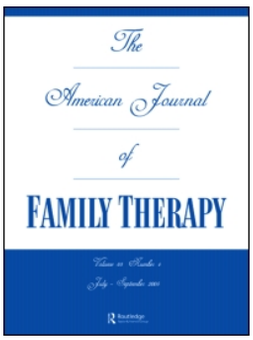

The American Journal of Family Therapy

ISSN: 0192-6187 (Print) 1521-0383 (Online) Journal homepage: http://www.tandfonline.com/loi/uaft20

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To cite this article: Emma Gatfield & Raymond Ho (2017) Exploring Patterns of Relationship Between Trauma Symptomization and Family Constellation: Implications for Working With Trauma Presentations in Systemic Practice, The American Journal of Family Therapy, 45:4, 220-234, DOI: 10.1080/01926187.2017.1348267

To link to this article: https://doi.org/10.1080/01926187.2017.1348267

Published online: 15 Sep 2017.

THE AMERICAN JOURNAL OF FAMILY THERAPY
2017, VOL. 45, NO. 4, 220–234
https://doi.org/10.1080/01926187.2017.1348267

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Exploring Patterns of Relationship Between Trauma Symptomization and Family Constellation: Implications for Working With Trauma Presentations in Systemic Practice

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ABSTRACT

This paper presents findings from research investigating trauma symptomization in children with prior trauma experiences from intact families (n = 32) compared with those from non-intact families (n = 32). Using a mixed method approach, a file audit of an Australian child/youth mental health service database was undertaken. Statistical analysis identified a significant relationship ($p = < 0.05$) of high numbers of trauma symptoms (NTS) for children from non-intact families, and low NTS for children from intact families. This finding indicates that children from intact families manage trauma better in terms of reduced symptomization. Other key patterns of relationship were identified and implications for systemic practice explored.

Introduction

Experiences of trauma for children not only cause distress to affected individuals but create ongoing complications that are associated with a family's capacity to achieve reasonable functionality (Briere & Lanktree, 2012; National Child Traumatic Stress Network, 2014). Traumatized children often struggle emotionally with the affects of trauma leading to long-term and complex mental health disorders that burden families and communities, social welfare and health systems (Davis, Martin, Kosky, & O'Hanlon, 2000). This paper reports on a mixed method investigation, which explored family constellation factors that impact on children's experiences and symptomization following trauma experiences. The investigation sought to identify factors that correlate with lower symptomization in order to guide systemic practice for families with trauma presentations and, in the long term, promote better mental health outcomes and optimize service delivery to this population.

This investigation sought to answer two questions: Research question A, which is, do intact families, where biological parents and their biological under 16-year-old

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children live together, exhibit different levels of trauma symptomization than children and youth from families that are non-intact? and, Research question B, which is, what implications can be drawn from the findings of the first research question for the best practice of family therapy that addresses trauma?

Background

Trauma has profound impacts on the brain development of children (Cook et al., 2005; Spates, Samaraweera, Plaisier, Souza, & Otsui, 2007). Heavily traumatized individuals normally experience automatically generated defensive operations that involve a complex cascade of brain and body system recruitments (Briere & Lanktree, 2012; Spates et al., 2007; Stein & Kendall, 2004). These present in a unique configuration of three hyperarousal, avoidance and numbing, and re-experiencing symptoms (Blake et al., 1995; Bryant, Moulds, & Guthrie, 2000; Tarren-Sweeney, 2013). These responses create a range of functioning issues for traumatized individuals that vary from minimal to pervasive (Abbassi & Aslinia, 2010; Berson & Baggerly, 2009; Briere & Lanktree, 2012; Cook et al., 2005; Hanney & Kozlowska, 2002; Spates et al., 2007; Stein & Kendall, 2004). From a family therapy perspective which is fundamentally non-pathologizing, individuals may be seen as exhibiting symptomatic behavior that is functionally responsive to the underlying structures, rules or stories held within their social systems. It views trauma as a unique set of interactive coping symptomizations responsive to individual contexts that may have long term developmental health impacts (MacKinnon, 2012).

McDermott (2011) indicates that early trauma events precipitate abnormal development by interrupting developmental continuity, leading to functional impairment that engenders more pervasive impairment across the lifespan. Trauma emerging in infancy or childhood is considered significant in shaping the architecture of the brain, and in influencing the onset of mental illness later in life (Arseneault et al., 2011; Powell, Cooper, Hoffman, & Marvin, 2014). Traumatic stress precipitates a chemical imbalance in children which manifests in dysfunctions of learning, memory, behavior and emotions, and may ultimately lead to negative alterations in personality development (Spates et al., 2007).

