

Acknowledging complexity in the impacts of sexual victimisation trauma

Liz Wall & Antonia Quadara

Traumatic events are those that overwhelm the “ordinary human adaptations to life” (Herman, 1992a, p. 33). However, one particular type of trauma is increasingly being recognised as a driver of many complex social and mental health problems in those affected by it. The repeated trauma caused by ongoing sexual abuse that is prolonged, occurs in the developmental stages of a person’s life, and is often perpetrated by an authority figure is now being more readily perceived as a causal feature of multiple social and mental health issues and the consequent need for human services. Although not officially recognised in diagnostic classification, the term “complex trauma” or “complex post-traumatic stress disorder” describes a broad-ranging set of disorders, symptoms and social problems that are not captured by a limited diagnostic category of post-traumatic stress disorder (PTSD). People suffering complex trauma need treatments that are multifaceted and varied to accommodate their particular range of symptoms. Isolated treatment of particular symptoms may only impact on one aspect of their needs and will not resolve the underlying issues that have created the problem.

KEY MESSAGES

- The mental health impacts of sexual victimisation are frequently acknowledged but there are specific and additional impacts where victims have suffered a particular type of abuse that is: interpersonal, commences at an age where emotional development is affected, is ongoing, chronic or features multiple types of abuse.
- Many researchers and practitioners in the fields of psychiatry, psychology and social work do not see the mental health diagnosis of post-traumatic stress disorder (PTSD) as sufficient to capture these specific effects of multiple types of abuse and chronic victimisation. There have been calls for an additional category called “complex PTSD” or “complex trauma”.
- The impacts of complex trauma symptomatology on victim/survivors can be a driver of need for many human services, including mental health, medical and substance abuse services as well as social services like housing and relationship services.



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The Australian Centre for the Study of Sexual Assault is funded by the Australian Government Department of Social Services through the Women's Safety Agenda. The Centre is hosted by the Australian Institute of Family Studies.

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Acknowledgements

The authors thank Dr Pam O'Connor, Clinical Psychologist and Associate Professor at the University of Canberra; Jackie Burke, Clinical Director of the Rape and Domestic Violence Services Australia (Formerly NSW Rape Crisis Centre); and Daryl Higgins, Deputy Director – Research at AIFS, for their valuable input.

ACSSA Issues are peer-review publications.

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ISBN 978-1-922038-42-5

ISSN 1833-7856 (print)

ISSN 1833-7864 (online)

Edited by Lauren Di Salvia
Printed by Mystique

... KEY MESSAGES

- Acknowledging an underlying basis of trauma could enhance service delivery to the victim/survivor that may have multiple needs across services.
- It is important to acknowledge the link between ongoing sexual victimisation and complex trauma in order to facilitate a cultural shift towards the connectedness of services and a person-centred approach to service use.

The adverse impacts of sexual victimisation have been extensively documented, and significant amongst these is the negative impact on the mental health of victim/survivors (Boyd, 2011). Some psychological and behavioural responses to sexual victimisation have been recognised as coping strategies for victim/survivors to deal with traumatic events. The dominant framework through which the mental health responses to trauma are understood and organised has been through a diagnosis of post-traumatic stress disorder (PTSD). However, the diagnostic category of PTSD was developed in response to the symptoms seen in survivors of one-off, or relatively contained events, such as a natural disaster. Many researchers in the fields of psychiatry, traumatology, and social work do not see PTSD as adequately capturing the effects of chronic and/or multiple types of victimisation (Briere & Spinazzola, 2005; Herman, 1992; Higgins & McCabe, 2000). Sometimes the reach of effects can extend beyond mental health and surface as somatic complaints or substance abuse issues. In such instances, it may not be immediately apparent that there is a link to sexual victimisation trauma.

It is a particular type of victimisation that gives rise to complex trauma, usually prolonged or multiple types of interpersonal abuse. It often commences at an early age, thereby affecting emotional development and often the perpetrator is an authoritative figure in the victim's life. The variety of impacts arising from sustained or chronic trauma has resulted in the development of the concept of complex trauma to reflect the varying symptomatology, co-occurring disorders and multiple adverse experiences that combine to impact on victim/survivors of multiple or ongoing and interpersonal traumas such as childhood sexual abuse. The impacts of ongoing trauma can be seen in the links between many social issues and the traumatic experiences of victim/survivors. For example, it is estimated that up to 80% of women seeking treatment for substance abuse disorders have histories of sexual or physical abuse or both (Cohen & Hien, 2006). A history of abuse trauma is also a feature in the lives of many homeless people (Morrison, 2009). The complexity of different needs that people with traumatic abuse backgrounds often have can encompass assistance with social care, such as finding employment or housing, to dealing with a range of psychiatric disorders. The levels and types of service needs involved mean that traumatised people are frequently the highest users of costly care in the health system (Jennings, 2004) and government services. However, these problems are still often treated separately as if they are distinct issues, instead of a complex suite of human responses to trauma.

What has become apparent to services that deal with clients suffering multiple disorders and a complex array of trauma symptoms is that treatment needs are multifaceted and varied. Isolated treatment of trauma symptoms may only impact on one aspect of their needs. An approach to intervention that looks at encompassing the whole cluster of symptoms is more likely to facilitate sustainable improvement (Cohen & Hien, 2006).

This Issues paper aims to provide an overview of complex trauma as a concept for classifying a varying range of symptomatology that is also a pervasive driver of need for many users of human services. The literature reviewed shows that the particular trauma associated with ongoing interpersonal violence, such as sexual violence, has complex impacts and effects that will vary on a case-by-case basis. The term “complex trauma” is used in this paper, not as a diagnostic term but in order to refer to a particular range of symptoms and connected social issues that manifest in many victim/survivors who have experienced early onset, chronic sexual victimisation. Other terms are often used in relation to victim/survivors or service users who experience the significant and particular symptomatology that is being discussed to here. Other terms, such as “complex post-traumatic stress disorder” have developed from the fields of psychology and psychiatry to encompass the complex and varying set of symptoms and social problems, such as substance abuse and vulnerability to re-victimisation, often seen in individuals that have suffered prolonged and repeated trauma experiences often beginning in childhood (Connor & Higgins, 2008a). This Issues paper provides an overview of complex trauma as a response to chronic sexual victimisation and considers what this means for services and service configurations. It will also look at the implications of acknowledging complex trauma for policy responses in health and human service fields.

The complexity of trauma—clarifying terminology

The term “complex trauma” is now frequently used in mental health and service provision circles to encompass the range of symptoms that are not covered by PTSD, but are experienced by trauma survivors, particularly where that trauma has an ongoing element.

