A Rationale for the KidsXpress Therapy Model

2016

KidsXpress Limited

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Acknowledgements

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Abbreviations

AMR	Australian Market Research
AT	Art Therapy
C4C	Communities for Children
DAE	Deloitte Access Economics
DMP	Dance Movement Psychotherapy
DT	Dramatherapy
EBP	Evidence Based Program
ECI	Early Childhood Intervention
ET	Expressive Therapy / Expressive Therapist
GCQ-S	Group Climate Questionnaire – Short Form
KTI	Key Transformation Indicators
MT	Music Therapy
NCTSN	National Childhood Trauma and Stress Network
NMT	Neurosequential Model of Therapy
ODD	Oppositional Defiance Disorder
OOHC	Out of Home Care
PCT	Primary Contact Therapist
PT	Play Therapy
RMT	Registered Music Therapist

Glossary of Stakeholder Terms

Referrer	This describes a professional who refers children into the program on an individual basis. They may work in health, community, welfare, or education pathways.
Group Referrer	These are referrers from scholastic institutions who refer groups of children simultaneously into the program. Group referrers are typically involved with the KidsXpress Outreach therapy model.
Parents/Carers	These are the people listed as the primary caregivers to a child in the program.

KidsXpress Expressive Therapists

The KidsXpress Staff is a collection of some of Australia's leading expressive therapists. All are tertiary qualified with professional accreditations to their leading modality's National / International Authority.

David Anthony	BLAS(Hons); MA Music Therapy
Christine Hagan	Dip. Teaching Early Childhood
Lesley Miller	Registered Nurse; MA Art Therapy
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Therapy Program Rationale

1.1 Executive Summary

This report introduces the KidsXpress early intervention Co-Led Group Expressive Therapy program with a comprehensive program rationale. It presents details of the Australian Institute of Family Studies' (AIFS) accredited evidence based program's (EBP) structure and purpose and may be used to inform professional audiences interested to learn about KidsXpress and the KidsXpress intervention methodology.

KidsXpress delivers a short-term intensive therapy intervention to children and youth (aged 4-14) that have experienced or are experiencing traumatic childhood experiences.

> *"A trauma is a psychologically distressing event that is outside the range of normal childhood experience and involves a sense of intense fear, terror, and helplessness" (Perry, 2002 p.23).*

Typically, children and youth are referred to KidsXpress for reasons relating to abuse and neglect, grief and loss, domestic violence, family breakdown, disturbed out of home care (OOHC), or issues arising from living with family members suffering mental illness, or the consequences of substance misuse. Trauma does not discriminate whom it impacts; thus KidsXpress' intakes comprise children and youth from across the sociodemographic spectrum. Numerous referrals however, do come from areas where concomitant challenges such as entrenched poverty, housing instability, difficult or unstable caregiving relationships, and other parallel social challenges may be faced.

The KidsXpress program is underpinned by a wealth of research literature from the fields of Trauma, Attachment, and Neurodevelopmental theories. Each field independently articulates long-term implications of childhood trauma upon optimal development, with many studies drawing connections between mental illness in adulthood and unresolved childhood trauma (Breckenridge, Salter & Shaw, 2010; Draper et al, 2008; Haliburn, 2014; Stien & Kendall, 2004). The KidsXpress program provides reparative early intervention, assisting children to

develop resilience and coping strategies that benefit them by preventing their challenges from persisting and growing with them into adulthood.

Trauma can profoundly impact a child's emotional, social, behavioural, cognitive, and physical functioning, with pervasive effects on their lifelong potential if not addressed, as well as have profound outcomes for their family and others around them (Cozolino, 2002; Giarratano, 2004; Van der Kolk, 2005). Chronic trauma and pervasive toxic stress disturb the brain's regulatory functions (Burke-Harris, 2014), interfering with subsequent developments of the higher order, executive functioning regions of the brain (Perry, 2006). Furthermore, such inhibition leads to interference when integrating other brain systems (Perry et al, 1995; Schore, 2016) and thus the implications of childhood trauma can exert influence throughout an individual's generalised functioning.

This cascading effect from the original event (Hawes et al, 2014) is the reason for the entrenchment of challenges across the lifespan. Burke-Harris (2014) also indicates that children who have experienced high levels of unresolved trauma are at markedly increased risk of physical disease as well as mental health and well-being challenges across the lifespan, highlighting how ensuing consequences reach far beyond the realm of emotional well-being alone. This assertion corroborates Higgins and McCabe's (2001) indication that individuals that had experienced trauma in childhood are more likely to experience high levels of trauma related symptoms as adults, particularly if the traumatic response is not addressed[1].

Schofield and Beek (2006) explain how compromised caregiving environments leave children at greater risk of developing complex and far reaching difficulties. They indicate numerous repercussions, including: challenges in self-regulation; impulsivity; reduced self-esteem; poorly developed, negative perceptions of self- and others; and pervasive difficulties understanding, trusting, and relating to others. These can stem from a paucity of reliable, consistent and appropriate caregiving behaviours to soothe the child when distressed (Carr & Landau, 2012). KidsXpress provides an environment rich in consistency, safety and attunement.

Secure relations with others are central to optimal human functioning (Rockett, 2013); and *relational transactions* (Carr et al, 2013) shape individual behaviours in accordance with how

[1] See AIFS 'Effects of child abuse and neglect for adult survivors' for a review of the implications of childhood trauma upon adults. Accessed: https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-adult-survivors

we have learned to understand ourselves, others, and ourselves in relation to others (Pearce, 2009). This premise that early interactions shape how we come to see ourselves and others renders seminal interactions and experiences of great importance to subsequent functioning across the lifespan. This interrelation of intra- and interpersonal relationships is of central importance to psychosocial well-being (Rockett, 2013). That relationships and identity are educated through our relational transactions renders them locked within the parameters of our perception of reality (Dykas, Ziv & Cassidy, 2008).

An infant uses their caregiver as a protective shield from harm, but when trauma occurs, that perceived shield gets broken (Dadds, 2012). The overwhelming stress disrupts a child's internal working model - internalised relational patterns that guide perceptions of security - and disrupts their ability to find safety in the form of their caregiver (Malchiodi & Crenshaw, 2015). As a result, a child may feel alone and isolated, powerless to self-soothe and restore a sense of calm regulation. Furthermore, traumatic incidents may also impinge upon the caregiver's ability to reassure and comfort the child.

Traumatic experiences, therefore, may reframe a child's reality with fear and trepidation as central to their perceptions; and this leads to hyperarousal of the child's defence mechanisms, holding them captive to the lower-brain and limbic systems (Hughes & Baylin, 2012). These states encode traumatic memories within sensory focussed areas of the brain, located in the non-verbal right hemisphere. If not addressed promptly and sensitively, the experience may begin to interfere with regulatory capabilities of the affected individual.

Expressive therapies, in particular those operating in accordance with early intervention theory, can dramatically reduce the chances of further emotional (and other) problems later in a child's life and minimise the impact of trauma across the life course (Cozolino, 2002; Giarratano, 2004). Indeed, expressive therapies are thought to markedly support restoration of health and wellbeing (Staricoff, 2004). Enhancements in neuroimaging have depicted the increased malleability of young brains compared to mature brains, demonstrating the pernicious impacts of trauma on continuing brain development (Gaskill & Perry, 2014; Tronick & Beeghly, 2011).

The primary implication of this knowledge is that programs and practices promoting safe, predictable, nurturing and enriched early childhood experiences are more capable of helping to restore normative brain organisation and functioning when compared to programs that seek to influence and change the brain later in life.

The KidsXpress intervention focuses on altering the parameters of reality for those children who have been exposed to traumatic stimuli. KidsXpress structures the therapeutic environment to be so rich in secure, consistent, safe interactions that a child's insecure working model of relationships becomes incongruent with the therapeutic reality. In doing so, the intention is to interrupt the trauma cycle, instigate the accommodation of new relational models with self- and others, and facilitate 'enhanced relational capabilities' (Emmens, 2007) that enable children to better connect to others and seek support and comfort to work through their challenges. KidsXpress provides engagement with, and expression of, internal processes relating to difficult events, so that they can be externalised by the children, processed and understood, then perceived as distinct from the self.

Expressive therapies are increasingly seen as an innovative, leading edge method of intervention for children impacted by trauma given their efficacy at reconnecting the implicit (sensory) and explicit (declarative) memories of trauma (Malchiodi & Crenshaw, 2015). Using insights from neuroscience and trauma studies, expressive therapies are able to be mindful of, and appropriately reparative towards, how the mind and body respond to trauma. Being cognisant of the sensory nature of trauma experience retention, expressive therapy environments facilitate developmentally appropriate intervention strategies to repair fearful perceptions held by children and the subsequent building of pathways toward resilience and emotional wellbeing.

Recognising that children – particularly those who have experienced trauma - are likely to be less able to employ conscious, verbal and rational processing to address their issues (Schore, 2016), expressive therapies are increasingly highlighted for their capacity to develop regulatory systems that incorporate unconscious, non-verbal and emotional information with somatosensory activities such as music, drama and art (Mission Australia, 2015). This approach is foundational to the KidsXpress Co-Led Group Expressive Therapy Program, and is set out in detail herein.

Given the extensive insights to how trauma and toxic stress impact the brain, we are ever more aware that childhood is a critical time for early intervention if we are to restore the optimal, healthy development trajectories of children impacted by trauma (Hughes & Baylin, 2012; Schore, 2016; Tronick, 2016).

