Literature Review: Trauma-Informed Therapeutic Services for Children

Prepared by Inside Policy for the Department of the Prime Minister and Cabinet

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1. Introduction

This document captures the findings of a literature review of effective trauma-informed therapeutic services for children. The review scanned evaluation reports, peer-reviewed studies and grey literature on trauma-informed interventions for children in Australia, the United States of America, New Zealand, United Kingdom and Canada.

This literature review sought to identify and define trauma-informed interventions for children and their key elements for addressing family violence. The findings of this review will frame the co-design process for Indigenous specific services to be delivered under the Third Action Plan of the National Plan to Reduce Violence against Women and their Children

The purpose of this review was not to discuss the broader framework of trauma-informed care and practice, although principles to guide such practice at an organisational level are contained at Appendix A.

2. Setting the context: trauma & its impacts

For the purposes of this paper, trauma refers to a person's psychological, physiological and social response to an event (or events), which elicits fear, horror, and/or helplessness that overwhelms the person's ability to cope.[1] Domestic and family violence falls under this definition as an event, which can deeply traumatise its victims. The breadth of this definition includes 'single-incident', or Type 1, traumas (such as accidents, natural disasters and one-off instances of abuse)[2], which overlooks the continuous and repetitive nature of domestic and family violence. Therefore, a more apt definition for this paper is that of complex trauma otherwise known as Type 2.[3]

Complex trauma refers to violating and/or exploitative trauma that is cumulative and ongoing and is (usually) inflicted on one person by another.[4] As with trauma, complex trauma severely cripples the individual's ability to cope and impedes biological functions.[5] The nature of complex trauma necessitates complex responses. Thus, when dealing with trauma and complex trauma victims, solutions must be sought to restore their ability to cope.

Impacts of trauma

[1] Hopper, Bassuk, & Olivet, 2010:80; Atkinson, 2012:11
[2] Gimson & Trewhella, 2014:9
[3] Ibid.
[4] Bateman, Henderson, & Kezelman, 2013:8; Campo et al, 2014:24; Atkinson,2012:15; Gimson & Trewhella, 2014:8
[5] Bateman, Henderson, & Kezelman, 2013:8; Atkinson, 2012:15

Trauma can manifest with different symptoms, which impede physical, cognitive, behavioural and emotional processes.[6] A trauma victim may display (a mixture of) the following signs:

- constant vigilance for danger
- fatigue
- disturbed sleep
- intrusive thoughts
- poor concentration
- alteration of self-perceptions
- confusion
- social withdrawal and isolation
- sense of lack of control
- detachment
- grief
- depression
- guilt
- anxiety, and/or
- panic.[7]

Many of these symptoms precipitate from the creation of extreme coping mechanisms such as hyperarousal or avoidance in order to overcome the victim's adverse situation.[8] At the end of the spectrum, coping strategies include substance abuse and addition, suicidal tendencies and self-harm, and re-enactment of abusive relationships.[9] These impacts of trauma interfere with a victim's ability to seek help and impact how victims interact and engage with services.[10]

Children's experience of trauma

Trauma can have specific effects on children, which can hinder their development and can have life-long implications if left unresolved.

In the case of family violence, psychologically, when a child experiences violence at the hands of their parents or a close family member, two simultaneous reactions are played out in the child's mind: one reaction is to run away from the danger and the other reaction is to go toward those to whom they are attached – usually the person inflicting the violence.[11] This paradox leads to the collapse of the child's ability to cope. The creation of nurturing attachments to a non-abusive caregiver, parent or family member may help to protect children from further effects of trauma and help rebuild their resilience.[12] Notably for Indigenous cultures, a reorientation from dyadic to network understandings of attachment need to be made to encompass the multiple caregivers a child may have within Indigenous communities.[13]

From a neurobiological standpoint, when a child experiences trauma their brain secretes potent neural chemicals to protect them from harm. However, over long

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[6] Procter et al., 2017:5
[7] Procter el al., 2017:5; Hopper, Bassuk, & Olivet, 2010:80; Campo et al., 2014:24; Rosen, 2015: 45; These are just example and are not an exhaustive list of symptoms.
[8] Bateman, Henderson, & Kezelman, 2013:9; Elliot et al., 2005:463
[9] Bateman, Henderson, & Kezelman, 2013:9
[10] Elliot et al., 2005:463
[11] Siegel, 2012:21-4
[12] Rosen, 2015:45; Procter et al., 2017:6
[13] McClung, 2007:7

periods of time, this excessive arousal compromises maturation and can lead to permanent damage through toxic stress on the developing brain.[14] This neurological impairment has repercussions for how a child will grow and learn.[15]

Finally, trauma has implications for identity formation in children.[16] When the trauma is inflicted by a family member, children may believe that it is their fault. This self-blame creates a negative self-image which may continue into adolescence and adulthood.[17] Thus, programs that are aimed at intervening in the lives of children must be informed by neurobiology, attachment theories, and identity formation to counter the impacts of trauma.