Complex trauma has been described as cumulative, underlying trauma (Kezelman & Stavropoulos, 2012). People with complex trauma symptoms have usually suffered from exposure to chronic, interpersonal trauma that has caused them to respond with a range of psychological impacts, including problems with regulation of moods and impulses, self perception, attention, and memory and somatic disorders (Briere & Jordan, 2004; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Burstow (2003) argued that trauma is a spectrum or continuum with people at different points, but noted that this is not straightforward as people can be traumatised more in some respects and less in others. The term “trauma” in this publication, is used to refer to a particular type of trauma that is linked to a history of repeated, interpersonal victimisation that has impacted adversely on a person’s mental and potentially physical and social health across their lifespan.

The particular features of the trauma exposure that are linked to these symptoms are that the trauma is sustained, or features multiple episodes and is interpersonal in nature, with a link between cumulative trauma and symptom complexity being observed (Cloitre et al., 2009). In addition, interpersonal trauma experienced at an early age appears to have a developmental impact on the individual (Briere & Jordan, 2009; Herman, 1992; Kezelman & Stavropoulos, 2012)

Currently, the psychological disturbances outlined above are not necessarily captured by the PTSD framework, but may be captured by a diagnosis of “associated features” or by other diagnoses such as substance-use disorders, borderline personality disorder, dissociative identity disorder, or antisocial personality disorder. This can be problematic where sufferers do not meet the criteria for the symptoms of the core features of PTSD but display many associated features. Increasingly, an empirical and clinical research base is developing which uses “complex trauma” or “complex post-traumatic stress disorder” as a construct that more coherently captures the impacts of repeated or multiple forms of victimisation on mental health, cognition, interpersonal relationships, and self-capacity (Briere & Spinazzola, 2005; Courtois, 2004; Goodwin, 2005; Herman, 1992; Kezelman & Stavropoulos, 2012; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Van der Kolk et al., 2005). To this effect, the terms “complex trauma” and “complex post-traumatic stress disorder” are used interchangeably within this paper to describe the symptoms and impacts of the particular type of interpersonal trauma that is increasingly associated with chronic and repeated abuse and victimisation. The term “trauma” where it is used here refers to that particular kind of trauma that is linked to the symptomatology that is the basis of discussion in this paper.

The use of the term “complex trauma” arguably offers a more comprehensive and robust understanding of the relationship between trauma, mental health problems and social problems than using “co-morbidity”, or “dual diagnosis” alongside PTSD. Complex trauma can offer an overarching framework to inform interventions across different domains of need such as trauma support, mental health treatments, and substance use treatment.

However it should be kept in mind, as noted by Briere and Jordan (2004), that the effects of violence on victims can be so varied and/or specific to individual circumstances that any limited diagnosis of a disorder or syndrome is unlikely to capture the overall symptoms of each particular victim of violence. The implication of variation and complexity is that interventions need to be flexible, and customised to the specific experiences of that victim/survivor (Briere & Jordan, 2004).

Post-traumatic stress or complex trauma?

Traumatic events overwhelm the “ordinary human adaptations to life [and] generally involve threats to life or bodily integrity, or a close personal encounter with violence and death” (Herman, 1992a, p. 33). The subsequent reactions to such experiences of terror, helplessness, and vulnerability may involve hyperarousal and hypervigilance, intrusion or flashbacks, and, as antidote to these states, numbing.

It is well established that sexual victimisation occasions traumatic stress responses (for a summary of the impacts see Boyd, 2011). Over 30 years ago, the effects of sexual assault on victims was termed “Rape Trauma Syndrome”. This was characterised by an acute or disruptive phase that could last from days to weeks and featured general stress reactions followed by a second phase of a process of re-organisation lasting months to years (Burgess & Holmstrom, 1974). Briere and Spinazzola (2005) argued that reactions to psychological stressors as being a complexity continuum with single incident traumatic events experienced by adults at one end, while responses to early onset, multiple or extended events, frequently interpersonal and involving shame or stigma at the other (Briere & Spinazzola, 2005). Post-traumatic stress disorder as a clinical diagnosis arose in the 1980s from a need to classify the adverse reactions being experienced by Vietnam War Veterans who had been in combat situations. Researchers at the time began to understand many similarities between the symptoms of those suffering from combat related trauma to many of the interpersonal traumas faced by victim/survivors of sexual abuse and physical abuse (Courtois, 2004).

Despite similarities in reactions across acute, sustained and long-term trauma responses (e.g., hyperarousal, avoidance, memory impairments), the clinical and empirical literature finds distinctions in the overall nature of trauma impacts arising from early, chronic victimisation.

Herman (2000) argued that PTSD is ultimately about the “memory imprint” of an event, about the ways in which the terrifying memory intrudes unsolicited into consciousness, resulting in hypervigilant, finely tuned startle responses to unrelated stimuli, and is ameliorated by techniques of avoidance. Treating PTSD focuses on the impacts of the past event and processing them so that the memory imprint is better integrated into the person’s sense of self. Those working in the sexual assault field note that this is indeed possible for many survivors of a sexual assault, providing that there is also a sense of being able to impact one’s own destiny (i.e., internal locus of control, high levels of sociability, skill at communicating with others, and a social environment in which the self can be rebuilt safely).

Researchers have argued that PTSD defines only a limited aspect of post-traumatic psychopathology, and does not reflect the range of symptoms that abuse survivors experience, such as unmodulated aggression, poor impulse control, and dissociative problems, or subsequent problems later in life such as substance abuse, personality disorders, affective disorders, and somatoform disorders (Van der Kolk et al., 2005). Van der Kolk and colleagues concluded that:

Despite the ubiquitous occurrence of numerous posttraumatic problems other than PTSD, the relationship between PTSD and the multiple other symptoms associated with early and prolonged trauma has received surprisingly little attention. In the PTSD literature, psychiatric problems that do not fall within its framework are generally referred to as “comorbid conditions”. (p. 390)

The evidence about the symptomatology of complex PTSD indicates a great deal about the following:

- ▣ the relationship between victimisation, mental health and drug use;
- ▣ the ways in which the dimensions of complex trauma may affect the capacity of victims/survivors to engage with services; and
- ▣ the best therapeutic approaches for this population.

There is debate, however, about complex PTSD or complex trauma as a separate diagnosis. The literature typically uses “complex trauma” and “complex post-traumatic stress disorder” to describe trauma responses to chronic or multiple victimisation. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA], 2013), as an international classification system for mental health, does not currently recognise “complex trauma” or “complex PTSD”. This is despite significant consideration by the mental health, traumatology, and psychiatric sectors and field trials undertaken to empirically test its symptomatology. There is concern about how this exclusion will affect interventions with people with this type of symptomatology as the tangled interactions of biological, psychological and social factors may not be responded to collectively, thereby providing only individual responses to symptomatology as it occurs.

