COMPLEX TRAUMA: A RESOURCE FOR FOSTER PARENTS

CASE STUDIES

Four-year-old Dani was recently diagnosed with ADHD by her pediatrician. When her mother was incarcerated, she was placed with a kinship caregiver, her grandmother. Dani seems to cry all the time, but her grandmother is unable to comfort or calm her. When she is told no, she sometimes cries for hours. She is unable to focus or concentrate on tasks, and she is behind her peers socially and developmentally. Her grandmother is overwhelmed by her behaviors and wonders if Dani would be better off in foster care.

Seven-year-old Chandra was placed in foster care when her mother could no longer care for her. Chandra rarely speaks or makes eye contact, and she gets upset when she is touched. She has the verbal ability of a much younger child, and she often ignores her foster family. When she becomes frustrated or doesn't get her way, she acts out violently. When she hit a younger child in the home, her foster family asked for her to be placed elsewhere.

Eleven-year-old Dylan has been in foster care since he was eight. He has no memory of abuse and neglect and only a vague memory of his biological mother, who died of a drug overdose. He has been diagnosed with ADHD and depression. Dylan is easily frustrated and gives up on tasks quickly. When he becomes irritable and is corrected by a caregiver or teacher, he hits and scratches himself. He often says he is worthless and has threatened to kill himself. His foster parents are afraid Dylan will attempt suicide.

Fifteen-year-old Christopher has an explosive temper and was diagnosed by his pediatrician with oppositional defiant disorder. He was placed with his uncle after getting in a violent fight with his father. During an argument with his uncle, Christopher assaulted him and was arrested. He told the judge, "I felt like it was him or me—like he was going to kill me."

Although their caregivers do not know this, the four children described in the fictional case studies above have all experienced profound and extended abuse and neglect in their early years. Caregivers of children displaying these types of behaviors often don't understand why the children behave the way they do, or why their tried-and-true parenting techniques don't work. Some worry that the behaviors are somehow their fault or that their efforts to parent are just making matters worse.

The children described above are all showing symptoms of "complex trauma"—a term that describes a constellation of symptoms and behaviors caused by traumatic experiences that have persisted for months or years. In the foster care system, complex trauma is usually caused by years of abuse and neglect. This can have a profound effect on a child's emotional, behavioral, and cognitive development—even when a child has no memory of traumatic events.

This guide is designed to help foster parents and kinship caregivers to 1) recognize the symptoms of complex trauma, 2) understand its impact on typical childhood development, and 3) seek out treatments and resources to help children in their care.

WHAT IS TRAUMA?[1]

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma results from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[2] Trauma often triggers the "fight, flight, or freeze" survival response and can cause feelings of helplessness and fear, as well as abrupt physiological reactions, such as a racing heart. Witnessing a traumatic event that threatens life or physical security of a loved one can also cause trauma.

Some people who experience a traumatic event recover quickly with no long-term effects. Others develop a trauma- or stressor-related disorder, such as post-traumatic stress disorder (PTSD). In general, people with PTSD continue to re-experience the "fight, flight, or freeze" response in benign situations—even if they know they are perfectly safe. This interferes with daily life and can cause the individual to avoid thoughts or situations that might "trigger" a fear response.

How the "Fight, Flight, or Freeze" Response Affects the Mind and Body

As adrenaline and cortisol (stress hormones) flood the body:

- Heart pounds, breathing speeds up.
- Senses sharpen; mouth gets dry; skin may sweat, break out in goosebumps, or feel hot or cold.
- "Normal" thinking process can be overwhelmed by feelings of terror, panic, dread, rage, or an impulse to act.
- Can experience the sensation of "watching" oneself act or being helpless to control impulses.
- Time may seem to slow down, speed up, or become disjointed; later, memories of traumatic event may be absent or confused.

WHAT IS COMPLEX TRAUMA?

Researchers are beginning to differentiate between short-duration traumatic experiences and "complex trauma"—a term that describes a response to traumatic experiences that have persisted for months or years. The impact of complex trauma on children can be profound, especially when that trauma is related to abuse and neglect. In addition to causing PTSD symptoms, complex trauma can disrupt many aspects of a child's development.

Complex trauma is especially damaging to very young children. When young children experience ongoing physical abuse, emotional abuse, sexual abuse, neglect, and/or chronic violence in the home, normal brain development can be disrupted. Young children who experience constant fear, stress, and unpredictability may not fully develop the ability to process negative emotions in a healthy, age-appropriate manner. In addition, because brain maturation has been affected, these children can have trouble learning, focusing, following

[1] Adapted from information from the National Child Traumatic Stress Network (NCTSN). https://www.nctsn.org.
[2] From SAMHSA's webpage, "Trauma and Violence." https://www.samhsa.gov/trauma-violence.

directions, processing and remembering information, controlling their impulses, and forming healthy relationships with others. They are also more susceptible to physical and mental health problems. This constellation of symptoms can continue long after the abuse has stopped and persist into adulthood.

Unfortunately, without therapeutic intervention, the damage complex trauma causes during the formative years may not heal itself over time. Adults who experienced significant childhood trauma are more likely to drop out of school, suffer from mental and physical health disorders, have difficulties maintaining employment, abuse substances, experience homelessness, become incarcerated, and perpetuate the cycle of abuse on their own children.

It is important to note that many children who have experienced abuse and neglect and who exhibit symptoms of complex trauma fully recover and lead happy, productive lives. Children have a remarkable capacity for resiliency, and with the right support, most will overcome their trauma and flourish.