Family therapy conceptualizations mirror general trauma theory in understanding trauma experiences as having a profound impact on the developmental and mental health trajectories of young people (Hanney & Kozlowska, 2002; James & MacKinnon, 2012). However, systemic approaches also position the family centrally in supporting affected family members and in helping them address trauma and resolve its symptoms. While families may sometimes be the cause of trauma for children they are also seen as having the capacity to support traumatized members and bring healing (Diamond, Levy, & Diamond, 2014; James & MacKinnon, 2012). According to Cook et al.'s (2005) analysis, the response of a child's support system is perhaps the most important factor in determining their

long-term mental health outcomes. However, it is suggested that this may be significantly disrupted if parents separate and psychologically distant parent-child relationships develop (Taanila, Laitinen, Moilanen, & Jarvelin, 2002).

Research relating to family structure and trauma suggests a significant association between post-separation family structure, particularly in relation to quality of co-parenting relationship, and mental and physical health and behavior issues (Abelsohn & Saayman, 1991; Hardesty et al., 2012). Children with divorced or separated parents are found to score lower on emotional, behavioral, social, health, and academic outcomes, exhibiting twice the level of difficulty in adjustment and socialization compared with those from married or intact families (Amato, 2010; Kelly, 2006). Constellation shifts in the first five years (Irving, Benjamin, & Troche, 1984; Ryan, Markowitz, & Claessens, 2015) and loss of broader supportive family systems through family separation (Ahrons, 2006) are found to impact on children's adjustment, development, and psychosocial outcomes, while high-quality parenting facilitates adaptive coping and trauma recovery (Cook et al., 2005; Velez, Wolchik, Tein, & Sandler, 2011).

Age of children, quality of parenting and economic factors are identified as relevant to the adjustment of younger family members, however, little is yet understood about the impact of other family constellation-related factors on children and young people's trauma symptomization. The investigation examined in this paper sought to identify, for children who show evidence of trauma symptoms, the patterns of relationship between factors associated with family constellation and therapeutic intervention, and to make recommendations for best family therapy practice based on these.

Method

In order to investigate phenomena associated with the first research question, a mixed methods approach was used to conduct a file audit investigation and analysis. To elicit data of interest a client file audit was conducted at an Australian Child and Youth Mental Health Service (CYMHS). CYMHS is a state government funded acute care mental health service which uses a multidisciplinary approach to provide mental health care services to children and youth who are self-referred or referred through primary services including hospitals, general practitioners, and school guidance officers. Through the use of the CYMHS client file data base, Consumer Integrated Mental Health Applications (CIMHA), phenomena of interest were explored, including: client-identified gender and age grouping; family constellation (intact or non-intact); number of biologically related under 16-year-old children living in client's family home/s; number of biological-related under 16-year-old children living out of client's family home/s; prior or current parental or immediate family mental illness; number of family constellation changes over client's lifetime; age of client at time of first family separation; types of intervention utilized (therapeutic

or other); numerical Child's Global Assessment Scale ratings; client's International Client Diagnosis Manual 10 (ICDM10) diagnoses; and trauma symptom rating (using an exploratory measure). These factors were examined using quantitative methods to elicit differences between cohorts. The number of trauma symptoms (NTS) were estimated using an adapted exploratory measure derived from categories of empirical trauma measures. An exploratory symptom measure was developed for the purpose of identifying NTS identifiable in clients' case file notes. Categories from empirically validated trauma scales were used to develop a 17-item exploratory symptom measure. Empirical measure categories focused on three key dimensions of trauma symptomization: hyperarousal, avoidance and numbing, and re-experiencing. These were drawn from the Acute Stress Disorder Scale (Bryant et al., 2000), Clinician-Administered PTSD Scale for DSM IV (Blake et al., 1995), Assessment Checklist for Children, and Assessment Checklist for Adolescents (Tarren-Sweeney, 2013). Qualitative evidence from client files was identified, which related to the three trauma symptom categories and the NTS identified was converted to a raw numeric score (out of 17). To verify the utility of the measure and the reliability of qualitative data collection, an expert panel was formed, incorporating the principal researcher, a senior psychologist, a senior social worker and a psychiatrist who have extensive experience with child and youth trauma.