1.2 Background & Vision

1.2.1 KidsXpress' History & Formation

Founder and CEO, Margo Ward formed KidsXpress in 2005 following extensive work in Sydney Children's Hospital as head of Play Therapy, and her leadership of an Adult Suicide Prevention program as part of *LifeForce*. These experiences led Margo to identify the need of addressing the connections between unresolved childhood trauma and later mental health challenges in adulthood. In deducing a way to address the root of the issues, Margo formulated the concept which is now embodied as the KidsXpress Therapy Centre in Moore Park; a place for children, inspired by children.

In doing so, KidsXpress became a pioneer in the movement of early intervention trauma therapy, recognising the profound impact that early intervention has upon minimising the impacts of trauma and traumatic stress across the lifespan. It was believed that early intervention therapeutic models could have a direct impact upon reducing the incidence of adults affected by mental illness.

KidsXpress therapists are educated to postgraduate level in their specialist discipline; are members of their professional modality's governing authority; and are obliged to partake in extensive professional development activities to ensure optimal knowledge in keeping with industry Best Practice. The unique nature of the KidsXpress program means that few therapists are trained in accordance with the KidsXpress model of co-led group therapy. Accordingly, the induction and training process of new staff is structured to provide experiential as well as theoretical exposure to the therapy model.

Recognising the power of the expressive therapies, and in particular their collaborative transdisciplinary efficacy (Malchiodi, 2005), KidsXpress conceived the idea of a transdisciplinary model to encapsulate Music, Art, Drama, and Play Therapies in concert; strategically designed to enhance the potency of expressive capability in ways that are developmentally appropriate for the groups and mindful of the needs of children in the therapy space.

Grouping the children is a critical component of the KidsXpress model; and one which is supported by extensive research explicating the efficacy and social advantage of group therapy programs (Kivlighan, 2012; Mahamid, Rihani & Berte, 2015). By grouping children in accordance with age and referral reasons, KidsXpress is able to provide an environment in which children and youth can find peer connection, insight, and belonging (Mahamid et al, 2015). “The unique supportive elements of sharing similar experiences, receiving acceptance from fellow group members, and getting the opportunity to help others, often function as an antidote to isolation and a boost to the experience of self-worth and self-esteem for the group members” (Bakali, 2013).

The therapy space is held concurrently by three therapists. This plurality of therapists was built into the model because of the interpersonal subjectivities that are inherent within therapy. In providing multiple therapists synchronously, the KidsXpress model provides children with options for the development of multiple therapeutic alliances and to more salient positive connection at the point of learning new interpersonal skills. Kivlighan et al (2012) found that single-therapist led groups were not as capable at following multiple interactions, and that groups noted greater benefits as a result of having multiple therapists lead the group. In addition, co-led therapy facilitates the modelling of positive interpersonal dynamics such that group members may vicariously observe positive interpersonal relations (Rockett, 2013).

KidsXpress has grown from its humble beginnings to an Australian Institute for Family Studies (AIFS) accredited Evidence Based Program (EBP). KidsXpress has extensive performance data to clearly understand and articulate its role, outcomes, and impact upon the lives of children and their communities; and it intends for this document to share its operating model and offer its professional field a highly effective reparative strategy in the space of early intervention trauma therapy.

KidsXpress believes that collaborative service delivery is paramount for optimal intervention efficacy, and proactively shares best practice insights that concomitantly inform, and are informed by, other service providers working with children, and the families and communities of children, impacted by trauma. To facilitate optimal reparative support, KidsXpress therapy teams champion care-team approaches to care provision, advocating for informed referral to the program by professionals that understand the value of expressive therapy and can identify those clients for whom it may be a pertinent method of therapeutically intervening in the cycle of trauma. This working set up also ensures continuity of support for clients and engagement from collaborative providers. Collectively, the wholesome meeting of needs is more possible through a united approach to care (Mitchell et al, 2012).

To that end, KidsXpress remains curious about optimal reparative strategies and seeks collaboration, opportunities for growth, and collective impact through the active pursuit of evidenced based interventions. KidsXpress believes that care services cannot achieve all that is needed without working together, thus adopting Mitchell et al.'s (2012) guidance that for treatments of greatly complex issues, explicit acknowledgment and purposeful cultivation of the team, ensures systematic inefficiencies and errors are addressed and prevented. "Now, more than ever, there is an obligation to strive for perfection in the science and practice of interprofessional team based healthcare" (Mitchell et al, 2012 p.2). This model allows KidsXpress and allied service providers to work with parents, other services, schools and referrers, and children - all bringing their own expertise - and working together toward the development of strategies that are successful across the range of a child's environments - their inner world, their family, school, and wider community. This notion underscores the motivation for KidsXpress producing this report.

In total, KidsXpress has delivered its therapy to more than 2,000 children since inception in 2006. There exists a well populated wait list with an increasing number of referrers seeking access for children to the KidsXpress program. This is, of course, a positive insight given that a growing number of referrers see KidsXpress as leading experts in the amelioration of emotional trauma (AMR, 2015). However, it also carries the negative insight that there is still a great number of people who need KidsXpress' intervention service. With this insight KidsXpress is mindful that organisational growth is essential if it is to extend the reach of its therapeutic design, philosophy, and delivery model.

With such rich and informed history, KidsXpress is now in a position to contribute meaningful data to demonstrate and explicate its significant impact at addressing the consequences of traumatic experiences in childhood. Utilising such knowledge, KidsXpress contributes evidence based insights to the fields of trauma-attachment related practice, early intervention therapy, and an innovative approach to the utilisation of expressive therapies through a Co-Led Group Expressive Therapy model. In the context of international developments, this study contributes insights to those of Mahamid et al (2015) and Klorer (2005) who articulate the elevated capability of expressive therapy over cognitive oriented therapies at addressing trauma related challenges in children.

The mission is to create generational change by inspiring children to thrive.

1.3 Trauma Overview

1.3.1 The Pervasive Implications of Trauma on Childhood Development

KidsXpress operates in accordance with the definition of stress as held by the National Child Trauma and Stress Network's (NCTSN, 2016) which states that:

> *"Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations that overwhelm their ability to cope."*

Extensive research has identified the neurobiological adaptations that can take place as a result of trauma which then seriously compromise a wide range of developmental capabilities (e.g. Gaskill & Perry, 2014; Perry, 1995; Schore, 2001, 2013; Siegel & Gottman, 2015; Van der Kolk, 1994). The presence of caring and supportive adults before, during, and after a traumatic event is integral to a child's ability to make sense of overwhelming experiences. Where positive support exists, children will inevitably recover from the event, developing coping strategies and resilience as a result. This is characteristic of healthy functioning in response to inevitable events as part of a life course (Klorer, 2005).

However, in circumstances where children are exposed to prolonged or repeated traumatic events and lack appropriate support from others, such experiences have the potential to impact the child's overall development. Pervasive traumas – sometimes referred to as 'Type 2' or 'complex traumas' – are suggested to most often be interpersonal in nature, occurring within a child's care-giving system (Van der Kolk, 2005). Where trauma is experienced and adults are the source of the trauma, or if caregivers have limited capacity to support the child, the potential for prolonged impact of the trauma is far greater. This is now extensively depicted in research literature and has been demonstrated to have ramifications for a child's well-being and ongoing development (Klorer, 2005; Schore, 2002).

Chugani et al (2002) were early investigators in the neurological imaging of the brains of children that had experienced trauma. Their neuropsychological assessments "showed neurocognitive impairment, impulsivity, and attention and social deficits" (Klorer, 2005 p.215). Furthermore, developmental deficits were found in areas of the brain associated with

emotions, alongside deficits in linguistic development, memory, and executive functioning. These profound impacts suggested early trauma was associated with long-term cognitive and behavioural deficits (Klorer, 2005).

1.3.2 Trauma and Attachment

Attachment Theory is perhaps the most comprehensive theory for articulating and understanding the consequences of traumatic experiences on the interpersonal relationships of children impacted by trauma. From a relationship perspective, trauma has profound implications for a child's attachment perceptions; in how the child sees themselves, others, and themselves in relation to others. Attachment describes the dependency relationship between a child and its caregiver(s), where a caregiver is someone who provides physical and emotional care, has continuity and consistency in the child's life, and who provides comfort and safety to a child in times of need or distress (Pearce, 2009).

Perry (2013) explains how the formation of emotional relationships is related to the organisation and functioning of specific parts of the brain which develop during the first few years of life. The attachment literature refers to such patterns of relating as Internal Working Models (Ainsworth et al, 1978; Bowlby, 1969), which guide an individual's perceptions of interpersonal relationships based off the framework established in seminal relationships.

In the instances of traumatic experiences, children may not be afforded the opportunity to establish these positive relationships with a caregiver; or these relationships may be interrupted, and the resulting impact may manifest in emotional dysregulation and challenges in interpersonal relationships. Contemporary neurological research has found the connection between insecure attachment and brain development through which, evidence has been presented that details how compromised attachment leads to altered neural pathways, which in turn can lead to regulatory and developmental challenges across the lifespan (Perry, 2013).

Trauma and attachment studies inform us about the organisation of emotions, and the perceptions of self and others. Central to the formation of secure attachment, and thus healthy brain system formation, is predictability around the sensitive, appropriate and responsive caregiving environment. Factors that interrupt bonding experiences also interrupt secure attachment development and are responsible for compromising the neural development of healthy brains (Hughes & Baylin, 2012). By experiencing trauma, children's perceived 'protective shield' is shattered and their perception of supportive others as being available to soothe them is harmed (Dadds et al, 2012; Malchiodi & Crenshaw, 2015). This influences how

they subsequently interact with their caregiver(s) and can result in states of chronic stress and dysregulated help-seeking strategies (Pearce, 2009). Moreover, once the secure patterns of relating are interrupted, insecure working models serve to bias an individual's ongoing appraisal of social cues.

