

# Rarely an isolated incident

## Acknowledging the interrelatedness of child maltreatment, victimisation and trauma

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It is increasingly recognised that experiences of child maltreatment are rarely isolated incidents; different forms of abuse often co-occur, and trauma often develops over prolonged periods. This paper provides practitioners, policy-makers and researchers with an overview of a number of influential recent approaches to conceptualising, recognising and responding to the complexity of child maltreatment and trauma.

### KEY MESSAGES

- One of the most recent major shifts in the focus of child maltreatment research has been recognition of the interrelatedness of childhood victimisation experiences. Two main frameworks have been developed to better understand and measure this interrelatedness: *multi-type maltreatment* and *polyvictimisation*.
- Alongside this shift, has been the growing recognition in the fields of traumatology and psychiatry that traditional mental health diagnoses often do not adequately capture the effects of chronic and/or multiple types of victimisation. *Complex trauma* and *cumulative harm* are both popular models that account for complexity in traumatic outcomes.
- Researchers investigating the consequences of a specific form of victimisation should account for the effects of other victimisation experiences, as well as for the effects of cumulative experiences.
- Practice and policy responses to children who experience single maltreatment events should be different to those for children who experience multiple maltreatment events. Survivors of multiple maltreatment events are more likely to experience complex trauma and the negative effects of cumulative harm, both of which require more comprehensive intervention and treatment.

## Child maltreatment, victimisation and trauma: broadening concepts

Although concern about child maltreatment dates back centuries, it is only in the last few decades that it has been widely acknowledged, systematically studied, and recognised as a public policy issue (Feerick & Snow, 2006; Miller-Perrin & Perrin, 2007). Indeed, academic interest in child abuse and neglect<sup>1</sup> only gathered momentum relatively recently, catalysed by Kempe and colleagues seminal 1962 article on “battered child syndrome” in the *Journal of the American Medical Association* (Feerick & Snow, 2006; James, 2000).

Two of the defining features of the first few decades of child maltreatment research were a focus on individual forms of abuse and neglect, and the attempt to identify risk factors and outcomes specific to these forms (Anderson, 2010; Higgins, 2004a). In the 1960s and 1970s, much of the child maltreatment research focused on physical abuse and, to a lesser extent, neglect (Herrenkohl & Herrenkohl, 2009; James, 2000). The 1980s saw the focus of attention move to child sexual abuse and paedophilia (James, 2000), which grew out of the second wave of feminist literature focusing on rape and sexual assault. In the 1990s, more attention was directed towards understanding the nature, prevalence and consequences of psychological (or emotional) maltreatment (Higgins, 2004a), and many began to consider witnessing family violence an independent subtype of abuse (James, 1994; Miller-Perrin & Perrin, 2007). Although understanding of the different forms of abuse increased markedly in this period, attempts to identify risk factors and outcomes specific to individual forms of maltreatment were largely unsuccessful (Higgins, 2004a, 2004b).

Part of the reason for this lack of success is that most children who are maltreated are subjected to multiple forms of abuse and childhood adversity. Focusing on individual forms of abuse can create the misleading impression that there are strong lines of demarcation between the different types of childhood adversities, or that they occur in isolation (Miller-Perrin & Perrin, 2007; Child Family Community Australia [CFCFA], 2012). However, there is a growing body of evidence to suggest that experiences of abuse or neglect seldom occur in isolation, and that the majority of individuals with a history of maltreatment report exposure to two or more subtypes (Arata, Langhinrichsen-Rohling, Bowers, & O’Farrill-Swails, 2005; Higgins & McCabe, 2000b; Ney, Fung, & Wickett, 1994). There is also evidence to suggest that broader experiences of victimisation tend to accumulate for certain individuals or in certain environments. For example, children who have been maltreated in a family context may be more susceptible than others to peer violence or exposure to crime, or those who were sexually abused may be more susceptible than others to revictimisation (Finkelhor, Ormrod, & Turner, 2007a; Tseloni & Pease, 2003).