Intergenerational trauma

Intergenerational trauma refers to the cycle of abuse and violence which occurs within families and communities when sources of trauma are not resolved or are ignored.[18] These detrimental patterns of behaviour are passed through the generations and essentially 'normalised'.[19]

While intergenerational trauma is a general term, the concept aids understanding of family violence within Indigenous communities. Historically, Indigenous Australians have experienced tremendous trauma through colonisation, massacres, removal from homelands, assimilation and 'stolen generation' government policies, incarceration, and introduction of addictive substances.[20] The collective traumatisation can bring about the collapse of traditional ways of life and change community culture and dynamics.[21] Importantly, strong positive kinship ties and cultural connections can serve as a protective buffer for those experiencing trauma and can help to ameliorate its impacts.[22]

3. Defining Trauma-Informed Therapies or Interventions

Trauma-informed (also known as 'trauma-specific' or 'trauma-focused') interventions directly address the impact of trauma on a child or young person through the goals of decreasing symptoms and facilitating recovery.[23] Within the framework of trauma-informed care (see Appendix A) sits trauma-informed therapeutic services.

Frederico, Jackson & Black (2010) make a distinction between two different types of therapeutic service. The first type refers to the sessions that occur between client and therapist.[24] The second is the therapy or 'therapeutic moments', which occurs outside of the sessions in the client's environment.[25] This type of therapy involves the creation of safe spaces outside of the therapy sessions. In the case of children, this means working with family or caregivers to resolve their trauma and minimise possible triggers that a child may encounter outside of sessions. Therapy is not fruitful if the client is in continual contact with traumatic environments.

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[14] Bunston, 2008:334; Fox et al, 2015:65
[15] Jackson et al., 2013:11; For breakdown of impact of trauma at specific ages, see: Gimson & Trewhella, 2014:9
[16] Gimson & Trewhella, 2014:9
[17] Ibid.
[18] Atkinson, 2012:18
[19] Ibid.
[20] Atkinson, 2012:10; Closing the Gap Clearinghouse, 2016:3
[21] Closing the Gap Clearinghouse, 2016:3; Atkinson, 2012:12
[22] Procter et al., 2017:9
[23] Fallot & Harris, 2001
[24] Frederico, Jackson, & Black, 2010:81
[25] Ibid.

Therapeutic responses should promote safety, allow clients to make sense of their trauma and identity, and help foster positive relationships and connections.[26] Most programs offer a psycho-educational element to help their clients to understand the ways in which they act and the impacts of trauma, thereby offering possible pathways to recovery.

In order for therapy to be effective, it must occur in a place where the client feels physically and emotionally safe.[27] Therapeutic responses can occur through a range of activities and may engage with cultural practices such as 'yarning' and creating stories (especially around the construction of identity), 'dadirri' (contemplation) and art and music.[28] These activities help a client to contextualise and make sense of their experiences.[29] These therapies can occur in an individual, group, or family setting depending on the needs of the client. The flexibility of setting and activities mean they can be tailored for the individual.

Children's trauma-informed interventions

Children are impacted differently by trauma depending on where they are in their development and the duration of the trauma.[30]

Child-specific services should adopt a range of responses to cover these variables and can be more directed at addressing trauma than adult services.[31] Child-specific services usually involve a psycho-educational component, creative activities, and may also provide structured counselling services.[32] Therapies seek to help children create new meanings from their traumatic experiences, address the behavioural and developmental impacts of trauma, and foster safe healthy relationships.[33] Expressive interventions such as art, music or drama therapy, and sand play may be utilised to allow infants and children to communicate without words.[34] Like in adult therapies, it is encouraged that children are viewed as active participants in their recovery no matter how they communicate and are not passive to treatment.[35] The use of play therapies allow children to process their traumatic experiences and complex information.[36] Creating safe and secure attachments aids the recovery of children from trauma which suggests the inclusion of the family or caregiver in the therapeutic process.[37]

At a minimum, therapeutic services should provide support and guidance for family and caregivers. Lastly, the longer a child is exposed to trauma, the more detrimental are the impacts on their development.[38] Therapeutic services must try and intervene as early as possible to ward off the detrimental impacts.

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[26] Jackson et al., 2013:19
[27] Campo et al, 2014:43
[28] Carnes, 2015:8; Memmott et al., 2006:23; Atkinson, 2012:5
[29] Atkinson, 2012:24
[30] Gimson & Trewhella, 2014:6; It should be noted that development may be a different from chronological age due to the stunting impact of trauma.
[31] Quadara & Hunter, 2016:40
[32] Campo et al., 2014:57
[33] Quadara & Hunter, 2016:40; Gimson & Trewhella, 2014:6
[34] Malchiodi, 2008:11
[35] Bunston, 2008:335
[36] Ibid. p.337
[37] Gimson & Trewhella, 2014:6
[38] Ibid.