The challenge when intervening with compromised attachment is considering not *what* the child does, but *why* they do it and the motivation behind the behaviour (Pearce, 2009). KidsXpress is mindful of this distinction and therefore embraces therapeutic approaches that tend to the larger caregiving system and the array of impacted developmental tasks, rather than simply targeting the post traumatic symptoms (Mission Australia, 2015).

By being trauma informed, and intervening with methods of engagement that are safe, predictable and nurturing, KidsXpress' program affords opportunities for children's lower order brain systems to find calm; being soothed - in part - through activities that reflect a child's earliest interactions with their caregivers. This approach aids regulatory capabilities and subsequent confidence to explore both internal and external environments, whilst maintaining the ability to return to nurturing interactions if and when distressed. This regulatory function is the premise of developing a secure base (Waters & Cummings, 2000).

Whilst it takes repeated secure relational transactions for insecure attachment relationships to be reworked toward security, the provision of secure interactions propagates positive engagements with others which then lead to enhanced relational capabilities over time (Emmens, 2007). Consistent exposure to positive and secure interpersonal interactions amplifies the integration of secure working models into the patterns of attachment held by an individual.

1.3.3 Trauma and Attachment Patterns across the Lifespan

The impact of trauma and toxic stress can be more damaging for children by comparison to adults. Gaskill and Perry (2014) explain that this is because of the impact on the brain's development as well as its functioning.

> *"Although traumatic experiences may have a negative impact on adult functioning, the same adverse experiences have a much more deleterious impact on children because of the pervasive impact on development. Traumatic stress in adulthood affects a developed and functioning brain; trauma in childhood affects the organisation and functioning of the developing brain. Adults suffering a traumatic event have been found*

> *to attain asymptomatic posttreatment status 75% of the time, but children suffering a traumatic event have been found to achieve asymptomatic status only 33% of the time"* (Gaskill & Perry, 2014 p.183).

When traumatic experiences alter neural functioning, individuals may be so severely impacted that lasting emotional, behavioural, cognitive, sensory-motor, and physical health problems occur (Burke-Harris, 2015; Blaustein & Kinniburgh, 2010). In the case of children, this impact during developmental, formative years may be deleterious for academic performance, focus and reflective analytical abilities (Smilan, 2009); impaired self-regulation and aggression against the self and others, character pathology and dissociation (Van de Kolk et al, 2003); have trouble processing new experiences and forming positive relationships (Fosha, 2003); be perceived more negatively by others in light of their unclear presentation of self (Herzberg et al, 1999); and poor, or challenging behaviour including lack of joy, humour, reciprocal enjoyment, eye contact, empathy, guilt, remorse, and appropriate communication and physical boundaries (Hughes, 1998; Schofield & Beek, 2009).

Adult attachment theorists have indicated the pervasive nature of attachment styles across the lifespan (Hazan & Shaver, 1987), which is explained through the predictable effect of relational schemas - how subsequent interactions are interpreted through the perceptual apparatus shaped by an individual's prior experiences. Thus, insecure relational models bias an individual's perceptions of interactions with others, and their expectations of others, more negatively in accordance with their understanding and expectation of interpersonal relationships.

Adult attachment theorists have also outlined the intergenerational transmission of attachment patterns, showcasing how interpersonal patterns of relating shape how caregivers provide care and support to their dependents; ultimately cultivating the working models of their offspring symbiotically with their own insecurities (Obegi, Morrison, & Shaver, 2004). For this reason, trauma intervention services must be mindful of not only their role in addressing an individual's reactions to a traumatic experience, but the future implications of that intervention for an individual's diverse relationships: That of peer, parent, partner, and professional relationships, amongst others.

That attachment relational patterns are pervasive across the lifespan, and that they are transposed to offspring via styles of caregiving relationships, means that those working with trauma need to be mindful of the role their intervention plays in altering the relational

trajectories of clients within future relationships. Accordingly, this speaks to the imperative need for working with root causes and moving beyond symptomatic treatment (Pearce, 2009).

1.3.4 Trauma and Neurological Functioning

Gaskill and Perry (2014) describe the brain as a hierarchical structure where the higher regions of the brain mediate the complex, executive functions whilst the lower regions mediate regulatory functions. The regions are woven together by numerous neural networks which have their origins in the lower areas of the brain (Perry, 2001), from which they distribute information across the brain and throughout the body. Therefore they have a direct influence upon all forms of functioning (motor, social, emotional, cognitive) and are also integral to the regulation of the body's stress response (Burke-Harris, 2014; Porges, 2014). Typical development of these neural networks facilitates functional integration of the different networks, but neural connections are altered through experience. When those experiences are characterised by traumatic disruptions or toxic stress, the neurological networks may become dysregulated to the extent that all developmental functions become compromised (Mission Australia, 2015).

> *"When input into the brain's lower areas is unfamiliar, chaotic, or threatening, the activity of these systems will alter. That is, 'novelty, chaos and threat change the "state" of the individual' (Gaskill & Perry, 2014). This involves shutting down the higher-order networks that could usually be recruited to modulate 'primitive' feelings and perceptions such as anxiety, hunger, thirst and anger, often resulting in immature, poorly regulated, and impulsive behaviours"* (Mission Australia, 2015).

Neuroplasticity describes how life experiences develop and reorganise the neural pathways in the brain. Pervasive, functional change in neural pathways occurs as a result of learning through exposure to new experiences. Repetition of experiences concretes the neural pathways, bringing coherence and predictability about one's environment and actions within it. Neural adaptation may be in response to positive and negative experiences, but through repeated relational transactions individuals develop *working models* which influence general perceptions of interactions between the self and others (Carr, 2012). Therapeutic endeavours are increasingly informed by the field of enviromimetics, which involves environmental manipulation to bring about change in neural pathway function. Insights from this field are now able to give objective substance to Bowlby's early theorisations of *accommodating* new working models as a result of changed caregiving environments (Hughes & Baylin, 2012, 2016).

Of critical working insights to the trauma and neural functioning literature is the knowledge that traumatic exposure inhibits the cortical areas of the brain by dysregulating the lower-brain and limbic system, rendering the afflicted individual subject to repetitive disruption and disintegration of the higher order brain functions. Perry's (1997) earlier brain imaging investigations revealed cortical atrophy in more than half of the subjects in his study; and these were children that had experienced trauma in the form of severe neglect.

Klorer (2005) further outlined the neurobiological consequences of childhood trauma. He stated that "the earlier during childhood the abuse occurs, the more severe the effects" (p.215). This is based on the assertion that earlier disruptions leads to greatest dysregulation of concomitantly developing and integrating systems. Furthermore, research indicates that childhood trauma has a cumulative effect on adverse effects of brain development (Felitti et al, 1998).

1.3.5 Trauma and Physiological Response

The NCTSN explain that growing up under constant or extreme stress causes adaptations in how the body's stress response systems develop. This may lead to disproportionate reactions of the individual to ordinary levels of stress, reacting as if they are under extreme stress. Whilst extreme reactions may be adaptive, coping mechanisms when faced with actual extreme threats, reacting in such an extreme way as standard can lead to extensive interpersonal dysregulation.

> *"Complexly traumatized youth frequently suffer from body dysregulation, meaning they over-respond or under-respond to sensory stimuli. For example, they may be hypersensitive to sounds, smells, touch or light, or they may suffer from anaesthesia and analgesia, in which they are unaware of pain, touch, or internal physical sensations. As a result they may injure themselves without feeling pain, suffer from physical problems without being aware of them, or, the converse – they may complain of chronic pain in various body areas for which no physical cause can be found"* (NCTSN, 2016).

Pearce (2009) was mindful of these insights when explaining that interventions seeking to help children will be most effective at doing so when they focus upon *why* children behave the way they do, and not *what* the behaviour is. Accordingly, the provision of intervention that seeks to explore the underlying reasons for behaviours may more readily address the response mechanisms that prevent positive connection to self and others.

McEwen (2007) outlined the dual outputs of stress as that of *protection* and *damage*. Short term stress facilitates positive adaptation, allowing the body to recognise the stress, attend to it, and develop adaptive responses to deal with it. This speaks to the protective function of the body's stress response (McEwen, 2007). However, where stress is continuous, the otherwise adaptive stress response becomes damaging. Hyperarousal leads to deleterious consequences which compound and aggregate, resulting in cumulative and perpetuating challenges. Prolonged stress can inhibit optimal sleep, which can lead to increased blood pressure, reduced parasympathetic tone, elevated cortisol levels, increased inflammation of joints and skeletal muscles, as well as psychomotor performance decrements, and immune system suppression (McEwen, 2007).

Accordingly, when considering the impact of childhood trauma on more directly related developmental challenges in the brain, one must also consider the impact of trauma throughout the body (Van der Kolk, 2014) for it poses remarkable danger to all people, especially young children. Exploratory studies are now considering the consequences of unresolved trauma and its subsequent pervasive stress loading on the body with health challenges at the opposite end of the life course, particularly in relation to neurodegenerative conditions such as Alzheimer's disease (R.Bowlby, 2014).

1.3.6 Coping & Defence Mechanisms

Unresolved trauma can lead to a wide range of entrenched emotional difficulties which impact an individual's ability to identify, express, and manage emotions (Perry, 2013). Resulting from the limited linguistic capabilities in childhood is the risk of internalising the stress reactions. The incoherent processing of these can then manifest as anger, anxiety, or depression (Pearce, 2009). In the wake of experiencing trauma, an individual's emotional responses to situations may be unpredictable or explosive (ibid).