A recent major shift in focus of child maltreatment research has been the recognition of the *interrelatedness of childhood victimisation*<sup>2</sup> experiences (Anderson, 2010; Higgins, 2004a). In addition, a significant recent shift in the fields of traumatology and psychiatry has been the growing recognition that traditional mental health diagnoses, such as post-traumatic stress disorder (PTSD), do not adequately capture the effects of chronic and/or multiple types of victimisation (Briere & Spinazzola, 2005; Herman, 1992). The following section of this paper outlines a number of influential recent approaches to conceptualising, recognising and responding to the interrelatedness of child maltreatment, victimisation and trauma.

## Models accounting for multiple forms of maltreatment and victimisation

Two main frameworks have been developed to better understand and measure the interrelatedness of child maltreatment experiences:

- *multi-type maltreatment*—which provides a theoretical framework for the inclusion of five forms of maltreatment in a single measure (i.e., sexual abuse, physical abuse, psychological maltreatment, neglect, and witnessing family violence); and
- *polyvictimisation*—which focuses not only on different forms of maltreatment, but also on broader experiences of victimisation, such as bullying and exposure to neighbourhood conflicts.

<sup>1</sup> In order to enhance readability, the terms “child maltreatment”, “child abuse and neglect”, “childhood adversity” and “victimisation” are generally used interchangeably in this paper. However, on some occasions “child maltreatment” is used to denote a limited subcategory (i.e., the five forms of abuse and neglect measured in multi-type maltreatment) of broader “victimisation” experiences (i.e., the 34 forms of victimisation measured in polyvictimisation). It should be clear from the context which type of use is intended.

<sup>2</sup> The British spelling of “victimisation” is generally used in this paper, unless the word is used as part of a title (e.g., Juvenile Victimization Questionnaire) or quote.

## Multi-type maltreatment

In order to convey the interconnectedness of child maltreatment experiences, Australian researchers Daryl Higgins and Marita McCabe introduced the term *multi-type maltreatment* in 1998 (Higgins & McCabe, 1998). Initially, these researchers investigated multiple forms of abuse and neglect as a way of accounting for the varying effects of sexual abuse. By the mid-1990s, hopes of identifying symptoms specific to sexual abuse were not being fully realised,<sup>3</sup> so attention shifted to the ways in which other forms of maltreatment may either mediate or contribute to the negative outcomes associated with sexual abuse. At this time, the case for adopting a framework that encompassed multiple forms of maltreatment became so compelling that Higgins and McCabe began to focus on the co-occurrence of maltreatment subtypes as an independent topic, rather than as an adjunct to sexual abuse research. They reasoned that measuring multi-type maltreatment could help researchers account for the variability in the short- and long-term psychological adjustment of children and adults who had experienced various forms of child abuse and neglect.

In 2001, Higgins and McCabe conducted a systematic review of studies that had measured more than one type of child abuse or neglect (Higgins & McCabe, 2001b). They identified only 29 such studies, the majority of which measured two or three types of maltreatment. Indeed, at that time, only two studies were found which measured all five forms of maltreatment (i.e., Higgins & McCabe, 2000b; McGee, Wolfe, & Wilson, 1997). Although the studies in this systematic review varied considerably in their aims and methodologies, they tended to share two key findings. First, a large proportion of adults who experienced maltreatment in childhood were subjected to more than one type; in other words, maltreatment subtypes tended to be correlated. Second, those adults who reported experiencing more than one form of maltreatment demonstrated significantly poorer wellbeing than adults reporting a single form of abuse, or those reporting none.

Higgins and McCabe (2001a) developed and utilised the Comprehensive Child Maltreatment Scale (CCMS), which measures five forms of child maltreatment:

- sexual abuse;
- physical abuse;
- psychological maltreatment;
- neglect; and
- witnessing family violence.