Additionally, within mainstream children's therapeutic services, it has been documented that the outcomes of Indigenous children are smaller than that of non-Indigenous children.[39] Possible explanations include:

- Indigenous children may experience greater degrees of traumatisation (especially as a result of intergenerational trauma) thereby impeding recovery outcomes
- mainstream interventions may need to be further adapted to address the issues of this population, and
- the current indicators of assessment of outcomes may be dominated by western conceptions of recovery.[40]

A note on duration and intensity of the intervention

The duration and intensity of therapeutic interventions must be informed by the needs of the client. Therapeutic programs that are preventative, such as mother and child groups or school-based workshops, are not required to be intensive and may range from approximately three to 12 weeks.

On the other end of the spectrum, people who have experienced complex and intergenerational trauma need more intense, longer initiatives. These services may have their clients for eight weeks to four years.[41]

Clients must be engaged as long as necessary to reap the full benefits of therapy. Specific to Indigenous communities, a report undertaken in Canada suggests that holistic healing services may take up to three years to engage with a community, and it will take about 10 years for a safe environment to be created in which to deal with trauma.[42]

3. Types of Trauma-Informed Therapeutic Services for Children

An ACT Government examination of trauma-informed therapies for children noted the existence of the following common therapeutic interventions:

- Trauma-Focused Cognitive Behavioural Therapy
- Therapies address neural challenges such as Neurosequential Model of Therapeutics and Neurological Reparative Therapy
- Family counselling approaches including Dyadic Developmental Psychotherapy
- Developmental approaches including Marte Meo Model
- Intensive family focused approaches including Multisystemic Therapy
- Attachment/Parent-Child Focused Interventions
- Expressive/Sensory-Based Interventions and Therapies
- Life Story Work
- Relationship-Based Work.[43]

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[39] Frederico, Jackson, & Black, 2010:157; Fox et al, 2015: 99
[40] Frederico, Jackson & Black, 2010:157
[41] For example, Newpin aims to engage clients for 18 months, Holding Children Together for up to 44 weeks and Take Two has long-term models which may extend up to 4 years. (Uniting Care Burnside, 2013:2; Arney & Brooke, 2012:37; Frederico, Jackson, & Black, 2010:3)
[42] Aboriginal Healing Foundation, 2006 referenced in Healing Foundation, 2012:11;
[43] Gimson & Trewhella, 2014.

Memmott et al. have created a categorisation of program type according to what stage of violence they target.[44] The four classifications are: early proactive, late proactive, early reactive, and late reactive.[45]

As early proactive and late reactive programs target violence from occurring or reoccurring respectively, they are essentially preventative.[46] Whereas late proactive and early reactive programs, targeting those who are at high-risk of experiencing violence, or are experiencing/have just experienced violence respectively, are essentially interventionist.[47]

Trauma-Informed interventions may be implemented at each of these stages of violence but vary in what they involve to address the circumstance.

Early proactive therapeutic programs for children are likely to be educational such as school programs like the Berry Street Education Model. Late proactive programs that target high-risk children may include services such as mother/child groups, individual counselling, or parenting programs. Early reactive therapeutic children's programs may work in tandem with children's housing services and women's refuges, or provide other therapeutic services to support non-abusive parents/carers to create safe environments. Late reactive programs are concerned with dealing with traumas that have occurred and resolving its negative outcomes, these include most individual, family, or group therapies. The following sections help to elucidate the variety of services through examples. It must be noted that this distinction may be arbitrary in categorising services as many are fluid in their scope, but is helpful in showing the variety of responses to childhood trauma.

Early proactive therapeutic approaches

An example of an early proactive program is the Berry Street Education Model (BSEM). It was found in America that 40 per cent of students were trauma-affected due to exposure to a traumatic stressor.[48] Thus, there is a need for schools to be trauma-informed and provide therapeutic learning. The BSEM is comprised of three tiers of "therapeutic learning and growth".[49] The first focuses on repairing regulatory abilities, the second seeks to repair disrupted attachments, and the third increases the student's resiliency and resources for dealing with traumatic events.[50] This is implemented in two main ways:

- through informing the teacher's approach to their classes (garnered in intensive training), and
- offering specific classroom activities.[51]

This seeks to provide safe, trauma-informed environments to foster the growth of children and to build their capabilities, manage behaviours, and learn resiliency strategies.[52] The activities created for the program include physical and emotional regulation sessions involving:

- 'aligning the body'

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[44] Memmott et al., 2001:74-75
[45] Ibid.
[46] Memmott et al. 2006:3
[47] Ibid.
[48] Stokes & Turnbull, 2016:6
[49] Ibid.
[50] Ibid.
[51] Ibid. p.4
[52] Ibid. p.7

- identity building
- communication, and
- strategies for calming down and returning to a comfortable state.[53]

The BSEM was implemented as a pilot in 2015 in two mainstream government schools which deal with high levels of disadvantage, behavioural issues, and Child Protection notification.[54] Interviews with staff and students suggested that the program was helpful in giving teachers a range of strategies to deal with student disengagement and gave children the ability to overcome problems to focus on learning.[55] Within both school trials, negative incidents resulting in suspensions was decreased.[56] Overall, morale of students, teacher empathy, learning stimulation, confidence in learning, motivation, peer connectedness, behaviour, and student safety were improved.[57]

Late proactive therapies

Successful examples of late proactive therapies provide therapeutic support for children and offer opportunities for their parent or carer to engage in the process to create therapeutic environments.