As Klorer (2005) outlined, this can be understood as the adaptive coping mechanism - the child may be reacting to both conscious and or unconscious stimuli that remind them of a traumatic event. They may tremble, withdraw, get angry, or disproportionately sad. The research literature identifies how traumatic memories are stored and thus accessed differently to non-traumatising memories; and explicates how they are re-experienced in real time, and in the present (Marloes et al, 2009; Van Der Kolk, 2015). This means reminders of traumatic events are particularly threatening to the individual. Reminders may be everywhere in their day to day environment, and trigger intense emotional responses. This is because children that have not been calmed, soothed, and regulated develop perceptions of the world as a dangerous place in which it is essential to remain vigilant, be guarded, and pre-emptive of

threats from the environment and from others within it - sometimes even caregivers. This defensive mechanism biases perceptions of the environment and interactions with others, making interactions appear stressful or dangerous (Pearce, 2009; Rockett, 2013).

Rockett (2013) noted the importance of recognising the value of the defence mechanism, given how it served a valuable purpose in the environment where threat was present. However, in non-threatening environments, the same defence mechanisms are activated and interfere with non-threatening perceptions of novel situations. An unnecessary reaction therefore becomes problematic in circumstances that do not require such intense reactions (NCTSN, 2016).

Conversely, some individuals develop coping mechanisms that remove the threat from their perceptions and 'tune out' to the stressors of their environment. These individuals are particularly at risk of subsequent internalisation challenges and are also intensely vulnerable, as children, to re-victimisation (ibid).

The challenge with a coping mechanism such as that noted above, is the learned assumption that the individual cannot rely on others for support. These children learn to suppress their desire to seek out support when frightened, distressed, or in pain. Cassidy (2008) detailed these children's overly reliant coping strategies, explaining that they learn to self-soothe in order to avoid the pain of rejection and/or punishment that comes through making their distress known to a rejecting or neglecting caregiver. These children may appear to take care of themselves, displaying little obvious distress (Rockett, 2013), but somatic investigations have revealed that the seemingly calm exterior masks high levels of physiological distress (Sonkin, 2005).

In order to deliver effective reparative intervention - whether formally through a therapy program, or informally through personal relationships - one must be mindful of the defensive strategies that have been developed as a result of the traumatic events. In being aware of defence mechanisms, ameliorative relationships can consciously attempt to mitigate the enactment of the defence mechanism. When the individual is in a state of feeling safe and calm, they are able to engage with memories and experiences in a way that fosters reflection and considered thought. By going through such a process, an individual can learn new ways to understand their reactions to stimuli and recognise the opportunity for accommodating new working models of self and other.

1.3.7 Trauma and Cognition Development

Trauma readily impacts an individual's ability to think clearly (NCTSN, 2016). Reasoning, problem-solving, and thinking through consequences may be noticeably inhibited. As such, future planning and pre-emption may not feature and this is because traumatising experiences shackle the individual in the present, where resources are directed toward survival. Calm consideration of responses outside of the defensive coping mechanism is not possible and thus the acquisition of new skills and new patterns of relating to others are not so easily come by (Rockett, 2013). Positive future consideration evades children impacted by chronic trauma.

Resulting from inhibited cognitive development, children are less capable at academic, executive pursuits. Learning may be delayed and additional support required, which has implications for educational and professional outcomes. Diminished cognitive capabilities can also impinge upon an individual's ability to self-regulate. Without knowing how to calm down, an absence of self-soothing may manifest through a lack of impulse control (Ceschi et al, 2014). By not being able to think before acting, individuals may convey disjointed thoughts through disruptive behaviours.

This does not mean a child will always be oppositional, volatile, or extreme, but that a child may also become over-controlled and unusually compliant to their own detriment, or even react with intense defensiveness if having been exposed to a fearful or abusive caregiver. The long-term ramifications of under-development in this domain include engagement with risky behaviours, heightened risk of being taken advantage of, or practicing of self-destructive behaviours such as self-harm or substance abuse (NCTSN, 2016).

Owing to the cognitive challenges that manifest through trauma, reparative strategies must be mindful of an intervention's efficacy in light of the sought after outcomes. Incongruence between reparative strategy and an individual's capabilities may hinder the process of recovery.

1.3.8 Trauma and Self-Concept

As infants we learn how to perceive ourselves through our interactions with others (Pearce, 2009; Rockett, 2013). Caregivers have the greatest potential impact upon how an individual eventually perceives themselves, by teaching self-concept through attuning interactions that validate a child's emotional experiences (Parish-Plass, 2008; Tronick, 1989).

"Abuse and neglect make a child feel worthless and despondent. A child who is abused will often blame him- or herself. It may feel safer to blame oneself than to recognise the parent as unreliable and dangerous. Shame, guilt, low self-esteem, and a poor self-image are common among children with complex trauma histories" (NCTSN, 2016).

Self-worth is a vital component for future oriented thinking. Valuing the self and recognising the self as worthy and deserving of love is central to engaging in secure interpersonal relationships. One must conceive their plans as having meaning and value. The implication of unresolved trauma in early life, particularly complex traumas, is that children learn to perceive themselves as powerless to change their circumstances, that the world around them is not safe, and that they are unable to trust other people. These negative perceptions of self also manifest as negative expectations of others, which combined makes the individual feel powerless to make a difference in their life. Hope becomes a great difficulty, and life becomes constrained by a focus upon the moment-to-moment without the inclination or ability to think about, plan, or dream for a more secure future.

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Bloom (2005) explains how, as a result of the breadth of trauma manifestations, the origins of the trauma often fall outside of diagnostic consideration. Instead, children impacted by trauma are often diagnosed with and treated for an array of concomitant psychiatric disorders, such as ADHD, anxiety, ODD, personality disorder, or conduct disorder, to name a few (Cook et al, 2005; Perry et al, 1995).

In line with a growing number of traumatologists, KidsXpress believes this approach of addressing symptoms fails to address the complexity of the challenges that individuals impacted by trauma are facing. Rather than focusing on one single, perhaps easily identified and diagnosed symptom, effective amelioration of the root causes requires consideration of the complex interrelated nature of childhood trauma. Working with this in mind deepens the challenge, but directs efforts towards addressing the underlying structures which have been compromised as a result of traumatic experiences.

1.4 KidsXpress Therapy

1.4.1 KidsXpress Co-Led Group Expressive Therapy Program Aims

KidsXpress inspires generational change by inspiring children to thrive.

KidsXpress was born in 2005; emerging in Sydney, Australia with its unique therapy program – a world first, transdisciplinary approach to early intervention trauma therapy. Its founder and founding therapists recognised the need for such an approach following extensive work in child and adult mental health services. The KidsXpress model was devised with knowledge of what constituted appropriate and effective responses to the developmental needs and abilities of the children. That design was heavily shaped by the works of Dr Bruce Perry, Dr Allan Schore, Dr Bessel Van der Kolk, and Dr Dan Siegel. The establishment Ultimately, KidsXpress was established to effectively interrupt the cycle of trauma and help support the happier, healthier, more resilient and secure development of children who have experienced or are experiencing traumatic events.

Specifically, KidsXpress seeks to bring about the following outcomes through the therapy:

- Enhanced Self Regulation
- Enhanced Self Awareness
- Enhanced Self Expression
- Enhanced Connection with Others
- Enhanced Receptive Communication
- Enhanced Empathy
- Greater Ability to Recognise the Impact of Self on Others
- Improved Sense of Safety
- Improved Ability to Work in a Group

1.4.2 Expressive Therapy Rationale

Contemporary research in trauma studies have revealed the neurobiological implications of adverse childhood experiences. Neuroscience researchers have found right hemisphere development to be compromised through adverse caregiving environments (Schore, 2001)

have highly dysregulating consequences for normal brain development, impacting future states of mental and emotional well-being (van de Kolk, 1994).

Porges (2011) explained how hyperarousal may result from the dysregulation of the individual's stress arousal system, putting them in a continuous state of heightened stress sensitivity. This has severe implications for self-regulatory capabilities as aforementioned and, over time, can render individuals at far greater risk of physiological and mental ill health (Burke Harris, 2014).

Through the relentless state of hyperarousal, individuals who have experienced or are experiencing traumatic challenges have been found to maintain higher perceptions of threat, even in situations where threats are not present (Perry, 2004; Van der Kolk, 1994). This includes the misperception of facial cues; non-threatening / neutral expressions are perceived as threatening or rejecting (Meyer, Pilkonis, & Beevers, 2004). Such responses stem from the over sensitisation of the amygdala, where the resulting effect is that of individuals rapidly escalating into acute states of stress arousal (Perry, 2004).

An individual's organisation and storage of traumatic memories leads to further, repetitive experiences of trauma. This contributes to the trauma cycle, as the incomplete nature of the memory storage leads to repeatedly intrusive pieces of a memory returning to conscious awareness. These are often sensory memories and can also lead to the escalation of acute states of stress arousal (Kleim, Graham, Bryant, & Ehlers, 2013), for memory intrusions comprise mostly sensory impressions from the moments of the trauma, such as visual, auditory, or bodily sensations, and emotional responses from the trauma (Ehlers, Hackman, & Michael, 2004). Kleim et al (2013) explain how trauma sufferers' fragmented memories are experienced with "here and now quality" (p.998) which contributes to a current sense of threat, without realisation that they are from a past event.

In light of these adaptations it is clear that childhood trauma is a serious health challenge. The implications are so great as to affect the already discussed social, emotional and cognitive functioning of a child as the result of the brain's heightened response to the traumatic stress. This happens as a result of the lower regions of the brain remaining engaged in the stress response, thus inhibiting the higher orders of the brain in their operational functioning for systems such as cognitive reasoning (Van der Kolk, 2014).