In revising the DSM-5 from the previous edition to its most recently released version (2013), the diagnosis of PTSD has had some changes though these do not seem to provide much assistance in clarifying the difference between PTSD and the features of complex PTSD. There is an acknowledgment of the developmental impact of trauma, with specific criteria for children under 6 years. Other changes include a more explicit description of “traumatic” events as well as a revision of criteria for a diagnosis of PTSD, moving some symptoms from what were previously “associated features and disorders” to form part of the overall PTSD diagnosis. Within a slightly different configuration of symptom clusters, some new symptoms have been included under PTSD, such as reckless or destructive behaviour and distorted cognitions around blame of self or others. However, there is still no distinction of the particular symptomatology differentiating complex PTSD, and the link between that and the ongoing type of interpersonal trauma such as the nature of much sexual abuse. The DSM-5 does note that the disorder (i.e., PTSD) “may be especially severe or long-lasting when the stressor is interpersonal and intentional (e.g., torture, sexual violence)” (APA, 2013, p. 275).

What may be the most helpful approach is to acknowledge that the trauma of violence against women and children is pervasive and manifests in many complex modalities. Briere and Jordan (2004), in a review of types of violence against women as they relate to psychological assessment, noted that the complexity of post-victimisation responses arises from the corresponding complexity of many acts of interpersonal violence, for example, the relationship with the perpetrator, the context, whether there was exposure to multiple forms of abuse over a long time period. All can affect the victim’s trauma responses. By acknowledging this complexity, policy and services may be able to direct intervention strategies to best target service users needs.

Co-occurring disorders or complex trauma?

Given the absence of an over-arching construct for trauma-related behaviours, individuals are often diagnosed with a range of other disorders such as major depressive disorder; anxiety; psychosis; borderline personality disorder; substance abuse disorder; schizophrenia;

conduct disorders; or oppositional defiant disorder—and behaviour such as self-harm, suicidal ideation, and substance dependency or misuse as symptoms of these.

This complexity has significant impacts on treatment approaches, and about what the most important element to address is and at what point—the sexual abuse trauma, the mental health problem, or the substance use? Indeed, it is often the secondary (e.g., substance abuse) or tertiary (e.g., drug-induced mental illness) expressions of trauma that result in treatment and/or support. Screening for histories of abuse has not traditionally occurred within the mental health services (Huntington, Moses, & Veysey, 2005). Often, the underlying trauma history is treated as a separate mental health need, is rarely integrated into treatment, and/or the complexity of symptoms results in multiple and changing diagnoses (Savage, Quiros, Dodd, & Bonavota, 2007).

The manifestation of complex trauma

Complex trauma differs from the “memory imprint” of PTSD in two aspects—the circumstances of the trauma event/s and the effects this has on core aspects of a person’s sense of self (e.g., cognitions, mental health, emotional stability, and personality).

In relation to the first aspect, part of this is about the length, frequency, and severity of abuse. It is also about the contexts in which such abuse occurs. Child sexual abuse is fundamentally located within familial, care, and social networks, particularly for girls.¹ Boys are more likely to be abused outside the home and appear to be at greater risk in institutional settings or an extra-familial environment (Crome, 2006). Boys are also more likely to be abused by a same-sex perpetrator, to experience violence, and more likely to be abused by multiple perpetrators (Cashmore & Shackel, 2013). Within the relevant contexts, perpetrator tactics involve secrecy, complicity and threat. In other words, they are contexts of “captivity”, in which perpetrators attempt to create accommodating or “willing victims” (Herman, 1992, pp. 74–113). These two elements together (the nature of the abuse and the context in which it occurs), actively impact on the construction of the self—emotionally, cognitively, and relationally. Repeated trauma in adulthood “erodes the structure of the personality already formed” whereas repeated trauma in childhood “forms and deforms personality” due to the many adaptations developed by survivors to cope with sexual abuse by a guardian figure (Herman, 1992, p. 96). There is an emphasis in the literature on the impact that early onset repeated sexual abuse by a caregiver or guardian has on the development of attachment systems (Liotti, 2004; Van der Kolk et al., 1996).

Expanding research continues to connect developmental dysfunctions and childhood abuse that can result in poor mental health and emotional functioning. There is interest in the link between stress responses in children and atypical development of neuroendocrine and immunological functions. These developmental issues have a relationship to the psychological and behavioural problems associated with childhood abuse. The connection appears to tie structural developmental differences, that can result in an increased risk of psychopathology, to the type of stresses experienced in abusive situations (Cashmore & Shackel, 2013).

¹ Nationally representative figures show that fathers, stepfathers and other male relatives made up half (51.6%) of perpetrators for girls, compared to one fifth (21.4%) of perpetrators against boys. Boys were more likely than girls to be sexually abused by individuals known to them other than family, such as family friends, acquaintances or neighbours (e.g., doctors, coaches, and clergy) (Australian Bureau of Statistics [ABS], 2006).

The trauma literature also identifies issues of attachment and child development as being a key factor in the development of complex trauma symptomatology, whereby early onset trauma has a particular impact on the developing brain, especially when the trauma is prolonged, repetitive and unrepaired (Kezelman & Stavropoulos, 2012). Where early caregiving 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 (Cook et al., 2005).

Forming primary attachments to caregivers who are “either dangerous, or from [the victim's] point of view, negligent, [developing] a sense of basic trust and safety with caretakers who are untrustworthy and unsafe” and maintaining a sense of control in situations of unpredictability (Herman, 1992a, pp. 101–102), requires a range of adaptations and survival strategies that can manifest in a variety of ways such as denial, dissociation, fragmented/disordered attachment or self blame (Briere & Spinazzola, 2005; Herman, 1992a; Luxenberg, Spinazzola, & Van der Kolk, 2001; Van der Hart, Nijenhuis, & Steele, 2005; Van der Kolk et al., 1996; Van der Kolk et al., 2005).

Although these are often adaptive reactions at the time of experiencing abuse, in the longer term they may become maladaptive alterations in functioning. Based on clinical and empirical research, six “symptom clusters” are involved in a complex trauma response:

- ▣ *altered self-capacities*: dysfunctions in the areas of affect regulation (i.e., regulating emotional states and reactions), distress tolerance, and behaviours and impulses (e.g., self-destructive behaviour, self-harming, excessive risk-taking, sexual involvement and suicidal ideation);
- ▣ *alterations in attention or consciousness*: changes in memory function (e.g., amnesia) and the tendency for dissociation;
- ▣ *alterations in self-perception*: perceptions about one's self as a stigmatised, ineffective or damaged self, internalisations of shame, guilt and responsibility, and minimising impacts;
- ▣ *alterations in relating to others*: changes to the capacity to trust others, maintain personal safety and agency (e.g., re-victimisation experiences or dominating relationships), or victimising others;
- ▣ *somatisation*: experience of persistent physical illness and difficulties relating to the digestive system, chronic pain, heart and lungs, and urogenital systems (e.g., headaches, irritable bowel syndrome, high blood pressure etc.); and
- ▣ *alterations in systems of meaning*: changes to personal systems of meaning in relation to the world, one's purpose or self-efficacy within it, and the motivations of others (Briere & Spinazzola, 2005; Herman, 1992b; Luxenberg et al., 2001).