File audit sampling procedures were applied, converging CYMHS client data from Logan City regions given the prevalence of vulnerable families located in these areas (Australian Bureau of Statistics, 2012). Exclusion criteria were: clients identified as having a diagnosed intellectual disability; clients who have had no trauma experiences; and clients living in foster care placements. The number of client files included was 64. Clients were matched across two cohorts: children from intact families (where under 16 year old children lived with their biological parents) ($n = 32$); and those from non-intact families ($n = 32$). Within-group clusters were matched across four age/developmental stage groupings and randomized within clusters (Adler & Clark, 2011), including: 3–5 years (early childhood), 6–11 years (middle childhood), 12–14 years (pubescence), and 15–18 years (adolescence) (McGoldrick, Carter, & Garcia-Preto, 2013). Age/developmental stage clusters and gender were matched in client number across cohorts ($n = 4$).

Data relating to the two cohorts was analyzed for identifiable patterns. Findings were coded and analyzed using SPSS 22.0 (2013), through a cross comparison of data sets using nonparametric testing techniques. Descriptive statistics were reported with between-group differences assessed using Fisher's exact test.

In order to address the second research question, findings from the file audit component were explored and implications for family therapy practice presented. These were examined against contemporary literature focusing on best family therapy practice where trauma is a presenting concern.

Results

Quantitative results from the study using nonparametric testing yielded one significant finding and a number of patterns of interest. Fisher's exact tests were conducted on a range of variable combinations to determine patterns of relationship between family constellation and other phenomena of interest including: NTS identified; number of children living in client's family home/s; number of children living out of client's family home/s; immediate or extended family mental illness history; number of family constellation changes over clients' lifetime; age of clients at time of first family separation; and, number of therapeutic sessions clients engaged in.

Table 1 shows findings from Fisher's exact test which indicates differences between NTS for intact and non-intact family constellations, indicating a distinct difference between the two variables with a significance level of $p = < 0.05$ ($df = 1$, $n = 64$). It was found that 88% of children from intact families had a NTS between 4 and 10, and 12% had a NTS between 11 and 15. This contrasted to the non-intact family group where 68% of the cohort had a NTS between 4 and 10 and 32% had a NTS between 11 and 15.

Table 2 provides a crosstabulation summary indicating a pattern of relationship between variables, NTS and the number of therapeutic sessions. Results indicated that children with a larger NTS had more therapeutic sessions than children with a smaller NTS, although it failed to reach a level of significance using Fisher's exact test. Further, 53% of clients from intact families were found to have had 0–6 therapeutic sessions with 47% having 7 or more sessions. This contrasts with children from non-intact families where 28% of the cohort were found to have 0–6 therapeutic sessions, with 72% of clients having 7 or more sessions.

Other patterns of relationship between variables were indicated by Fisher's exact test and crosstabulation but did not reach levels of significance. The three findings that warrant attention are presented below.

Table 3 summarizes the relationships for non-intact families between NTS and age of clients when their parents separated. It indicates that when children were between 0 and 5 years at the time of parental separation, 59% of children had a NTS between 11 and 15, compared to 41% who were identified as having 4–10 trauma symptoms. However, this difference is less significant than for clients whose parents separated when they were 6–18 years, where NTS is between 4 and 10 in 10% of cases and between 11 and 15 in 90% of cases.

Table 1. Relationship between number of trauma symptoms for intact and non-intact families.

		Family constellation		
		Intact	Non-intact	*Total*
No. of trauma symptoms	4–10	28	10	38
	11–15	4	22	26
	Total	32	32	64

Table 2. Relationship between number of trauma symptoms and number of therapeutic sessions.

		Number of therapeutic sessions		
		0–6 sessions	= or > 7 sessions	*Total*
No. of trauma symptoms	4–10	19	19	38
	11–15	7	19	26
	Total	26	38	64

Table 3. Relationship between number of trauma symptoms and age of client at the time of first parental separation (non-intact families only).

		Age of client at parental separation		
		0–5 years	6–18 years	*Total*
No. of trauma symptoms	4–10	9	1	10
	11–15	13	9	22
	Total	22	10	32

Table 4 depicts crosstabulation between NTS and number of children living at home and number of children not living at home. It indicates that NTS was varied between intact and non-intact families on this dimension. For children from intact families, where n = 1–2 or 3 and more of children are living at home, NTS ratings were between 4 and 10 in 85–88% of cases. For children from non-intact families, where n = 1–2 or 3 and more of children are living at home, NTS ratings are between 11 and 15 in 65–78% of cases. Eight percent of the non-intact family cohort has 1 or 2 children not living at home, of whom 80% exhibit a NTS between 11 and 15.

Table 5 depicts the relationship between NTS exhibited by clients and family members of clients who have a mental illness. Fifty-two percent of clients whose

Table 4. Relationship between number of trauma symptoms and number of children living at home/number of children not living at home for intact and non-intact families.