This is detrimental to interpersonal function as well as individual functioning. It inhibits one's reasoning and logic, behavioural control and emotional regulation, and thinking, reflection, and learning abilities (Perry, 2006).

With this wealth of research from converging but disparate fields of study, a clear picture emerges for how we can understand the impact of traumatic and stressful environments and devise early interventions that may be effective in enabling children heal and regain developmental trajectories into healthier, happier, more resilient adulthoods.

Accordingly, expressive therapies are a pertinent approach in trauma reparation. Particularly with child clients, trauma may so profoundly impact upon seminal developmental processes that the neural infrastructure required by traditional talking based therapies is maladaptive or under developed in those impacted by trauma. Thus, methods of engaging clients' somatic and emotional experiences through the physical nature of doing, being, and feeling, help access and activate the processing of otherwise problematic memory experiences (Malchiodi & Crenshaw, 2015).

Malchiodi and Crenshaw (2015) outline five overarching components to explain the merit of expressive therapies for ameliorating trauma related challenges: (1) Sensory-based intervention; (2) Non-verbal communication; (3) Affect regulation; (4) Relational interventions; and (5) Right hemisphere dominance.

Multisensorial approaches to therapy are suggested to play a critical role for developing feelings of security (Perry, 2008). The tactile, rhythmic, physical, auditory, embodied components of expressive therapies provide opportunity for attuned affiliation with others where one's actions and responses are noticed and validated by others. Such practices help identify and recognise sensations, emotions, and relationships (Siegel, 2012), and develop a sense of safety and security in interactions.

Expressive therapies allow for our more basic communication skills to be engaged, reflecting the non-verbal methods of communication that exist in a child's early interactions with their caregiver. Allan Schore (2003) notes that children may lack the linguistic repertoire to articulate their thoughts and feelings with the accuracy required for coherence, and therefore expressive therapies facilitate communications that are not dependent on verbal capabilities; instead clients may engage with experiences that evade the realms of spoken conversation (Malchiodi & Crenshaw, 2015).

Trauma that is a result of relational difficulties is known to create insecurity within patterns of attachment. Disrupted attachments leave children with affect regulation difficulties, alongside hyperarousal of the stress response system. Insecure attachments are characterised by feelings of lacking safety. These defensive strategies are adaptive within environments in which threats to the child exist, but they are non-discriminatory of environments, and can become pervasive within a child's life. Expressive therapies enable soothing activities that disarm a child's defence mechanism, allowing for restorative feelings of calm to be experienced. Whilst defence mechanisms are not engaged, the brain is able to experience novel and adaptive behaviours which induce a sense of safety, peace, and security.

Expressive therapies are:

> *"...relational approaches to treatment that may involve mirroring, role play, enactment, sharing, showing, and witnessing. They may be helpful in repairing and reshaping attachment through experiential and sensory means, and may tap those early relational states that existed before words became dominant, allowing the brain to establish new, more productive patterns (Malchiodi, 2012 in Malchiodi & Crenshaw, 2015).*

The process and methods involved within expressive therapy intervention leads to numerous opportunities for positive, attuning interactions between clients and therapists. Such relationships are pivotal in repairing relational perceptions of self, others, and self in relation to others and are integral to the development of feeling secure and confident (Perry, 2009).

Expressive therapies are also pertinent methods of engagement for trauma reparation due to their contextualisation within the right hemisphere of the brain. Siegel (2012) explains that this region of the brain is 'non-word-based' and is dominant in infant-caregiver communications. Interestingly, Van der Kolk (2006) explicates that trauma is stored in the right brain as sensory memories, requiring sensory engagement in order to successfully address the root of the challenges. Contemporary insights from neuroscience which have given detailed knowledge of brain structure and function further outline the efficacy of sensory intervention owing to the less effective results when reliance is placed upon linguistic (left brain) capabilities for integrating experiences with understanding.

Marloes et al, (2009) explain in further detail how toxic stress influences memory formation. The authors detail how aversive events are extremely well remembered, rooted in an evolutionary explanation that such processes were advantageous for survival. However, the clarity with which stressful memories are stored may also be maladaptive and culminate in

hypervigilance towards cues associated with the stressor. When the stressor happens to be another person, in particular a potential figure of attachment, relational interactions become extremely stressful for the individual to navigate. Furthermore, memories that are formed in the presence of toxic stress can reside in the subconscious, meaning that sensory cues, even when not recognised consciously, can re-trigger the recall and experiencing of disturbing memories, or the difficult emotions that arose at the time of the traumatic event. For this reason, interventions that rely upon one-to-one relationships with verbal interactions and sensitive articulations at their core may be difficult for children to embrace.

What makes the expressive therapies so appropriate when working with traumatic memories is that traumatic experiences may be recalled, accessed and engaged from a safe distance. Marloes et al (2009) and Van der Kolk (2016) articulate how traumatic memories are re-experienced in the present – i.e. they do not have a timestamp that holds the event in the past – and thus engaging directly with traumatic memories may serve to re-traumatise the individual. Instead, creating a safe environment where indirect engagement with the memories is made possible, clients are able to express and experience the original event and learn new reactions to the event.

Klemm (2010) makes it clear that “re-living the original event must include dealing with the negative emotions in the light of reason and new emotional experience. Therapy requires critical thinking about thoughts and feelings, especially those that are unhelpful and unrealistic. The patient is gently led to face memories anew and to learn new ways of thinking and behaving. This re-creation of the bad event allows us to extinguish memory of the original bad situation and its negative emotions.” Van de Kolk (2016) details this process of recognising the event being in the past and that effective therapy enables clients to no longer see this as a component of the present.

Expressive therapies are cognisant of how the mind and body respond to trauma, recognising that a child’s responses to trauma are actually adaptive strategies to the adversity (Malchiodi & Crenshaw, 2015). KidsXpress uses the expressive modalities given the notion that they are developmentally appropriate for the reconnection of implicit and explicit memories of trauma, in such a way that children are better able to externalise their problems and to work through them.

1.4.3 Group Therapy Rationale

Children are placed in groups of six for their ten-week program at KidsXpress. The rationale for group therapy is very clear. Financially, it is more cost effective to place children through group therapy as opposed to one-to-one therapy from the simple perspective of resource allocation (Paturel, 2012). In addition, a comprehensive meta-analyses of more than 50 clinical trials demonstrated the equivalence of individual and group formats for producing the same degree of improvement (ibid).

Kivlighan (2012) explicates these pivotal findings. He explains how a group influences individual group members, particularly when a common identity exists among the members and there is a sense of shared purpose. Burlingame et al (2009) deduced this important characteristic to effective group therapy outcome from a meta-analysis of another 40 empirical investigations. For this reason, KidsXpress aims to allocate children by age and referral reason, meaning that strategic allocation of children to each group ensures there may be common purpose amongst group members.

Paturel's (2012) article aggregating group therapy efficacy findings suggested, in addition to common purpose, that peer interactions offer many therapeutic qualities. Groups can help people heal when they provide social support. Improving social networks is integral to psychosocial health and can reduce perceived stigma and feelings of alienation amongst those attending therapy. Indeed, Yalom (2005) posits that group therapy with peers may prove more influential than one-to-one therapy with a therapist as a result of peer to peer identification. Peers may more readily receive guidance from their peers due to more easily identifying with them and their similar challenges than they can a therapist and, furthermore, these connections have been found to translate into real-world contexts of the group members' lives.

KidsXpress utilises this knowledge to also understand the impact of the group on the individuals. Paturel (2012) cites findings which show that as individuals improve, the group as a whole benefits. By witnessing others' progress through similar challenges, individuals may become aware that they, too, can overcome their challenge and feel better. This is understood as clients being agents of change for each other and demonstrates the co-dependency of the group upon its individual, and of the individuals on their group.

The final piece of the puzzle in KidsXpress' rationale for group therapy utilisation is what it offers to the therapists. Having multiple therapists facilitates therapist observations; they gain

a chance to observe the relational interactions and interpersonal skills used by group members. This provides a more accurate depiction of accommodated skills and removes the requirement and potential inaccuracy (owing to perceptive limitations) of clients' self-report. The group ultimately becomes a small scale version of the members' social lives. Kivlighan (2012) states: "You have so much more data available to you in a group setting. All you have to do is watch."

1.4.4 Early Intervention Rationale

Experiences early in life are particularly influential in organising the brain's basic structures. Indeed, these early experiences establish the neural foundation upon which subsequent development and behaviour are based (Derrington, Shapiro & Smith, 2003). The young brain is therefore malleable; being shaped by the early experiences made available to the young child (Siegel, 1999), which in the context of compromised experiences, may lead to suboptimal development of neural pathways and thus the impairment of optimal functioning in the child.

In referring to Early Intervention we must understand and appreciate how the term is (often diversely) utilised. On one hand, it refers to intervention in the early years of a child's life. Specifically, this is *Early Childhood Intervention (ECI),* because it occurs in the early years of life; a timeframe which Moore (2014) frames as "from birth through to school age" (p.2).

On the other hand, early intervention may describe the early intervention following a problematic stimulus or event. The motivation of such early intervention is to affect the mental health outcomes either now, or into the future; thereby managing the presenting challenges to reduce or mitigate them. Early Intervention in this context may occur at any age, with the central focus being upon the reparative process toward recovering a healthy developmental trajectory, encompassing healthy social, emotional, and behavioural regulation and preventing the entrenchment of the response to the trauma.

