructs children and young people with a background of child abuse and neglect experience/present with are extremely varied (as demonstrated in Figure 2) and change markedly across the lifespan, and as such, providing direct and simple answers is unlikely to be possible. For lack of a better phrase, its more complex than that. However, some of the examples given within the focus groups included difficulties in the areas of identity/sense of self, relational and attachment capacity, sense of safety, regulation, development, biological or innate traits, cognition, as well as some more specific examples such as flashbacks, sleep issues, play issues, educational troubles, internalising/externalising behaviour, sexualised behaviour, risk-averse or risk-taking behaviour, and food-related behaviours.

2. *How do these symptoms compare with current diagnostic criteria and are they reflected holistically in any one diagnostic tool?*

These symptoms do not fit neatly with any of the current diagnostic criteria, nor are they reflected holistically in any one diagnostic tool. Rather there were conversations about needs for new diagnostic tools and criteria for complex trauma and its own diagnosis, but more so a critique of the need for diagnosis itself as it is more for funding and treatment structure than explaining these children's experiences.

3. *Can these symptoms be grouped into symptom clusters/categories?*

These symptoms could be grouped into symptom clusters/categories (e.g., internalising symptoms, externalising symptoms) but usually only with a radical shift in how we understand this clustering, especially in a way that stops people with complex trauma being found to be the source of their disordered behaviour as it is a reasonable reaction to their context.

4. *What makes complex trauma from child abuse and neglect distinct from other types of trauma?*

Complex trauma from child abuse and neglect is difficult to make distinct from other types of trauma. Clinicians tend to use different trauma terms interchangeably. The pervasive and interpersonal nature of abuse and harm as well as the multidimensional effect due to child abuse and neglect often occurring at an early age means other types of trauma are often complex (e.g., relational, and developmental trauma), while not all complex trauma is developmental or relational. There is however distinction between precipitating traumatic events that cause complex trauma, that is there was consensus that child abuse and neglect experiences were more likely to be associated with a presentation of complex trauma rather than exposure to other forms of traumatic events (e.g., fire, earthquake, medical trauma that does not include perceived or real attachment disruption).

5. *What factors influence the development of complex trauma in children and young people who have experienced child abuse and neglect?*

Similar to the aetiology of PTSD or acute stress disorder there is an event or experience of profound harm and threat that is present within the background of children and young people who develop complex trauma. Unlike these disorders, however, this study suggested that there is a requirement

for prolonged, or sustained periods of multiple events and experiences of profound harm, threat, and/or deprivation and that these be accompanied or occur within the context of a disruption to key attachment relationship/s (i.e., with a parent/s or caregiver/s). The failure of (or even absence of) an attachment relationship that provides unconditional regard, nurturance, and safety is a critical factor that together with repeated threat and harm influences the development of complex trauma.

6. *What mechanisms serve to maintain complex trauma presentations into adulthood for some children and young people who have experienced child abuse and neglect?*

There is a cycle to the development of complex trauma in children and young people who have experienced child abuse and neglect. This cycle can continue throughout the lifespan, while changing in behavioural presentation, those behaviours could be the same type or kind of reactions. This is especially so for those that enter systems of welfare and care as there are issues in how these spaces perpetuate low-attachment or transient relationships that are core to the description of complex trauma and its presentation. The reality of their experiences and reactions may be lost however as they meet different diagnostic criteria as these changes occur. Moreover, continued exposure to the same low-attachment or transient relationships across contexts and systems tends to provide a lack of counter reference points and corrective validating experiences, which in turn, may function to maintain complex trauma presentations across the lifespan. As this cycle is repeated over time, a child's externalising and/or internalising behaviours may become so deeply ingrained that they simply become a way of being, a lens through which they see themselves and the world, and how they relate to others rather than an episode of acute distress. When this occurs, personality pathology is added to the complex trauma symptoms that present.

DISCUSSION AND CONCLUSIONS

This research project presents an exploratory pilot study which aimed to adopt a symptoms-based approach to the conceptualisation and formulation of children with abuse and neglect related complex trauma and to increase understanding of the development, maintenance, and uniqueness of child abuse and neglect related complex trauma. The pilot study used a qualitative exploratory expert focus group design to explore the opinions of professionals with practice experience around child abuse and neglect and/or complex trauma from abuse and neglect. The findings of this research suggest that the concept of complex trauma remains somewhat nebulous and there appears to be a lack of clarity around the distinctiveness and definition compared to other types of trauma and/or diagnostic constructs. The focus group discussions demonstrated that the concept of child abuse and neglect related complex trauma tends to be used interchangeably with other constructs and concepts within clinical practice (e.g., relational trauma, developmental trauma). This adds to the body of research indicating the lack of clarity and interchangeable use of the term 'complex trauma', and the inherent difficulties associated with operationalising the concept. Although the aim of this pilot study was to take a ground level approach by exploring and understanding abuse and neglect related complex trauma amongst professionals with significant experience and expertise in this area, the

findings suggest that further research refining the distinctiveness and overlap between abuse and neglect related complex trauma and other types of trauma may be needed.