Multi-type maltreatment is normally indicated when participants report having experienced at least two of these forms of child maltreatment.

The majority of studies that have investigated correlations between multi-type maltreatment and psychosocial outcomes have focused primarily on internalising problems (e.g., depression and anxiety) and externalising problems (e.g., anti-social behaviour, aggression) (Higgins & McCabe, 1998; Higgins, 2003). More recent data has revealed that the lifetime prevalence rates of multi-type maltreatment range from 8% (Price-Robertson, Smart, & Bromfield, 2010) to over 57% (Sesar, Zivcic-Becirevic, & Sesar, 2008).<sup>4</sup> Higgins and McCabe (2001a) found significant overlap in the occurrence of all types of child abuse and neglect. They also found that those with high scores on scales for two maltreatment types had poorer outcomes (e.g., internalising and externalising behaviours) than those with only a single type, and those with high scores on three or more abuse types had poorer outcomes still (Higgins & McCabe, 2000a). Indeed, Higgins (2004a) noted that:

Results from an analysis of parent-report and adult self-report data suggest that the degree (frequency and severity) to which young people experience a range of abusive/neglectful behaviours is more important than the particular sub-type of maltreatment in explaining subsequent psychological problems. (p. 50)

<sup>3</sup> One exception to this is the finding of greater sexualised behaviour among sexually abused youth (Miller-Perrin & Perrin, 2007).

<sup>4</sup> Such large discrepancies in prevalence figures primarily reflect differences in sampling strategies (e.g., clinical samples versus representative community samples) but could also be related to differences in measurement (i.e., the continuous maltreatment scales of the CCMS versus dichotomous measures of maltreatment).

### Further reading

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## Polyvictimisation

David Finkelhor was among the first to advocate for an approach to child maltreatment research that considered multiple forms of victimisation together. In 1983 he said:

It may be important, both for the benefit of research and theory, and also to counteract some of the divisive tendencies, for researchers on the disparate forms of domestic violence to see what they can find in the way of commonalities (Finkelhor, 1983, p. 17).

However, it was not until more than 20 years later—in 2005—that Finkelhor and colleagues at the University of New Hampshire introduced the concept of *polyvictimisation* (Finkelhor, Ormrod, Turner, & Hamby, 2005). Polyvictimisation has been defined as: “having experienced multiple victimizations of different kinds, such as sexual abuse, physical abuse, bullying, and exposure to family violence” (Finkelhor, Turner, Hamby, & Ormrod, 2011, p. 4). As this definition suggests, polyvictimisation includes not simply child maltreatment (e.g., sexual and physical abuse), but also a broad array of other adversities, including peer bullying, witnessing community violence, and property crime.

Finkelhor and colleagues began investigating polyvictimisation for similar reasons to those that saw Higgins and McCabe introduce the concept of multi-type maltreatment almost a decade earlier: a number of independent lines of research pointed to the fact that children who experienced multiple forms of victimisation were at a particularly high risk of additional victimisation (whether of the same or different kind) and ongoing negative psychological effects (Finkelhor et al., 2011). Similarly to Higgins and McCabe, they also hypothesised that measuring polyvictimisation would help account for large variation in the traumatic symptoms seen in children subjected to various forms of childhood adversity.

The main research tool used to measure polyvictimisation to date has been the Juvenile Victimization Questionnaire (JVQ) (Finkelhor et al., 2005). The JVQ measures 34 individual forms of victimisation,<sup>5</sup> which can be grouped into five general categories:

- conventional crime (e.g., robbery);
- child maltreatment (including physical, emotion, and neglect);
- peer and sibling victimisation (e.g., bullying);
- sexual victimisation (including peer or adult perpetration); and
- witnessing and indirect victimisation (e.g., witnessing family violence, witness to assault with a weapon).

Polyvictimization is normally indicated when an individual has experienced four or more of these forms in a 12-month period.