COMPLEX TRAUMA AFFECTS THE DEVELOPING BRAIN

Case Study: Kai

An inexperienced young mother—who was abused by her own mother—is overwhelmed by caring for her first infant, Kai. Unable to cope, she sometimes ignores Kai for hours and frequently forgets to feed or change him. Sometimes, she gets so angry that she slaps the child over and over until he stops crying. Eventually, a relative calls CPS, and Kai is taken into foster care at 10 months old.

Kai's foster parents assume that such a young child cannot remember past abuse and neglect, and they are confident that consistent, supportive parenting will erase any damage that may have been done. However, despite their best efforts, Kai is extremely difficult to care for. He seems to cry constantly and cannot be consoled or soothed. As he gets older, he is hyperactive and unfocused, easily frustrated, and has frequent, violent tantrums. Although his caregivers are loving, experienced parents, none of their tried-and-true parenting techniques seem to help Kai or improve his behavior.

Kai shows symptoms of complex trauma caused by abuse and neglect in infancy.

Early childhood trauma can have a profound effect on healthy brain development, regardless of whether a child has any memory of the abuse. To understand why, it is important to consider these key concepts:

- **At birth, the human brain is not fully developed.** Instead, a baby's brain is a learning machine, forming millions of new neural connections every hour. The prefrontal cortex—the "thinking" part of the brain that can guide the expression of emotions and impulses—is especially underdeveloped. In fact, the prefrontal cortex doesn't fully mature until a person is in their mid-twenties. This is why infants are unable to sooth themselves without the help of a caregiver, why children can become overwhelmed by frustration and have temper tantrums, and why teens who "know better" find it so difficult to resist their impulses.

- **A child's brain develops through a bond with a primary caregiver.** The importance of a child's bond with a primary caregiver cannot be overstated. It is through this relationship that children learn to trust others, regulate their emotions, and interact with the world. This bond begins in infancy. Because babies have no

ability to regulate their own emotions, it is imperative that a caregiver is in tune with an infant's emotional state and sooths signs of distress. In this environment, the infant "learns" that the world is a predictable, safe place, and normal development proceeds rapidly.

- **Toxic stress affects brain development.** When the fear center—called the amygdala—of a child's brain is activated, the child may experience a "fight, flight, or freeze" response in which brain resources are focused on survival. Most children experience fear and stress in small doses. However, an abused child who lives in a constant state of toxic stress, unpredictability, and fear is constantly in survival mode—which affects how the brain develops. The ability to control impulses and emotional responses, as well as the ability to focus and concentrate, can develop more slowly when a child is constantly under stress. Insecure attachment to the caregiver can also impact the child's ability to trust and form healthy relationships with others, including foster parents.

- **Because brain development is affected by early childhood trauma, children are often "stuck" in an earlier stage of emotional development, especially in response to stress.** Older children who have not developed the ability to control their feelings and impulses may react like much younger children in response to stress—by shutting down, crying, or exploding with rage. Stress and frustration may also trigger the "fight, flight, or freeze" survival response—even though the child is no longer in any physical danger. The result is behavior that can appear to a caregiver to be out of character, difficult to understand, or irrational.

WHAT ARE THE SYMPTOMS OF COMPLEX TRAUMA?[3]

Symptoms of trauma and complex trauma exist on a spectrum and vary from person to person. In addition, many symptoms overlap with typical childhood behaviors or with symptoms of other disorders. The symptoms described below are intended to alert caregivers that a child may be suffering from complex trauma and that further evaluation and intervention may be needed. Signs and symptoms are summarized in Table 1.

Emotional Responses

Children who have experienced complex trauma often have difficulty identifying, talking about, and managing emotions. Instead, they internalize and/or externalize their negative emotions, which can lead to persisting depression, anxiety, and/or anger, in addition to other posttraumatic responses.

Their emotional responses may be unpredictable or explosive. Responses are often triggered by reminders of a traumatic event—even if they have no conscious recollection of that event. Reactions can be powerful, and they can have difficulty calming down afterwards. Since trauma is often of an interpersonal nature, even mildly stressful interactions with others may serve as trauma reminders and trigger intense emotional responses.

Having learned that the world is a dangerous place where even loved ones can't be trusted, children with histories of trauma are often vigilant and guarded in their interactions with others and are more likely to view even safe situations as stressful or dangerous. Alternately, many children also learn to "tune out" threats in their

[3] This section has been adapted from information provided by the National Traumatic Stress Network. https://www.nctsn.org.

environment, making them vulnerable to revictimization. Children may also experience disassociation (see next section).

Having never learned how to effectively calm themselves down once they are upset, many of these children become easily overwhelmed. For example, in school they may become so frustrated that they give up on even small tasks that present a challenge. This can affect their sense of competency and self-esteem, which can exacerbate feelings of low self-worth, shame, and depression.

What is Disassociation?

Dissociation is often seen in children with histories of complex trauma. When children encounter an overwhelming and terrifying experience, they may dissociate, or mentally separate themselves from the experience. They may perceive themselves as detached from their bodies, on the ceiling, or somewhere else in the room watching what is happening to their bodies. They may feel as if they are in a dream or some altered state that is not quite real, or as if the experience is happening to someone else. Or, they may lose all memories or sense of the experiences having happened to them, resulting in gaps in time or even gaps in their personal history. At its extreme, a child may close off or lose touch with various aspects of the self.