In the context of KidsXpress, Early Intervention refers to the motivation to help children who are at greater risk due to compromised caregiving environments. In numerous cases, these environments result from the ramifications of intergenerational trauma. Scholars often refer to this as chronic trauma (Misson Australia, 2015). Acute trauma on the other hand, refers to those events which are one-off in frequency, but create an intense state of fear, horror or helplessness (NCTSN, 2016). In this KidsXpress context, intended outcomes focus on the children's additional needs as a result of both chronic and acute traumas, in an attempt to

process and understand the events causing the trauma, rather than focusing purely on addressing comorbid symptoms (Cook et al, 2005).

Both types of Early Intervention are critical for mental health and well-being. In the context of children who face additional needs, intervening early can promote healthier interaction, enhanced well-being, social inclusion and community engagement. In and of themselves, these outcomes may buffer against secondary problems for those children with additional needs (Dept. of Health and Ageing, 2010).

Critical to the purpose of early intervention is its role in reducing the severity or duration of symptoms arising from a particular event or occurrence. This type of early intervention seeks to interrupt negative trajectories associated with particular challenges.

The Department of Health and Ageing (2010) explain when Early Intervention may be needed:

- *"Early childhood intervention may be needed when a child's behaviour or abilities appear to be out of step with peers at a similar age and stage of development. For example, there may be differences in language acquisition or motor skills. Isolated incidents or temporary problems may not need intervention, but assessment should be considered if difficulties persist over time, interfere with the child's progress and further development, or cause concern for the family.*

- *Early intervention specifically for mental health may be needed when there are early signs of emotional, behavioural or mental health difficulties, or when a child has experienced difficult life events such as trauma or abuse."*

In light of the above, KidsXpress is positioned not as an Early Childhood Intervention (ECI) but an early intervention that addresses emotional trauma as soon after an event as possible, before the ramifications become entrenched, i.e. in the immediate timeframe following a stressful stimulus. Additionally, KidsXpress works only with children from four to 14 years of age, thus falling outside of Moore's (2014) Best Practice guidelines for what constitutes ECI.

Nonetheless, KidsXpress does work with children who have been impacted by intergenerational trauma, and are thus still facing challenges where ECI would have been beneficial. Thus, the delivery of KidsXpress is formulated in such a way as to bear these needs in mind when constructing the groups in which children attend the program. Accordingly, KidsXpress' program logic is to some extent, malleable to the needs of each group that moves

through the program, but holds central to its approach the notion of intervening as early as possible as a traumatic event.

1.4.5 Transdisciplinary Rationale

“Transdisciplinarity emerged…in response to a host of concerns about the pitfalls of specialisation and the compartmentalisation of knowledge” (Bernstein, 2015. p.8). It has risen to a form of research inquiry that helps understand real world challenges that demand practical solutions.

The concept of transdisciplinarity was introduced by Piaget (1972) as an articulation of how various disciplines might interact in a wider system where there were no distinct boundaries between the disciplines. He proposed it as succeeding interdisciplinary and multidisciplinary service delivery because these remain focused on the pursuits of the individual domains. Jantsch (1972) later suggested that transdisciplinarity is the coordination of disciplines in a system on the basis of a generalised axiomatics – in other words, multiple disciplines working in coordinated ways to effect change of a generally accepted truth, or consistent set of desired outcomes.

Offering a set of suggested guidelines to the establishment of transdisciplinarity, Mahan (1970) repudiated the acceptance of traditional ‘discipline compartmentalisation’ for the detachment and individualism that was associated with disparate disciplinary inquiry. Bernstein (2015) has organised the concept of transdisciplinarity to reflect its utilisation in macro-level thinking, where meaningful linkages between subjects are made and utilised, rather than being kept apart by superficial difference. At the heart of Bernstein’s (2015) assertion is the interconnectedness of potential disparate approaches.

Bernstein (2015) notes how transdisciplinary approaches have transgressed from philosophical assertion to a matter of urgent uptake, suggesting the segmenting of knowledge and the individual categorisation of knowledge actually harms the ability of systems to operate comprehensively. The challenge, he posits, is not so much the recognition of transdisciplinarity but the uptake of its methods in a practical system. In order to comprehensively address significant challenges, we must seek to derive insight from as many perspectives as we can, so that we may be best positioned to enact the most appropriate – and flexible – response.

Nicolescu (2010) also considered complexity a fundamental feature of reality. Indeed, his work calls for a move beyond compartmentalised disciplines and a move toward considering what

is between, across, and beyond the disciplines. Perhaps most clearly conceptualised is the notion that transdisciplinary approaches fuse knowledge from a number of disciplines and engage with numerous stakeholders in the process of generating working knowledge.

Thus, what this means for KidsXpress, as a transdisciplinary therapy model, is a commitment to the fusion of insights and knowledge brought from each of the therapeutic modalities that comprise the KidsXpress therapy program. Therapists at KidsXpress operate in a transdisciplinary environment where they operate both within and outside their primary therapy modality and engage in other modes of thinking and service delivery. Klein (2015) asserts this as a positive approach to intervention as it eschews reductionist approaches to problem solving, refuting a single 'best way' to go about delivering change.

Accordingly, KidsXpress calls upon the understandings and insights from Music, Art, Drama, and Play Therapies each, as therapeutic modalities in their own right, with their own viewpoints and interpretations of therapeutic focus. However, in the context of KidsXpress' therapy program, Klein's (2015) and Bernstein's (2015) direction is taken; the fusion of the modalities, and the recognition of their complementary pursuits, enables collaborative macro-level approaches to address the challenges associated with childhood trauma via the most comprehensive approach possible.

"What sets transdisciplinarity apart from other approaches … is its acceptance of, and its focus on, the inherent complexity of reality that is seen when one examines a problem or phenomenon from multiple angles and dimensions with a view toward discovering hidden connections between different disciplines" (Madni, 2007 in Bernstein, 2015 p.8).

What sets KidsXpress apart from other approaches is its implementation of transdisciplinary expressive therapy as an appropriate means by which to address the complex developmental, cognitive, and processing capacities of children impacted by chronic emotional trauma. In recognising the collaborative efficacy of that which exists between, across and beyond the individual disciplines (Nicolescu, 2010), KidsXpress provides greater opportunity to consider the children's challenges differently, thereby providing a greater repertoire of reparative approaches to find the most pertinent in assisting children with their needs.

This could be considered the antithesis of Maslow's (1966) law of the hammer, which asserts that: "When all you have is a hammer, every problem looks like a nail".

1.4.6 Co-Led Therapy Rationale

Having multiple therapists allows for a comprehensive and versatile approach in meeting the wide-ranging abilities and needs of the individuals within the group, particularly with the expressive therapies and their sensory nature (e.g. by enacting experiences in play, by using their whole bodies, creating an artwork or engaging in music; and where appropriate, being able to combine our approaches and work simultaneously with different disciplines). There is the unique opportunity for interplay between therapists, the space that is created and the expressive therapies, as well as reflection on the play space or space between (creative distancing) where the creative act can take place before subsequently being reflected upon (usually by the individual but this can also be done by other group members - children and adults – verbally or creatively).

Kivlighan et al's (2012) research investigations interrogated therapy outcomes in accordance with the number of therapists present. His research concluded that multiple therapists in a group context were more efficacious because of the extra awareness that could follow multiple interactions between group members. Important cues, particularly non-verbal, are in danger of being missed when there is only one therapist present. His study found that multiple therapist presence was correlated with increased engagement and decreased avoidance as measured by the Group Climate Questionnaire (MacKenzie et al, 1983). These relational components of cohesive groups are long established requisites for positive therapeutic outcomes.

Furthermore, co-led leadership in group therapy has been found to influence greater levels of therapy attendance (e.g. Hendrix, Fournier & Briggs, 2001). The added social relational complexity of group therapy requires more skilled leadership to develop cohesion and a sense of belonging to the group to ensure adherence to therapy sessions (Kivlighan et al, 2012).

Having multiple therapists in a team can also provide professional support/supervision in practice for the benefit of KidsXpress' clients. It's also a great way to learn from each other and to adapt and refine therapist techniques.

(i) Therapeutic Alliance:

A therapeutic alliance is the term given to the operational relationship that exists between a client and a therapist in the context of psychological therapy (Ardito & Rabellino, 2011). Its conceptual origins may be traced back to Freud's construct of transference, from which, the relationship that existed between client and therapist became an object of study in identifying

psychotherapeutic outcomes. This process and outcome focused interrogation of psychotherapy (Ardito & Rabellino, 2011) landed on the explication of nonspecific factors of therapy which have a significant impact on the outcomes. These nonspecific factors are namely "the personal characteristics of the therapist and the positive feelings that arise in the patient - feelings which can lead to the creation of a positive therapeutic climate from an emotional and interpersonal perspective" (ibid. p.1).

KidsXpress provides three therapists to each group of six children. This ensures a high therapist:client ratio and therefore the opportunity for children to form the best possible working relationship with the therapist (or therapists) to whom they feel most strongly; or the creative medium or combination of interventions that resonates for them. The therapy team can also provide the opportunity for children to observe, and even be part of, position negotiation and collaboration.

(ii) Therapeutic Plurality:

Kivlighan (2012)'s extensive meta-analysis of more than 50 clinical trials elucidates the impact of therapist plurality. He notes that multiple therapists facilitate greater observation of group members, helping recognise and elaborate on the nonverbal components of group members that a sole therapist would not be able to negotiate. Through observation and timely interjection, multiple therapists are able to hold the therapy space in accordance with the therapeutic aims, whilst modelling and enabling group members to serve as agents of change for each other.