5 That is: exposure to war or ethnic conflict, sexual assault by peer, rape (attempted or completed), flashing/sexual exposure, verbal sexual harassment, nonspecific sexual assault, bias attack, witness to parent assault of sibling, kidnapping, witness to murder, exposure to random shootings etc., custodial interference/family abduction, physical abuse by caregiver, dating violence, robbery, gang or group assault, witness to assault with weapon, attempted assault, psychological/emotional abuse, non-sexual genital assault, murder of family member or friend, assault with weapon, personal theft, witness to assault without weapon, witness to domestic violence, vandalism, assault without weapon, sexual assault by known adult, burglary of family household, neglect, emotional bullying, bullying, peer or sibling assault.

Most of the studies that have used the JVQ alongside outcome measures have focused on short-term trauma symptoms (i.e., anxiety, depressive symptoms, and anger/aggression) (e.g., Finkelhor et al., 2005; Finkelhor, Ormrod, & Turner, 2007b). These studies have tended to find that polyvictimisation is highly predictive of trauma symptoms, and when controlled for, greatly reduces or eliminates the association between individual victimisations (e.g., sexual abuse) and symptomatology. However, when assessing the prevalence of victimisation across the whole of childhood, maltreatment experiences (e.g., sexual and physical abuse) have been found to uniquely predict adult outcomes, even when controlling for “polyvictimisation” as a separate construct (Finkelhor, Ormrod, & Turner, 2009). Finally, the incidence and prevalence rates have varied considerably, depending on how polyvictimisation has been defined or the particular study sample used. However, in the largest representative studies, it was estimated that almost a quarter (22–23%) of all US children were subjected to four or more victimisation experiences in the 12 months prior to the study (e.g., Finkelhor et al., 2005; Finkelhor et al., 2007).

### Further reading

Juvenile Victimization Questionnaire <[www.unh.edu/ccrc/juvenile\\_victimization\\_questionnaire.html](http://www.unh.edu/ccrc/juvenile_victimization_questionnaire.html)>

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## Models accounting for the complexity in traumatic outcomes

Two concepts are frequently employed to explain the complexity in traumatic outcomes of survivors of victimisation:

- *complex trauma*—which covers a broad range of cognitive, affective and behavioural outcomes; and
- *cumulative harm*—which is similar to complex trauma, but focuses on the ongoing trauma (often with caregivers as perpetrators) and negative outcomes experienced by children.

### Complex trauma

Outcomes for victim/survivors of abuse have frequently been viewed through the mental health framework of PTSD. However, PTSD was developed with survivors of single, or relatively contained, events in mind. Many researchers in the fields of psychiatry, traumatology, psychology and social work do not see PTSD as adequately capturing the effects of chronic and/or multiple types of victimisation (Briere & Spinazzola, 2005; Herman, 1992). In 1992, Judith Herman proposed a diagnosis of “complex post-traumatic stress disorder” (Herman, 1992) to reflect the combination of co-occurring symptoms, disorders and multiple adverse experiences that combine to impact on victim/survivors of ongoing traumas such as child sexual abuse. The term “complex trauma” is now frequently used in mental health and service provision circles to encompass the types of problems that are not covered by PTSD, but are experienced by trauma survivors.

Research findings indicate that trauma occurring early in life, that is prolonged, and which has an interpersonal element (e.g., sexual abuse), can impact on psychological health beyond the traditionally diagnosed PTSD symptomology (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). A characteristic of complex trauma is dysfunction in the individual’s ability to relate to others, often affecting their capacity to form healthy relationships. Other features include inability to regulate emotions, changes to the sense of self, changes in sense of wellbeing, potentially leading to despair and hopelessness as well as elevated risks to personal safety and somatic symptoms (i.e., physical symptoms for which there is no medical explanation) (Pearlman & Courtois, 2005). Many of these manifestations appear to function as adaptive reactions to the experience of the abuse but then become problematic for the individual.