Reactions and behaviours such as dissociation, impulsivity, and substance use disorder are described as, or within, separate and distinct diagnostic categories in the DSM-5.

An array of social and cultural factors are linked to the development and experience of complex trauma. The interaction of particular social problems such as homelessness and the mental health impacts of complex trauma, mean that help-seeking for multiple treatment needs or access to multiple services is potentially overwhelming in its difficulty.

Table 1: Complex trauma response, expressions and relevant social factors

Symptom categories	Components	Expressions	Social & cultural factors
Alterations in self-regulation and impulses	<ul style="list-style-type: none"> ■ Affect regulation ■ Self-destructive ■ Suicidal pre-occupation ■ Difficulty modulating sexual involvement ■ Excessive risk -taking 	<ul style="list-style-type: none"> ■ High levels of self-harm ■ Substance abuse & addiction ■ Overwhelmed by anger ■ Casual & unprotected sex ■ Suicide plan ■ Eating disorders 	<ul style="list-style-type: none"> ■ Collective and intergenerational history of trauma ■ Low collective efficacy & community capacity
Alterations in attention or consciousness	<ul style="list-style-type: none"> ■ Amnesia ■ Transient dissociative episodes ■ Depersonalisation 	<ul style="list-style-type: none"> ■ Clouded perception ■ Feeling/being dazed ■ Automation/being on "autopilot" ■ Difficulty remembering appointments, discussions, events 	<ul style="list-style-type: none"> ■ Social marginalisation ■ Social isolation ■ Poverty and homelessness ■ Victim-blaming attitudes
Alterations in self-perception	<ul style="list-style-type: none"> ■ Personal ineffectiveness ■ Changes in personal identity ■ Disturbances in identity formation 	<ul style="list-style-type: none"> ■ Feelings of hopelessness & helplessness ■ "Malignant" sense of self (contaminated; guilty; bad; self hatred, shame) 	<ul style="list-style-type: none"> ■ Negative social reaction to disclosure ■ Perpetrator tactics to silence, threaten victims ■ Perpetrators not held to account
Alterations in relations with others	<ul style="list-style-type: none"> ■ Inability to trust ■ Re-victimisation ■ Victimising others ■ Perceives perpetrator as all powerful 	<ul style="list-style-type: none"> ■ Difficulty seeing danger signs/ unsafe situations ■ Confused boundary setting ■ Conflictual relationships ■ Desire for a "rescuer" 	<ul style="list-style-type: none"> ■ Being a client in multiple, poorly integrated systems ■ "Trauma blind" services & responses
Somatisation	<ul style="list-style-type: none"> ■ Digestive system ■ Chronic pain ■ Cardiopulmonary symptoms ■ Conversion symptoms ■ Sexual symptoms 	<ul style="list-style-type: none"> ■ "Acid" stomach ■ Irritable Bowel Syndrome ■ Pelvic pain ■ Headaches ■ Unexplained symptoms (e.g., numbing, tingling) 	<ul style="list-style-type: none"> ■ Rape-supportive attitudes in the community ■ Structural inequality between men and women ■ Racism
Alterations in systems of meaning	<ul style="list-style-type: none"> ■ Fatalism ■ World/people as malevolent ■ Loss of hope ■ Loss of belief 	<ul style="list-style-type: none"> ■ Lack of self-efficacy ■ Despondency, despair ■ Anger ■ Apathy 	

Source: Adapted from Herman (1992a,b), Luxenberg et al. (2001), and Haskell & Randall (2009).

The pathway to complex trauma—revictimisation, and poly-victimisation

The relationship between complex trauma and sexual victimisation requires consideration of the extent and type of traumatic experiences that are linked to the presence of complex

trauma. Throughout the literature are descriptions of severe victimisation histories that indicate the cumulative and devastating impact of repeated abuse and multiple forms of abuse.

The particular experience of sexual victimisation that is highlighted by the research as linked to complex trauma is extensive re-victimisation over the lifespan and poly-victimisation (co-occurrence of different forms of abuse). Multi-type or poly-victimisation includes multiple types of abuse, including sexual abuse, physical abuse, neglect or psychological abuse, and emotional abuse. Poly-victimisation has been shown to link to greater impairment than single forms of child maltreatment (Higgins & McCabe, 2000). Revictimisation later in the lifespan is likely to compound the effects of prior abuse experiences (Briere & Jordan, 2004; Fortier et al., 2009). Severe and repeated victimisation experiences are strongly related to a range of mental health outcomes that often take the form of depression, addictive and self-harming behaviour, substance abuse, and dissociative and personality disorders. Moreover, these adverse outcomes are rarely singular—co-occurring disorders are extremely prevalent among traumatised populations.

Attempts to classify a type of abuse such as sexual or physical as associated with particular consequences for the victim seems to be less useful than looking at the frequency and severity of child abuse (Higgins, 2004). In an extensive review of the literature on sexual revictimisation, Classen, Palesh, and Aggarwal (2005) found a link between the severity of previous sexual victimisation and individuals who are then revictimised. This review also found a correlation between being sexually victimised in adolescence and adult revictimisation and that for women, being abused in adolescence had a stronger correlation to adult revictimisation than the correlation between child sexual abuse alone as a revictimisation risk factor. There was also evidence that the victim/survivor's relationship to the perpetrator can impact on the likelihood of sexual revictimisation, with intrafamilial abuse being the highest risk for adult victimisation (Classen et al., 2005).

It is clear that experiencing childhood abuse creates an increased risk of revictimisation. In the Australian Component of the International Violence Against Women Survey, Mouzou and Makkai (2004) found that the risk of sexual violence is almost double for women who were sexually abused in childhood (54%) compared to other women (26%). The results also indicated women who suffered childhood abuse, regardless of type, experienced higher levels of violence compared to women not suffering childhood abuse. This finding accords with the 1996 Women's Safety Australia Survey (Australian Bureau of Statistics [ABS], 1996), that a history of victimisation strongly predicts future victimisation regardless of other potentially protective factors such as education and income.