		No. of children living at home				No. of children not at home
		Intact families		Non-intact families		Non-intact families
No. of children		1–2	= or > 3	1–2	= or > 3	1–2
No. of trauma symptoms	4–10	17	11	8	2	1
	11–15	2	2	15	7	4
	Total	19	13	23	9	5

Table 5. Relationship between number of trauma symptoms and family member/s mentally ill.

		Family member/s with a mental illness			
		Paternal or maternal extended family	Nuclear (immediate) family	Nuclear family and extended family	*Total*
No. trauma symptoms	4–10	7	15	13	35
	11–15	4	15	4	23
	Total	11	30	17	58

case notes reported a within-family mental illness, had one or more mentally ill immediate family members. Within this group, 50% had a NTS rating of 4–10 and the remaining 50% had a rating of 11–15. Twenty-nine percent of clients whose case notes reported a within-family mental illness, identified both immediate family members with a mental illness and a maternal or paternal family history of mental illness. Seventy-six percent of those reported a NTS rating of 4–10, and 19% reported a NTS rating of 11–15. For the smallest number of clients, comprising 19% of those whose case notes reported a within-family mental illness, only a maternal or paternal family history of mental illness was identified. Of these, 64% had NTS ratings between 4 and 10, and 36% had NTS ratings between 11 and 15.

For the quantitative component of the study a number of key implications for systemic practice are identified. The first implication for therapeutic practice is that, since children whose parents and siblings remain together manage trauma experiences better, intact families should be supported to remain intact where appropriate to retain the inherent protective qualities this status affords. A corollary finding to this is that separating parents should be supported in a mediated process to negotiate low-conflict divorce with maximal shared parental involvement with children, and facilitated access to nuanced nurture imparted from biological parents. A third significant implication for practice is that early intensive support for whole families should be offered where a nuclear family exhibits mental illness to arrest the development of further familial mental health issues. Efficacious systemic approaches for trauma presentations that comply with these guidelines are explored in the following section.

Discussion

In answering the investigation's first research question, the findings of the study indicate that children from intact families exhibit a significantly lower NTS than children from families that are non-intact. This finding may be limited to similar populations where there is existing evidence of exposure to traumatagenic experiences and where clients comprise a similar lower SES grouping, placing them at a higher risk of developing mental health concerns as adults (Australian Bureau of Statistics, 2014). More importantly, in the debate regarding outcomes for youth and children whose parents separate, this finding lends support for the argument that children whose parents stay together are less symptomatizing. This may be due to more effective management of trauma experiences, or greater inherent resilience to the impacts of trauma, or possible other unspecified factors warranting investigation.

This initial finding is supported by the corollary finding, though not statistically significant, that regardless of their age at the time of separation, children whose parents separate exhibit a higher NTS. This supports research by Amato (2010) and Kelly (2006) which indicate that children who have divorced or separated parents score lower on emotional, behavioral, social, health, and academic outcomes. A further findings from this study is that children whose parents separated

when they were between ages of 6 and 17 exhibited a higher NTS than children aged between 0 and 5 at the time of parental separation. This challenges the dominant perspective expressed in current literature that parental separation influences children's adjustment most when it occurs during the first five years of a child's life (Ryan et al., 2015), however, the limited sample size of the study may have skewed findings in this part of the investigation.

A comparison of NTS for children living at home (biologically related and under 16 years) with NTS for children living away from home, yielded a finding that trauma symptoms are lower for children whose siblings remain at home. However, this is seen as more accurately reflecting the general trend of difference in this study between intact and non-intact families rather than suggesting a separate relationship between these variables. The finding that children from non-intact families who had siblings not living at home exhibited a higher NTS may indicate a relationship between trauma symptomization and the absence of protective family members. This assertion is spurious given the small representative number of this group (n = 5) but may warrant further investigation to create a clearer understanding of family protective factors and trauma resilience.

The investigation identified a high percentage of clients (50%) with a high NTS (11–15 symptoms) from families where other nuclear family members had a mental illness. While this group had equal numbers (50%) exhibiting a low NTS (4–10 symptoms), the finding of interest is a pattern of relationship between a high NTS and nuclear family members experiencing a mental illness. This may be seen as supporting findings in the literature that when families experience major stresses, there is an increased likelihood of mental health issues emerging in individuals. Such stressors are suggested in the literature to include parent marital status, marital conflict, family size, poor parenting skills, parental psychopathology, alcoholism or drug use, exposure to negative family events including bereavement, family separation, trauma and family illness; importantly, children who are burdened by existing traumatization are especially vulnerable to retraumatization (Ahrons, 2006; Berson & Baggerly, 2009; Spence, 2000).