Although children may not be able to purposely dissociate, once they have learned to dissociate as a defense mechanism, they may automatically dissociate during other stressful situations or when faced with trauma reminders. Dissociation can affect a child's ability to be fully present in activities of daily life and can significantly fracture a child's sense of time and continuity. As a result, it can have adverse effects on learning, classroom behavior, and social interactions. It is not always evident to others that a child is dissociating, and at times, it may appear as if the child is simply "spacing out," daydreaming, or not paying attention.

Behavior

A child with a complex trauma history may be easily triggered or "set off" and is more likely to react very intensely. The child may struggle with self-regulation (i.e., knowing how to calm down) and may lack impulse control or the ability to think through consequences before acting. As a result, the child may frequently experience emotional dysregulation (see next section) and behave in ways that appear unpredictable, oppositional, volatile, and extreme. A child who feels powerless or who grew up fearing an abusive authority figure may react defensively and aggressively in response to perceived blame or attack. Alternately, they may at times be overcontrolled, rigid, and unusually compliant with adults. A child who dissociates may seem "spacey," detached, distant, or out-of-touch with reality.

Children with complex trauma are more likely to engage in high-risk behaviors, such as self-harm, unsafe sexual practices, and excessive risk-taking, such as operating a vehicle at high speeds. They may also engage in illegal activities, such as alcohol and substance use, assaulting others, stealing, running away, and/or prostitution, thereby making it more likely that they will enter the juvenile justice system. When these behaviors are present, it is important to recognize both the behavior itself and its context, in order to address it effectively.

What is Emotional Dysregulation?

Children who have experienced complex trauma often have great difficulty regulating their emotions. They often cannot cope with normal stressors in an age-appropriate way. When they experience frustration, anger, or fear, they may respond as a much younger child would respond—throwing tantrums, crying excessively, withdrawing, or displaying oppositional or aggressive behavior. Typical parenting techniques, such as instituting time outs or applying consequences, can be ineffective and sometimes cause the behavior to escalate. In addition, problematic behaviors can be triggered by situations that may seem benign but that the child associates with past abuse. Since many children who have experienced early childhood trauma cannot articulate (or in some cases even remember) the specifics about their trauma, avoiding these triggers can be extremely difficult for a caregiver.

Attachment and Relationships

When children have unstable or unpredictable relationships with their primary caregivers, they learn that they cannot rely on others to help them. When primary caregivers exploit and abuse a child, the child may believe that they are bad and the world is a terrible place. For this reason, many abused or neglected children have difficulty developing a strong, healthy attachment to foster or adoptive parents.

Children who do not experience healthy attachments may be distrustful and suspicious of others and may have trouble accepting comfort, even as young children. As they get older, they can have difficulty understanding the motivations, emotional states, and personal boundaries of others. Later in life, they may have trouble with romantic relationships, friendships, and authority figures, such as teachers or police officers.

Cognition: Thinking and Learning

When children grow up under conditions of constant threat, all of their internal resources go toward survival. Because their bodies and minds have learned to be in chronic stress response mode, they can have problems thinking clearly, reasoning, or problem solving—even when in a safe, calm environment. For instance, when compared to their peers, they may find it difficult to plan ahead, anticipate the future, and act accordingly. They may have trouble thinking a problem through calmly and considering multiple alternatives. They may find it hard to acquire new skills or take in new information. They may struggle with sustaining attention or curiosity or be distracted by reactions to trauma reminders. Or, they may show deficits in language development and abstract reasoning skills.

Many children who have experienced complex trauma have learning difficulties that may require support in the academic environment to reach their full potential.

Self-Concept and Future Orientation

Children learn their self-worth from the reactions of others, particularly those closest to them. Caregivers have the greatest influence on a child's sense of self-worth and value. Abuse and neglect may make a child feel worthless and despondent. Children who are abused will often blame themselves. It may feel safer to blame oneself than to recognize the parent as unreliable and dangerous. Shame, guilt, low self-esteem, and a poor self-image are common among children with complex trauma histories.

To plan for the future with a sense of hope and purpose, children need to value themselves. Children surrounded by violence in their homes and communities learn from an early age that they cannot trust, the world is not safe, and that they are powerless to change their circumstances. They may view themselves as powerless and "damaged" and may perceive the world as a meaningless place in which planning and positive action is futile. Having learned to operate in "survival mode," these children can live from moment-to-moment without pausing to think about, plan for, or even dream about a future.

To understand more about the thoughts, feelings, and behaviors of complex trauma victims, see Appendix 1.

Physical Health: Body and Brain

When a child grows up afraid or under constant or extreme stress, the immune system and body's stress response systems may not develop normally. Later on, when the child or adult is exposed to even ordinary levels of stress, these systems may automatically respond as if the individual is under extreme stress. For example, an individual may experience significant physiological reactivity, such as rapid breathing or heart pounding, or may "shut down" entirely when presented with stressful situations. These responses, while adaptive when faced with a significant threat, are out of proportion in the context of normal stress and are often perceived by others as "overreacting," or as unresponsive or detached.

Children with complex trauma histories who experience constant, toxic stress may develop chronic or recurrent physical complaints, such as headaches or stomachaches. Adults with histories of trauma in childhood have been shown to have more chronic physical conditions and problems. They may also engage in risky or otherwise unhealthy behaviors that compound these conditions (e.g., smoking, substance use, and diet and exercise habits that lead to obesity).

Children with complex trauma 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 anesthesia and analgesia, in which they are less aware of pain, touch, or internal physical sensations. As a result, they may injure themselves without feeling pain, or suffer from physical problems without being aware of them. Or, they may complain of chronic pain in various body areas for which no physical cause can be found.