Although not inevitable, there is a strong link between sexual and other types of violence occurring in the developmental phase of an individual (childhood), and their later experiences of victimisation. There are many negative effects for those who suffer repeated sexual victimisation, including evidence of links to mental and physical health problems, and high-risk behaviours (Noll & Grych, 2011). Sexual revictimisation is also associated with greater distress and more psychiatric problems including difficulties with interpersonal function and addiction (Classen et al., 2005).

Although there is consistency in the research indicating the phenomenon of revictimisation, there is still a lack of understanding about the exact causes and mechanisms underlying the relationship (Ullman, Najdowski, & Filipas, 2009). It is not clear why abuse victims are more vulnerable to further victimisations. One perspective suggests that revictimisation becomes an issue of the broader social context in which psychological and interpersonal

functioning increases vulnerability to perpetrators, for example, by self-soothing with alcohol or other substances or engaging in compulsive sexual behaviour (Messman-Moore, Brown, & Koelsch, 2005). This view reflects an ecological approach² to understanding sexual victimisation. In accordance with this, Grauerholz (2000) noted that the victimisation can be multifaceted, can occur over time, may include childhood and adult instances of abuse, and may co-exist with other factors in the social environment that the person is situated. It is important to understand the interacting factors in order to see the complete picture of revictimisation over the lifespan. Grauerholz (2000) hypothesised that individual experiences (e.g., the initial victimisation) combine with factors in the microsystem (such as a victim's decreased ability to be assertive) and the macrosystem (such as perpetuation of victim blaming culture) to create an environment ripe for revictimisation of the individual. Using an ecological conceptualisation of lifespan victimisation, the process of the individual being shaped into a victim by the perpetrator as well as social and personal factors is more comprehensively understood.

The increasing focus on trauma in the revictimisation literature indicates that the collection of coping mechanisms that can be viewed as part of the complex PTSD concept is an important consideration for sexual assault, mental health, and drug and alcohol services to utilise when aiming for prevention of revictimisation.

How sexual victimisation trauma impacts on victim/survivors

Mental health

Child sexual abuse victimisation is strongly associated with a range of issues around health and wellbeing well into adulthood (Cashmore & Shackel, 2013). Adults with child sexual abuse histories have been found to have a higher risk of mental health problems such as depression, anxiety, substance abuse and self-harm when compared to community populations (Cutajar et al., 2010; Henderson & Bateman, 2010; Horvarth, 2010; Mullen & Fleming, 1998).

The coping mechanisms that victim/survivors develop to deal with the impacts of abuse—namely traumatic sexualisation, betrayal, stigmatisation, and powerlessness—can have an effect on the rest of their lives (Herman, 1992). For instance “avoidant coping”, or more simply learning to cope with the abuse by avoiding dealing with it, has been associated with trauma symptoms (Fortier et al., 2009). Survivors of child and adult sexual abuse use a range of strategies to cope with these impacts, for example, psychological escape, socially withdrawing, and reframing. In the short term and depending on context, these can be effective ways of minimising distress. However, the available research shows that in the longer term, such strategies can become ingrained avoidant coping strategies. Examples such as substance use, emotional numbing, and self-harm, can have negative outcomes for mental health (Walsh et al. 2010) and interpersonal relationships (Davis & Petretic-Jackson, 2000). One obvious example is where greater levels of depression and mental health issues can lead to women who have experienced sexual abuse to have more difficulties with parenting.³

2 For a more detailed explanation of the ecological model see ACSSA Wrap 11, *What is Effective Primary Prevention in Sexual Assault?* (Quadara & Wall, 2012)

3 For a more complete discussion on parenting with a history of sexual abuse see ACSSA Research Summary, *Mothers With a History of Childhood Sexual Abuse: Key Issues for Child Protection Practice and Policy* (Tarczon, 2012).

Complex trauma and substance abuse

It is very clear from research that many people with substance use disorders have experienced interpersonal violence, including sexual and physical violence (Cohen & Hien, 2006). It has been suggested that the abuse of drugs and alcohol may have an anaesthetic effect on negative feelings or to induce a more pleasurable bodily sensations or emotions to alleviate a sense of emotional numbness or to reduce stress and tension (Briere & Spinazzola, 2005). In the fields of substance abuse, users with additional mental health and other problems are associated with poorer prognosis in substance abuse treatment (Covington, Burke, Keaton, & Norcott, 2008). Past victimisation may intersect with mental health issues and is often exacerbated by drug and alcohol abuse (Battle, Zlotnick, Najavits, Cutierrez, & Winsor, 2003; Sarteschi & Vaughn, 2010). Substance users with abuse histories (including child sexual abuse) reported higher rates of suicidal ideation and attempted suicide compared to users without such histories (Rossow & Lauritzen, 2002). This was particularly the case for those who had experienced multiple adverse experiences in childhood.

Making the connection between a history of trauma and the range of problems related to that history has implications for substance abuse support services who may have to acknowledge the traumatic origins at the basis of the substance abuse problem (Cohen & Hien, 2006). Services may not always feel equipped to deal with the complexity of issues related to a history of trauma.

High-risk behaviours

As well as being at risk of experiencing difficult and often violent interpersonal relationships (Davis & Petretic-Jackson, 2000), women with a history of child sexual abuse are more likely to engage in casual and unprotected sex while reporting less satisfactory sexual rewards and greater sexual costs (Lemieux & Byers, 2008). In examining self-dysfunction (i.e., dysfunctional behaviour such as substance abuse and indiscriminate sexual behaviours) as an aspect of sexual revictimisation, a study by Messman-Moore et al. (2005) noted a link between risky sexual behaviour and sexual revictimisation, suggesting tension reducing and maladaptive sexual behaviour may function as a strategy to cope with post-traumatic symptoms related to previous victimisation experiences.

Complex trauma and incarcerated women

Complex trauma appears to have a disproportionate profile in the incarcerated female population, where sexual victimisations histories are more common than not and correspondingly high rates of poor mental health and substance abuse characterise these women's lives. Complex trauma in the form of childhood sexual and physical abuse plays a role in the offending pathways of women—with mental disorders, anger problems, substance abuse, housing instability and other social disadvantage contributing to women's offending (Stathopoulos, 2012).

Complex trauma and Indigenous women

It has been acknowledged that Indigenous women and children are the most victimised groups in Australian society and often suffer repeated and ongoing trauma within their families and communities (Lievore, 2003). Violence, including sexual violence, is prevalent in the lives of those in many Indigenous communities (Atkinson, 2002).

