"A deep wound under my heart":
Constructions of complex trauma and implications for women's wellbeing and safety from violence

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ΛNRØWS

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List of abbreviations

AOD	Alcohol and other drugs
CALD	Culturally and linguistically diverse
CBT	Cognitive Behavioural Therapy
CDCP	Child Development–Community Policing
CF	Compassion fatigue
CM	Child maltreatment
CPA	Child physical assault
CS	Compassion satisfaction
cPTSD	Complex post-traumatic stress disorder
CSA	Child sexual assault
DID	Dissociative identity disorder
D-PTSD	Post-traumatic stress disorder dissociative subtype
DSM-5	Diagnostic and Statistical Manual of Mental Disorders (5th edition)
EMDR	Eye Movement Desensitisation and Reprocessing
ICD-11	International Classification of Diseases (11th revision)
IPV	Intimate partner violence
PTSD	Post-traumatic stress disorder
STS	Secondary traumatic stress
TIC	Trauma-informed care
VPTG	Vicarious post-traumatic growth
VR	Vicarious resilience
VT	Vicarious traumatisation

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Executive summary

Women with experiences of complex trauma are a significant but overlooked group of victims and survivors of gender-based violence in Australia. Complex trauma refers to multiple, repeated forms of interpersonal victimisation and the resulting traumatic health problems and psychosocial challenges. In Australia, one quarter of women subject to gendered violence report at least three different forms of interpersonal victimisation in their lifetime, such as child sexual abuse, domestic violence, sexual assault and stalking (Rees et al., 2011). This group has a high level of healthcare utilisation linked to mental illness, suicidality and substance abuse. They are in frequent contact with crisis services and police due to domestic violence and sexual assault, with some women reporting extreme forms of gender-based violence that fall outside existing policy frameworks (Middleton, 2013; Salter, 2017). The health and safety needs of women with experiences of complex trauma are interlinked, since poor health and unmet need can increase their risk of victimisation, while ongoing victimisation compounds trauma-related mental illness (Salter, 2017).

The relationship between complex trauma, mental illness and violence unfolds in diverse ways according to women's social position, lived experience and geographical location. Experiences of complex trauma are not well recognised across mental health practice or related fields, leading to inconsistent, inappropriate and sometimes re-victimising treatment. Complex trauma is a contested area in which the medical model of mental illness, and the widespread stigmatisation of distressed women as "hysterical", malingering or simply "mad" (Ussher, 2011), is in conflict with trauma-informed paradigms of support and treatment (Herman, 1992). This conflict is evident in the unpredictable responses faced by women with experiences of complex trauma in a range of settings. At the policy level, complex trauma overlaps with frameworks on violence against women and mental health. However, the impact of complex trauma is not comprehensively addressed by these frameworks, and this contributes to the fragmented response to women in distress.

Responses to women who have experienced complex trauma need to be sensitive, coordinated and consistent between services and agencies to ensure women's wellbeing and safety from violence. However, the development of shared frameworks of practice for addressing complex trauma has been forestalled by a lack of professional consensus and understanding. There is a need for holistic research into "best practice" responses to address complex trauma that place the needs and understandings of diverse women at the centre. This project sought to develop a comprehensive picture of how complex trauma is being constructed in public policy and practice and by women with experiences of complex trauma.

Research question and aims

The guiding question of the study is, "How can agencies and services improve collaboration to meet the health and safety needs of women with experiences of complex trauma?" This question informs four key aims:

1. Analyse how complex trauma experienced by women is constructed in public policy at a national, state and territory level.

2. Examine institutional responses to women's complex trauma in the mental health, alcohol and other drugs (AOD) and sexual assault/domestic violence sectors in New South Wales and Queensland.

3. Document how women with experiences of complex trauma understand complex trauma, and their experiences and encounters with agencies while seeking help.

4. Develop models of improved and collaborative responses to enhance the wellbeing and safety of women with experiences of complex trauma and their children.

Methodology

The project took a psychosocial approach to complex trauma, which recognises that traumatisation is a process that occurs via the interaction of psychological, social and systemic factors. Psychosocial theory makes use of select psychoanalytic and sociological approaches in conceptualising women's adaptations to conditions of violence and inequality (Frosh, 2003). We also draw on feminist understandings of the concept of "complex trauma", which lie in feminist clinical practice and theorisation of the unique impacts of gendered oppression across the lifespan (Herman, 1992; Warner,

2009). This psychosocial framework is complementary to the prevailing social–ecological model of gendered violence, which recognises that risk and protective factors for violence exist at the individual, relational, community and systemic levels (Our Watch, Australia's National Resesarch Organisation for Women's Safety [ANROWS], & VicHealth, 2015), as well as intersectional perspectives, in which categories such as gender, race and class intersect in dynamic ways that shape women's experiences and responses to violence.

This was a multi-method study that combined policy and service analysis with qualitative research with women with experiences of complex trauma and the professionals who work with them, via:

- a policy audit of approaches to complex trauma
- service documentary analysis and qualitative interviews with 63 professionals in Queensland and New South Wales
- qualitative interviews with 40 women with experiences of complex trauma in Queensland and New South Wales
- seven online workshops in which professional stakeholders and women with experiences of complex trauma provided feedback on the findings of the study.

The implementation of the project methodology and the findings of the study were also informed by a project advisory group. Online meetings were scheduled with the advisory group three times during the course of the project, with the initial meeting focused on identification of key services and recruitment, the second meeting held to discuss the progress of the study and initial findings, and the final meeting to review key policy and practice recommendations. The project team was also in contact with advisory group members via email and one-to-one meetings to discuss specific challenges or questions as they arose.

Key findings

Policy review

The review found that references to complex trauma in public policy are typically brief and undefined. In policy documentation, the term "complex trauma" is frequently used interchangeably with "trauma", "cumulative harm", "childhood trauma", "early onset trauma", "significant trauma" and "severe trauma". Frameworks and documents pertaining to "trauma-informed care" are often implicitly focused on the impact of complex trauma, although this is not acknowledged. Relevant psychiatric diagnoses such as "complex post-traumatic stress disorder", "personality disorder" and the dissociative disorders are referred to rarely in policy frameworks. However, "intergenerational trauma" and related terms such as "transgenerational trauma" feature prominently in Aboriginal and Torres Strait Islander policy frameworks and documents, recognising the ongoing effects of invasion, the Stolen Generations, disadvantage and racism.

The lack of shared terminology and understanding of complex trauma raises questions about the adequacy of current policy frameworks to address the multiple needs of people with experiences of complex trauma and the effects that varying understandings of the long-term impact of complex trauma may have on program and service delivery. While an apparent increase in services and programs engaging with complex trauma and trauma-informed practice is promising, the review suggests that these efforts are currently piecemeal and in need of systemic guidance and coordination.

Understandings of trauma and complex trauma among women and professionals

In interviews with women with experiences of complex trauma and healthcare workers working in this sphere, the distinction between trauma and complex trauma appeared to be a matter of degrees. The complexity of trauma was placed on a continuum from comparatively simple and short-lived to more complex and enduring. Women indicated that the vocabulary of "trauma" can assist them in articulating difficult experiences but can also pathologise and individualise reasonable responses to overwhelming situations. Women's descriptions of trauma impacts were more likely to focus on the somatic and psychosocial implications of complex trauma, whereas workers framed responses to complex trauma as primarily a psychological problem. Women's links with their children and grandchildren are a strong motivator to seek treatment, however they did not always feel that they had been supported in their parenting and caring responsibilities. Women were astute in the identification and self-management

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of their distress related to experiencing complex trauma over time and described a wide range of self-care and coping strategies. The findings of Chapter 5 and 6 suggest that women with experiences of complex trauma would benefit from a more holistic treatment paradigm, and one that builds on the considerable strengths and skills that they have developed in the self-management of complex trauma.

Interactions with the service system

Women with experiences of complex trauma typically have multiple needs, however, the majority of services are funded to address a particular issue or concern. As a result, women with experiences of complex trauma typically needed to navigate multiple services and agencies in order to have their needs meet. Service systems and agencies can place unrealistic expectations on women with experiences of complex trauma to understand and navigate the (formal and informal) rules governing each service system, often simultaneously, and often while the woman is in crisis. A lack of support and early intervention options predictably escalated women's needs until they presented in crisis, at which point they were vulnerable to being dismissed as "crazy" and unstable. Self-harm and suicidality are particularly stigmatised in service settings and can attract punitive and dehumanising responses from professionals. Women with experiences of complex trauma frequently encountered sexist and disparaging views about women's mental health, encapsulated in the common stereotype of the "crazy woman".

Connecting with a trauma-informed professional service is typically a matter of luck or perseverance on behalf of women, and where they received a supportive or effective response in one context, this level of care was often not maintained across their other encounters with services and agencies. Women diagnosed with a dissociative disorder and/or with exposure to extreme trauma, including prolonged sexual abuse, enslavement and trafficking, experienced particular challenges in accessing specialist services and effective responses. The process of the service response is crucial for women who have experienced complex trauma: how women are treated, and the way that they feel about the response, is just as important as the outcome. Both women with experiences of complex trauma and healthcare professionals pointed to models of holistic, wrap-around and place-based service provision that aims to meet the multiple impacts of complex trauma as a blueprint for best practice, including specialist providers in community health, women's health, sexual assault, community legal practice and the refugee sector.

Key findings in relation to specific sectors are summarised below.

Health settings
- Women with experiences of complex trauma attract a range of psychiatric labels that do not result in referral to effective treatment, but instead pathologise women as difficult and non-compliant.
- A public-health focus on highly time-limited, contractual care is an obstacle to the safety and wellbeing of women with experiences of complex trauma.
- There is currently a lack of trauma-specialised services and professionals, and women's experiences of health care are typically segmented and uncoordinated.

Criminal justice
- Successful criminal justice outcomes for women with experiences of complex trauma are rare. All women interviewed for the study had been extensively victimised, however no woman reported that the full extent of her victimisation had been prosecuted in the criminal justice system.
- Women and workers felt that police and prosecutorial decisions about women with experiences of complex trauma are not transparent or accountable.
- Initial assessments and informal judgements by police have a significant impact on women with experiences of complex trauma and their access to justice.

Child protection services
- Workers and women report that the child protection system's understanding of trauma-informed practice differs considerably from other service sectors.
- There is widespread concern that the impact of trauma on parenting is not being addressed in the child protection system, resulting in late and punitive interventions.

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Family law

- In family law matters, women are frequently not believed or supported when reporting abuse by an ex-partner and are often worse off financially and psychologically for their contact with the legal process.

Best practice in complex trauma services

A picture of best practice in service provision for people with experience of complex trauma emerged from interviews with women and professionals. Interviewees emphasised the effectiveness of community-based and community-controlled services that are sensitive to the local needs, contexts and histories of their client group. This model of service provision was not limited to health services but included child protection, family support, legal and other areas of work. Ideally, these services should be embedded within a broader network of services that foster mutual learning, partnerships and referrals of clients where necessary. To ensure cultural safety, strength and accessibility, it was broadly seen as important that therapeutic activities were culturally grounded and appropriate, with the provision of well supported, trauma-informed interpreters where necessary. Key points of best practice are outlined below.

- *No wrong door with "soft" and low entry points:* Women who present with experiences of complex trauma should be able to enter into health, legal and other systems through multiple pathways that are supportive and helpful, with low or no barriers to entry.

- *Focus on self-determination and recovery:* The explicit task of services and agencies should be to support the client to be self-determining, autonomous and thriving.

- *Safety first:* Women's safety needs are assessed and addressed, including safety from perpetrators and their housing and security needs. The service also needs to feel safe for women, including in its physical design and culture of clear boundaries.

- *Flexibility:* Within those clear boundaries, services are flexible and able to accommodate the needs of women with experiences of complex trauma, which may include difficulties attending sessions or after-hours crises.

- *Continuity and predictability of care:* Women are able to establish a connection and safe relationship with a key staff member that endures over time, and decisions about the woman's care are ultimately made with the woman.

- *A "whole of life", "whole of person" perspective:* Current presentation and need is framed by a holistic view of women's experiences and selves that addresses how women's histories influence their expectations and interactions with the service.

- *Stepped care within services:* Women receive more intensive care when/if their needs escalate and are referred back to lower threshold care when stabilised (i.e. retained in care rather than being dropped out of treatment because they are no longer "acute"). Stepped care should be available within services where possible, or else through close collaborations between services.

- *Multi-disciplinary teams offering multiple modalities of treatment:* Services address physical, psychosocial and mental health needs as well as practical life challenges, incorporating cultural knowledge and expertise where necessary.

- *Psychoeducation:* Women have the opportunity to learn about the impact of trauma on their life.

- *Welcoming physical environments, including spaces for recovery after treatment:* Women are often disorientated after trauma-related service, and it may not be safe for them to travel, hence it is important that the physical environments of services are welcoming and can provide rest spaces.

- *Case management and advocacy:* Clients are supported to navigate complex and challenging systems, including police and the National Disability Insurance Scheme (NDIS).

- *Supporting parenting:* Services can accommodate parenting and also promote good parenting as part of the service.

- *Practical accommodation of clients' needs:* Services have brokerage or provisions in place to address women's problems with childcare and transport.

- *Investment in staff care, support and vicarious trauma prevention and the promotion of vicarious resilience:* A

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culture of care should be evident among and between workers and extended to clients.

The risks and benefits of working with clients with experiences of complex trauma

There are parallels between the processes that result in experiences of complex trauma and those that produce vicarious or secondary trauma in professionals who work with survivors of complex traumatic events. Risk factors for experiencing vicarious trauma exist at the individual, workplace and systems levels, and can produce trauma-related cognitive changes and secondary traumatic stress in workers. There is considerable evidence for effective vicarious trauma prevention at the individual and workplace level. In this study, workers described experiencing significant benefits, including growth in personal strength and resilience, as a result of working with people who have experienced complex trauma.

Mainstreaming complex trauma work will require workers and workplaces to adopt active vicarious trauma prevention strategies. It is likely that services that are not trauma-informed in their approach to clients are also not trauma-informed in their approach to their employees. Formal vicarious trauma prevention and management frameworks are critically important, and ideally foster informal workplace cultures of debriefing and mutual support that are optimal for worker health and wellbeing. Workplaces have a key role in promoting and building upon these benefits.

Strengths and limitations of the study

The focus of the study was on the narratives and understandings of women with experience of complex trauma and the professionals who work with them. The study foregrounded the voices of women and professionals at the frontline of the response to complex trauma, drew on their insights and expertise to recommend improvements to policy and practice, and demonstrated how patterns of disadvantage as well as dignity and resilience can be reproduced through multiple systems and services. However, the study has a number of key limitations. The policy review was limited to publicly available information that could be ascertained via website searches

and so the research team could not gather information on policy documentation and approaches unavailable on public-facing websites. The interviewees were self-selecting, which produced a cohort of a) women who all spoke English and were predominantly (although not exclusively) heterosexual, cisgendered Anglo–Australians; and b) professionals who were highly trauma-literate. There is a need for further research into broader cohorts of women who have experienced complex trauma, as well as with professionals who are unfamiliar with trauma-informed practice.

Recommendations

Domain-specific recommendations

Public policy

- Prevent and reduce the intergenerational impact of childhood trauma via:
  - pre- and post-natal care and screening for abuse and violence
  - trauma-informed parental and family support programs
  - early intervention for boys and girls exposed to trauma.
- Embed trauma-informed care within a holistic wellbeing framework that integrates mental, physical and psychosocial wellbeing.
- Improve access to comprehensive treatment for complex trauma under current policy arrangements, including Medicare and the NDIS, to minimise short-term and disjointed interventions and treatment.
- Implement acute intervention services for women being domestically trafficked, exploited and enslaved.
- Ensure sustained and long-term funding for specialist trauma programs and services.

Health

- Integrate trauma care into health and medical training, covering psychological, physical and behavioural impacts and implications for professionals interacting with clients.
- Implement protocols for the compassionate treatment of

self-harming individuals in a range of settings, including emergency departments.

- Ensure clear pathways for clients impacted by complex trauma to effective care, with "warm referrals" and collaboration between services.

- Mainstream the acknowledgement and treatment of comorbidity in mental health and AOD settings and address barriers to comprehensive mental health/substance abuse treatment.

- Invest in vicarious trauma and burnout prevention among health staff and actively promote and foster salutogenic effects through service design and culture.

- Build and promote trauma-informed cultures within and between health services through an explicit focus on identifying and meeting clients' needs, and promote the recovery, resilience and autonomy of people with experiences of complex trauma.

Mental health

- Implement mental health workforce planning to ensure that professionals have the skills to meet demand for services in complex trauma and dissociation.

- Provide outpatient and inpatient complex trauma and dissociation care.

- Reform tertiary education and accreditation for psychiatrists and clinical psychologists. Curricula should:
  - discuss the roles of trauma and complex trauma in mental illness and distress
  - provide an overview of available treatment modalities
  - address the mental, physical and psychosocial dimensions of trauma
  - include the dissociative disorders
  - destigmatise emotional dysregulation, psychosocial difficulties and other issues categorised as "borderline".

- Develop and implement non-traumatising models of involuntary care.

- Develop a network of trauma-informed professionals and services.

Law enforcement and prosecution

- Implement trauma-informed policing: all police need training in trauma and complex trauma presentations.

- Promote partnership models where police attend mental health incidents with allied health.

- Implement intelligence-based policing: violence and abuse can be very complex and require careful police work.

- Implement trauma-informed prosecution, including continuity of contact and care in a case from a trusted individual, with careful handover from police to prosecution, and from lawyer to lawyer.

Child protection services

- Conduct further research on the experience of women who have experienced complex trauma as parents in the child protection system. Key issues flagged in this study include:
  - questions about whether assessments of parenting reflect current knowledge and practice on trauma and attachment
  - a lack of access to non-stigmatising early intervention and family support services.

Improving interagency collaboration

- Encourage whole-of-government commitment to the implementation and coordination of trauma-informed practice across sectors.

- Identify and prioritise women with experiences of complex trauma within public policy and service frameworks.

- Conduct an audit to identify barriers to service cooperation for women with experiences of complex trauma, with participation from service consumers.

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Introduction

So, for me, about the trauma, it's something—it's like—is it a wound, like when you cut yourself? It's like a deep wound under your heart. It's never healed. It can be covered with plaster, but it will never get dry and heal. It's like it was still there. Unless if they take off my brain and bring someone else's brain, but I will never forget it. (Jeanette)

The title of our report was inspired by the story of Jeanette, a Rwandan woman living in Australia who survived the genocide in her home country. She was in her early teens at the time of the genocide, now over a quarter of a century ago. After the genocide, she had to flee to another country; she came to Australia as a refugee a decade ago. She recalls the genocide as a real-life "horror movie" that still plays inside her head when she is confronted with reminders of that time. Additionally, "When I'm sad, when I feel lonely, when I have no one talk to, it always comes back like that."

For Jeannette, trauma was not solely an individual experience. Trauma reverberated throughout her Rwandan–Australian community in the absences of loved ones lost to genocide, the presence of traumatised family and friends, the vocal grief of public memorials, and in the silences that can engulf women's experiences of conflict and forced migration. While some trauma, such as political conflict, is publicly acknowledged, those traumas that differentially impact women, such as sexual violence, are often hidden and unspoken. Jeannette said:

I wish someone can listen to me in my language, like just listen to what I said, but because we all went through, it's—and we lose trust—we lost our trust in our community—what happened because there's some really bad thing and no one—sometimes feel even ashamed to tell someone you know that you've been raped when genocide [happened], and there is some people who went through that, but they need—I don't know how they can make them talk and—or whatever they did, but sometimes for me, I felt like when I talk and from—even if you don't listen—you don't know what I'm talking about, sometimes it really releases me. It's like—yeah, I feel like I'm okay now. But hiding it, covering it, it kills people out.

For Jeannette, sharing the "deep wound" of trauma could "release" its pain. Her advice to other women was to find

"someone who can listen", whether a family member, a friend, or a counsellor, or else "you feel you are not even loved like and everything you do, it's all wrong". For Jeannette, and for many women, the journey from the infliction of that "deep wound" to finding "someone who can listen" was often long and hard. This report outlines the findings of a study into that journey, and the ways in which services and agencies can improve their responses to women with experiences of complex trauma.

Our study

The concept of complex trauma emerged in the early 1990s from the work of pioneering feminist psychiatrist Judith Herman (1992). In the aftermath of the Holocaust and the Vietnam War, the notion that the human mind can be injured by overwhelming or violent events had been recognised with the inclusion of post-traumatic stress disorder in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (the formal diagnostic tool of the American Psychological Association). However, Herman (1992) identified that the traumatic injuries of interpersonal abuse, such as child abuse or domestic violence, required a specific response. She formulated the notion of "complex post-traumatic stress disorder" (cPTSD) to fully capture the symptoms and experiences of those who have experienced prolonged, entrapping and frightening abuse in interpersonal life. Almost a generation later, cPTSD has been incorporated into international diagnostic manuals (to be discussed further in the State of knowledge review). However, it is broadly recognised that current treatment and policy approaches are not sufficiently attuned to the challenges of complex trauma, and this has significant implications for public health and community wellbeing (Ford, 2015).

While the notion of complex trauma originates in clinical practice and research, it is not a medical diagnosis akin to cPTSD. Instead, it describes the diverse aftereffects of experiences such as child abuse, domestic violence, sexual assault and stalking, and recognises that these experiences are not discrete but often cluster and overlap (Ford & Courtois, 2009). One in four Australian women have experienced sexual abuse as a child (Child Family Community Australia [CFCA], 2015) and one in five Australian women has been

sexually assaulted after the age of 15 (Australian Bureau of Statistics [ABS], 2017). One in four report physical violence from a current or former partner, and one in six women has been stalked (ABS, 2017). However, one quarter of women reporting any form of gender-based violence in Australia report experiencing at least three different forms, such as child sexual abuse, sexual assault and domestic violence (Rees et al., 2011). The experience and impacts of these multiple forms of victimisation can be understood in terms of complex trauma, with the recognition that not all children and women will be impacted in the same way.

The aim of our study is to examine current responses to women with experiences of complex trauma, and to develop a blueprint for policy and service reform that is practical and achievable. We did not just want to know what was wrong with current responses. We wanted to know what was right, too. We also wanted to know, for example:

- which services and professionals are doing a good job with women who have experienced complex trauma
- the views of women with experiences of complex trauma about the current state of service provision to them
- how professionals across a range of sectors understand complex trauma and respond to it in their practice.

We interviewed 103 people who felt passionately about these questions. This report presents their answers.

We interviewed 40 women living in New South Wales and Queensland who had experienced complex trauma. We did not narrowly define "complex trauma". Rather, we asked women in interviews what "trauma" and "complex trauma" meant to them, since a key focus of the study was to examine the various ways that trauma was understood by women and service providers. The women who spoke to us were diverse. They ranged in age from their early twenties to their late sixties, and lived in urban, regional and remote areas. They came from different cultural and social class backgrounds and had lived through many different forms of trauma across their lives: child abuse, neglect, removal from their families of origin, sexual assault, domestic violence, trafficking, sexual exploitation, poverty, disadvantage, and experiences of oppression and discrimination.

Despite their many differences, the women we spoke to expressed similar sentiments to Jeannette, who described the wound of complex trauma as both deep and hidden "under the heart", unseen by others and sometimes unknown to the woman, too. Women explained how the injuries of the past endured in the present through unresolved grief, shock and anxiety; through chronic pain and fatigue; and through feelings of loneliness and challenges in relationships. These experiences often propelled women to seek help and understanding from many different sources, including services and agencies, while also drawing on their own resources. In interviews, they described the strengths, skills and insights they developed as they navigated through the impacts of trauma on their lives.

We also interviewed 63 professionals from a range of services who work with individuals with experiences of complex trauma living in New South Wales and Queensland. We asked workers what "trauma" and "complex trauma" meant to them, and about their professional experience and practices with clients who have experienced complex trauma. They came from many different sectors: mental health, community health, homelessness, alcohol and other drugs (AOD), community legal centres, sexual assault, domestic violence, multicultural services, refugee services, and disability. Some were frontline workers and others were managers and coordinators. They volunteered for our study because they were passionate about the issue of complex trauma which they uniformly felt was a crucial underlying problem for many or most of their clients.

While they were often highly trauma-literate in their own practice, the workers who we interviewed agreed with women that it was very difficult to find "someone who can listen" to complex trauma stories in the Australian service landscape. Across sectors, appropriate and effective responses to women with experiences of complex trauma were grounded in a variety of forms of "listening" and sensitivity to hidden needs and vulnerabilities. Interestingly, listening for and to trauma was not only positive for women with experiences of complex trauma. Many professionals insisted, emphatically, that their own strength and resilience had grown as they listened to and learnt from their clients. They also identified many systemic obstacles across the Australian service system to these kinds of mutually beneficial interactions between professionals and women with experiences of complex trauma.

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The structure of the report

The report begins with a review of the relevant literature, focusing on what we know about the causes and impacts of complex trauma as well as understandings of trauma-informed care. There are already a range of excellent guidelines for trauma-informed practice with clients in a range of specialist sectors, and the intention of our study was not to attempt to replicate or repeat their recommendations, which have been drawn up by practitioners and scholars with in-depth knowledge of their particular communities and sectors. Instead, the literature review aimed to summarise this work so that our research could build on it further. The next section provides an overview of the research methodology, including our theoretical approach.

The report then presents the outcomes of our multi-method research project. The State of knowledge review presents an overview of the existing literature on trauma impacts and pathways, and documentation on multi-sectoral, trauma-informed practice frameworks, and is followed by the Methodology. Chapter 4 outlines our policy analysis related to complex trauma in Australia, involving an analysis of the ways in which complex trauma is addressed in policy frameworks at Commonwealth, state and territory levels. Chapter 5 describes how women and workers defined "trauma" and "complex trauma" and distinguished between them, grounded in women's accounts of trauma as a psychosocial and embodied experience. While trauma is often conceptualised as a psychological problem, women's narratives included a strong focus on the somatic and relational dimensions of trauma. This chapter also discusses how women developed unique skills and strengths in their self-management of trauma impacts.

Chapter 6 presents qualitative data on the health response to complex trauma from the perspectives of both women and professionals working in this sphere, whom we refer to as "workers". The chapter addresses a number of systemic issues in the health system, including the hegemony of a biomedical model of mental illness and the widespread misdiagnosis and maltreatment of women with experiences of complex trauma. The chapter then highlights those elements of best practice identified by workers and women. Chapter 7 discusses the encounters of women with experiences of complex trauma with agencies with legal and statutory power, such as criminal justice, child protection and family law courts. This chapter highlights a continuity of misunderstanding and stigma experienced by women with experiences of complex trauma across those services and agencies ostensibly tasked with protecting them and their children from harm. The chapter points to promising practices that offer women a dignified and hopeful experience of legal processes.

Chapter 8 considers the role of workplaces and service systems in supporting professionals to support women with experiences of complex trauma. The chapter summarises how vicarious trauma has been conceptualised in the scholarly literature and draws on interviews with workers and women to illustrate the complexity of trauma in the workplace. While emphasising the need for institutionalised support for professionals encountering complex trauma, the chapter acknowledges the deeply meaningful and compelling nature of complex trauma work, and the joy that many workers experienced in their encounters with services.

The Conclusion draws together our policy and practice recommendations, identifies models of best practice and points to future research work.

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CHAPTER 2

State of knowledge review

The notion of "complex trauma" was first popularised by Judith Herman (1992) and is now widely used in a range of professional sectors and social movements. Complex trauma refers simultaneously to complex forms of interpersonal victimisation, involving repeated incidents of abuse and betrayal, and the complex traumatic and dissociative symptomology that results from it (Ford & Courtois, 2009). Complex trauma is distinguished from single-incident trauma, such as a car accident or a mugging, which can induce an acute traumatic reaction, as well as post-traumatic stress disorder (PTSD), which was originally formulated in 1980 to describe the symptoms of returned Vietnam servicemen. While the sequelae of complex trauma can include symptoms of PSTD, they also encompass chronic alterations to identity, memory and relationships with others, as well as psychosocial problems such as self-harm, suicidality and substance abuse. Complex trauma is associated with sustained violation and betrayal in interpersonal relations, intersected by social inequalities such as sexism and racism that increase the risk of trauma and compound its harms (Herman, 1992).

This literature review draws together contemporary research on the multiple paradigms of complex trauma before going on to examine how treatment and support for those who have experienced complex trauma is being operationalised and applied in policy and practice under the rubric of trauma-informed care (TIC). The review suggests that complex trauma emerges through the dynamic intersection of traumatising abuse, psychological adjustment and adaptation, and social and systemic responses. Where appropriate, the review makes critical comment on current strengths and weaknesses of the empirical literature. Much of the available information on TIC involves "grey" literature that provides recommendations for changes to individual and organisational processes and practices, with some consideration given to drivers of and obstacles to system change. Building on recent Australian literature reviews (Quadara, 2015), our review provides a summary of TIC in health-related fields before discussing emerging areas of TIC, including Aboriginal and Torres Strait Islander models of trauma care and trauma-informed policing and legal practice. The review includes discussion of the risks and benefits of working in the complex trauma field. Finally, the literature review proposes a multi-dimensional and inclusive definition of complex trauma and points to key gaps in research and knowledge.

Review methodology

Given the wide-ranging nature of this topic, we employed a narrative scoping review methodology to survey the state of knowledge across relevant research areas, including psychological and psychiatric studies of trauma, patterns of violent victimisation and psychological responses, and models of TIC. Narrative scoping review methodologies thematise and synthesise research findings, support theory building and provide scope for the identification of research strengths and gaps (Baumeister & Leary, 1997). The multiple, flexible aims of a narrative methodology provide an appropriate framework for literature reviews that address multiple research areas and call for some conceptual clarification. The terms "trauma" and "complex trauma" are routinely used in research and professional literature without a clear definition or apparent consensus on what they refer to, and there is a clear need for a critical summary of conceptualisations of complex trauma and related areas of practice that identify points of strength and complementarity as well as points of difference or disagreement.

Peer-reviewed literature was initially located using a range of databases accessed via Western Sydney University, including Family and Society Collection, Health and Medical Collection, PsychInfo, Proquest, PubMed, Psychology and Behavioural Sciences Collection, Social Services Abstracts, and SocIndex. An initial search on "complex trauma" was undertaken and followed by further searches to explore gaps in the literature:

- post-traumatic stress disorder OR posttraumatic stress disorder OR PTSD AND dissociative subtype
- complex PTSD OR complex posttraumatic stress disorder OR complex post-traumatic stress disorder
- borderline personality disorder OR BPD AND trauma
- dissociative disorders OR dissociative identity disorder AND trauma;
- child sexual abuse, CSA, child physical abuse, emotional abuse, psychological abuse, neglect, child abuse, child maltreatment, adverse childhood events, ACEs, witnessing domestic violence, child pornography
- revictimisation OR revictimization.

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"Grey" literature (that is, research that has not been commercially published, including government reports, policy statements and issues papers) is an important source of information on complex trauma and TIC. Key reports and resources were identified via Google and Google Scholar searches using the terms "complex trauma" and "developmental trauma".

Pathways and outcomes of complex trauma

Experience of complex trauma is a dynamic process between recurring traumatic events, physiological and psychological sequelae, and interpersonal and relational contexts. As is well articulated in *Change the Story: Australia's National Framework on Preventing Violence against Women and their Children* (Our Watch, Australia's National Research Organisation for Women's Safety [ANROWS], & VicHealth, 2015), abusive relationships and individual and collective reactions to them are mediated by institutions, structures and social norms and values. From this socio-ecological perspective, complex trauma occurs at the intersection of violence perpetration and victim adaptation, within a broader context that may enable the violence to take place while often failing to offer the victim a protective response. Complex trauma necessarily implicates social inequalities along the lines of gender, race, class and other factors that can increase the risk of violence and abuse while also diminishing a supportive or protective response in its aftermath (Herman, 1992).

An intersectional, multi-factorial understanding of complex traumatisation helps to explain why not all abusive or violent experiences necessarily result in traumatisation. For example, large-scale surveys of American adults have found that over half the population has been exposed to at least one form of childhood adversity (including abuse, neglect and household dysfunction) (Felitti et al., 1998). While developmental trauma is often equated with complex trauma, the majority of these children exposed to trauma will not go on to develop problems that can be described as responses to complex trauma. However, complex trauma is a likely outcome where abuse is repeated and severe, occurs across multiple domains or involves multiple perpetrators, and where the

child is blamed or shamed for their abuse (Ullman, 2007). The qualitative research of Hegarty et al. (2017) with adult survivors of sexual violence emphasised how the development of mental illness after sexual abuse or rape can be exacerbated by isolation, stigma, the dismissal of disclosures or blaming the victim for her abuse. Such experiences of powerlessness and betrayal during or following assault are linked to social structures of sexism, racism and other axes of oppression, emphasising that the risk of complex trauma is heightened for disadvantaged or marginalised groups (Salter, 2012).

The following section examines how complex trauma has been constructed and examined in psychiatric and epidemiological research, with a focus on the symptomatology of traumatic response and dissociation and subsequent patterns of developmental trauma and revictimisation. It includes discussion of research on extreme abuse and intergenerational transmission of trauma. While research findings remain largely consistent regarding the relation of abuse and violence to traumatic symptomatology and subsequent effects on biopsychosocial wellbeing and vulnerability to further violence, the repetition of cross-sectional studies is notable, stymieing the development of a more robust evidence base. In particular, research findings remain focused on associations rather than causative attributions between violence and its impacts due to a lack of longitudinal and cohort methodologies. Furthermore, the absence of an empirically sound theoretical framework of complex trauma, elaborating upon its individual, relational, community, systemic and transgenerational dimensions, prevents the systematisation of research findings in such a way that would guide policy and practice interventions beyond clinical settings.

Traumatic and dissociative symptomatology

In contemporary psychiatry, post-traumatic stress disorder (PTSD) is considered the primary mental disorder arising from exposure to potentially traumatic events. Post-traumatic stress disorder is defined specifically in relation to the experience of a traumatic event and involves fear-based symptoms directly related to this exposure. PTSD, however, is not the only mental disorder related to trauma. Rates of trauma are elevated across a number of disorders including dissociative, personality and substance use disorders. Thus, a

number of researchers and clinicians have argued that trauma is a transdiagnostic or non-specific risk factor for mental disorder (Freedman, 2017; Lewis et al., 2019; Schore, 2003). However, there is a distinction between mental disorders where trauma is a precipitating factor—such as PTSD—versus disorders where trauma is better conceptualised as a predisposing factor (Friedman et al., 2011). With this in mind, this section reviews the evidence related to PTSD and recent debate regarding its conceptualisation in relation to complex trauma.

Complex post-traumatic stress disorder

PTSD was initially conceived in relation to single-incident or combat trauma, and it has been argued that it is inadequate to describe the diverse presentations accompanying more complex experiences of trauma (Taycan & Yildirim, 2015). Complex PTSD (cPTSD) was therefore understood as a distinct psychiatric category for responses to complex trauma, with a focus on the experiences of women and children subject to prolonged patterns of abuse and powerlessness. However, there has been debate about whether responses to complex trauma should conceive of it as a single diagnostic category (i.e. cPTSD) or a pattern of personality and other mental disorder comorbidities (Resick et al., 2012). Other researchers have argued that cPTSD offers a simplified and coherent diagnostic category and thus reduces the over-pathologising of individuals by using multiple diagnoses to explain a person's presentation (Nickerson et al., 2017). That is, in the absence of a cPTSD diagnosis, an individual might be given multiple diagnoses covering dissociative, anxiety and mood diagnostic categories.

The two diagnostic systems—Diagnostic and Statistical Manual for Mental Disorders (DSM) and the International Classification of Diseases (ICD)—have responded differently to these debates. While the DSM–5 retained a single diagnostic category of PTSD and created a dissociative subtype (Murphy et al., 2018; Perkonigg et al., 2016), the ICD–11 described two "sibling" disorders of PTSD and cPTSD. In the ICD–11, PTSD was described as a fear-based response to trauma including the traditional hyperarousal, avoidance and re-experiencing symptoms. cPTSD additionally includes disturbances in self-organisation (DSO) which are defined in terms of three symptom clusters: emotion dysregulation,

negative self-concept and disturbed relationships (Hyland, Shevlin, Brewin, et al., 2017).

There is growing and consistent evidence for the separate diagnostic category of cPTSD as defined by ICD–11. Several studies have confirmed the distinct structure of PTSD versus cPTSD across a range of populations with high exposure to complex trauma, including child sexual abuse victims and refugee populations (Ben-Ezra et al., 2017; Hyland, Shevlin, Elklit, et al., 2017; Kazlauskas, Gegieckaite, Hyland, Zelviene, & Cloitre, 2018; Nickerson et al., 2016; Palic et al., 2016; Shevlin, Hyland, Karatzias, Fyvie, et al., 2017). What is less clear is whether the type of trauma can distinguish between the two categories, with complex trauma explicitly linked to cPTSD and single incident trauma associated with PTSD. For example, the findings for child maltreatment (CM)—commonly conceived as complex trauma—have been inconsistent (Hyland, Murphy, et al., 2017). Some studies have found elevated rates of CM among individuals diagnosed with cPTSD compared to individuals diagnosed with PTSD (Palic et al., 2016; Shevlin, Hyland, Karatzias, Fyvie, et al., 2017); however, other studies have failed to find a difference between the two groups. Such inconsistencies may be due to differences across studies in the measurement of CM (this is considered in more detail in the next section). This type of evidence would confirm a distinct aetiological pathway associated with exposure to specific traumatic events and also provide evidence of clinical meaningfulness (Palic & Elklit, 2014; Resick et al., 2012).

The most recent edition of the DSM–5 chose a different conceptualisation of PTSD. Rather than endorsing a separate cPTSD diagnosis, the construct of PTSD was revised to more explicitly capture traumatic sequelae. The revised classification tightened the definition of trauma exposure (thereby restricting the traumatic experiences on which a diagnosis could be made) and expanded the number of symptom clusters by including a fourth group of symptoms related to negative cognitions (Galatzer-Levy & Bryant, 2013; Murphy et al., 2018; Perkonigg et al., 2016). The evidence for this conceptualisation is underwhelming. A number of studies utilising modelling techniques to detect different groups or clusters of symptoms have failed to confirm the four symptom groups described by the DSM–5 (Armour, Mullerová, & Elhai,

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2016; Chen, Yoon, Harford, & Grant, 2017; Cyniak-Cieciura, Staniaszek, Popiel, Praglowska, & Zawadzki, 2017; Murphy et al., 2018). Instead, up to seven factors have been identified (including symptom clusters related to anxious arousal, dysphoric arousal and externalising behaviour), indicating the construct of PTSD is not adequately conceptualised by the current DSM–5 criteria.

Criticisms have also been made regarding the large number of symptoms specified by the DSM–5 which yield an extraordinary number of combinations from which a diagnosis of PTSD could be derived (Galatzer-Levy & Bryant, 2013). Relatedly, prevalence estimates of PTSD have varied considerably across these different models, from 22 percent based on the DSM–5 four-factor model to 10 percent based on the seven-factor hybrid model (Murphy et al., 2018; Shevlin, Hyland, Karatzias, Bison, & Roberts, 2017). Moreover, the degree of risk attributed to CM also depended on the model used, raising further questions about whether PTSD is being consistently diagnosed across the different models (Shevlin, Hyland, Karatzias, Bison, & Roberts, 2017).

It seems that the ICD–11 complex PTSD may be better than the DSM–5 PTSD construct at capturing the diversity of trauma experiences found in both community and clinical populations. For example, in a community sample of African–American women, severity of CM and multi-type exposure was higher among those classified with ICD–11 cPTSD compared to those classified with DSM–5 PTSD. Psychiatric burden was also higher among the women with cPTSD despite similarities in overall trauma exposure between the two groups (Powers et al., 2017). Other researchers have similarly argued that the two classifications are diagnostically distinct (Hyland, Shevlin, Fyvie, & Karatzias, 2018).

Dissociation as a marker of complexity

Dissociation refers to an inability to integrate objective experience into conscious awareness and is reflected in alterations in memory, emotion, identity and behaviour. Dissociative symptoms can range from non-pathological, transient lapses in awareness through to severe identity dissociation. Dissociation represents significant distress, and is associated with high rates of suicidal ideation, self-

injury and multiple suicide attempts (Carlson, Dalenberg, & McDade-Montez, 2012).

Chronic traumatic stress of an interpersonal nature is strongly associated with dissociative experiences. As such, dissociation has been construed as a defence against overwhelming experiences from which no physical escape is possible (as is the case, for example, with CM and torture) (Lanius, 2015). Studies controlling for general psychological distress demonstrate significant, moderate associations between trauma exposure and dissociation, lending support to the idea that dissociation is a traumatic response rather than a response to general distress (Carlson et al., 2012).

PTSD-related dissociative symptoms have been described along three dimensions (Carlson et al., 2012):
- loss of continuity in subjective experience as reflected in re-experiencing symptoms
- inability to access or control mental functions as reflected in gaps in awareness
- experiential disconnectedness such as depersonalisation and derealisation.

A review of studies exploring dissociation in relation to PTSD (Carlson et al., 2012) showed that dissociative experiences peak in the aftermath of trauma and gradually decline over time for most people. A significant minority of individuals exposed to trauma, however, continue to experience high levels of dissociation. Studies comparing dissociation among participants exposed to trauma with and without PTSD have found a strong association between dissociation and PTSD which persists even when dissociative PTSD symptoms (such as re-experiencing) are removed. The studies reviewed also showed that the severity of dissociative symptoms was positively related to the severity of PTSD symptoms experienced. These findings suggest PTSD and dissociation are phenomenologically related in some people, however the mechanism by which these two constructs are interrelated is not yet fully understood (Bryant, 2007).

Given this evidence, the DSM–5 specified a dissociative subtype of PTSD (i.e. D-PTSD) and makes a distinction between PTSD symptoms that are conceptually related to

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dissociation (e.g. flashbacks and emotional numbing) and additional dissociative symptoms of depersonalisation and derealisation (which refers to a state in which a person's thoughts and feelings seem unreal or as though they belong to someone else) (Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012). This conceptualisation assumes that dissociation may be, but is not always, part of a traumatic response and is consistent with commentary in the literature on the prevalence of dissociation following trauma exposure (Bryant, 2007; Hansen, Ross, & Armour, 2017). It can also be implied that the presence of dissociation indicates greater severity of post-traumatic distress. Only a few studies have examined the structure of D-PTSD. Most of these studies have found the severity of dissociation—rather than specific types of dissociative symptoms—differentiates between the two PTSD constructs (Burton, Feeny, Connell, & Zoellner, 2018; Frewen, Brown, Steuwe, & Lanius, 2015; Hansen et al., 2017). Further research is needed to clarify the dissociative processes reflected in the D-PTSD construct, including better delineation and measurement of the different dissociative symptoms (Bryant, 2007; Hansen et al., 2017).

The most severe dissociative disorder is diagnosed as dissociative identity disorder (DID), characterised by the presence of two or more distinct personality states that recurrently take control of the individual's behaviour, accompanied by amnesia for everyday and life events that cannot be explained by ordinary forgetfulness (International Society for the Study of Trauma and Dissociation, 2011). DID typically develops in children subject to chronic and overwhelming abuse from early childhood, inhibiting the development of a coherent worldview and self-identity (Spiegel et al., 2011). Substantiated reports of CM in people with DID include burning, mutilation and sexual exploitation (Otnow, Yeager, Swica, Pincus, & Lewis, 1997). In addition to a disruption of identity and memory, people diagnosed with DID typically experience a range of other problems, including depression, suicidal thoughts and self-harm, anxiety, and vulnerability to physical and sexual victimisation. Research in multiple countries using a variety of methodologies finds that DID occurs in approximately 1 percent of the general population, and up to one fifth of patients in inpatient and outpatient mental health settings (Spiegel et al., 2011).

Complexity of post-traumatic stress among marginalised populations

In the general Australian population, lifetime trauma exposure among women has been reported to be 74 percent (Mills, Teesson, Ross, & Peters, 2006). While this rate is similar among men, women were found to have a higher prevalence of specific trauma types such as physical violence from an intimate partner, rape, sexual assault, stalking and witnessing domestic violence. Among women with experiences of trauma, about two thirds (63%) had experienced multiple types of trauma and almost 75 percent had experienced multiple episodes. The overall prevalence of PTSD (based on DSM–IV classification)[1] among Australian women was found to be 9.7 percent (Chapman et al., 2012).

The rate of trauma exposure and PTSD is much higher, however, among marginalised populations such as asylum seekers and refugees, people experiencing homelessness, or people with substance use problems. The reason for these elevated rates is thought to relate to the complexity of the social environment in which these people live, involving multiple stressors.

Refugees and women seeking asylum

Refugee populations are exposed to persecution, political imprisonment, torture, sexual exploitation, and mass trauma or genocide (Nygaard, Sonne, & Carlsson, 2017; Palic & Elklit, 2014). Additionally, displacement experiences can mean a loss of interpersonal connections and support; limited or no access to effective systems of justice; uncertainty of living situations, including perceived safety and security; and loss of meaningful activities (such as employment) that provide purpose and identity (Nickerson et al., 2017; Nickerson, Steel, Bryant, Brooks, & Silove, 2011; Silove, 2013). Such factors operating in the post-trauma environment have been found to increase levels of post-traumatic stress (Li, Liddell, & Nickerson, 2016; Porter & Haslam, 2005). As a result, refugees exposed to trauma often present with diverse symptoms that do not necessarily fit within a PTSD diagnosis.

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1   Australian estimates of ICD–11 PTSD and complex PTSD and DSM–5 PTSD and D-PTSD are not available.

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The extent to which the current ICD–11 and DSM–5 conceptualisations of PTSD are relevant to refugee populations has been examined by a number of studies. These studies suggest that additional descriptors are needed to appropriately describe post-traumatic distress for this group, in order to facilitate appropriate and targeted support. For example, compared to other groups exposed to trauma (e.g. combat-related trauma and motor vehicle accidents), refugees demonstrate less belief in positive world assumptions (ter Heide, Sleijpen, & van der Aa, 2017). This finding was not explained by differences in trauma exposure as both refugees and individuals exposed to combat had experienced prolonged trauma. The authors suggested that such changes in world view may reflect experiences of discrimination and post-migration stress (including low social status) in the host country.

Similarly, other researchers have suggested that a sense of persistent injustice is related to post-traumatic distress in refugee populations (Tay, Rees, Chen, Kareth, & Silove, 2015). Additionally, trauma appears to have a greater impact on relatedness in collectivist cultures, which suggests symptoms of diminished self (as articulated in DSM and ICD diagnostic categories) may be less relevant for this population. For example, loss and grief have been found to complicate post-traumatic distress in refugee populations at both an individual and family level (Nickerson, Bryant, et al., 2011). Another study identified a group of refugees who did not wholly qualify for a PTSD diagnosis but had elevated distress and high functional impairment related to re-experiencing and avoidance symptoms (Minihan, Liddell, Byrow, Bryant, & Nickerson, 2018). It was suggested that this elevated distress reflected the ongoing threat to self and family that can be experienced in this population even after resettlement in a new country.

A handful of studies have confirmed that the symptom profile of traumatised refugees is better described by the ICD–11 cPTSD diagnosis (Nickerson et al., 2016; Tay et al., 2015). Prevalence of PTSD and cPTSD was reported to be 20 percent and 33 percent respectively among treatment-seeking refugees re-settled in Switzerland (Nickerson et al., 2016), which is much higher than estimates reported for the European general population.

Women experiencing homelessness

Trauma features strongly in the history of many homeless people. Research has found the lifetime prevalence of trauma to be almost ubiquitous among homeless persons, with estimates of 90–100 percent reported (Buhrich, Hodder, & Teesson, 2000; Larney, Conroy, Mills, Burns, & Teesson, 2009; Mission Australia, 2012; Taylor & Sharpe, 2008). The rates of PTSD are similarly high and greater than those found in general populations. For example, Taylor and Sharpe (2008) used a structured clinical interview to diagnose PTSD in an inner-Sydney sample of homeless individuals and found a lifetime prevalence of 79 percent and a 12-month prevalence of 41 percent. In the only other published Australian study to examine PTSD among homeless adults, 57 percent of participants recruited from an inner-Sydney crisis accommodation service screened positive for past month PTSD as measured by the Trauma Screening Questionnaire (Larney et al., 2009). Unfortunately, neither of these studies reported prevalence by gender; international research, however, has found rates of trauma exposure and associated mental health problems to be greater among homeless women compared to homeless men (Hutchinson, Page, & Sample, n.d.; Tinland et al., 2018). In particular, homeless women have reported multiple and repeated experiences of physical and sexual violence that begin in childhood and continue into adulthood (Browne & Bassuk, 1997).

Compared to the Australian general population, homeless persons have more experiences of interpersonal traumas (such as sexual and physical assaults) that carry a greater risk of developing PTSD (Buhrich et al., 2000; Conroy et al., 2014). While there is some evidence that trauma and PTSD precede the onset of homelessness for many people (Taylor & Sharpe, 2008), few Australian studies have investigated the interrelationship of trauma exposure, mental health and homelessness over time. This is an important gap given the high rate of violent re-victimisation that people experience while homeless (Larney et al., 2009).