Long-term Health Consequences of Complex Trauma

Traumatic experiences in childhood have been linked to increased medical conditions throughout the individuals' lives. The Adverse Childhood Experiences (ACE) Study is a longitudinal study that explores the long-lasting impact of childhood stressors. The ACE Study includes over 17,000 participants ranging in age from 19 to 90. Researchers gathered medical histories over time, while also collecting data on the subjects' childhood exposure to abuse, violence, and impaired caregivers. Results indicated that nearly 64% of participants experienced at least one exposure, and of those, 69% reported two or more incidents of childhood trauma. Results demonstrated the connection between childhood trauma exposure, high-risk behaviors (e.g., smoking, unprotected sex), mental health problems, chronic illness, such as heart disease and cancer, and early death.

Table 1
Some Possible Signs and Symptoms of Complex Trauma in Abused or Neglected Children

Emotional Responses	Behavior	Attachment and Relationships
• Problems managing or controlling emotions • Hypersensitivity to interpersonal conflicts • Hypervigilant—always looking for signs of danger or conflict • Easily overwhelmed or frustrated • Significant depression, anxiety, and/or anger • Reacts out of proportion to a stressful event • May dissociate or "tune out" when under stress • May feel numb, empty, or unreal	• Difficulty understanding or complying with rules • Poor impulse control • Volatile, aggressive, or oppositional behavior • Defensive or aggressive response to perceived blame or attack • Overcontrolled or rigid behavior • Overly compliant behavior • Self-destructive behaviors (e.g. self-harm, eating disorders, substance abuse, etc.) • Reenacts trauma • Inappropriate sexual behaviors • May engage in illegal activities	• Uncertainty about the reliability and predictability of the world • Problems attaching to caregivers • Inability to be comforted • Difficulties with personal boundaries • Difficulty attuning to other people's emotional states • Difficulty with perspective taking • Distrust and suspiciousness about those around them • Difficulty enlisting others as allies or making friends • Volatile relationships • Social Isolation
Cognition: Thinking and Learning	**Self-Concept/Future Orientation**	**Physical Health: Body and Brain**
• Poor attention • Problems with planning and goal-oriented behavior • Problems with learning • Problems thinking clearly, reasoning, or problem solving • Lack of sustained curiosity • Problems processing new information or acquiring new skills • Difficulties with language • Impairments in auditory, visual, or spatial perception and comprehension • Problems with memory, including amnesia about traumatic events	• Low self-esteem, feelings of worthlessness or despondency • Shame or guilt, blames self for trauma • Feelings of hopelessness and meaninglessness about the future • Feelings of powerlessness or helplessness • Disturbances of body image • Lack of awareness of emotional states of self and others	• Hypersensitivity or lack of sensitivity to pain, physical contact, noise, smells, etc. • Unexplained physical pain (e.g., headaches, stomachaches) • Problems with coordination and balance • Autoimmune disorders • Pseudo-seizures • Sleep disturbances • Disordered eating; substance issues • Depression and anxiety • Attention-deficit/hyperactivity disorder (ADHD) or ADHD-like symptoms • Self-harming behaviors, suicide

DIAGNOSIS

Children showing symptoms of complex trauma can be diagnosed with post-traumatic stress disorder (PTSD), complex trauma, complex PTSD (cPTSD), developmental trauma disorder, or early childhood trauma. Trauma may also be described in terms of Adverse Childhood Experiences (ACEs). In general, the official diagnosis and terms used are less important than the recognition that childhood trauma has occurred so that it can be addressed in a child's treatment plan.

It is important that a child is evaluated by a health care professional who is familiar with symptoms of childhood trauma disorders. Symptoms of complex trauma can differ from the typical symptoms of PTSD—especially if the trauma was perpetrated during the developmental years. Two common symptoms of PTSD are 1) re-experiencing the traumatic event (sometimes referred to as "flashbacks") and 2) avoiding situations that remind the individuals of the traumatic event. Children suffering from complex trauma often don't have either of these symptoms.

COMPLEX TRAUMA AND OTHER MENTAL HEALTH DISORDERS

Even though trauma disorders are common in children who suffer abuse and neglect, they can be very difficult to diagnose and are sometimes misdiagnosed or overlooked—especially if the extent of the abuse and neglect is not known. For instance, one of the core symptoms of complex trauma—emotional dysregulation—is also a common symptom of a host of other childhood mental health disorders. Therefore, emotional dysregulation may be due to past abuse and neglect, a mental health disorder, or both. It may also be a reaction to being removed from a primary caregiver—which is itself a traumatic experience.

This section describes some of the mental health disorders that share symptoms with trauma disorders or frequently co-occur with trauma disorders. Some key points to consider:

- Abuse and neglect can make some children more vulnerable to mental health disorders, and mental health disorders can make some children more vulnerable to abuse and neglect.
- It is common for complex trauma and other mental health disorders to occur at the same time.
- Complex trauma may be confused with another disorder because of common symptoms.
- Whether a child has experienced trauma can affect choice of treatment and how that treatment is delivered.

If abuse or neglect is suspected, it is crucial that a child is evaluated by a mental health care professional who is well-versed in trauma disorders and their treatments.

Anxiety and Depression

Children who have experienced trauma—including the trauma of being removed from their primary caregivers—can show symptoms of anxiety and depression, and in some cases, develop anxiety and depressive disorders. However, it's important to note that many of the symptoms of complex trauma overlap with those of

anxiety and depression. Hypervigilance, restlessness, fear and nervousness, and avoidance of seemingly benign situations are signs of complex trauma that can be easily mistaken for an anxiety disorder, especially if the extent of the abuse and neglect is not known. In addition, children often express depression as irritability and anger, which are both signs of complex trauma. For this reason, it is important that diagnosing clinicians assess for underlying trauma when treating for anxiety and depression to determine an appropriate treatment. Treatments should be trauma-informed to avoid re-traumatizing the child.

Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is a neurodevelopmental disorder—in other words, it is a disorder present at birth that manifests in early childhood and persists throughout one's lifetime. The main characteristic of ADHD is difficulty focusing (especially on activities that are not particularly interesting to the child), with or without hyperactivity. This can lead to school problems, social problems, low self-esteem, and depression.

Children who have experienced childhood trauma can have very similar symptoms. Fear and anxiety, hypervigilance to danger, and emotional dysregulation can cause hyperactivity and prevent a child from being able to focus, stay on task, and learn—even after they have been removed from an abusive situation. These children can also have trouble trusting others or enlisting allies, which can cause social problems. Finally, abuse and neglect cause feelings of low self-worth and depression. For this reason, some clinicians mistake the symptoms of early childhood trauma for ADHD—especially if they are unaware that abuse has occurred.

This does not mean that a child who has experienced early childhood trauma does not also have ADHD. In fact, the challenges of parenting a child with ADHD may make that child more vulnerable to abuse and neglect.

If a child is suspected to have ADHD and has experienced early childhood trauma, they should be evaluated by a mental health care professional who is able to distinguish between organically-based ADHD and symptoms of trauma. A proper diagnosis is critical to ensuring that the child receives the correct treatment.

Autism Spectrum Disorder (ASD)

ASD is a neurodevelopmental disorder—in other words, it is a disorder present at birth that manifests in early childhood and persists throughout one's lifetime. The main characteristics of autism are 1) difficulty relating to and communicating with others, and 2) restricted, repetitive behaviors, interests, and activities.

Although ASD is well-studied and testing is usually reliable, ASD can be confused with complex trauma. Traumatized children can experience dissociation or cope with stress by withdrawing into themselves. If this behavior is chronic, they may never have learned to effectively communicate with others, or they may choose to stay silent because it is "safer." They also may have developed coping methods to sooth anxiety that can appear to be the restricted, repetitive behaviors seen in ASD.

ASD and trauma disorders also co-occur, and children with ASD can be more at risk for experiencing adverse childhood experience (ACEs)—which include child abuse and neglect—than typically developing children.

Borderline Personality Disorder (BPD)

Case Study: Maya

Fourteen-year-old Maya was removed from her home by CPS and placed with a foster family. At first, Maya is unusually affectionate and clingy with her foster family, wanting to call them "mom" and "dad" immediately. At her new school, she seems to attract drama, and she has a new circle of friends, including boyfriends, every week. Soon, she begins to exhibit extreme mood swings—she burst into tears over minor frustrations or breaks things when she doesn't get her way. When her foster mother refuses to let her go to a party, Maya flies into a rage and smashes a window and accuses her foster family of not wanting her, just like everyone else. Later she swallows a bottle of pills and must be rushed to the emergency room.

Maya shows symptoms of complex trauma and borderline personality traits.

Personality disorders involve severe disturbances in how individuals view themselves and other people. In general, these disorders involve clusters of maladaptive personality traits that interfere with social interaction. Because personality is somewhat fluid until adulthood, children are usually not diagnosed with personality disorders.

However, one of the personality disorders—borderline personality disorder (BPD)—has a strong correlation with childhood abuse and neglect. In fact, studies have shown that 30 to 90 percent of adults diagnosed with BPD have experienced early childhood trauma.[4] For this reason, abused children who have BPD traits are at increased risk of developing BPD as adults.

One of the main characteristics of BPD is an uncertain sense of self. People with BPD have a poorly developed or unstable self-image and often feel empty, disconnected, and extremely self-critical. They also have intense, unstable, short-lived relationships marked by neediness, mistrust, and an anxious preoccupation with abandonment. They lack self-direction and their goals and values are unstable. Finally, they have difficulty understanding the feelings and motivations of others.

In addition to these core traits, they can have frequent and abrupt mood swings and display chronic anxiousness, separation insecurity, depression, impulsivity, risk taking behavior, and hostility. They also are at very high risk of suicidal behavior—60 to 70 percent of people with BPD attempt suicide and 10 percent die by suicide.[5]

Because the suicide risk of youth with BPD traits is high, early intervention is critical. BPD is often treated with dialectical behavior therapy—therapy designed to help youth and their caregivers understand and manage strong emotions and impulses and successfully manage interpersonal relationships.

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[4] Nadia Cattane et. al., Borderline personality disorder and childhood trauma: Exploring the affected biological systems and mechanisms, *BMC Psychiatry*, 2017 (17:221). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5472954/#:~:text=Several%20studies%20have%20shown%20that,severity%20%5B9%E2%80%9311%5D.

[5] John M. Oldham, Borderline personality disorder and suicidality, *American Journal of Psychiatry*, January 2006. https://ajp.psychiatryonline.org/doi/pdfplus/10.1176/appi.ajp.163.1.20.

Oppositional Defiant Disorder (ODD) and Intermittent Explosive Disorder (IED)

ODD and IED are disorders related to disruptive behavior and a lack of impulse control and involve acting angrily or aggressively towards people or property. Some symptoms of ODD are a chronic angry or irritable mood, argumentative or defiant behavior, and a pattern of vindictiveness. Some symptoms of IED include frequent impulsive, aggressive, angry outbursts disproportional to the event that triggered them. Although childhood abuse and neglect is a risk factor for both disorders, many symptoms of ODD and IED overlap with those of trauma disorders. Children who have experienced complex trauma often display aggression, rage, and a lack of impulse control. They may have developed these behaviors to help them survive abuse.