There is a limited body of scholarship that suggests complex trauma as a useful construct for describing the impacts of sexual abuse on Indigenous women and within Indigenous communities (Haskell & Randall, 2009; Söchting, Corrado, Cohen, Ley, & Brasfield, 2007). The historical factors that play out for Indigenous women and children exacerbate the concept of trauma in an Aboriginal context. The influence of many factors, such as the historical impacts of colonisation on Aboriginal people, poverty, racism and substance abuse in Indigenous communities are part of a multifaceted historical picture of disadvantage and oppression (Keel, 2004). Intergenerational and transgenerational trauma are also a feature of the Indigenous experience. This refers to trauma passed down through the generations. Intergenerational trauma carries down to children from traumatised parents. Sometimes this can include the secondary trauma of witnessing a parent being traumatised, possibly by family violence or racism. When trauma is transmitted across a number of generations, this is known as transgenerational trauma (Atkinson, 2002). The younger generations can experience this type of transmitted trauma as entrenched to the point that it becomes a cultural norm. The consequences of transgeneration trauma must also consider the disruption that has occurred over time to the relationships between family, community and between the genders. Atkinson (2002) described this as a fracturing of the responsibility to nurture and protect children, that has been undone over time as the learning of younger generations comes from experiencing violence within institutions, families and as social support networks of traditional Aboriginal life were gradually disrupted and dismantled.

Complex trauma provides a framework through which drug and alcohol addiction, high-risk behaviours, and violence can be viewed as responses to accumulated and entrenched trauma, rather than see them as pathologies and health problems.

The insidiousness of complex trauma as the underlying service need for Indigenous women can be even more difficult to pin down as the silence around sexual assault can be magnified by issues such as lack of culturally specific services and responses, concerns about gossip and shame in small communities, and a risk of ostracism from family and community (Taylor & Putt, 2007).

The literature on culturally competent trauma interventions stresses the need for awareness about values and paradigms of knowledge/belief, particularly in relation to:

- ▣ the reliance on the individual as the locus of action and meaning;
- ▣ the reliance on scientific knowledge compared to spiritual knowledge and meaning;
- ▣ conceptions authority and respect; and
- ▣ the political, historical and institutional sources of trauma that interact and compound the particular trauma of sexual abuse.

Complex trauma and homelessness

Australian and overseas research indicates that trauma, including sexual abuse, is prevalent among homeless populations (Morrison, 2009; Buhrich, Hodder, & Teesson, 2000). Australian researchers also found that homeless adults in Sydney reported exceptionally high rates of multiple trauma and high rates of psychopathology including psychosis, substance abuse and depression. In a study by Taylor and Sharpe (2008), 98% of participants ($n = 70$) had experienced a traumatic event, commonly physical or sexual abuse, with 93% experiencing more than one event. A trauma history and PTSD often precede homelessness and are characteristics of a high proportion of homeless people (Foster, LeFauve, Kresky-Wolff, & Rickards, 2010). Taylor and Sharpe's (2008) findings are similar to other homelessness

research, indicating that complex trauma plays a role in facilitating homelessness as well as being a traumatising experience in itself. Housing services deal frequently with traumatised people, often with serious mental health problems and comorbidity of other disorders such as substance abuse that can impede their ability to maintain housing and could be an ongoing issue (Taylor & Sharpe, 2008; Foster et al., 2010). Sexual victimisation trauma appears to be a risk factor for homelessness and a result of homelessness, with very high rates of sexual violence victimisation seen in women, men and young people who are homeless (Morrison, 2009).

Acknowledging complex trauma in service delivery

In view of the many hurdles and additional social problems that some people with complex trauma face, some of which are outlined above, a protracted issue is the difficulty involved in negotiating a variety of life issues at once within a fragmented service system. The term “complex needs” refers to the span of need for an array of services that some service users require over a lifetime. Often, people with complex trauma have complex needs. Service delivery that acknowledges trauma as the basis of this need can respond accordingly and overcome some of these difficulties (Huntington et al., 2005). As discussed earlier, homelessness, poverty and substance abuse feature strongly for many people with trauma histories. These needs can change over time and at different phases of the lifespan. For example, accessing housing or employment might be difficult for someone who is also dealing with substance abuse issues or parenting concerns. A focus on individual problems or symptoms, rather than targeting the basis of need as a whole, means that service users can find themselves on a sequence of service use with no clear direction for moving forward. Unless trauma is treated as the underlying driver for service use, re-traumatisation can occur with a compounding effect that will be costly for services and to the individual (Kezelman & Stavropoulos, 2012).

Understanding healing and recovery

People experiencing complex trauma have a very strong need to feel safe (Herman, 1992). Healing and recovery is stage-based and emphasises establishing safety first. The trauma literature recognises core stages for treatment and recovery. These are: stabilisation or establishing safety; processing trauma—the exploration and reintegration of traumatic memories into a personal narrative; and the positive reconnection with others (Herman, 1992; Kezelman & Stavropoulos, 2012).

Although there may be no “final” resolution, healing from an experience of trauma should be focused on the need to increase the capacity of survivors to be aware of and control their reactions to a range of trauma stimuli, including flashbacks, extreme emotion states, and interactions with others. Importantly, this needs to occur within a safe and predictable external environment. A safe environment is one which supports and encourages this, and which does not recreate situations of humiliation, disempowerment, isolation, danger, unpredictability and disempowerment. It is important to be aware that such situations may be created unwittingly and by unintentional omission or commission of certain procedures and processes. By understanding the impacts of trauma, service organisations will be more aware of the possibility of retraumatising people inadvertently.

Service support for sexual abuse histories and complex trauma

The needs of service users with complex trauma often transcend just the mental health or medical sector to encompass social issues such as employment and housing (Rankin & Regan, 2004). Usually these issues are dealt with by fragmented systems with different treatment approaches and little referral and connected follow-up (Kezelman & Stavropoulos, 2012). Although it has been acknowledged that services are not meeting the needs of people whose problems may be a result of trauma, and that this is expensive in terms of service failure (Rankin & Regan, 2004), there hasn't been a consistent approach to guiding services to become more responsive to trauma.

Sexual violence is so prevalent in our society that it is likely that most, if not all, human services would at some point deal with people suffering trauma (Elliot, Bjelajac, Fallor, Markoff, & Reed, 2005). Where there is a lack of understanding and sensitivity to trauma in service delivery, some programs and services may inadvertently trigger trauma symptoms so that patients or clients revert to using coping mechanisms that can impact on their ability to successfully engage with the service (Savage et al., 2007).

Siloing of different services may have ramifications for women with complex trauma symptoms in that each particular problem she faces may be dealt with out of context and individually with little focus on the core problem, instead short-term goals, such as stopping drinking or dealing with family violence are addressed in isolation (Fels Smyth & Goodman, 2006). The literature around services and people with complex trauma supports the use of a trauma-informed person-centred approach for helping the recovery from trauma inflicted on victim/survivors of sexual abuse and polyvictimisation (Chung, Domino, & Morrissey, 2009; Huntington et al., 2005; Kezelman & Stavropoulos, 2012). One of most influential developments in the evidence around service provision for women with complex trauma, was the US-based Substance Abuse and Mental Health Services Administration's (SAMHSA) 5-year study into Women, Co-occurring Disorders and Violence Study (WCDVS). The study was a multi-site, longitudinal, quasi-experimental study to determine the effectiveness of integrated services for women affected by substance abuse and mental illness who were also victims of violence (Toussaint & VanDeMark, 2007). This study helped formulate the principles and application of appropriate services to deal with women who have complex trauma linked to histories of violence (Elliot et al., 2005). These principles are discussed in more detail below.