Women with substance use problems

It is fairly well established that women with substance use problems have extensive histories of trauma, including child maltreatment, intimate partner violence and other sexual violence (Dore, Mills, Murray, Teesson, & Farrugia, 2012;

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Mills, Lynskey, Teesson, Ross, & Darke, 2005; Roxburgh, Degenhardt, & Copeland, 2006; Shand, Degenhardt, Slade, & Nelson, 2011). For example, rates of trauma exposure among street-based sex workers in Sydney found 99 percent had experienced at least one trauma, with much of this complex exposure: 93 percent had experienced multiple traumas with 53 percent experiencing more than six different trauma types, 75 percent experiencing child sexual abuse (CSA), 81 percent having been raped as an adult (37 percent while working) and 81 percent being physically assaulted as an adult (Roxburgh et al., 2006). The most common types of trauma reported by women in treatment for substance use problems include serious physical assault (51–56%); being threatened with a weapon, held captive or kidnapped (42–59%); rape (51–54%); witnessing someone being badly injured or killed (42–58%); and child sexual assault (51–52%) (Dore et al., 2012; Mills, 2013).

Similarly, rates of PTSD are significantly elevated among women with substance use problems and have been reported to range from 47 percent among street-based sex workers (Roxburgh et al., 2006) to 61 percent among people with lived experience of heroin dependence (Mills, Teesson, Ross, Darke, & Shanahan, 2005). These rates are higher than comorbidity rates detected in general population samples, possibly because the study samples reflect a more complex trauma exposure. For example, in the 2007 National Survey of Mental Health and Wellbeing, approximately one third of Australian women with a diagnosis of PTSD also met criteria for a substance use disorder (Chapman et al., 2012). Trauma exposure and post-traumatic stress symptoms, however, were found to pre-date the development of substance use problems in around half of all women classified with the comorbidity. It has been suggested that self-medication for PTSD symptoms contributes to the development of substance use disorder following trauma exposure (Darke, 2013).

Comorbidity of substance use disorders (i.e. being dependent on more than one drug type) has been found to be associated with experiences of child sexual abuse and child emotional neglect, adult victimisation, suicide attempts, mental disorder and prison history (Shand et al., 2011). This paints a complex picture of psychosocial problems reinforcing each other over time. Similarly, although findings were not reported separately for females, involvement in substance use, violent crime and

PTSD symptoms were found to be interrelated over time in a drug treatment sample (63%) (Barrett, Teesson, & Mills, 2014).

Developmental trauma

Developmental trauma refers to trauma that occurs in childhood and adolescence. Exposure to trauma during these developmental periods can have significant impacts on brain structure and functioning and create long-term vulnerabilities for physical, psychological and social wellbeing (De Bellis & Zisk, 2014). Much of the literature on developmental trauma is concerned with child maltreatment (including witnessing domestic violence), however it also includes other types of trauma exposure, and it is the collective impact of repeated or multiple exposure to trauma during key developmental periods that contributes to a complex trauma presentation (Bifulco and Moran, 1998).

Child maltreatment encompasses a range of related but distinct behaviours including sexual abuse, physical abuse, psychological/emotional abuse and neglect. Studies have shown that child maltreatment is a common experience. General population surveys provide good estimates for sexual and physical abuse, as definitions of these types are applied with relative consistency across studies (Stoltenborgh, Bakermans-Kranenburg, Alink, & van IJzendoorn, 2015). Rates of psychological abuse/emotional abuse and neglect are more difficult to estimate because measures of these forms of child maltreatment are less well developed. Thus they are rarely included in large-scale epidemiological studies, and assessment in community samples has been inconsistent. Additionally, prevalence estimates are not always reported separately for males and females. Available Australian data is presented below.

- *Child sexual abuse:* Child sexual abuse includes the spectrum of unwanted or harmful sexual experiences in childhood, including sexual activity with an adult and non-consensual sexual activity with a minor. Australian research into the prevalence of child sexual abuse finds that women have prevalence rates of 4–12 percent for penetrative abuse and 14–26.8 percent for non-penetrative abuse (CFCA, 2015).

- *Child physical abuse:* Child physical abuse refers to any act of intentional physical aggression by a caregiver

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towards a child. The majority of Australian studies suggest prevalence rates of between 5–10 percent (CFCA, 2015).

- *Emotional and psychological abuse:* Emotional abuse includes instances in which the child is verbally insulted and criticised, whereas psychological abuse comprises negative parental behaviours such as humiliation, degradation, terrorising, cognitive disorientation, emotional blackmail, corruption/exploitation, and deprivation of valued objects (Bifulco & Moran, 1998; Kaufman Kantor et al., 2004). Given the varying characteristics of this form of abuse, Australian research has identified a prevalence range of 6–17 percent, with a likely prevalence rate of between 9–14 percent (CFCA, 2015).

- *Neglect:* Neglect encompasses inadequate supervision and failure to provide for the physical needs of a child, whereas emotional neglect is defined as a lack of emotional responsiveness and support. Australian prevalence estimates of neglect range from 1.6–4 percent (CFCA, 2015).

- *Exposure to domestic violence:* Violence between parents is sometimes considered as an additional category of child maltreatment and sometimes viewed as a subtype of existing categories such as neglect (e.g. failure to protect) or psychological abuse (e.g. terrorising). It is also strongly associated with exposure to all forms of child maltreatment. Australian prevalence estimates range from 4–23 percent (CFCA, 2015).

Child maltreatment tends to co-occur with a range of childhood adversities such as parental conflict and separation, chaotic family and poor parental supervision, parental substance use, social isolation, poor housing and unemployment, and bullying and social rejection by peers (Cohen et al., 2006; Dong et al., 2004; Symes, 2011).

Multiple exposure during childhood

The research reviewed above indicates that while some children may be exposed to a single incident of child maltreatment, many experience repeated incidents of the same child maltreatment (see e.g. Swanston et al., 2002). There is also strong and consistent evidence that the different types of child maltreatment tend to co-occur, thus exposing children to multiple types of child maltreatment (Conroy, Degenhardt, Mattick, & Nelson, 2009). Some studies that have examined different combinations of child maltreatment experiences have found different outcome trajectories associated with these (Green et al., 2010; Vaughn, Salas-Wright, Underwood, & Gochez-Kerr, 2015). For example, Vaughn et al. (2015) found four clusters of maltreatment and family violence exposure among adults presenting with non-suicidal self-injury:

- one group with low levels of maltreatment and family violence
- a second group with elevated levels of sexual abuse only
- a third group with elevated levels of physical abuse, neglect and family violence
- a fourth group with elevated levels across all four subtypes (sexual abuse, physical abuse, parental neglect, family violence).

Females accounted for all of the cases in the fourth group, with this cluster of maltreatment exposure demonstrating the highest rate of "clinical and personality disorders". In comparison, group 3 had the highest rates of substance use disorder and criminal and violent behaviour. A recent review paper found that although there was a lack of consensus across studies in terms of the number of clusters found (and the maltreatment types contained within them), there was empirical agreement for a poly-victimised group which was associated with the poorest psychosocial outcomes (Debowska, Willmott, Boduszek, & Jones, 2017).

Impact of developmental trauma

Child maltreatment occurs during development, when neurobiological and psychological systems are maturing. Studies of maltreated children commonly report aberrant physiological responsiveness, dysfunctional patterns of attachment, and deficits in self-system process (e.g. self–other relatedness, emotion regulation) (De Bellis & Zisk, 2014). Deficiencies in these key developmental processes may underlie the later expression of mental disorder such as the dissociative and trauma-related disorders described previously (Cicchetti & Toth, 1997; Mullen, Martin, Anderson, Romans, & Herbison, 1996). The literature also suggests that women who have experienced trauma in early life are more likely to have poorer health as adults and be higher users of the health care system (Bonomi et al., 2008; Chartier, Walker, & Naimark, 2010).

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The impact of developmental trauma is driven to a substantial degree by the nature of the trauma episode. A younger age at trauma exposure is generally associated with poorer outcomes, possibly because older children are psychologically more robust and have more psychological and physical resources to draw upon in coping with traumatic events. Manifestations of child maltreatment and other trauma may differ, however, depending on the developmental stage at which the maltreatment occurred (Mullen, King, & Tonge, 2000). Both the chronicity and severity of developmental trauma are associated with poorer outcomes, likely because of the greater disturbance to developmental processes and systems. As previously mentioned, there is a high degree of overlap among maltreatment types, as well as with other childhood adversities and consistent evidence of a dose-response relationship between multiple exposure and risk for later psychopathology (Bifulco, Moran, Baines, Bunn, & Stanford, 2002; Bolger & Patterson, 2001; Cohen et al., 2006; Dvir, Denietolis, & Frazier, 2013; Higgins & McCabe, 2000). In particular, early childhood trauma is associated with elevated rates of substance use disorder and a greater risk of self-injurious behaviour (Cecil, Viding, Fearon, Glaser, & McCrory, 2017; Conroy et al., 2009; Farrugia et al., 2011; Mills et al., 2005).

Re-victimisation

Individuals who experience maltreatment or other victimisation in childhood are at increased risk for re-victimisation in adulthood. Re-victimisation has been defined as the re-experiencing of abusive behaviour in adolescence or adulthood that was first experienced in childhood (Clarke & Llewelyn, 1994; Schetky, 1990). It can be distinguished from re-traumatisation in so far as it involves interpersonal trauma (as opposed to other trauma types such as natural disasters or motor vehicle accidents) (Pratchett & Yehuda, 2011). Predominantly the research in this area has focused on the link between CSA and re-exposure to sexual violence. Some studies have also examined child physical abuse (CPA) or a combination of maltreatment types as well as physical re-victimisation such as intimate partner violence (IPV). Much of the research utilises cross-sectional study designs with lifetime estimates of trauma experience. While informative about the types of traumas that tend to co-occur, these types of studies are limited in what they can say about how and why re-victimisation occurs. Longitudinal studies or those that take a life-course or narrative perspective would be helpful in this regard. Moreover, differences in the type of victimisation included in studies (sexual versus physical) and how these are defined (broad versus narrow definitions) also make it difficult to tease out results. The sections following describe the research that is available, focusing on studies that use longitudinal designs or review methodology, or cross-sectional studies with general population samples.

Sexual re-victimisation

There are a number of retrospective studies demonstrating a link between CSA and sexual re-victimisation among women (Coid et al., 2001; Desai, Arias, Thompson, & Basile, 2002; Kessler & Bieschke, 1999; Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007; Van Bruggen, Runtz, & Kadlec, 2006; Werner et al., 2016). Although far fewer in number, longitudinal studies have confirmed the association between CSA and sexual re-victimisation in late adolescence and adulthood (Barnes, Noll, Putnam, & Trickett, 2009; Cyniak-Cieciura et al., 2017; Fergusson, Horwood, & Lynskey, 1997; Gidycz, Coble, Latham, & Layman, 1993; Humphrey & White, 2000). Additionally, the association has been shown to persist even when poverty and family environment were taken into account (Barnes et al., 2009; Kimerling et al., 2007; Nelson, Heath, Madden, Cooper, & Dinwiddie, 2002).

In terms of the attributes of CSA that carry greatest risk for sexual re-victimisation, a meta-analysis of studies found more severe incidents of CSA were associated with the greatest likelihood of sexual re-victimisation (Roodman & Clum, 2001). There is limited evidence on whether risk of re-victimisation is associated with other characteristics of CSA. In one of the few studies examining the different characteristics of CSA together, severity and duration of CSA were found to be associated with re-victimisation, but degree of force used or type of perpetrator were not (Arata, 2000). Another study compared the perpetrators of the re-victimisation incidents for individuals with a history of CSA versus peer victimisation. Those with a history of CSA were more likely to be re-victimised by a non-intimate partner than an intimate partner (Desai et al., 2002).

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Multi-type re-victimisation

More limited is evidence on exposure to other forms of child maltreatment and subsequent exposure to both sexualised and non-sexualised forms of traumatic experience. Studies utilising cross-sectional and quasi-experimental designs have produced conflicting results with regard to the impact of CPA on re-victimisation (Dietrich, 2007; Gladstone et al., 2004; Van Bruggen et al., 2006; Werner et al., 2016). These studies have generally involved small or specific samples (including clinical, community, and homeless populations), varying measures and definitions of CPA, and different types of adult victimisation. CPA often co-occurs with emotional abuse, but this CM type is only sometimes included in studies. Moreover, CPA is difficult to classify into severity levels (unlike CSA). The few studies that have examined this issue in the female general population found CPA and CSA were associated with both physical and sexual re-victimisation in adulthood (Desai et al., 2002; Kimerling et al., 2007). However, CSA was found to be a stronger risk factor for adult sexual victimisation than physical victimisation; likewise, CPA was found to be a stronger risk factor for adult physical victimisation than sexual victimisation. This suggests that child maltreatment confers both general and specific risk for re-victimisation among women. This finding was confirmed in the only longitudinal study to examine multiple CM exposure and re-victimisation (Widom, Czaja, & Dutton, 2008).

This same study additionally found that individuals with a history of neglect or CSA were at increased risk of being kidnapped or stalked (Widom et al., 2008). Few studies have examined outcomes other than sexual or physical assault. This is an important gap to address in understanding the complexity of violence against women over the life course.

It may be that risk of re-victimisation depends on the clustering of exposure to different types of trauma. Analysis of exposure to violence among a general population sample of women in the United Kingdom identified four clusters of victimised women (Shevlin et al., 2013): 4 percent of women were identified as having experienced multiple victimisation (defined as CSA, adult sexual victimisation and IPV); 15 percent had experienced partner violence but no sexual victimisation; and 10 percent had experienced sexual victimisation in both childhood and adulthood. Although not reported separately

for gender, a longitudinal study found that individuals with experiences of multiple types of child maltreatment were 11 times more likely than non-maltreated children to experience physical re-victimisation and almost five times more likely to experience sexual re-victimisation (Widom et al., 2008). Other studies have similarly found an increased likelihood of adult re-victimisation with increasing exposure to more severe or multiple types of maltreatment (Coid et al., 2001; Edalati, Krausz, & Schutz, 2016; Janowski, Leithenberg, Henning, & Coffey, 2002; Mackelprang et al., 2014).

With regard to IPV, an Australian longitudinal study found rates of IPV did not differ for women who stayed with or left an abusive partner (Ahmadabadi et al., 2018). This suggests that risk of IPV continued even after women left a violent relationship. Physical re-victimisation has been found to be more commonly perpetrated by an intimate partner whereas sexual re-victimisation was commonly perpetrated by a non-intimate partner (Ahmadabadi et al., 2018; Desai et al., 2002).

Mechanism and impact of re-victimisation

Re-victimisation has been found to be associated with an elevated risk of mental disorder, particularly PTSD (Ahmadabadi et al., 2018; Desai et al., 2002; Nishith, Mechanic, & Resick, 2000; Roxburgh et al., 2006). For example, in a general population survey of women in the United States, women exposed to any violence were four times more likely to experience PTSD symptoms than women not exposed to violence; however, this risk increased to 12 times that of women not exposed among those that had been re-victimised (Kimerling et al., 2007), with symptoms including substance use disorder and difficulties in interpersonal, behavioural and cognitive functioning. Some studies have also found increased feelings of shame, blame, powerlessness and some coping strategies among individuals that have been re-victimised.

A range of factors has been identified to explain the pathway to re-victimisation. These can be grouped into two main camps.

- Vulnerability arising from the psychological sequelae of child maltreatment such as PTSD symptoms of emotion dysregulation and dissociative symptoms (Janowski et al., 2002; Wager, 2012): this may be underpinned by changes in the way the brain perceives and responds to threat

(Pratchett & Yehuda, 2011). Cross-sectional studies that have controlled for the effect of PTSD and depression on the association between CSA and re-victimisation indicate there may be a role for mental disorder, however this needs to be verified by longitudinal research (Werner et al., 2016).

- Vulnerability arising from disturbances in self–other relatedness: trauma involving a high level of betrayal may lead to dysfunctional interpersonal schemas that affect decision-making in relationships (e.g. appropriateness of interpersonal boundaries) and reduce capacity to form healthy social bonds (Dietrich, 2007; Mackelprang et al., 2014; Nishith et al., 2000). At a phenomenological level, this has been described by women as being homeless within the self and non-existent outside the abusive relationship, thus perpetuating "the relationship of exploitation"; other women described a sense of confusion about their behaviour with abusive men and feeling captive within these relationships, and of a loss of boundaries that created a sense of powerlessness in negotiating risky interpersonal situations (Ben-Amitay, Buchbinder, & Toren, 2015). It has also been suggested that early or chronic victimisation could lead to an acceptance of violence and gender role norms which persist across relationships (Yodanis, 2004).

- Other explanations involve risky or self-destructive behaviour such as substance misuse or problematic sexual behaviour. CSA in particular may affect sexual development and the formation of intimate partner relationships (Janowski et al., 2002). For example, a prospective birth cohort study in New Zealand found CSA was associated with early onset of sexual intercourse, which in turn increased the likelihood of involvement in other sexual behaviours such as unprotected sex and multiple partners. These risky sexual practices were in turn associated with a greater risk of re-victimisation (Fergusson et al., 1997). In another study, CSA and psychological maltreatment were both associated with sexual re-victimisation via their impacts on sexual self-esteem which in turn was associated with sexual behaviours (Van Bruggen et al., 2006).

Severe/extreme interpersonal victimisation

Research in mental health, sexual assault and domestic violence services has documented a group of clients with complex trauma who are reporting severe and extreme interpersonal victimisation. Their abuse histories involve deliberate and systematic traumatisation within interpersonal relations, including patterns of prolonged incest, often overlapping with organised abuse involving multiple offenders (Salter & Richters, 2012) and the physical and sexual abuse of women and children in the context of gangs and criminal networks (Cooper, 2004; Salter, 2014). This group of clients typically meets the criteria for DID and members are frequently still entrapped in severely abusive relationships at the time of presentation (Cooper, 2004; Middleton, 2013). Women escaping sexually abusive family networks and criminal gangs appear to be overrepresented in domestic violence and sexual assault services (Cooper, 2004; Schmuttermaier & Veno, 1999) and in mental health contexts that specialise in treating sexual abuse and dissociation (Middleton, 2013; Middleton & Butler, 1998).

Cooper's (2004) research with women with complex needs in Adelaide emphasised the presence of extremely violent family networks who inflicted "abuses that are ritualistic, violent in the extreme and that involve a known or sometimes amorphous chain of persons who can track, stalk and report on the women's movements" (p. 4). These reports correlate with Salter's (2013a, 2017) research with Australian women subject to organised sexual abuse in childhood, and Middleton's (2013) clinical work and research with women diagnosed with DID in Brisbane reporting prolonged incest and sexual exploitation. The confluence of extreme trauma, typically beginning in early childhood and extending into adulthood with the development of symptoms associated with DID and the potential for ongoing victimisation, makes this group particularly challenging for professionals and services. In the United Kingdom, Sachs (2019) foregrounds the dual role of attachment disorders and dissociation in women's ongoing entrapment in sexually exploitative family networks.

People diagnosed with DID typically require specialist mental health treatment following evidence-based guidelines for phased therapy (International Society for the Study of Trauma and Dissociation, 2011) as well as support from a range of other agencies including AOD services, child protection, medical care and the police. However, due to a lack of training and understanding, women reporting symptoms of DID and

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histories of extreme abuse frequently fall through the cracks in their efforts to engage mental health, police, child protection and other agencies (Cooper, Anaf, & Bowden, 2008; Salter, 2017). Policy frameworks for prevention, intervention and treatment of sexual violence and domestic violence rarely acknowledge the complexities of the kind faced by women with DID symptomatology, including traumatic attachments to abusive families and groups and the strategic use of sexual violence as a means to control and silence women.

Intergenerational and collective trauma

The intergenerational transmission of traumatic symptoms and vulnerabilities from parent to child has been widely observed across populations, including survivors of child abuse, domestic violence and genocide. The academic literature identifies different pathways for the intergenerational transmission of trauma, including through culture-wide changes and social disorganisation (frequently associated with colonial dispossession and genocide), parenting styles and potential epigenetic transmission. The possibility of intergenerational trauma transmission first emerged in studies of the children of Holocaust survivors. Psychological research and clinical literature found that survivors and their children responded in diverse ways to Holocaust experiences, including a strong focus on family relationships and caregiving, however the second generation were at increased risk of depression, anxiety, difficulties in emotional expression, feelings of guilt and self-criticism, and somatisation (Felsen, 1998).

Research has also considered the collective and cultural impacts of trauma (i.e. on whole communities and groups). For example, Bezzo and Maggi (2015), in their analysis of Ukrainian Holodomor survivors and two generations of their descendants, described large-scale cultural changes taking place directly after the Holodomor, resulting in widespread mistrust, indifference and hostility to others; a focus on survival and self-preservation; and increased alcohol and drug use as a coping mechanism. While their model also acknowledged the roles of the individual, family and community in trauma transmission, culture-wide changes were presented as taking place at the time of or soon after the event. Historical traumas and cultural loss, and traumas experienced by individuals and transmitted within the family,

gradually result in a scenario of cultural breakdown where trauma-coping responses are transmitted and there is a loss of traditional cultural norms and practices.

In the Australian context, intergenerational and transgenerational trauma have been important concepts for Aboriginal and Torres Strait Islander scholars and clinicians examining the contemporary effects of colonisation— linked to a loss of social and cultural norms, values, meanings and structures—and the subsequent imposition of an alien system (Atkinson, 2002; Hoffart & Jones, 2017; Krieg, 2009). A variety of terms has been used to describe the legacy of colonialism and its effects on Aboriginal and Torres Strait Islander people, including "collective trauma" (Atkinson, 2002; Krieg, 2009), "historical trauma" (Atkinson 2002; Treloar & Jackson, 2015), "communal trauma" (Atkinson, 2002), "cultural trauma" (Halloran, 2004), "transgenerational trauma" (Atkinson et al., 2010) and simply "trauma" (Commonwealth of Australia, 1997; Funston, 2013; Herring et al., 2012). Milroy (2005, p. xxi) describes the intergenerational and collective nature of trauma transmission for Australian Aboriginal peoples in the following terms:

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

In her seminal work *Trauma Trails* (2002), Judy Atkinson, a Jiman and Bundjalung woman, writes that Western models of post-traumatic stress disorder are not applicable to Indigenous people as they are premised on an individualist understanding of mental illness. She argues that collective

trauma affects the whole society, rather than only affecting people on an individual level. She claims that trauma is "the normal human response of traumatic violations that remain unhealed" (p. 92) and therefore should not be viewed as a mental illness using a pathologising lens. Atkinson (2002) views Aboriginal and Torres Strait Islander trauma as "cumulative" or "compounding", which distinguishes it from a one-off traumatic event such as a natural disaster or unique event of interpersonal victimisation. Colonisation, she argues, "set in motion a series of disasters, one precipitating another, to propagate trauma on trauma on trauma" (2002, p. 59). In this model, trauma is both individual and collective and is passed on through survivors to their descendants. Trauma is further entrenched through policies, structures, and systems of control that disempower Aboriginal and Torres Strait Islander people.

The Australian practice of mass Aboriginal and Torres Strait Islander child removals during the 20th century, in which 10–33 percent of all Aboriginal and Torres Strait Islander children (the Stolen Generations) were forcibly removed from their families and communities between 1910 and 1970, is recognised as a profoundly traumatic period in Australian history (Human Rights and Equal Opportunity Commission, 1997) and a major driver of intergenerational trauma. A recent report by the Australian Institute of Health and Welfare (2019) found that Indigenous children under the age of 15 who lived in the same household as a Stolen Generations family member had poorer school attendance and reported more racism at school, higher levels of stress, poorer self-assessed health and higher rates of household poverty than other Indigenous children. The disproportionate involvement of Aboriginal and Torres Strait Islander families in the Australian child protection system, including ongoing high rates of child removal, is linked to the intergenerational effects of dispossession, colonisation, racism and the impact of the Stolen Generations (Bamblett & Lewis, 2007).

Understandings of trauma-informed care

Trauma-informed care (TIC) refers to models of professional and organisational practice that recognise and aim to address the effects of trauma on clients and staff. The foundations of TIC lie in the women's movement and in social movements for survivors of child abuse who have advocated for gender-sensitive, client-focused models of practice since at least the 1970s (Wilson, Pence, & Conradi, 2013). These efforts were bolstered by empirical findings on trauma impacts as research into abuse and violence burgeoned during the 1980s and 1990s. As the prevalence of trauma in the lives of female service users in mental health and substance abuse treatment became apparent in the mid-1990s, the central principles of "trauma-integrated" and "trauma-informed" practice began to take shape. The core principles of trauma-informed practice are:

- safe environment for clients and service providers
- promoting interpersonal relationships
- cultural awareness and knowledge
- supporting consumer control, choice, and autonomy
- understanding trauma and its impact
- sharing power, inspiring hope, and supporting recovery
- integrating different healthcare services
- sharing power and governance (Cleary & Hungerford, 2015).

There are multiplying lists of TIC principles, and TIC has been subject to a recent Australian literature review (Quadara, 2015). With that in mind, this section will focus first on briefly describing the state of knowledge of TIC, particularly in Australia, noting the growing interest in implementing TIC beyond the levels of individual and organisational practice and embedding TIC within and across sectors. The section will then discuss TIC in mental health and AOD settings, before examining the burgeoning literature on TIC in disability care, refugee and migrant services, Aboriginal and Torres Strait Islander community response, and trauma-informed policing and legal practice. This comparison of TIC models suggests that further research is necessary on the challenges of integrating and coordinating TIC across professional systems and sectors, rather than within them, and also in understanding the role of community-based programs and interventions in TIC. The TIC literature to date has been largely concerned with the transformation of service contexts and bureaucratic systems. However, as the following review indicates, paradigms of TIC in Aboriginal and Torres Strait

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Islander communities and refugee and migrant groups frequently combine community strengthening with service reform and collaboration.

TIC in health and human services

In the Australian context, there has been considerable interest over the last ten years in promoting "trauma-informed" health and human services to improve client outcomes, bolster collaboration and reduce the risk of re-traumatisation (Bateman, Henderson, & Kezelman, 2013; Kezelman & Stavropolous, 2012). Nonetheless, interlinked trauma sequelae such as mental illness and substance abuse remain somewhat "siloed" within distinct response systems (Quadara, 2015). Professionals in diverse sectors have indicated they are not adequately trained, resourced or supported to address trauma in their service or agency (see e.g. Salter & Breckenridge, 2014). Meanwhile, trauma-specialist agencies and workers evince reluctance to engage with non-specialist mental health agencies or other supports due to a lack of confidence in their trauma skills (Salter, 2017). Care following a history of traumatic exposure continues to be fragmented and often involves contradictory, ineffective or re-traumatising encounters with services.

Wall, Higgins and Hunter (2016) emphasise the need for a framework of service delivery that ensures complementarity and consistency between the service experiences of traumatised people and families, and warn of the potential for "inconsistent or piecemeal development of trauma-informed models and practices" in the absence of an overarching policy framework in Australia (Wall et al., 2016, p. 2). They identify a number of challenges to the implementation of a trauma-informed approach to care, including:

- a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs. the concept and principles of trauma-informed care)
- translating trauma-informed care to specific practice and service settings
- consistency across service settings and systems
- care coordination
- a lack of guidance for facilitating complex system change
- a lack of evaluation of models of trauma-informed care.

These challenges are the subject of ongoing research and policy innovation. In Australia, Hegarty et al.'s (2017) research focused on how to implement trauma-informed care and empowerment approaches within health systems for women who had experienced sexual violence and mental health problems. Their findings emphasised the need for a framework that is simultaneously "woman-centred" (empowering and holistic responses) as well as "practitioner-centred" (addressing practitioner needs and providing education and resources). Drawing on interviews and focus groups with women who had survived sexual violence as well as practitioners, they identified four main building blocks of women and practitioner-centred approaches:

- *Relationship building:* Opportunities should be provided so that individuals and teams within services as well as different services can develop trust and shared understandings.
- *Integrated coordinated care:* Care coordination requires clear roles for staff and working referral pathways within and outside the service, with trauma-informed work supported by policies and staff "champions".
- *Reflexive systems and monitoring:* Systems should actively seek the feedback of women into system and service improvements, and professionals should have the opportunity to provide input into improvements in strategy, policy and resources. Auditing and evaluation of how women move through systems would promote quality improvement.
- *Environmental and workplace scan:* Regular assessments of the adequacy of workplace and process arrangements, including appropriate physical spaces for consultation and counselling; reviews of workflow patterns to ensure appropriate care; assessment of workplace culture, values and beliefs; and ongoing monitoring and evaluation.

The following two sections consider the current state of TIC in key health sectors, namely mental health and AOD treatment.

Mental health

As discussed above, the evidence suggests that trauma is a general but nonspecific risk factor for a host of psychiatric disorders, and challenges prevailing medical and biological models of mental illness. It also means that women with

experiences of complex trauma will potentially present to any part of the mental health system as well as to multiple other service systems. This highlights the need for integrated service delivery for women who have experienced complex trauma, including support from mental health professionals to help women navigate these multiple systems (Cleary & Hungerford, 2015).

While there are no estimates of the number of Australian women presenting to mental health services with experiences of complex trauma, international research found 69 percent of women accessing community mental health services had experienced IPV and 61 percent had experiences of sexual assault since the age of 16 (Khalifeh et al., 2015). Compared to non-psychiatric controls, the women were more than three times more likely to experience IPV and had four times the risk of experiencing sexual assault. However, less than half the women disclosed their abuse to a health professional, despite all of the participants being engaged in mental health services. Relatedly, research has found that mental health clinicians either do not assess for trauma experiences or fail to incorporate knowledge of such experiences into treatment plans (Kim, Ford, Howard & Bradford, 2010).

It has been suggested that the high rate of victimisation among women with serious mental illness is related to them being perceived as easy targets by perpetrators. It is thought that women with a mental illness may be less capable of resisting an assault, less likely to report an assault, or—if they do—less likely to be believed (Mason & Lodrick, 2013). This propensity for their accounts not to be believed can reverberate through their interactions with other systems including mental health care. For example, a substantial minority of women described their interaction with the health system following a sexual assault as harmful (Jordan et al., 2010). Other reports have found that women with experiences of violent victimisation continue to experience stigma and discrimination within the health care system (Horsfall et al., 2010).

In reviewing the application of trauma-informed practice for mental health nurses, Cleary and Hungerford (2015) make a number of suggestions/comments regarding implementation:

- The perceived lack of safety experienced by women in mental health settings may be somewhat alleviated by having private rooms and gender-specific wards. However, a broader notion of safety goes beyond the physical environment to include interpersonal, emotional and spiritual safety.
- There is a need to promote the personal agency of women in an inpatient setting that is highly regulated and constrained and which can induce a sense of powerlessness similar to that experienced in previous traumatisation. This would include an appraisal of "symbols of control" such as the demeanor and business of staff and abrupt dismissal of clients.
- There is a recognised importance for mental health nurses to take a lead in raising the possibility of traumatic distress during case reviews and interdisciplinary team meetings.
- The limitations of single-day awareness training and the need to develop skills in trauma-informed practice over a longer time period need to be addressed.
- As opposed to the traditional focus on reducing symptoms, importance should be placed on identifying the woman's own treatment goals and making these a priority within treatment plans.

The authors conclude by acknowledging the significant challenge that trauma-informed practice poses for mental health services and the need for more coherent research "to better inform a transmissible pedagogy for education and research programmes in this area" (Cleary & Hungerford, 2015, p. 376). Similarly, the Mental Health Coordinating Council (MHCC) has advocated for a National Strategy for Trauma Informed Care (NS–TIC) (Bateman et al., 2013).

Alcohol and other drugs

Previous trauma experiences can make it difficult for women to engage with alcohol and other drugs (AOD) treatment. This is particularly the case where services adopt a punitive approach aligned with an expectation that clients take responsibility for their substance use and associated chaotic lives (Salter & Breckenridge, 2014). This expectation is problematic for women clients whose trauma histories have often involved repeated physical and sexual victimisation starting in early childhood. Experiences of women in AOD services has been characterised by aggression and intimidation, as well as controlling and coercive behaviour. These experiences

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undermine women's recovery from both trauma and substance dependence.

Despite heavy investment in a National Comorbidity Initiative (see e.g. Australian Institute for Primary Care, 2009), women continue to report being denied access to trauma-focused treatment, with this being provided only after substance use issues have been addressed (Salter & Breckenridge, 2014). However, recent trials show that integrated treatment for trauma and substance use is both effective and acceptable to clients (Mills et al., 2012; Mills et al., 2014). Further, addressing PTSD results in improvements in substance use symptoms, but improvements in PTSD symptoms do not necessarily follow on from treatment and improvement in substance use outcomes (Hien et al., 2010; Read et al., 2004).

The process of detoxification and rehabilitation can therefore be highly problematic given the interplay between trauma symptoms and substance use. Programs stipulating abstinence effectively remove an established strategy from women's coping repertoire. The role of substance abuse as a trauma coping mechanism is not always understood by AOD staff (Salter & Breckenridge, 2014). As such, PTSD symptoms may resurface in the treatment setting and present challenges for both the women and service staff (Read et al., 2004).

Despite recognition of the need for AOD services to adopt a trauma-informed approach, this has largely not been implemented. Mills (2015) outlines several reasons for this, including a lack of routine assessment of trauma due to ill-informed concerns regarding client safety. These concerns relate both to a perception of clients' incapacity to tolerate disclosure as well as clinicians' lack of confidence and skills to respond appropriately. Other research has similarly reported on the inability of staff to manage women with comorbid mental disorders despite a general awareness of substance use being highly comorbid with other mental disorders (Salter & Breckenridge, 2014). This was explicitly linked to denial of treatment because problematic behaviour was not understood as mental distress.

Mills (2015) recommends that AOD clinicians need to:

- be aware of the extent of trauma and post-traumatic distress symptoms among their service users
- understand what this means for treatment engagement, retention and outcomes
- integrate this knowledge into clinical practice.

Disability care

It is widely recognised that children and women living with disability experience trauma and violence at disproportionate levels (Wilczynski, Connolly, Dubard, Henderson, & Mcintosh, 2015). Jones et al.'s (2012, p. 899) review of research on violence against children with a disability found that 21 percent of children with mental or intellectual disabilities were exposed to violence, including a 15 percent prevalence rate for sexual violence. Key drivers of abuse and violence for children and young people living with a disability include stigmatisation and discrimination, isolation and stress amongst carers, the impact of impairment (for instance, difficulties in communication and disclosure) and vulnerability in situations of care or institutionalisation (Jones et al., 2012). Research has consistently found very high rates of physical and sexual violence among women living with a disability (Jones et al., 2012).

Services and systems that aim to support people with a disability have not generally acknowledged their vulnerability to violence or high levels of trauma exposure. In Australia, NSW Family and Community Services and Berry Street have published *Taking Time*, a framework for TIC for people with an intellectual disability (Jackson & Waters, 2015). The core principles of the *Taking Time* framework include focusing on individual goals, strengths and support needs; understanding the impact of trauma on people with disability; and creating safe and empowering environments in which individuals are supported to communicate their needs and experiences. A recent evaluation of the implementation of the framework in two services in New South Wales emphasised significant organisational shifts as a result of implementation, with workers describing themselves as feeling more confident, empathetic and empowered in working with traumatised clients (Gray & Tracey, 2016). The evaluation suggested that ongoing efforts to improve trauma expertise and build

skills, trust and understanding within and across teams were important enablers in TIC, potentially requiring more resources than were made available to services at the time.

Refugee and migration services

Refugee services include community development as a core part of their response in addressing complex trauma. Such an approach acknowledges the systemic aspect to the trauma experiences in this population. The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) (n.d.) recognises the impact of political persecution and mass trauma on community cohesion and the loss of connectedness and social capital that ensues.

Foundation House has published a framework for community capacity building which outlines the role that community development plays in their integrated trauma recovery service model (Foundation House, 2017). Trauma-informed community capacity building recognises the responsibility of the host country to provide opportunities that enable refugee communities to rebuild and recover their self-reliance. This is achieved by supporting cohesive relationships, strengthening community resources, and enabling leadership and decision-making within the community. The steps to implementing trauma-informed community capacity building are listed below:

1. Understand a community.
2. Establish a relationship with a community.
3. Develop and plan strategies.
4. Identify people of influence.
5. Establish a structure.
6. Map assets to identify community goals.
7. Form relationships with external agencies.
8. Engage in dialogue towards community goals.
9. Extend reach of outcomes.
10. Support community sustainability (Foundation House, 2017, p. 12).

To support the implementation of these steps, the framework also makes clear the need for skilled staff who are trauma-informed and culturally aware, and who also have competence in facilitating groups and can work effectively with interpreters. Furthermore, Kira and Tummala-Narra (2015) advocate for an ecological model of recovery for traumatised refugees, foregrounding how the specificity of an individual's life history intersects with the sociopolitical and cultural contexts of their countries of origin and destination to produce highly varied outcomes, even within the same refugee population. This individualised but ecological approach acknowledges and addresses the varied accumulation of diverse traumas in the lives of refugees in their past and current settings.

Aboriginal and Torres Strait Islander models of trauma care

Aboriginal and Torres Strait Islander models of trauma care have been championed by clinicians such as Atkinson et al. (2014) and by the Healing Foundation (2014), the national Aboriginal and Torres Strait Islander organisation established to address the ongoing traumas of the Stolen Generations and forced child removal. These approaches generally emphasise the fundamental importance of collective healing processes grounded in Aboriginal and Torres Strait Islander cultures and perspectives, recognising the ongoing suffering of colonisation, the mass impacts of genocidal practices such as the Stolen Generations, and the realities of ongoing racism and interpersonal violence. According to the Healing Foundation:

> Trauma-informed practice is a strengths-based approach to healing that: is based on an understanding of, and responsiveness to, the impact of trauma; emphasises physical, psychological, and emotional safety for people seeking help and for the helpers; and creates opportunities for people affected by trauma to rebuild a sense of control and empowerment. It recognises the prevalence of trauma and is sensitive to and informed by the impacts of trauma on the wellbeing of individuals and communities. (2014, p. 47)

Atkinson et al. (2014) advocate for a "sociological and historical perspective" in order to understand the traumatic experiences and symptoms of Aboriginal and Torres Strait Islander people, and call for trauma-informed approaches that include both "individual treatment" and "whole of community healing" (p. 292). They emphasise the early onset and persistence of

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multiple, cumulative stressors in the lives of Aboriginal and Torres Strait Islander peoples, which are linked to abuses within unequal power relations (such as by authority figures) as well as within intimate and family relations. Intentional racism further compounds and perpetuates intergenerational trauma and current stressors. Drawing on theories of post-genocide recovery, Atkinson et al. (2014) suggest that, following mass traumatisation, "community level interventions may be an essential precursor to the provision of individual care" in which community services are controlled and directed by the community impacted by trauma (p. 298). They endorse capacity-building programs that are focused on promoting the strength, confidence and skills of Aboriginal and Torres Strait Islander workers and communities in order to change behaviours and attitudes linked to dysfunction and abuse. In particular, these programs are focused on "establishing and equipping a core group of community members with the skills necessary to direct vulnerable individuals away from disruptive and damaging behaviour, substance and alcohol misuse and family violence and neglect" (p. 298).

The Healing Foundation agrees that individual and community self-determination of healing experiences and approaches is restorative of "personal agency, self-determination and responsibility" (2017, p. 13). The Healing Foundation (2017) has proposed eight elements of quality Indigenous healing programs, drawing on the emerging evidence from their funded healing projects around the country. They indicate that quality healing programs:

- are developed to address issues in the local community
- are driven by local leadership
- have a developed evidence base and theory base
- combine Western methodologies and Indigenous healing
- understand the impact of colonisation and transgenerational trauma and grief
- build individual, family and community capacity
- are proactive rather than reactive
- are designed with strong evaluation frameworks. (p. 15)

Trauma-informed policing

The term "trauma-informed policing" describes models of law enforcement that recognise the prevalence of trauma in the lives of people in contact with the criminal justice system, and the role of trauma in both criminal perpetration and victimisation. Despite growing interest in TIC among law enforcement, the field of trauma-informed policing is in its infancy. The most well researched and evaluated model is the Child Development–Community Policing program, developed in partnership between the Yale Child Study Center and the New Haven, Connecticut Department of Police Service in 1991 (Marans & Berkman, 1997). The CDCP program integrates trauma-specialist mental health workers with community-focused police officers, so that police receive training on traumatic impacts and sequelae, and trauma clinicians work and consult directly with police. Mental health specialists are on call to respond immediately to police calls involving child witnesses or victims of violence and trauma, and can provide a free and confidential trauma-focused treatment intervention where requested. A weekly case consultation between police and clinicians enables improved discussion and management of particularly complex or difficult cases. Priority areas of the CDCP initiative have included delivering clinical care for juveniles exposed to trauma who are beginning to engage in criminal offending, and providing interventions for children and families where there is domestic violence (Berkowitz & Marans, 2000). A key goal of the program is to work together with multiple agencies and services to re-establish feelings of safety, security and wellbeing in the aftermath of violence. In the New Haven public school context, there is evidence that the CDCP program has improved young people's feelings of safety and security in their community, with surveys of teenagers indicating increased feelings of community safety and decreased exposure to shootings or stabbings (Marans, Berkowitz, & Cohen, 1998).

Trauma-informed legal practice

There has been increased enthusiasm for the integration of trauma-informed practice into the law and judiciary. Katz and Halder (2015, p. 3) describe "the hallmarks of trauma-informed practice" as when the legal practitioner

> puts the realities of the clients' trauma experiences at the forefront in engaging with clients, and adjusts the practice approach informed by the individual client's trauma experience. Trauma-informed practice also encompasses the practitioner employing modes of self-

care to counterbalance the effect the client's trauma experience may have on the practitioner.

Legal TIC recognises that many legal clients and many people in the criminal justice system have a trauma history, and that their experience and outcomes within legal processes can be improved by addressing trauma impacts. TIC in legal contexts poses a number of challenges, however. Kezelman and Stavropoulos (2016) note that the Western tradition of law is grounded in a view of individuals as "rational actors" whose offences are motivated primarily by self-interest, and who can be deterred from offending by threat of punishment. However, "privileging of a narrow conception of self-interest can neither account for the complexity of other motivations and needs or the neurobiological impairments with which unresolved trauma is correlated" (Kezelman & Stavropolouos, 2016, p. 9). Instead, they argue that traumatised people will privilege the need to protect themselves against re-traumatisation over and above their self-interest, and that much criminal or otherwise challenging behaviour reflects this prerogative to avoid or manage overwhelming emotions or memories. Implementing TIC in legal practice and the courts requires a shift in perspective that focuses on the personal history of clients and a reconsideration of what constitutes rational and reasonable behaviour in light of traumatisation and abuse.

Legal TIC is designed to support lawyers in their work with clients whose lives are complex or chaotic and who may display difficult or challenging behaviours, particularly where legal practice with such clients is heavily constrained—such as where clients are under orders or lawyers are working with mental health clients, asylum seekers or refugees (Carnes, 2017). In these contexts, clients are often anxious and fearful, and trauma impacts, including difficulties regulating emotion and behaviour, are exacerbated. Carnes (2017) emphasises that legal training and education on trauma is insufficient and that both lawyers and judges need capacity and skills building in order to improve their encounters with traumatised people and manage the effects of trauma exposure on their own mental health. Available TIC models propose significant changes for legal curriculum and training, including training in trauma and TIC, reflective practice skills and cultural safety skills-building (Carnes 2017). Carnes (2017) proposes that all legal professionals should receive regular independent supervision in which they can reflect on their practice with complex and difficult clients, while Katz and Haldar (2015) define four elements for trauma-informed legal practice:

1. *Identifying trauma:* Lawyers should learn to identify when a client is describing a traumatic experience or may be exhibiting psychological or behavioural indicators of trauma.

2. *Adjusting attorney-client relationship:* Lawyers should be versed in a range of strategies to respond appropriately to the individualised impacts of trauma on their clients.

3. *Adapting litigation strategy:* Lawyers should seek to adjust their approach to litigation in order to accommodate the needs of the client. Adjustments may include reassuring the client through careful explanation of court processes, desensitising the client by rehearsing their testimony, and decreasing the stress of testifying by providing breaks in testimony and encouraging support people to attend court with the client.

4. *Preventing vicarious trauma:* Lawyers should seek to manage the risk of vicarious trauma through self-care strategies, taking on diverse clients, and promoting an organisational culture that is supportive and trauma-informed.

Vicarious trauma

A key feature of TIC is recognition of the potential impacts on workers of professional engagement with traumatised clients. While the bulk of the literature has focused on what is often called "vicarious" traumatisation, in which immersion in details of the traumatic lived experiences of others can produce traumatic symptoms in workers, there is also an important body of scholarship on the positive and beneficial impacts of trauma work. The following section provides an overview of the three most commonly used constructs in descriptions of the negative impacts of trauma work—namely, secondary stress, vicarious traumatisation and compassion fatigue—followed by a discussion of the salutogenic effects of engaging professionally with traumatised clients.

Secondary traumatic stress

The development of post-traumatic stress symptoms in workers who are exposed to the trauma narratives and

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symptoms of clients has been described as secondary traumatic stress (STS) (Figley, 1995a). Figley (1995a, p. 7) defines STS as "the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other" and "the stress resulting from helping or wanting to help a traumatized or suffering person". Secondary traumatic stress refers to three of the four types of symptoms described in post-traumatic stress disorder (American Psychiatric Association, 2013): intrusions, behavioural avoidance, and nervous system dysregulation. The onset of STS can occur suddenly and includes symptoms such as intrusive imagery of the client's trauma, avoidance of the client or reminders of the client's trauma, physiological arousal (such as development of a startle response), dissociation, hypervigilance, and outbursts of anger (Bride, Robinson, Yegidis, & Figley, 2004; Choi, 2011). Further to these physiological and psychological repercussions, the development of STS can also create relational challenges, disrupting the professional's personal relationships (Robinson-Keilig, 2014) and their functioning within their workplace (Ting, Jacobson, Sanders, Bride & Harrington, 2005). STS is generally recognised to be a normal consequence of caring for traumatised people and one that can be actively mitigated through a variety of strategies (Figley, 1995a).

Vicarious traumatisation

Vicarious traumatisation (VT) acknowledges the vicarious development of PTSD symptoms among those indirectly exposed to trauma, as well as changes to cognitive schemas that can, in turn, impact previously held beliefs about the safety and security of the self and others (Pearlman & Saakvitne, 1995). Cognitive schemas refer to mental constructs generated through experience that are used to make sense of the world, and are constituted by our assumptions, inferences and perceptions. In relation to VT, those schemas which are most vulnerable to negative transformation are those relating to safety, trust, control, esteem and intimacy (McCann & Pearlman, 1990, 1991). Research into VT positions it as a work hazard for professionals working with traumatised clients, who may experience a variety of impacts on their interpersonal relationships; health; and views of themselves, their world and others (Arnold, Calhoun, Tedeschi & Cann, 2005; McLean, Wade, & Encel, 2003; Pearlman & MacIan, 1995). VT has been identified across a range of professions including

social workers (Aparicio, Michalopoulos, & Unick, 2013), interpreters (Darroch & Dempsey, 2016), psychotherapists (Pearlman & Saakvitne, 1995), and correctional health nurses (Munger, Savage & Panosky, 2015). Unlike the sudden onset of symptoms that can occur with STS, VT is a cumulative process which occurs via sustained and repeated work with trauma populations, and is also considered a normative and expected consequence of trauma work (Pearlman & Saakvitne, 1995).

Compassion fatigue

Figley (1995b) coined the term "compassion fatigue" (CF) to offset the stigma associated with secondary traumatic stress and thereby increase effective responses to workers suffering such impacts. Working compassionately with distressed clients in challenging or stressful work situations over an extended period of time can create the conditions which lead to the development of CF. The term refers to a reduced desire or capacity within the worker to be empathetic towards their clients (Adams, Boscarino & Figley, 2006; Figley, 2002). Those impacted by CF are encumbered with trauma symptoms such as hypervigilance, avoidance, numbing, intrusive imagery and anger, as well as "burnout", which describes a state of emotional exhaustion and depersonalisation within the worker, and a sense of reduced effectiveness within the work role (Maslach, Jackson & Leiter, 1996).

Unlike STS and VT, which primarily relate to physiological and psychological changes within the caregiver, CF is understood as a hazard of caring work that can directly impact a worker's ability and professional effectiveness (Collins & Long, 2003). CF is characterised by cognitive and relational shifts, as well as feelings of hopelessness and isolation, which can lead to errors in professional judgement, poor client treatment planning and clinical errors (Bride, Radey & Figley, 2007; Figley, 2002). Research suggests that the risks of CF increase for those with a higher percentage of clients with PTSD (Craig & Sprang, 2010), a longer duration of time working with sexual abuse survivors (Cunningham, 2003) and those who perceive they have less control over their workplace (McKim & Smith-Adcock, 2014)

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Vicarious benefit

The potential risks of trauma work are now well recognised across a variety of professional settings. However, a growing body of research has pointed to the many rewards and benefits that professionals gain from trauma work, including increased sensitivity, compassion, insight, tolerance, and empathy (Arnold et al., 2005); and joy, hope, and becoming richer, deeper, and better people (Splevins, Cohen, Joseph, Murray, & Bowley, 2010). The relational benefits of trauma work have also been identified, including paying closer attention to intimate relationships (Hyatt-Burkhart, 2014) and spending more quality and meaningful time with loved ones (Barrington & Shakespeare-Finch, 2013), as well as changes on perspective of life such as gratitude for their life and appreciation of the human spirit (Arnold et al., 2005) and a sense of spiritual broadening (Manning-Jones, de Terte, & Stephens, 2015). The following section summarises key literature on compassion satisfaction (Stamm, 2002), vicarious post-traumatic growth (Calhoun & Tedeschi, 2006), and vicarious resilience (Engstrom, Hernández, & Gangsei, 2008).