Health care providers who do not have experience with childhood trauma, or who are not aware that abuse has occurred, may diagnose a child with ODD or IED based on their behavior. Unfortunately, a diagnosis of ODD or IED can carry stigma, because children with these disorders can progress to more serious antisocial behavior. For this reason, it is important that if abuse is suspected, children receive a thorough assessment from a clinician experienced in childhood trauma.

"Slow Learner" or "Lower Intelligence" Labels

Psychologists often administer intelligence quotient (IQ) tests to children who are not meeting developmental milestones or who are struggling academically. It is well established that IQ scores rarely change over time. Therefore, a child who scores low on an IQ test may be permanently labeled as being a "slow learner" in need of special education classes.

However, children who have experienced early childhood trauma can have learning difficulties, as well as difficulty taking IQ tests, even with an experienced proctor. They can have problems with memory, concentration, and following directions; they can become easily frustrated; they may be unwilling to put forth their best effort; they may have little experience with answering questions in a testing situation; and they may have one or more learning disorders. For these reasons, children with a history of abuse and neglect who test poorly on IQ tests should be tested again when their symptoms improve.

This does not mean that special education classes are not appropriate for a child who has difficulty in the learning environment due to complex trauma. However, the child should be reevaluated as trauma symptoms subside.

TREATMENTS

Usually, parents and caregivers do not choose a specific treatment for their child; instead they choose an individual therapist or service provider skilled in helping children and families deal with complex trauma. However, it is very useful for caregivers to understand what types of therapy are used with traumatized children so that they can participate more fully in their child's therapy and discuss alternate interventions when necessary.

While therapeutic treatments are an important part of healing from trauma, experts believe that children also must establish a secure attachment with a caregiver. For this reason, caregiver education and involvement is critical. Healing happens through consistent, loving, trauma-informed parenting in conjunction with therapy.

The following treatments are commonly used to treat PTSD or complex trauma in children. Those that have received a "not able to be rated" rating by the California Evidenced-Based Treatment Clearinghouse (CEBC) have been recommended by the National Child Traumatic Stress Network as effective treatments for complex trauma. Many of the program websites listed below have links to help caregivers find a provider, as well as parent resources, such as videos, books, and other educational materials. Treatments have been summarized in Table 2.

Children with behavioral issues often benefit from **Intensive In-Home Services.** These services are designed to help children and families "in the moment." They involve a therapist visiting the home for several hours, several times a week, so that they can deal with emotional and behavioral problems as they occur and involve the whole family. The type of treatment used by intensive in-home therapists usually depends upon the needs of the child and the training an individual therapist has received.

Table 2
Summary of Treatments for Trauma Disorders

Treatment	Age	Disorder	CEBC Rating[6]
Eye Movement Desensitization and Reprocessing (EMDR)	2-17	PTSD/Trauma	Well-supported
Prolonged Exposure Therapy for Adolescents (PE-A)	12-18	PTSD/Trauma	Well-supported
Trauma-Focused Cognitive Behavioral Therapy	3-18	PTSD/Trauma	Well-supported
Child-Parent Psychotherapy	0-5 (includes primary caregiver)	PTSD/Trauma	Supported
Dialectical Behavior Therapy (DBT)	7-18	Borderline personality disorder traits	Promising
Trust-Based Relational Intervention (TBRI)	Parent training	PTSD/Trauma	Promising

[6] Note that CEBC ratings only reflect the quality and amount of scientific evidence supporting a treatment. Programs with lower ratings are not necessarily less effective than those with higher ratings. Treatments proven to be ineffective or harmful have not been included.

Treatment	Age	Disorder	CEBC Rating[7]
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A)	10-18 (includes caregivers)	Complex Trauma	Promising
Attachment, Regulation, and Competency (ARC)	0-21 (includes caregivers)	Complex Trauma	Not able to be rated
Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)	12-21 (may involve caregiver)	Complex Trauma	Not able to be rated
Real Life Heroes (RLH)	6-12 (includes caregivers)	Complex Trauma	Not able to be rated
Strengthening Family Coping Resources (SFCR)	0-17 (includes caregivers)	Complex Trauma	Not able to be rated
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	Adolescents	Complex Trauma	Not able to be rated

Rating: Well-Supported

Eye Movement Desensitization and Reprocessing (EMDR)

Summary Therapy that uses eye movements or sound in conjunction with other therapy to help the brain process trauma, with the goal of alleviating PTSD symptoms.

Target population Children ages 2 to 17 suffering from PTSD, anxiety, fears, and behavioral problems related to traumatic experiences.

Type and duration Typically one 50 to 90 minute session per week in an office-based setting. Often, major gains are apparent within a few weeks, ranging from 3 to 12 sessions.

Rating Rated "Well-Supported" (level 1) for trauma disorders in children and adolescents by the California Evidence-Based Clearinghouse.

Description

EMDR is based on the theory that the powerful and disturbing "re-experiencing" symptoms associated with trauma disorders are the result of the brain not properly processing traumatic experiences into long-term memory. Typically, the emotions connected with painful past experiences fade with time. However, a person with a trauma disorder often re-experiences an intense "fight, flight, or freeze" response when a traumatic memory is triggered. For instance, a caregiver who scolds an abused child may trigger extreme fear, violent or oppositional behavior, excessive passivity or "tuning out," or other extreme behaviors. These reactions are not in the child's control, and can happen even if the child does not have a clear memory of the abuse.