They can shift and vary depending on age, support networks and the origin of the trauma (van der Kolk et al., 2005). For example, behaviours such as aggression, self-injury or substance abuse may be an attempt to manage distress or to self-soothe (Pearlman & Courtois, 2005).

The phenomenon of revictimisation is frequently faced by sufferers of complex trauma, as previous victimisation is known to be a strong predictor of further episodes of victimisation (Classen, Palesh, & Aggarwal, 2005). In an overview of literature on sexual revictimisation, prevalence rates across studies suggested that approximately two out of three individuals who are sexually victimised are revictimised over their life course (Classen et al., 2005). The risk of revictimisation appears to escalate where there are multiple types of abuse, and in correlation with many of the features of complex trauma, such as psychiatric disorders, substance abuse, poor interpersonal function and powerlessness (Classen et al., 2005). It is still not clear what factors lead to some people experiencing revictimisation compared to those who do not, though it appears that consequences of trauma and risk factors are closely linked. For instance, substance abuse and poor social interaction appear to be both consequences of victimisation as well as risk factors for revictimisation.

Currently, “complex trauma” or “complex PTSD” is not recognised by the international classification manual known as the Diagnostic and Statistical Manual of Mental Disorders or DSM. This is despite extensive consideration by the mental health, traumatology and psychiatric sectors. Instead, reactions and behaviours such as dissociation, impulsivity, and substance dependency are described as, or within, separate and distinct diagnostic categories. There is concern that without the diagnosis of complex trauma as an umbrella term for the set of behaviours and features common to some abuse victims, there is potential for a negative impact on treatment interventions. Parallel diagnoses (i.e., in different diagnostic categories) do not fully acknowledge the interaction of symptoms and social factors that often result in the problems experienced by complex trauma sufferers (van der Kolk et al., 2005). There is also potential to stigmatise a victim/survivor with multiple diagnoses and problems (Cloitre et al., 2009).

Complex trauma arguably offers a more comprehensive understanding of the relationship between trauma, mental health and social problems than “co-morbidity”, or “multiple diagnosis”. A framework based on complex trauma provides a comprehensive starting point for interventions across various domains of need including trauma support, mental health, housing and substance abuse needs.

### Further reading

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## Cumulative harm

As with complex trauma, the concept of cumulative harm encompasses a range of negative experiences that are difficult to capture in clinical, social welfare or child protection settings. While complex trauma tends to be applied to people of all ages who have suffered a wide variety of abuse at any age, cumulative harm is used to describe both the ongoing trauma experienced by children (often with caregivers as perpetrators) and the negative outcomes resulting from multi-type maltreatment and polyvictimisation.



Complex trauma outcomes often focus on negative mental health or psychological outcomes, whereas cumulative harm includes the substantial negative developmental outcomes. Similar to complex trauma, cumulative harm interventions often require multi-service responses, however the identification and response coordination is usually the responsibility of child protection services.

Cumulative harm, sometimes also described as *chronic maltreatment*, refers to the effects of multiple adverse or harmful circumstances and events in a child's life. As Miller and Bromfield (2010) described:

The unremitting daily impact of these experiences on the child can be profound and exponential and diminish a child's sense of safety, stability and wellbeing. (p. 5)

Cumulative harm may involve repeated exposure to a single adverse event by a single perpetrator, or multiple adverse events with multiple perpetrators over a period of time. Research has shown that the effects of cumulative harm are greater if the abuse occurs over multiple developmental stages and that adverse events include maltreatment such as emotional abuse, neglect, sexual abuse, physical abuse, and witnessing domestic violence (Jaffee & Kohn Maikovich-Fong, 2011).