Compassion satisfaction

While engaging compassionately with people who are in psychological pain can be personally taxing, the meaning and beneficence of such work also has lasting positive effects. One such benefit is compassion satisfaction (CS), which has been described as the pleasure that helpers derive from being able to do their job well and feeling efficacious and competent in their role (Stamm, 2002). The development of CS can provide a buffer from the hazards of compassionate work by fostering joy and hope in the role of helper (Bride et al., 2007; Stamm, 2002). Being one of the three subscales on the Professional Quality of Life Scale (Stamm, 2005), CS relates directly to the value one feels in their work life and correlates negatively to burnout (Rossi et al., 2012), compassion fatigue (Stamm, 2002) and psychological distress (Rossi et al., 2012). CS is linked to factors within the worker as well as within their working conditions (Frey, Beesley, Abbott, & Kendrick, 2017; McKim & Smith-Adcock, 2014) and is more commonly found in professionals who have specialised trauma training (Craig & Sprang, 2010), a longer duration of clinical experience (McKim & Smith-Adcock, 2014), well

developed emotional regulation skills and self–other awareness (Wagaman, Geiger, Shockley & Segal, 2015) and who have emotional competence and problem-focused coping skills (Zeidner & Hadar, 2014). Aspects of the work environment implicated in the promotion of CS include the perception of being supported by management, support via supervision (that is, the counsellor or worker has a designated person with whom they can debrief, reflect and learn in the context of ongoing professional development) (Sodeke-Gregson et al., 2013), organisational support (Frey et al., 2017) and perceived control within the workplace (McKim & Smith-Adcock, 2014).

Vicarious post-traumatic growth

Traumatised individuals who are supported to respond constructively to trauma-related challenges and changes report experiencing post-traumatic growth: that is, positive changes in self-relationship, a greater appreciation of interpersonal relationships, and changes in life goals and values as a consequence of trauma exposure (Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996). Vicarious post-traumatic growth (VPTG) describes the occurrence of these same positive personal, relational and world-view changes, but through vicarious rather than direct traumatisation (Arnold et al., 2005). Arnold et al. (2005) first named VPTG in their study exploring perceptions of the impact of trauma work on 21 mental health professionals. They found that, while all interviewed professionals identified being impacted negatively by trauma work, they also reported benefits, including being inspired and encouraged by clients' growth, an appreciation of the resilience of the human spirit, and a deepening of their own spirituality (Arnold et al., 2005). These changes are often sequential, in that the internal disruption and dissonance of vicarious traumatisation is a precursor to VPTG (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013). Barrington and Shakespeare-Finch (2013) interviewed 13 clinical and 4 administrative frontline staff who work with refugee trauma survivors to explore the positive and negative effects of trauma work. Similar to the findings of Arnold et al. (2005), all of the workers reported elements of vicarious trauma and described the emotional toll and burden of their role, but they also described experiencing VPTG. Barrington and Shakespeare-Finch (2013) located VPTG within the three

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domains of self-perception, interpersonal relationships and philosophy of life, as well as in feeling a sense of purpose and privilege, and being honoured to be trusted with their clients' stories (Barrington & Shakespeare-Finch, 2013).

Vicarious resilience

Vicarious resilience (VR) describes a further positive consequence of trauma work where therapists are impacted positively through witnessing the resilience of their clients throughout the therapeutic process (Engstrom et al., 2008). The term was first used by Hernandez, Gansei, and Engstrom (2007) in their exploratory study of 12 mental health professionals working with clients who had suffered torture, kidnapping and political violence. Hernandez et al. (2007) noted that these professionals spoke of drawing strength from their clients, an increased tolerance for frustration and adversity, and a greater sense of perspective in relation to their own problems. Engstrom et al.(2008) explored this phenomenon further in a follow-up study of 11 mental health professionals working with survivors of torture, and broadened the concept of VR into three main themes. As a positive consequence of working with resilient clients, these professionals 1) re-evaluated their own lives and problems, 2) recognised the human capacity to thrive, and 3) were reaffirmed in the value of their work. Key resilience markers include positive changes in personal goals and priorities, increased hopefulness and inspiration, and increases in self-care (Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). Research has also defined a number of individual and organisational contributors to VR, such as self-awareness and reflective practice (Pack, 2013), quality peer relationship and support (Frey, Beesley, Abbott, & Kendrick, 2017), training, supervision, and a workplace culture that normalises VT as an expected outcome (Pack, 2013).

Summary

The expansion of research on trauma and abuse over the last three decades has revolutionised understandings of mental illness and social problems, including violence against women and child abuse. Moving away from simplistic, victim-blaming notions of individual disorder and pathology, the concept of psychological trauma calls attention to a universal human vulnerability to psychological injury in dysfunctional interpersonal relationships. The notion of "complex trauma" signifies in particular the ongoing entrapment of children and women in abusive intimate and family relationships and the feelings of helplessness and betrayal that often accompany child abuse, domestic violence and multiple experiences of sexual assault. As such, complex trauma remains a central concern within efforts to prevent, identify and respond to violence against women and their children.

This literature review has emphasised how the concepts of trauma and complex trauma have been operationalised in research in order to examine the impacts of chronic victimisation on children and adults, and the dynamic interplay of individual, relational, social and systemic factors shaping victim pathways and recovery. Evident in the literature were multiple definitions of complex trauma, in which the term was used to refer to:

- *Psychiatric diagnosis:* Complex trauma was often a "catch-all" term that included complex PTSD, dissociative disorders, borderline personality disorder and aspects of bipolar and psychosis, such as fluctuations in mood or "hearing voices".

- *Presentation:* Complex trauma sometimes referred to complex presentations amongst clients with a trauma history, particularly where clients present with multiple, chronic needs that exceed the capacity of a single service or professional.

- *Trauma history:* Complex trauma was a term that, at times, was used specifically to refer to the mental health impacts of child sexual abuse, particularly where abuse was initiated early in life. In adulthood, "complex trauma" could signify multiple "types" of victimisation, such as IPV involving sexual assault and stalking.

- *Extremity of abuse:* Complex trauma is also used as a euphemism for under-acknowledged and extreme forms of violence, such as organised abuse, prolonged incest, and sexual exploitation.

- *First Nations theories of trauma:* Aboriginal and Torres Strait Islander scholars and clinicians link complex trauma to intergenerational, transgenerational, collective, historical, communal and cultural trauma.

Each of these approaches points to an important perspective and practice orientation on complex trauma. Drawing together their respective insights, we propose a conceptualisation of complex trauma according to three axes of complexity:

1. *Complexity of victimisation,* including:
   - frequency and severity of abuse, early onset, and duration
   - multiplicity of abuse types (i.e. physical, sexual, emotional) and multiplicity of perpetrators
   - abuse ongoing at the time of presentation.

2. *Complexity of presentation,* including:
   - mental illness such as post-traumatic stress disorder (dissociative subtype), dissociative disorders and other comorbid mental illness
   - psychosocial problems such as substance abuse, self-harm and suicidality
   - other needs including housing, poverty and child protection concerns.

3. *Complexity of context,* including:
   - pre- and post-abuse context—a chaotic or disorganised family, community or social environment can make abuse more likely and a supportive response post-abuse less likely
   - inequality and disadvantage—social and historical factors including misogyny, racism and heterocentrism destabilise family and community structures and create the conditions for trauma and invalidating, victim-blaming responses
   - collective and intergenerational trauma.

The TIC literature contains a vast amount of professional experience and practice wisdom relating to the support and care of traumatised children and women. The majority of TIC literature concerns the reform of human service delivery with some consideration of health systems, although the mental health sector remains, somewhat paradoxically, resistant to TIC. A range of novel TIC frameworks are under development across disparate areas of professional practice where workers are in routine contact with traumatised children and women. Research indicates that the impact of this work on professionals is significant, with the enduring positive and negative impacts of trauma work evident across a range of workforces.

Nonetheless, in the absence of an overarching policy framework for TIC in Australia, it would seem wise to heed Wall et al.'s (2016, p. 2) warning about the potential for "inconsistent or piecemeal" TIC models to perpetuate fragmented, re-traumatising discontinuities in care. The focus on community-led interventions to address complex trauma in Aboriginal and Torres Strait Islander, refugee and migrant communities also points to another area of TIC that has been overlooked in many models focused on service responses. Where mass and intergenerational traumatisation is in effect, community strengthening and healing methods may be a crucial precursor to TIC reform and clinical intervention (Atkinson et al., 2014).

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Methodology

As the preceding literature demonstrates, there is a need for holistic research into "best practice" responses to complex trauma that place the needs and understandings of diverse women at the centre. Guided by an expert advisory committee, this project has brought together an interdisciplinary research team drawn from academic and practice backgrounds to develop a comprehensive picture of how complex trauma is being constructed in public policy and practice, and by women with experiences of complex trauma. The guiding question of the study is, "How can agencies and services improve collaboration to meet the health and safety needs of women with experiences of complex trauma?" This question informs four key aims:

1. Analyse how complex trauma experienced by women is constructed in public policy at national, state and territory levels.

2. Examine institutional responses to women's complex trauma in the mental health, AOD and sexual assault/ domestic violence sectors in New South Wales and Queensland.

3. Document how women who have experienced complex trauma understand complex trauma, and their experiences and encounters with agencies while seeking help.

4. Develop models of improved and collaborative responses to enhance the wellbeing and safety of women with experiences of complex trauma and their children.

Theoretical framework

The project is grounded within a psychosocial approach to complex trauma. This approach recognises that complex trauma is shaped by psychological as well as social and systemic factors, which are understood as closely intertwined (Frosh, 2003). The particular qualities of relationships, and the formation of identity and capacity in relation to others, is a key focus in psychosocial theory, which makes use of select psychoanalytic as well as sociological approaches in conceptualising women's adaptations to conditions of violence and inequality (Frosh, 2003). We also draw on feminist understandings of the concept of "complex trauma", which lie in feminist clinical practice and theorisation of the unique impacts of gendered oppression across the lifespan (Herman, 1992; Warner, 2009). While recognising the role of family and interpersonal relations, feminist and psychosocial theories also attend to those forms of governance that act to shape the individual's ability to secure redress and protection after experiencing events such as domestic violence, sexual assault, and childhood abuse and neglect. A psychosocial approach is complementary to the prevailing social–ecological model of family violence and child maltreatment that informs public policy at the state and national levels. This model positions risk and protective factors for violence at the individual, relational, community and systemic levels, and identifies opportunities to prevent and reduce the risk of violence beyond interventions at the individual level (Our Watch et al., 2015). Feminist and psychosocial perspectives highlight the relevance of women's development and lived experience within the broader social and political structures and histories that shape patterns of violent abuse, and their understanding of, and negotiation with, these contingencies. Our approach recognises that categories such as gender, class and race interact in dynamic ways that are closely linked to those structures, institutions and discourses that impact on psychological formation, subjective experience and human behaviour (Bowleg, 2012). Through this conceptual framework, the project offers an important contribution to the development of a comprehensive understanding of women's complex trauma beyond the dynamics of perpetration and victimisation, to include service and systemic contributions to the risk of violence as well as women's health, safety and healing.

Study components

This is a multi-method study incorporating:

1. a policy audit of approaches to complex trauma

2. documentary analysis, qualitative interviews and focus groups with 63 professionals (approximately half in Queensland and half in New South Wales) about their understandings of complex trauma, and their experiences providing services to women with complex trauma

3. qualitative interviews with 40 women who have experienced complex trauma (21 in Queensland and 19 in New South Wales) about their understandings of complex trauma, and their experiences accessing services in relation to their health and safety needs

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4. seven online co-design workshops in which professional stakeholders and women with experiences of complex trauma were invited to comment on the research findings and develop improved models of policy and practice.

Identification of services, recruitment of participants and the location of workshops was targeted to ensure that the project accommodated diversity of experiences and included consideration of the challenges of service delivery in different geographical contexts.

Policy audit

The policy audit was conducted in July–September 2018 and involved the collation of all relevant national, state and territory policies and frameworks on violence against women and mental health. Federal, state and territory government websites were searched to identify policy documentation using the following terms: trauma, complex trauma, complex PTSD, intergenerational trauma, transgenerational trauma, dissociat* and personality disorder. Further Google searches revealed additional documents related to trauma in areas such as child protection and education. The search strategy identified that the majority of relevant documentation was sourced from health departments, with 53 relevant policy documents (see Appendix A) drawn from the following sites:

http://www.health.gov.au/

http://health.nsw.gov.au

https://www.health.qld.gov.au/

https://health.nt.gov.au/

http://ww2.health.wa.gov.au/

http://sahealth.sa.gov.au

http://www.dhhs.tas.gov.au/

http://www.health.act.gov.au/

https://www.coaghealthcouncil.gov.au/

All policy documents were imported into NVivo (Version 11), a qualitative data analysis software package that enables codes (or themes) to be identified and assigned to blocks of text. A directed qualitative content analysis methodology was applied to the documentation, in which a predetermined coding matrix is developed based on the existing literature. The initial coding process used the search terms above. Text search queries for all keywords were run in NVivo to identify these codes. Each keyword was set up as a node and all documents were coded at each node. Further nodes were created after common terms related to complex trauma were identified during the coding process.

Documentary analysis and interviews and focus groups with service providers

The project sought to identify and engage a range of services and agencies involved in responses to women with complex trauma in New South Wales and Queensland. Potential services and agencies were identified through discussions within the project team and with the project advisory committee, as well as via web searches. From June to November 2018, services were then approached via email or phone call and sent information about the study. Services who agreed to participate could then internally distribute information about the study to their employees. The specific sectors targeted were AOD, mental health, sexual assault and domestic violence, legal services, refugee and migrant services, homelessness, Aboriginal and Torres Strait Islander community-controlled services and law enforcement.

Services and agencies could participate in the study via a documentary analysis, in which they consented to provide service documentation relevant to complex trauma to the study, and/or through interviews and focus groups with workers. These services were identified in consultation with the project's advisory committee and considered to be exemplars of trauma-informed service delivery. Twelve services in total (six in each state) were approached to participate in the study across a range of sectors (legal, refugee, homelessness, AOD, mental health, women's health, sexual assault and domestic violence, Aboriginal and Torres Strait Islander community-controlled and women's services) via email and follow-up phone calls. The potential participation of services was then discussed in more detail with service managers and coordinators via email, telephone calls and in-person meetings. Service documentation for discourse analysis was available from services from the sectors outlined in Table 1.

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Table 1: Availability of service documentation for analysis

Sector	NSW	QLD
Legal	2	
Refugee		1
Homelessness	1	
Alcohol & other drugs		
Mental health		1
Women's health	2	1
Sexual assault & domestic violence	1	

Through the course of discussions with services, it emerged that few services had documentation that was directly relevant to our study; that is, complex trauma was frequently not named or addressed specifically in service documentation. Furthermore, where service documentation or information was provided, it was frequently necessarily to then interview staff from the service in order to fully document their model of care.

The project aimed to interview 30 professionals from a range of sectors working with women with experiences of complex trauma. Due to the level of interest in the project, and also the preference of some services for group interviews, the project interviewed 63 professionals. Workers were drawn from a range of sectors and disciplinary backgrounds; some were identified through the documentary analysis and thus were from agencies with a clearly articulated model of trauma-informed care. Professionals from other services and sectors who came into contact with women with experiences of complex trauma were also sought regardless of whether they were trauma specialists or had expertise in trauma-informed care. Thus, the recruitment of professional participants included notices via social media and emails to peak bodies, advocacy networks and professional societies. Participant details are shown in Table 2. The research team spent 18 months seeking to engage the NSW Police Force in the study, however they were ultimately unsuccessful. Given the time constraints of the two-year study, we were not then in a position to initiate research processes with the Queensland Police Service (QPS). The first-hand experiences of police in their interactions with women who experienced complex trauma were therefore unavailable to this study, although this is an important area of future inquiry.

Interviews were conducted by members of the research team trained in qualitative research, including three chief investigators and two research officers employed to assist with the data collection. A number of services opted for focus group interviews which provided the research team with rich conversations between staff about their practice and experiences. Individual interviews were conducted either in person or by telephone, depending on the preference of the participant, whereas all group interviews were conducted in person. The interviews were semi-structured and included questions about service providers' definitions of complex trauma, their experiences of working with complex trauma clients, and their perceptions of the strengths and weaknesses of current service provision and system responses (see Appendix B for the interview guide). The semi-structured approach allowed the interview questions to be adapted to the particular context that agencies were operating within, including the particular groups of women they were working with. Interviews were audio-recorded using a digital recording device with the consent of participants and transcribed by a professional transcription company.

Interviews with women with experiences of complex trauma

Forty-one women who had experiences of complex trauma participated in interviews about their understanding of complex trauma and their experiences with services. Participants were eligible for the research if they 1) were over the age of 18, 2) identified as a woman, and 3) identified as having experienced, or been affected by, complex trauma. The term "complex trauma" was not predefined during recruitment since the study was interested in the ways that

Table 2: Participant details for the service provider interviews

STATE	Agency ID	Interview type	Role	Service/sector
NSW	1	Individual	Manager/supervisor	Legal
NSW	2	Individual	Educator/policy	Legal
NSW	3	Individual	Manager/supervisor	Migrant/refugee
NSW	3	Individual	Trauma counsellor	Migrant/refugee
NSW	3	Group	3x community educator	Migrant/refugee
NSW	4	Individual	Trauma counsellor	Legal
NSW	4	Individual	Lawyer	Legal
NSW	4	Individual	Lawyer	Legal
NSW	4	Individual	Lawyer	Legal
NSW	4	Individual	Lawyer	Legal
NSW	5	Individual	Lawyer	Women's health
NSW	6	Group	Therapist, case manager	Alcohol and other drugs
NSW	7	Individual	Nurse	Homelessness
NSW	7	Individual	Manager/supervisor	Homelessness
NSW	8	Group	2x manager, trauma counsellor	Women's health
NSW	9	Individual	Support worker	Sexual assault
NSW	9	Individual	Manager/supervisor	Sexual assault
NSW	9	Individual	Manager/supervisor	Sexual assault
NSW	9	Individual	Manager/supervisor	Sexual assault
NSW	9	Individual	Trauma counsellor	Sexual assault
NSW	9	Individual	Trauma counsellor	Sexual assault
NSW	9	Individual	Trauma counsellor	Sexual assault
NSW	10	Individual	Social worker	Private practice
NSW	11	Individual	Psychiatrist	Private practice
QLD	12	Group	Clinical social worker, manager/supervisor	Child sexual assault
QLD	13	Individual	Support worker	Disability/mental health
QLD	14	Group	2x mental health worker, manager	Mental health
QLD	15	Group	Clinical services manager, clinical supervisor	Migrant/refugee
QLD	16	Group	Manager/supervisor, counsellor	Sexual assault
QLD	17	Individual	Support worker	Domestic violence
QLD	18	Individual	Psychiatrist	Private practice
QLD	19	Individual	Psychiatrist	Private practice
QLD	20	Individual	Psychiatrist	Private practice
QLD	21	Individual	Counsellor	Sexual assault
QLD	22	Individual	Psychologist	Private practice

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women employed and constructed notions of "trauma". There were no explicit exclusion criteria, although a woman's capacity to provide informed consent and tolerate the content of the interview was discussed as part of an informal screening process (discussed below). Similarly, although all interviews were undertaken in English, women who spoke a language other than English were not specifically excluded from the project, and interpreters were available for non-English speakers. However, recruitment and project information was distributed in English, which necessarily limits the availability of information to non-English speakers. Nonetheless, the project engaged a small number of refugee and migrant women. The research team also approached three Aboriginal and Torres Strait Islander community and health services to explore models for partnership and collaboration; however, these did not eventuate due to timeframe and resourcing limitations.

Recruitment for interviews with women with experiences of complex trauma took place through 1) service providers who participated in the documentary analysis, 2) professional mailing lists and networks, and 3) social media. Recruitment was "arm's length", which means that women were not directly approached by the research team, but rather that information about the project was distributed to women by health professionals and social media, and women interested in the study could contact the project team. Recruitment material asked simply, "Are you a woman with experiences of complex trauma?" and invited women to participate in a research interview "about their understandings of complex trauma, experiences of help-seeking, and views on how service responses can be improved" (for the full recruitment flyer and text, see Appendix C).

Initially, the recruitment plan had focused on the first two pathways. While some services and professionals supported clients to participate in the study, others expressed concern about the fragility and vulnerability of this client group. However, social media proved to be a very successful recruitment strategy. A Facebook page was set up with details about the study and boosted via paid Facebook advertising. The research team received a high number of contacts from women interested in the project but were unable to interview everyone due to time constraints. The women who missed

out on being interviewed were invited to participate in the workshops.

For all research participants, informal screening took place through initial contact with the research officer. Informal screening included discussing the women's comfort levels in participating in the interview and their current access to care and support. Psychological symptoms (including intoxication or acute withdrawal states) that might abrogate a participant's capacity to provide informed consent were the sole reason for declining a woman's participation, however this criterion was not invoked in this project. As other researchers have found, trauma survivors are generally skilled at predicting and managing distress in the context of trauma research and do not volunteer for unsuitable research projects (see e.g. Becker-Blease & Freyd, 2006; Salter, 2013). Nonetheless, the capacity to participate in an interview about complex trauma was discussed with each woman and adjustments made to the interview process to ensure women had the opportunity to participate if they wished to. These adjustments included conducting the interview over more than one session, clarifying in advance whether particular topics in the interview were to be excluded from discussion, organising the interview at times and locations where the woman's safety was maximised, and encouraging women to organise a session with their counsellor or other support person following the interview. Participants were also offered the option of a post-interview debrief session with one of the registered psychologists on the research team who has clinical expertise in working with women with experiences of complex trauma, if necessary; however, no participant invoked this option. Participants were also provided with a range of referral options to telephone and online support services.

De-identified information about the women interviewed for the study is available in Table 3. The majority of women who volunteered for the study identified as Anglo–Australian. The youngest participant was in her early 20s and the oldest participant was in their late 60s. Over one third of the sample was in their 40s.

Interviews were conducted over a six-month period (Jul–Dec 2018) by two research officers with expertise in conducting

Table 3: Participant details for interviews with women with experiences of complex trauma

State	Pseudonym	Background	Age
NSW	Madeline	Anglo-Australian	25-29
NSW	Steph	Anglo-Australian	25-29
NSW	Eleni	Anglo-Australian	25-29
NSW	Megan	Anglo-Australian	30-34
NSW	Natalie	Anglo-Australian	30-34
NSW	Lena	Anglo-Australian	30-34
NSW	Bernadette	African refugee	30-34
NSW	Laura	Anglo-Australian	30-34
NSW	Jeanette	African refugee	35-39
NSW	Josephine	Anglo-Australian	40-44
NSW	Rose	Anglo-Australian	40-44
NSW	Phoebe	Anglo-Australian	40-44
NSW	Charlotte	Anglo-Australian	45-49
NSW	Kasia	Anglo-Australian	45-49
NSW	Michelle	Anglo-Australian	45-49
NSW	Debbie	Anglo-Australian	50-54
NSW	Louise	Anglo-Australian	50-54
NSW	Heather	Anglo-Australian	50-54
NSW	Carol	Aboriginal Australian	65-69
QLD	Vicky	Anglo-Australian	20-24
QLD	Lauren	Anglo-Australian	25-29
QLD	Amber	Anglo-Australian	25-29
QLD	Miranda	Anglo-Australian	30-34
QLD	Noor	Middle Eastern–Australian	30-34
QLD	Chloe	Anglo-Australian	40-44
QLD	Kerry	Anglo-Australian	40-44
QLD	Nicole	Anglo-Australian	40-44
QLD	Linda	Anglo-Australian	45-49
QLD	Rita	Pacific region refugee	45-49
QLD	Abigail	Anglo-Australian	45-49
QLD	Julie	Anglo-Australian	45-49
QLD	Kim	Anglo-Australian	45-49
QLD	Samantha	Anglo-Australian	45-49
QLD	Simone	Anglo-Australian	50-54
QLD	Margaret	Anglo-Australian	50-54

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Table 3: Participant details for interviews with women with experiences of complex trauma cont.

State	Pseudonym	Background	Age
QLD	Jill	Anglo-Australian	50-54
QLD	Jodie	Anglo-Australian	55-59
QLD	Rebecca	Anglo-Australian	55-59
QLD	Kylie	Anglo-Australian	65-69
QLD	Jacqui	Anglo-Australian	65-69

semi-structured interviews, supervised by the psychologist on the team with expertise in complex trauma. Depending on the woman's preference and geographic location, interviews were either conducted in person, via telephone or video conference. They focused on the women's understandings of trauma and complex trauma, and their experiences seeking care and support. Interviews were semi-structured and conversational in style, loosely based on a series of standard questions that could be adjusted depending on the participant's responses (see Appendix D for the interview guide). Interviewers took a strengths-based stance via a sustained inquiry into and focus on women's resilience as well as the difficulties and challenges they faced. This approach to interview was underpinned by the research team's experience in qualitative research and counselling with women who had experienced complex trauma. All interviews were audio-recorded (with participants' consent) using a digital recording device and transcribed by a professional transcription company.

Analysis of interviews

Data from the interviews with professionals and women who had experienced complex trauma were analysed thematically (Braun & Clarke, 2006). All interviews were transcribed verbatim, and then integrity-checked to identify errors. The process of analysis began with a close reading of transcripts to capture initial concepts or "codes" within the data. Examples of first-order codes included identification of different kinds of trauma impacts described by women and workers, including "physical", "psychological" and "social or relational" effects, as well as the various definitions of trauma advanced by interviewees, which we began categorising as "medical", "psychological" or "other".

Members of the research team then met to discuss first-order codes—where commonalities occurred—and higher order codes, which included "survivor responses to trauma", referring to trauma-related impacts, symptoms and manifestations; and "understandings of trauma", which grouped those codes in which participants offered

definitions and constructions of trauma and complex trauma. This process of discussion facilitated the refining of codes and definition of data to be included within each code to ensure consistency. Transcripts were then imported into NVivo, a software program that facilitates the electronic organisation of qualitative data into the relevant codes. The overall interview coding framework can be found in Appendix E.

Once coding of all data was complete, the coded data were summarised within a coding summary. This involved reading the coded data line by line and extracting statements or brief quotes that identified what had been said. This information was inserted into a table identifying participant details. This process helped to refine commonalities across the data set, and served as a map for the data in the writing process. Separate coding summaries were made of the interviews with women with experiences of complex trauma and the interviews with workers, which enabled their responses to be considered separately but also compared and contrasted. Appendix F includes an illustrative section of a coding summary for the subcode "physical impacts" under the first-order code "survivor responses to trauma" based on interviews with women. The development of themes from the coded data involved reviewing the codes and collating the codes according to similarities in concepts (Braun & Clark, 2006). Core themes were identified and, where necessary, subthemes were then developed for each of these core themes to capture specific aspects of these dominant themes.

Workshops

During July and August 2019, seven online workshops were held with women who had experienced complex trauma (two workshops involving eight participants in total) and professionals (five workshops involving 22 participants in total). The purpose of the workshops was to feed back some of the findings of the project to key stakeholders, discuss any inaccuracies or misinterpretation of the data, identify gaps in knowledge, and discuss how the findings might be applied in different sectors. Workshops were generally small, with two to

four participants in each, enabling a detailed discussion and elaboration of the research findings and recommendations. Participants were drawn from previous interviewees who had indicated their interest in the workshops, as well as from women and workers who had contacted the study after the interview phase was over, and opted for the workshops. In the case of the worker workshops, some professionals were actively involved in promoting the workshops to their colleagues and encouraging their participation.

The workshops took 90 minutes each and were conducted using the Zoom online platform, which is a relatively easy-to-use conference software that enables participants to see each other's faces and hear each other speak. The workshops were conducted with a main facilitator and a second facilitator who took notes from the discussions. The facilitator presented a short slide show of the project's main findings and invited comments, questions and suggestions from attendees. At the close of the workshops, participants were asked to collectively create a short statement. The first two workshops were held with women who had experienced complex trauma, resulting in two statements that the women directed at service providers. In the professional workshops, we then showed these statements to workers and invited them to write back. This process produced a series of very touching statements from both the women who had experienced complex trauma and professional stakeholders, which are found at the beginning and end of the findings chapters.

Ethical concerns

Ethical review of the project was provided by Western Sydney University's Human Research Ethics Committee (H12501) and the Queensland University of Technology (1800000678). Ethics applications were also submitted for institutional review for a number of services and agencies. The project recruited a significant population of women who had experienced complex trauma and attendant vulnerabilities for interview, as well a large number of workers in a sensitive area of service provision. Confidentiality, anonymity and safety were core concerns throughout the project. These concerns were addressed through careful arm's-length recruitment strategies that aimed to recruit women with existing access to care and support, and workers in services who represent best practice in trauma-informed care, as well as through

the use of pseudonyms for names and places in the interview transcripts to ensure that individuals cannot be identified via their research participation.

Interviews with women were grounded in the principles of respectful research with vulnerable populations, which aim to maximise the therapeutic and empowering dimensions of qualitative research while recognising the particular vulnerabilities and needs of trauma survivors in interview (Salter, 2013b). Robust informed consent measures have been in place throughout all phases of the project. These included introduction and referral via service professionals;, discussion with each woman about their capacity to participate and adjustments that could be made to the interview process to ensure their sense of safety; observation of participants responding; and routinely checking in with participants regarding their wellbeing and continued consent during and immediately after the interview. Participants were provided with referral information for 1800 RESPECT and other relevant agencies, and were provided with the option of post-interview debriefing with one of the psychologists that were members of the research team. The potential for the vicarious traumatisation of researchers due to extensive exposure to traumatic and upsetting research material was significant in this project. The research team includes an internationally recognised expert in vicarious trauma, Dr Jackie Burke, who provided group and individual consultation to other members of the research team on vicarious trauma management during the project.

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Review and analysis of "complex trauma" in Australian policy frameworks

In recent years, there has been an increased interest in incorporating trauma-informed care principles into social services and government programs. However, what the term "trauma-informed" refers to is not always clearly defined. There have also been recent moves towards understanding complex trauma, referring to serious multiple victimisation and its sequelae, as distinct from trauma caused by a single event (such as an accident, natural disaster, or hospitalisation). It is well recognised that people experiencing complex trauma require a different response to people recovering from single-incident trauma. This review of Australian federal and state policy documents was undertaken in order to understand how, and if, "complex trauma" and related terms were being used in Australian policy. The review identified policy documents referring to trauma and complex trauma in diverse areas such as health, education, prisons, mental health, perinatal health, residential care, violence against women, Aboriginal and Torres Strait Islander health, sexual violence and refugee health.

Search strategy

The policy review was conducted in July–August 2018 via a search of the following federal and state government websites:

http://www.health.gov.au/

http://health.nsw.gov.au

https://www.health.qld.gov.au/

https://health.nt.gov.au/

http://ww2.health.wa.gov.au/

http://www.sahealth.sa.gov.au

http://www.dhhs.tas.gov.au/

http://www.health.act.gov.au/

https://www.coaghealthcouncil.gov.au/

The following search terms were used: trauma, complex PTSD, intergenerational trauma, transgenerational trauma, dissociat* and personality disorder. Further Google searches revealed additional documents related to trauma in areas such as child protection and education.

Directed qualitative content analysis was used as a method. Directed content analysis is a more "structured" form of content analysis. This is a deductive approach that works from a theory or findings from the existing literature (Hsieh & Shannon, 2005, p. 1281). Predetermined codes were identified based on common terms related to complex trauma in the complex trauma literature. Text search queries for all keywords were run in NVivo (Version 11) to identify semantic (surface-level) codes. Each keyword was set up as a node and all documents were coded at each node. Further nodes were created after common terms related to complex trauma were identified during the coding process. The additional nodes established were: childhood trauma, cumulative harm/trauma, developmental trauma, historical trauma, severe trauma, and significant trauma. Manifest content analysis was undertaken where instances of each code were searched using NVivo and counted.

Overall, 58 relevant policy documents which mentioned at least one keyword were retrieved. Of these documents, 36 contained the term "intergenerational trauma", 18 contained the term "complex trauma", 14 contained the term "personality disorder", and 14 contained the term "cumulative harm". Within these documents, there were 89 references to complex trauma, 88 references to personality disorder, 60 references to intergenerational trauma, and 30 references to cumulative harm. Other terms were discussed less frequently in the relevant literature.

Manifest or semantic categories were developed, rather than creating categories through searching for underlying meanings in the text. This was related to the purpose of the research: to understand constructions of complex trauma. In order to explore the way complex trauma was discussed and situated within government policy, it was necessary to search for keywords related to complex trauma and identify the context of their use and the way in which trauma was discussed. Therefore, instances of the key terms were identified and coded, rather than instances in which concepts such as complex trauma were referred to indirectly or implied in the texts.

Findings

Complex trauma and complex PTSD

Evident in the Australian policy documents analysed was a tendency for brief identifications and discussions of complex trauma. Within the 18 documents in which complex trauma was discussed, the words "complex trauma" appeared only once in nine documents, and only twice in two of the documents. Complex trauma was often not clearly defined, and was frequently used interchangeably with "trauma", "cumulative harm", "childhood trauma", "early onset trauma", "significant trauma" and "severe trauma". In documents where complex trauma was mentioned only once, the meaning of the term and its significance in relation to the topic were unclear. Where the term is defined, the definitions may not be consistent with other definitions of complex trauma.

For example, in the chapter "Understanding Risk-Taking Behaviour" in the *Youth Health Resource Kit* published by NSW Kids and Families, the text shifts immediately from "early onset trauma" to complex trauma:

> Early onset trauma requires the brain to shift its focus from learning to survival and disrupts the neural integration necessary to respond flexibly to daily challenges. The effects of complex trauma on individual functioning are pervasive and deeply disruptive to the key developmental [*sic*] of attachment, self-regulation and the development of competencies. (NSW Kids and Families, 2014, p. 84, references removed)

There was some slippage in the policy documents between the terms "complex trauma" and "trauma". This indicates that the documents may not be clearly capturing the differences between "complex trauma", which results from exposure to generally early onset, repetitive (van der Kolk, 2005) and often severe trauma, and "trauma", which may result from a one-off incident, or an incident experienced in adulthood, such as a vehicle accident or disaster event. Policy documents about youth care often describe "childhood trauma" or "early onset trauma" or "cumulative harm" which may be more likely to meet the definition of complex trauma, as they often occur at an early age and are sustained or recurring. While

it is necessary to address both complex trauma and trauma, there is increasing recognition that they are aetiologically and typologically distinct.

The trauma-informed care literature often implicitly refers to complex trauma. While "trauma-informed" could also refer to models of care designed not to exacerbate single-incident or simple trauma, the term "trauma-informed care" is most often used in relation to childhood trauma, including child sexual abuse and severe neglect, and ongoing interpersonal violence. Trauma-informed care is a response to the potential for re-traumatisation in mental health, social welfare and community services, and it encourages workers to recognise that anyone contacting their service may have trauma (Isobel, 2016, p. 589). In particular, the trauma-informed care literature drew implicitly on complex trauma scholarship in positing that the behaviour of difficult or challenging clients is often linked to underlying traumatic histories of abuse and neglect. For example, the *Custodial Youth Justice Options Paper: Report for the Tasmanian Government Department of Health and Human Services* states that:

> Many young people in the justice system have experienced multiple traumas, so rehabilitation aims to address the underlying trauma first. A trauma-informed practitioner understands that a young person's responses or ways of coping have developed in the context of trauma, and helps them to understand their patterns of behaviour on this basis. (Noetic Solutions, 2016, p. 81)

While the term "complex trauma" was regularly used in policy documents, "complex PTSD" or "complex post-traumatic stress disorder" did not occur regularly in searches. Complex PTSD was only mentioned seven times in three source documents. This is perhaps to be expected in reports in non-medical areas, such as child and youth welfare and education, where medical terminology may be less commonly used. However, medical reports about mental health treatment, for example, did not commonly use the term complex PTSD. This may be because complex PTSD, although recognised by many psychiatrists and psychologists, was not recognised as a disorder separate to PTSD in the ICD–10 or the DSM–5. However, it has been included as a separate diagnosis in the ICD–11, the preliminary, implementation version of which was released in late June 2018.

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Personality disorder

Fourteen documents that contained at least one instance of the term "personality disorder" were retrieved. Personality disorder was one of the search terms that generated the most references in NVivo. One reason "personality disorder" occurred so frequently in the literature was, perhaps, due to the complexity of treating patients with personality disorder diagnoses. Some documents clearly identified the links between complex trauma and the development of borderline personality disorder. Certain documents specifically addressed the treatment of borderline personality disorder, such as SA Health's *Borderline Personality Disorder Implementation Plan* (2017) and the Australian Government/NHMRC's *Clinical Practice Guideline for the Management of Borderline Personality Disorder* (2012). The South Australian Department of Health issued three sets of guidelines around pregnancy and post- and antenatal health that explored the effects of borderline personality disorder on reproductive health. Similarly, the Australian Government's *Clinical Practice Guidelines—Pregnancy Care* (Department of Health, 2019) discussed maternal health care for women with mental illnesses, including borderline personality disorder.

Dissociation

The term "dissociation" was searched due to the strong association between dissociative identity disorder and experiences of childhood trauma. Dissociation is also a common symptom among those who have experienced trauma and complex trauma. Dissociation was only referred to 12 times in the documents reviewed. It was identified as a symptom of both trauma and personality disorders. In *A National Framework for Recovery-oriented Mental Health Services: Guide for Practitioners and Providers*, dissociation is identified as a "coping strategy" for "people with unresolved trauma issues" (Department of Health and Ageing, 2013, p. 41). Education guidelines also identify dissociation as a symptom of trauma, with the State Government of Queensland's Child Safety Commissioner's report *Calmer Classrooms: A Guide to Working with Traumatised Children* (2017) including six instances of the term. Similarly, the same government's report, *A Contemporary Model of Residential Care for Children and Young People in Care* (Department of Communities, 2010, p.

66), draws on van der Kolk's (2005) work on developmental trauma to claim that "hyper-vigilance, hyper-arousal and dissociation are observable responses to trauma".

The Tasmanian Government's *Chief Civil Psychiatrist Clinical Guideline 9—Seclusion* also includes dissociation as a potential trauma-related response to seclusion. The Government of South Australia's Department for Health and Ageing's *South Australian Perinatal Practice Guideline: Sexual Abuse in Childhood—Pregnancy Care Considerations* includes two references to dissociation that explore what to do if a woman is dissociating during labour, as well as connecting the possibility of dissociation during labour with experiences of sexual abuse as a child.

Intergenerational, transgenerational and historical trauma

The term "intergenerational trauma" (or inter-generational trauma) referred, in the policy documents, to the dispossession and colonisation suffered by Aboriginal and Torres Strait Islander Australians. There were 60 references to intergenerational trauma across 36 policy documents. Out of these references, only five did not refer clearly to Aboriginal and Torres Strait Islander experiences. While intergenerational trauma can refer to trauma experienced by any cultural or social group across generations, it has been used extensively in the context of Indigenous health outcomes in postcolonial countries, such as Australia, the United States, and Canada. Aboriginal and Torres Strait Islander people experience twice the disease burden of non-Aboriginal and Torres Strait Islander Australians, as well as higher rates of family violence and sexual assault.

Intergenerational trauma refers to the ongoing legacy of original dispossession, as well as more recent and continuing traumas and secondary trauma experienced by being raised by people who had experienced trauma themselves. Intergenerational trauma is often mentioned in order to explain the context in which Aboriginal and Torres Strait Islander health outcomes occur. It is also cited as a causal or risk factor for issues such as family violence or child sexual abuse. As well as providing context for health outcomes, intergenerational

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trauma is discussed as a health issue to be remedied. A third context in which intergenerational trauma is discussed is as a consideration that needs to inform future policy and guidelines, particularly for health workers.

The term "transgenerational trauma" (or trans-generational trauma) appeared seven times in the policy documents. In practice, this term seems to be used interchangeably with "intergenerational trauma", to refer to the impacts of multiple generations of trauma on families and communities. In the context of this policy review, the term "transgenerational trauma" is used to refer to Aboriginal and Torres Strait Islander experiences. This term is used in two reports about prisons, reports on Aboriginal and Torres Strait Islander health and health workers, and reports on mental health.

Historical trauma

The term "historical trauma" comes from the work of Indigenous scholars working in North America. It was originally coined by Maria Yellow Horse Brave Heart in the 1980s. Brave Heart (2011, p. 283) defines historical trauma as "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma". While the term captures the ongoing nature of colonisation and colonial policies, and the transfer of trauma across generations, there is perhaps more of a focus on the originating event, such as colonisation, that caused the trauma.

While "historical trauma" is less commonly used than "intergenerational trauma" in the Australian policy space, there were still 20 instances of the term in the policy documents reviewed. However, the *COAG Advisory Panel on Reducing Violence against Women and their Children—Final Report* (2016) accounted for nine of the instances.

In *Trauma-informed services and trauma-specific care for Indigenous Australian children* (Atkinson, 2013) the definitions of intergenerational and historical trauma are interlinked—that is, historical trauma is presented as necessarily intergenerational:

> Historical trauma is a type of trauma transmitted across generations (that is, intergenerational trauma). It is defined as the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes as "cumulative emotional and psychological wounding" (Mu'id 2004:9). Duran and Duran (1995) suggest that historical trauma can become normalised within a culture because it becomes embedded in the collective, cultural memory of a people and is passed on by the same mechanisms through which culture, generally, is transmitted. (Atkinson, 2013, p.4)

SA Health's three policy documents on perinatal care each acknowledge historical trauma in a separate section at the start that outlines its ongoing impacts.

Developmental trauma

There were four appearances of the term "developmental trauma" across three documents. This is perhaps surprising, as many documents cite Bessel van der Kolk's work, and particularly his proposed diagnostic category of "developmental trauma disorder" (van der Kolk, 2005). Developmental trauma is seen as a separate category, as the symptoms and impact differ from PTSD in terms of their impact on children's development of social and interpersonal, cognitive and motor skills and sense of self. According to van der Kolk (2005, p. 405):

> The results of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM–IV) Field Trial suggested that trauma has its most pervasive impact during the first decade of life and becomes more circumscribed (i.e., more like "pure" PTSD) with age. The diagnosis of PTSD is not developmentally sensitive and does not adequately describe the effect of exposure to childhood trauma on the developing child.

Given that van der Kolk's work is frequently cited in the policy documents in relation to complex trauma, it is interesting that his concept of developmental trauma has not been more widely adopted. However, like complex post-traumatic stress disorder (initially), this may be due to its lack of official recognition as a disorder in the ICD–11 or the DSM–V.

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Childhood trauma and early onset trauma

"Childhood trauma" and "early onset trauma", as they are used in the literature, have significant overlaps with "complex trauma". There were 29 references to childhood trauma across 13 documents. While childhood trauma could refer to a one-off experience of trauma, such as an accident, the literature refers, in general, to childhood trauma that is of a more ongoing and interpersonal nature. There were just three references, in two documents, to early onset trauma, and this term is also used in a similar way to "complex trauma". For example, the Royal Commission into Institutional Responses to Child Sexual Abuse's *Redress and Civil Litigation Report* states:

> *The trauma literature also identifies early onset trauma as having a particular impact* on the developing brain, especially when the trauma is prolonged, repetitive and unrepaired. According to Wall and Quadara: "Where early care-giving relationships are dysfunctional, either as a source of trauma or an inability to nurture and protect a child, the child's developmental competencies in the areas of sense of self, agency, communication, and interpersonal relationships can be negatively impacted, thereby setting the scene for many of the problems associated with complex trauma." (2015, p. 180, emphasis added, references omitted)

The term childhood trauma was not confined to one policy area; it appeared in documents from health, corrections, child protection, Indigenous health, mental health, sexual violence, youth health, and trauma-informed practice.

Severe trauma and significant trauma

Similar to the term "complex trauma", the term "severe trauma" acknowledges trauma of a prolonged or ongoing nature. There were seven references to severe trauma in the policy documents reviewed, across six documents. *A Contemporary Model of Residential Care for Children and Young People in Care* (Department of Communities, 2010, p. 69) states,

> It is clear that young people whose background is impacted by *severe trauma* will be significantly hampered in developing resilient qualities unless provided with environments that ensure against on-going daily stress and provide "scaffolding of social supports" (Ong et al., 2009, p. 1796). (Emphasis added)

Similar to "complex trauma" or "developmental trauma", this term acknowledges the developmental effects on young people. *The COAG Advisory Panel on Reducing Violence against Women and their Children—Final Report* claims that, "Women with disabilities experience forms of violence that are particular to their social and economic disadvantage and increased dependency. Their experiences of violence also tend to occur over a longer period of time, resulting in more *severe trauma*." (2016, p. 57, emphasis added) This is also similar to definitions of complex trauma, as it takes into account the more prolonged nature of this kind of trauma.

There were 16 references to the term "significant trauma", across nine sources. In some cases, significant trauma reflected definitions of complex trauma, while in other cases it referred to different kinds of trauma. For example, the *COAG Advisory Panel on Reducing Violence against Women and their Children—Final Report* states that, "In particular, governments are increasingly recognising that facing a perpetrator in court, and possibly also under cross-examination when the perpetrator is representing himself, can cause additional *significant trauma* to a victim who may have experienced years of coercive control and abuse." (COAG Advisory Panel, 2016, p. 43, emphasis added) This is perhaps more similar to re-traumatisation than to most definitions of complex trauma. *The Right to Be Safe—Ensuring Sexual Safety in Acute Mental Health Inpatient Units: Sexual Safety Project Report* discusses significant trauma in the following way: "In this instance, the purpose of the limitation of any right is to prevent the significant trauma that can occur for people accessing acute mental health services when sexual safety is breached." (Mental Health Complaints Commissioner, 2018, p. 42) This also does not quite accord with definitions of complex trauma. However, in the *Guide for General Practitioners in Tasmania—Refugee Health Care* (Tasmania Department of Health and Human Services, 2005, p. 11), the following discussion of significant trauma is closer to definitions of complex trauma:

> Medical consultations may be a source of anxiety for refugee patients, especially those who have experienced significant trauma. Symptoms such as memory loss, confusion, hyperanxiety and poor concentration may affect their capacity to hear and understand instructions and to provide information to the doctor. Intrusive traumatic memories may be triggered in the course of consultation.

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Cumulative harm

There were 17 appearances of "cumulative harm" in five documents. Similar terms used included "cumulative trauma" (two instances) and "cumulative emotional and psychological wounding" (one instance). While PTSD could result from a single traumatic incident, such as a natural disaster, the cumulative nature of complex trauma is acknowledged in the term cumulative harm. In fact, in some definitions of complex trauma, the cumulative aspect is an integral factor. For example, in the *Youth Health Resource Kit: An Essential Guide for Workers*, complex trauma is defined as "exposure to stressors that are interpersonally generated, ongoing and cumulative, often occurring in childhood or adolescence— such as abuse, neglect or emotional or physical deprivation" (NSW Kids and Families, 2014, p. 151). It is clear that many of the instances of cumulative harm could equally be named complex trauma.

Summary

It is clear from the above analysis that a range of different terms are being used to refer to quite similar concepts. In some circumstances, it may be useful to highlight differences in trauma, for example if it is "early onset" or "intergenerational". However, there is a wide range of labels currently being used in policy contexts to refer to ideas that are conceptually similar, and would likely fall under the rubric of complex trauma. There is not always a clear differentiation in the policy literature, between trauma which may have resulted from a one-off event, and complex trauma which has myriad effects, including shaping coping mechanisms, brain development, interpersonal relationships and physical health outcomes. Clearer differentiation may help services to more effectively plan service delivery for clients with complex trauma, and better take their specific needs into account in order to avoid re-traumatisation. Where programs and services have only mentioned complex trauma in passing, which was the case in many of the policy documents, lack of clarity may result in services not clearly identifying the healthcare needs of women who have experienced complex trauma. While some service providers may discuss terms related to trauma-informed care, such as "safety" and "stabilisation", or "choice" and "empowerment", if these services do not clearly outline how they plan to implement these values, this may result in "trauma-informed care" functioning as an ideal—that is, without concrete plans on how services will ensure safety, or in which circumstances clients will be given choice, for example. However, some documents defined complex trauma carefully and provided clear guidelines on how to work with people who had experienced complex trauma. This demonstrates that there is variability in understandings of complex trauma between government departments and services, with some services able to clearly operationalise trauma-informed care for people with complex trauma, and others having less clear understandings and less developed practice.

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Constructions of trauma and complex trauma by women and professionals

" We are people who have had some awful experiences and we might be really messy right now but don't give up on us. Don't look at the behaviours but focus instead on what's driving them. We need you to acknowledge the journey, and the fact that we are still alive and holding on is a testament to our strength. It is hard to convey just how difficult our experiences have been. Your patience and compassion validates us and empowers us to see that change is possible.

Statement to professionals from a workshop of women who have experienced complex trauma

This chapter begins by describing women's and professionals' understandings of trauma and complex trauma, before going on to discuss women's accounts of how complex trauma has impacted their lives. Women's narratives of trauma were decidedly relational and psychosocial. Not only were the psychological and bodily effects of trauma experienced in the context of relationships, but trauma also had specific psychological, relational and social effects: on friendships, intimacy, parenting and connections to family and community. In the accounts below, we have indicated the identity of women with a pseudonym, and provided the occupational details of the professional workers.

Understandings of trauma

Women and professionals used the language of trauma in a variety of ways. Trauma could describe impactful and harmful events as well as the wounds and scars, both visible and invisible, left in the aftermath of violence. For the women we interviewed, their experiences and understandings of trauma drew together the multiple impacts of violence and fear upon their bodies, minds, identities, social relationships and responsibilities. In discussions over what trauma meant to them, women and professionals often spoke to the ways in which the violence of the past—their personal past but often their shared and intergenerational history as well—had left an enduring mark on many aspects of life.

Trauma as an extraordinary event

When asked how they defined trauma, or what the difference between trauma and "everyday" stress might be, most women identified trauma as an extraordinary or life-changing event.