PARKAS (Parents Accepting Responsibility Kids Are Safe) was a two-tier therapeutic service which ran from 1996 until 2010 in Victoria.[58] The program ran for ten weeks at a time and ran two parallel groups:

- one for the children aged eight to 12 years old, and
- one for their mothers or carers.[59]

The children's sessions would usually occur on a weekday afternoon for an hour and a half and the mother/carer session would occur the following day, usually in the morning for two hours.[60] In the middle of the program, the two groups were brought together to work on dyadic relationships and attachment.[61]

Both groups had a 'child-up' focus:

- the child group focuses on their needs and healing through play, music, and art and creation of safe spaces where they can process their trauma, and
- the parent groups discussed the needs of the child and understanding the child's experiences.[62]

The success of PARKAS led to the creation of Just For Kids (JFK) and Peek a Boo. JFK was created as a precursor to PARKAS as a way to engage children without their mothers, with the hope that the mother may become involved later on in the program.[63] Peek a Boo was created as an infant/mother intervention which targeted infants up to three years old.[64] Peek a Boo was seen as a necessary step to support

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[53] Ibid. This is not an extensive list of activities.
[54] Ibid. p.4
[55] Ibid. p.31, 34
[56] Ibid. p. 36
[57] Ibid. p.37
[58] Bunston, Pavlidis & Cartwright, 2016:86; Bunston, 2008:336
[59] Bunston, Pavlidis & Cartwright, 2016:86
[60] Bunston, 2008:337
[61] Ibid.
[62] Ibid. p.335; Bunston, Pavlidis & Cartwright, 2016:88
[63] Bunston, Pavlidis & Cartwright, 2016:86
[64] Bunston, 2008:338

the infant's neuro-psycho-physiology development.[65] The Peek a Boo program consisted of two hour sessions over eight weeks and was based off the PARKAS model. From all programs, mothers reported positive feedback on quality of attachment, reduced hostility, and more enjoyment of their relationship with their child/infant.[66]

Early reactive therapies

In America and Canada, ChildTrauma Academy has a number of residential service sites based on the Neurosequential Model of Therapeutics (NMT) which provide trauma-informed therapies for infants, children, and adolescents.[67]

NMT does not provide a set of interventions but provides an understanding for how interventions should occur.[68] NMT focuses on the developmental impact that trauma has on the brain and uses this understanding to inform intervention creation.[69] NMT suggests that where there is early exposure to violence and traumatic incidences, the formation of the brain is affected leading to impediments on basic psychological and arousal functions which in turn impact thoughts and feelings.[70] The impact to the sub-cortical parts of the brain through trauma are very difficult to access and change but must be targeted first to improve psychological arousal regulation before cognitive processes can be improved.[71] Thus, interventions following NMT focus on creating safe spaces and the capacity for a child to self-regulate from which a child can make sense of their traumatic experiences.[72]

For the six sites described by Taylor, children stay in the services for about six months to two years, with three of the services averaging 18 months.[73] While the children stay at the residences for long periods of time, families (whether biological, kin, or foster) are engaged with the care of the child through visits, family therapy sessions, staying over at the residence, and/or through internet services such as Skype.[74] Each of the residences also provided trauma-informed education services for the children.[75]

What is most notable about the ChildTrauma Academy sites is the range of therapies they offer. Most of the staff across the sites were trained in Cognitive Behavioural Therapy (CBT) and its trauma-focused counterpart (TF-CBT), play/art/creative therapy, and Therapeutic Crisis Intervention (TCI).[76] All sites implemented Eye Movement Desensitization and Reprocessing (EMDR); a psychotherapy which uses eye movement procedures to help process distressing memories.[77] In addition to these therapies, each location also offers different therapies. These included:

- Animal Assisted Therapy (with horses or dogs)
- sensorimotor therapy

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[65] Ibid.
[66] Ibid. p.340
[67] Taylor, 2014:4; Berry Street Take Two is also part of ChildTrauma Academy; See *Determine the Theoretical Underpinning* for more information on NMT
[68] Frederico, Jackson & Black, 2010:82
[69] Ibid.
[70] Ibid. p.84
[71] Ibid.
[72] Ibid.
[73] Taylor, 2014:5-6; Sites include: Sumner Mental Health, Sandhill Center, Cal Farley's Boy's Ranch, Alexander Youth Network, Mount Saint Vincent Home, & Hull Services
[74] Ibid. p.8
[75] Taylor, 2014:15
[76] Ibid. p. 7
[77] Ibid. p.8

- neurofeedback (which teaches control of brainwaves through the use of a mind controlled videogame)
- structured exercise
- relaxation training
- massage
- gardening
- journaling
- drumming
- adventure-based activities
- ropes courses
- occupational therapy
- sensory rooms/boxes, and
- brain breaks in the classroom.[78]

The key to successful interventions is the tailoring of the therapeutic approaches to the needs of the client and to match their development level.[79] For example, when dealing with adolescents, services tended toward teamwork and group programs and focus on sensory stimulation such as hands-on woodwork or mechanic workshops, cooking classes, drumming, creative therapies, and animal therapy with horses.[80] It is difficult to assess the outcomes of these programs as no evaluations have been undertaken by the six sites. However, the Australian ChildTrauma Academy site, Berry Street Take Two, has been evaluated and is discussed in the following section.