[7] Note that CEBC ratings only reflect the quality and amount of scientific evidence supporting a treatment. Programs with lower ratings are not necessarily less effective than those with higher ratings. Treatments proven to be ineffective or harmful have not been included.

According to the EMDR International Association, EMDR therapy helps the brain process traumatic memories. The therapist accomplishes this by leading the youth through sets of eye movements, sounds, or taps that alternately activate the left and right hemispheres of the brain. During this process, the therapist prompts the youth to remember elements of the traumatic event while carefully attending to the youth's emotional state. The goal of therapy is for distressing emotions and sensations to no longer be triggered by reminders of the event. The event is still remembered, but the fight, flight, or freeze response is resolved.

EMDR is a well-researched and effective treatment that tends to work faster than traditional talk therapy. Unlike trauma-focused cognitive behavioral therapy, it does not require the youth to talk in detail about the trauma or create a trauma narrative. Instead, it relies on the brain's natural capacity to process and heal from trauma. This can be beneficial to youth who are unable or unwilling to talk about traumatic experiences, or to youth who do not have a clear memory of specifics surrounding abuse.

Learn More:

EMDR website: **https://www.emdr.com/**

CEBC program information: **https://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/**

Prolonged Exposure Therapy for Adolescents (PE-A)

Summary	Therapy that repeatedly exposes children to trauma "triggers" to reduce their triggering effect.
Target population	Children ages 12 to 18 who have experienced a trauma and have experienced PTSD and related symptoms. Also used with children aged 6 to 12.
Type and duration	Once- or twice-weekly sessions that are 60 to 90 minutes in length, typically in an office-based setting. Treatment includes parental involvement and homework (practicing at home). Typically lasts 2 to 4 months.
Rating	Rated "Well-Supported" (level 1) for trauma disorders in children and adolescents by the California Evidence-Based Clearinghouse. However, it should be noted that experts caution against exposure therapy until a child is ready, to avoid retraumatizing the child.

Description

PE-A is a therapeutic treatment where clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment. The aim of therapy is to help clients emotionally process their traumatic memories and to learn that 1) they can safely remember the trauma and experience trauma reminders, 2) that the distress that initially results from confrontations with these reminders decreases over time, and 3) that they are capable of tolerating this distress.

Learn More:

PE-A website: **https://www.med.upenn.edu/ctsa/workshops_pet.html**

CEBC program information: **https://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adolescents/**

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Summary	Therapy that teaches children how to reduce symptoms and overcome trauma by changing the way they think.
Target population	Children ages 3 to 18 suffering from feelings of shame, distorted beliefs about self and others, acting out behavior problems, and PTSD and related symptoms of trauma.
Type and duration	Weekly 30 to 45 minute sessions in an office-based setting. Treatment typically continues for 12 to 16 weeks, but may take longer if the youth has experienced complex trauma.
Rating	Rated “Well-Supported” (level 1) for trauma disorders in children and adolescents by the California Evidence-Based Clearinghouse. Commonly adapted as a treatment for complex trauma.

Description

TF-CBT helps children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It incorporates trauma-sensitive interventions with the principles of cognitive behavioral therapy. Most therapists who treat children who have undergone complex trauma integrate some or all of the elements of TF-CBT into their treatment plans.

The basic premise of CBT is that emotions are difficult to change directly, so CBT targets maladaptive or distressing emotions by changing thoughts and behaviors that are contributing to the emotions. CBT builds a set of skills that enables an individual to be aware of thoughts and emotions; identify how situations, thoughts, and behaviors influence emotions; and improve feelings by changing dysfunctional thoughts and behaviors. The behavioral aspect of CBT addresses how behaviors influence mood. The therapist works with the child to

increase behaviors to improve mood and reduce behaviors associated with negative mood. Treatment usually includes the child developing a trauma narrative (in which the child learns to be able to discuss the events when they choose in ways that do not produce overwhelming emotions).

Learn More:

TF-CBT website: **https://tfcbt.org/**

CEBC program information: **https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/**

Rating: Supported

Child-Parent Psychotherapy (CPP)

Summary	Therapy that engages both parent and child to create secure, healthy attachment.
Target population	Children ages 0 to 5 who have been exposed to trauma and are displaying symptoms related to PTSD. Treatment typically includes parent or caregiver.
Type and duration	Weekly 1 to 1.5 hour sessions in a home-based setting. Treatment is recommended for one year.
Rating	Rated "Supported" (level 2) for trauma disorders in children and adolescents by the California Evidence-Based Clearinghouse.

CPP is a treatment for trauma-exposed children ages 0 to 5. Typically, the child is seen with the child's parent or primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the caregiver's relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture, socioeconomic, and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.

Learn More:

CPP website: **https://childparentpsychotherapy.com/**

CEBC program information: **https://www.cebc4cw.org/program/child-parent-psychotherapy/**

Rating: Promising

Dialectical Behavior Therapy (DBT)

Summary	Individual and group therapy for youth with borderline personality disorder traits that targets symptoms of BPD.
Target population	Youth ages 7 to 18 who suffer from emotional and behavioral dysregulation that leads to impulsive, self-destructive, or self-harming behaviors typically seen in borderline personality disorder, such as suicidal/self-harm ideation or behavior, substance abuse, disordered eating, or aggressive behavior. Developed as a treatment for symptoms of borderline personality disorder, DBT has also been used to treat symptoms of extreme emotional instability associated with other mental health disorders, including trauma disorders.
Type and duration	Individual and group sessions (typically one of each per week) delivered by a therapeutic team trained in DBT in an office-based or residential setting. Treatment typically lasts six months, although programs of more or less intensity are available.
Rating	Rated "Promising" (level 3) by the CEBC for chronically suicidal youth with behaviors found in borderline personality disorder.