Jill was in her early 50s and currently in treatment for a dissociative disorder. She described the difference between trauma and stress as "enormous". For her, trauma is "an event that's just unbearable … something that not anybody else would expect to see in a normal day".

Professionals similarly described trauma as a "bad experience in the past" (Trauma therapist) and one "that is affecting the innermost being of the person" (CALD community educator). A CALD community educator identified that the notion of trauma was not common in her Filipino community, but she held regular education sessions for women in which "we define trauma as something that's really bad that really affected the person, spiritually, physically, emotionally as whole person, so one way of coping is to open up". Likewise, it was distinguished from stressful events in terms of the degree of distress it caused, as another community educator explained:

> Probably for my understanding or my community's understanding about the trauma or traumatic experience, the seriousness of level is different. For us, like the loss of job or those kinds of thing, there probably could be just challenges or difficulties in Australia, but trauma is kind of quite bad or quite deep impact on a person, maybe causing very serious level of emotional and maybe need to seek special treatment, these kinds we might call trauma, traumatic experience or loss a child, or loss a family member caused her a lot of problems which affect a lot of peaceful life, ability of seeking job and they need some treatment or special service, that's what we consider as traumatic but this is my understanding of trauma. (Community educator, migrant/refugee service)

Not only did trauma "have a big impact" (Royal Commission policy advisor) but it was also something that stayed with

women; the impacts of trauma "carried on" through women's lives impacting "every component of their life" (Disability support worker). This was also described by a community educator:

> Trauma is like something that's affect you for long time, like whatever happened, that stayed with you for longer and the effect of that for person to person will be different but still it's trauma. (Community educator, migrant/refugee service)

Most professionals described the impact of trauma in general ways, however for one professional a defining aspect of this was the ever-present sense of threat that permeated women's lives:

> One is that they never ever feel safe … So they still have the trauma impacts, long-term impacts. They're always vigilant about their safety. Because they don't know who can come from anywhere, anytime. (Trauma counsellor, sexual assault service)

Trauma as grief and loss

For refugee women, trauma was defined in relation to grief and loss. This included losses across multiple domains, but primarily losses within the family and the loss of "home". These losses were described as having significant impacts on a woman's wellbeing. This can be seen in the excerpts below from community educators working with different migrant/refugee communities:

> Most of the women, they lost their husband, they left the country, they don't know where they are going, they stay on—for example, some of the Sudanese, they went to Egypt and they have no settlement there … So this is part of their trauma. They know they're losing husband, losing house, losing some of the children. I have some that—she is here and one of the child is still there. So that's makes a lot of effect on the brain. (Community educator, migrant/refugee service)

> It's quite similar like trauma, we don't talk a lot in detail but we normally put grief and loss and trauma together … It's about lost of the country, lost family members, and there's a child in there—child who in the past, so we put them together talking about the grieving and loss, and that's kind of traumatic experience. That's a bad experience

which caused a lot of, what has been said, emotional or affect the life experience in Australia, and we will try to help them how they can cope this emotional and settling in the country better. (Community educator, migrant/refugee service)

> And also, there was 10 years of civil war going in Nepal, and lots of people lost their family members, from both sides, from the armies as well as the terrorist groups, so those sorts of incidences will be more traumatic. (Community educator, migrant/refugee service)

Professionals working with refugee women also described the multitude of losses that made up the experience of trauma for this group:

> In the work that we do, it is so associated with a whole series of losses as well and whether those are tangible or intangible losses so those two things are connected, there can be a series of events and it can be really hard for people to identify what those events are and to have a narrative around that but, it is also associated with so many different losses which then lead to another range of impacts as well. (Manager, migrant/refugee service)

Trauma as an injury or wound

For some women, trauma was "scar tissue" or even a "scab" over an injury that has not healed. Steph recounted how her psychologist described trauma as like an infection that needed to be drained:

> He's just like, "It's like a festering wound with a big scab over it. You need to get through the scab to let the stuff out." But letting it out is really unpleasant and then you sit there, and you still got all this gross stuff in you, and you have to keep going back and letting it out, because it takes a long time to heal.

One professional reflected on the different connotations that trauma has had in his professional life; while working in a hospital, trauma meant physical injury, but in other settings, it refers primarily to psychological injury:

> I think the language of trauma is so confusing and mixed up, because when you talk to an ED [emergency department] doctor, an ED nurse, trauma to them is about

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blood and guts and car crashes and helicopters. You talk to drug and alcohol workers and mental health workers and it's about relationships and trauma and children with repetition and chronicity. (AOD counsellor, AOD service)

Trauma as the past in the present

For women such as Jeannette, trauma was an indelible link to a past that

we try to give up, to think about something else to go on and see the future, but it's always there. If something happens to me—then if it's something small, makes me sad, will bring everything out.

These reminders and reinforcement of her country's traumatic history occurred externally as well as internally. Jeannette said:

[People ask] "Where are you from?" [I say] "I'm from Rwanda." Straightaway they know about genocide. And it's not something—I will never forget and it's not something—I wish I can be healed and forget, but I don't know if I'll ever forget. So, it's always there.

However, the "event" of trauma is not limited to a particular act or experience of violence in the past, but includes the way in which the survivor is drawn back to the memories of that event in the present. Jill explained:

My experience of trauma is being re-traumatised through events and things that trigger memory and experiences from past events from being traumatised as a child.

For professionals, the question of psychological trauma was inextricably linked to the client's background and past. Focusing on trauma in a service context therefore required a reorientation of workers and service culture to include "history" and "childhood" as well as the "here and now". Taking trauma into account meant, fundamentally, taking the client's life and history into account, rather than solely focusing on their immediate presentation. An AOD counsellor put it simply: "It's just reconceptualising things. Rather than thinking, 'What's wrong with you?' I think—'What happened to you?'"

Trauma as a mode of life

For some women, trauma was not a departure from "everyday" stress; trauma was everyday life. A refugee woman and community educator said, "For my community, trauma starts the day they arrived in this world, because if they have been suffering for a long time and for our community, trauma is forever." Other women described lives that had been marked by trauma since birth, involving sexual abuse and exploitation for as long as they could remember. This included experiences of child trafficking among Nepalese women:

So it's more traumatic because it's going to last for their whole life, and trafficking of women, as well because they're mostly women who are from the very poor economic background and from the rural area, are being trafficked so with no education mostly and they are lured to new jobs and, "We're going to take you to city and find you a new job. You'll be able to support the family" and so on but they have no idea that they are being trafficked, so those sorts of things are more traumatic. (Community educator, refugee/migrant service)

Trauma as silence

Silence was a common theme in discussions about refugee women and trauma. The women and professionals referred to silence in relation to the disclosure of trauma, service access, and social isolation. When asked about the major impacts of trauma on her clients, a multicultural service provider said: "The women, I think they suffer in silence. Many women of culturally and linguistically diverse backgrounds, refugee backgrounds, suffer in silence because they don't know where to go." For refugee women, disclosure was complicated by language barriers and an unfamiliarity with law, services and systems in Australia. A program coordinator for refugee women in Australia described her experience running educational programs for recently arrived immigrants about domestic violence:

Many women disclosed during the program or were surprised that this was the law in Australia—they were not aware about law in Australia, that this is—they were surprised. "Is it domestic violence? It's just normal in our community. We all live the same way—our mothers, our sisters. Men are in control. Men have the last say, or any

say." So, this really—really opened their eyes and when there were disclosures, then the referrals were made to [a multicultural mental health service]. Women were not able to leave their relationship. They were not ready for it, but some were actually contemplating this already, and they just were looking for help. They didn't know where to go and how to do it.

Silence also came about through the social isolation that often followed experiences of trauma, due to the loss of husbands and the process of migration, as well as cultural understandings of trauma and mental distress. This was explained by a CALD community educator:

Mostly men they lose but they were the breadwinner of the family and after that, the families are left with no income. They lost their one of the head of the family as they say, and then women after losing their husband, would be doomed, they will have to take care of the children, take care of the house, and they usually don't go outside, too … Again, coming back to Australia, in our community, they hardly disclosed these sort of things because it brings shame to the family and it's not usually discussed, and it's very hard to approach and talk about these things to them and even if they disclose, they are very reluctant to go to counselling and stuff because they'll be ostracised as being crazy or with mental health issues, so it's difficult to approach these issues.

Trauma as pathologising

Among both women and professionals there was disagreement and ambivalence over the ways that the notion of trauma could pathologise women's suffering and adaptations to abuse and violence. In the health system as well as in the community, mental illness and certain trauma-related diagnoses carried a stigma that made some women cautious or reluctant to identify with psychiatric notions of trauma and disorder. On the other hand, the medical vocabulary of a trauma-related diagnosis could offer women a resource for articulating their experiences and asserting their rights, and was often a relief after years of stigmatising misdiagnoses. Linda is a trans woman who has survived child sexual abuse and family violence, and expressed great relief at finally being

diagnosed with PTSD six years after her partner made an attempt on her life:

I mean, to think it's taken me six years to have a psychiatrist listen to me … I just think it's a bit shocking and a bit slack, and it's not good. But it's taken me six years to get diagnosed with post-traumatic stress disorder for a near murder attempt. I mean, what does that say?

While a trauma diagnosis enabled some women to receive appropriate and effective counselling, other women were clear about the drawbacks of a medicalising framework of "traumatisation" around their experiences. While acknowledging the impact of trauma on her mental state and quality of life, Louise rejected the notion that she was mentally ill.

[My therapist] talks about mental illness, and I say to him all the time, "Don't ever use that." And he goes, "Why? It's what it is." And I said, "No, it's not." I said, "When you use the word illness, you're saying that I'm sick. I'm not sick. I have a set of symptoms as a result of what was done to me. I'm not sick."

Other women gave accounts of attempting to reconcile the "good" and the "bad" in being labelled with a mental disorder. In the quote below, Madeline described the dizzying array of diagnoses that she has accumulated across her medical history. She felt that some of these labels adequately described her psychological and psychosocial struggles, but she recognised that accepting those labels left her vulnerable to stigma and re-victimisation.

I have a bunch of things. So I have PTSD, depression, anxiety diagnosis. My old psychologist would say I have complex PTSD even though that's not in any books despite the efforts of the folks that wanted it there. And then when I was at a private hospital and a psychiatrist diagnosed me with DDNOS [dissociative disorder not otherwise specified] Type 1a. But the strange thing about that is, I've … another psychiatrist I've seen since, he's like, "Well, that's DSM–4" and under DSM–5, Type 1a is now type of DID [dissociative identity disorder]. And then I've also been diagnosed with borderline [personality disorder] by everyone who's met me … I'm happy to use those diagnostic labels in so far as they get me in the right direction and access to the right things. So I

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would describe myself as someone who has a borderline personality structure and is on the dissociative spectrum, and has PTSD, but I wouldn't. The connotations with being manipulative and a liar are really re-traumatising.

The poor fit of diagnostic labels to the experiences of women who have experiences of complex trauma was also raised by professionals. A trauma counsellor discussed the use of an alternative framework that acknowledged the resilience of the woman rather than her mental health struggles:

Yeah, and we see that there's a medical but we've moved away from that medical, and we're socio-political, and we saw that it's just to see the person that they do have the resilience to recover. For me, if there's no recovery, I don't want to work there. I see recovery is a little light, I would say, that is little light that's still there and for that reason, the—and you are the same. What we do is different to many other people because we believe that the recovery can be done in a different way and without using that label. (Trauma counsellor, migrant/refugee services)

Trauma as crisis

The women of this study also shared that their experiences of trauma extended beyond the point of the traumatic events: trauma is also experienced as recurring moments of extreme distress and overwhelm. Lauren, a young woman who has been involved with mental health services since her early adolescence, spoke about her experiences of recurring moments of crisis, and how she insightfully prepares for these inevitable times:

I've had part of my safety plan for eons that I'm very aware of my own signals, and aware of when I'm starting to decline, and so, instead of catching me after a crisis has happened and then going inpatient, I catch myself just before the crisis happens and go inpatient, and to prevent it being a more distressing situation.

For others though, the recurring difficulties and emergencies of their lives were not as clearly linked in their own mind to their experiences of repeated trauma, as this AOD worker explains:

Often they present maybe forcefully by parole or they present with a history of acute anxiety, unemployment. Therefore, Centrelink takes some time to explore it and then you sort of point out to them the complex trauma in their own lives. And—but they've come to you for anxiety or because the kids have just been removed by DOCS [Department of Community Services] or for something completely different, but this is really the trigger. (AOD counsellor, AOD service)

Working with complex trauma can sometimes have less to do with dealing with the deeper impacts of the experiences of trauma, and more to do with managing these acute times of crisis when they recur:

Sometimes it is just crisis work, just helping them get through each crisis until stability can happen, sort of stability can happen that you can start doing the therapeutic work, so you've got to just keep working it wherever they're up to, what they're capable of. (Trauma counsellor, sexual assault service)

This crisis management stage can span years, particularly for women who have had an extensive trauma history, as a psychiatrist who works with clients with DID explains: "Yeah, there's always crises, it's been crises for 2 years. Crisis management and now we're actually kind of starting to have a bit of time to do a bit of therapy." Supporting women in these times of acute distress is more about helping them to feel safe and grounded, rather than exploring the deeper issues that would come up in restorative therapy:

Most of our scope is crisis management. Not all, we do do some longer-term stuff, but I'm wondering about whether that's got an impact on how people engage with us. Because often with our complex trauma clients, they're calling to manage the acute distress, often. Someone will call and all you'll hear on the end of the line might be hyperventilating or a panic attack and so you're able to get support in that moment, and the support is very different to what you might be getting from an appointment. All we might do in that call would be grounding, settling, that's it. Whereas we're not necessarily, with those clients, doing the broader stuff. (Manager/supervisor, sexual assault service)

Distinguishing trauma from complex trauma

All women and professionals were asked whether and how they distinguished trauma from complex trauma. For some participants there was a clear distinction between the two terms; others described variable patterns of trauma or referred to notions of severity and degree. A consistent theme in their responses was the compounding nature of multiple incidents of abuse and violence; the sense of betrayal inherent in the trauma experience, as well as the way disclosure was responded to; and the intersection between trauma and disadvantage that played out across generations.

Accumulation of multiple and compounding events

Women and professionals said that complex trauma tends to be ongoing over long periods of time, involving many different kinds of abuse and sometimes multiple perpetrators. As Steph said: "It's a very connected web." Amber was in her late 20s and had survived a sexually abusive and neglectful childhood. She described how traumatic incidents layered on top of each other to create a sediment of unprocessed and unresolved abuse, building the foundation for a "warped sense and distorted reality" upon which women react to further trauma:

> I think the idea of what it means is that there're multiple traumas layered on top of each other. I don't know if that's it but that's, I guess, just what my understanding is. It's like one trauma and maybe multiples happen in one incident or it's just like one went unresolved and another on top of it, and another on top of it, and as you have never reprocessed and cleared out the one, you're just layering more trauma on a warped sense and distorted reality and then you're reacting based from that point of view, and then it's like a really, really scary Frankenstein basically that comes out of that … (Amber)

Complex trauma was also discussed by professionals in terms of cumulative impacts in which recovery opportunities were eroded and survival became a normalised mode of being. This was described by a number of professionals working

across AOD, legal and sexual assault services, as evidenced in the quotes below:

> The difference with our clients is that complex trauma becomes the norm. So, it is consistently triggered. And consistently having more complex trauma … But I really want to sort of make it clear that I really see trauma as a single event, and complex trauma as life-long. But it's unaddressed. And that's the thing. And manifests—and then, I think complex—the difference with complex trauma is, it manifests into other vulnerabilities. (Manager/supervisor, homelessness service)

> My definition with trauma is both the injury so to speak so the traumatic event, but it's also the trauma that a person experiences in trying to I suppose heal from that event so for me it's very much—and I suppose this is where the complexity or the complex trauma comes into play for me—it's very much in terms of the person trying to navigate the world post experiencing that trauma. (Manager/supervisor, sexual assault service)

> And this is just again my working definition now that you're asking me, but I imagine trauma is the impact of perhaps a small number of events or one isolated event and it's probably more acute, and complex trauma, I would see as something that has either be something that's experienced over a very long period of time and so you've adapted to that environment and it's almost become—you found a way to adapt into being in it in traumatic environment or to suffering trauma over years and years and years or, and it's the same, but if it's something you've experienced as a child so again, you've adapted because it's been part of your developmental period, so it's been a lot more immersed in your physical health, in your psychological makeup. It becomes a part of you. (Manager/supervisor, legal service)

Similarly, a community educator explained that "complex trauma" wasn't the right word for the experiences of her clients. Instead, her service used the term "cumulative trauma", recognising that sexual assault is "pandemic" as a weapon of war, as a "way of survival" in refugee camps, and throughout the refugee journey. She described one of her clients as an example:

> She was kidnapped as a young woman … She was kidnapped

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and she was taken as a young soldier, trained as a young soldier, and then used in the sexual slavery for the forces. And she's been there for many—I think she's been six or eight years old when it happened. So, she's been doing this for a very long time. And she actually thought that it's normal—normalised and she came to Australia and she saw the program on sexual assault and she was just like, "Wow! This happened to me and this is a crime." She didn't know that. So she started to realise and she's fine now. She got help and treatment, et cetera. (Manager/supervisor, migrant/refugee service)

It was also acknowledged that cumulative or complex trauma could affect people in different ways. As some of the accounts above indicate, for some women the trauma is so embedded that they can hardly move through their life without noticing the impacts of the trauma in every aspect of who they are or in what they do. As outlined in this and subsequent chapters, complex trauma was often experienced as severe distress, successive crises, and an inability to independently navigate service systems. For other women, however, the impacts of trauma were more hidden and they would appear to be moving more easily through life. A trauma counsellor mentioned the following about one of her clients:

[She would say:] "I wear a mask the whole time which has impacted me and the whole time I've got to work through. I'm doing this but there's a second line that's playing under that the whole time. I'm functional, I'm at the university, I've got a degree, I've got a good job but underneath there is my mask, my façade. There is always complex trauma playing out about how vulnerable I am, what do I need to do, how do I protect myself, what's the underground game here. (Support worker, sexual assault service)

This quote highlights the complexity in the varying ways that women responded and adapted to their trauma.

Some women emphasised the qualitative differences between childhood and adult-onset trauma. Women who experienced sexual abuse or family violence in childhood felt that this form of trauma presented specific challenges. Children's experiences of abuse and violence had a normalising quality because, as Lauren explained, "Children don't have a frame of reference for how the world should be and they're taught that by the people around them." As a result of childhood trauma, a number of women felt that they were particularly vulnerable to being victimised as an adult. Miranda linked her recent experiences of an abusive relationship to her sexual abuse as a child, suggesting that predatory men "are attracted to certain types of women, and usually the woman has been through some kind of abuse before".

In a focus group of transcultural trauma counsellors, workers also noted the ways that other adverse childhood experiences, such as neglect, may increase vulnerability to traumatisation in adulthood. Workers emphasised the ways in which attachment in the context of neglect is a form of subtle traumatisation.

[Trauma counsellor 1:] The single incident of trauma, that might be that natural disaster or a car accident or sometimes one incident of sexual assault. Mind you, that can spark off other things. And then the ongoing trauma someone might experience which I would see more as complex trauma where it's ongoing child sexual assault or ongoing exposure to domestic violence, neglect. I mean neglect can have a huge impact on people, and then the re-traumatisation that can happen in adulthood … (Trauma counsellor, migrant/refugee service)

[Trauma counsellor 2:] Especially with attachment because, as a young child, they need to be so much physically and emotionally attached and with this neglect, that [attachments] have not existed, so the trauma will be quite big when they grow up. They will find other ways to cope with it. (Trauma counsellor, migrant/refugee service)

Although complex trauma is often equated with developmental trauma, another trauma counsellor noted the narrowness of this definition for the refugee women that she worked with:

Just on that, the terminology on that that I find tricky to sit with is in the broader space, maybe it is because it's based on different populations that complex trauma seems to be because something has happened in your childhood, that's just my assumption that is frequently what I have come across that this complex trauma is that it had to happen early to therefore be accumulative. Whereas for me, sitting in this space, we define that refugee experience, and I would put it as often complex

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trauma, is that for us there is probably a few things, it is repeated, it is sustained, it is of human design and it is very much to undermine that victim being left feeling quite helpless to prevent things happening again and I think for me, why I react sometimes to the other definitions of complex trauma is because a refugee experience of those repeated things can happen at any point in their life. It doesn't just mean that it has happened at one stage and is therefore accumulated so, I probably look quite often at what we deal with as complex trauma for that reason. (Manager/supervisor, migrant/refugee service)

Involving a sense of betrayal

Complex trauma is often inflicted by people closest to a woman such as a partner, parents and family members, and trusted figures in the community. The incommensurability of the love that the woman feels, and the pain that the perpetrator inflicts, is key to the complexity of this trauma. Miranda had experienced abuse in childhood and adulthood from those close to her and she explained,

I don't understand why someone would do that to me. I don't understand how someone can say they love me and then do that. You know what I mean? It doesn't compute. It's hard for me to process that.

This betrayal may then be reactivated and reinforced by widespread prejudices and discrimination, including misogyny, racism, classism and ableism. One of the professionals interviewed was an Afghan woman and community educator. Her history in her home country, her transition and resettlement in Australia, and her life as a Muslim woman meant that just "thinking" was "like trauma":

But complex trauma is like a series of trauma together, it's complex. For example, I'm Afghan. For us, we always have complex trauma. We don't have like one thing to deal with. From my childhood to now, when I'm thinking, it's almost like trauma. Even now, I'm here but I'm a Muslim, and this is another trauma that we will suffer here. As a woman, as a Muslim, that's trauma. (Community educator, migrant/refugee service)

This sense of betrayal at the socio-political level was also acknowledged by a policy manager who explained how her organisation came to understand complex trauma:

In the report we spoke about accumulated trauma and intergenerational traumas, community-wide traumas, those are the complex layers, really, that actually compound. It's compound trauma, really, and in the context of a society that has not wanted to believe such things. (Policy manager, legal service)

Trauma and disadvantage

Professionals discussed trauma as embedded within or occurring against a background of other adversity. For example, a trauma counsellor working in a sexual assault service described how earlier experiences of childhood adversity impacted the way individuals responded to later experiences of sexual violence:

And people can experience a trauma, and working in an area of sexual violence it's still a very broad area of, of the women that would access us. If you've had a fairly good attachment, a fairly stable life, good coping strategies, good—an ability to express your emotions and regulate your emotions and you experience a trauma, that is very different to someone that has a lifetime of [poor] attachment and disruptions as a child, poor sense of self but hasn't learnt how to cope in life and hasn't been given that support or that modelling and experiences, unhealthy relationships and multiple exposures to abuse, I guess that would be part of that difference that we would see. (Trauma counsellor, sexual assault service)

The AOD workers emphasised the ways in which disadvantage, trauma and substance abuse could profoundly erode self-esteem and self-confidence. Clients may not get the opportunity to acquire the kinds of skills that are required to navigate increasingly bureaucratised health and welfare agencies, or identify services that could meet their needs. As governments increasingly "responsibilise" people on low incomes or welfare assistance to solve their own problems, complex trauma survivors with multiple needs can be left behind. One worker commented:

You have to start with self-esteem and just being confident

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and their knowledge—"What's going on for me? How do I fix this? Is this okay? Is this acceptable?" Just not a lot of information, but it is out there. I'm not saying it's not out there. It is. But how do they access it? And I've got a lady at the moment who's doing her first computer course and she's 50 years old—never touched a computer. (AOD counsellor, AOD service)

In a focus group with an AOD service, the AOD workers also commented on how trauma could be built into the landscape of disadvantaged neighbours. Many of the clients from the service they worked in came from a low-income suburb with a significant Aboriginal population in which the primary school, high school and juvenile detention facility were built side by side. This configuration suggested not only a lack of care or concern for local children, but some kind of inevitable "graduation" from one facility to the next. This embedded geographic insult was made all the more sharp by the proximity of the suburb to another urban centre of considerable wealth, displaying a quality of life to the service's clients that they were unlikely to achieve.

> 'Cause if you think of the juvenile facility sharing a common fence with the primary school … Opposite it, there's high school … It's like—I'm not sure where the council has got that idea from. So we've got a juvenile centre, it'll share a common fence with a primary school and opposite, we'll put the major high school … We are like a 10-minute maximum drive, like—so we're that close to pretty extreme wealth and big houses, beautiful golf courses. And across the road, there's massive disadvantage and crime and drug use and—yeah. (AOD counsellor, AOD service)

Moreover, the AOD workers discussed the entanglement of intergenerational trauma with the generational transmission of substance abuse. Their AOD service was located in a socioeconomically depressed area of NSW and workers emphasised the ways in which trauma and substance abuse could pass down generationally.

> It's generational. And if we can step in and try to break that cycle, that's what I want. That's what I love because

I've never seen and I didn't realise how generational this was … To see it [drug use], to see it as acceptable and, "This is what I've grown up with, so it's okay for me to go on and [use]." (AOD counsellor, AOD service)

The experience of dissociation

As discussed in the review of the literature, dissociation describes the separation of mental processes that are normally associated and is reflected in alterations in memory, emotion, identity and behaviour (see Chapter 4). For example, the emotions associated with a traumatic memory may be disconnected from that memory. As a result, the traumatised person may then describe the event without any emotion, however the panic or the fear associated with the event may return in other ways or at other times. In the trauma literature, dissociation is often understood as a way of coping with experiences that would otherwise be overwhelming, albeit one that comes with considerable costs. In the absence of other strategies to self-regulate and self-soothe, or to escape from an abusive situation, becoming internally "disconnected" or "detached" provides some distance from intolerable feelings or experiences. However, in the long term, this disconnectedness can also create feelings of internal emptiness and a lack of connection with others, and can encourage coping strategies that centre on avoidance, illustrated in the following examples.

> I think the best way that I could describe it, when I feel disconnected, I want to disappear. There's no feelings about wanting to be around. (Josephine)

> Because I've learned kind of emotional distance from other people, and then so I've emotionally distanced myself and my memories of what's happened, so there is no kind of emotional connection. (Lauren)

> If you just box things up and put them away forever and ever and a day and they're not dealt with, that can be just as damaging. (Miranda)

Women described dissociation in a variety of ways. For example, Lena recounted periods of derealisation in which her focus narrowed to one object until all other aspects of her experience receded.

I usually—my vision gets very—like tunnel vision, I usually will be staring at one thing and unable to blink. I feel like I'm watching myself from above, like I'm floating and not connected, and I end up just completely shutting down where I can't move my body at all, and just kind of frozen and—yeah, there's no thoughts or anything.

Louise described periods of depersonalisation, in which she no longer felt real or really "there".

I could never connect the feeling to the experience. For me, was—I was an observer. If I did remember, I was always the observer as opposed to the participant and the person who it was happening to never looked like me.

Some women described dissociative experiences involving two or more identity states with significant discontinuity in memory, feelings and behaviour between them. For these women, early childhood abuse and neglect precipitated a developmental pathway in which they never had the chance to develop a coherent sense of identity or selfhood. Louise explained:

Because my trauma happened at such a very early age, I've never had a central understanding of a core identity. I don't know what that means. I have no understanding. It's like you're trying to explain the sky to me if I'm blind. I have no understanding what you're talking about. I don't know what it feels like. I have no idea what it feels like to wake up in the morning and go to bed at night and actually remember the day. I know there's bits and pieces where there may be a bit of confusion, but you still know that you woke up in the morning and what clothes you were wearing, you know what I mean? I don't have that continuous narrative. I have blanks in my narrative. I have periods where I watch, I have periods where I observe, you know what I mean, I don't participate, and I have complete blackness, and I don't know what that feels like.

Laura is a survivor of child sexual exploitation and she credits dissociation with her survival. She says, "We were able to put it all in a vault and lock it and bury it under 50 metres of cement." Louise also felt that dissociation enabled her to remain alive, stating:

For me, DID has always been a gift. I've never seen it as anything but a gift and the way that I see it that if I didn't dissociate, I'd be dead.

The psychosocial and embodied experience of trauma

This section focuses on how women experienced the psychological, physical and relational impacts of trauma, as well as workers' views on the effects of complex trauma on their clients. Clinical accounts of PTSD emphasise impacts on individual cognition, feeling and function and acknowledge the role of trauma on physical health, including "conversion" symptoms in which distress manifests somatically in bodily pains and other somatic symptoms. This clinical picture has been criticised by scholars on the basis that it overlooks the relational qualities of trauma in cultural contexts with a stronger focus on family and social bonds, and where trauma has been a shared or collective experience (Atkinson, 2002; Fernando, 2008; Summerfield, 1999).

It is therefore notable that the women in our study, who came from a range of cultural backgrounds, tended to situate the physical and mental health impacts of trauma in terms of their relationships, family obligations and histories. Cognitive impacts on concentration, for instance, were experienced via difficulties in communicating and connecting with others; changes in mood such as depression and anxiety were described in terms of loneliness and alienation; psychosomatic pain was described in terms of the impossibility to properly articulate and share the experience. Women spoke extensively about how trauma shaped their relations with children, partners, family, friends and workplaces. So, while Western psychiatric discourse tends to individualise the experience of trauma and traumatic symptoms, women's descriptions of trauma were decidedly social and relational. Workers also advanced a holistic understanding of trauma impacts. However, it was notable that workers tended to focus on the psychological dimensions of complex trauma while women's accounts of the embodied and often physically painful or discomforting aspects of trauma were extensive. This section is divided into psychological, physical and relational impacts of trauma, however we emphasise that these were not distinct but rather overlapping areas of experience.

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Psychological impacts of trauma

Trauma is a non-specific risk factor for a range of psychiatric problems and forms of mental and emotional distress. The women in this study described anxiety, depression, overwhelming emotions, intrusive flashbacks, nightmares and dissociative experiences. Living with and managing these symptoms put a strain on their emotional, physical and economic resources. For instance, the cognitive load of anxiety and depression had significant impacts on concentration, making it difficult to learn or organise information. Michelle said that, at the moment, "my brain is really like mush" and was interfering with her current efforts to separate from her abusive husband:

> And you can't articulate properly because all the things that have happened to you become very mixed up and there's so much trauma trying to come into your head, but when you're trying to explain it to someone important like a solicitor or family reporter or something, it's chaos for them to try to understand.

For traumatised women, daily stress and anxiety could be particularly difficult to manage. Megan described regular angry outbursts throughout her teens and twenties which stopped only when she was supported by her therapist to learn to better identify and manage her emotions.

> I'd get stressed out at the tiniest little things. I'd have absolutely zero patience in every area and it would come out as anger outbursts, just absolutely zero mood regulation. A real difficulty maintaining and starting relationships whether it's friends, intimate, family, whatever it is. So for me, I just thought that was stress and I didn't feel like I had any ability whatsoever to cope with it. (Megan)

Learning about trauma gave Megan a framework in which she could not only make sense out of her overwhelming feelings but gain control over them as well. Without a trauma-informed framework, women typically blamed themselves for otherwise unexplained feelings and responses, leading to feelings of being different from others.

> I never had a sense of belonging in a lot of places in a lot of ways. (Amber)

> So from a very early age, it wasn't a really clear idea but it was a sense, just like an instinctual sense, that I was different and my life was different somehow. (Sophie)

> I think even for myself just having no clue what was wrong with me other than I knew I was incredibly different to everyone else. (Jill)

Flashbacks and trauma-related nightmares were described as particularly debilitating trauma impacts. Louise described profoundly frightening and painful nightmares every night, in which the physical pain associated with her childhood abuse would return in full force.

> Every night, I wake up at 3:20am in a total state of full-on nightmares. I can't breathe, wanna scream, but it's also the body memories. And what I've noticed is since hitting menopause, the body memories are worse, like the pain … when I wake up at 3:20am, I crawl across the ground 'cause I'm in so much physical pain in my ankles that they can't support themselves.

Women experienced symptoms associated with a dissociative disorder, such as hearing voices, which are often associated clinically and in public awareness with psychotic illness. Due to limited awareness and training in dissociative symptomatology in the mental health workforce, such women were at risk of being misdiagnosed as schizophrenic or psychotic. For instance, in her twenties, Louise was initially misdiagnosed as schizophrenic since she reported hearing voices as well as visual hallucinations. She was later diagnosed with dissociative identity disorder.

> The reason they thought I had schizophrenia 'cause when I was first in, every time you go into hospital they ask you, "Do you hear voices?" and I said, "Yes, of course." And I was like, "Everybody heard voices." And then they were like, "Oh my gosh! She hears voices" and was like, "And can you describe the voice?" And I said, "Oh, there's a woman's voice and a man's voice and child's voice." "And what do they say to you?" And I'm thinking, "I don't know. Sometimes they tell me things. Sometimes, they say really bad stuff to me, sometimes you know, they say really horrible stuff to me." And they said,

"Do you ever see things?" And I said, "Oh, yeah, I see a lot of things. I see people getting hurt. I see little girls screaming and being tied down." And so, they thought I was hallucinating. (Louise)

Women diagnosed with a dissociative disorder also described living with significant gaps in their memory. Margaret said: "I can see photos and I have—I can, 'Okay, I think that was at this place.' I have no memory whatsoever of that. No memories." Kerry discussed her relief at her DID diagnosis, saying:

It explained why I had my lack of memory and didn't know. You know? I see people, and they're like, "Oh, you know when we did this?" And it's like, "What?" Or I say, "Oh we should go and see that movie … I haven't seen it yet." And my sister goes, "Yeah, we went to the movies and saw it. Remember?" It's like, uh-uh.

Workers in this study spoke of the psychological impacts of complex trauma as being global and long-lasting, impacting on women's identity and self-relationship. For instance, this sexual assault worker described the burden of trauma as having an all-encompassing, global effect on women's lives:

There's a whole range of stuff that goes on with something that's supposed to be normal and easy. Nothing is normal and easy, because of those experiences that someone has done to them. Not through their own fault, DNA or own personalities, because everything has changed from that moment on. Their way of thinking and learning and being is different from what it was going to be. (Manager/supervisor, sexual assault service)

The effects of compounded traumas are further witnessed by professionals in distorted beliefs of self-hatred, self-blame, shame and guilt. Being deprived of the opportunity to develop a positive sense of self impacts women's beliefs of their ability to make changes for their future, as described by this sexual violence service professional:

… their sense of self and that sense of self-efficacy, so their belief that they can be successful at making change, so I guess there's that potential risk for people to not perceive themselves as being capable of getting better, so that has clinical implications obviously for us, but has implications

for the way that they live as well. (Trauma counsellor, sexual assault service)

Women who have endured organised, sadistic abuse can suffer effects of trauma that are not only difficult and complex for them, but can be challenging for workers and support services to understand and address. As one rape and domestic violence counsellor notes,

We have a small but significant amount of clients who that [organised and sadistic abuse] would be their experience. What we tend to see with them is that they're very complexly impacted. They tend to present more with impacts that I think professionals find it very difficult to engage with so they can experience a lot of disbelief because some of their memories or disclosures, and some of their impacts, can appear quite, for want of a nicer word, bizarre. People I think find it difficult at times to believe that that's possible. (Trauma counsellor)

For women and workers, complex trauma was a phenomenon with wide-ranging and lasting impacts on women's emotional and psychological wellbeing, requiring a sensitive and specialist response that often challenged the limits of individual workers and services.

Physical health and trauma

Physical manifestations of trauma were diverse and varied, but intimately linked to the psychological impacts of abuse and violence. A high and chronic state of stress and anxiety produced bodies that were always "switched on" and never relaxed. Jill described the physical pain caused by permanent muscle tension. She said, "Just being someone who's been through trauma, you just go through so much pain physically because you get so much muscle tension." High levels of psychosomatic pain were also commonly reported. Carol said: "Well, the trauma part—it's very profound at the moment because this pain I've had has just been excruciating and there's no physical reason for it." Flashbacks and psychosomatic pain took a serious toll upon women's energy levels. During a particularly difficult period, unable to sleep from flashbacks, pain and hypervigilance, Piper had to resign from her job: "I was just getting sicker and sicker and sicker so I had to give

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up everything." Madeline also identified ongoing fatigue as a major issue for her: "I've had a lot of pain throughout my life and a lot of fatigue, like what my occupational therapist describes as chronic fatigue, so that like adrenal exhaustion."

Developmental trauma could have a range of impacts upon the acquisition of basic emotional, social and practical skills, and result in physiological dysregulation in adulthood. Madeline described "shooting nerve pain" in the form of fibromyalgia and Carol complained of trembling and "the shakes" when she tried to perform a difficult task. A number of women described severe "pseudo-seizures", in which they had fits with no obvious physiological cause. Women diagnosed with a dissociative disorder reported a particularly high level of somatoform symptoms. Laura explained that her body "processes" psychological distress and trauma through physical experiences:

> We[2] have chronic pain, we lost the ability to walk, we lost the ability to talk, even just to use our hands, and we also have aspects of something called dissociative attacks or pseudo-seizures and—yeah, just funny sensations. We get hallucinations—yeah, just pins and needles, neurological sort of based symptoms—we're chipping away at it, but we know that it's—our body tends to go that way than think about our mind and what—all the stuff that's going on in our mind, our body tends to take it on physically and process it that way. And so, when we know something is up with our body or anything we realise that—okay, something is going on in—what's going on in—emotionally for us.

Women's coping strategies and responses to trauma could have significant implications for their physical health and complicate their efforts to seek treatment. Like a number of other women in the study, Madeline has struggled with an eating disorder since her teenage years. Her eating disorder has considerably complicated her treatment for both mental and physical health issues. For example, she was prescribed an anti-depressant that included weight gain as a side effect, which in turn triggered her eating disorder: "Every time I went back there, I was like, 'Please don't put me on that

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2   Like many people with DID, Laura refers to herself using plural pronouns.

[medication] again.' It's dangerous because if I put on weight, then my eating disorder gets worse."

While women described many physical manifestations of trauma, service professionals spoke less extensively about the somatic dimensions of complex trauma. Nonetheless, there was broad awareness of the presence of chronic pain in the lives of women who have experienced complex trauma. A women's health worker's aide mentioned: "We see a lot of the clients presenting with physical pain or chronic health issues, things like that. We see that in abundance." Other workers expanded on the embedding of trauma in bodily systems, and the physical discomfort of living in a traumatised body:

> It's about how bodily entrenched trauma is for many people, like, "Don't touch me"—they are averse to all sorts of things or they're very tense the whole time, their hypervigilance. (Support worker, sexual assault)

> Huge difficulties in managing arousal, dysregulation, day-to-day kind of functioning is hard because it's really hard to feel okay in their skin. Also, their own capacity to regulate, due to impacts of trauma is very disrupting. (Trauma counsellor)

Those who experience early deficits in health care can suffer serious long-term physical health consequences. This mental health nurse described the adverse health effects on Aboriginal and Torres Strait Islander women who were removed and placed in "care" as children:

> The people that we work with already have limitations to life expectancy, for example, a lot of them are Indigenous, they've had care histories in which they may not have been fed properly or all these other things, so not only do they have these impacts upon their lives from other circumstances but then they also have the impact of trauma which greatly reduces their life expectancy. (Manager/ supervisor, sexual assault)

The physical ramifications for women who had suffered extensive abuse, including exploitation and trafficking, can be significantly invasive and devastating. A sexual assault service professional spoke about a client she has been supporting for many years who has been sexually abused within a family

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network, with significant implications for her reproductive health. She said that the client has "had chronic health issues, where she's losing most of her body, like 'down below', just one thing after another and she's about to have a total hysterectomy". Similarly, a social worker who was supporting a severely abused and trafficked woman commented that, "The physical sort of legacy of all of this is shocking. She's got lots of serious physical problems from the abuse."

Relational aspects of trauma

Complex trauma is inherently relational: it is inflicted in relationships, and becomes woven into the survivor's biography, attachment style and way of relating to others. Women recounted how the multi-faceted impacts of trauma were evident across their relationships with partners, families, friends and strangers. For example, Megan grew up in poverty and her mother was a heavy drug user. Megan was the "parentified" daughter who took over a range of familial responsibilities when her mother could not. A car accident in her early twenties triggered an acute trauma response that required significant therapeutic support. In the context of therapy, Megan was able to reflect on how the intensity of her attachment and abandonment fears were impacting her current relationships, resulting in considerable depression, anxiety and anger.

> Looking back, yes, I was so just angry at the whole world. And a lot of it too now I realise was learned behaviour. I learnt it from my mum, that's how she dealt with issues and problems, that's how I did. But then in the last year or two realising, "Oh okay, it's not that I have an anger issue and I'm a very angry person, I have mood regulation issues." And I can't regulate my mood myself and I have to learn to self-soothe 'cause I was never soothed as a child. And the reason I want to be held really, really tight after I've had a massive fight with my ex-partner is probably because as a child I wasn't held when I was crying. (Megan)

The entanglement of trauma within families and communities means the people closest to the traumatised survivor can be important sources of support, but at the same time they can also be hostile or ambivalent towards the woman's needs. For instance, Piper experienced what she described as a "mental breakdown" in her forties as she began to remember being

sexually abused as a child. She had also grown up with her father's domestic violence, which had been normalised by Piper's mother as "what goes on behind closed doors". The long-standing family ethos of "pull yourself together" shaped how Piper's mother responded to her disclosure of sexual abuse:

> Her thing was, "Well, just get over it. You've got to put yourself together." I said, "Mum, I need you to understand that I've got complex PTSD." I think that took a lot. It's hard for her and even my sisters to comprehend what that means. (Piper)

In the context of abuse, women can develop a range of adaptations in relationships, including subordinating their own wants and needs, in order to survive, which can impact the formation of friendships and romantic relationships. A number of women identified how their traumatic childhoods had primed them to take on "helping" and "caring" roles that made it difficult to establish healthy boundaries. Josephine described how her involvement in supporting a friend with mental health needs escalated to the point where she became, effectively, her full-time carer:

> I don't know how I got myself into that position, but I ended being up being her carer. She was living with me rent-free. I take her to appointments—just happened like that. I don't know how I did that, but I do. I recognise now I just needed to help them. It was me playing out maybe some power I needed … It was about five years ago where my then female partner said that to me. And I realised that I didn't wanna be a carer. Yep. And so, I tried for the last four years not to be a carer. (Josephine)

Interestingly, many women with experiences of complex trauma were engaged in the "caring" professions: social work, nursing, mental health, child protection. Similarly, some of the female professionals interviewed for the study disclosed their own histories of complex trauma. A trauma history does not compromise a professional's capacity to provide others with care and support; indeed, such a history can be a resource that professionals draw upon for insight and empathy. Nonetheless, integrating contemporary care work with the consequences of a trauma history could be a challenge and was something a number of women had identified.

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Intimacy and sexuality could be fraught terrain for women who had prior exposure to abusive sexuality and/or controlling partners. Developing a sense of sexual self-determination and autonomy, and learning how to safely trust other people, was a particular challenge. Amber remarked:

> Even now, for me, more of the sexual stuff is still what's left to deal with and it is impacting the way [I] view like men's views of me and the way that I engage with male friendships and just always feeling … that men always just have a sexual agenda all the time.

Service professionals identified relational impacts of trauma for women as difficulties in trusting others and services; social isolation and silence; as well as intergenerational impacts for women, families and communities. In interviews, women discussed how the erosion of trust that comes from repeated interpersonal traumas made it difficult to trust their own decisions and could increase their suspicion of service providers. A sexual assault worker commented:

> Their belief around themselves and the world and others is really, really disruptive, I guess. "I'm bad, the world is unsafe, I deserve this. Other people are unsafe." A lot of, even difficulty trusting our service and trusting us, being able to talk to us. (Trauma counsellor)

One rape crisis service counsellor spoke of how this erosion of trust is particularly poignant for women who have suffered organised and systematic abuses, and can be a real obstacle to them accessing services they need:

> What we know in terms of impacts of trauma is that their level of trust is zero. They don't trust anybody. And when they've been systematically [abused] the likelihood that they would take a referral from us is unlikely, often, because they just do not trust anyone. People have such … people who've experienced that type of abuse will feel that their abusers will have access to any information about them. (Manager/supervisor, sexual assault services)

Social isolation was identified as a significant impact by a number of service professionals, who mentioned different ways this manifests for women. For CALD women, isolation can arise from the unique nature of their experiences in comparison to what services are available and equipped to understand and work with them in this country. A lack of a supportive family and connection to a stable base is a reality for many women who have suffered complex trauma. For some highly marginalised and isolated women, their only support may be the care team who is supporting them, as described by this multicultural worker:

> So one of my clients is really, really severely isolated, feels like she's got no one in her life, very few people she can talk to, chronic self-harm, suicidality, and self-hate really. And she really doesn't feel like she's got many people in her life who were supportive apart from she's got a support team which was set up and that is really very tough. (Trauma counsellor, migrant/refugee services)

Supportive relationships play a prominent role in healing from trauma, and can be healing in and of themselves. For those women who have a positive social network of supportive relationships, the difference was tangible. One trauma counsellor commented:

> Everyone is so different. You can have one client who's had the same kind of trauma history but just responding in a very different way but that often means they've got—I often see if someone has got some more supportive relationships in their life, it's often relationships are crucial. (Trauma counsellor, migrant/refugee service)

Service professionals witness the legacy of attachment trauma on women in the ways they engage in their intimate relationships. Women who have inherited negative representations of intimate relationships through their family of origin are vulnerable to ongoing abuse and mistreatment in their adult relationships:

> These women, you can see they are vulnerable, and they are manipulated and exploited in society … no family support, and really clinging on to anyone that gives them hope, [including] a dysfunctional relationship. (Manager/supervisor, homelessness service)

> Someone's paying them attention, someone's putting the focus on them so they're seeking that out. That nurturing that they've never had from the early age. Or they think that is what nurturing is and that's what love is. Everything all mixed up. Someone tells them "I love you" and then they're mistreating them, those two kind of become

associated together, so if someone's mistreating them it's still a sign they care for them. (Trauma counsellor, mental health service)

When trauma is enacted upon entire communities, the ramifications of impacts extend well beyond the point of the wounding. Service professionals who work with refugee women who have suffered extensive trauma and displacement describe how entire communities and generations are impacted:

The intergenerational impact of trauma, and trauma that accumulates over generations, especially when you are working with clients or client groups where there has been generations of displacement, generations of persecution and acts against communities, it's not just the individual that suffers that experience, it's the whole community and that continues beyond one moment in time that the impacts kind of ripple through different generations as well. (Manager/supervisor, migrant/refugee service)

The negative outcomes of complex trauma are many and varied, and without care and assistance can lead to life-long impairment. However, these outcomes can be seen as understandable, even expected as a consequence of repeated and sustained trauma. As one service professional aptly stated: "I mean I often find myself thinking, imagine living one day in the life of some of my clients. I just think I would be exactly the same, if not worse."

Trauma and mothering

In interviews, women often reflected on the impact of trauma and violence on their own parenting. They were also clear about the significance of their bonds with their children (and grandchildren), which served as important anchors to the present rather than the traumatic past, and often functioned to motivate them to pursue treatment and recovery. Louise discussed, with some sorrow, the effect of trauma and violence on her daughter. Louise was sexually abused as a child and developed a dissociative disorder as a result. She describes herself dissociating in her abusive marriage as an adult, and the "parentification" of her daughter, who from a young age had the responsibility of looking after her:

With my kids, for example, I remember my kids saying to me as they were growing up—in the early stage of

our marriage—my marriage, it was an abusive—it was a domestic violence marriage. And because of the violence in the house plus the fact that I—because every time my husband hurt me, he'd hit me, I dissociate and I became very sick, and then my daughter, who was very, very young, had to take care for me. And I remember many nights—I was in a dissociative state, but I remember watching my daughter washing me and showering me and feeding me, and she was like six [years old]. That's what I'm saying. That's the effect that it had on my kids. (Louise)

Other women spoke with concern and regret about those times where they were so overwhelmed by trauma symptoms that their usual parenting and caring activities were affected. Discussing periods of her life where she had been acutely impacted by trauma symptoms, Piper said:

[PTSD] affected me greatly. I'm sure it affected my son. He's very unhappy as well, and he saw his mum was heartbroken, and I didn't want him to see that but he did, because how do you hide it when you have to look after him, I couldn't make his dinner, I couldn't make his lunch, I just couldn't function … I'm so lucky to have my husband because without him …

Debbie grieved the impact that her ex-husband's violence had on her parenting when her daughter was young:

I didn't lose a relationship with my daughter, but I lost the small things, like I look at my grandchildren, and because I was consumed with fear, you didn't get to experience those little things, because someone's ranting—and how can you be in touch with stuff when you're consumed with fear? … So what I'm saying is because my daughter, when she was young, I missed those little things, but now with my grandchildren, I don't ever miss them, and I understand how special it is. So, I have this sense of loss a lot of the time.

Concern for their children could also be a major impetus for women to leave violence or seek help for trauma. Reflecting on her time in a violent relationship, Miranda noted that "one of the biggest reasons why I'm getting out of this relationship is because I don't want my daughter ending up in a relationship like I did". For Chloe, her daughter's response to her suicide

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attempt made her "wake up" and realise how much she mattered to the people in her life. Her daughter's anger at her suicide attempt challenged her assumption that nobody "would care that I was gone"; this feeling of worthlessness is common amongst abuse survivors.