In terms of therapeutic sessions conducted with clients, though therapy may have been ongoing for some, there was a clear pattern of difference between the number of sessions for clients from intact families compared with the number of sessions for clients from non-intact families. The cutoff of 6 sessions was used, reflecting Australian government policy for the number of funded therapy sessions under current mental health care plans (Australian Government Department of Health & Ageing, 2012). While 54% of clients from intact families had 6 or fewer therapeutic sessions, 72% of clients from non-intact families had 7 or more therapeutic sessions. The need for ongoing or extensive therapy for clients who have experiences of trauma may be rationalized in a range of ways. However, this finding can be seen as supporting current literature which highlights that children with divorced or separated parents exhibit twice the level of difficulty in adjustment and socialization when compared to those from married or intact families (Amato, 2010; Kelly, 2006).

Implications of findings for systemic practice: Family constellation and best practice for systemic therapy where trauma is a presenting feature

In answering the second research question, a range of implications can be drawn from the investigation findings for the best practice of family therapy that addresses trauma. Study findings indicate that children with experiences of trauma who are from intact families exhibit lower NTS, thus family therapy practices supporting intact family structures where children have experienced trauma are considered important. In addition, family therapy approaches that facilitate healthier divorce and separation processes as a culturally unscheduled event are also considered highly relevant, mostly in terms of preventing further vicarious trauma (Ahrons & Rodgers, 1987). While intact families may circumvent a range of difficult transition points that family separation and divorce presents, positive interactions between family members can support and nurture positive relationships and health outcomes for all family constellations (Ahrons, 2013; Davis et al., 2000).

The decision for parents to end their relationship is generally more difficult and prolonged than their decision to partner (Ahrons, 2013). Therefore, there may be many points of support or intervention where family therapists can work to reaffirm the continuation of a parents' relationship if the couple is willing to seek therapy. However, this raises ethical concerns in relation to the role of the therapist and their fidelity to clients' agendas. Perhaps the most ethical place to reaffirm intact families is in couples work, where family therapists support couples in their journey either towards healing and strengthening or towards constructively dissolving their relationship. In helping couples resolve interactional issues and impasses, systemic therapists may support families to remain unified (Scheinkman & Fishbane, 2004). Ongoing domestic violence and abuse constitute an untenable context for supporting family unification therapeutically. However, where relationships may be supported into more healthy function, therapeutic processes may promote couple and family strength and cohesion which supports implications from findings of this study.

While the study identified that intact families support reduced symptomization in traumatized children, the importance of family therapists providing mediation between couples who are separating or divorcing cannot be understated (Amato, 2010; Kelly, 2006). Parents in conflictual co-parenting arrangements are at high risk of being emotionally disengaged from their children and unable to focus on their needs (Kelly, 2006). Not only is ongoing parental conflict a further source of stress for already traumatized children, trauma is a well-documented by-product of highly conflictual separations (van Lawick & Visser, 2015). In terms of family mediation, of relevance to this study are reflexive interventions that promote a climate conducive to mutual decision-making, supporting families who are separating by facilitating ongoing helpful collaboration in family matters (Kressel & Deutsch, 1977). Interventions that support parental collaboration for separating families may reduce conflict where family separation is unavoidable. In so doing

they may preserving some of the qualities that intact families retain which assist them in maintaining low symptomization for traumatized children.

Attachment theory-based systemic approaches are considered salient trauma therapy practice, which complies with implications for findings of this study, particularly where trauma is relational. They support family system functioning through reinforcing vulnerable parent-child relationships with ripple-effect gains across whole families. Holding the child's primary attachment system as central to healthy child development and healing of trauma, these approaches confirm an ecological perspective of individuals as formed through interpersonal processes (Cook et al., 2005; McGoldrick et al., 2013). Cogent approaches nurture positive intra-familial interactions and strengthen family bonds, therein assisting vulnerable families to function more constructively and reduce relational disruption (Diamond et al., 2014; Jernberg & Booth, 2001; Lacher, Nichols, & May, 2005).