Late reactive therapies

Uniting's Newpin Restoration service aims to reunite children under five who have been in care with their families.[81] Newpin is based upon attachment theories.[82] Thus, significant focus of the intervention is on helping parents to resolve their own attachment issues and teaching them how to provide nurturing care for their children.[83] It is the creation of a therapeutic environment, healthy attachment, as well as child/parent play that healing for the child can occur. Parents attend the program up to nine months before restoration and continue to attend for another nine months after restoration.[84] The program offers parents therapeutic support groups, a structured personal development program to learn parenting skills, home visits, and a partner parenting group.[85] The knowledge and skills gained from this component of the program is integrated into the home environment.[86] For the child, contact is kept with the parent and visits are created at the Newpin centre. When the child is restored to the family, the child and parent participate in therapeutic play to build the dyadic relationship and attachment, and is monitored by Newpin staff.[87] Parents must attend the service twice a week for the duration of the program and children minimum once a week.[88]

Therapies for Indigenous children

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[78] Ibid. p.8-10
[79] Ibid. p.16
[80] Ibid.
[81] Uniting Care Burnside, 2013:2
[82] Rosen, 2015:45
[83] Ibid.
[84] Uniting Care Burnside, 2013:3
[85] Ibid. p.4, 8-9
[86] Ibid. p.3
[87] Ibid.
[88] Ibid.

Each of the aforementioned therapeutic services are mainstream services which do not cater specifically to the needs of Indigenous people.[89] Most programs have a dyadic element which may not accommodate the kinship and wider family attachments that children may have within Indigenous communities.[90] Additionally, the lack of evaluation of services or lack of disaggregation of Indigenous outcomes clouds the level of success that is achieved by the programs. In other mainstream services where Indigenous outcomes are given in evaluations, it has been found that outcomes are not as significant as their non-Indigenous counterparts.[91] The possible reasons for this are that Indigenous children may experience multiple types and greater degrees of trauma which impacts their recovery and/or indicators may have a western-centric focus.[92]

Dr Judy Atkinson, a leading academic in the area of healing and trauma-informed care for Indigenous Australians, suggests that some trauma-informed therapies such as narrative, sand play, art and music are useful starting points for engaging Indigenous children.[93] In a study on trauma-informed care and services for Indigenous children, Dr Atkinson concludes that interventions – to be effective for Indigenous children – should:

- be grounded in the 'richness of the child's cultural and spiritual identity'[94].
- recognise Indigenous worldviews, and
- acknowledge that trauma for some Indigenous children can be intergenerational stemming from colonisation and dispossession.

4. What trauma-informed therapies can achieve

It is important to note that few of the interventions outlined above have been evaluated and even less have been examined by way of experimental study. Nowithstanding the dearth of evaluative evidence, a recent examination of trauma-informed therapies for children by the Australian Centre for Posttraumatic Mental Health and the Parenting Research Centre, found the most effective intervention to be TF-CBT.[95]

A review of seven studies of TF-CBTs, four being randomised controlled trials, found the intervention resulted in positive gains at 12 months after completion of the therapy in the areas of:

- Child Post Traumatic Stress Disorder
- Child-abuse-related shame
- Child dissociation, and
- Parent distress.[96]

A survey of practitioners conducted as part of the same study found that other outcomes achieved by this therapy include:

- increased parenting confidence
- improved child relationships

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[89] Except Berry Street Take Two which is discussed later
[90] McClung, 2007:7
[91] Frederico, Jackson, & Black, 2010:157; Fox et al, 2015: 99
[92] Frederico, Jackson & Black, 2010:157
[93] Atkinson, 2013.
[94] Atkinson, 2013.
[95] Australian Centre for Posttraumatic Mental Health (2014).
[96] Australian Centre for Posttraumatic Mental Health (2014).

- increased child engagement in school / education, and
- improved child behaviour.[97]

The same study found that other interventions – parent/child attachment, developmental approaches, intensive family-focused therapies – had some effect in improving outcomes for children. These include:

- reduced behavioural problems
- reduced aggression
- reduced mental health symptoms
- reduced out of home care placements.

It should be noted that the study found that Multisystemic Therapy resulted in all of the above outcomes while other interventions based on attachment and development theory achieved only one of the outcomes outlined above.