Trauma-informed services

Trauma-informed services understand trauma, particularly complex trauma, but the service they provide is not specifically targeted at the trauma. Their core service may be dealing with features of complex trauma—for example, relationship counselling or substance abuse—but they are attuned to the possibility of trauma in each individual, regardless of whether it is apparent in their presentation. Trauma-informed services are adept at responding to the issues and complexity of needs that a traumatised person may have within a particular setting and are able to incorporate principles of care appropriate for traumatised people including trust, safety, person-centred care, choice, collaboration, and empowerment (Kezelman & Stavropoulos, 2012; Salasin, 2005).

For some services, the adoption of trauma-informed care may require organisational change, including policy and procedure review to ensure the safety and relevance of the service

for trauma survivors. Staff within the relevant fields should understand the connective relationship between complex trauma and the array of needs that clients may have (Elliot et al., 2005; Kezelman & Stavropoulos, 2012).

Huntington et al. (2005) outlined the core principles of a comprehensive approach for providing services to women with co-occurring disorders or complex trauma. Developed based on findings from the Women, Co-Occurring Disorders and Violence Study, Huntington et al. indicated that services must be:

- ▣ *integrated*: services are linked and able to share information and resources to enable treatment of the whole person in a coordinated fashion;
- ▣ *trauma-informed*: services are based on an understanding of trauma and its impacts on victims;
- ▣ *consumer integrated services and systems*: services seek input and consultation with service users to empower them to have a significant say in shaping the services they use; and
- ▣ *comprehensive*: core services that are necessary to meet the needs with regard to complex trauma including outreach, screening, ongoing treatment for specific issues, parenting skills training, resource coordination and advocacy, trauma specific services, crisis interventions and peer-run services.

Kezelman and Stavropoulos (2012) further indicated that trauma-informed services are:

- ▣ committed to safety, trustworthiness, choice, collaboration and empowerment;
- ▣ have considered systemic components in acknowledgement of the role violence plays in the lives of service users;
- ▣ apply the understanding to service system design to avoid re-traumatisation; and
- ▣ have close collaborative relationships with other relevant services.

Trauma-specific services

Trauma-specific services are those that aim to deal directly with the trauma and aim to treat it and manage trauma related symptoms. This should be done within a trauma-informed environment (Elliot et al., 2005; Kezelman & Stavropoulos, 2012). Trauma-informed services can be delivered across the service settings (e.g., mental health, general healthcare, substance abuse). Some recommendations are made in the literature that most of the users of human services have experience of trauma, whether that appears directly apparent or not, and therefore best practice is to rely on procedures that treat all women as if that is the case and utilise those least likely to be retraumatising (Elliot et al., 2005). Many standard procedures in service environments have the potential to trigger trauma responses in victim survivors and can be disempowering for them. As a result, there can be a cost in terms of failing to engage clients in the services/programs or see an unnecessarily high drop-out rate (Elliot et al., 2005).

A recovery-oriented approach

Another framework for considering support for complex trauma is a recovery-oriented approach based on the concept that people with severe mental illnesses can recover and go on to participate fully in a healthy and fulfilling life (Farkas, Gagne, Anthony, & Chamberlin, 2005). A recovery or person-centred approach will ensure an approach in which the individual is centralised and has full rights to a partnership in their recovery,

including individual choices about service use. At the organisational level, services will need to focus on the inherent capacity of the individual to recover, including by ensuring policies, programs, staff and processes are consistent with this (Farkas et al., 2005). A recovery approach is consistent with the principles of trauma-informed care in terms of placing the individual at the centre of service need.

A guideline-based treatment for complex PTSD

Connor and Higgins (2008a) outlined the use of guideline-based treatment for complex PTSD for use by therapists called the HEALTH treatment program. This type of treatment acknowledges the inadequacy of approaches that are based solely on a PTSD formulation and that fail to address some of the complex PTSD symptoms. This particular program focuses on the needs of the individual by working to strengthen a person's capacity to deal with the basis of the complex trauma while reducing the symptomatology of the complex PTSD. The program provides a pathway to achieve the strengthening of the self, while allowing sufficient flexibility to tailor to the needs of the client (Connor & Higgins, 2008b).

Overcoming service delivery silos—collaborative and connected care

There are various ways for services to provide person-centred care to aid recovery from trauma. One way is to establish relationships between services that enable the person to be cared for in relation to each aspect of assistance they require.

In accordance with the recognition of trauma as underlying service need and with a focus on recovery, the way in which victim/survivors utilise health and care services should be holistic with the focus on the individual, not just one aspect of his/her needs. This requires strengthening connections between services and overcoming administrative/jurisdictional boundaries of responsibilities where the limitations of different objectives, budgets and accountabilities impede a shared vision of how to address service needs collectively.

In financially constrained environments, and without policy-driven structural change directing service connection, this type of connected care can fall to services to form informal relationships and connections.

Collaboration between, and integration of, services is one way of overcoming the short falls of siloed service systems that alone are unable to provide the range of services required by people suffering from complex trauma symptoms (McDonald & Rosier, 2011).

Collaboration is different to integration in that it is not a complete merging of services but is a culture of relationship building and information sharing between services (McDonald & Rosier, 2011). Informal and creative approaches to connecting services may include partnerships, cross-training and resource sharing (Rosengard, Laning, Ridley, & Hunter, 2007).

There are different types of integrated services, for example, those that operate by creating a network of organisations that coordinate services in a continuum, or those that coordinate provision of care for each particular instance it is required (Chung et al., 2009). Using one worker as a link or service navigator can be one way of more smoothly intersecting care between services (Rosengard et al., 2007).

Collaborative care has been shown to be effective, but there is less evidence to enable pinpointing which aspects of any particular model enhanced effectiveness the most.

Therefore it is difficult to emphasise the benefits of any particular model over another (Butler et al., 2008; Sieber, Kessler, Kallenberg, Miller, & Patterson, 2012). Without service collaboration or relationships of some kind however, it is difficult to envisage how an individual can be at the centre of the recovery picture.