> It was actually my daughter who had to admit me [to hospital], my 20-year-old daughter. The reality of that and that—I can't even think of the right word, but just the weight of that, it hit me. And some of the things that she said to me, "How dare you leave, of trying to think of leaving us. How could you do that to us?" talking about her and her sister. And I never stopped and thought about it because I didn't think about how it would impact other people because I just thought I was—at that time, I saw myself as a huge burden on everybody. I didn't think that anyone would care that I was gone. So her saying that, plus being hospitalised and all of that sort of stuff was just—it's as awful as it's all been and as guilty as I feel about putting my child through that, it's really just made me wake up and address things and do something about it. (Chloe)

As will be discussed in the next chapter, many women struggled with suicidality throughout their lives. For Kylie, her bond with her granddaughter was a strong anchor and counter to recurrent suicidal ideation:

> I get the [suicidal] intent quite often. And yesterday, I had it. It was so strong, but luckily, every Monday and Tuesday, my youngest grandchild comes and stays with me. She's just turned 12 and she is just—I can't describe how incredible she is, not just because she's my granddaughter … She stays Monday, Tuesday nights, and I do the school run and the school lunches. I love it … This morning when we got up—she's got hair down to here, that thick, beautiful hair, and she always gets me to get the last of the knots out and plait it for her. And I was plaiting her hair, and it just engulfed me, the love that she has for me. And I said to her, "I can't leave you. I can't leave you." She just hugged me and cried. I couldn't hurt her.

For Margaret, her responsibilities to her daughter helped her to stay grounded in the present, and set aside time to "deal" with trauma with her therapist:

> Trauma tries to take over your life and you have to be able to say, "No, you're a trauma, you're in the past, I will deal with you, but I have a daughter I need to help right now, so you're gonna have to just sit aside while I do this, and I've made time to deal with you with someone else a little bit later."

The need to support women in their parenting as part of trauma treatment was both a priority and a challenge for services. In their focus group, AOD workers noted that a lack of childcare arrangements could prevent women from participating in treatment; they also noted that many of their male clients could themselves be violent or otherwise "unsafe". Ensuring a child-safe environment in a substance use service would likely require a significant investment of time, funds and skill.

> We'd like it [our service] to be more child-friendly, not that they bring their children in but that we could have somewhere where people could leave their children, then come and attend our groups, 'cause a lot them don't have childcare. (AOD counsellor, AOD service)

> I agree. That's a huge issue for us. Often this population includes perpetrators of domestic violence, people with criminal histories, perhaps may not be the most savoury characters. So, there are other risks that are associated around having children and so forth. But at the same point, our ladies with kids that have been abused with domestic violence … So, trying to manage both needs—to be child-friendly and welcoming, but at the same time, safe, that's a real challenge. Well, for us, it's—our office is so un-child-friendly. (AOD counsellor, AOD service)

Service professionals identified challenges for mothers engaging with organisations and systems that are not trauma-informed. Workers identified the field of child protection as one that can be particularly stigmatising:

> In our area, there's been a lot of mother-blaming and in the child protection field, so that is being addressed through various project, like PATRICIA project [Pathways and Research in Collaborative Inter-Agency working], that's part of ANROWS [Australia's National Research

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Organisation for Women's Safety], PATRICIA project. They're trying to address that. (Trauma therapist)

Without credence given to the significant contextual links between historical or current trauma and existing parenting practices, service professionals witness mothers being labelled as deficient and lacking aptitude in parenting:

> So what I find is that what has happened to the woman and the children gets personalised. As for mum, it's her parenting, there's something wrong with her parenting or she has been triggered from the past. She has been triggered from the past, we hear a lot, and it gets personalised too. Something deficient within their own character and their own personality so I think that really impacts, whether they even get to keep the children. (Manager/supervisor, domestic violence service)

> I really used to get really fired up when women would go to a service and it may be a specialist DV service or it might not be, and or they might go to Family Court or even DV court and would be either told or suggested to that they do things like parenting courses. (Support worker, sexual assault service)

Workers in the domestic violence sector also noted that women whose behavioural presentation is affected by trauma are further disadvantaged and stigmatised:

> The perpetrators may be presenting quite well and mum is not presenting well at all because of her own childhood trauma impacts and then the current domestic violence, and then also it impacts them by how they get treated by the system. (Manager/supervisor, migrant/refugee service)

While there was acknowledgment by some women's health professionals of personal challenges women needed to work through for their children's wellbeing, they also identified that these root-cause issues were not acknowledged or catered for in case plans or parenting plans:

> In addition to a lack of understanding around the impacts of trauma, even the impacts of trauma have resulted in the outcomes and that—when we look at case plans and parenting plans, we see a lack of information around the impacts of trauma. For instance, it might say, you have

to go to the drug and alcohol unit and sober up. Sure, absolutely. But there's no actual understanding as to why that impact was there in the first place and how do we address that. (Support worker, women's health service)

For these women to be efficacious in meeting the demands that systems place on them, service providers in the women's health sector noted that more adequate support was needed to help women work through what could be a lifetime's legacy of impacts:

> So, it's a multitude of reasons around that lack of understanding and how that impacts that defeatist feeling that the client has of, "I've got to do this. But then if I fail it, I'm never going to see my kids again and I don't know how to not fail so I may as well just give up." (Support worker, women's health service)

Women from CALD backgrounds can face additional challenges from within their communities and families when trying to make protective choices for themselves and their children, illustrating the intersection of gender and cultural identities in dealing with the impact of trauma. One worker described how women are held responsible for domestic violence and family conflict:

> She tries to leave the relationship or complain about it, it's seen that she's not actually—she's not a good mother, she's not a good partner. She should do better to please the man rather than complain. So, basically, she should cop it, and it's very common. And if they complain to family members or some people in the community, they push back, "Be the better mother. Try harder and everything will be all right." So, it's not—especially in refugee communities, domestic violence—it's not seen as power and control, and not like intimate partner violence and imbalance in power. It's more seen as family conflict, marriage difficulties, but definitely not power and control. (Manager/supervisor, migrant/refugee service)

Professionals spoke of the strengths of the women they engage with, who work hard to overcome challenges and provide a better life for themselves and their children. One community educator reflected on how, during their introductory information programs for CALD women, the

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women would ask for classes that would assist their children: "They were asking for [a] session too on—more of a program on stress management, how to become better parents in this country when they settled." Speaking of their experiences of working with women who have had their children removed from their care, a multicultural worker acknowledged the struggle and determination of the women: "They put so much effort into being a parent." This sentiment was also reflected by their colleague, who sees a mother struggling with her circumstances:

> For me, all the mums are great mums … I know that some mums—there was this mum neglect the kids and mum will do this, mum will do that, but if you look at the trauma that they went through, it's just that they're really struggling. (Trauma counsellor, migrant/refugee service)

Service professionals spoke of how challenging it can be for mothers to regain care of their children once they have been removed: "It's very hard to get kids back." One community educator expressed their own devastation at witnessing women try so hard to overcome and do better for their children, but still not regain access to them:

> How come the person that kills someone or did something wrong goes to jail for a couple of years, get punished, and they're out? And mum has done bad with the kid, they fix the kids, and they keep [them] away from her? She's done everything to really provide and they cannot have their kids back? I don't understand that. (Trauma counsellor, migrant/refugee service)

Service providers witness the impacts of complex trauma flowing from one generation to the next. This worker from a domestic violence centre speaks to this issue: "[We see] a lot of attachment issues in terms of most of the families that we are working with, the members have complex trauma in their own childhoods." Just as violence can ripple across generations, so too can maternal deprivation. A sexual assault counsellor spoke of the impact on women's parenting when their own mother was institutionalised as a child: "Their mother is really institutionalised and it's amazing the connection between mum being put into girl's home and then how that's impacted on their parenting."

Some of the professionals interviewed for the study observed that Aboriginal and Torres Strait Islander women who were stolen from their families and placed into children's homes suffered multiple, compounding traumas, which also had a flow-on effect on their parenting. This service professional spoke of how being deprived of nurturing parenting experiences impacted First Nations women's confidence and practices as parents:

> Some older women who went into hospitals as domestics [cleaners] were much better off than people who went into service on farms because usually they were sexually abused and or treated badly and had stolen wages there as well. And so they often got married very young and ended up in relationships that were difficult, and their parenting was difficult as well, so it was the intergenerational stuff of "I wasn't parented well, I don't know how to parent well", a lot of guilt around parenting and the ability to parent and whatever … That trauma was really entrenched in childhood and then moves on. (Support worker, sexual assault service)

Women's and worker's accounts of mothering in the context of complex trauma spoke to the toll that trauma can take on families and generations, but also the restorative power of relationships in women's lives. Services and institutions had a key role in either exacerbating the trauma of mothers and children or ameliorating it—however, for services to make a constructive impact, they needed to consciously support women as mothers rather than ignoring the women's relational responsibilities.

How women skilfully deal with trauma

It is safe to say that most of the services and institutions that women had encountered across their lives were not trauma-informed. However, despite the many challenges that women who have endured complex trauma face—from internal conflicts and triggers and difficulties within their own families and relationships, to economic hardships and the issues and struggles outlined here in terms of navigating systems—women still find ways to not only cope with these challenges, but deal with them in skilful and meaningful ways. The women of this study spoke of a wide range of practices

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they engage in and connections they make that contributed to their wellbeing and brought with them healing and growth, allowing the women to demonstrate agency and resilience.

Connections with others

Women noted the positive impact on their wellbeing arising from meaningful connections to important people and communities around them. For some, this was found through prayer or in church. Jeanette said: "When you go to church—the church is amazing and there is always community in church." Others found their healing connections out in nature, or in their garden. Phoebe's advice to other trauma survivors was:

> Get something to care for, a fish tank, a garden. I'm a gardener. I go out in the garden a lot … caring for something makes me be able to deal with my trauma.

Spending time and communicating with friends and family was an immense source of support for some women, while other women spoke of the healing bonds found among fellow trauma survivors. Amber said:

> I really love the connection in just a really, really deep meaningful existence that occurs because of that, because it allows you to connect in such a way that you can't get deep with anybody else.

For refugee women, spending time with people from their country of origin brought them peace: "Then sometimes I bring the kids and we meet any [person from] our country, we speak our language. I feel calm." (Rita)

Being present to the "here and now"

Being present to the here and now can be a challenging and triggering experience for many people who have suffered complex trauma. Women deal in skilful ways with their discomfort by engaging in practices that enhance their ability to get out of their heads and come into their bodies. Many women found grounding practices to be particularly useful. Piper said: "Small things like being able to ground myself when I'm triggered, when I have flashbacks and things like that, just bringing myself back in the room and calm myself down, basically that [helps]."

Women spoke of a variety of methods that helped to ground them in the present moment, including walking, craft, listening to music, using a weighted blanket, splashing their face with cold water, cooking, yoga and following their breath. Meditation was also beneficial for some women, who spoke of using guided tapes, imagery or specific mindfulness meditations.

Journalling was another avenue that connected women to their here-and-now experiences. For Jill, writing down thoughts was helpful in providing perspective and clarity on issues:

> The process of writing it out was really helpful because it helped me to gain some clarity and at times, it was almost like it was a coming together for myself and it's like, "Okay, that makes sense now."

Writing was also useful in helping to calm the mind, while providing an opportunity for women to voice their experiences, even if it were only to themselves. Louise said:

> Writing helps. I find if I write, it de-escalates it in my head and because my parts write as well … it is important to them. So, it's being able to have a voice, even if you're not having a voice.

Providing healing to the body

Women found healing in avenues that allowed them to feel peace within their bodies. Connecting to their bodies through yoga, particularly hatha yoga or trauma-sensitive yoga, was a meaningful practice that established a feeling of safety within their bodies. Yoga also helped women to connect with unacknowledged emotions, and to have the feeling of really being in their bodies:

> [Yoga] has been so valuable for the dissociation because it teaches you that proprioception and interoception, so you can be less numb, and that's really painful at first … but I went from not being able to tell when I needed to use the bathroom to actually being able to like cry for the first time at 24, basically through yoga. (Madeline)

Other body-based practices women found healing included dance, swimming, running, reiki, playing sport, going to the

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gym, having acupuncture and learning a martial art: "[Karate] is giving me a sense of possibly, a bit of power, whereas before it's like I would cringe in the corner." (Siobhan) Megan spoke of how the experience of getting a massage put her in touch with how disconnected she was from feeling the sensations of her body:

> I got a massage and then I actually physically within my own body was—I just felt like I'd taken a breath, that I must've been holding on physically, so tight for so long that I didn't even recognise how disconnected I was and how really sore my body was, really. So I think I've become much more aware of the body element of it and how that's incorporated with it.

Developing new paradigms and perspectives

Women deal with their trauma by learning to see their situation and their lives from a different perspective. For some, this came in the form of acceptance for where they were and for changing things they had control over. Laura said:

> I think even if you take one small step of change in one degree of change, years later, you will be somewhere else. But everything does change and everything in time changes, and I think even trauma can change.

For some, these changes came about through work with a counsellor or practitioner, developing skills and learning how to manage themselves in new and positive ways. Josephine commented, "I think I got the skills in counselling and then I … came off medication … I felt capable of self-managing. I feel like I've had a few fall-downs in that time, but nothing drastic."

Moving away from old ways of being and rebuilding one's life was restorative for women. Debbie spoke of rejoicing in the simple pleasures of daily life and doing things for herself after years of living with domestic violence:

> The simplest things in life that most people don't even consider bring me great joy, like if I go shopping and bring stuff home, I can actually feel the joy of—"This is mine, this is safe, I can eat it."

Letting go of old ways of being that no longer serve her was a healing decision and practice for Piper:

> The more I let go of everything as well, the more I actually let go and to give up everything, the better of—let go of everything and let go—I was always kind of a high achiever. I let go of everything.

Developing a new self-relationship

Women found healing and growth through the cultivation of a new relationship with themselves. Some women described this as having compassion for themselves and for where they were right now, even though it may still be difficult and messy. Piper said:

> The most important thing I felt was just to allow yourself to be, so not beating yourself up about it all the time, not beating yourself up because you can't make your kids lunch, that you can't get out of bed for a week.

For others it was investing in themselves, by studying hard or taking great pride in their work, and ensuring the future they made was better than the past they had been given. Megan said: "So for me, my strategy was: get a fucking education and get out." Choosing new ways of being that were self-honouring was significant for some women. For some this came as learning to enforce personal boundaries, even when it was uncomfortable. For Josephine, "the courageous honesty is about—is actually about being able to verbalise, 'that doesn't work for me' and actually being able to risk being unloved … and being able to deal with the backlash".

Women also spoke of going through the necessary work of healing, even though it is tough. Natalie's advice to other women was:

> It's a long road and you got to just keep going with it. It's not gonna be easy, that's the hard truth of it … and know that healing isn't linear and you're working towards just managing through it, because it is something that will always be with you. It's not gonna be a magic-cure end-goal. Don't believe anyone who's gonna tell you there's a quick miracle cure or fix or anything like that because that's not the way it is.

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Summary

Professionals and women alike had difficulty separating out "trauma" from "complex trauma"; these terms are categorical while the experiences of the women were pervasive, cumulative and intergenerational. Trauma was experienced as life-defining and life-changing; as loss, exclusion and disadvantage; as a psychological wound that wept into every aspect of a woman's life; and as a relational and embodied experience involving disconnection from self and others. Complexity was evident in the multitude of traumas experienced, the cumulative and compounding impacts of trauma and the entanglement of trauma with other life adversity and socioeconomic disadvantage, reflecting intersecting identities and experiences. In this sense, complex trauma is best seen as a dynamic process rather than a unitary construct.

The experience of complex trauma was psychological, embodied and relational. The emphasis from the professionals interviewed for this study fell on the psychological impacts, consistent with a biomedical framing of trauma. Women, on the other hand, were clear about the ways in which their physical and relational lives were heavily intertwined with their psychological experiences of trauma. As will be discussed in the following chapter, the biomedical conceptualisation of trauma and its focus on psychological distress has significant implications for the recovery of women. Based on the accounts of women described in this chapter, recovery requires services that take a holistic approach and build on the different ways that women are already managing their traumatic experiences.

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Health responses to complex trauma

> Remember that we are here because of what happened to us and not because of what is "wrong" with us. My emotions might be running wild but I'm still here and I'm an expert in my life. Instead of telling us what we need you should ask us what we need. Trauma impacts us as a whole person: physical, mental, financial, spiritual, social.
>
> Our experience is part of a bigger picture. We need a sense of progress, safety and understanding as individuals, in services and in society.
>
> Statement to professionals from a workshop of women who have experiences of complex trauma

> We acknowledge the courage that it takes to continue to look for the services that are right for you. Sometimes we are amazed that you've walked through the door and opened up to a stranger. To think of you as anything other than strong is a disservice to you. We are so privileged and honoured to be in the presence of women who have survived so much.
>
> We are grateful that you would share your wisdom and patience as we become more healing-centred and as we grow and learn. You are our greatest teachers.
>
> Statement from a workshop of professionals to women with experiences of complex trauma

Given the complexity of their needs and experiences, women's engagements with a spectrum of services and agencies were fraught with potential for misunderstanding and misrecognition. This chapter describes the variety of women's modes of engagement with community mental health services, inpatient care and hospitalisation, emergency departments, and general practice and psychology services. A consistent theme running throughout their experiences was the risk of traumatisation when they entered these systems voluntarily or involuntarily. Through self-advocacy and persistence, some women were able to connect with specialist services and professionals who were able to provide trauma care. However, major obstacles to effective and appropriate responses to women with experiences of complex trauma included the scarcity of affordable and accessible trauma services, an endemic lack of trauma training and literacy across health care settings, discriminatory attitudes to traumatised and abused women, and convoluted service systems in which women often fell through the cracks.

Problematic response based on a biomedical model

One of the key factors invoked by participants to explain the challenges in accessing appropriate services was the biomedical model underpinning mainstream mental health services (Ussher, 2011). Some participants explicitly used the terms "biomedical" or "medical model"; commonly, these were professional stakeholders, but there were also a few women with experiences of complex trauma that used these terms in explaining why their interactions with the healthcare system were problematic.

Overall, it was clear from participant accounts that the biomedical model adopted by the mainstream mental health system had particular problems in relation to responding to the complex trauma experiences of women. This was seen in primary health care (e.g. general practitioners), community mental health and hospital settings. There were two main areas in which the biomedical model caused significant distress for women: the disbelief and intolerance they encountered from health professionals and the lack of understanding of their distress resulting in pathologising labels that followed them through the health care system.

Disbelief and intolerance from a "helping" system

Health professionals' views that some trauma-related diagnoses are illegitimate was reported to result in some women being denied or excluded from professional support. A number of professionals gave accounts of colleagues who simply did not believe in diagnoses like DID, which created conflict within the treating team, as explained by a mental health nurse:

> [A colleague] kept undermining my diagnosis and kept undermining my plan, kept undermining the patient. And, said it was just all a load of crap … She'd asked many consultants over the years and they said that DID doesn't exist. (Trauma counsellor, mental health service)

This experience was echoed by the women. In inpatient settings, women with a diagnosis of DID frequently encountered psychiatrists who denied their experience and attempted to undermine their diagnosis and treatment. Louise said:

> That particular hospital, even though I was diagnosed with DID, I was told by my doctor at that hospital, not my treating psychiatrist—the doctor at that hospital that I do not have DID, that my treating psychiatrist convinced me that I had DID, he created the alters and it's all in my mind and if I leave my treating psychiatrist and go and see him, then I'll be okay.

By far, most accounts of intolerance within the health care system related to health care professionals disbelieving or discrediting women's experience and misattributing their behaviours to a difficult personality rather than seeing them

as "real" distress. As explained by Beth, the experiences of women went beyond common notions of trauma understood by most health professionals:

> In terms of the complex PTSD clients, where the trauma is from a more organised or ritualistic kind of abuse, or when sometimes abuse history is extreme, it can be really confronting for some practitioners and people report a lot of not being believed …

This resulted in a punitive response that dismissed trauma and minimised symptoms. For example, a social worker commented that once it was known a woman had a label of "personality disorder", then "mental health seems to shut down quite quickly and say, 'They are problematic. They are non-compliant. They are attention-seeking. There's nothing we can do for them.'" This commonly resulted in exclusion, described by one trauma counsellor as "scapegoating" and "punishing" women by withdrawing treatment.

> Harm is even sometimes due to inaction rather than action … Often the inactions are due to the staff summing up the person as bad, not mad, and therefore not worthy. Or, not bad and mad, therefore not worthy, and they do develop this attitude, give them nothing, take them nowhere. If they behave a certain way, they are just putting it on, they are acting or attention-seeking. (Mental health worker, mental health service)

This misattribution of behaviour as a personality problem rather than legitimate distress was thought to be driven by a lack of awareness and understanding of the impact of complex trauma. Some professionals described the need for practitioners to ask the question of "why this behaviour?" rather than responding with anger or dismissiveness. An AOD professional suggested awareness training in complex trauma should be part of the mandatory orientation for new staff members, alongside "fire safety or CPR".

The chronic nature of complex trauma was not something that mainstream health professionals always understood, and this was associated with fatigue or desensitisation in the women. For example, a sexual assault service professional relayed,

> We've had people who are working for the CAT [Crisis

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Assessment and Treatment] teams saying, "Don't worry about it. It's just mental health. Don't worry about it, she's okay. She says she's suicidal every day, I'm not going to ring her."

This was also explained by a trauma counsellor:

Sometimes for clients that are chronically suicidal with chronic significant attempts done on multiple occasions, the understanding of where that pain is coming from, all the reasons behind [it] wears very thin for mental health. The response often is "We're not going to do anything or if we do we're going to go and tell them to have a warm bath."

The delegitimation of distress and the minimisation or dismissal of self-harm and suicidal ideation had serious implications for the safety of women. Professionals commented on the lack of understanding of the need for short hospital stays when women were feeling unsafe, as described by a sexual assault service professional:

When our clients are wanting to self-harm or they're suicidal, it's so very hard to get them to be admitted to hospital and at times all our clients need is a break. Just some time out to be safe. They can sit in ED for hours and then just be sent home, in the middle of the night in an unsafe environment and timeframe. (Trauma counsellor, sexual assault service)

The hospital setting was deemed by some professionals to be inadequate for managing mental health problems, let alone complex trauma. Professionals commented that there was insufficient specialist mental health support within the hospital setting, and that the emergency department was particularly unsuitable for dealing with complex trauma because of its inherent time pressures. Unfortunately, this was often the only service available to women after hours. This unsuitability was also borne out in the accounts of a number of women who had presented at emergency rooms after an episode of suicidality and/or self-harm. They were uniformly critical of the attitude and culture of emergency room staff towards women with experiences of complex trauma. Louise worked in the medical profession and the attitudes of emergency staff were neatly encapsulated by an ED manager at her place of work:

I had one manager from one hospital say to me, "When you guys [women with experiences of complex trauma] are a bit sad and you come into ED, it takes so much effort for my staff to make you happy when there's real patients out there with real problems and all you're doing is taking up my time."

Margaret provided a detailed description of her presentation in an emergency room when she became suicidal after a session with her psychologist. It is evident from her account that emergency room staff were simply unable and unprepared to support her through her suicidality.

And when I got there, I told them exactly what the problem was. I told them that it was a mental health issue … I felt unstable. I felt that I should either be sedated or go to the hospital and see what the hospital could do for me. And they left me in the waiting room for quite a while, then they took me in and they just checked a few things, then they took me in and they had another person ask me the story and I told them the same thing. And then I got sent back out and then they took me in and they asked me [for] the same story again. I told them the same story again and then—so they decided to give me some Valium. They put me back out in the waiting room where I fell asleep because I don't like taking opiates or whatever Valium is. I think it's an opiate. I don't like taking—I don't like taking medication actually. And then after a while, after about an hour, the doctor came out, woke me up, frightened me so much, and gave me a discharge letter. They weren't gonna keep me in. They weren't going to have anyone else actually talk to me about anything like—I knew that the session had stirred something up and I just didn't feel safe. And so, they told me to call my brother to be taken home. And on the discharge letter, it said that I had depression and I felt so unheard … You can't trust yourself. But then trying to trust the medical system to see if the medical system will help and you just get drugged and then sent home, and that invalidates what's happening to you because they can't see it. They can't put a bandaid on it. They can't see the booboo. (Margaret)

This attitude that people presenting with mental illness or self-harm are not "real" patients was gruesomely evident in

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Josephine's account of being denied anaesthetic while being treated for self-inflicted injuries.

> I had a very limited episode with the hospital, where I did have to go in to get my wrist stitched up. And I was treated ridiculously bad and they hurt me a lot and didn't bother with anaesthetic and treated me like I was a piece of trash … They were so resenting of having to spend their time stitching me up, they just didn't take any care. And I wouldn't treat an animal like that, let alone a person. (Josephine)

Workers had also observed the sadistic treatment of self-harming women by doctors. A sexual assault service professional said:

> I think a lot of people get dismissed when they do go to hospital and they've cut themselves and that is due to the trauma and that is dismissed … Look, I can remember years ago a doctor saying, "Look, if you are going to do it [attempt suicide], do it properly [i.e. kill yourself]" and that's absolutely unethical. (AOD counsellor, AOD service)

Many women had experienced voluntary and/or involuntary hospitalisation. As a rule, their accounts of involuntary admissions, particularly in the public system, emphasised their fraught and re-traumatising potential. Madeline said:

> I've had maybe 17 or 18 hospitalisations, maybe four or five of which were being scheduled, and I would say that the public ones [hospitals] were really bad. And then, there are some private ones that are benign and some private ones that are okay … Just like being on 24-hour watch in the acute care and not being able to close the bathroom door. I totally understand why they can't let us have phone calls or whatever. It was not calming for my body to be watched like that and hovered over. And then the other main thing was that there were no activities. There was no groups therapy, no individual therapy except seeing the psychiatrist. Of all the psychiatrists I've seen, they were some of the worst in the public inpatients hospital. They were particularly prone to what I've found many hospitals are prone to, which is they recommend an antipsychotic [medication], and I would say, "I've tried that antipsychotic, it has really bad side effects for me, I would prefer to try a different route", and they would

look at me, look at their notes, look at me, and then write down "borderline, manipulative, defiant, oppositional, noncompliant", and sometimes they would just say, "Oh, sorry, you're here involuntarily so you don't have a choice."

The lack of autonomy and the degree of surveillance that women were subject to during involuntary hospitalisations were experienced as humiliating, and often left women determined not to return to hospital. Chloe was involuntarily admitted due to suicidal ideation, and she felt that she was treated like "scum".

> You are told what to do, if you don't do it, they call security on you. They bring the security guards. If you refuse to take medication, they call two huge big-bellied security guards [to] come, and … they hold you down and the nurse injects you with the medication. I dared to question because they changed all my medication, just medications that I'd been on for a long time and that were working quite well for me and then this psychiatrist decided to change it and I dared question, "What is this?" 'cause I'm very careful about what I take and I'd like to know what I'm putting in my body, and I was told in [no] uncertain terms, "It doesn't matter what it is. This is what the doctor prescribed for you, take it or I'm calling security." (Chloe)

Sticky labels and mistreating the problem

Pathologising and labelling trauma responses as particular mental disorders (e.g. BPD) resulted in a stigma that stayed with women as they moved through the health care system, as has been reported in previous research (Becker, 1997; Wirth-Cauchon, 2001). These "sticky labels" were difficult for women to lose once applied, and coloured subsequent interactions with the health system, often in a negative way. Many professionals described the use of medical labels such as PTSD, BPD and DID as stigmatising and, in the opinion of one professional, unnecessary. A trauma counsellor described that using stigmatising labels from the DSM implied the problem was inherent in the woman:

> Psychiatrists are so fond of diagnosing and those diagnoses are often from DSM. There is no complex trauma in DSM. What they are diagnosing people with is just something's wrong with them, so personality disorders.

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Not that something happened to you, not that so many people did so many things to you, and each part reacted differently or protected you and that's very normal and let's work here. Your personality has been fragmented, let's put them [back] together. (Trauma counsellor, sexual assault service)

Pathologising trauma in this way indicated a missed opportunity, as explained by a sexual assault service professional:

If you're going down the medical model you're just getting a label and a problem with your personality. That's what's caused all this kind of stuff. I just think that's really, you're missing a great opportunity there to really let someone understand that experience and to not pathologise them and label them again.

Pathologising women positions the problem within the woman, and the woman as inherently faulty, rather than as someone who is exhibiting an understandable reaction to an unliveable situation (Ussher, 2011; Warner, 2009). A social worker also observed the routine stigmatisation of particular trauma-related diagnoses, such as DID and BPD, in inpatient settings:

That perception can make a huge difference to the patient because by rejecting what they're projecting, you're feeding into that trauma, you're feeding into it. You are piling on top of the abandonment, and hurt, and rejection they've got. You're feeding right into that. (Therapist, women's health service)

Poor responses from health professionals were described as "detrimental" and potentially setting women back in their recovery (Walker, 2009). This effect was observed by both professionals and women. After profoundly negative experiences of hospitalisation, women went to great lengths to avoid being re-admitted. This placed them in something of a bind when they were seeking support, in which they needed to appear in crisis enough to access services, but not so in crisis that they would be admitted. Chloe described this conundrum:

I remember going to this appointment with the acute care team and I made sure that I put on makeup and ironed my clothes and dressed well and everything and I had my hair done and everything that day because I'm like, "They're gonna be judging me on every single level. I need to present well." So I treat it like as I was going to almost like a job interview, because I don't wanna be hospitalised again. I was so scared of having to go back to hospital, and they actually said to me, "You presented so well. You dress really well. You're obviously able to perform all your self-care and all this," that sort of thing by myself, "so you're fine" … You've got to freaking look a bit deeper than that, aye. People learn how to present. People learn how to protect themself from being drawn into the system. That has like self-protection—like for me, that's worked well. I've protected myself and been able to stay out of the public system a bit but then it's a double-edged sword, because it's also stopped me from accessing the support that I need.

Related to the issue of "sticky" labels was the reticence of some health professionals to treat "difficult" disorders, which meant it often took women a long time to get recognition of their complex trauma and then appropriate treatment. More often than not, women with experiences of complex trauma felt they were a bad fit within services and agencies, and their core needs and issues were going unrecognised. For example, some women described spending considerable time in the mental health system before receiving what they viewed as an accurate diagnosis or effective treatment. Instead, many women felt that medication was the first-order treatment, and that medical professionals were disinterested or frustrated when their symptoms persisted or side effects outweighed the benefits of medication. For example, Michelle's anxiety when she separated from her abusive husband was preventing her from sleeping or performing adequately at work, but her prescribed anti-anxiety medication also became a problem:

I found that the medication that every male doctor gave to me was masking the issues, and in fact zombie-ing me so that when I would get inundated with court information, I couldn't take it in and read it, and didn't quite understand half of it. (Michelle)

Similar sentiments were heard from community workers in relation to the large number of medicines that some CALD women were taking: "The doctor is not paying attention to

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the trauma. They are paying attention to what are the physical problems and treating with medicines." (CALD community educator) Such medication was deemed by professionals not only to be ineffective because it was not treating the cause but also harmful because of the sedative effect and the potential for misuse—both by women who may be dissociative or suicidal, as well as doctors who sometimes prescribed medications off-label for the explicit purpose of sedation. The use of medication in the management of trauma-related distress was acknowledged by a trauma counsellor as having a limited role, and one that should not be used in isolation:

> Medication does sort of play a part in the treatment but I think it does need to go hand-in-hand with some sort of counselling or group work or things that are focused on the aspect of managing that, that trauma, and a lot of doctors who, who do this medical model, they don't have the time to do the psychotherapy. (Trauma counsellor, mental health service)

There were numerous accounts from professionals about how the health care system went about treating the wrong problem by focusing on the presenting symptom(s) and failing to respond to the core underlying issue of trauma. This was evident at both the primary and tertiary levels of the health care system. For example, a trauma counsellor working in a specialist service relayed how some women accessed their service because sexual violence was not something that their current psychologist (under a mental health care plan) would work with. This was directly linked to the limits of the medical model in being able to deal with trauma:

> When you're making a referral as a GP to a psychologist under a mental health care plan you have to have a diagnosis, so it's anxiety, it is depression, rather than … dealing with trauma where you're looking at that whole life … They're picking off some symptoms. (Trauma counsellor, sexual assault service)

This minimalist approach to the treatment of complex trauma was also evident with psychiatric admissions, as explained by a sexual assault service provider:

> The gaps are that people don't really get complex trauma and even if you present having a real episode to ED you might be [placed] into a mental health unit or you might

get sectioned but still, they don't actually respond to the issues … It's just a quick triage and a bit of medication and bye bye, so it's difficult. (Support worker, sexual assault service)

AOD workers also emphasised the need to address the underlying traumatic experiences linked to substance use for many of their clients. They felt that the failure to address the traumatic background to drug use undermined client recovery.

> [AOD worker 2:] I think often the trauma is the trigger [of substance use] or maybe the drug use disorder [contributes to trauma], so trauma that's untreated or unmanaged or maybe unacknowledged—there's always gonna be increased chances of relapse and retriggers. [AOD counsellor, AOD service]

> [AOD worker 1:] I would agree. As soon as they enter our service, start trying to get that [trauma] dealt with because it's usually—and I think we've said it's 99 percent of the time—there's underlying trauma there and you've got to deal with it, because if you don't deal with it, chances of relapse are huge. [AOD counsellor, AOD service]

Systemic issues that undermine an effective response

The short-term, contractual nature of health care

The structure and policies of mainstream health services were not seen as conducive to supporting women with experiences of complex trauma. This lack of support was predominantly tied to the constraints imposed by a Medicare-funded primary health care system that limited the number of psychological sessions available to women, as well as the length of appointments for both GPs and psychologists.

Megan emphasised the quality of care offered by her current GP, which was in contrast with her previous GPs, or the other GPs that she has to see if her GP is unavailable. The intricacies of complex trauma cannot be communicated in the short appointment times required by the Australian

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Medicare system, and Megan was worried about being judged or misunderstood in the short time she had to explain her situation.

> But 99 percent of the time, it's just you'd rather not [see a GP], you just sit in your own stress and trauma, rather than go and try and talk to a GP about it. Who you don't know. They don't know you. You're there for 15 minutes and there's just so much judgement behind. And it might just be my own perception, because they are medical professionals, likely they have more understanding and more credit than I give them, but it's just the experience that you have again and again and again that puts you off it. (Megan)

Laura also emphasised the brevity of the standard GP appointment as a barrier to disclosure and rapport building. At the time of interview, Laura was implementing a plan to leave her family home. She had been sexually exploited and abused by her parents since childhood and this abuse was continuing at the time of interview. She'd been able to work with her psychiatrist to make this move possible, however her GP wasn't part of her support team:

> We can't tell our GP this. She can't quite cope with us in terms of dissociation. We—yeah, it's a bit difficult. Yeah, we have to be quite composed and quite—when we see her. And with GPs, you don't always have a lot of time. You can't tell them everything. If it's 15 minutes, you kind of walk in and say, "Hello, I have a problem. Goodbye." Like my doctor's surgery, a long appointment is 20 minutes. So we have to pace it and—but—yeah, I think the services—people do judge when you mention ongoing abuse. Automatically you're judged and like, "Why are you doing that?" or it's almost, "You're attached to it. Why are you part of it? Why don't you run away? Why don't you tell someone? Why don't you go to the police? Why don't—?" It's really—it's like your worst nightmare you have to live every day and want—you don't want the nightmare but you don't know how to end the nightmare. It's really hard. (Laura)

Professionals also talked about the structured approach to health care delivery that was incompatible with responding to complex trauma and alienated women. One professional in the policy area explained: "So rigidity is a problem for trauma. Trauma does not a follow a path, trauma bursts out of all kinds of places." Rigid or highly structured organisations were seen as less capable of responding to complex trauma. Rigidity could be seen in small practices, such as in making a treatment contract[3] at the beginning of psychological treatment, which was described as particularly foreign to refugee women. Additionally, while some non-government organisations (NGOs) were seen to "sometimes have a bit more flexibility", the rigid processes adopted by larger organisations to manage the throughput of clients were viewed as highly problematic. This was explained by a homelessness worker:

> They'll try to push volume, and by pushing volume you need to have a much more rigid process attached to it … by having a high volume, really structured service, by its very nature, it will become exclusionary … a defined intake form where … if you can't tick all of the boxes they say no to you. I don't see a way for an organisation like that structured in that way to be able to adequately provide what's needed for a woman who is presenting to them with complex trauma. (Manager/supervisor, homelessness service)

These types of service structures required the women to be in good mental health in order to be able to engage with them. A sexual assault service professional explained that the impact of complex trauma "is getting in the way" of women being able to connect with the supports on offer "in a way that the systems would see as meaningful or good enough".

To some extent the problem of a highly structured approach to health care was a response to the high demand for services and insufficient staffing due to funding constraints. A number of professionals commented on the high caseloads of workers across health, housing and child protection sectors and the impossible situation of being able to respond adequately to women with experiences of complex trauma in such circumstances. A professional working in the homelessness sector cautioned about the move "towards consumer-directed care models like the NDIS":

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3   A treatment contract is an agreement between the health professional and a client regarding the treatment plan including the responsibilities of the health professional and client in managing the client's mental health problem.

Theoretically you should see the program problems get better because people need to put the clients at the centre of the care but what you'll find is a lot of agencies will move and reposition to support people who are easy to get outcomes for because if your ability to function as an organisation is contingent on you getting those outcomes, you're going to try to find the people who are the easiest people to get outcomes for. (Manager/supervisor, homelessness service)

Overwhelmingly, professionals argued for the need for greater funding of health care services in the areas of mental health and homelessness, as well as in other sectors catering to those affected by complex trauma. There were accounts from a number of professionals of services having to choose between sub-groups of clients in deciding which programs to fund as well as a sexual assault service that had been de-funded as a result of an inability to manage the increasingly complex presentations of the women attending the service. A longer-term approach to the funding of services and programs was suggested to counter the current "sporadic" nature of investment.

Lack of specialist support and inappropriate referrals

Trauma-informed or trauma-specialist services are rare, and typically women had to travel considerable distances in order to access them. This was a significant issue for women in regional and rural areas, sometimes requiring hours of return travel to and from a capital city. Trauma-informed therapy may leave women feeling unstable, unsafe or dissociated after a session, which could make travelling home distressing or even dangerous, particularly if the woman was driving. Travel was an additional burden to address alongside women's other responsibilities, including child care. An AOD worker observed the difficulties facing women trying to access trauma-informed substance abuse treatment given the considerable distances they needed to travel, and their often demanding life circumstances:

One of the things about our region is it's so spread out and also with the lack of public transport, so it's really only one train line. There's an occasional bus. It's not very much. And so, moving people to another service,

especially if they live even further out … it's just massive vast distance. And the great majority of people I meet would have family, and kids and stuff, so it's really so difficult to address this sort of level. (AOD counsellor, AOD service)

Access to trauma-specialist care was particularly fraught for women living in regional and rural areas. In Kerry's case, the state health department made financial arrangements for her to see a specialist psychiatrist once a month in the nearest capital city, but only after she attended the hospital in her regional town and called the office of the Minister for Health and threatened to kill herself. She had previously made multiple attempts to contact her local mental health team and psychiatrists without luck.

I contacted the health minister's office while I'm standing in admin at the hospital, saying "I'm suicidal. What do you want me to do? Do you actually want me to jump off the hospital building and kill myself before I get seen by a psychiatrist?" So, that's how intense it really was, and funny, I got a psychiatrist up there within about ten minutes. (Kerry)

The majority of women did not have private health insurance and were reliant on the public system, where they faced a series of obstacles illustrating the influence of social class on women's experiences. Getting access to trauma-specialist treatment was difficult. The obstacles to accessing effective, affordable psychological care for complex trauma was also noted by professionals, particularly in one AOD discussion group:

[AOD worker 1:] I do try for a lot of the time to—because then you'll see there's depression, there's anxiety, there's PTSD and bipolar. And so, I am very much in sort of, get a mental health plan going and get those six visits or ten [Medicare-funded] visits [to a psychologist] … They need access to a mental health worker, and some of [them have] maybe seen someone once and they've never gone back. The last couple weeks, [I've] been trying to find a clinical psychologist for one of my clients—very hard because what I'm hearing is, "Well, we can't see them 'til March next year." And I did eventually find three. So then I gave the client the number and got them to ring

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them and that is still ongoing. So, that is quite difficult.

[AOD worker 2:] Yeah, true. Yeah. And then often you ring them, say, a clin[ical] psych[ologist], you'll find someone and then you find out they're 600 dollars or 800 dollars. You are dealing with people with complex trauma and they're financially disadvantaged, they're struggling to put food on the table—they're not gonna pay 600 dollars.

Finding support during these times of heightened distress can be particularly challenging. Carol spoke about the difficulties she has faced in getting support during these time of crisis, which for her are triggered by situations where there is an imbalance of power:

> I can never get an advocate or anyone to really help me when things are in crisis. I tried for so long to get someone to go to meetings and interviews and things with me and I could never get anyone … to help me to go to interviews and stressful things and police and things like that. I've had the most horrific problems with police. (Carol)

Although there are services that are equipped to deal with complex trauma and assist people through these points of crisis, they may not be available when these moments arise. One sexual assault service provider recounted a conversation with a woman who had experienced significant abuse in detention as a child and further abuse in foster care. She recalled the woman speaking of how crisis periods often occur out of "business hours":

> "Darling, just pretend you're me one rainy Saturday afternoon and open up your phone book because I don't have my crisis from 9.30 'til 4 Monday to Friday, I have my crisis at night-time, the weekend, school holidays, any other time is when I have a crisis and you go through that, just start at the beginning, honey, and pretend you're me and try and find a service that'll be responsive because you're not going to find one." (Support worker, sexual assault service)

Even when services are specifically set up to address points of crisis, they still may not provide adequate care or understanding during these times. Lena speaks about her initial encounters with calling a hospital crisis team:

> And even once I rung—I never ring the crisis team here. And then once I finally did ring the crisis team and I had dissociated, I didn't know where I was and I found myself on the train tracks and I rang the crisis team and their response was, "You know where you are. There's nothing we can do to help you", and literally hung up on me. And I was like, "I don't know where I am. I'm on the train tracks. I called you for help." So now I wouldn't—I never call them.

Some of the women reported that the publicly funded trauma treatment programs available in their area were aimed at combat veterans, accident survivors or "first responders" such as police, rather than survivors of interpersonal violence. Some programs explicitly excluded child sexual abuse survivors. Nonetheless, a number of women had been able to connect with a psychiatrist or psychologist who specialised in complex trauma, often after many years of searching. Women noted the ways in which trauma-specialist professionals were more sensitive to the power dynamics of treatment and generally evinced a more holistic set of concerns for their health and wellbeing. In interview, Abigail described the moment that she knew, in her late teens, that she could trust the psychiatrist who she still sees twenty years later. She'd been taken to the appointment by her abusive parents, and her psychiatrist clearly signalled to her that she was the priority, and that he would not be influenced by her father:

> The first time that we had an appointment with him, we were brought here to the appointment by our parents, right? We were waiting downstairs. [The psychiatrist] came down to greet us and, and the parents were fully expecting to be involved in the consultation. My father's first words to [him] were, you know, "Well, we're here for Abigail." You know, to support her and all this other shit. And so dad's trying to get his foot in the door, and make sure he's in the room while we're talking to our psychiatrist. [Our psychiatrist] said, "No, you can wait in the waiting room [Laughter.]" (Abigail)

Most women in our study had to persevere for years in order to locate a single professional or service who specialised in trauma. For many women, learning about the system and becoming an effective self-advocate was essential in securing good outcomes for themselves and their children. Professionals

also noted significant delays in women being able to access treatment. For example, referrals by GPs under the Medicare-funded Better Access initiative[4] meant that women were presenting late to specialist trauma services because they were being diverted to private practice psychologists in the first instance. This was in part due to a misunderstanding of women's presenting issues and inappropriate referrals for psychological treatment of a non-specific problem (e.g. anxiety management techniques) as well as a lack of recognition that trauma work requires specialist knowledge and training.

Doctors were also described as the power brokers in the health care system. Treatment approaches that had longstanding value in allied health disciplines became legitimate and worthy of funding once endorsed by medical professionals. This can be seen in this exchange between two trauma counsellors regarding acupoint tapping:[5]

> [Trauma counsellor 2:] Tapping is a technique. You know that one?
>
> [Interviewer:] Yeah, I know that one.
>
> [Trauma counsellor 2:] Okay. And I did a course years ago, that people say you're crazy, that doesn't work, where do you get that background, so I stopped doing it. I got scared. I didn't tell anyone that I was doing it. After someone from the state comes had said tapping work, everybody went to this tapping institute because someone else has said it works. So the point with doctor saying it or the social worker practicing is a big gap. So now, I'm using it back and I found it because we've got permission to do it. So the medical people are the one that create changes.
>
> [Trauma counsellor 1:] Hierarchy power.

The trauma counsellors in this exchange felt this type of medical vetting of trauma treatment was detrimental to women's recovery because it narrowed their treatment options. Significant time was then required to be invested

by practitioners to counter the powerful messages of the biomedical model:

> [Trauma counsellor 1:] Well, I think also sometimes they don't see those ways as legitimate as well.
>
> [Trauma counsellor 2:] Because they're being convinced there's something wrong with them and it's been years and years to say that this and that, and post-traumatic stress—post-traumatic stress, this is what happened me, so there's so much in there that when you give them other tools, they resist to that and it's really hard.

National Disability Insurance Scheme

Related to discussions of accessibility were accounts of difficulties in being able to access funding through the National Disability Insurance Scheme (NDIS). The NDIS is a social welfare insurance scheme that entitles people under the age of 65 with a "permanent and significant disability" to apply for public funding for support needs related to their disability.[6] Healthcare costs are expected to be borne by the public or private health system and the NDIS is focused specifically on disability-related supports. Under the NDIS, people with a mental illness can be understood to have a "psychosocial disability" and may be eligible for funding. Much like the other services and systems that women encountered, women described the NDIS as opaque and bureaucratic, and virtually impossible to navigate on their own.

For example, Lena has been diagnosed with a severe dissociative disorder and is currently living with a significant spinal injury and chronic pain. She needs but is unable to afford trauma psychotherapy, which her psychologist feels would considerably improve her day-to-day functionality, and hopes that NDIS funding will enable her to access trauma treatment. This places her in a bind, however. The NDIS provides support for permanent disability, but, if funded to access effective treatment, Lena may well recover from her disability.

> We're kind of in the process of trying to go through the NDIS. I've already applied once and been rejected and we're trying to reapply again because that's probably the only way I will get that [trauma treatment], but then

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4   See https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-ba

5   Acupoint tapping is used in Emotional Freedom Techniques to treat a range of psychological symptoms including trauma symptoms. See Clond (2016) and Dawson, Stapleton, Yang, & Gallo (2018) for a review of the technique and treatment efficacy.

6   See https://www.ndis.gov.au/

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there's the problem. My psychologist thinks that, with the right treatment, yes, I will probably recover, but then to get the NDIS, you need to have a condition that's not going to recover. So, she's like, "You need—the only way you're gonna get better is to get this treatment from the NDIS to be able to afford the treatment", but then she's like, "I can't write a report saying you're not going to get better because I do think you're going to get better", but I'm like, "I'm only gonna get better if I get the treatment and I'm not going—I can't get the treatment any other way." (Lena)

Applying for NDIS funding also placed Lena in the uncomfortable position of choosing between psychiatric diagnoses. While she said her psychiatrist feels that the most appropriate diagnosis is complex PTSD, he is worried that the exclusion of this diagnosis from the psychiatric diagnostic system (DSM–V) might compromise her chances of success. However, the closest diagnostic label available in DSM–V is "borderline personality disorder", which Lena's psychologist refuses to endorse.

And that's the other thing. It's like what diagnosis do you put down? So my friend managed to get it [NDIS funding] with [a diagnosis of] complex PTSD but, well, my psychiatrist kind of thought [that we wouldn't do that] because it's not an official DSM diagnosis—so now I'm having to go through under the borderline diagnosis, which I hate, and everyone is like, "I don't really agree with it, but this is kind of what we have to do to try and get the funding", and my psychologist won't write anything because she doesn't think it's borderline, and—but that was literally the only way. (Lena)

Natalie had recently been approved for NDIS funding, after a previous application was rejected. Her interview emphasised the complexity of the application process, which was unclear to her psychiatrist as well as to her.

Like the first time around, I got rejected because I didn't know what I was doing with it and I had terrible advice from people and an unhelpful psychiatrist, unwilling to write me support letters, saying that they would call him, that the NDIS would call him and that's how they would conduct it. That's not even the case … I'd given all the NDIS all the information I felt that they needed above

and beyond, but they still sent me an extra thing that they wanted more information and I just shot myself in the foot and didn't continue with it. I thought, "What more do they freaking want from me?" but I didn't understand the process and I was doing it by myself at the time and so I got rejected from that. And it was months and months of waiting to hear back. And then I finally got a rejection letter. (Natalie)

The impact of the rejection letter was reported to be devastating. Natalie said she felt hopeless and suicidal, and approached a welfare service asking for support, only to be told that the service couldn't support her unless she had NDIS funding. She told us, "I was just like at my wits' end. I feel like I'm in the cracks of society, like I have no options." With persistence, Natalie convinced the service to explain the NDIS process to her and support her application, which has been successful.

Well, they helped explain a lot of how the NDIS works and the rigmarole and how they want things worded, all these kinds of things. It's just so much game-playing. They'll be managing my case now when I have the NDIS, so I won't have to have the stress of dealing with services or things. If I don't like a service or something, they'll be the ones to ring up and say, "Okay, Natalie doesn't like this service. We're going to have to end with you, and she'll get this one", that I do want to try. That'll hopefully be good. (Natalie)

Participants were not asked direct questions about the NDIS but rather discussed it in the context of their broader history of seeking health care. The NDIS is a relatively new scheme and its operations and access process continue to evolve. Women's accounts of the NDIS generally blurred into their experiences of navigating health bureaucracies more generally, the difficulties of self-advocacy within administrative processes and the sense that the impacts of complex trauma remain marginal to the concerns of health schemes.