A range of narrative and dialogical approaches to trauma management and resolution are also considered compatible with study findings in supporting families to externalize trauma and promote family cohesion. Locating alternative storylines is described as offering hope against the despair of pervasive trauma stories (White, 1995), providing an "alternative territory of identity" from which to express trauma experiences, and preventing re-traumatization (Penn, 2001; White, 2005, p. 20; Yuen, 2007). A range of these approaches incorporate a trauma lens into therapeutic work, welcoming the whole family into therapy and connecting individually and vicariously traumatized family members (James & MacKinnon, 2012). While differing from attachment theory-based approaches in their theoretical focus, narrative and dialogical approaches, similarly, empower families to take ownership over their internal processes. Through identifying preferred and hopeful narratives and supporting parent-child relational constructs, these two approaches promote constructive and cohesive family function, which supports the preservation of families' intact status, in line with implications from the study's findings.

Further findings of the quantitative component of this study indicate that having an immediate family member with a mental illness increases a child's risk of exhibiting a high number of trauma symptoms. This supports contemporary research, which identifies parental mental illness as a significant risk factor for children across a range of social, emotional and health outcomes (COPMI, 2015). Family Therapy approaches, which are essentially non-pathologizing, focus on supporting family function rather than identifying illness. However, the study finding that other family members experiencing a mental illness predicts children having stronger trauma symptomization has implications for best practice. It supports the notion that, where one family member is experiencing trauma-related concerns, providing support for the whole family system, especially where mental health concerns are apparent, is likely to optimize outcomes for all and reduce the overall burden of trauma and mental illness on families. Salient approaches facilitate early intervention where dysfunctional patterns are emerging, highlighting strengths and promoting unique family-embedded factors of resilience (Ungar, 2013).

Resilience emerges in the literature as a key focus for best practice systemic interventions where trauma is a presenting concern. The facilitation of family members accessing and utilizing resilience is considered important to the findings of this study since the promotion of resilience may serve to reduce the emergence of complex mental health presentations across families. Resilience-based approaches may be used as central or adjunctive to other systemic frameworks. These explore family resources such as existing strengths, shared beliefs and narratives which shift therapeutic focus from problem-saturated circumstances to affirmation of families' reparative potential (Walsh, 1996, 2003). Hope is identified by some practitioners as analogous to resilience with hopeful individuals manifesting greater resilience (Weingarten, 2010). It is expressed as a viable and reliable resource through which possible futures emerge which, within a family trauma context, can confirm a resilient family identity (Ungar, 2013; Weingarten, 2010). Resilience-focused approaches support families to recognize the strengths they have developed through their transition out of prior traumatic or difficult events. Through therapeutic support that increases families' access to early interventions that promote resilience, the risk of families developing multiple mental health concerns may be reduced, as a significant risk factor indicated by the findings of this study.

Limitations

There were a number of limitations of the study that should be noted. Limitations of the study design include potential concerns with: client case managers and other involved clinicians under-reporting, over-reporting or inaccurately reporting family constellation and trauma symptom phenomena; researcher error in translating phenomena documented in cases into coded data; and, variabilities of trauma reporting in files.

Further, there were issues of generalizability of study findings to standard Australian populations, since: all clients investigated have a trauma and mental illness history; this study used a small sample size; and, a nuanced ethnic, racial, cultural, religious and SES grouping is represented by the study population.

Also, due to the categorical nature of data collected, nonparametric test analysis has been undertaken, where a larger sample that generated continuous data may have aided parametric testing, yielding more statistically powerful results. Finally, it is an acknowledged limitation of this study that the review of current systemic trauma practice is unlikely to provide an exhaustive picture of current theory and practice relating to family therapy with trauma presentations.

Further research

This study has investigated the impact of a range of family constellation-related factors on trauma symptomization in children. However, there are other family constellation-related factors that warrant further investigation if a clearer picture is to be gained about both risk factors and mediating impacts of these on children's

experiences of trauma. In relation to the findings of the study, the small sample size has limited its broader applicability. Given the apparent significance of primary findings, further investigations of a similar nature with larger sample sizes may lend greater statistical power to these findings, which may inform mental health service delivery in organizations such as CYMHS.

Making use of existing data on client databases has proven an effective way of acquiring aggregated information about vulnerable populations in a non-invasive manner. It is recommended that this database be used to generate further information which may shape service delivery to this population in line with findings of importance. In combination with client interviewing, data from case notes may be confirmed or disconfirmed and by incorporating empirically validated measures, rigor may be added to future investigations in this area.

In therapeutic work where child trauma is a presenting concern it is apparent that systemic approaches most consistently acknowledge the role of the whole family in contributing to and bringing healing to trauma. Since children do not grow in isolation, a family-focus to future child trauma research is considered highly salient. It is recommended that future research should integrate a focus on the contributions of families as well as broader ecological systems and explore systemic approaches that comply with future findings.