King, Rowe and Leonards (2011) explored the impact of trusted others on the spread of trusting perceptions to new objects. They unpacked the notion that joint attention increases observer trust in the joint attention partner, influencing the liking of objects. In the context of KidsXpress, these findings may be used to understand how multiple therapists may enhance group members' perceptions of others by jointly paying attention to them, increasing observer trust through modelling of joint attention. The notion of 'I trust you; hence I like the things you look at' (King et al, 2011) bears influence on how positive interpersonal affect is facilitated through the group therapy program.

(iii) Modelling Relational Interactions:

Rockett (2013) presented research findings which explored the relational mechanisms behind Emmens' (2012) notion of *Enhanced Relational Capabilities.* This research with children aged 8-14 years focused upon the relationship development inclination and skill of children that had

experienced inconsistent caregiving relationships and severe loss. At the core of the investigation was the assertion that insecurely attached children had working models of relationships that made it difficult for subsequent caregivers to side step.

The findings demonstrated that if the attachment system can remain deactivated, there exists a capability to learn relational skills through observation. When the child is an observer they are able to process the observed experience without being faced with the threatening stimuli that they have learned leads to difficulty. Thus, in the KidsXpress therapy space, it is possible to educate children about relational interactions through modelling behaviours between therapists and more capable others. This influential process is predicated on children's desire to bond with others, particularly in times of distress, and requires that the attachment system remains deactivated as new *relational transactions* (Carr, 2012) are noted and included in the child's repertoire of working models. Albeit relationship specific, Rockett's (2013) work identified the accelerated process of new working model accommodation (Bowlby, 1969) when caregivers were actively and strategically displaying model behaviours for children to observe from a safe relational distance, with the added benefit of deactivated defence mechanisms.

These findings speak to an indirect approach to communication. While there may be positive gain from direct interaction with group members, KidsXpress utilises a multiple therapist approach to ensure that opportunity for direct *and* indirect interaction with group members can occur.

1.4.7 KidsXpress Delivery Context – Centre Based and Outreach

KidsXpress receives referrals from professional referrals, with children and youth being referred into the program from Education, Medical, Welfare, and Community pathways. KidsXpress facilitates inter-agency services, enhancing service delivery and communications between stakeholders in the children's lives and the agencies delivering their services.

KidsXpress' services also extend this integrated approach to include the parents/carers of disadvantaged or vulnerable families. KidsXpress operates in a position of committed integration, facilitating onward referrals in order to further child and family support services following completion of the program. The essential reasoning behind this is that it supports and develops the work completed in therapy by having it informed, extended, and supplemented by other interventions and services available to KidsXpress' clients and their families.

Saxe, Ellis and Kaplow (2009) note that inter-agency collaboration is an essential feature of addressing the social environment in which traumatised children live. These scholars indicate the importance of understanding how the core problem of dysregulated emotional states results from traumatic events, rendering a child with heightened reactivity to stressors and threats within the social environment. A service which is disconnected from a child's social environment is rendered powerless to impact the underlying sources which lead to the child's traumatic stress.

With this insight, and in light of the developmental literature's wealth of knowledge that explicates the need for the social environment to be properly equipped to help the child, KidsXpress strategically engages with members of each child's caregiving network. This is done with the knowledge that care-network support is imperative for holistic support of change. Services which assume the role of intervention, such as KidsXpress, are therefore becoming part of that system of care, with the aim of addressing the social environment as well as the child's individual needs. Operating from this stance is essential to delivering efficacious services and influencing long-term impact (Saxe et al, 2009). KidsXpress is committed to being cognizant of how the social environment and the developing child interact.

Indeed, the NSW ECI Chapter (2014) states:

> *"Early intervention supports need to be provided in a way which is inclusive of the family so that activities are targeted to encourage the learning and development of the child and are reinforced and complemented in family settings. In this sense, the goals of the family, their values and priorities need to be integral to the developing early intervention approach to ensure that [early intervention] will make the most significant impact."*

In keeping with its commitment to its intended outcomes, KidsXpress has had a history of critical appraisal, seeking any avenue through which to enhance the impact of its program and benefit more children with its program. KidsXpress initially launched its therapy centre in Moore Park; the design of which was completed by children, for children. The centre still operates today with therapy sessions taking place for groups comprising individually referred clients. In response to KidsXpress' community research which indicated a strong need for our services within the communities themselves, both in Inner Sydney and in Sydney's Western regions, KidsXpress developed and launched its outreach program to take the therapy space 'on the road' in order to serve those communities most in need. Accordingly, KidsXpress operates a dual therapy program with therapy programs delivered either via our flagship therapy centre in Moore Park, or via our Inner Sydney and Western Sydney outreach program.

This delivery context is comprised on the foundation of Trauma Systems Therapy which recognises that for the most efficacious outcomes, a child with dysregulated emotional states and a social environment that is unable to help the child regulate these emotional states, requires concomitant intervention. KidsXpress' delivery context is therefore predicated on Saxe et al's (2009, p.6) Trauma System Therapy guidelines of:

1. Treatment being developmentally informed
2. Treatment addressing the social ecology
3. Treatment being compatible with systems of care
4. Treatment being disseminate-able

1.4.8 KidsXpress Ten Week Program

Interventions are predetermined actions which are performed to bring about change in people (Australian Psychological Society, 2016). Interventions may range in duration, and typically those of 10 weeks or fewer are referred to as short-term interventions, whilst those over 10 weeks are longer-term interventions (Mayer et al, 2008). Of great interest to efficacy studies is the optimisation of intervention duration.

KidsXpress operates with a ten-week therapy structure. Week one includes orientation, where group members meet each other and explore the therapy space. Children get to meet the therapists and this week also serves as assessment, which is important for familiarisation of the therapeutic space for the child and parent/carer. It is also important for determining the readiness of the referred children into the program. Assessment is a two-way process and allows the children and their parents/carers to determine if KidsXpress is a program they can commit to. The concept of KidsXpress is introduced and a child's suitability and interest in group therapy is determined.

The focus of therapeutic sessions during weeks two to ten are discussed and decided at weekly therapy meetings to determine appropriate interventions to best support the needs of the children within the group. During these weeks, communication with parents/carers and referrers is established and maintained to collect information regarding ongoing happenings for the child; to provide parents/carers and referrers with information and feedback on the child's participation; and to strengthen the child's care-team.

Weeks two to three are the first times children engage in their first session together with their allocated therapy team. Groups are often invited to create their own group agreement or rules.

Children explore the therapeutic space and the therapy team observe and respond to emerging group dynamics. The KidsXpress journey is dynamic and the general framework of the sessions is discussed at weekly therapy team meetings. There are many ways a session can be facilitated.

The focus in the middle of the program – weeks four to eight– encourages children to express what is important to them with regards to their feelings, relationships, and life situations. Feelings and stories may be represented through music, art, drama, and play and opportunities for their meaning to be processed and reflected by the children are facilitated during the therapy sessions.

The focus at the end of the program – weeks nine and ten – ensures closure for the group. It reviews each child's journey as an individual and as a group member. The primary contact therapist communicates with parents/carers, updating them on their child's journey, to provide feedback and also advise when summaries will be sent out. As part of the closure and evaluation process, children, parents/carers and referrers are asked to provide feedback on the child; therapists also complete a post-program questionnaire on the child.

Mayer et al (2008) report a meta-analysis which explored the effect sizing of various length interventions. The study revealed greatest outcomes from those programs that were eight to ten weeks in length. In addition, the study suggested that interventions had diminishing returns if longer than ten weeks. This suggests there may be an optimal duration over which an intervention takes place. In light of these, and other studies' findings which find strength in a ten week model, KidsXpress structures the therapy program in accordance with the framework noted above. For practical reasons, KidsXpress also delivers the program over ten weeks to align with the school terms. This structure makes commitment and adherence to the program that bit easier for children and their parents/carers.

Of course, other factors are at play when devising a sound business model to coincide with an optimal service model. KidsXpress was also created with mindfulness about the financial constraints of longer-term therapy, particularly within the model of co-led therapy, which is expensive.

1.4.9 KidsXpress Program Design

KidsXpress' therapy program is a world first early intervention model that operates a transdisciplinary approach to trauma therapy. Utilising expressive therapies, principally Art, Music, Drama, and Play Therapies, KidsXpress deliberately and strategically interfaces the expressive modalities for their combined efficacy in accomplishing therapeutic objectives (Malchiodi, 2005). With such a theoretical underpinning, KidsXpress observes developments in children from a trauma-attachment understanding, supported by insights from neuroscience research. Accordingly, child development across the program is considered in accordance with key indicators of wellbeing: (a) Self-awareness; (b) Expression of Feelings & Emotions; (c) Connection to Others; (d) Recognition of Self Impacting Others; (e) Empathy; (f) Self-regulation; (g) Social wellbeing (ability to work with others).

These indicators of child development and emotional well-being have been selected with cognizance of Perry's (2002) articulation of Six Core Strengths for healthy child development. They do not map exactly to Perry's core strengths, but are characterised by both personal and interpersonal elements of attachment, attunement, empathy, regulation, belonging and acceptance.

KidsXpress' program is delivered in accordance with the school terms. Thus therapy journeys are ten weeks long with weekly sessions lasting 60-90 minutes. Children are typically grouped by age and referral reason, and teams of three expressive therapists work with closed groups of up to six children and youth at a time. This high therapist to client ratio facilitates greater opportunity for children to form effective therapeutic alliances within their group therapy dynamic.

1.4.10 Hello and Goodbye Rituals

Developing trust in the therapeutic dynamic is of critical importance to subsequent therapy outcomes. Central to the development of security is one's ability to predict events in their environment and ascertain comfort in their interactions. For an infant, this predictability is developed through the responsiveness of a caregiver to the infant's signals of distress. When an individual learns that they are able to trust and rely upon close others, they develop a secure pattern of relating which instils an optimal perception of the availability of caregivers in times of need.