One argument against using trauma as a basis for connectivity of service is that these services are at best drawn together only as a collection of short-term, highly focused interventions (Fels Smyth & Goodman, 2006). This is where it becomes paramount to acknowledge and respond to the personalised and individualised needs of each victim/survivor (Briere & Jordan, 2004; Rosengard et al., 2007).

Briere and Jordan (2004) identified that complexity of individual victimisation experiences means that there are clear implications for service interventions. They should be customised to the various issues and problems of the victim, be multimodal, which means, individualised, and flexible with referrals to other supports as required.

Acknowledging trauma from the policy perspective

The body of evidence (outlined above) that links trauma to human service use, has implications for policy. It is difficult to ignore the benefits of more effective, recovery-oriented service design for people with multiple needs. As the pathway between sexual victimisation and complex trauma becomes clear, it is important that this link is acknowledged and incorporated into health and service designs. Policy reform around service design and delivery can play an important role in creating a cultural shift to a better understanding of complex trauma, and in facilitating the connectedness of services as discussed. This requires the implementation of systems of care that are person-centred and can provide the holistic overview necessary to deal with the social and health aspects of complex trauma in order to enable recovery. There is a need to create partnerships between services in different fields, such as mental health, substance abuse, relationship services, and those less directly involved in health such as employment and housing (Treloar & Holt, 2008).

The risk of not acknowledging the manifestation of trauma in various aspects of people's lives is the failure to engage those who need assistance, which may result in less successful treatments. There can also be the need for repeated service use for the same issues, which can be inefficient, expensive, and can negatively impact on the wellbeing of clients (Domino, Morrissey, Chung, Huntington, & Larson, 2005). Research around drug treatment clients, for example, indicates clients are significantly more likely to remain in treatment if other life issues are also addressed (Treloar & Holt, 2008). Review and analysis of appropriate human service policies for victim/survivors of complex trauma is a task beyond the scope of this paper, however, there are some important points for consideration when conceptualising service use for people suffering because of a history of trauma.

Policy development has the ability to impact on service provision by creating shared understanding of trauma for individual service providers. It can help shift health care focus from a medical, diagnostic approach, to a person-centred, recovery emphasis. Ideally, a trauma-informed approach to policy would operate to ensure awareness and collective understanding of complex trauma and help create a philosophy common to service providers to enable person-centred solutions. By creating policies that emphasise a culture of interagency collaboration, the impetus to approach the problem of trauma collectively is highlighted.

Structure of services

For people experiencing complex trauma, the need for organisational and structural factors to be appropriate is important. For example, social situations such as homelessness and poverty, where higher levels of trauma are common, can generate serious barriers to accessing services. Service engagement can be limited by transport, lack of trust of bureaucratic entities, and organisational cultures that are incompatible with particular aspects of people's lives, such as homelessness or parenting. Policy can impact and help to overcome problems with these structural factors by considering the infrastructure and barriers to access that may impede collaborative service use (Rosengard et al., 2007).

A key feature in the design of trauma-informed services is the need to ensure consumer empowerment. By policy development that directs a consumer-empowered approach in service settings, this important element can become a key goal of service delivery.

Accessibility and knowledge of services

For a range of reasons, service users may not be aware of all the services they are able to use and factors around entitlement to use. Service systems may be complex and difficult to navigate for people with particular problems. One suggestion of overcoming this is to ensure cross-promotion of other services within GP offices or across services (Rosengard et al., 2007).

One suggestion in the literature is to emphasise outreach services to ensure that those in need of a particular service have more opportunity to find out about and utilise the appropriate care (Rosengard et al., 2007).

Policy directives can motivate development of appropriate service availability and relevance by driving an understanding of optimum service delivery and relevance.

Joined-up/integrated/single point entry for services

The literature emphasises the need for flexibility and case-specific approaches to people suffering from complex cases of trauma (Briere & Jordan, 2004). Aspects of human service policy that may be effective for encouraging engagement and successful service use may include the ability for services to collaborate in a variety of ways and policy can ensure that information and resource sharing between services is maximised by facilitating connections between them. It can do this by directing and shaping structural connections and inter-service communications.

Measuring outcomes

For people with complex trauma and a range of needs, the issue of how to measure outcomes will be difficult. This will require considering what constitutes success and effectiveness and how to measure the cost of people's multiple engagements with services. This is an expansive question and beyond the scope of this paper. The trauma literature indicates that a very clear conceptual framework will be important in order to acknowledge the experiences of sexually victimised people and their resulting trauma and an understanding that the needs may be varied and that engagement and recovery may be difficult for a variety of reasons. Policy should consider the adoption of evaluation techniques that can most appropriately measure outcomes and service use by providing a more contextual and

complete picture that includes consumer feedback and satisfaction aspects (Wall, 2013). In program evaluation aimed at considering effectiveness of treatments and programs, it should be acknowledged that a recovery trajectory wouldn't necessarily reflect clear, linear improvement but that functioning can drop before increasing once recovery commences.

Conclusion

Trauma permeates the lives of victim/survivors of sexual assault and potentially creates many problems for them. Complex trauma is the name given to symptoms recognised as occurring frequently in people who have suffered severe, ongoing trauma, particularly where that trauma is caused by abuse that is of an interpersonal nature, and especially where it occurs in a childhood context, which has particular impacts on the development of a person's sense of self, and a negative impact on attachment with caregivers. Despite a lack of settled diagnosis, the terms "complex trauma" and "complex PTSD" are relevant to the care of victim/survivors of interpersonal abuse.

Services need to consider the likelihood of trauma as the basis of symptoms or problems experienced by their users. Becoming trauma-informed is a way for services to be able to provide clients with a service that is attuned to the whole person's array of needs. It enables services to be more understanding of some behaviour and potentially to provide victim/survivors with a more comprehensive approach that might improve and be of benefit in engagement and retention of those who may otherwise have been unable to complete certain treatments.

Flexible and individually focused care is a very important factor in the care of people with complex trauma. The nature of victimisation is such that cases can be varied in type, intensity of abuse and impacted by factors such as the relationship to the abuser and the age and developmental stage of the victim. Because each victimisation experience can be so vastly different and result in different symptoms or degrees of need, it is important that care can be attuned to the level and type of need of that person.

There is a need to acknowledge the role that trauma plays in the requirement for services and to design policy and services to facilitate the comprehensive form of care that people suffering from complex trauma symptoms require. This includes enabling mechanisms that allow users to be empowered in their choices and service use. It will also require consideration of how care outcomes will be measured and evaluated as traditional quota focused results will not be appropriate.

The insidious nature of complex trauma arising from sexual and other interpersonal abuse and the huge price that society and victim/survivors pay to deal with its many and far-reaching consequences is yet to be fully understood. However, as the expanding evidence base indicates, the need to combat the impacts of trauma with policies, funding and informed and integrated services is an increasing priority at multiple levels for public health.

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