Conclusion

This paper has presented findings of a mixed method study focusing on the impact of family factors on trauma responses in children. The results of the investigation have yielded some valuable insights into trauma-related symptomization in children and relevant family constellation factors. This research file audit highlighted that children who have experiences of trauma and are from intact families have lower numbers of trauma-related symptoms compared with children from non-intact families. Further, it supported existing research findings that mental illness is frequently clustered within nuclear families. The paper has indicated a range of salient systemic interventions that respond to these findings; interventions that may support families in modifying interactive processes and the unhelpful narratives which may inform them, in order to promote experiences of trauma recovery and resilience for both intact and non-intact families. Based on the study's limitations, a number of recommendations for future research in childhood trauma and family work were highlighted that serve to contribute to existing knowledge and practice in intervention approaches to ameliorate the impacts of trauma on children and families.

References

Abbassi, A., & Aslinia, S. D. (2010). Family violence, trauma and social learning theory. *Journal of Professional Counselling: Practice, Theory and Research*, *38*(1), 16–27.

Abelsohn, D., & Saayman, G. S. (1991). Adolescent adjustment to parental divorce: An investigation from the perspective of basic dimensions of structural family therapy theory. *Family Process*, *30*, 177–191.

Adler, E. S., & Clark, R. (2011). *An invitation to social research: How it's done* (4th ed.). Belmont, CA: Wadsworth Cengage Learning.

Ahrons, C. R. (2006). Family ties after divorce: Long-term implications for children. *Family Process*, *46*(1), 53–64.

Ahrons, C. R. (2013). Divorce: An unscheduled family transition. In M. McGoldrick, B. Carter, & N. Garcia-Preto (Eds.), *International edition: The expanded family lifecycle: Individual, family and social perspective* (4th ed., pp. 292–306). Boston, MA: Allyn & Bacon.

Ahrons, C. R., & Rodgers, R. H. (1987). *Divorced families: A multidisciplinary development view*. New York, NY: W.W. Norton & Co.

Amato, P. R. (2010). Research on divorce: Continuing trends and new development. *Journal of Marriage and Family*, *72*, 650–666.

Arseneault, L., Cannon, M., Fisher, H. L., Polanczyk, G., Moffitt, T. E., & Caspi, A. (2011). Childhood trauma and children's emerging psychotic symptoms: A genetically sensitive longitudinal cohort study, *The American Journal of Psychiatry*, *1*, 65–72.

Australian Bureau of Statistics. (2012). 4102.0 Australian Social Trends: June 2012. Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features40Jun+2012#SE

Australian Bureau of Statistics. (2014). 4159.0 – General social survey: Summary Results, Australia, 2014 Quality Declaration. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0

Australian Government Department of Health & Ageing. (2012). Better access to mental health care. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/4754FC33D76F2043CA257BF0001F95EC/$File/Q&As.pdf

Berson, I. R., & Baggerly, J. (2009). Building resilience to trauma: Creating a safe and supportive early childhood classroom. *Childhood Education*, *85*(6), 375–379.

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress*, *8*(1), 75–90.

Briere, J. N., & Lanktree, C. B. (2012). *Treating complex trauma in adolescents and young adults*. Thousand Oaks, CA: Sage Publications.

Bryant, R. A., Moulds, M. L., & Guthrie, R. M. (2000). Acute stress disorder scale: A self- report measure of acute stress disorder. *Psychological Assessment*, *12*(1), 61–68.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & Van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, *35*(5), 390–398.

COPMI. (2015). Emerging Minds. Retrieved from http://www.copmi.net.au/parents/parenting-with-a-mental-illness/support-networks

Davis, C., Martin, G., Kosky, R., & O'Hanlon, A. (2000). *Early intervention in the mental health of young people: A literature review*. Canberra: Commonwealth of Australia.

Diamond, G., Levy, S., & Diamond, G. (2014). *Attachment based family therapy: An introductory workshop*. Philadelphia, PA: Author.

Hanney, L., & Kozlowska, K. (2002). Healing traumatised children: Creating illustrated storybooks in family therapy. *Family Process*, *41*(1), 37–64.

Hardesty, J. L., Raffaelli, M., Khaw, L., Mitchell, E. T., Haselschwerdt, M. L., & Crossman, K. A. (2012). An integrative theoretical model of intimate partner violence, coparenting after separation, and maternal and child well-being. *Journal of Family Theory & Review*, *4*, 318–331.

Irving, H. H., Benjamin, M., & Troche, N. (1984). Shared parenting: An empirical analysis utilising a large data base. *Family Process*, *23*, 561–569.