5. Examples of effective trauma-informed interventions for children

Trauma-Focused Cognitive Behavioural Therapy

As noted above, studies indicate that Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is the most effective trauma-informed intervention for children. TF-CBT combines elements from:

- cognitive therapy i.e. changing behaviours by addressing unhelpful thought patterns
- behavioural therapy i.e. changing habitual responses, and
- family therapy i.e. identifying and alleviating patterns of negative interactions between family members.[98]

Unlike other interventions, TF-CBT is short in duration being provided over 12 to 18 sessions of between 50 to 90 minutes each. Treatment involves:

- Individual sessions for the child and for the non-abusing parent. These are designed to 'build a therapeutic relationship' while providing skills and a safe environment for processing memories of trauma. The parent component teaches stress management, parenting and behaviour management, and communication skills. [99]
- Joint sessions with child and non-abusing parent together. These are designed to help parent and child practice their newly acquired skills in a safe environment. The child is also encouraged to share their 'trauma narrative'. This sharing fosters effective communication between parent and child around issues of abuse and violence.[100]

TF-CBT is framed around the eight components of:[101]

- Psychoeducation and parenting skills which educates parents about trauma, its effects and how to discuss these issues with their child.
- Relaxation techniques for both parent and child including deep breathing, muscle relaxation and visualisation.

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[97] Ibid.
[98] https://www.childwelfare.gov/pubPDFs/trauma.pdf#page=2&view=Features of TF-CBT
[99] Ibid.
[100] https://www.childwelfare.gov/pubPDFs/trauma.pdf#page=2&view=Features of TF-CBT
[101] https://www.childwelfare.gov/pubPDFs/trauma.pdf#page=2&view=Features of TF-CBT

- Affective expression and regulation to assist both parent and child to manage their emotions when triggered and develop self-soothing strategies.
- Cognitive coping and processing which involves changing negative behaviours by changing unhealthy thought patterns.
- Trauma narrative and processing which involves the child gradually sharing their story of trauma through verbal, written or symbolic accounts.
- In vivo exposure which involves gradually exposing the child to trauma reminders so they learn to control their emotional reactions.
- Conjoint parent / child sessions involves the child sharing their trauma narrative with their parent in a supportive therapeutic environment.
- Enhancing personal safety and future growth assists the child to develop healthy interpersonal skills.

The protocols for TF-CBT state that it may not be appropriate for use with children / adolescents:

- with serious conduct problems unrelated to the trauma
- who are acutely suicidal, or
- who actively misuse substances.[102]

Children-Specific Therapy: Holding Children Together

Holding Children Together is a therapeutic service launched in Alice Springs in 2012 by Relationships Australia Northern Territory (RANT) in partnership with the Australian Childhood Foundation (ACF). The service targets children between 5 and 12 years old who have experienced trauma, abuse and neglect.[103] Community consultation directed the creation of the service for this group as a gap in services had been identified.[104] The service provides therapeutic services to children and established a Community Therapeutic Team (CTT).[105] The CTT utilizes existing service networks by borrowing counsellors from other services to help with Holding Children Together, thereby overcoming the scarcity of practitioners.[106] Each member of the CTT commits to taking on at least one child to help with the caseload.[107] Additionally, an Aboriginal Advisory Group was created to inform the services as the vast majority of clients were Aboriginal.[108] The program has been extensively evaluated and resulted in marked improvements in child behaviours.[109]

The success of Holding Children Together relies upon the ability of the service to create a holistic therapeutic approach around the child through direct services and through the creation of therapeutic environments. Generally, at least an hour a week was spent on therapy with the child.[110] An emphasis was placed upon being flexible with services around the needs of the child.[111] Thus, the time could have been spent in the counselling room, playground, or school classroom.[112] A range of activities are

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[102] https://www.childwelfare.gov/pubPDFs/trauma.pdf#page=2&view=Features of TF-CBT
[103] Arney & Brooke, 2012:2,11
[104] Ibid. p.11
[105] Ibid.
[106] Ibid. p.2 & 11
[107] Ibid. p. 11
[108] Ibid. p.17; 90% of clients were Aboriginal as of June 2012.
[109] Ibid. p.3
[110] Ibid. p.18
[111] Ibid.
[112] Ibid.

also included such as sand play and somatic techniques.[113] Outside of these sessions, practitioners engage with schools, caretakers, peers, and family members to create a therapeutic environment for the child. Practitioners worked with teachers to develop their strategies at dealing with and supporting the child, as well as supporting the teacher.[114] Broader training events were also conducted in schools to help teachers learn about trauma and its impacts on students.[115] The practitioner would also assist with transportation of the child to and from school to increase their school attendance.[116] Engagement with schools created a stable meeting point where a child's home life was inconsistent.[117] Holding Children Together also focused on creating a safe home environment by creating supporting strategies with the families and peers.[118]

Mainstream Services for Indigenous Children: 'Take Two' Berry Street

Berry Street is a mainstream service provider in Victoria, which has experience in therapeutic services ranging from school engagement (Berry Street Education Model), to home-based care and foster care, and to mother and child playgroups.[119] One of their most successful services has been Take Two.[120] The Take Two service provides intensive therapy in tandem with facilitation of safe and healthy relationships for children, ranging from newborns to those verging on adulthood, who are protection clients.[121] Take Two does not have a manualised therapy guide, instead emphasising the need to be flexible around the needs of clients.[122] Thus, therapies may be individual or with carers/family and include a range of, but not limited to, play with a range of toys and puppets on which the feelings of the child can be projected, drawing and creative activities, sensorimotor interventions, incorporating animals, and psychoeducational activities.[123] To help foster healthy relationships and environments for recovery, Take Two has created 'care teams' – which include the case manager, therapist, carer, and any additional supportive people in the child's life – which meet regularly to support the needs of the child.[124] Take Two also offers support, therapy, and strategies to other member of the child's life like peers and teachers to help promote safe environments for healing. The service has seen a reduction of trauma-related symptoms such as depression, anxiety, anger, and posttraumatic stress symptoms in its clients.[125] Unfortunately, Indigenous and adolescent clients have seen less improvement than their younger and non-Indigenous counterparts.[126] Thus, whilst Take Two is trying to adapt to the needs of Indigenous children, more research needs to be conducted to establish best-practice.