In line with previous research, the focus group discussions elicited a pervasive range of symptoms associated with complex trauma, including a spectrum of symptoms and constructs linked to internalising and externalising psychopathology and the impact on emerging personality traits (Gardner et al., 2019; Schmid et al., 2013; Tarren-Sweeney, 2008). Further, the findings of this study highlighted the significant negative impact of child abuse and neglect related complex trauma on the emerging sense of self and the development of beliefs about self, others, and worldview. Ultimately, while a myriad of symptoms and constructs were discussed and presented, the notion of simplifying and refining child abuse and neglect related complex trauma to a set of discrete concrete symptoms was posed to be too challenging and restrictive for clinical formulation and conceptualisation.

As articulated in the results, there was consensus that the symptoms associated with child abuse and neglect related complex trauma are not comprehensively reflected within current diagnostic symptoms and nosology. The results demonstrate that the spectrum of symptomology associated with abuse and neglect related complex trauma is widespread and suggests the need for attention to be given to the idiosyncratic pattern of symptoms that develop, the way in which these symptoms present and are expressed at different developmental stages, and the interplay of contextual, systematic, and relational factors within each stage that contributes to the unique manifestation of emotional, cognitive, and behavioural processes across the lifespan. Consistent with research and clinical practice, the findings demonstrated that the experience of child abuse and neglect related complex trauma is significantly complex, multifaceted, and the presentation and manifestation of symptoms tends to change across the lifespan and across developmental periods (Ford, 2021; Morelli & Villodas, 2022; Tarren-Sweeney, 2013).

As expected, and consistent with the extant knowledge base, explicit references to neglect throughout the focus group discussion was somewhat limited. As neglect was conceptualised as the absence of an event or action and need being met relative to the presence of an event or an action (albeit negative) such as with other types of abuse (e.g., physical abuse, sexual abuse), neglect may be more challenging to operationalise and formulate. Future research on neglect is needed to better understand the differential effects between the varying types of abuse and neglect and the ways in which exposure to abuse and neglect contribute to the development and expression of symptoms across different contextual settings and across the lifespan.

With regards to the development and maintenance of child abuse and neglect related complex trauma, the findings suggest a cyclical dynamic whereby children exposed to abuse and neglect tend to be vulnerable to and more likely to experience abuse and neglect across the lifespan within their intra- and inter-personal relationships through to the macro-level and societal systems (Lawson, 2017). Moreover, in line with the cyclical nature of complex trauma, exposure to abuse and neglect in early critical periods becomes repeated over time based on the reinforcing effect of the surrounding environments, reception of invalidating messages, and interpersonal and systematic reactions to the

expressed symptoms, which tend to perpetuate an unstable sense of self and core maladaptive schemas about self and others (e.g., the relational, social, and educational consequences associated with displays of externalising behaviours and aggression serve to maintain such behaviours and the ripple effect on regulatory processes and core beliefs and schemas; D'Andrea et al., 2012; Flechsenhar et al., 2022; van der Kolk, 2005). As such, complex trauma symptomology and the environments and relationships that children with abuse and neglect related complex trauma tend to be exposed to throughout their development and/or in their journey in care, tends to provide a lack of counter reference points or corrective relational experiences, which in turn, compound the effects of complex trauma and contributes to the complexity and multiplicity of symptoms, and different presentations across developmental stages and the lifespan (e.g., divergent trajectories and multifinality; Flechsenhar et al., 2022; Lawson, 2017).

Consistent with prior literature, the findings highlighted the pervasiveness of complex trauma, the multiple types of abuse experienced, and the relational and interpersonal nature inherent to child abuse and neglect related complex trauma (Cook et al., 2005; Spinazzola et al., 2018; van der Kolk, 2005). The relational component integral and specific to complex trauma was present in all elements of clinical formulation and conceptualisation. There was consensus within the findings that child abuse and neglect related complex trauma occurs within the context of key attachment relationship/s with a caregiver/s and that the sense of safety and safe haven that is meant to exist as part of this attachment relationship is disrupted and compromised through experiences of abuse and neglect.

The results of this study further highlight the challenges associated with working within a system that tends to rely on discrete nosology and diagnostic classifications (Cuthbert & Insel, 2013; Ford, 2021; Tarren-Sweeney, 2008). Although it was acknowledged that provisions of a diagnosis may be associated with some benefits (e.g., access to funding and support across educational and institutional settings, directions for intervention), there was general agreement that the current diagnostic criteria are plagued with gaps and there is an increased likelihood for misdiagnosis and multiple diagnoses to be administered across the lifespan. The findings lend support to the notion that diagnosis (and potential for misdiagnosis and multiple diagnoses) does not accurately reflect or capture the idiosyncratic experience, multifaceted nature of symptoms, and the interplay of particular symptomology with surrounding systems that serve to contribute to (and maintain) the presentation of complex trauma and associated symptomology throughout development. The findings demonstrated that focusing on diagnosis can potentially perpetuate cycles of stigma towards those who have experienced abuse and neglect related complex trauma. Moreover, the findings suggested that focusing on diagnosis tends to maladaptively force attempts to refine an idiosyncratic and markedly varied presentation of symptoms into a discrete clinical box that does not represent the meaning-making and lived experience associated with child abuse and neglect related complex trauma.