James, K., & MacKinnon, L. (2012). Integrating a trauma lens into a family therapy framework: Ten principles for family therapists, *The Australian and New Zealand Journal of Family Therapy*, *33*(3), 189–209.

Jernberg, A. M., & Booth, P. B. (2001). *Theraplay: Helping parents and children build better relationships through attachment-based play*. San Francisco, LA: Jossey Bass.

Kelly, J. B. (2006). Children's living arrangements following separation and divorce: Insights from empirical and clinical research. *Family Process*, *46*(1), 35–52.

Kressel, K., & Deutsch, M. (1977). Divorce therapy: An in-depth survey of therapists' views. *Family Process*, *16*, 413–443.

Lacher, D., Nichols, T., & May, J. (2005). *Connecting with kids through stories: Using narratives to facilitate attachment in adopted children*. London: Jessica Kingsley.

MacKinnon, L. (2012). The neurosequential model of therapeutics: An interview with Bruce Perry. *The Australian and New Zealand Journal of Family Therapy*, *33*(3), 210–218.

McDermott, B. (2011). Child and youth emotional trauma: An explanatory model of adverse outcomes. *Psychiatry, Psychology and Law*, *11*(2), 269–279.

McGoldrick, M., Carter, B., & Garcia-Preto, N. (2013). *International edition: The expanded family lifecycle: Individual, family and social perspective* (4th ed.). Boston, MA: Allyn & Bacon.

National Child Traumatic Stress Network. (2014). *Complex trauma: Facts for service providers working with homeless youth and young adults*. Los Angeles, CA: Author.

Penn, P. (2001). Chronic illness: Trauma, language, and writing: Breaking the silence. *Family Process*, *40*(1), 33–52.

Powell, B., Cooper, G., Hoffman, K., & Marvin, B. (2014). *The circle of security intervention*. New York, NY: Guildford Press.

Ryan, R. M., Markowitz, A. J., & Claessens, A. (2015). Associations between family structure and child behaviour problems: The moderating effect of family income. *Child Development*, *86*(1), 112–127.

Scheinkman, M., & Fishbane, M. D. (2004). The vulnerability cycle: Working with impasse in couple therapy. *Family Process*, *43*(3), 279–299.

Spates, R. C., Samaraweera, N., Plaisier, B., Souza, T., & Otsui, K. (2007). Psychological impact of trauma on developing children and youth. *Primary Care: Clinics in Office Practice*, *34*, 387–405.

Spence, S. H. (2000). The prevention of anxiety disorders in childhood. In P. Cotton & H. Jackson (Eds.), *Early intervention and and prevention in mental health* (pp.87–105). Melbourne: Australian Psychological Society.

Stein, P. T., & Kendall, J. C. (2004). *Psychological trauma and the developing brain: Neurologically based interventions for troubled children*, New York, NY: Haworth Maltreatment and Trauma Press.

Taanila, A., Laitinen, E., Moilanen, I., & Jarvelin, M. (2002). Effects of family interaction on the child's behaviour in single-parent or reconstructed families. *Family Process*, *41*(4), 693–708.

Tarren-Sweeney, M. (2013). *Clinician's guide to assessment checklist series: Specialised mental health measures for children in care*. London, England: Taylor & Francis.

Ungar, M. (2013). Resilience, trauma, context and culture. *Trauma, Violence and Abuse*, *14*(3), 255–266.

van Lawick, J., & Vissier, M. (2015). *No kids in the middle*: Dialogical and creative work with parents and children in the context of high conflict divorces. *Australian and New Zealand Journal of Family Therapy*, *36*(1), 33–50.

Velez, C. E., Wolchik, S. A., Tein, J., & Sandler, I. (2011). Protecting children from the consequences of divorce: A longitudinal study of the effects of parenting on children's coping processes. *Child Development*, *82*(1), 244–257.

Walsh, F. (1996). Family resilience: A concept and its application: The concept of family resilience: Crisis and challenge. *Family process*, *35*, 261–281.

Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process*, *42* (1), 1–18.

Weingarten, K. (2010). Reasonable hope: Construct, clinical applications, and supports. *Family Process*, *49*(1), 5–25.

White, M. (1995). Naming abuse and breaking its effects: Interview with C. McLean. In M. White (Ed.), *Reauthoring lives: Interviews and essays*. Adelaide: Dulwich Centre Publications.

White, M. (2005). Children, trauma and subordinate storyline development. *The International Journal of Narrative Therapy and Community Work*, *3–4*, 10–22.

Yuen, A. (2007). Discovering children's responses to trauma: A response-based narrative practice. *The International Journal of Narrative Therapy and Community Work*, *4*, 3–18.