As a mainstream service provider, it has invested significant resources to implement strong cultural practices for its Indigenous clients.[127] This has seen the creation of an 'Aboriginal team' to provide clinical work, research and program development

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[113] Ibid.
[114] Ibid.
[115] Ibid. p.20
[116] Ibid. p.18
[117] Ibid. p.19
[118] Ibid.
[119] McClung, 2007:22-3; Morris et al, 2013:38; Stokes and Turnbull, 2016
[120] Atkinson, 2013:10
[121] Frederico, Jackson, & Black, 2010:xxiii-xxiv, xxi; Youngest client in study was 6 weeks
[122] Ibid. p. 91
[123] Berry Street, 2016:32; Frederico, Jackson, & Black, 2010:94-99
[124] Frederico, Jackson, & Black, 2010:85
[125] Frederico, Jackson, & Black, 2010:120,124
[126] Ibid. p.157. See above, *Children's Trauma-Informed Therapeutic Services.*
[127] Ibid. p. xxiii

including the development of Indigenous assessment tool, and training (such as Yarning up on Trauma).[128] The assessment tool helps to measure an Indigenous child's connection to culture, history, identity, and community.[129] The tool was created to help provide a holistic understanding of a child's social and emotional wellbeing.[130] Main findings from the assessment tool were that when an Indigenous child is placed with a family member, it does not guarantee that they are connected to their culture or community.[131] The same lack of connection to culture and community applies to those under the care of non-Indigenous people. However, where a child was placed with an Indigenous carer, they were significantly more likely to have a connection to their culture, history, and community.[132] Take Two has also become partners with the Victorian Aboriginal Child Care Agency (VACCA) to help inform the service.[133] Berry Street acknowledges that non-Indigenous organisations cannot address the multi-layered needs of Indigenous children without partnership with Indigenous communities.[134] The Take Two program also facilitates the involvement of Indigenous communities and Elders within the recovery process.[135]

5. Implications for the design of trauma-informed therapeutic interventions for children

The literature findings highlight a number of implications for the design of trauma-informed therapeutic interventions for the purposes of the family violence service co-design project. Framed as possible design parameters for future trauma-informed interventions for children, these implications are:

1. *Preference for TF-CBT*. As the most effective intervention, TF-CBT must be explored as a credible program for Indigenous children and their parents.
2. *Dosage depends on the intervention*. If TF-CBT is used, the dosage is more intense but shorter in duration. While other interventions require more or less intensity over a longer period.
3. *Trauma includes intergenerational trauma and its impacts*. Trauma therapies for Indigenous children must acknowledge and understand the ongoing impacts of colonisation and dispossession and how these continue to play out in some communities and families by way of violence and poor parenting.
4. *Therapies need to be culturally enriched*. The type of therapy used (i.e. narrative, play, art) should be reflective of an Indigenous child's cultural and spiritual heritage.
5. *Community and family focus*. Interventions must support the child as well as their parents and extended family network.
6. *Service integration.* The therapeutic intervention is offered as part of a broader wrap around system of support for the child and their family.

[128] Atkinson, 2013:10
[129] Frederico, Jackson, & Black, 2010:63
[130] Ibid.
[131] Ibid. p.xxiii
[132] Ibid. p.xxiii
[133] Ibid. p.xxiii
[134] Ibid. p.59
[135] Ibid. p.81

Appendix A: Principles of Trauma-Informed Care and Therapeutic Services

Understanding Trauma and Its Impact

Understanding trauma is the central tenant of the framework and underpins all the principles set out in this section. This involves recognising that clients may present with challenging behaviours which may be symptomatic of adaptive responses to trauma.[136] Trauma-informed practitioners must use their understandings of trauma to overcome the client's apprehension of services and make it easy as possible for them to access services. By understanding trauma, practitioner's may help to validate a victim's experience of trauma and its impacts. When a service does not understand trauma or its impact, it is "the equivalent of denying the existence and significance of trauma".[137]

Cultural Competency

Cultural competency should be the foundation for services that work across cultures. It involves establishing attitudes, policies and behaviours which acknowledge culture, seeks to understand the different dynamics between people of diverse backgrounds, adapts to meet cultural needs and incorporates them, and is inquisitive of diversity.[138] All interventions under this framework are conscious of shared histories, are respectful, and specific to culture.[139] To be culturally competent, an organisation must take on the framework at all levels including its board, management, staff and services.