The varied presentations of symptoms, and the tendency for the presentation of symptoms to change markedly across time, suggests that therapeutic intervention tailored specifically to treating a diagnosis is unlikely to capture the full symptom sequalae associated with child abuse and neglect

related complex trauma (Conway et al., 2018; Ford, 2021). Moreover, beyond targeting symptoms, a focus on treating a specific diagnosis may not account for the relational and interpersonal disruptions and the impacted emerging sense of self inherent within child abuse and neglect related complex trauma and the pervasive effect of attachment disruption on the full sequalae of emotions across the lifespan.

The findings of this research should be interpreted within the context of study limitations, which also offer additional avenues for future research. With regards to the sample, the total sample size is relatively small with literature recommending at least five experts per group to allow discussion but also the technical level of insights, over three to four groups for a total of 15-20 participants (Krueger & Casey, 2015, pp. 64, 198-199). Though we also note the many issues about minimum participant claims in qualitative research as a point of rigour alone. Moreover, the recruitment of participants was based on a purposive sampling technique drawing on the networks of the research team and the recruitment of participants was limited to Australia. As such, the generalisability of the results should be done so with caution and future research with larger and more culturally diverse samples is needed.

Of note, however, there was a degree of heterogeneity in participants specific practice experience across the sample, and yet, the findings of the focus group discussions were closely aligned and consistent with the literature on complex trauma. While participants did draw heavily on their practical experience working with clients, they also spoke to their book knowledge. This is perhaps unsurprising given that clinicians are likely to keep up with literature in their area of practice and/or attend training/professional development by those who are actively across the literature. However, this lends itself to somewhat of a paradox in that the data elicited from expert practitioners is likely to parallel the extant literature and knowledge base around complex trauma. Alternatively, as much of the literature in complex trauma is authored by those who are (or were) clinicians themselves working with this population, this could perhaps account for the similarities seen across what was discussed in the focus groups and the literature.

The current research presents an exploratory pilot study approach to the conceptualisation of complex trauma from abuse and neglect and although the analyses conducted are preliminary in nature, they set the stage for a refined and member-checked analysis to be undertaken with the data from the focus groups. The proposed next phase of this research study is to create a follow-up survey to clarify whether the information collected from participants is accurate and provide opportunity for any gaps in the data to be addressed. In addition, participants will be asked to reflect on conclusions drawn from the data in the form of a preliminary framework to conceptualise complex trauma. As such, it is important to note that it is possible that the data collected and findings from the follow-up phase of this research may change the findings and conclusions presented in the current report.

Notwithstanding these limitations, given the challenges with conceptualising and operationalising abuse and neglect related complex trauma and disadvantages of applying strict nosology, the findings of this pilot study lend evidence to the benefit and need for adopting a symptoms-based and phased-

based approach to the conceptualisation of child abuse and neglect related complex trauma. This has implications for research whereby the efficacy and effectiveness of evidence-based therapeutic interventions can be examined more thoroughly within the context of child abuse and neglect related complex trauma to inform clinical practice rather than attempting to generalise treatments that have been designed and evaluated for different types of trauma and/or single incident trauma. Adopting a symptoms-based approach enables a shift from diagnostic and definitional challenges, and in turn, enables a focus on the idiosyncratic presentation and myriad of symptoms expressed (which are vast and widespread across domains). Further, the findings lend support to a symptoms-based approach given the perpetuating cycle of abuse and neglect related complex trauma in and of itself, and the ways in which the constructs and symptoms change and manifest across different developmental stages. A clinical formulation based on a holistic assessment of symptoms and psychopathology dimensions (without the pressure of adhering to narrow diagnostic criteria), allows for interventions to be client-focused, eclectic, and flexible (Cloitre et al., 2012; Conway et al., 2018; Cuthbert & Insel, 2013). Clinical formulations based on symptoms provides an avenue for specific evidence-based therapeutic techniques to be adapted and mapped to intentionally target each symptom or construct that manifest across development while considering the intersectionality of complex trauma, which functions to precipitate and perpetuate emergence of complex trauma symptomology at different times. Adopting a symptoms-based and phased-based approach may promote posttraumatic growth (Ford, 2021) as it enables a deeper focus on repairing the compromised sense of relational safety, the meaning-making of the abuse and neglect experiences, and the impact of this meaning-making on self-regulatory processes, emerging sense of self, and schemas and beliefs about self, others, and worldview.

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