Resulting from those relationships is the valuable gift of predictability, or expectation. Consistency in interactions leads to stability in expectations which in turn leads to security in relational working models (Rockett, 2013). Security facilitates exploration of one's environment, and where that environment is saturated with positive, consistent interpersonal potential, enhancing relational capabilities becomes possible through the practicing of positive and rewarding interpersonal dynamics. This establishes a future oriented mindset; one that is not hyper aroused to process the present or to scan for threat.

KidsXpress' program is deliberately structured to reproduce a pattern of secure development. Therapists and children engage in a 'Hello Song', or other creative opening ritual appropriate to the age and needs of the group, at the start of every session. By convening children in the group setting consistently each week, children develop a sense of predictability about the environment which has the effect of presenting the familiar – and deactivating the defence response that can arise through uncertainty of one's environment (Paylo, Darby, Kinch, & Kress, 2014). In similar fashion, each session concludes with a 'Goodbye Song' or other creative closing ritual that is appropriate to the age and needs of the group.

This structure helps reorient clients' cognitive and emotional selves to the external world of the therapy program, group, and environment (Paylo et al, 2014). In doing so, these behaviour prime individuals with a secure mindset which serves to enhance positive perceptions, belonging, and membership within the therapy group.

1.4.11 Data Collection: Multiple Stakeholder Approach

KidsXpress has been an accredited Evidence Based Program (EBP) since 2015, where that accreditation is governed by the federal department Australian Institute of Family Studies (AIFS), part of the Department of Social Services (DSS). The AIFS is the Australian government's key research body in the area of family wellbeing. It conducts original research to increase understanding about Australian families and the issues that affect them.

The KidsXpress program is subject to numerous and extensive forms of assessment with defined therapy outcomes and clearly articulated performance indicators (Mission Australia, 2015). By reviewing the KidsXpress program in this manner, insights are derived about the continuing effectiveness of the program in supporting the social and emotional well-being of the children and youth who partake in the program. Additionally, such performance evaluation enables continued professional development through reflection and evaluation of service delivery in accordance with industry Best Practice guidelines (AIFS, 2016).

To best understand the outcomes achieved and the degree of impact of the KidsXpress intervention, KidsXpress capture insights from each of the key stakeholders in the children's community. This establishes an evidence base for the program's outcomes and subsequent impact (a) within the program, (b) in the home / family context, (c) in the school context, and (d) from the perspective of the professional referrers.

Outcome and Impact data is collected via:

- GCG-S (MacKenzie, 1983) from each week of therapy (client)
- KTIs from four time points across the program (client)
- Pre and Post Quality of Life and emotional expression (client)
- Pre and Post appraisal of children (parent/carer)
- Pre and Post appraisal of children (group referrer)
- Post program appraisal of children (therapists)
- Weekly Therapy Notes (therapists)
- Three month assessment of sustained impact (parent/carer)
- Six month assessment of sustained impact (group referrer)
- Twelve month assessment of sustained impact (parent/carer)

This comprehensive multi-stakeholder approach to data collection facilitates understanding about the complex domains in which the children live by considering each of them for evidence of change. Equally, it offers opportunity for subsequent needs to be identified - and the context in which those needs arise - and the enlistment of ongoing supportive strategies to meet those needs.

1.4.12 Scope and Reach of KidsXpress' Therapy

A total of 480 children currently gain access to the KidsXpress program each year. These attendance numbers are derived from five therapy teams. KidsXpress operates with a reasonable waitlist, demonstrating the need and the demand for its services. Equally, this demonstrates the need for KidsXpress to grow in order to provide its services as soon as they are sought.

These numbers currently reflect an annual total of 800 therapy sessions, amounting to 1000 hours of therapy taking place. This does not consider the triple therapist presence, which, if considered, would reflect 3,000 hours of therapy delivery annually.

sum: (Ngroup x 6 = Nchildren) x (Nsessions x 75minutes) = 1,000 hours of therapy. Thus 3,000 hours of therapy if multiplied by 3 to reflect presence of three therapists

Additional engagements from the program include parents/carers who are able and willing to attend the parent/carer Expressive Communication Workshops and parallel events that take place alongside the children's therapy program. While numbers of engaged parents/carers vary, and for multiple reasons, we estimate that KidsXpress engages directly with 300-350 parents/carers of children in the program during the course of any one year.

The numbers expressed above reflect only direct engagements. Independent research by Deloitte Access Economics (2015) surveyed parent/carers and referrers to understand the impact of the KidsXpress program over 12 months post-program completion. Their survey noted benefits in family functioning, increased communication, and reduced burden of the reason children were referred to the program. Thus, the reach of KidsXpress' therapy outcomes extends beyond those children directly engaged through therapy, to impact members of those children's close networks - siblings, peers, parents/carers, and teachers.

1.4.13 Client Outcomes

The extent of KidsXpress' research program means that numerous elements of the program's impact on children's well-being and functioning are scrutinized for the purpose of establishing outcomes judgement criteria. KidsXpress is acutely mindful of the integrated nature of historical experience, current caregiving environments, and developmental trajectories of children, and thus consider the viewpoints of multiple key stakeholders across the children's lives in deducing the Client Outcomes:

- Pre-program assessment of a child's social and emotional functioning
- Post-program comparison of a child's social and emotional functioning
- Pre-program parent insight to the needs and challenges for a child, with benchmarking analysis of parents/carers' assessment about child's social & emotional functioning.
- Post-program insight to the status of the needs and challenges for a child, with time-series comparison of social and emotional functioning.
- Analysis of therapists' weekly session notes, denoting progressive change and pivotal moments that matter across the therapeutic journey.

- Analysis of therapists' appraisals across four time points of the therapy process to denote changing trajectories pre, within, and at completion of the program.
- Analysis of the group referrer's insights to the child's referral motivations, compared as time series data pre- and post- program.

In rare cases, KidsXpress may re-enter cohorts of clients into a second program. This is at the discretion of the therapy teams and the referrers. Nonetheless, KidsXpress recognises that treatment effectiveness is dependent upon the sustained change that is initiated over the course of the therapeutic investigation.

Broadly, there are two areas that KidsXpress focuses the outcomes:
1. Children have an improved capacity to respond to difficult experiences in ways that enhance their well-being. It is intended that post program:
    - Children have improved *self-awareness*
    - Children have an improved capacity to *express their feelings and emotions*
    - Children have improved ability to *understand others*
2. Children have an improved capacity to respond to difficult experiences in ways that better build relationships with self and others. It is intended that post program:
    - Children have greater ability to develop *connection with others*
    - Children have greater empathic ability to recognise the *impact of self on others*
    - Children are better to able to self-regulate and *regulate / control behaviour*
    - Children are more capable with receptive communication and to *listen*
    - Children are better able to *work in a group*

1.4.14 Referral to the Program

Children may be referred to the KidsXpress program through professional pathways. Currently KidsXpress does not accept referrals directly from parents/carers. Referral pathways include those from education routes, such as school counsellors, pastoral staff, or teaching staff; medical routes, such as General Practitioners (GPs) and psychiatrists; and community services, such as psychologists, therapists and other community service providers.

Owing to the strategic focus of placing children into groups matched by age and referral reason, children are typically placed on the KidsXpress wait-list until an appropriate group of children may be formed. At present, this wait-list is approximately six months from the point of referral. In the case of group referrals, children are referred into the program by their school staff and delivery of therapy in this setting is dependent on the formation of a relationship

between KidsXpress and the partnering school. Where a school seeks the placement of more than six children, partnering may include multiple session deliveries on a given day (i.e. an AM and a PM group), or longer-term partnering where KidsXpress attends the school for consecutive school terms.

1.4.15 Implications of the KidsXpress Program

KidsXpress research indicates the positive short-term outcomes and immediate impact of participation in the program. Judged against KidsXpress' KTIs, data show that children are better able to express themselves, regulate their emotions, connect with others, and communicate with peers and adults in more appropriate ways. Further data – the KidsXpress longitudinal follow ups – highlight the longer-term benefits of participation in the program, and demonstrate the lasting impact of the ten-week program on the children's developmental trajectories, self- and interpersonal well-being (Deloitte Access Economics, 2015; KidsXpress, 2016).

Group referrers describe children as better able to form and maintain relationships with peers, and respond more positively to relationships with school staff. Furthermore, group referrers highlight the increased engagement within KidsXpress program graduates at a behavioural, emotional, and cognitive level within the classroom and school community.

Knowing that KidsXpress has positive implications for the children who complete the ten-week program is highly significant in the address of childhood trauma. Given the widespread implications of unresolved trauma, effective intervention as early as possible, is the most effective and influential way of managing and minimising the onward impact of the trauma (Malchiodi & Crenshaw, 2015).

KidsXpress endeavours to engage with parents/carers where possible. This is to share the insight of the KidsXpress program and to inform parents/carers in ways that can foster sustained uptake of the newly learned expressive skills. With this in action, KidsXpress not only involves developmental and individual transformations, but also pivotal change within child-caregiver relationships as well, facilitating a greater likelihood of positive and lasting change in the future. KidsXpress recognises that care-network engagement is a major area for impact growth and KidsXpress are currently developing a formal parent/carer engagement plan to elevate the care-network development to best support children through their challenges.

This purposeful and strategic development is driven by understanding that collaboration between services is integral to fostering greatest outcomes. Recognising the often interconnected nature of children's and families challenges and the need for simultaneous intervention (Hobeck, 2014), KidsXpress, through its participation within the AIFS research community, is exploring how this can be achieved with greatest outcomes for all concerned.

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