Wrong ways of going about trauma work

Aside from the lack of specialist treatment for complex trauma there were also accounts of services and professionals that declared themselves to be trauma-informed but engaged in behaviours entirely inconsistent with this. This included

misplaced empathy or over-identifying with the woman and paternalistic approaches that deprived the woman of agency. A community educator recounted an interaction between a counsellor and a woman who had experienced years of sexual slavery:

> And [the counsellor] said, "I know what you went through. I really understand." And this was like a—she absolutely froze. And say, "How?" … I wanted to ask her [the counsellor], "Have you been raped every single day by 12, 15 men? Do you know what it is?" But just like saying this like very casual, "I understand", she never went back. And it took her a while that she got to—that she accessed again the service that was helpful to her and helped her to heal. (Manager/supervisor, migrant/refugee service)

There were also accounts of health professionals being voyeuristic in their assessment processes—"Really? You went through this, and this, and this? Oh really, tell me more …", wanting to go straight into the detail of the trauma without taking the time to build rapport with the woman. Sometimes this type of behaviour was interpreted as professionals being naive and overwhelmed by the woman's experiences.

On occasion, health professionals were observed to be working to a limited agenda—"current behaviour as they see that is being exhibited, that they think is important, and what they think is important are the behaviours that pose a risk to them" (Disability support worker)—and adopting a disempowering approach of advising women what they "should" be doing. This was observed in relation to GPs, mental health clinicians and community workers and was described as the antithesis of good practice where "you work with them, they need to work with you—you're not doing things to them" (Mental health nurse). For example, a women's health professional explained:

> People get into this profession because they want to help … want to make a difference, and you want the world to be a great place … Sometimes those views can become blinding and they start to think, "I know what you need to do. I know how to help you. I know how I can fix this." (Support worker, women's health service)

This was experienced by women as patronising and re-traumatising, as described by community educators working with refugee women, one of whom explained it demonstrated the "lack of training and understanding that there is resilience", before continuing: "This approach, it's actually traumatising because it's using tactics in a way, disempowering women and leading them, not allowing them to have a say." (Manager/supervisor, migrant/refugee service) According to this manager, the flipside of this was not providing enough support to women and calling it empowerment—"that philosophy where it's like 'I know they're adults, they have to take responsibility for themselves, have to do this themselves, they have to be independent and it's up to them'".

Segmented and uncoordinated service response

For some women, their service encounters began in childhood and shaped how they interacted with services in the present. This was described in relation to the jarring impacts of having to retell their story as they passed through each gate within a service and between services. For example, Natalie was sexually assaulted as a child and the confusion and frustration that attended her entry into the public mental health system as a teenager was vivid for her now:

> I went into the public health system and they don't communicate properly with you. Like, they'll bring you in and they have the first person they get you to talk to them and you think that that's gonna be your psychologist, but—and you kind of bond with them, you think, you get this feeling that you're connecting with them. You tell them all your experience. You open up to them and then they're like—tell you after all that—"No, no. Hang on. Wait. No, I'm not actually your psychologist. I'm just your triage person who's going to pass you on." Nobody explains it to you. And it's just really difficult from day dot and when you're new to that whole thing and it's like when you've learnt it you know that's how it's gonna be and you might play it differently. You might not open up as much. You might be a bit more guarded. You might protect yourself a bit more, but being a young girl and not knowing, I just got the carpet swept out from under me for a long time with dealing with these kind of institutions. (Natalie)

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There were also accounts of segmentation between services, especially across sectors. Systems designed to act as a safety net (e.g. Centrelink, Housing) often failed women with experiences of complex trauma because they were unable to "consistently communicate" their needs to these systems. Relatedly, there was a lack of responsibility demonstrated by organisations when dealing with women presenting with complex needs, as identified by a worker in the homelessness sector: "I think they fall through the gaps. I think no one wants to pick them up and take the lead." Professionals also gave accounts of women being told to stop disclosing trauma if they weren't in the right setting—"We're drug and alcohol, we don't do sexual assault." The segmentation of the service system meant that "it feels there are these gaps, where people just kind of don't fit in services sometimes", with one homeless worker explaining the more complex the issues, the less support there is:

> The service sector is built in such a way where people focus on a particular issue so as you add more and more presenting complex issues that an individual is facing, the smaller and smaller the amount of services are there that can support that individual which makes access very hard … The more complex issues you start adding into that mix, suddenly you get to a position where there's no services that can tackle every single one of those presenting needs, which in itself is traumatising, do you get what I mean? So you get to this thing where there's just nothing left, and you just can't address it. (Manager/supervisor, homelessness service)

An AOD worker commented on the multiple intersecting services and systems that their clients were often navigating simultaneously. She described having to "chase" most services—except for child protection who were generally proactive about monitoring and removing children from substance abusing parents. She identified the need for a "chasing person": someone whose job it was to help the client manage these multiple demanding systems.

> So, so it might be FACS [Department of Family and Child Services] and the school, so the school principal, and then it might be Centrelink because often then payments are being cut off. It might be Housing because they are at risk of losing their housing. Yeah, multiple services—it might be the Women's Health Centre. So many, many services

and, with probably most services except for FACS, you often get a lot of information back in your network, once you give them the information and it becomes an unknown as to what's gonna happen next or, you know, that that child of that family still seems to suffer and abuse goes on, and you think—"Well, FACS told me they're doing something", so you leave it at that, whereas you'd often chase other services and sort of say, "Hey, where're you at with that client." I don't feel you can do that because you don't often have a person that's the chasing person you can sort of have a single name for. (AOD counsellor, AOD service)

Collaboration between services was difficult without a shared understanding of trauma and how to respond to it. Services operating without a trauma-informed framework did not understand "how a person's going to present, the difficulties they have in accessing services, why it might present in different ways and why it means that we need to work together to respond to a person's complex trauma". These services were also described as having "disrespectful attitudes towards clients" and failing to understand the long-term approach to care. An AOD worker discussed the challenges of referring traumatised clients to other services with confidence that the person will receive adequate, trauma-informed care:

> If I have a client who I know that they need to go to rehab or do a detox, I'm mindful of where I'm going to send them, whether they'll get a proper help, where I know that there's psychologists there. And there's some services where I know they won't have psychologists and that I wouldn't want them to go there. I'd want them to go somewhere where someone is monitoring them and they are getting the help. (AOD counsellor, AOD service)

Another AOD worker agreed, commenting in particular on the importance of trauma-informed care for Aboriginal and Torres Strait Islander clients:

> Our Aboriginal health worker has visited a few of the detox and rehab places and has identified a few that we wouldn't send Aboriginal clients—well, because of the fact that it might bring up a past trauma of previous generations … This particular rehab is a dorm-type set-up. And the experience that the Aboriginal staff talk about is that they'd often heard the stories that have been passed

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down about the Stolen Generation in terms of living in—or being kept in dormitories—the discipline, the sort of military-type structure. Yeah. So we wouldn't send an Aboriginal person through us to one of those rehabs.

Knowing when and how to make referrals could involve a considerable amount of research and engagement on behalf of staff. An AOD worker noted:

I think there are a lot of great organisations and every one of them have some specific thing that I need for my client. So, normally, I might use one of them for something, and then I'll use another for a day group for something else … I think networking is my number one priority—get to the other services and knowing how you help the client the best. If you are not knowledgeable and if you just don't want to connect with other services, you cannot help your client as much as you want. (AOD counsellor, AOD service)

Best practice approaches to working with women who have experienced complex trauma

Despite the issues described above, some women described promising models of service that they felt had significantly improved their health and safety. This section describes the key principles of practice and service design that contributed to these outcomes, as identified in the interviews with professionals. All of these fit within the model of trauma-informed care which is discussed in the State of knowledge review—the information presented below provides practical examples of how trauma-informed care can be implemented in practice and the different ways it is reflected in service delivery.

It was noted by many professionals that trauma-informed care represented a whole-of-system paradigm shift. Every aspect of the organisation required a thorough review using a trauma-informed lens, as explained by a professional in the homelessness sector:

Every single thing that we do across every element of the business needs to be built in a manner that is trauma-

informed, and all those little pieces start to build up and cascade over time to build that culture of putting our clients' needs first. (Manager/supervisor, homelessness service)

This included the outward-facing aspects of the service such as the website and other promotional material:

We don't use those sob stories, we don't have photos on the side of buses where women are like, "I'm escaping being beaten up by my husband", because it's like, we're here to support that person, we're not here to objectify that … (Manager/supervisor, homelessness service)

Training was identified as a key facet of becoming a trauma-informed organisation. Professionals talked about the degree of training undertaken with staff "who are engaging at different levels and at different stages" (CALD community educator), regardless of how small the client contact is. This training included non-clinical staff, such as IT staff, because "one of the most important things to first do is get everyone on the same page" (Disability support worker). This also extended to the external groups that an organisation had to work with. For example, one sexual assault service professional described how their organisation approached a taxi group to work exclusively with them on the provision that they identified two taxi drivers that the organisation could train in a trauma-informed approach. This included an understanding of trauma triggers and how to minimise these. Another professional in the homelessness sector gave an example of tradesmen coming on-site and the importance of ensuring they do not "act in a manner that is in conflict with our values and in conflict with trauma-informed care".

The following sections discuss how some of the principles of trauma-informed practice were translated into practice. These are discussed in relation to establishing safety, demonstrating understanding and providing a flexible response.

Safety first

Some professionals noted the challenge for services in managing the multiple needs of women and the need to create stability before approaching therapeutic work. For example, the AOD workers commented on the ubiquity of trauma

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among their client population, and the fact that their clients often presented at their service with basic and acute needs relating to housing, finances, domestic violence and legal problems. These were fundamental safety and stabilisation issues that needed to be prioritised so that clients were in a space where their mental health and traumatic histories could be addressed.

> I think probably [one of] the biggest issues that we could talk about is, right at the beginning, before the complex trauma—is housing. It's safety and security, and you need all of these things working to even touch on the trauma or move forward and often when people present—chaotic—housing is not sorted. Financially, they're in debt, maybe have legal issues. There's active domestic violence and so you've got all those little issues to sort first. (AOD counsellor, AOD service)

Connecting with women around these more practical issues not only helped to create stability in women's lives but also helped to build trust. Trust was seen by both women and professionals as something that needs to be earned, "that has to be earnt" and demonstrating care in small, practical ways helped this along. However, this had to be done in a way that was transparent because, as explained by a domestic violence worker, "we want women to be able to assess whether we are a safe option for them".

Creating safety meant getting it right from the beginning, from the moment a woman arrived in a service:

> I think when someone comes in, privacy, dignity and intake that's a narrative, that lets a woman tell her story is a really good place to start. (Manager/supervisor, homelessness service)

> They can just come and sit in a room, just collect their thoughts … Camp out there for a couple of days, use the shower, get the mail delivered here, or we have women who come in and just the craft and have their safe space to do that or store documents or jewellery. (Support worker, women's health service)

As the above quotes indicate, safety was reflected in many different facets of service delivery from the environment or setting, intake and other processes, to the way in which staff interacted with women. In this regard, language was seen as highly important and a way of collaborating with them in their treatment or recovery. For example, a worker in the homelessness sector explained how they had moved away from a biomedical framework in their intake process: "the way we say, 'have drugs and alcohol got in the way of the life you want to lead?' instead of saying, 'your primary drug of choice'". This approach was a means of collaborating with women on what a meaningful life looked like to them and was seen as "super important" by a number of professionals.

Creating a "non-trigger environment" (that is, an environment that was not triggering) was also highlighted as an important part of establishing safety. Some professionals discussed the ways they had physically remodelled their service to achieve this, for example, planting shrubs or putting up a screen near the entrance to offer privacy to women attending the service. However, a trauma-informed environment was not always possible to achieve within the physical space that some services occupied, particularly given funding constraints. As a consequence, it was sometimes necessary to make a decision to move "a woman to a safer space where she's not going to be easily triggered or exploited". This acknowledgement of a service not being right for everyone was consistent with other comments that noted trauma-informed practice should be about offering women choices and facilitating access to those choices if the woman wished:

> The idea that you always have options, that you can always come back, that if it is possible and within our criteria, you can come back for assistance or we can help you be linked in with who can [assist]. (Support worker, sexual assault service)

Safety was also discussed in relation to establishing clear and consistent boundaries, as the following quotes demonstrate:

> One thing that we know about really any type of trauma that is inflicted on a person is that the person inflicting the trauma had zero boundaries so ensuring that we model excellent boundaries is so important when working with people with complex trauma because it provides a safe base from which then to receive support. (Support worker, sexual assault service)

> When I think about trauma I think about it as being a boundary violation, especially in terms of relational trauma

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… How we build relationships with our clients—whether it's in individual therapy, whether it's in a group—that is clear and consistent, is predictable and doesn't replicate the boundary violations, even in a really small way that people have experienced in any way that we have to work to provide something very different to those relational experiences that cause such harm. (Manager/supervisor, migrant/refugee service)

Another professional spoke of how ensuring consistency and holding good professional boundaries builds trust in their service with the women they work with, and aids women to feel safe:

These people are presenting 90 percent of the time, they are presenting in a crisis state and that trauma world is a crisis-driven world. Our space then, we focus on keeping those boundaries in place and that they've got something that is consistent in this whirlwind of chaos, and that is tested to the max, but it's that test that then builds … that trust. Builds that confidence and allows them to see an alternative path, that becomes crucial. (Support worker, women's health service)

Establishing and maintaining boundaries was challenging, however, because of the need to create trusting and collaborative relationships while also having clarity regarding the professional nature of these: "You're not friends. You should never be friends." To ensure safety for both women and staff, a trauma counsellor described how their model of practice involved a team approach:

Our model of practice is we don't have a one-worker model of support … People then only trust one person in an agency and that one person they actually work at having them cross boundaries because they want that person to be a friend … So it's really important for us that people [have] at least two but multiple workers … It's really recognising your role, recognising your boundaries and understanding that you're a piece of the pie and not the whole pie. (Support worker, sexual assault service)

In contrast to the rigid service delivery structures and processes described in the first half of this chapter, boundaries within services practising trauma-informed care were clearly understood in terms of expectations and making these explicit in a collaborative way with the woman:

I'm very strict on my boundaries but I'm also very open with what they are. I'll be really clear: "These are the rules of what I expect of you, these are the rules of what I expect of me, what else do you expect of me? Do you think that sits well with you?" (Manager/supervisor, sexual assault service)

Once established, boundaries needed to be maintained in a consistent and predictable manner. This included:

- consistency in the relational aspect of the connection: "I think stability and consistency are two things that I have in their life, being that same person every time" (Amanda)
- predictability in the practical aspect of the connection: "I don't promise anything I can't deliver, no way. Because this is just, it's basically re-doing to them what was done to them in the past". (Sexual assault counsellor)

It was recognised that establishing safety took time and this was not always understood by other organisations or by funding bodies, as explained by a professional working in the domestic violence sector:

This didn't just happen in a quick amount of time and isn't going away and so really strongly advocating for that and also understanding things, like even how long it takes, the five session[s], for a person to even engage and feel well with a regular counsellor. (Manager/supervisor, domestic violence service)

Other professionals acknowledged that, organisationally, they were in a privileged position within the service system:

We are in a very fortunate position … so we're funded to provide long-term counselling. So we see clients weekly for up to, sometimes over two years. So in that way we can establish their safety first which might involve working with some of the more presenting issues of stabilising then creating trust and collaboration with clients, to then work and process [the] underlying problem[s] and bring it all together. (Therapist, women's health service)

The two-year timeframe indicated in the above quote was something that most professionals alluded to. This was considered an approximate timeframe and professionals

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emphasised that support was not time-limited but determined by the woman. In practice, this meant not cutting the client off "if they were in a precarious space" or in a recovery space "where they are just about to make a quantum leap" (Counsellor, women's health service). This stands in stark contrast to the short contractual nature of the mainstream health system outlined earlier in this chapter.

Understanding to the best of your ability

> But what I have come to believe is that, in order to respond to the best of your ability to people with complex trauma, you need to understand them and their lived experience to the absolute best of your ability and, in order to do that, you have got to pay attention and you have got to consciously try and learn and understand what they are experiencing and the reasons behind [it]. (Mental health worker, disability service)

The quote above indicates that a whole-of-life perspective and an understanding of the woman's relational world was important. For professionals this meant seeing the whole person, "not just a set of symptoms", and making an effort to "understand in depth instead of just cutting [them] off and trying to make an assessment" (Child protection worker). Developing understanding was something that needed to be practised. It came about by engaging in trauma-informed reflection and creating self-awareness around personal reactions to a client. As described by one professional, this did not mean a practitioner did not experience an emotional response to a challenging presentation:

> So the more you understand and the more supported you are, the more the likelihood is that, okay, you may default to that way of thinking, but you will work through it very quickly. (Mental health worker, disability service)

> If there is borderline personality disorders, that can be very challenging for workers. So to really get workers to step outside of that and self-reflect and then look at the complex trauma lens so it's not about the worker's success or failure or the worker's ego or anything like that. (Manager/supervisor, domestic violence service)

The professionals interviewed for this study were recruited because they were working in exemplar services that were doing trauma-informed care well. In some ways their accounts represent what is possible when you are not constrained by the structures and processes of mainstream health care. While few in number, there were some instances of good relational care being implemented in mainstream health care settings. In Abigail's case, her family literally came to the clinic with her, enabling her psychiatrist to see first-hand the controlling family dynamic in which she'd been entrapped and abused. In other cases, women appreciated professionals who made other efforts to understand them in their relational context. Rebecca remembered very fondly a psychiatrist who she was able to see for only a short period of time who was interested in her connections to her partner and family. She said:

> It really resonated with me because he asked about my family. He didn't just ask about me. He actually came to my home to meet my husband, meet my children. He saw me as being a part of this family or network, this social network and how important that was, whereas every other psychiatrist or doctor, it was just this whole person-centred, it's just all about you. But we don't live just with ourselves. You know what I mean? (Rebecca)

In another example, Chloe provided a description of high-quality medical care in which she was supported to understand the origins of her recent seizures at a critical juncture in her life. At the time, Chloe's teenaged daughter had disclosed sexual abuse by Chloe's father. Shortly after, Chloe began having seizures a couple of times a week, and she was no longer able to attend her workplace. She was diagnosed as epileptic, however anti-epileptic medication had no effect on the seizures. Chloe lived in a regional area and was flown to the capital city where she was monitored and tested for a week in hospital.

> So after all the data had been processed and collated, he basically came in to me and said, "Well, these things that you've been having, yes, they look like seizures. They're not seizures. They're dissociative episodes. The team and I believe that you have experienced childhood trauma. Is this something that rings true for you?" All this time I thought I had epilepsy. I've been on medication for epilepsy and everything. This has been an extremely long process. And then all of a sudden, and he says this and he says, "We have a neuropsychiatrist on our team. I'm

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going to bring him down to see you." So I saw him that same day. It was about half an hour afterwards. Their services are amazing.

That neurologist sat down and said to me, "Yes, do you think this is something that may have happened?" At first I'm like, "What? What are you talking about?" And then I was like, "Oh, hang on, if he [my father] did it [abuse] to my daughter … " and then—I don't know. I can't explain all the psychological processes that were going on at that stage but it was just massive …

That's when it was basically revealed, and it just all came to, and I'm always in absolute shock, and I stayed in that bed in that room in hospital for—I don't know how many days. And then all of a sudden, it was so bizarre, but all of a sudden, all of these memories just started coming back—flashbacks, the physical stuff, the anxiety, and everything that comes with all of that. It's [a] really, really difficult time. (Chloe)

Flexibility in responding

When asked about best practice models of service for complex trauma, professionals commonly emphasised comprehensive and flexible services that incorporated multiple modalities. The deliveries of these required a loose organisational structure in which organisations had to give up "control and structure in order to create an environment that facilitates trust and facilitates agency" (Manager/supervisor, homelessness service). This was premised on the notion that women are the experts in their own life: it involved recognising and honouring the resilience of women and allowing them to be the "authority over their own experience and trusting that" (Rape crisis worker).

Flexibility was evidenced in the way an organisation was able to meet women where they were at, rather than working to its own agenda. Part of this included staff "having a big repertoire" to respond to the woman's needs in any given moment:

So on those appointments you have to have what you've prepared and what you're expected to get from that appointment and you have to be able to put that aside and as you're talking and as you're deep listening, you

need to also be thinking about what's actually best for this person and for what we need to get done today—is it actually pushing this agenda or is it actually setting that agenda aside and thinking about some other things … She's come for an hour so we'll do that [respond to where the woman is at] and you'll have to use your other skills … (Lawyer, legal service)

It was also evidenced in the capability of staff to be persistent despite the presentation of challenging behaviours. A professional from the domestic violence sector commented about the challenge of honouring the woman "but also really lean into it, really not push away" when the woman's behaviours appeared to be disengaging:

… but to really extend that compassion and extend that professional care so that we are not a service that only fits this nice little sliver of women who are like this. (Manager/supervisor, domestic violence service)

Other professionals also noted this as a distinction between their service and mainstream health care settings where these behaviours were often misinterpreted as the woman making a choice to disengage and "choose homelessness" (Manager/supervisor, homelessness service) or another option.

Flexibility and continuity of care was explicitly linked to an outreach approach that had a more expansive model of service delivery, recognising also the intergenerational nature of trauma. One mental health nurse spoke with pride about her current service, which had offered care to generations of families. She said:

I think 'cause we often see people from birth to death—maybe their mother has their antenatal care through us and so we did the child health check and then they develop some depression as an adolescent and so it may get in touch with us and then actually they've got a toothache, so we link them to our dentist and—yeah. And then all the stages of life for some.

She staffed a mental health van that was able to drive to clients, recognising that people with complex trauma may struggle to meet appointments. This enabled her to connect with people whose mental health needs made it difficult for them to attend the service, and to build a rapport and

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connection with people not accessing the service, including young people and the homeless.

> We got funded for a mental health van. I go out into community, I home visit, I go to schools, wherever the people are. So often, people with complex trauma, they're not really craving to have appointments, and they can't schedule things real well. So you need to be super flexible, go to the house and take them out to shops or whatever. You've gotta, I think, be really, really assertive and really, really flexible. (AOD counsellor, AOD service)

Other practitioners made similar comments about appreciating the difficulty women had in following through with appointments and addressing this in a non-judgemental way—"How about I take you to that appointment next time?" Accessibility was also increased by having services available after hours. A community worker said of her service, which was staffed 24 hours, "We get a lot of, just calls from people who are wanting to check in and have a bit of social support by phone on the weekend with a worker." After-hours availability had the added benefit of increasing choice. For example, a telephone crisis worker noted that when women accessed the service "they're initiating the contact and calling … when they're able, rather than having to meet someone else's schedule".

Professionals often nominated models of care that not only sought to meet a broader range of health needs, but also brought other government services into the agency to connect them with clients. One mental health nurse commented on the multidisciplinary nature of service provision of her organisation:

> Not blowing our own whistle, but [my service includes] doctors and medical specialists and child health nurses, who offer health care and assistance with education and Centrelink comes once a week, the Department of Housing comes once a week. And in my team—so, I'm a mental health nurse, two psychologists, a female Aboriginal health worker. So it's quite multidisciplinary, it's like a one-stop shop. So there's a dentist as well on site. (AOD counsellor, AOD service)

As gatekeepers of the health care system, general practitioners were figures of considerable importance and influence in the lives of the women we interviewed. They were the first points of contact for physical and mental health, and could take an active role in coordinating their care with other specialists. Megan emphasised how crucial her GP has been in improving her quality of life:

> I've found this GP just by fluke, really. About seven years ago I needed to see a female GP and found her, and she has been an absolute godsend. So she has seen me through two bouts, one currently of very significant depression, she's so incredibly educated and informed on the psychology … I get it quite often because I do have to go to the GP and I need a doctor certificate today because my anxiety and depression is so bad I can't get out of bed … So my GP has been absolutely incredible. With all due credit to her, if I hadn't met her seven years ago, I mean I don't know where I would be because she also made me feel okay about having to use antidepressants …

General practitioners were also important entry points for refugee women into the Australian health system, but Anal felt that the responses of GPs to traumatised women were highly variable. She noted that refugee women, unfamiliar with the Australian health system, "don't know how to ask for help". They didn't know, for instance, that if they raised a mental health issue with their GP, they could get a referral to a psychologist or counsellor.

Multi-modal treatment

After years of ineffective treatment, Madeline described the relief she experienced when she was finally referred to a service that was explicitly tasked to promote her recovery:

> I was on a waitlist, triaged to see them between the ages of 14 and 22. It wasn't until after suicide attempt number seven that they said, "Now you're at the top of the triage and we'd like to help you." Their help has been mostly excellent. A few clinicians, they didn't work for me, but mostly it's been excellent. Not psychotherapy—I get that elsewhere—but I had six months of one-on-one DBT [dialectical behaviour therapy]. I did a very short-term like a ten-week Conversational Model of Therapy thing and have an occupational therapist who helps me with some of the sensory processing problems from PTSD. I have a case manager who, she's kind of like the best social

worker ever 'cause she does the things like helps you fill out the Centrelink and NDIS paperwork, yada yada. So they've been just brilliant as well because they've been able to connect me to other resources and they sort of are familiar with the patchwork of inadequate services that we have, so they know where to refer you and things like that. (Madeline)

This account demonstrates the benefits afforded to women when they are able to access treatment that works across sensory, psychological, relational and physical domains. This should not be surprising given the relational and embodied experiences of complex trauma described by women in the preceding chapter. However, the accessibility of these treatment modalities was described as limited because many do not have an established evidence-base.

Professionals talked about how they used a range of different approaches by "weaving in different aspects" (Counsellor, women's health service) of each so as to respond to the range of needs women presented with. There was no single standout intervention, rather professionals acknowledged that "you need to assess where your client is and what is the best tool in the toolbox that would be good for her at this moment" (Counsellor, women's health service). This was linked to teachable moments. A professional described how they would use psychoeducation to identify and name what was happening and then engage with other modalities over a number of sessions to embed the learning. Figure 1 presents a summary of interventions and approaches that the professionals interviewed for the study have found to be helpful when working with women with experiences of complex trauma. It should be noted that there is a limited evidence-base available for some of these approaches and the diagram is based on the practice wisdom and experience of interviewees.

Cultural considerations in service delivery

There were some additional considerations involved in providing an appropriate response to complex trauma for Aboriginal and Torres Strait Islander and refugee women.

The professional participants discussed how, for both groups of women, community played a significant role in the ways in which trauma was understood and experienced. This created unique tensions in terms of accessing services that were not generally present for other women. One of these issues was having the choice to access support outside of their community to ensure privacy.

A non-Indigenous mental health worker discussed his health work in Aboriginal communities, and the question about privacy that faced Aboriginal clients with experiences of complex trauma. Although formal service protocol was that Aboriginal clients should be seen by, or with, an Aboriginal health worker, he reported that some Aboriginal clients would ask to speak to him precisely because he's not from their community, and therefore their confidentiality was more assured.

I think something important is that [for] Aboriginal people … trauma is almost a given. It is intergenerational. So to walk through the door actually that there's gonna be a trauma history. There's a huge stigma in the community here about other Aboriginal people—aunties and uncles knowing and often the Aboriginal Medical Service is staffed by Aboriginal people and often their community, because they live in the community, so they're the auntie of that young person on the street that's self-harming or they're the neighbour of that alcoholic or … that brings huge issues as well because then they worry about—will you talk to them? Will you tell my auntie? Who has access to your records?

And so, I think for us, one of—probably the interesting findings when I started working in there was … in the description you would never see a [Aboriginal] person without an Aboriginal health worker. So wherever I went and whatever I did, I had to have an Aboriginal health worker and that sounded quite reasonable and I was aware that I was coming in to that environment. I'm happy to do that, but we learned after about a month to do the opposite. Some people would come out of the woodwork and they would present and they would say, "I'll talk to him" [pointing to himself]. 'Cause they were thinking that "he doesn't know my auntie/uncle, he's not from the

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Figure 1: Summary of interventions and approaches helpful to women with experiences of complex trauma

PSYCHO-
EDUCATION

Normalising the trauma response, including dissociation
Identiyfing and responding to triggers
Naming and understanding abusive relationships, perpetrator tactics
Safe exit planning
Learning healthy relationships and trust

Acknowledging, honouring
Strengths-based approach
Engaging in meaningful activities
Connecting with supportive others

RESILIENCY

ATTACHMENT
WORK

Boundaries
Teaching healthy, nurturing parenting practices
Adopting a pseudo-parent role to model healthy attachments

Narrative therapy
EMDR
Ego-state therapy
CBT (but not sufficient on it's own)

PSYCHOLOGICAL
INTERVENTIONS

SUBSTANCE
USE

Motivational interviewing
Harm minimisation
12-step approaches

Mindfulness (not on its own)
Tapping treatment (acupoint stimulation)
Massage
Yoga

BODY
WORK

ART-BASED
APPROACHES

Art therapy
Music therapy (combined with movement)
Sensory healing

Grounding techniques
Self-soothing, self-regulation

EMOTIONAL
REGULATION

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community, I can tell him more of this stuff", and be confident that things are not gonna leave [here]. So we found the opposite—in fact, really helped to have a non-Indigenous person in the team. (AOD counsellor, AOD service)

Similarly, the community educators talked about how refugee women may not feel confident and comfortable using an interpreter, particularly when disclosing sensitive matters such as domestic violence. Interpreters sometimes behaved in ways that were complicit with the perpetrators:

Also about interpreters, even if they are physically present during that interview or video talking to the client, sometimes when you are from the same cultural background again with the same cultural thoughts and everything they tend to—you can see the client clearly trying to say something but then the interpreters interpreting, "No, it's your fault. Don't worry. It's nothing." There's so much more going on over there but it's just one sentence from the interpreter. It's sometimes difficult to work in that situation. (Community educator, migrant/refugee service)

Being from the same community, interpreters were also likely to have grown up with similar experiences of trauma that clouded their "interpretation" of a woman's disclosure:

I believe if they have training, like trauma training or something, because it is from the same culture, interpreters from the same culture … sometimes they're not even paying attention to that trauma or that person. They are normalising the situation, like this has happened for everyone, so why she's complaining or is complaining. So that's not her job to—have the job to judge that. Maybe that trauma, the same trauma, somebody has maybe so much to deal with and somebody doesn't care. For the interpreter, I think many times I pick up, they are normalising, "Oh, that's not important." They don't say or not interpreting that. (Community educator, refugee/migrant service)

A multicultural trainer emphasised that women need the choice of a CALD-specific or a generalist service due to privacy concerns. For example, women may have a wish

for care from someone who is not already known in her cultural community.

But also, they have the choice to go to generalist service, who have interpreter or ethno-specific service 'cause some still have—there are those very strong barriers. They don't believe that it might not go back to the communities 'cause those workers are very known in their communities as well. They have a status because they have a role, they work for the service, so they're looked at—"Oh. They achieved. They are from our community", et cetera, but there might be a trust issue as well … (Manager/supervisor, migrant/refugee service)

In addition to issues of confidentiality with interpreters there were also cultural notions of privacy that affected how women connected to services as well as to others in their community. The ways in which women understood the notion of trauma, and responded to prolonged experiences of violence, loss and grief, were shaped by their cultural backgrounds. Tala was a Filipino community educator who described her cultural community as "open" and willing to "share", including crying with one another. On the other hand, Shirisha—a Nepalese woman—emphasised the intersection of culture and politics in the silence of traumatised Nepalese women. Their experiences in Nepal might include sexual trafficking, loss of loved ones in political conflict and financial hardship but, once in Australia,

They hardly disclosed these sort of things because it brings shame to the family and it's not usually discussed, and it's very hard to approach and talk about these things to them and even if they disclose, they are very reluctant to go to counselling and stuff because they'll be ostracised as being crazy or with mental health issues, so it's difficult to approach these issues. (Manager/supervisor, migrant/refugee service)

This reluctance to access support for mental health problems because of cultural meaning around psychological distress and healing was also described by a community educator:

Many cultures look at mental health or mental problems as "being crazy". So it's actually labelling people. So, many would be very reluctant to have assistance from mental health services. But also understanding of healing process would be different in some cultures. So some

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cultures look at it that it's actually—that your soul—it's more spiritual approach—that your soul is actually taken by devil. So, if your mind is not working and you have mental problems, you're actually lost completely and if the soul is taken by those forces, bad forces, there's no return. So it's this understanding as well, and this fear. (Manager/supervisor, migrant/refugee service)

For women from a refugee background, the notion of speaking to a counsellor or a therapist was not always normal or comfortable. Bernadette was a refugee who had been imprisoned in her home country and survived genocide, domestic violence and multiple resettlements. She discussed the cultural challenges in seeking help for trauma:

I think in our culture, it's really rare for some people to talk about what they've been through. Even if our parents—so I can't really—because what I was experiencing that time, they are also there. So they had also that bad experience. They've had also that bad life. So it's hard to go to them and tell them, "Oh, this is what happened to me. This is what I've had. This is what happened." Because it feels like it's hard for them—they will understand you, but they will just tell you that, "Forget about it. Now you've got a better life. Focus on what is the future."

And back home, women don't feel comfortable to talk about what they've been through. It's shameful. Some people feel like, "Oh, if I tell you, you'll be laughing at me." So, that kind of thing—so it's hard for people to open themselves and feel like, "Okay, I've got this problem." … That's why especially women, they don't talk, they keep it inside until one day, you see it all come out and maybe they're dying, or maybe they get killed, or maybe they just get more and more abused every day. That's how it is back home because I think that we don't really have that access of getting to a counsellor that easily, and we feel like we are strong enough to resolve our problem. So it's just a—it's [an] individual thing to accept that, "Okay, I think I need help. I just need to talk to someone." [Bernadette]

In women's home countries, domestic violence was often a family matter and so speaking about it to a third party was unfamiliar and frightening. One worker described the challenges she faced working with Afghan women experiencing

domestic violence in Australia:

In our community back in our country, it's not that there is such supporting environment or system around and also the concern is the family issue and they just keep [to] themselves, and then endure it for such a long time, but when they arrive there, it depends and trust is a very big issue and lack of information. If they know there is a support, enough support, they might start disclosing and start looking for support. But if they're not supported enough if they don't have trusted environment or they are not very certain, "If I can disclose, what would be in the future?" So in a lot of reason behind which will result in what decision they might make—they might decide to keep [to] themselves, "because if I disclose, I might lose my family, lose children, I might leave, and I can't live here and I go back to country because I don't have financial support". So I think individual has really different knowledge or it's not the time yet, so as a support worker, we probably just provide as much information support as we can but it's the time for our client themselves to make decision, "There's a time, I want to talk and I want help." (Community educator, migrant/refugee service)

Summary

This chapter has made clear the ways in which the mainstream healthcare system—despite being positioned as a "helping" system—can compound the complex trauma experiences of women. Psychosocial and embodied understandings of complex trauma, as outlined in the previous chapter, were rare among health professionals working in mainstream settings. This had the effect of downplaying the distress of women or misattributing their distress to flawed personalities or dysfunctions of the self. The subsequent labelling of women with experiences of complex trauma as difficult, attention-seeking and unworthy served to re-traumatise the women and effectively denied them acknowledgment, support and treatment.

It is also clear that we know how to work well with women with experiences of complex trauma. The women's health and refugee sectors have well developed approaches to working in a trauma-informed way. There is a need to extend the reach

of these services so that women with experiences of complex trauma are not overlooked, misunderstood or dismissed, as so many of our study participants have described.

If we are to develop a more responsive health care system for women with experiences of complex trauma we need to invest in:

- systems that acknowledge the existence of complex trauma and its impact, without pathologising women
- training for health professionals around what complex trauma is and is not, and practical support for health care settings to make changes in alignment with trauma-informed practice
- mental health, including the availability of mental health support within emergency departments and other acute care settings
- an expanded range of support and other treatment options that include multi-modal approaches to address the embodied and relational impacts of trauma
- specialist programs that can work with the more severe dissociative experiences of some women with experiences of complex trauma.

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Complex trauma in criminal justice, child protection, and family law

> We are in awe of your courage, strength and resilience. We hear your voices and know your challenges. Stay hopeful, keep believing that what you are experiencing is real. There are services out there that understand you and will help you.
>
> We will continue to work toward better options for all women who experience complex trauma. We will keep advocating for change in awareness, policy and funding to make this possible.

Statement from a workshop of professionals to women with experiences of complex trauma

> A lot of women feel like "I can't traumatise another person". We can hold whatever you need to tell us. We can provide a safe space for you to speak to us.
>
> We hear you. We see you. Our clients are inspiring to us, and the reason that we do this work is our clients, and the brilliant and inspiring people that they are.

Statement from a workshop of professionals to women who have experienced complex trauma

This chapter is focused on the encounters between women who have experienced complex trauma and agencies with legal and statutory authority such as police, criminal courts, family law and child protection services. First, the chapter discusses the ways in which the women who participated in our study experienced interactions with police. This section of the chapter highlights the perspectives of women who have experienced complex trauma about the gatekeeping role of police, the significance of the tone of interactions with trauma survivors, the need for more widespread trauma-informed policing and the specific challenges faced by women in regional and remote communities.

Second, the chapter addresses the impact of criminal justice processes that result from police intervention on women who have experienced complex trauma. This section builds on issues related to police judgements and assessments of traumatised women and considers how these overlap with prosecution and court practices. The chapter discusses women's motives for pursuing criminal charges, the implications in the event of unsuccessful prosecution, and the symbolic importance of court decisions not to proceed or to pursue lesser charges. It

also takes up some of the ways that the women experienced inadequate regard for their safety and best interests in court.

Third, the chapter addresses child protection systems, highlighting contradictory approaches to child and adult protection across systems, and unintended outcomes of systems intended to protect children and their primary attachments to caregivers. The fourth section presents women's experiences of the ways family law systems fail to recognise and account for trauma and the safety of children and adults, forcing survivors and non-abusive parents into a catch-22 situation where they can be penalised for efforts to protect children from an abuser and simultaneously risk loss of custody to the same abuser for failing to actively promote his access to the children. Fifth, the chapter discusses the significant challenges for systems supporting severely traumatised women. This section takes up systems' punitive responses to survivors of extreme trauma and abuse. Once severely traumatised women are identified as imperfect victims, even clear and convincing evidence of victimisation may be ignored. The complex needs of the most vulnerable women pose a challenge for systems designed to address individual incidents or siloed

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issues. Finally, the chapter discusses key, promising processes that emerged out of the Royal Commission into Institutional Responses to Child Sexual Abuse. This section foregrounds the important role of validation, dignity and hope in justice and redress processes.

Police

Access to and cooperation with police is both vital and very challenging for women in situations where they are experiencing complex traumatic events. Women's and professionals' accounts indicated that police play a vital gatekeeping role in women's safety and access to justice. Women observed that they had to make the right impression on police if an investigation was to proceed, or if women were to receive a proactive or protective response from police. However, women with experiences of complex trauma frequently interacted with police during periods of crisis, and their traumatised presentations rendered the women vulnerable to a range of pejorative assessments and judgements by police officers. Police featured in women's stories in a number of ways. Women had to contact police for protection against perpetrators and abusers, police took statements and were often present in court matters, and police also attended a number of incidents of self-harm.

The critical importance of constructive police interaction with traumatised women in crisis was a consistent theme throughout the interviews. When they encountered women experiencing complex trauma, police often exercised a high degree of discretion and were perceived to have little accountability, which could amplify women's existing feelings of humiliation and powerlessness. Descriptions of police attendance at incidents of self-harm provided stark illustrations of the punitive interactions between study participants and police officers. The following section is drawn from interviews with women and workers in the social services sector. This section is focused on articulating women and support workers' experiences of complex traumatic events and system responses. Police were not interviewed as part of this study and their experiences of engaging with women with experiences of complex trauma are therefore not represented here.

Assessments and judgments by police

It is important to recognise the symbolic power and authority of the police. What individual officers say, their demeanour and offhand comments can profoundly impact women who are seeking assistance and support, often at their most vulnerable times. Women in our study consistently complained that law enforcement could not identify, and did not understand, their traumatised presentations, and described being dismissed them as mentally ill or "crazy". Michelle described feeling stigmatised by police and court personnel due to her fear and shock during court proceedings against her violent ex-partner.

> We had the local police saying, "Oh, she's crazy", and when you're presenting as a shaking, blubbering mess, or you're hiding behind big black sunglasses when you're seven months pregnant. I don't know why, but for some reason the people in court don't have a clue about trauma. (Michelle)

Support workers reported that the initial presentation or appearance of the woman to police had a significant impact on the kinds of responses that they received. A domestic violence worker commented on prevailing stereotypes about the "good victim", and how women who are not seen to present "well" to police can be "written off".

> I think that it [contact with police] is really difficult for some [women]. Again, going back to that whole idea of the "good victim". I don't think people talk about that enough in our sector but just even in police responses, just in terms of how a woman is presenting and if she gets upset and if she gets angry with police, if she has been drinking when she has the call out, often we will see it just that she gets written off. It's that not listening and not being heard and being invisible to the system. So that feeling of frustration for women and for workers that she doesn't matter because she is coming however she is on that day. That feeling like that, if you are pre-packaged in a certain way, you are going to get a better response and I think that that definitely is the case. (Manager/supervisor, domestic violence service)

Women with experiences of complex trauma often experience intense feelings of shame and low self-esteem, and are predisposed to feel that police are not listening to them and do

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not take them seriously. A sexual assault worker commented on the ways in which police could pre-judge the likelihood of prosecution and conviction, truncating investigations and attempting to "cool" women out from pursuing their complaint. She said:

> I've had police officers call me and say "Can you please encourage your client not to make a report because she will be torn apart." We can't tell her that. We can't tell her not to report. "We've gone back through her records, her records of contact with police, say we've got her mental health file, if this gets to court they will …" I think the word they used is "they'll slaughter her. So can you tell her not to [proceed]." Which is very problematic conduct from police, I would say, but also, don't call in and ask me to ask my client to not report. There's something in that that is about the process as well. This officer was saying "We believe her. We believe that this has happened to her. She is not a good witness."

> I found myself, with this example, saying to this police officer, "What have you written about her in your file? Like, so help me understand. So you're saying you have someone who you believe, you believe her current disclosures, you have this 20-year file of her contact with you. What does it say in there? Like what have you …" and that is part of the, so what are we writing about people that then if these files get to court means …

> They sort of said, "Oh you know we … She's been charged with public nuisance for ringing the ambulance too many times when she's saying that she's overdosed and she hasn't really or …" There's all these little things that then get used to say, "Well, what's a defence barrister going to do with that? These 100 calls that you made to ambulance saying that you were overdosing when you hadn't really, you're prepared to lie to get attention." [That] is where that goes. (Trauma counsellor)

In this example, a police officer applied the logic of a defence barrister to the woman's complaint before it got to court, characterising her testimony as incredible even where the police officer believed the woman had been assaulted. As this case illustrates, in a system that is saturated with sceptical narratives about women's complaints, police may characterise women who have experienced complex trauma as incredible even as they attempt to protect the woman from further hardship and disappointment.

Police attendance at self-harm and mental health crises

Women in this study reported that police attendance at incidents of self-harm and suicidality often resulted in physical confrontation and re-traumatisation. For instance, a few years ago, Abigail self-harmed at home and then contacted her local doctor and asked him to visit her at home to care for her wounds. Instead, he notified the ambulance who attended her home with the police. Abigail refused to leave with them, and instead went to her bedroom to find her mobile phone so that the police could speak with her psychiatrist. The response from police was forceful, re-traumatising and humiliating. As Abigail notes, the brutal nature of this experience was a strong disincentive for her to reach out for help should she harm herself in the future.

> So I went into my bedroom to get my mobile phone to tell him the phone number of my psychiatrist so he could have a chat to him, so that I don't get sectioned, which would be a great trigger for me. And I'm bending down to the bed to get the mobile phone, right? And because I've been refusing to be taken away by them …

> There was a cop each side, got me by the back. Handcuffed me. One was sitting on my tail bone, and I had another one like that on my … his hand was on my hair, and I started screaming. I went into a flashback situation where I thought my father was on top of me. And they're saying, "Stop resisting, stop resisting …" and all this sort of shit.

> Well, firstly they didn't, they didn't ring my psychiatrist until I had complied to come to hospital. They said, "We have a duty of care." I said, "I'm well aware that you do." I said, "But I actually didn't call you. I am actually okay now. Despite the fact I haven't had time to clean the blood up in the house, I am okay. I can vouch for my own safety tonight. All I needed was medical attention. And this is the first time anyone's ever put handcuffs on me."

> And then, just to top it all off, before I get on the ambulance, right? The policewoman has to strip search me. So I had to take all my clothes off. And all the men are waiting in the hallway, right? Charming.

You actually go out of your way to actually make sure you're looking after yourself … And look what happened. So next time, you think to yourself, "Well, I won't tell a person. And I'll be okay." Right? Yeah, sure, I might need stitching, but I'm not going to risk it. That's not the line you should encourage with me, but, I mean, that's the reality of it, and you wonder why people don't ask for help. It's like, well, why would you? (Abigail)

Workers had observed similar problems with police attending mental health presentations. A mental health nurse recalled his involvement in a similar situation to the one described by Abigail, in which police attended the home of a mentally unwell woman who needed to be hospitalised.

Some of the police officers are not very trauma-informed as well in terms of the use of paddy wagons and officers. I remember a very unwell young lady that wouldn't come in for care and ended up—we sent a GP and we got a scheduled appointment [and needed to] get to the hospital, so needed an ambulance because she was ill. She wasn't bad. So—but she didn't wanna go, so needed the police for a bit of extra persuasion. And so when I get to her address, to her property, the cops are in the paddy wagon and they put their leather gloves on and he checks his taser's there and he says to me, "Mate, me and Sam [the other officer], we're not ready for any shit today. We're gonna go and sort this out." So even that [approach] in itself is such a huge issue, so that's something about practice and language and expectation and awareness.

And also that [police] concept that [if] the person's unwell, maybe they're violent, maybe they're aggressive and angry, maybe they're swearing and cursing but they're doing it 'cause they're actually—they're really unwell or they're hearing voices, or—they're not bad, so they don't need force, they don't need a paddy wagon, they don't need handcuffs. They need medical treatment. (AOD counsellor, AOD service)

In this example, in a situation that could have benefited from de-escalation, police tactics escalated the encounter until the vulnerable person was being treated as a criminal. The betrayal trauma experienced by survivors who are further harmed by institutions that are meant to help exacerbates the negative effects of trauma (Smith & Freyd, 2013).

In contrast, the mental health nurse noted how specially trained police teams could greatly improve responses to trauma:

So most areas now, the police force has a mental health intervention team. And they have an officer or multiple officers at most stations now that are there to respond. Now, whether that's enough for every shift is another question—but I think it's a significant development, because there are specialist police these days [who] are for mental health presentations that may occur … So, the call comes up—"We've got a call about a person harming themselves …" They would think about the whole presentation. A nurse and the police officer, and they'll manage it together. That's a really, really effective model.

In the excerpt above, partnerships with health professionals and a need to "think about the whole presentation" are key to an appropriate law enforcement response to women exposed to complex trauma. The consequences of a poor or re-traumatising police response to an incident of self-harm or mental illness could be catastrophic. As Abigail notes, she is precisely the kind of person who should be encouraged to reach out for medical assistance if she has self-harmed or feels suicidal, but after her last experience with police, "I'm not going to risk it."

Issues for isolated communities

Michelle faced a significant dilemma living in a small country town in the aftermath of a violent relationship, due to the familiarity between police and her ex-partner. She felt that the attitudes of police "were more traumatic than the broken bones and the abuse that we all incurred". Michelle indicated that when she reported violence to police while she was still married, officers evinced concern about the fitness of her parenting while she remained with a violent man. However, after she left the abusive marriage, Michelle felt that the police viewed her as a "bitter ex", particularly once her daughter disclosed sexual abuse by her father and family law proceedings commenced. Michelle was fearful due to the social links between her perpetrator and police that became evident even as criminal proceedings against him were taking place:

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After he'd been charged with assault with a weapon and breaking a restraining order, they were playing in a darts comp at the local pub where the police played against the perpetrator. So in a small country town, it's easy to go, "Oh, don't listen to her, she's crazy" and become friends with the local police because there's pool and dart comps. (Michelle)

As workers in a rural women's health service pointed out, perpetrators are often friends or family with police and other service providers, which introduces significant concerns for women about confidentiality and impartiality. One social worker noted, "I think across any rural community, with the policeman or the doctor, there's always fear [that] the person you talk to is somebody connected to the person you're talking about." This problem becomes particularly acute for women when the perpetrator is the local policeman or doctor. Another worker said, "I think too often in rural communities, the perpetrators can be the local doctor, the local police person, the local person everyone in the community respects … The community can't possibly do without that person, and that can add to the isolation and also who does that person [who needs help] access?" In very remote communities, there may not be a permanent police station. Instead, police may visit periodically. In such circumstances, community members who approach police become highly visible to others. One clinical coordinator with considerable experience in regional and remote communities observed:

> In a lot of the communities actually, there are no support services in that community and the services charged with providing that support are based often over 100 kilometres away, and might visit once a month, once a year, depending on the referrals they got. And so if you are not reporting it to somebody who can then make the referral, then nobody's coming. Often reporting it to somebody means that police might visit once a month, and to report it you would need to actually walk yourself up to the police truck and be seen to be talking to police, which you're not going to do, it's so unsafe. For those communities it's really tricky, I think. (Manager/supervisor)

This example points to multiple barriers to effectively supporting women who have been exposed to complex trauma in isolated communities. The lack of full-time services and

permanent police officers, the realities of social relationships and the overall lack of privacy in small communities can exacerbate the challenges of dealing with police for women exposed to complex trauma.