Safety

A core belief of trauma-informed care is that recovery cannot occur while a victim is physically or emotionally unsafe. A key task of a provider is to identify the sources of trauma and to ensure that the client is out of the way of ongoing harm.[140] This involves identifying strategies to remove the client from harm and to create a safe environment where healing can occur.[141] To create this environment, workers must be consistent, transparent and respectful in their responses to ensure that clients feel physically, culturally and emotionally safe.[142][143][144]

Supporting Consumer Control, Choice & Autonomy

For trauma-informed therapeutic services to be effective, they need to establish client control and autonomy so that the client feels strengthened and competent at the end of the program. Control over services and their treatment helps a client to regain a sense of control over their lives and decisions, and rebuild their sense of autonomy.[145] This involves providing opportunities for clients to be engaged with all aspects of the service, to be in charge of decisions and to collaborate in goal setting. Services need to collaborate with clients on their treatment and need to keep the client informed of any changes;[146] allowing the client to choose their treatment can be

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[136] Hopper, Bassuk & Ollivet, 2010:81; MHCC, 2013:10
[137] Elliot et al., 2005:462
[138] Whaley & Davis, 2007:564; Aboriginal Cultural Competence Framework, 2008:23 cited in Lumby & Farrelly, 2009:4
[139] Bateman, Henderson, & Kezelman, 2013:10
[140] Jackson et al., 2013:19
[141] Hopper, Bassuk, & Olivet, 2010:81; Atkinson, 2012:22
[142] Bateman, Henderson, & Kezelman, 2013:10
[143] Jackson et al., 2013:19
[144] Lumby and Farrelly, 2009:11
[145] Bateman, Henderson, & Kezelman, 2013:10; Atkinson, 2012:33
[146] Atkinson, 2012:33

very empowering.[147] A key element to success is creation of 'predictable environments' where clients know what to expect and have control over the space.[148] One helpful aspect may be outlining what the service can provide and setting out with clients what is expected from the service and from them. Though anecdotal evidence, it has been reported by Maari Maa Health that when they set out behavioural expectations for their community members they found reductions in aggression and threats.[149]

Sharing Power and Governance

Within the trauma-informed framework, sharing power and governance refers to equalising power differential through the promotion of democracy within the organisational structures, allowing those at all levels of the organisation to contribute to decision making and review of policies and procedures, and recruiting those with lived-experiences onto the board.[150] Being community owned and controlled is one key element of effectively addressing family violence within Indigenous communities.[151]

Integrating Care

As mentioned in the section on *Safety*, clients benefit when services are integrated and provide a holistic response to their needs. Under the common understanding of trauma-informed care, services need to be brought together to provide support for all facets of the individual whether emotional, physical, spiritual, social, or cultural.[152] Currently, spiritual and cultural elements of a person's wellbeing have been considerably overlooked by mainstream services but are necessary for a holistic approach to recovery from trauma. [153] It is only through bridging the gap between services and providing an integrated approach that the complex needs of clients can be addressed. Many women presenting to family violence services will also experience homelessness, substance abuse, and mental health problems.[154] Services must be integrated to improve the client's prospects for recovery.

Healing Happens in Relationships

Creation of authentic relationships aids healing and recovery of trauma survivors by restoring core neural pathways.[155] The creation of a 'therapeutic alliance' between a client and practitioner is a necessary step for successful client outcomes.[156] The relationship between a client and practitioner may initially be strained and difficult to enter into due to the client's experience of abusive or untrustworthy authority figures.[157] However, this relationship is crucial not only for addressing issues that the client is currently experiencing, but also for allowing them to feel safe to deal with past traumas.[158] The connection can "provide a corrective emotional experience" for the client.[159] Once trust is gained, a practitioner can best guide their client and speak

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[147] Hopper, Bassuk, & Olivet, 2010:82
[148] Ibid.
[149] Grealy, Milward & Farmer, 2015:35
[150] Bateman, Henderson, & Kezelman, 2013:11; Atkinson, 2012:33; Procter et al., 2017:18
[151] Memmott et al, 2006:8
[152] Atkinson, 2012:33; McEwan et al., 2008:3
[153] McEwan et al., 2008:3
[154] Bateman, Henderson, & Kezelman, 2013:16
[155] Atkinson, 2012:33; MHCC, 2013:11
[156] Knight, 2014:27
[157] Ibid. p.26
[158] Ibid. p.25
[159] Ibid. p.27

honestly and openly about a client's vulnerabilities.[160] Additionally, peer-to-peer relationships may be facilitated to help create networks of support for the client.

Strength-Based Approach

Rather than focusing on the negative behaviours and aspects of a client, this approach seeks to identify their strengths and develop healthy coping skills which align with their capabilities.[161] This means orientating the therapies to be future-focused and involve skill building exercises for increasing resiliency.[162] Therapies which have multiple components that play to the different strengths of clients are likely to be successful.[163]

[160] Wendt & Baker, 2013:519; Stirling et al., 2012:6
[161] Atkinson, 2012:33
[162] Hopper, Bassuk & Olivet, 2010:82
[163] Munro, 2012:4

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