Whereas a single traumatic incident tends to produce an isolated behavioural response to reminders of the trauma, chronic trauma can have long-term and pervasive effects on children's development, and adversely affect their functioning in adult life. It has been shown that chronic child maltreatment reports are a robust indicator of future negative health and behavioural outcomes, including behavioural, neuropsychological, cognitive, emotional, interpersonal, and psychobiological disorders (Becker-Weidman, 2009; Johnson-Reid, Kohl, & Drake, 2012). van der Kolk (2003) found that exposure to chronic trauma may lead to serious developmental and psychological problems for children. These problems include:

- disturbed attachment patterns;
- complex disruptions of emotional regulation;
- rapid behavioural regressions and shifts in emotional states;
- lack of self-motivation;
- aggressive behaviour against self and others;
- lack of awareness of danger, resulting in self-endangering behaviours; and
- self-hatred and self-blame and chronic feelings of ineffectiveness.

Identifying and responding to cumulative harm is challenging because the cumulative effects of chronic low-level abuse and neglect can be easily missed (Miller & Bromfield, 2010). Systemic barriers, such as each child protection report being treated as a discrete event, mean that information is not accumulated from one report to the next and information is lost over time. Finally, an assumption is sometimes made that problems presented previously were resolved at case closure so files are not scrutinised for pattern of cumulative harm (Bromfield, Gillingham, & Higgins, 2007).

### Further reading

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## Implications

This paper has highlighted gaps in the current conceptualisation of child maltreatment, victimisation and trauma. Evidence shows that most survivors of child maltreatment experience more than one type of maltreatment, often coupled with other forms of victimisation, often over a long period of time. It also shows that once a person has been victimised, they are more likely than the general population to be re-victimised. However, current diagnostic and treatment approaches tend to view incidents of maltreatment and victimisation separately or in parallel. Some of the implications of the models outlined in this paper for research, policy and practice are described below.

### Implications for research

The evidence presented in this paper gives reason to question any research that measures individual types of maltreatment and attempts to draw conclusions about associated outcomes or risk factors. For instance, if researchers only measure physical abuse, how can they be sure that any correlations they find with long-term psychosocial outcomes are not actually the effect of various other victimisation experiences that are likely to co-occur with physical abuse?

This does not mean that all types of child maltreatment or victimisation are the same, or that they should not be investigated separately. To be sure, research has identified some unique outcomes associated with specific forms of victimisation (e.g., greater sexualised behaviour among sexually abused young people). It does mean, however, that researchers investigating the consequences of a specific form of victimisation should at least control for the effects of other victimisation experiences, as well as for the effects of cumulative experiences (e.g., using measures of multi-type maltreatment or polyvictimisation).

Whether one chooses multi-type maltreatment, polyvictimisation, or some other framework that accounts for multiple experiences of victimisation, it is clear that the era in which researchers routinely measure only one form of child victimisation is drawing to a close—there is simply too much evidence suggesting that experiences of victimisation routinely co-occur.

### Implications for policy

The role of policy in responding to child maltreatment is to provide an evidence- and context-informed framework within which practitioners can operate. It needs to have aspirational goals, accompanied by realistic objectives that can be achieved through carefully constructed guidelines and appropriate resourcing, training, tools and support. Therefore, policy needs to support practitioners to enable them to respond in a way that is supported by the evidence. As Jonson-Reid et al. (2012) identified, responses to children of single maltreatment events are different (or should be different) to responses to children of multiple maltreatment events (i.e., multi-type maltreatment and polyvictimisation). Children (or adults) who have experienced multiple maltreatment events are likely to be experiencing complex trauma and/or cumulative harm, both of which require much more comprehensive intervention and treatment.

Policy development also needs to consider the range of practitioners responsible for recognising and responding to instances of child maltreatment. For example, consistent identification and referral processes are required throughout public health settings such as maternal and child health centres, early childhood education centres, schools, GPs, dentists, hospitals and child protection services. The cooperation and joint action of all child health settings and systems is required to identify and appropriately respond to both single and multiple maltreatment events.