Criminal justice processes

There is broad agreement in the literature that the criminal justice system is not designed to accommodate people who have been affected by trauma (Dudley, 2015; Hohl & Stanko, 2015; Jordan, 2002, 2004; Mayor's Office for Policing and Crime, 2019). This group can be apprehensive about approaching police for the reasons described above, and experience significant difficulties in providing a statement and testifying in court. Making a statement to police is a foundational step in the initiation of an investigation and prosecution of a criminal matter. A consistent issue noted by women and professionals was that women exhibiting signs of trauma are often viewed as lacking credibility by police and the criminal justice system. One clinical coordinator commented on this problem:

> I guess it's tricky because for someone with what you would think of as a complex post-traumatic stress presentation, they're not a "good witness", if I can use that term, because their presentation doesn't typically look like someone who's got it together and who's reliable, so that can be really tricky and may in fact impact on your ability to seek justice if that is what you're seeking. (Manager/supervisor, sexual assault service)

One of the social workers based in a sexual assault service discussed the kinds of guidance that she provides to police in an effort to improve their engagement with women with experiences of complex trauma. She said:

> When we went to go and see the detectives recently, we said to them, "People with complex PTSD are not going to walk in and give you an articulate statement in an hour. They're not going to be remembering all the details that you need. How do you help them with that? Complex trauma effects the way we present. It affects the details that we have in our memory." In that conversation they [police] were saying [to me], "Look, we're happy to have multiple attempts at it [taking a statement]. They can come

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as many times as they need. Most people have to come in more than once." (Social worker, sexual assault service)

At times, this social worker's service tried to mediate between their clients and police. Often, clients had a strong wish for "the trained support of understanding professionals who can go in and listen to these statements or provide the support so that the person with complex PTSD feels supported and believed and is likely to be giving a better police statement". However, her service was rarely able to provide this kind of in-person support to clients.

Another counsellor noted that some of her clients have had positive experiences of criminal justice processes, but she emphasised: "It's much more about the relationship than it is about the process." She said, "if people are able to build a good relationship with the investigating officer and the DPP prosecutor and those sorts of things", then they are more likely to report a positive impression of the justice system. However, on the whole,

> I think most people find, and again I'm generalising, the process is quite excruciating for them and if they don't have those supportive kind of relationships with people I think that can be pretty horrendous. We don't have much success as a justice system in getting convictions. Even things getting to court is incredibly rare. (Counsellor, sexual assault service)

The research indicating that sexual assault matters are rarely prosecuted, in part because of common responses to trauma (Hohl & Stanko, 2015; Mayor's Office for Policing and Crime, 2019), was borne out in our interviews with women. While a few women had assaults that were prosecuted in court, none of the women reported that the charges reflected the extent of their victimisation. For instance, Lauren was sexually assaulted about a decade ago while jogging in a park. The offender in that incident was charged and convicted. However, the trauma of the assault and the criminal justice process triggered what Lauren described as a mental "breakdown" as she began to recall an extensive history of child sexual abuse. The perpetrators who assaulted her as a child have never been investigated, charged or prosecuted.

In another case, Madeline grew up in a severely abusive family and was homeless and couch-surfing by her mid-teens. She was sexually assaulted by multiple offenders while she was homeless. The accused perpetrators were charged with sexual assault and she prepared for the trial only to have it cancelled at the last minute.

> It got investigated by the police and we spent a year preparing for trial and then a couple of days, three days before it was due to go to trial, they cancelled it. They just decided that because the offenders were under age, they thought it was going to be too hard, they'd been preparing it all year, but then … the deputy director of public prosecutions came in and looked at it and went, "This has a low chance of conviction, so it's a waste of our time."

> It was really horrible because although in hindsight, I'm glad I didn't have to go through the cross examination—I think that would have been really bad—it was bad because I was already dealing with a lot of real-life and cyber harassment from not only those people, but people at school who'd chosen sides and people from three local schools. It had become a big, big town drama and it validated the people who were calling me a slut and all of that. (Madeline)

This example reflects the well-documented reality that rape reports are rarely successfully prosecuted (Hohl & Stanko, 2015; Jordan, 2004; Mayor's Office for Policing and Crime, 2019), and victims' reports (Epstein & Goodman, 2018) are regularly discredited. As Madeline's narrative illustrates, survivors of sexual violence may be blamed for violence against them or otherwise find the violence and its impact devalued by authorities. Despite the costs to women of participation in justice processes, workers reported that women's motivations for reporting their own victimisation were often highly altruistic. Women not only sought justice for themselves, but felt a responsibility to help protect others from abuse. One of the counsellors called this a "beautiful motivation" that she observed frequently in her clients. However, their experience of the criminal justice process was fraught, to say the least. She noted:

> Criminal prosecution is not about the survivor, it's about the state … Civil [lawsuits are] slightly more [about the

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survivor], and there's a big move to people sueing civilly for damages, and that's much more about [the survivor] … We see often, and in the current system as is the DPP's right, them negotiating charges down in the attempt to try to secure some sort of prosecution, which is in society's interest, I'm not going to criticise them on that, but that's not about the victim. To have your charges argued down from something to something else with no consultation with you is pretty, it can be very minimising, it's very disempowering. They're not particularly present in those processes and that's the justice system that we have, yeah. (Trauma counsellor, sexual assault service)

One clinical coordinator at a sexual assault service explained how her service presented the criminal justice system as one option among many. This discussion was part of her service's emphasis on expanding women's feelings of choice and agency. However, the lack of understanding of the impact of trauma within justice systems could render women's testimony incredible once a court process has been initiated, which effectively "replicates those dynamics of abuse":

I guess we try and help clients think about and explore what's the benefit to them of doing it, and what's the cost, and helping them see that they have choice in this, which I guess is what they've … Trying not to mimic that abuse and saying, "Actually, you do have a choice here, you can choose to go down and try and prosecute, you can also not, and what inconsistent, they often don't recall things in the same consistent manner, that there's gaps, that the complexity of abuse means that they don't leave when they could have because they were so traumatised, and I guess that then makes them less of a credible witness. What we know in terms of prosecution rates are so low, and often I think what happens in courtrooms to witnesses completely replicates those dynamics of abuse. Putting people through that, that has to be a personal choice that they want to do, but then the likelihood of getting a conviction at the end, it's pretty poor. (Manager/supervisor, sexual assault service)

A clinical coordinator emphasised that criminal justice processes can proceed in ways that are contrary to the wishes and best interests of the victim. In the following excerpt, she describes a case in which prosecutors attempted to force a woman in a remote community to testify in the trial of her violent partner. When she refused to comply, she was arrested, strip searched and incarcerated.

I've mentioned this to a few people and everybody continues to assure me no one will ever be forced and no one is ever forced but I've seen it with my own eyes. The example that I'm thinking of is of a client who was assaulted, there was a third-party witness to the assault who was not connected to the survivor or the perpetrator, the survivor didn't report the assault, the witness did and the information that was provided to police was able to identify the survivor, the client … The survivor did provide information to police in the context of having just been hurt and taken for assessment and medical attention confirmed that, "Yes I was assaulted" and she wouldn't really say otherwise, and the criminal justice process took off without her being, I don't think, aware that that's what was going on.

The client and survivor, the whole way, was saying, "Nope, don't want to be involved. Don't want to be involved. It's not safe for me to be involved. The second he gets out I'm in trouble." And continued harassment from the perpetrator from prison via the phone to the point where on the day of trial, the survivor did not attend court having told everybody, "I'm not going to attend court" from the get go, and then had a warrant issued for her arrest for, I think it was … Is it contempt of court or is it? I can't remember what the judge used but [she] was subsequently arrested, strip searched, incarcerated herself until … Being a remote community there's not a magistrate there 24/7, so held in custody until a justice of the peace was able to look at the case. It was horrendous, absolutely horrendous. She was then ordered that she must attend court, then a new trial date was set, and she then skipped town. Which was the safest thing for her to do. (Clinical coordinator, sexual assault service)

This illustrates the disempowerment experienced by women in their interactions with the criminal justice system and the lack of accountability when decisions made by police and judicial personnel cause harm. The importance of empowering women with experiences of complex trauma was a core focus for many workers and services, in stark contrast to women's experiences in the criminal justice system.

Child protection services

The child protection sector was regularly singled out by workers as overworked, under-resourced and lacking trauma expertise. The lack of trauma-informed practice and training in this sector is counter-intuitive given that families who end up in contact with child protection services are overwhelmingly likely to be affected by some form of complex trauma (Greeson, Briggs, Kisiel, Layne, & Ake, 2011; van der Kolk, 2005). There were a number of comments made by workers in the study to the effect that child protection services lacked a trauma-informed approach to child safety and family support. For example, one professional transitioned into working as a counsellor in a sexual assault service after beginning her career in child protection. She noted that the same kinds of issues that were identified as a "trauma impact" in a sexual assault service might be articulated differently in a child protection setting as an issue with "parenting".

> I think the depth is very different here [in the sexual assault service]. In child protection, you are sort of working with the family as a whole, and things are not necessarily named as, "This is an impact of trauma for mum." [Instead, it was,] "This is what's happening in her parenting." … I think the linkages were not as clearly made. Whereas here, they are … I think absolutely it would help a great deal if child protection work was much more trauma-informed. Because it is central to most people's experience of being a parent and their ability to be in relationships with people. (Trauma counsellor, sexual assault service)

A community health nurse suggested that the pressures of child protection work compromised staff capacity to inquire into the parenting issues of clients in more depth. He said:

> I know they're very busy. I totally get it. I've been in their office. I've seen piles [of papers] like this [gestures], I know that—they are very busy. Having said that, my clients, they know it well. They always say to me, "FACS hates me. FACS is so unhelpful. They don't give me any information."

A domestic violence worker with a background in child protection articulated particular concerns about the ways that complex trauma is "personalised" and women are blamed for their own trauma in the context of child protection and family support. The woman's fragile or chaotic presentation could be in contrast with a perpetrator who knows how to present well, putting victimised women at a considerable disadvantage in a system that does not understand her traumatic presentation.

> And then often one of the difficulties with that is that, for example, the perpetrators may be presenting quite well and mum is not presenting well at all because of her own childhood trauma impacts and then the current domestic violence, and then also it impacts them by how they get treated by the system. So what I find is that what has happened to the woman and the children gets personalised. As for mum, it's her parenting, there's something wrong with her parenting or she has been triggered from the past. She has been triggered from the past, we hear a lot, and it gets personalised too. Something deficient within their own character and their own personality so I think that really impacts, whether they even get to keep the children obviously. I think it has got really major impacts [for] women, how they are perceived. (Manager/supervisor, domestic violence service)

A counsellor based in a women's health centre felt that an actuarial focus on risk assessments in child protection failed to account for the traumatic underpinnings of some women's parenting problems. The lack of early intervention and family support programs could result in reliance on acute interventions such as child removal that re-traumatise women, particularly with recent pushes toward the early adoption of children in care. Ironically, these removals were justified according to "attachment theory"—the need children have for permanent, stable relationships—while profoundly disrupting the bond between the primary caregiver and infant. The counsellor said:

> The client wanted the child back in her care. The little one was removed when she was diagnosed in late-pregnancy drug use. She was discharged from the [substance abuse] program when she was with the baby in the program for breaking, for me, sorry, not a very significant rule. It wasn't drug use. Because she was discharged from the program, her child was removed, so she starts using drugs. This was the only way she was able to cope, and then it was lack of support and the child stayed for too long with the

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foster parent and, at the moment, the FACS is pushing to adopt her child, adopt her out. And looking back, if there was more intervention around her circumstances, what happened to that woman, very chaotic life, a lot of trauma in her life, I feel that providing her with support services would be much better than removing the child and now putting the child on adoption. (Therapist, women's health service)

Some women had been removed from their own families as children and spent time in out-of-home care, and others had had their children removed. These interventions were profoundly impactful on their lives and could have intergenerational effects. Louise spent her 20s in a violent relationship, and during this time she was repeatedly hospitalised due to ongoing trauma, dissociation and suicidality. On one occasion, her daughter was taken into care. Her daughter is now an adult and currently in an abusive relationship, however her daughter's experiences in out-of-home care have increased her reluctance to ask for help.

My daughter herself is in a bad relationship and even though I say to her so many times, "You need to get help for yourself", she says to me, "If I do that, they'll take me away like they took you away into your hospitals", 'cause she was—when I was, I've been scheduled, OK, and she's seen me at a very young age be taken away in paddy wagons, and she gets taken off to DOCS. Her and my son were taken off to DOCS 'cause my husband wasn't home and I was taken off in a paddy wagon to the hospital and that's her memory. And I say, "Lucy, you need to get help. You and David are having problems in your relationship", and all she'll say to me is—"If I do that, I'll lose my kids." She said, "I'm not gonna do to my kids what you did to me and Daniel. I'm not gonna sit there and watch my kids screaming for me being taken away because mum's being locked up in a psych hospital." And I said, "Lucy, our situation's different. Our situation is very, very different." But that's what I'm saying. That's the effect of trauma. That's how it continues into generations. (Louise)

As she left her violent marriage, Michelle found herself trapped between the demands of the child protection system and the family courts. While child protection services insisted that they would remove her daughter if Michelle did not protect her from her father, the family court ruled that her daughter would be removed if she did not provide him with access.

It started off with Department of Human Services going, "It's really dangerous. You shouldn't be near him. If you go near him again, you're going to lose a child", so I keep away from him. After the assault where he broke my hand in two places, they sent us to another lot of counselling. Eventually, none of that seems to go into the family law court … By 2009, the abuser that would be convicted with breaking restraining orders and assault with a weapon was given custody. He went from supervised access to unsupervised, to given full custody because of the mother's mental state, being I was on anti-depressants and whatnot at the time. (Michelle)

The next section discusses Michelle's experiences in more depth. However, this collision between systemic prerogatives—to protect her children but also connect them with the man who abused her and them—illustrates the impossible situations that women face, being scrutinised by child protection while negotiating multiple competing demands and unmet needs. The absence of early intervention and supportive responses to families impacted by trauma and violence were striking throughout interviews with women and workers.

Family law

Family law is another key system for women who have experienced complex trauma. When former partners are unable to agree on parenting or other post-separation arrangements, issues may be adjudicated in family law systems. Family court cases are disproportionately likely to include reports of domestic violence and child sexual abuse (Moloney et al., 2007; Rhoades, Graycar & Harrison, 2000; Sheehan & Smyth, 2000; Young, 1996). Some women in our sample spoke extensively of their contact with the family court system and the ways in which their ex-partners manipulated court processes as part of campaigns of harassment and control. For example, although Michelle's family court proceedings had been resolved years ago, she was traumatised and exhausted by her experience in the family courts. One of Michelle's children remained with her, but her ex-husband had full custody of another child. Michelle's family law proceedings occurred following

significant law reforms in 2008, which prioritised the rights of fathers to continued access to their children. Subsequent reforms in 2012 were intended to prioritise the safety and best interests of children, but these came too late to affect the outcome in Michelle's case. Despite her ex-husband's criminal record of domestic violence, and her daughter's sexual abuse allegations, he was able to expand his access to their daughter until he received full custody of one child:

> I actually was so naïve to the system. When the first judge, at our first hearing, said one hour's supervised access a week, I thought "She's safe! I've done my job." Fifty grand it cost me and she was safe. And then from there, it was just ridiculous that he was allowed to get two hours [contact], then supervised with his parents. I just don't understand how all of a sudden they could have said that this person who was on speed, amphetamines, aggressive, who had been an alcoholic for years, who had lost numerous jobs because of his attitude towards women … how then, two years later, it can be overwritten. (Michelle)

Michelle described how her former partner self-represented in the family courts until she ran out of financial resources and could no longer afford legal representation.

> Unfortunately for me, when I had no more houses to sell—but basically I've kept us safe and it costs me $180,000 in court over those years to keep us safe. I had to sell the family home. The second I had to sell the family home, he went back and basically self-represented until he got full custody. (Michelle)

This form of abuse, leveraging systems to continue coercive control post-separation, has been termed "procedural stalking", "paper abuse", or "systems abuse" (DeKeseredy, Dragiewicz, & Schwartz, 2017; Douglas, 2018; Elizabeth, 2015; Miller & Smolter, 2011). Michelle felt that the family law system had provided her ex-partner with multiple points of leverage over her with which to extend his abuse and control even though their relationship had ended.

> They would force us to go drive to the city, sit in a room, with him there, and then expect us to be able to speak rationally and clearly, and everything was all over the place. We escaped him, but I can't express all the levels of trauma that then continued with a lot of them, he'd

already befriended the police, or he would self-represent and drag me down there, and then not actually be there for the hearing until all my money was wasted. And to this day, I still owe thousands. One final hearing, I had to borrow on bankcards. I lost everything. (Michelle)

Michelle was still uncertain about the safety and wellbeing of her daughter who was now being raised by her ex-husband. Her worry about her daughter was an ongoing source of anxiety and stress.

Despite attempts to improve the safety of children and women in family court proceedings, the most recent Australian Law Reform Commission (2019) review of the family courts has found that family law responses to domestic and family violence continue to fall short. Rose was currently undergoing family court proceedings with her ex-husband who continued to seek access to their daughter. Like Michelle, she remarked on parallels between her experience in court and her experiences with her abuser and the court's minimisation of her partner's known history of domestic violence.

> It's hard to imagine anything worse. Yeah. It's as bad as being abused—much worse though, I would say. You just don't really have any say and it's just so arbitrary. He [my ex-husband] has spent probably $400,000 [on legal costs]. So, it's just so persistent all the time. And he's been found guilty of falsifying documents, and lying and stuff, and there's no consequence … But I don't think he has any interest in my daughter at all. I don't think he is able to relate to her at all … I think he finds it quite exciting to have all these lawyers telling him that he's wonderful and go to court, and I think he enjoys it now. He's become— it's become really entertaining for him … [The domestic violence] doesn't matter 'cause that was too long ago. That's what they [the judges] said. (Rose)

The themes evident in women's encounters with family law were very similar to their accounts of criminal justice processes: women are frequently not believed or supported, disempowered and then left all the worse for the legal process, all of which is re-traumatising.

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Severely traumatised women

Within the spectrum of complex trauma, there are a group of women at the far end of the continuum, who have experienced severe and invasive trauma throughout their lives, typically at the hands of multiple perpetrators in their families and beyond. While making up a significant client group in domestic violence and sexual assault services, they are largely invisible to policy makers and the public, and struggle to find or access a specialist response (Salter, 2014). For example, Laura was raised in a family where sexual abuse and exploitation was normalised from early infancy, and she was sexually victimised by her parents and trafficked for abuse by her extended family and their friends. Now in her mid-30s, she lives with dissociative identity disorder, and is too disabled to leave the family home where she continues to be sexually abused by her parents. While she is working with her psychologist to separate from her family permanently, she identified a "big gap" in the current response to violence against women for people such as her.

> We Googled [trafficking] in Australia and what came up was services for refugees. So, lots of service—we found a few services, but you have to be a refugee. You could've gone through horrific trauma and trafficking but you have to be a refugee [to get access]. We felt like—we sort of felt like we had nowhere really to turn to. There is a big gap. There's a gap between ongoing trauma in [Australian] suburbia and in Afghanistan. There's a real big gap between the need of that [trafficking victims] and then the current services like for domestic violence or something like that. And there's a very big gap. And it's very hard I think for us leaving—separating from our parents. We're not just separating from them physically and emotionally. It's also financially … It's really hard. Basically, we've had to plan leaving for the past five years and planning our finances, and still for those five years being abused. (Laura)

A number of professionals interviewed for this study had experience with women such as Laura. They noted that women who did break ties with sexually abusive and exploitative family networks could face severe retaliation from perpetrators, similar to the way that risk of violence escalates for women leaving abusive partners. However, the lack of specialist services for severe trauma, and a general lack of awareness about diverse and complex forms of abuse, could leave women with few options. This notion was elaborated on by a social worker who supported a woman over many years to escape her abusive family, who was involved in a paedophile ring. She described what happened when her client contacted the police seeking assistance with bringing the ongoing abuse to an end:

> Oh, well initially they [police] were very sort of sympathetic, you know, they were horrified and she's a very, very smart woman, very competent, like brilliant woman. And she's very sort of careful about how she deals with it. In terms of trying to deal with the credibility sort of issue … And then they started to disbelieve. It's my experience generally, the worse the abuse, the worse the system's response. But the more severe the abuse, the more likely the system isn't going to be able to manage it. And the response will be then to turn on the client. (Trauma counsellor, sexual assault service)

A sexual assault worker described similar experiences with a client who she supported to approach police about organised sexual exploitation by her family and other offenders, which had been ongoing since early childhood. As she pointed out, there is no agreed-upon language for complex, organised and ongoing violence against women of the kind that her client was reporting, which put the client at increased risk of being misunderstood and disbelieved.

> I think there's that sense of, "Literally no one in the community actually believes that this happens. I don't even have a language around this necessarily. I don't know how to talk about it with anyone, it's actually impossible. I don't know how I'm going to go and speak to a police officer, who clearly doesn't get it. Who won't get it" and coupled with that, there's the very real risk of harm. The huge sense of danger that people have in going and disclosing. These perpetrators are very good at using tactics of fear and danger and threats. (Trauma counsellor, sexual assault service)

This domestic violence worker expressed frustration and bewilderment at the reluctance of police and prosecutors to pursue these complex cases. She noted that she has supported clients who gave birth as minors to the children of their

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abusers, and could not understand the decision not to lay charges against the offender.

> I find it hard to sit with, how is it okay … If you believe that this has happened, if there's evidence … I've had clients before who have had children from child sexual abuse, so there's biological evidence. [Prosecutors say,] "We're unlikely to secure a prosecution so we won't proceed." In terms of evidence hierarchies, what more could you have than a child who was born before this person was 16 years of age. Confessions and they won't [prosecute] … What I would say largely for survivors of complex trauma, the system is hugely problematic. Even when there's individual workers trying to do the best that they can, if the system is … We have a bit of a broken system. (Trauma counsellor, sexual assault service)

She further commented on the extreme vulnerability of some of her profoundly abused and dissociated adult clients. Since they are not minors, there is no statutory obligation to protect them; they are assumed to be competent to look after themselves. While she was adamant about the need to empower this client group, she was concerned about incredibly vulnerable adults who had experienced a lifetime of victimisation.

> There's some interesting stuff for me around the child protection, adult protection. We've made some, and I guess you have to with a bureaucracy, some arbitrary decisions about, like 18. I would say there's 17-year-olds who are less vulnerable than some of the 25-year-olds who I work with. At times I struggle with the, yes at 18 you're an adult, can vote and drink and all of these sorts of things. I believe in the importance of children being protected, and I don't necessarily want to be making mandatory reports about adults. We see incredibly vulnerable 19-year-olds who are experiencing complex victimisation, and have their whole lives, and are there because they're stuck there. There's little that can be done until we say, "Until you make a decision to do that". Which is great because I believe in the importance of empowerment and people making those decisions for themselves. (Trauma counsellor, sexual assault service)

A psychiatrist gave a concrete example of a client with a history of organised child sexual abuse within a closed religious sect who was still being sexually victimised as an adult. The client had a dissociative disorder and would not resist when threatened by the perpetrators. She also noted that, to an external observer, the client might appear to be consenting to the abuse:

> I entertained the idea [of going to the police] with her and she freaked out. So, I'm left kind of thinking, "Well, I have a duty to this patient … she keeps getting raped, but what am I, what am I going to do?" Oh, she got raped by someone that she's, you know, she's been part of this cult for many, many years. And, and often there's no sign of, not only is there no sign of resistance, but there's compliance. There's "Yes, I will. I will go there. I will do what I'm told." Externally at least, there's a compliant, consenting adult. No, not, she's not consenting at all. But in terms of a third party, like a police officer who doesn't understand DID standing outside this situation they may well see consent. (Psychiatrist, private practice)

Working with this population could be profoundly challenging and distressing for professionals, particularly if the worker is new to this field of work or unable to access adequate supervision. Another psychiatrist noted the difficulties in reality-testing with profoundly traumatised women who, due to dissociation, flashbacks and other trauma symptoms, may at times be confused in their allegations.

> One of the added complexities in working with severely dissociative people is that, and this has happened to me, is that when there's a report of an assault in the present. It's my job to believe my client and I take that quite seriously. Someone's got to be on their side. But I've had another incident, with a young women who had, I think now, DID, but a diagnosis of borderline, certainly complex trauma. She was put in a supportive, supported accommodation, and had a fellow patient in this supported accommodation masturbate in front of her, which she found very triggering. Fair enough? So she was moved to a different house because it was sort of thought they couldn't manage him and her together. And she developed a kind of close relationship with a male support worker, like they were friendly, and then she reported to me that he had done something inappropriate. I don't know what. He touched her, I think,

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was what. And, again, I have to … It's my job to believe that and to take it seriously. And to this day, I have no idea if she imagined that? If she dreamt about that and thought it was real? If he really did do it? You know? And, imagine if he didn't? That's so awful that he was accused of that. Because of someone who's, you know, like let's say it's possible that he's just a nice guy who likes to help people. It's also possible that he's a creepy person who's chosen a job where he has access to vulnerable people. I don't know what happened, but that puts me in a really … just a bit of a philosophical turmoil. I know what my role is as the clinician but I'm really glad I don't work for, you know, the police. (Psychiatrist, private practice)

This sexual assault worker provided a useful distinction between internal safety and external safety when working with severely traumatised and dissociated women.

> It's really hard. We talk about external safety, internal safety. Because both of those are really relevant. Sometimes it really is about working out, "Okay, what's happening in the present? Are you currently physically unsafe? Or is it that you're triggered and you're having re-experiencing symptoms?" It's like this is happening. In which case it's really about grounding and supporting someone to kind of come back into the present. If it's external safety … it's very difficult and there's often times where I have a sense of helplessness because I can't keep her safe. I know that when I say, "You need to call the police. Or, can you call the police?" it comes back, "I can't. I'm scared, or I don't know if I can trust them. Or I don't know if that's going to help." We still do practical safety stuff like, lock some doors and mobile phones and security systems and we write letters to help people move houses sometimes.

> We'll talk about really practical safety stuff. Refer where it's appropriate. Wonder about the possibility of talking to police. What else? For one client when she is … a huge kind of part of her getting better and establishing safety is, her developing the sense that she's okay to be in the world. She deserves a life outside of what happened and really restructuring or replacing somehow this kind of inherent belief that she deserves to be punished. Part of the work we do is around that, but when she's stuck in that she'll return to the abusers to be re-assaulted. Safety is then, "What would it be like if you didn't go back? What

would need to be happening if you didn't go back on the weekend? Or could you go back one day and not both days?" Or when she's come back from the assault, "Can we talk about your abuse, is that okay? What's going on, are you bleeding? How bad is the pain? I wonder if you could, how would it be to go to a doctor?" Safety is a big thing and it doesn't look like the safety I would have in my life. It's so different, my conception of safety, than other people have. (Trauma counsellor)

This counsellor's distinction between "internal" and "external" safety provides a useful framework for understanding the multiple threats to the wellbeing of severely traumatised women, which could include overwhelming "internal" symptoms and distress, as well as "external" threats to her safety, such as perpetrating family members. She describes the process of escaping the cycle of abuse as a slow and iterative one, as the client establishes trust and connections outside the abusive family. However, the significant disconnection between profoundly traumatised women and the police meant that law enforcement assistance was often unavailable. As this counsellor stated earlier, it was hard to know how to talk to other professionals who didn't have direct experience of extreme and ongoing abuse. The multi-perpetrator abuse of traumatised and dissociated women by family members and others is a recurring gendered violence that has been documented around the world, but has yet to be effectively addressed by policy makers (Sachs, 2013; Salter, 2017; Schwartz, 2000).

Promising practices

Workers and women felt that the key to improving legal responses to women experiencing complex trauma was to treat women with dignity and promote hope. In this context, dignity is characterised by acknowledging women's vulnerability and need while emphasising their value and worth (Hicks, 2011). Hope is a felt sense of the possibility of a better future. A dismissive or trivialising response from the authorities was a breach of women's dignity and could affirm negative self-perceptions, but it also negated the feeling that recovery and safety were possible. Dignity and hope need to be inherent in relationships and the way that

women are treated. This was emphasised by a worker from the domestic violence sector:

> Do you know to me though, it's so simple. It's so simple. It's believing them and saying, "I'm sorry that this horrible thing happened to you." Since some bit of belief, some empathy, and something around what do you want to do, like "I'm sorry this horrible thing happened to you and what do you want to do?" And that's it. I reckon almost anyone can say that … Belief and empowerment. Think about trauma model therapies of Judith Herman, those sorts of people, they talk about at the heart of victimisation is disempowerment and disconnection. Reconnecting with people, feeling believed and supported, and people helping you get your power back in whatever way that is possible. (Trauma counsellor)

This study included interviews with former staff of the Royal Commission into Institutional Responses to Child Sexual Abuse in order to learn more about the promising practices used in the Royal Commission. These staff provided compelling examples of investigatory processes that were dignified and hopeful. While the Royal Commission was in touch with thousands of traumatised Australians over the course of the inquiry, the Commissioners were committed to humane, non-objectifying and respectful engagement with traumatised survivors. This commitment is evident in the following excerpts, which describe the arrangements made by the Commission to ensure that the process of testifying clearly signalled survivors' value and dignity.

> We were really aware that many of our practices would be nearing some of the institutional practices in which people were abused, they're really aware of that. We deliver trainings so that staff understood some of the far-reaching impacts of trauma on the client … So for example, a person rings up our phone line and says, "I want to share what's happened to me"—to not call them back for three days, when that would be a really, really big step to make that decision to testify, it would be really, really impactful. So we had a really high expectation that people would be called back within 24 hours.

> We're booking someone a flight to come to Melbourne or we're booking them a train fare to come to Melbourne for a private session and they say, "Oh, I wouldn't be able to come that day because my son is having a baby and I'm on standby", we put that in our case notes, in our system and then we have this incredible logistics team who would then call back three weeks later and say, "Okay, just confirming that your session is on tomorrow. By the way, did your son have their—and you're a grandmother"—things like that, we know are really important in terms of survivors' strength and survivors' means of recovery, like grandchildren are really meaningful to survivors.

> We had maybe three or four people who passed away for various reasons over the period of the commission because quite a few of them were old or unwell, and their families rang us to say that they've passed away, and that we were like a family member, do you know what I mean? … I can remember quite clearly, because their families rang up to say, "I'm just letting you know that Bob passed away a month ago but he would've really liked me to let you know because sharing his story, finally, with the Commission was really important to him and he passed away having done that." And we then send a letter from the judge of condolence. I think one of the commissioners spoke at one of the funerals. (Policy manager)

One of the interviewees described the time and money spent by the Commission in developing a culturally safe approach in consultation with local Aboriginal communities.

> In community engagement and trauma, we were very keen to engage with Aboriginal communities that we see 'cause we knew the high rate of trauma there, and sexual abuse, so how this works, for example: there was a group in Queensland who, a couple of the representatives of the group have come forward and said, "Look, we would like to share our story to Commission but we are a survivors group already of about 50 men, and not all of us have been sexually abused as children. Some of us were physically abused but not sexually abused. Some of them may have been but they're not willing to talk about it but we are the group as one and we would like to come forward as a group of 50 Aboriginal men, and we want to do it in an Indigenous healing context, and we want to do it over a weekend, and we want two commissioners, and this is how we want to do it", which had nothing to do with our model. Our private session process had a legal framework around it, so the idea of having Indigenous healing for the

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framework was really—we didn't know what that meant.

And so we were like, "Okay, let's work it out." We had some incredible Aboriginal staff in my branch. So they came back to that idea, so we said, "Okay, why don't we work up what the proposal looks like and put together a budget, and then I'll take it to the judge." And over a month, we've talked and the judge just said, "We went through it all, okay, let's give it a go." And the amount of barriers that we had to overcome logistically and legally at our end was quite substantial but nothing compared to the trust and the risk that the community were taking to engage with another legal process. Of all the communities, for Aboriginal people to engage with the legal process, that's amazing. And we did it that way, and it was just the most incredible weekend, and we then repeated that model. We offered that as a model for lots of other groups of Aboriginal survivors and we did about four other times around the country. (Manager/supervisor)

In this fascinating excerpt, a service manager describes how the process of testifying to the Commission evolved into a dignified and profoundly moving process for survivors, who were greeted as guests rather than complainants.

This is something you might be interested in and I just have found it so fascinating … What happened, just by accident, was that when the Commission was first set up, and it is just the way things happened, it's all really chaotic and high profile, so you get all the commissioners on board, and in Canberra they have, well in every state government too, they have what they call protocol people. So these are people who organise royal events, and presidential visits, and they're really good at treating people as a guest of government.

So we had a group of those people who were just helping the commissioners get set up in terms of getting them their offices, and getting them support that they needed and then we started with these private sessions and we didn't have enough staff to start running them straightaway, so we just borrowed them. And of course, what happened is they're absolutely skilled at treating people like royalty or like the prime minister of India or the US.

So they then applied that to survivors because that's what

they do and we had all these survivors who just kept, in the first few months, writing to us and saying, "Honestly, I felt like I was treated like the Queen", because that's what they do. And so this idea that people were treated as guests rather than as victims was something that I would never have designed but was one of the best things that happened.

Yeah, because of course, if you could imagine these people were treated as—as children, they were just appallingly treated and often were in an environment where apart from being abused, they were also even neglected and so their physical needs weren't met. They were never ever treated with respect. In that institutional context where they were abused as state wards, or orphans, or Aboriginal children—and now to be greeted, and the door would open, welcomed in a quite a British way, like very—yeah, very formal, quite formal.

And then what happened is we decided then—because some people wanted to mark the occasion and were doing things like taking coasters, or taking a selfie, or whatever with the commissioners. So then again, we borrowed from protocol and we've got really beautiful cards made up that looks a bit like the card that the Governor-General gives for invitations. So it's beautifully embossed and it's on thick cream kind of paper, if you would imagine it, and we did really beautiful thank-you cards that were signed by all the commissioners and everyone who came would get this very beautiful card. They could put it on their fireplace. It was really amazing.

These examples show how responsive, humanising, validating responses that affirm the value of survivors' efforts to protect others from future harm can go a long way toward creating a sense of justice for people with complex trauma. In this study, the Royal Commission emerged as a unique case study in the effective engagement of adults with experiences of complex trauma in a justice framework with an integrated health component, and one that could inform future efforts to promote the wellbeing and civil rights of complex trauma survivors (Salter, 2020).

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Summary

Across service contexts, women who are experiencing or have experienced complex trauma and the professionals who work with them repeatedly emphasised the challenges of interacting with legal and child protection systems that fail to recognise trauma. Failure to recognise trauma, and misunderstanding trauma-related behaviours, can contribute to inappropriate and unhelpful responses to those seeking help. In some cases—as when police filter out cases they deemed unlikely to succeed in court before collecting evidence, child protection workers punish abused women and ignore the abuser, or family courts punish protective parents for disclosing abuse—systems effectively undermine their own intended functions. Study participants indicated that the dehumanisation of people with trauma, such as by labelling them "crazy", can result in dismissive and punitive responses that magnify the effects of trauma and reduce the likelihood of future help-seeking—a common practice for women experiencing extreme distress (Ussher, 2011). The failure to accurately recognise and respond to trauma is especially problematic as police work, criminal and family courts, and child protection are sites where trauma is a core component of day to day work (Kezelman & Stavropolous, 2012).

The tone of relationships between survivors and professionals emerged as a key factor in women's access to and experience of justice. Supportive and respectful relationships with advocates, police and prosecutors facilitated women's access to justice. On the other hand, dismissive or perfunctory interactions could seriously damage women's trust and self-confidence. Women and practitioners reported that bad experiences with systems decreased the likelihood that they would seek help when they needed it in the future. When systems reject people with complex trauma or invalidate their experiences, it doesn't get rid of the problem. Instead, failure to recognise and respond to trauma may generate repeated demands for service from a particular survivor, additional victims of the same perpetrator who is never confronted, and harm to children via invalidation and intergenerational trauma (Krause, Mendelson, & Lynch, 2003; Salter, 2012). Failing to recognise and respond to complex trauma is a missed opportunity to support those affected in managing their trauma symptoms and building resilience (Kezelman &

Stavropolous, 2012; Suzuki, Geffner, & Bucky, 2008). This dynamic may unintentionally escalate the seriousness of future system contacts and impede efforts to reduce harm.

A growing body of literature recognises and seeks to ameliorate the negative effects of exposure to trauma and vicarious trauma in the line of work for police officers, child protection workers, and other first responders (Manzella & Papazoglou, 2012, 2014; Papazoglou, 2013; Papazoglou & Andersen, 2014), including the ways intersectional forms of complex trauma contribute to staff misconduct (Bryant-Davis, Adams, Alejandre, & Gray, 2017). Accordingly, improved training about how to recognise and respond to trauma could not only help clients with complex trauma, it could also benefit workers in legal and justice systems, reducing risks and costs to staff and organisations as well as the broader community (Kezelman, Hossack, Stavropolous, & Burley, 2015). In addition to highlighting key challenges that need to be addressed to improve complex trauma survivors' experiences in legal and justice systems, this chapter points to promising practices.

Cross-sector training to recognise signs of trauma and education about how to de-escalate situations to avoid re-traumatising survivors could improve system responses to people affected by complex trauma (Kezelman & Stavropolous, 2012). Improved recognition of trauma and offering processes to support survivors of trauma can also improve the outcomes of legal and justice processes (Booth, 2019; Dudley, 2015; Hohl & Stanko, 2015). In addition, specialised interdisciplinary teams could assist professionals who regularly come into contact with traumatised people but are not experts in responding to trauma to know how to respond to incidents. Finally, taking the time to develop systems and practices informed by trauma survivors can point to directions for improved responses to their needs. Trauma-informed practice can help survivors to experience increased justice and safety. It can also assist police and courts to cope with the demands created by exposure to trauma. Ultimately, survivor-informed practice can produce benefits that extend beyond those exposed to complex trauma to the broader community.

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This work touches us at such a deep place: Vicarious trauma and working with complex trauma

> We see that there is so much more to you than what you present to us. We must look beyond the surface of what you can't help but show. We know that we need to do better and to continually be better in supporting you and we are not there yet. We owe you that much. You are so much more than the trauma you have experienced.

Statement from a workshop of professionals to women who have experiences of complex trauma

Elsewhere in this research report, we have documented the effects of more complex experiences of exposure to traumatic events, such as the impacts arising from repeated or prolonged traumatic events—especially when the exposure occurs during childhood, and particularly in the context of interpersonally perpetrated violence, abuse or neglect. Increasingly, clinicians and researchers in this field are also recognising a third phenomenon arising from exposure to traumatic information: vicarious trauma. Whenever traumatic events occur, more than one person is detrimentally affected. This ripple effect of traumatisation impacts most severely the people directly exposed, but also detrimentally effects those around them. Family members, friends and helping professionals very often experience negative impacts from their indirect exposure to information about the traumatic events and the impacts of these events on people they care for. The aim of this chapter is to examine the experience of vicarious trauma through the accounts of the workers interviewed as part of this study, and to reflect on the implications of the expansion of TIC for the workforce who are in contact with women with experiences of complex trauma.

People who have complex experiences of trauma often present to services with a multiplicity of needs. Links between traumatic experiences and inflammatory disease in the body are well established (Renna, O'Toole, Spaeth, Lekander, & Mennin, 2018), and explain the high levels of healthcare use among people with complex trauma (Kezelman, Hossack, Stavropoulos, & Burley, 2015). In addition, hallmark trauma impacts such as emotion and nervous system dysregulation commonly impair ability to secure and maintain employment, succeed in study, or sustain other types of social engagement. Subsequently, financial and housing challenges frequently occur. Multiple comorbid mental health issues; risky or harmful coping strategies such as substance use, self-harming and suicidal behaviour; and the need for professional assistance

in relation to justice, redress and healing the traumatisation together mean that workers in many professional roles are exposed to traumatic information in the process of assisting people with complex experiences of trauma. Professional roles that may be vicariously impacted include counsellors; psychologists; social workers; psychiatrists; nurses and other medical staff; legal, mental health, employment and case management practitioners; professionals who support people with accommodation and translation needs; and emergency services personnel such as police, ambulance, and hospital staff. As this section will detail, mainstreaming trauma care and support work necessitates the mainstreaming of supportive responses for professionals to prevent vicarious trauma and enhance the personal and professional benefits of trauma work.

Prevalence and awareness of vicarious trauma impacts

Vicarious trauma impacts have been studied most widely in therapists and social workers (Arvay & Uhlemann, 1996; Brady, Guy, Poelstra, & Brokaw, 1999; Follette, Polusny, & Milbeck, 1994; Ghahramanlou Holloway & Brodbeck, 2000; Jenkins, Mitchell, Baird, Roby Whitfield, & Meyer, 2010; Pearlman & MacIan, 1995; Schauben & Frazier, 1995), but research about vicarious trauma in humanitarian aid workers (Shah, Garland, & Katz, 2007), community mental health case managers (Meldrum, King, & Spooner, 2002), child protection workers (Cornille & Meyers, 1999), emergency service personnel (Figley, 1993), criminal lawyers (Maguire & Byrne, 2017), and animal welfare workers (Figley & Roop, 2006) also exists. The prevalence of vicarious trauma within these trauma workforces has been estimated as ranging from 27 percent (Wee & Meyers, 2002) to 100 percent (Shah et al., 2007).

Participants who were professional workers were asked about their understandings and experiences of vicarious trauma arising from their work, and what they did to manage vicarious trauma. The data suggest that most participants were aware that their work carried a risk of detrimental impacts arising from vicarious trauma. In interviews, workers often referred to the likelihood that professionals working in the complex trauma space would be negatively impacted in some way. A telephone counsellor in a sexual assault service commented:

> You can't do this work well and not be impacted [by] it, and there's no shame in that. In fact, it means that you were probably doing a very good job, that you cared. I know we need to not care too much, otherwise we won't survive, but we need to find, there's a middle ground of caring and going completely cold and hard and no emotion.

This account acknowledges the need to emotionally connect with clients while maintaining professional boundaries, and the potential emotional toll that can come with finding this balance. Workers in health and welfare settings were generally highly conscious of the potential for vicarious trauma in themselves and their colleagues in a variety of ways. In the excerpt below, a trauma counsellor reflects on the ways in which being pervasively exposed to narratives of abuse and violence can "skew" her thinking.

> When I've been away on holidays and I see families that look really happy and [are] just getting along, I'm thinking, "Wow, that's actually what it looks like outside violence." So you forget how—and that's really amazing, you're around [happy] families—they seemed to be [getting along, although] you never know. It's like, "Okay, that's really interesting." So you can get a bit skewed. (Trauma counsellor, women's health service)

Outside of trauma-specialist settings such as sexual assault services, awareness of vicarious trauma could be inconsistent. For instance, Megan discussed how she began her career in child protection, where a high caseload and her own difficult childhood intersected to produce a range of traumatic responses in her workplace.

> I started off in the intensive family support child protection stuff. And that was very, very I guess emotionally draining for obvious reasons and when I look back, probably quite

triggering as well, which I probably didn't recognise at the time but I just saw so many similarities in the lives my clients lived and the life that I have lived, which I thought helped me in my work but it was also very emotionally draining.

Across the workers interviewed in this study, some impact from vicarious trauma was identified as both an inevitable and ubiquitous dimension of working with traumatised clients. Understanding the multiple dimensions and experiences of vicarious trauma can help us to understand how professional workers interact with women who have faced complex trauma, and how they cope with any difficulties they experience through this work. This has implications for the efficacy of support services available for women.

Conceptualising vicarious trauma

While the data from our interviews demonstrate that participants were mostly aware of the risk of vicarious traumatisation from their work, conceptualisations of vicarious trauma were variable. Participants were confused about what constitutes vicarious trauma and how vicarious trauma is different from other stressors encountered in their work and personal lives. Vicarious trauma was at times conflated with post-traumatic stress disorder arising from direct experiences of trauma in participants' personal lives, burnout, the difficulties associated with challenging client behaviours, stress related to meeting clients' needs within an imperfect service system, the difficulties of adhering to agency constraints, and countertransference. Since an accurate understanding of vicarious trauma is key to its effective management, the following section sets out the four key terms used to describe vicarious trauma and its components. Following this, a glossary of related but distinct constructs is provided.

Vicarious trauma-related constructs

Secondary traumatic stress
As previously explained, STS is experienced by a person who has been indirectly exposed to traumatic events, for example,

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Table 4: Disruptions to cognitions as a result of exposure to traumatic information

Schema	Self	Others
Safety	Inability to feel safe	Belief that others are unsafe
Trust	Self-doubt	Inability to trust others
Intimacy	Lacking connection to self	Lacking connection with others
Esteem	Low self-esteem	Idea that others are not well motivated
Control/influence	Belief that one cannot sufficiently influence the world or one's own life outcomes	Belief that others' actions do not influence the world or their life outcomes

through working with a person who was directly exposed to traumatic events. Symptoms of secondary traumatic stress can include intrusions, avoidance of stimuli related to traumatic content, difficulties sleeping and/or concentrating, heightened anxiety and/or anger, hypervigilance and exaggerated startle response. Participants in our study identified numerous secondary traumatic stress impacts from their work. For instance, a mental health nurse described the "panic" and "dread" she experienced working in an inpatient unit with highly traumatised clients:

> I was actually having panic myself, like are you doing the visual obs [observation] and you get that panic yourself because you don't want to open that bathroom door. You've got to open that bathroom door to check they're in there—if they're in there or not, and you sort of have to actually, like, have that dread to open a door and then even open cupboard doors because you know patients will hide in cupboards and you're going to have to open the cupboard and the patient is there. (Mental health nurse, mental health service)

Cognitive changes

Trauma workers' adaptive cognitions about the world, people and their selves may be disrupted by repeated exposure to contrary evidence such as stories of violence and abuse. The truths they confront are that safety is far from guaranteed, that human beings can be deliberately cruel, and that life can be unpredictable and beyond personal control. Such repeated experiences can disrupt healthy cognitions about people and the world. Pearlman and Saakvitne (1995) explain that world view changes and cognitive disruptions occur to important psychological schemas about safety, trust, intimacy, control and esteem. Such disruptions can lead to workers interpreting life events in problematic ways, decreasing workers' abilities to maintain a stable and strong sense of self, and tolerate strong affect. Workers' interpersonal functioning may also be

affected, and their memories of the traumatic material they have confronted may be fragmented (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

As can be seen in Table 4, for example, a disruption in self-safety may render a worker highly anxious about sleeping or walking alone due to thoughts about the possibility of frightening events occurring to them. Disruptions to ideas about others' safety may lead a helper to insist on rigid safety behaviours for children. A disruption in self-trust can produce high levels of self-doubt about one's competence in major life roles including work, partnership and/or parenting. A disruption in connectedness with others could produce behaviours that foster social isolation.
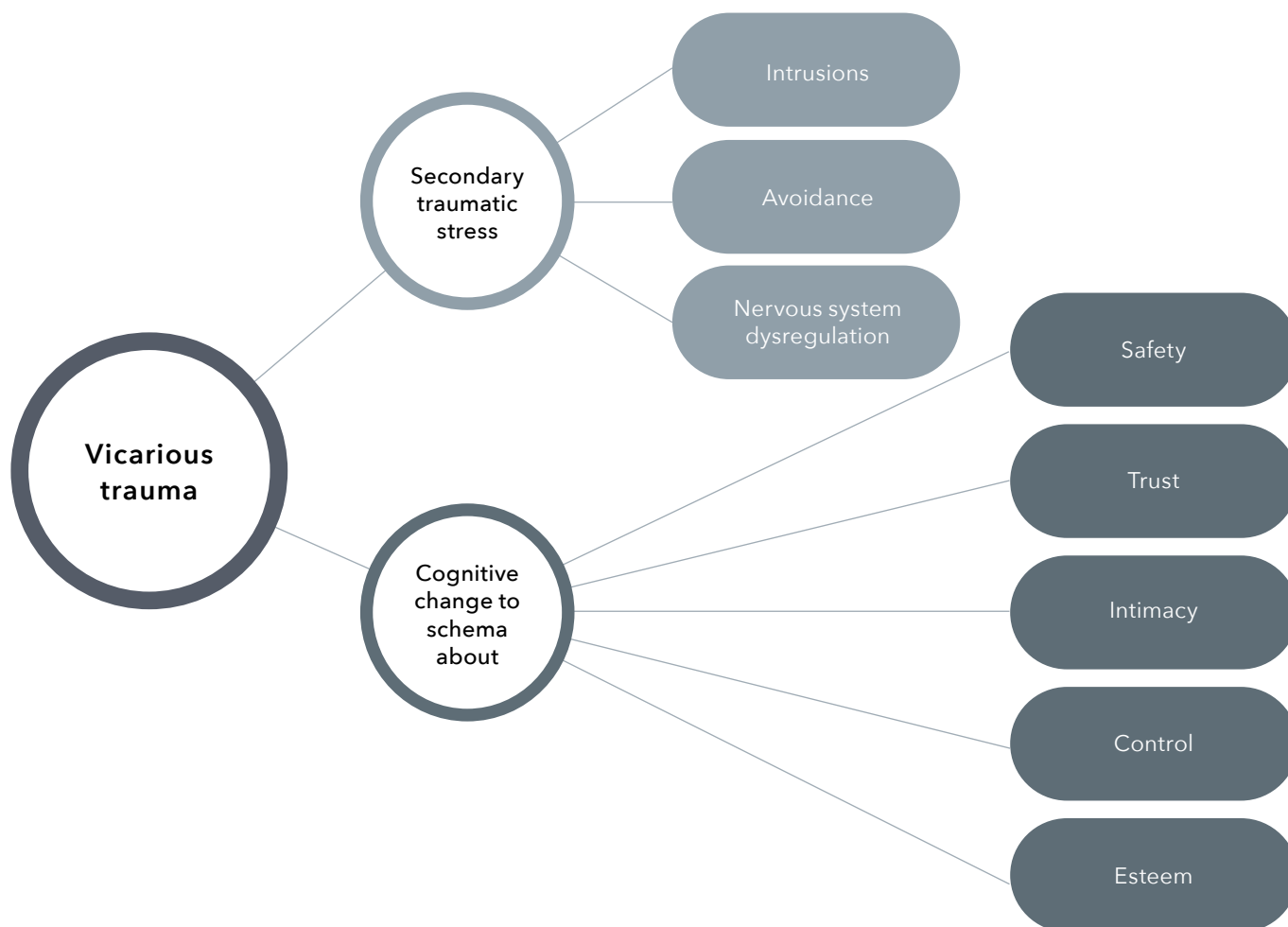
Participants in our study articulated a variety of cognitive changes. In the quote below, a trauma counsellor discussed how her work impacts her "world view", and particularly her view of men:

> We all get certain symptoms … but I don't have parallel symptoms to my clients, so I don't wake up at night with nightmares, I don't have panic attacks, I don't have that but it does impact your world view. I don't dislike men but obviously I have concerns about a lot of men and they're bad … I think in general, I might have different views to someone who hasn't worked in this area. (Trauma counsellor)

Compassion fatigue

The symptoms of CF are no different to the symptoms of secondary traumatic stress, though there is a great deal of variability in authors' comprehension of this throughout the available literature. This dual terminology adds to confusion about the constructs comprising vicarious trauma and so inhibits research growth. More of the participants in our

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Figure 2: Vicarious trauma encompassing Secondary Traumatic Stress and cognitive changes

study named compassion fatigue than secondary traumatic stress so it may be a better known term, although the term secondary traumatic stress refers more precisely to the nature and origin of symptoms arising from responding to the traumatic stress of others. A nurse in a mental health unit described her experience of compassion fatigue in the following terms:

> The other thing I sometimes struggle with is compassion fatigue where you just go, you know, I just can't be bothered. I'll go out and I will be bothered but I just can't be arsed today. Like—and you just get—just your level of compassion [sinks]. I've found when you start to articulate it, it does shift and you sort of—you use your peers as well and just sort of going, "I'm struggling with this", that does help. (Mental health nurse, mental health service)

Vicarious trauma

Vicarious traumatisation was the term first used by McCann and Pearlman (1990) to describe transformations to a person's cognitions as described in terms of cognitive changes above. However, the term is often used to refer to all the effects of vicarious exposure to traumatic material (Branson, 2019). The later definition includes both secondary traumatic stress impacts and cognitive changes, as illustrated in Figure 2.