As Miller and Bromfield (2010) articulated, the response must be holistic, not just in terms of consistency across public health settings, but also in identifying the range of circumstances experienced by the child. Not only does the child's current and future safety need to be assured, but they also need to be assisted in their short- and long-term recovery to address their psychological, behavioural and developmental needs. In addition, children need to have the adversity in their lives reduced (e.g., greater family stability, access to support services) and opportunities and strategies to build resilience against future negative events.



For adult victim/survivors of child victimisation, a policy framework based on complex trauma can provide a comprehensive starting point for interventions across various domains of need including trauma support, mental health, housing and substance abuse needs.

## Implications for practice

The challenge for practitioners working with children and families is to be alert to the possibility of multiple adverse circumstances and events in all reports, and to consider not just the information presented in the current report but in the past history of reports that may be indicative of cumulative harm. The focus of any assessment and intervention must be to answer two questions: “Is this child safe?” and “How is this child developing?” (Miller & Bromfield, 2010). A delay in child development can be one of the key signs of cumulative harm and complex trauma resulting from multi-type maltreatment and polyvictimisation (along with behavioural changes and disturbed attachment to caregivers).

Bromfield and Miller (2007) advised practitioners to be alert to multiple reports, previous substantiations, multiple sources alleging similar problems, reports from professionals, evidence of children not meeting developmental milestones, and allegations of inappropriate parenting in public. In addition, they indicated that the frequency, type, severity, duration and source of harm could help identify instances of cumulative harm.

Jonson-Reid et al. (2012) stressed the importance of differentiating between children who have single and multiple maltreatment events to better guide clinical interventions. Their findings also suggest the importance of not only ensuring child safety but also addressing behavioural and developmental needs among children who have experienced multi-type maltreatment or polyvictimisation. Miller and Bromfield (2010) suggested that in cases where children have experienced cumulative harm, the focus of intervention must be on reducing the adversity in the child’s life, assisting their recovery and increasing their resilience to future adversity. Box 1 describes a program for children, most of whom have experienced multi-type maltreatment and are suffering from emotional, behavioural and developmental problems. The program stresses the importance of safety, security and the development of supportive relationships.

### Box 1: The experience of the Take Two program

Auspiced by Berry Street in partnership with Austin Child and Adolescent Mental Health Service, School of Social Work and Social Policy, La Trobe University, Mindful (Centre for Training and Research in Developmental Health) and Victorian Aboriginal Child Care Agency.

Take Two is an intensive therapeutic program for children and young people in the Victorian child protection system. Between 2004 and 2007 the program accepted 1063 referrals, 16% of which were for Indigenous Australians. Almost all children (96%) referred had experienced more than one form of abuse, with almost 25% experiencing all five domains of maltreatment types. With regard to emotional, behavioural and developmental problems, the range is profound and almost all children (95%) had two or more areas of concern. While these problems (symptoms) are often the target of therapeutic intervention, a direct approach is unlikely to be effective if the symptoms are founded on a history of complex trauma and an absence of secure attachments. In these situations, the symptoms are often an attempt to adapt and survive unsafe and uncertain situations. Therefore, safety and predictability must form a platform for any other interventions. One of the most insidious consequences of trauma, especially chronic, relational trauma, is its impact on children’s capacity to form and sustain positive, safe and trusting relationships. The isolating nature of trauma, alongside, and yet in contrast to, the heightened need for supportive relationships, is one of the contradictory messages that challenge practice. As a result, an overarching feature of the Take Two program is developing and nurturing respectful relationships, which pervade all aspects of therapeutic interventions both directly with the children and in strengthening their relationships with others. The program includes training and supporting foster carers and residential carers to provide safe, nurturing relationships, stability and care that integrates the child’s experience and promotes healthy development. Therapeutic care emphasises relationships and considers and responds to the child’s underlying needs. A thorough biopsychosocial assessment provides an understanding of the child’s developmental history and needs from which an intervention plan is formed.

Source: Frederico, M., Jackson, A., & Black, C. (2010)

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