Related but distinct constructs

Burnout

Burnout describes the cumulative effects of stress arising in relation to one's work. While the antecedents of burnout are many, key factors include work stress, role conflict and individual locus of control (Maslach & Schaufeli, 1993). Burnout has mostly been studied within the human service professions, and while burnout may occur more frequently in those who respond to traumatised populations (Trippany, White Kress, & Allen Wilcoxon, 2004), the risk of burnout is also present for workers who have not been exposed to trauma. Burnout does not describe the effects of working with traumatised people or traumatic content, and it is a construct distinct from vicarious trauma. A sexual assault worker described burnout in the following terms:

> The [trauma] impacts that they [clients] experience mean that they can be really challenging to work with, which then maybe does not motivate people to either work with them and can make it difficult to hold empathy and compassion at times. I think there's a lot of system burnout. I think a lot of the stuff that happens that goes wrong in systems is about people not being properly supported to work with what is quite gut-wrenching stuff. Some really challenging presentations, and then people

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blame the person that you actually came there to help for what it's doing to you.

Countertransference

Countertransference refers to the emotional experience and reaction of a therapist or helping professional while providing services to a client. Helping professionals will experience emotions that relate to their client's story and presentations, and also emotions and subsequent behaviours that stem from their own unresolved conflicts or experiences. The latter is termed countertransference (Dalenberg, 2000). A social worker discussed how workers exposed to trauma can start to take on the feelings of their clients:

> Then as the trauma exposure continues, they start to feel that maybe their loved ones aren't safe or that they can't trust people or that they're no longer worthwhile and the relationships that they have they don't deserve good relationships. It can start to skew and alter people's thinking that necessarily may have been one way and then the trauma exposure happened and they think about the world in a different way. Then we get the "I can't sleep, I have nightmares" "I'm in the client's world", or "They're in my world" or "I'm snapping". All of that sort of stuff that is often mixed in with the "I'm not safe in this world either". That's kind of how it starts to look. It comes and goes and dips and varies.

Direct trauma at work

Another risk to the psychological wellbeing of workers exposed to trauma is the risk of encountering direct trauma at work. Clients who are threatening towards workers and the risk of physical injury arising from violence in the workplace are examples of possible direct trauma at work. A key example in our study came from Kim, a mental health nurse who was held hostage and almost killed by a dangerous client while at work:

> I ran out, but I ran into a ward of people who didn't know what had happened and so then I was covered in metho with a guy following me with a flip lighter trying to light me up, and then had to call an emergency response.

A psychiatrist speaks of finding her client's abuser waiting for her outside her clinic:

> There was an episode, which was quite disturbing for me, and actually I was quite concerned about my safety. Um, he, um, his, uh, the reports are that he's waited outside the clinic here a few times after my session with her.

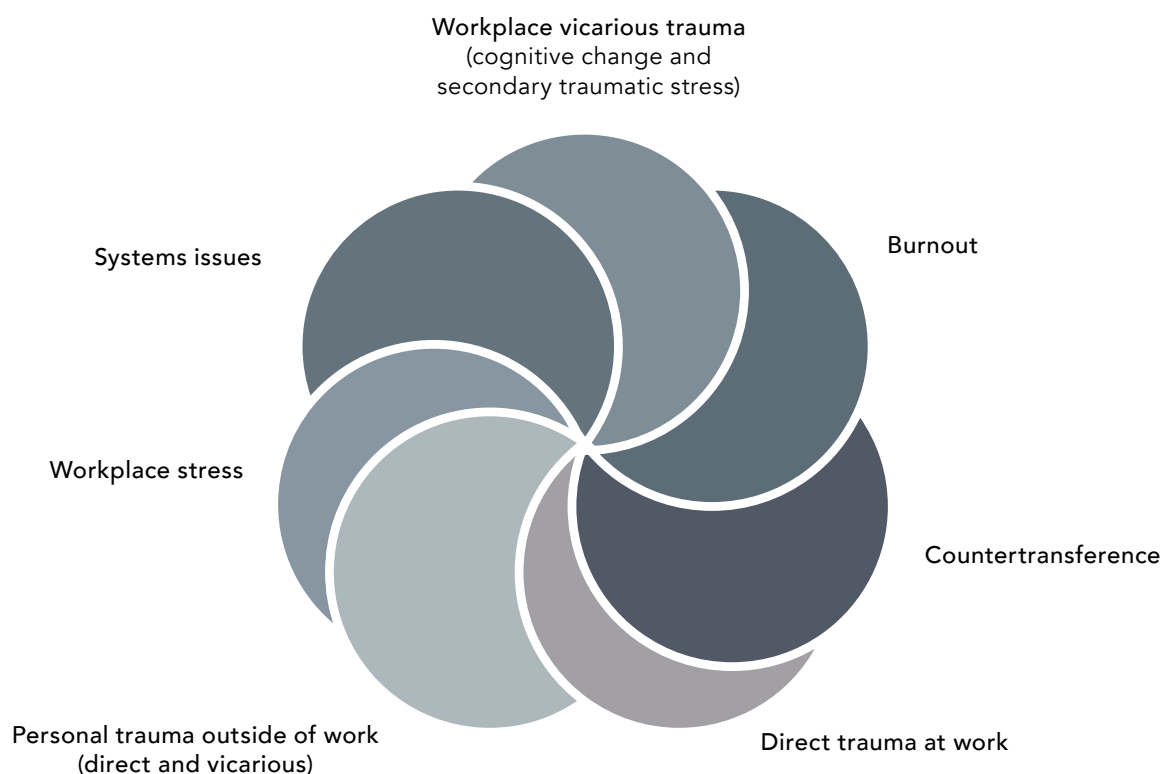### Personal trauma–Direct and vicarious

An estimated 89.7 percent of people will be exposed to one or more traumatic events during their lifetime (Kilpatrick et al., 2014). Most workers exposed to trauma are then bearing the impacts of both direct and indirect experiences of traumatic events. Personal trauma can be both direct and vicarious: for example, a worker who experienced abuse as a child has direct experiences of trauma. If the same person has a loved one who was traumatised by a natural disaster, they may also be vicariously traumatised by observing the impacts of these events on their loved one. These two types of personal trauma may be experienced concurrently with the impacts of vicarious trauma as a product of the person's work. For instance, Chloe had been working in child protection for many years when her own daughter disclosed sexual abuse by Chloe's father. Her daughter's disclosure precipitated Chloe's acknowledgement of her own abuse by her father. Chloe observed:

> I guess from my point of view, my experience of realising that my father done this to my precious child, that in itself is vicarious trauma or whatever you want to call it, and then still managing that. That went on for quite a long period, a couple years, [my daughter was having] really bad mental health issues, anxiety attacks at school.

Workplace stress

Grievances between staff members and the stress of performance appraisal, high workloads and challenging deadlines are all common stressors in the workplace that may be encountered by people working with clients who have experienced a complex history of traumatic events. These stressors are not directly related to trauma content and so do not represent a vicarious trauma risk, though they may certainly produce an additional stress response. A high caseload or a particularly demanding caseload was relatively common among interviewees and contributed significantly to the risk of vicarious trauma. One social worker observed:

> I left [my last role], I was really mentally unwell. It was

Figure 3: Confluence of vicarious trauma with related but distinct constructs

Workplace vicarious trauma
(cognitive change and
secondary traumatic stress)

Systems issues

Burnout

Workplace stress

Countertransference

Personal trauma outside of work
(direct and vicarious)

Direct trauma at work

just too much for me with like workplace bullying on top of the trauma and just so many things happening there. So I went on WorkCover and I got put on my antidepressants. Sleep initiation was a huge issue for me. And then I was abusing alcohol as well, which I don't do anymore, thankfully.

When she was asked about whether her current role presented the same challenges, she pointed to her lower caseload and greater "consideration" by her manager:

> For example, recently, when an incident happened in the workplace, I got a day off after that. So, we get a lot more consideration. [In my last role] the attitude was very much like just "Toughen up, this is what you've chosen to do", and that just adds to it, and the workload is much higher. (Social worker)

Service system issues

In Australia, only a small proportion of sexual violence and abuse offences are reported to police. Those offences that do go to court have high attrition rates, low rates of guilty pleas, and higher acquittal and lower conviction rates than other crimes (Lievore, 2004). The human services system is hampered by limited funding, sometimes rigid exclusion criteria, and siloed services (Burke, 2019), and therefore requires people who have experienced complex traumatisation to present to

multiple different agencies to resolve diverse needs. Helping people victimised by complex trauma within a system that is impaired in its ability to hold to account those responsible can create an emotional burden which commonly includes frustration and hopelessness.

The confusion evident in the data about what is and is not vicarious trauma is unsurprising since a variability of definition is also found in the available literature (Craig & Sprang, 2010). The lived experience for the worker represents a confluence of factors, including but not limited to vicarious trauma, as illustrated in Figure 3.

This confluence of factors will often result in workers being unable to accurately understand their symptoms, identify their origin, or respond to them effectively, thereby compounding detriment to worker wellbeing, impacting collegial relationships, and reducing work quality and productivity (Burke, 2008). Table 5 examines a partial interview transcript with a community lawyer who had transitioned to work with sexually abused clients after a background in working with refugees and migrants. It highlights vicarious trauma impacts co-existing with other related constructs and the worker's attempts to manage these. It is clear to see how the lived experience of vicarious trauma can be both complex and confusing to a worker when inadequate supports are provided in the workplace.

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Table 5: Transcript demonstrating lived experience of vicarious trauma impacts

Transcript of interview	Indicators of vicarious trauma, related constructs and attempts to manage these
"This [job working with sexual abuse survivors] is meant to be a break. I was trying to get out of refugee work and have a rest. I've done a number of refugees for a decade. It was not a break, it's really not—" Interviewer: Is it harder here? "Yeah. I would say it's harder dealing with this … that caught me off guard 'cause I was like, 'Nah, torture and rape, I've done that,' but it's a lot, a lot …" Interviewer: What's the difference? What's harder about this work than refugee and migrants …? "I was talking to another [helping professional] from [the same workplace] with a refugee background, and I was speaking her about this … we're trying to work out why this [working with sexual abuse survivors] is actually more difficult than refugees, 'cause I was burnt out from working with refugees …"	*Co-existent burnout and vicarious trauma*
"Even though I know that when I left [the refugee sector] I had these random issues that you don't realise when you're working with them." "You'd hear a car backfire and you'd think it was a bomb."	*Worker unable to identify vicarious trauma impacts while on the job* *Worker neurocepting danger when a loud noise occurs (indicative of a sensitised nervous system as a result of exposure to trauma)*
"Wait a second, I've never been anywhere where a bomb has gone off, why do I think it's a bomb? And obviously I've had clients that that's all they talk about. But you can still have that division, it's like, 'Well no, that was in Afghanistan, that was in Iraq and it's not down the road.' I'm not gonna have the Taliban come down the road and do this."	*Intrusions about client material* *Attempts to counteract intrusions (which stem from subcortical dysregulation) using cortical rationalisation. A purely cognitive approach such as this is rarely effective at resolving intrusions*
"Whereas, this is people that it's happened to, and it's like a school which is just down the road or just we can literally point out these institutions from my window. It's all very—I guess it's quite personal." Interviewer: How do you guys distance from all of that when it's very directly conducted with the client but they're not—just supposing it's not overseas, it's close to us, how do you get distance from it? "I don't know. So, I'm still trying to work that out."	*Not knowing how to respond to vicarious trauma impacts. Inadequate vicarious trauma management processes or systems in the workplace*
"… So at the end of the day, I try and do something which you can really focus on other things, but I did that with my other work as well. So, I exercise and I do all this other stuff that takes me away from that particular situation, but I'm still trying to work that out. The counsellors that we have, the one that I had, she sa[id], 'Try to ground yourself' but, again, I'm just not a fluffy hippy staff who [will] sit there."	*Lack of clarity about what would be helpful in terms of managing vicarious trauma* *Lack of ability to apply effective vicarious trauma management processes*
"I don't really think like that. So I'm not gonna sit there and go, 'Okay', so it's—yeah. A lot of the time, and this is maybe not the best, there'll always be that one or two clients, but you get numb to it."	*Numbing is an indicator of arousal dysregulation and a symptom of secondary traumatic stress (avoidance)*
"… So, I think, subconsciously, I've been just forgetting. At the end, I'll just go all right, that's done. And I've even noticed that now where I've gone—I know that name but I can't remember anything about the actual case until I pick up my notes and read them, which I haven't done before."	*Indicator of traumatic amnesia*

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Etiology of vicarious trauma

Many studies have sought to explain the etiology of vicarious trauma and hypotheses have ranged from individual variables—for example, age and duration in a work role that involves exposure to trauma (Craig & Sprang, 2010); empathy and emotional separation (Badger, Royse, & Craig, 2008) and self-efficacy (Cieslak et al., 2013); self-care activities (Killian, 2008); social supports (Badger et al., 2008; Ortlepp & Friedman, 2002); and the worker's own history of trauma (Boscarino, Figley, & Adams, 2004; Pearlman & Mac Ian, 1995)—to the supports available within organisations, for example supervision, debriefing, culture and workload (Bell, Kulkarni, & Dalton, 2003). While there has been debate about a number of these factors, two variables have emerged from the literature as having promise in predicting whether a person will experience vicarious trauma: prior direct traumatisation of the worker, and the dose of exposure to traumatic information.

Evidence that workers are more vulnerable to vicarious trauma if they have previously been traumatised is inconclusive. A number of studies suggest that previous history of trauma suggests greater likelihood of vicarious trauma (Boscarino et al., 2004; Gaharamanlou Holloway & Broadbeck, 2000; Pearlmann & Mac Ian, 1995), while others find a lack of correlation (Ortlepp & Friedman, 2002; Schauben & Frazier, 1995). Surprisingly, to date there appear to be no studies that have examined the dimension of recovery from previous experiences of trauma, and whether the degree of recovery is predictive of later vicarious traumatisation. In contrast, there is broad agreement that the dose of exposure to traumatic information is predictive of vicarious traumatisation (see for example Baird & Kracen, 2006; Schauben & Frazier, 1995). People exposed to a greater amount of traumatic content in their work are most likely to experience vicarious trauma and those who are exposed to a lesser amount are less likely to experience vicarious trauma.

Onset of vicarious trauma symptoms can be cumulative or sudden; which aspects of traumatic content will produce vicarious traumatisation is different for different individuals. A child protection worker described how the accumulation of traumatic exposures across her professional life intersected with the emerging trauma of her own abuse, and her daughter's abuse, to create a "perfect storm":

> And I mean I've seen and read so many horrific things over my time in doing that work but for some reason, that just really stuck in my head, and I didn't realise that that was like a catalyst at that time. It was kind of like a perfect storm.

Vicarious trauma as a WHS risk

Since indirect exposure predicts vicarious trauma, all work roles that include trauma exposure should treat vicarious trauma as a workplace health and safety hazard. According to Australian legislation, when a hazard is identified, employers and managers must take action to reduce the risk, and each staff member must proactively engage in managing the hazard. Many of the services that our worker sample were sourced from had some level of policy in place about the risk of vicarious trauma for workers. There were, nevertheless, multiple indicators of unmanaged vicarious trauma symptoms in our sample. Greater sophistication in vicarious trauma management programs within workplaces is needed.

Several participants articulated unhelpful ideas about vicarious trauma and how to manage it, or identified workplace cultures in which recognition of vicarious trauma was significantly impaired. These ideas were underpinned by an attitude of denial, or the notion that to be impacted by vicarious trauma is a sign of weakness. This demonstrates a misunderstanding of the etiology of vicarious trauma and such attitudes (expressed below) increase the likelihood of impacts being hidden, unmanaged and therefore increasing in severity over time:

> Be tough with yourself so you don't allow it to get to you. (Community lawyer)

> … this idea of manliness, about not being impacted. (Sexual assault worker)

> The attitude is very much like "just toughen up". (Child protection worker)

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The impacts of unmanaged vicarious trauma over time can be devastating on workers' lives, as articulated by one participant:

> I have known a couple of people who worked in these types of teams and they didn't come back. They didn't recover … they lost hope and they lost strength and well, that's unacceptable and it shouldn't happen. (Disability support worker)

Management of vicarious trauma

Participants were asked about the methods they used for coping with the impacts of vicarious trauma. They articulated a breadth of knowledge about what can be effective and highlighted the importance of having both personal ways of coping and ways of managing detrimental impacts within the workplace.

Personal ways of coping

Participants articulated seven methods for coping with the impacts of vicarious trauma.

Fostering positive
emotional and nervous system tone

Participants talked about the importance of having individually effective self-regulation strategies. For example, physical exercise, which has powerful stress-reducing effects (Bland, Melton, Bigham, & Welle, 2014), was cited as important. Helping professionals also noted that it was important to get enough sleep and use the self-regulation strategies that they commonly propose to people with complex experiences of trauma. Indeed, self-regulation strategies are critically important not just to worker wellbeing but also to working effectively with clients (Burke, 2019).

Creating opposite
experiences to those encountered at work

Many participants talked about the importance of creating balance in their lives by ensuring that they foster opposite experiences to those encountered at work. Spending one's

working hours facing problems and hearing about cruelty and suffering can be offset by attending to pleasure, fun, relaxation, kindness and beauty within personal time. It may be that this approach could be especially effective at offsetting the impacts of cognitive changes, by including activities that foster an opposing cognition to the one that has been disrupted by trauma material. If a worker experiences worries about their safety as a result of hearing multiple stories about people being unsafe, engaging in activities that promote a sense of powerfulness or security, such as practicing martial arts, or spending time with loved ones in a secure house may provide sufficient evidence of safety to restructure the disrupted cognition. As one psychologist stated: "Keeping connection to what's beautiful about life … [is important] because I spend all day at work hearing about what's not beautiful."

Creative and artistic pursuits

Aligned with the research evidence of the stress-reducing powers of creative and artistic pursuits (Kaimal, Ray, & Muniz, 2016), writing, drawing, sewing and gardening were named as useful strategies for offsetting the detrimental impacts of vicarious trauma by the participants in our study.

Reflection and processing

Many participants mentioned processing and reflecting on traumatic information to ensure that they are mentally integrating their experiences with clients. A number of participants accessed personal therapy to assist with this, and many others stressed the importance of clinical supervision and the use of reflective practice processes.

Boundaries

The importance of boundaries both at work and between work and personal lives was mentioned several times. Participants highlighted the importance of not working while on holidays, using annual leave to take breaks from work and taking breaks during the workday, as well as leaving work at work and refusing to think about work outside of work hours. Additionally, therapists mentioned the importance of not providing therapeutic assistance to friends and family in order to be able to turn off from helping and tune into other aspects

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of life. Workers also mentioned the importance of knowing the limitations of their service or agency when working with clients with multiple and complex needs. Workers' abilities to implement such boundaries are, however, influenced by both individual and situational factors, such as self-efficacy around setting limits with others, availability of appropriate services and resources in the community to meet multiple needs, and the severity of the client's presenting symptoms.

Attending to own needs

Many participants mentioned the importance of self-care and ensuring that they prioritise attending to their own needs after a day of prioritising the needs of others. Awareness was again mentioned as key to understanding what those needs are and how to respond to them. Practices of self-compassion were cited as useful, as was seeking support from others to ensure proper responses to one's own needs, with one psychologist noting the importance of "accepting that you will have lots of attachment needs or nurturing needs if you're doing this work, and it's okay to have those because we all need that".

Knowing that the work makes a difference

Many participants talked about the importance of knowing that their efforts to support and help others made a difference. One of the challenges of working within a system that has siloed services is the lack of feedback loops about client recovery and success. Our sample included legal practitioners whose role was to assist people with complex trauma to lodge applications for redress payments. This work requires time-limited engagement with clients, and the conveyance of sometimes very unwelcome news. Many of the counsellors we interviewed provide services via the telephone as part of a team-based model of service delivery. In these kinds of work environments, workers often provide services to clients for limited time periods during times of crisis. When the crisis abates, the client often ceases accessing the service and therefore information about the abatement of the crisis—and subsequent, more positive functioning—is not available to the worker. Efforts to render visible information about client recovery and success to workers may support workers' vicarious resilience and compassion satisfaction (discussed further in the Salutogenic effects section):

> I've seen little kids arrive … and they'll say, "Remember

you saw me [before]? Remember you gave me this? Look. I still have it, and it helps me every time I go from one place to another. I take it with me." (Trauma counsellor)

> I think that everyone in this organisation … is here because there's something about doing the work that feels fundamentally valu[able] … That's very sustaining. (Telephone counsellor)

> I also see people get better and that's beautiful. It's wonderful. It's what fills you up. (Psychologist)

> I also wonder if … the compassion and the empathy … that these cases can … draw out of the professional … have a therapeutic effect on the professional as well. It seems to be, you know, it's a very sustaining, nurturing emotion and it counterbalances the feelings of powerlessness. (Psychiatrist)

Managing vicarious trauma within the workplace

Most of the literature about how to manage vicarious trauma focuses on what individual workers can do to offset the detrimental effects of their work. Such self-care activities as articulated above can certainly be effective in sustaining workers who undertake the challenging work of assisting people with complex trauma. Recently, however, authors have been increasingly calling for organisational responses to managing vicarious trauma (Australian Centre for the Study of Sexual Assault, 2007; Bell et al., 2003; Burke, 2008; Pearlman & McKay, 2008). Participants in our study identified the following important approaches to managing vicarious trauma within the workplace.

Education about vicarious trauma

Participants discussed the importance of receiving training about vicarious trauma. Knowing what vicarious trauma is and differentiating it from other stressors, as well as developing the ability to recognise the symptoms, are pivotal to workers' ability to interact with vicarious trauma effectively.

Availability of debrief and/or defuse

Many workers talked about the critical role of debriefing

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or defusing in managing the impacts of their work role. Debriefing refers to a process usually administered to groups of people shortly after a traumatic incident, in which participants identify their thoughts and feelings in response to the incident. Though debriefing was used extensively in the 1980s and 1990s following traumatic incidents, the evidence of effectiveness for this intervention is limited and some claim that it can be damaging if administered involuntarily (Foa, 2009). Defusing is a much shorter process than debriefing and not subject to the same critique. Defusing can be a simple 10- to 15-minute process that assists people to identify the impacts of an event on them, and the strategies that may assist them to manage it effectively. Defusing is recommended as an effective strategy for offsetting the impacts of exposure to vicariously traumatising information (Burke, 2008). Several organisations that the author has provided consultation to on this topic have adopted this strategy as a regular daily approach to assist workers to leave work at work and therefore limit unnecessary re-exposure to traumatic information outside of work hours.

Supervision

A variety of methods of supervision were nominated by participants as effective in managing vicarious trauma. Most participants advocated for the availability of an external supervisor to assist them with managing the impacts of vicarious trauma. The need for specialist knowledge about managing vicarious trauma was clearly identified by most participants, with many voicing concerns about the ineffectiveness of more generalist supports in properly understanding and effectively interacting with vicarious trauma:

> We spoke to a psych[ologist], but just going to speak with a psych[ologist] and [saying] "I feel shit because this happened and this has happened", and them just listening, it doesn't really do anything. (Community lawyer)

> I accessed the employee assistance program a few times … I wasn't happy with it … He did the DASS [depression, anxiety and stress scale] questionnaire and he's like, "Oh you're moderate. The people that come through here are severe. You're fine." And then I felt like I shouldn't go back. (Child protection worker)

Participants who were positive about internal supervision noted that their supervisors were specifically trained in managing vicarious trauma and worked in an organisation that had implemented a sophisticated vicarious trauma management model:

> There's two full-time vicarious trauma supervisors, but we also have shift supervisors available 24/7 and then back-up support for that shift supervisor as well. At any point you need an intervention there is someone available for you. (Sexual assault worker)

Self-care

There are today many different techniques, audio and video recordings and even applications available online to assist people seeking to implement self-care activities. Self-care activities are most effective when they are tailored to each individual's needs. Given the variety of vicarious trauma symptoms that workers can experience, identifying the right self-care activity for each individual at certain time points can be a complex process requiring some skill development. Team-wide wellness initiatives are not expected to produce beneficial outcomes in terms of resolving vicarious trauma (Burke 2008), but organisation-provided assistance to identify appropriate, effective and individually tailored self-care activities was widely endorsed. Self-care activities, for example exercise, mindfulness, stress reduction techniques and attending to one's social needs, are by their nature health behaviours. Health behaviours have long been identified as resistant to change (Kelly & Barker, 2016). Efforts to effectively manage vicarious trauma therefore need to utilise the scientific evidence about changing health behaviours and include measures to evaluate and increase uptake of self-care behaviours. Two of the organisations we surveyed offer limited funding to staff members to support their implementation of self-care strategies. This initiative not only assists with the financial difficulties of implementing self-care, but also allows the organisation to require implementation and reports back about deployment of self-care activities, thereby fostering the individual worker's mastery of vicarious trauma over time.

Psychometric monitoring

Only one organisation was, at the time of the research, using psychometric monitoring of vicarious trauma in staff

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members as part of its approach to managing vicarious trauma. Monitoring levels of vicarious trauma in this way can produce robust and reliable insights into individual staff members' type and severity of vicarious trauma, as well as team-wide type and severity of vicarious trauma. Additionally, monitoring over time allows staff members to gain mastery over their own vicarious trauma by rendering visible those management approaches that are effective. There are important ethical considerations associated with measuring vicarious trauma that should be considered. Whether management staff receive identifiable data about their staff is important, as is communicating the organisation's courses of action when individuals' vicarious trauma levels are high.

Limiting trauma cases

A limited number of participants in our study identified limiting trauma cases in workers' caseloads as a strategy for managing vicarious trauma. This approach may well prove effective within organisations responsible for a diversity of issues. Trauma-specific services, however, may not be able to utilise this strategy.

Supportive workplace

The perception of supportive relationships between colleagues as well as supportive leadership from management were both seen by participants as important predictors of the ability to manage the vicarious impacts of trauma-exposed work. Attention to swift resolution of grievances among staff and attention to appropriate leadership style therefore seem warranted for organisations seeking to effectively manage vicarious trauma.

Early intervention

Participants from only one organisation in our sample articulated with clarity what workers were permitted to do while at work to effectively manage vicarious trauma. Activities like taking a short break to walk, contact loved ones, engage in self-soothing activities or simply enjoy a beverage were identified and promoted as acceptable self-care activities whilst at work.

Promote a positive vicarious trauma-management culture

Many of the workers who spoke positively about their workplaces and managers articulated a perception that their wellbeing was cared about at work and that vicarious trauma was recognised as a real and important concern in their professional lives. Participants voiced satisfaction when they perceived a collaboration between themselves and their organisations in managing the vicarious impacts of trauma exposure.

Salutogenic effects of working with trauma

It is important to note that working with traumatic content or traumatised people produces beneficial effects (referred to in the literature as salutogenic effects) as well as detrimental impacts. "Compassion satisfaction" and "vicarious resilience" are terms used to describe this phenomenon. Participants in our sample frequently referred to the beneficial effects of working with complex trauma, describing the benefits of a varied and fascinating work role in which they felt they were able to make a difference and contribute to positive outcomes for their clients. Participants frequently referred to their experiences of learning from the resilience of people who had faced horrific events and yet still demonstrated hopefulness about life and kindness towards others. Participants referred to enjoying and loving their work multiple times:

> I really can't imagine doing anything else. I find this really meaningful and important and you get the opportunity to make a big difference in people's lives … which is really nice. (Community lawyer)

> I really love my job … I'm really proud of what we're doing. (Women's health worker)

Summary

In conclusion, the amount and severity of impacts articulated by participants in our study supports the literature's position that working with complex trauma carries a risk of detrimental impacts. Symptoms of both secondary traumatic stress and cognitive changes were identified, with some participants articulating concerning symptoms that clearly impair their

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wellbeing as well as their ability to provide best possible services to clients. Most of the organisations in our study had some policy in place about vicarious trauma management. Few, however, had well conceptualised, robust and systemic vicarious trauma management programs in place. Such programs are increasingly being implemented for workforces exposed to trauma across Australia and internationally. Evidence from the literature is sufficient to build successful and cost-effective programs to manage this risk and move beyond reliance on individual self-care, which is insufficient to effectively manage the risk of vicarious trauma.

Recent changes to the criteria for post-traumatic stress disorder (American Psychiatric Association, 2013), the increase in worker's compensation claims arising from psychological injury, and a 2019 Australian civil law precedent about employer failure to protect a worker from the hazards of vicarious trauma from work together suggest a growing imperative to respond effectively. Greater documentation and evaluation of organisational approaches to vicarious trauma management is warranted to protect those who put themselves at risk to help others, and foster the best possible responses to people who have been subjected to complex traumatic experiences.

> What drew me to the work? I want to make the world a better place. So idealistic … I just want things to be better for people who are abused. (Disability support worker)

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CHAPTER 9
Conclusion and recommendations

This project has attempted to situate the lived experience of women with experiences of complex trauma and the professionals who support them within their broader systemic and political context. Women with experiences of complex trauma are a diverse group who share a common set of needs and experiences, not the least of which is their struggle to find recognition and support in mainstream services. This point of commonality was particularly apparent in the two feedback workshops that we conducted with the women. The women who joined the online workshops to discuss our research findings and help refine our policy and practice recommendations came from different backgrounds and were at different points in their lives. Some lived in cities whereas others were geographically remote; some were employed in white collar jobs, others were students, and others were not in paid employment; some had been in crisis recently whereas others were in periods of relative stability. Nonetheless, a sense of shared understanding emerged from the workshops as the women discussed what it felt like to enter into environments where they had been labelled "crazy", "attention-seeking" or otherwise unredeemable. Their feedback resonated strongly with the content of interviews with women who articulated their wish to be supported in their search for safety, wellbeing and self-determination, and to be treated with dignity and respect, particularly in times of crisis and vulnerability.

The workers who volunteered to be interviewed in this project were all strong advocates of trauma-informed care. Their interviews corroborated the descriptions provided by women of punitive and pathologising service systems. We convened seven online workshops of workers, and what emerged from these discussions was a distinct sense of loyalty and commitment to clients who present with experiences of complex trauma. Professionals shared with us the challenges they faced trying to support women with experiences of complex trauma to navigate their way through, and beyond, dense webs of service requirements and agency demands. The project has benefited considerably from their sophisticated understanding and critique of the service systems they are embedded within, as well as their descriptions of the impacts of vicarious trauma and burnout. It was in one of the online workshops that a professional first raised with us the concept of "vicarious resilience" (Hernandez, Gansei, & Engstrom, 2007), which describes the effect on workers of witnessing

their clients' resilience and strength. Hearing about this concept for the first time was like a light switching on. It gave us a term for the meaning and significance of complex trauma work for the many professionals we had interviewed, and it helped us to understand better the rewards that we experience as researchers of complex trauma.

The qualitative focus of the study illuminated the complexity not only of trauma but of service systems that have developed organically over time, intersecting and interacting with each other in often unplanned and chaotic ways. Our policy analysis presents a relatively simple explanation for the convoluted nature of women's trajectories into and between different services and agencies: there is a lack of high-level policy thinking and planning in relation to complex trauma. The voices of women and workers starkly illustrated the sedimentation of professional practices and bureaucratic processes over time. They also shone a spotlight on areas of excellent practice. These included community health and women's health centres, the refugee sector, Aboriginal and Torres Strait Islander services, community legal centres and sexual assault services. The "best practice" findings presented in our report are drawn from existing expertise and knowledge in a variety of settings.

Workers' reflections on their own professional lives suggest that the creation of supportive environments for women who are experiencing or have experienced complex trauma is therefore coterminous with creating safe and supportive environments for the professionals who work with them. Ideally, women presenting with distress and histories of complex trauma should be entering into systems with structures and practices of care that are extended to workers and clients. The opposing and all-too-common tendency to characterise the "ideal client" as compliant and having few needs brings with it a general intolerance of human vulnerability and complexity that rebounds on everyone within the service or system. Investing in humanising health, welfare, criminal justice and other systems will have multiple benefits (Benjamin, Haliburn, & King, 2019; Kezelman & Stavropoulos, 2016).

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Further research

The project has laid the foundation for future work in a range of areas. The ways in which different communities, such as Aboriginal and Torres Strait Islander communities, recently arrived communities or regional/remote communities, conceptualise and respond to trauma may offer insights into their specific needs as well as innovative community-based models of care. Sectors that have better developed understanding of and responses to complex trauma could inform policies and practices in other sectors where complex trauma is less well understood and recognised. The area of trauma-informed policing and prosecution is comparatively new compared to more established trauma-informed frameworks and would benefit from qualitative research with police and prosecutors working with complex trauma clients. In particular, research on the perspectives and experiences of police in contact with women with experiences of complex trauma would provide important evidence for the further development of effective law enforcement engagement strategies with this group. Research with other health stakeholder groups, such as general practitioners, could shed light on the ways in which women with experiences of complex trauma are entering mainstream health systems, and potential improvements in their access to Medicare-funded psychological care and the NDIS. Some professionals interviewed in this study showed clear signs of vicarious trauma despite being, in some cases, in highly trauma-informed workplaces, which emphasises the need for more detailed research into vicarious trauma as well as research into "vicarious resilience" and the benefit that workers accumulate through their exposure to the resilience and strength of their clients exposed to complex traumatic events.

The relationships between physical and mental health and psychosocial wellbeing in complex trauma has emerged in the study as critically important. Women who were receiving somatic therapies and support for chronic pain and fatigue were far more hopeful than women who were not. There is currently little evidence for these therapies and future research on the efficacy of these approaches, particularly in relation to different sub-groups of women, is urgently required. In both the qualitative interviews and workshop discussions with service providers, participants commented that the lack of empirical evidence meant agencies were unable to source funding to make these therapies available to women.

Dissociation was a clear marker of trauma complexity in this study but it is largely overlooked in the public mental health system. There is a clear need for further research into the development of effective and holistic treatment and service models for this group of women. Such research would also need to consider the training needs of health professionals to improve understanding of dissociative presentations in women and reduce the stigma and discrimination experienced by these women in the healthcare system. Furthermore, in this study, women with a dissociative diagnosis were likely to describe forms of abuse and violence that extended beyond commonly understood notions of domestic violence and sexual assault. They recounted experiences such as prolonged incest, where a woman continues to be sexually abused by her parent/s in adulthood, and sexual exploitation in childhood and adulthood. Workers in this study were deeply challenged by the difficulties facing this client group. Further research into these disturbing and extreme patterns of gender-based violence is necessary.

The impact of complex trauma on parenting and child protection assessments is also an important area of future inquiry. A history of complex trauma does not, in and of itself, undermine parenting skills or result in intergenerational trauma transmission. However, women with experiences of complex trauma may experience significant parenting challenges if they have high and unmet levels of need, if they are unsupported in their parenting and/or if they continue to be subjected to violence and abuse. This study suggests that the ways in which services and agencies engage with mothers with complex trauma histories can support women's parenting in a range of ways, but may also cause further harm and traumatisation. Workers expressed concern that theories of trauma and attachment were being applied in child protection settings to justify child removal rather than relational repair between mother and child. Future research could explore how childhood trauma is being conceptualised and acted upon in child protection services, and forms of

child protection practice that enhance attachment between children and caregivers.

Finally, there is a need for further research into the effective and skilful self-care strategies described by women who have experienced complex trauma and the development resources based on this knowledge. Such resources could be made publicly available for women with experiences of complex trauma—particularly for women who, for a range of reasons (geographical and financial constraints, or desire for anonymity), are unable to access specialist support.

Limitations of the study

There are a number of limitations to the study that should be kept in mind while reading the results. Firstly, the policy review was limited to publicly available information that could be ascertained via website searches. Health, welfare and legal systems are very complex and there may be initiatives, pilot programs or policy approaches that have yet to be registered on public-facing websites under the rubric of a "trauma-informed" approach. Secondly, the qualitative interviews with women who have experienced complex trauma and professionals were reliant on participants self-selecting for interview. The sample of women in the study were all English speaking and predominantly (although not exclusively) heterosexual, cisgendered Anglo-Australians in contact with health services. Although we had interpreter services available, all women who volunteered for the study spoke English. The accounts of women gathered in this study are likely to have overlaps with but also significant differences to women with other backgrounds and from other contexts. Third, and relatedly, the study does not explore in depth the experiences of Aboriginal and Torres Strait Islander women and workers. Our research team are of European descent and only two interviewees identified as Indigenous or coming from an Indigenous family. In interviews, some non-Indigenous workers discussed their professional experiences partnering with Aboriginal and Torres Strait Islander workers, working in Aboriginal and Torres Strait Islander communities or supporting Aboriginal and Torres Strait Islander clients. The report draws on their reflections as necessary, however we recommend that readers refer to past and ongoing research by Aboriginal and Torres Strait Islander academics, practitioners and agencies on Indigenous-led projects, some of which is referred to throughout the report. Fourth, the professionals who participated in our study were interested and passionate about trauma-informed practice, and their perspectives are likely to differ considerably from those professionals who lack trauma literacy. Fifth, interviewees in our study raised multiple concerns and issues that the project has sought to articulate and bring to the awareness of policymakers and practitioners, however the study had neither the time nor the resources to fully explore the implications of the multiple challenges bought to our attention. Stakeholders such as general practitioners and police were not engaged in this study although they were identified by workers and women as important to a comprehensive response to complex trauma.

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APPENDIX A

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Interview schedule— Professional stakeholders

1. Please tell me about yourself—your current position, how long you've been doing this work, your qualifications.

2. What is your area of specialty? What drew you to this work?

3. How does trauma impact your clients?

4. How do you define trauma? How do you define complex trauma? What do you see as the difference between the two?

5. What are the particular needs of people with complex trauma? What do you do to meet those needs?

6. What are some of the challenges or difficulties that you encounter working with people with complex trauma?

7. How do other agencies or professionals treat people with complex trauma, in your opinion? What do you think is working, and where do you see ongoing challenges?

8. What advice would you give to another professional who is encountering a client with complex trauma for the first time?

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Recruitment text for women with experiences of complex trauma

Call for research participants: Complex trauma and women's wellbeing and safety from violence

Are you a woman with experiences of complex trauma?

You are invited to participate in a study to understand what complex trauma is and how different services support (or not) women experiencing complex trauma. The objective of the research is to make recommendations for women's wellbeing and safety from violence.

The research is being conducted by Dr Michael Salter, Dr Elizabeth Conroy, and Professor Jane Ussher of Western Sydney University, with Associate Professor Molly Dragiewicz of Queensland University of Technology, psychologist Jackie Bourke, and Professor Warwick Middleton of the Trauma & Dissociation Unit, Belmont Hospital.

Who is eligible to participate?

Women with complex trauma living in NSW or QLD.

What would participation involve?

Women will be asked to participate in a research interview about their understandings of complex trauma, experiences of help-seeking, and views on how service responses can be improved. Women may also wish to be involved in a workshop where the findings of the study will be discussed including how professional responses could be improved to better meet the needs of women with complex trauma. You will not be asked to discuss experiences of abuse, either in the interview or the workshop.

If you are interested in participating, or would like further information on this project, please contact the Project Officer [name] on [name] @westernsydney.edu.au or phone xxx. Please also feel free to share this information with others you know who may be interested.

This study has been approved by the Human Research Ethics Committee at Western Sydney University. The ethics reference number is: H12501

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Interview guide—
Women with experiences of complex trauma

1. How did you hear about this project? What made you decide to participate?

2. Everybody experiences stress in their lives, can you tell me what you think is the difference between everyday stress and trauma?

3. What about the term "complex trauma". Have you heard this term before and do you think this captures what you have just described?

   a. Prompt for: What does "complex trauma" mean to you? Do you think it's a helpful term? Why/why not?

4. Have you tried to seek help from services or professionals for the trauma/highly stressful events that you have experienced? Have you spoken to someone about the effect these events had on you?

   a. Prompt for: Why/why not? What was that like for you?

5. Have you connected with other women who have had similar experiences of trauma/highly stressful events?

   a. Prompt for: Why/why not? What was that like for you?

6. Are there any other strategies or ways of dealing with trauma/highly stressful experiences that you or other women might have used? Can you talk about some of those?

   a. Prompt for: Helpful/unhelpful; where in the recovery process

7. Are there any types of help or support that you wished were available?

   a. Prompt for: Importance/how they would be helpful and when (at what stage in the recovery process)

   [If not already discussed, prompt for aspects of trauma: what about the timing of when it happens in women's lives (developmental timing), how often it happens (repetition & chronicity), how does the relationship of the perpetrator affect these experiences (power), displacement/social isolation/marginalisation, organised/systematic/social level of perpetration; system responses, validation from others]

8. What has been something that you have learned through your experiences that you would share with another woman in a similar situation?

9. What has it been like for you to participate in this interview? Do you have advice for women with similar experiences who might be thinking about participating in research like this?

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Qualitative data coding matrix

The coding framework is presented with five higher order codes and their associated sub-codes.

1. Understandings of trauma:
Definitions and constructions of trauma and complex trauma provided by practitioners and women.

- Medical: The framing of trauma as a medical or neurobiological phenomena.

- Psychological: The psychological impact of trauma, references to attachment theory, psychiatric diagnoses such as BPD, PTSD.

- Trauma vs complex trauma: Distinctions between trauma and complex trauma.

- Other: Notions of trauma that fall outside other subcodes.

2. Survivor responses to trauma:
Women's responses/experiences of trauma, symptoms, manifestations.

- Psychological impacts: including flashbacks, difficulty sleeping and concentrating, depression, anxiety, suicidality, self-harm, drug use.

- Physical impacts: including somatic symptoms, body pain, muscle tension.

- Social/relational impacts: including isolation, effects on relationships and family, lack of trust in relationships, lack of safety, disruption of education and employment.

- Women's coping strategies: techniques and methods that women used to self-soothe, manage, overcome, move on, help others.

3. Vicarious Trauma:
Effect of trauma material on practitioners' ability to do their work, their feelings and symptoms of secondary traumatic exposure, personal and workplace responses.

- How vicarious trauma is experienced: Psychological and physical reactions, burn out.

- Ways of coping with vicarious trauma:

- Personal coping strategies: How workers managed and coped with VT.

- Workplace support strategies: Effective VT management in the workplace.

4. What's not working:
Identified shortfalls and problems in service and system responses.

- **Poor medical/hospital response**: Emergency room and inpatient admission experiences, inappropriate medication, poor hospital care or lack of access to medical care.

- **Poor psychological response**: Inappropriate therapy, psychological practices that aren't useful for survivors, poor treatment within mental health settings.

- **Wider system response problems:** Problems with referrals, no linkages between services accessed by the same problem, contradictory demands between services, no practical assistance to manage multiple service requirements.

5. What's working/needed.
Examples or suggestions of effective/promising practices and approaches.

- Cultural or CALD issues: Discussion of effective or necessary practices and approaches for CALD women.

- Geographical issues: Obstacles and opportunities for women in regional and remote locations, issues relating to geographical access.

- Good medical support: Good experiences of interactions with medical personnel.

- Practical support: Assistance with practical issues including transport, parenting, housing.

- Specific psychological approaches: Mental health practices identified as effective, safe, appropriate, helpful.

- Trauma-informed principles: Principles for building trauma-informed services and systems.

APPENDIX F

Example of a coding summary—Survivor responses to trauma: Physical (women)

Self-harm
- Self-harming: Lauren, Vicky, Madeline
- Self-harm when dissociated: Lena
- Suicide attempts: Lena, Amber, Louise, Julie, Lauren, Sophie, Josephine
- Picking at skin: Madeline
- Tearing out hair in sleep as a three-year-old: Madeline

Nerve pain
- Nerve endings affected: Carol
- "Nerve pain and shooting nerve pain": Madeline

Trembling
- Trembling when needing to perform a difficult task: "I get the shakes. I shake all over and I can't rest until I do it." (Carol)
- Body shaking when talking about trauma: "I used to talk about stuff that was inside me with body memories my body would start to shake. And I didn't realise it was the trauma trapped in my body wanting to get out." (Simone)

Trouble getting out of bed
- Didn't get out of bed after remembering trauma: "I was just getting sicker and sicker and sicker so I had to give up everything." (Charlotte)

Developmental delays
- Worked in child protection and noticed children who had experienced trauma had developmental delays. Don't develop skills like using utensils and pencils: "Because of trauma, the body's response to development is impacted." (Eleni)
- Difficulty talking: "And because of the threats of my early life, I always had problems talking. I'd rarely ever talk." (Louise)

Somatoform dissociation
- Symptoms manifest physically more than mentally: "We have something called somatoform dissociation, so our body really feels everything more than us sometimes, but we have a whole range of symptoms our body does instead of having so much mental stuff." (Laura)
- Seizures/pseudoseizures: Laura, Sophie, Louise, Amber, Madeline. "So just going back to that time in hospital, what then appeared to be like absence seizures became tonic-clonic full-on seizures with a lot of body movement." (Sophie)
- Loss of abilities e.g. walking, talking, using hands: Laura, Louise
- Pins and needles, numbing, neurological symptoms: Laura, Madeline
- Not feeling pain: Laura, Lena. "And I think with our mother, we would not even feel things. She would hit us and we wouldn't feel it." (Laura)
- Involuntary movement: Louise
- Unexplained body pains: Louise, Carol. "Well, the trauma part—it's very profound at the moment because this pain I've had has just been excruciating and there's no physical reason for it." (Carol) "My body feels physical pain—physical intense pain. I'm not talking about, 'Ouch, It hurts.' I'm talking about like screaming, like gut-wrenching, like 'I cannot deal with this pain anymore.'" (Louise)
- Loss of consciousness: "And then the physical things like blacking out and well, I think I died, saw stuff. As a little kid, that's pretty mind-blowing." (Nicole)

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Body memories

- Experiencing body memories: Simone, Louise
- Body memories and pain worse with menopause: Louise
- Re-enacting traumatic experiences: "'A lot of the times when

I've seen you do that,' he goes, 'I've always watched the way you do it, the way your legs would move, and it looks like you're trying to pull away from a rope.'" (Louise)

Embodied shame

- Feeling that shame is "in the body": "I think our shame stays in our body and it just eats our body away or our body has to act on it, like our body has to have a symptom so it can bring out the issue." (Laura)

Vaginismus

- Vaginismus as a "protective response": Madeline

Loss of menstruation

- Lost periods for five years after a severe sexual assault: Madeline

Adrenal exhaustion

- Fatigue: "I've had a lot of pain throughout my life and a lot of fatigue, like what my occupational therapist describes as chronic fatigue, so that like adrenal exhaustion." (Madeline)

Vomiting/diarrhoea

- Vomiting and diarrhoea due to trauma triggers or needing to talk about trauma: Michelle, Madeline. "Like I spent, making sure my daughters each morning got to school, vomiting into a towel on my hands and knees for many years because

of the continuing trauma of going to the letterbox and finding that I'd be summoned to Melbourne again to face [perpetrator] for some other thing." (Michelle)

Not wanting to be touched

- Not liking physical contact (even if well- meaning like workmates patting her on back): Steph

Muscle tension

- Physical pain caused by muscle tension: "Even just being someone who's been through trauma, you just go through so much pain physically because you get so much muscle tension." (Jill)

Processing trauma

- Trauma leaving the body: "And it wasn't until 2012 that things were—we experienced as things were just coming out of our body. All this stuff was just oozing out. The animals walk out

of your body—a bit weird, but that's how we felt around the stuff coming out of us." (Laura)

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