Description

DBT is a type of cognitive-behavioral therapy that targets emotional and behavioral dysregulation. DBT helps individuals cope with extremely intense and seemingly uncontrollable negative emotions—especially when those emotions are related to interpersonal relationships, such as friends, romantic partners, and family members. DBT was originally developed to treat adults with borderline personality disorder (BPD), which has a strong association with childhood trauma. Although BPD is rarely diagnosed until adulthood, DBT can be an effective treatment for youth who have BPD-like symptoms, such as difficulty coping with intense emotion related to interpersonal conflict and impulsive, self-destructive, or self-harming behaviors, including nonsuicidal self-injury or suicidal behaviors.

DBT therapists help individuals avoid black and white, all-or-nothing styles of thinking and develop a balanced perspective. In addition, DBT provides individuals with new skills to manage painful emotions and decrease conflict in relationships.

DBT for adults is a well-established, evidence-based treatment for reducing symptoms related to borderline personality disorder. DBT has been adapted to treat adolescents ages 13 and older (DBT-A) and children ages 7-12 (DBT-C). In DBT-A and DBT-C, family members participate in group sessions. More research is required to establish DBT's effectiveness with youth, but uncontrolled studies have shown promising results. DBT can also be modified for use in residential settings, including juvenile detention settings, and has been shown to be effective in reducing aggressive behavior and recidivism rates.

Learn More:

DBT website: **https://behavioraltech.org/**

CEBC program information: **https://www.cebc4cw.org/program/dialectical-behavior-therapy-dbt/**

Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A)

Summary	Therapeutic program that helps youth and their caregivers understand and gain control of trauma-related reactions triggered by current daily life stresses.
Target population	Caregivers and children ages 10 to 18 with trauma symptoms, including PTSD and dissociative symptoms; problems with anxiety, depression, guilt, shame, and complicated grief; disruptive behavior disorders; problems with school/learning; and problems with peer and family relationships, addictions, and delinquency.
Type and duration	Weekly or twice-weekly 50 minute (individual) or 60 to 90 minute (family or group) sessions in a home-based, office-based, or residential setting. Treatment can continue for one month to six or more months.
Rating	Rated "Promising" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

TARGET is an educational and therapeutic approach for the prevention and treatment of post-traumatic stress disorders (PTSD). TARGET provides a seven-step sequence of skills - the FREEDOM Steps - that are designed to enable youth and adults to understand and gain control of trauma-related reactions triggered by current daily life stresses.

The goal in TARGET is to help youth and adults recognize their personal strengths using the FREEDOM Steps, and to use these skills consistently and purposefully when they experience stress reactions in their current lives. TARGET both empowers and challenges PTSD trauma survivors to become highly focused and mindful, to make good decisions, and to build healthy relationships.

TARGET explains post-traumatic stress disorder symptoms as the product of an ingrained, but reversible, biological change in the brain's alarm and information processing systems and the body's stress response systems.

Using graphics and simple language, TARGET describes the stress response system as an "alarm" in the brain that is triggered by trauma or extreme stress. When the brain becomes stuck in "alarm" mode, a person cannot access the brain's capacities for clear thinking, and therefore reacts to all types of current stressors as survival threats. This causes serious difficulties in relationships and daily life activities that can be addressed by using the FREEDOM skill set.

Learn More:

TARGET website: **https://www.atspro.org/targetcurricula**

CEBC program information: **https://www.cebc4cw.org/program/trauma-affect-regulation-guide-for-education-and-therapy-adolescents/**

Trust-Based Relational Intervention (TBRI)

Summary	Caregiver training program that teaches effective parenting strategies for children who have experienced trauma.
Target population	Caregivers of children ages 0 to 17 who have experienced maltreatment, abuse, neglect, multiple home placements, or violence, and are exhibiting behavior problems.
Type and duration	Typically delivered in four six-hour group sessions in an office-based or community setting. An online version is also available here: https://child.tcu.edu/tbri101/#sthash.7ELfcRTh.o7S8AUYq.dpbs
Rating	Rated "Promising" (level 3) for caregivers by the California Evidence-Based Clearinghouse.

Description

TBRI Caregiver Training is a trauma-informed caregiver training program that centers on creating trust and attachment between caregiver and child. TBRI consists of three sets of harmonious principles: Connecting, Empowering, and Correcting. TBRI is based upon how optimal development should have occurred. By helping caregivers understand what should have happened in early development (including prenatal development), TBRI principles can be used by parents and caregivers to help guide children and youth back to their natural developmental trajectory.

TBRI is designed to help caregivers who have children experiencing the following:

- Inability to give and/or receive nurturing care
- Hyper-vigilance and perceived lack of safety
- Inability to regulate their own emotions and/or behavior
- Problem behavior, including both internalizing and externalizing behaviors
- Sensory related deficits, including, for example, hypersensitivity and/or hypo-sensitivity to touch
- Poor social skills (e.g., doesn't know how to appropriately ask for their needs)

Learn More:

TBRI website: **https://child.tcu.edu/#sthash.mVpw0fUc.dpbs**

CEBC program information: **https://www.cebc4cw.org/program/trust-based-relational-intervention-tbri-caregiver-training/**

Rating: Not Able To Be Rated[8]

Attachment, Regulation, and Competency (ARC)

Summary	Home-based therapy that addresses symptoms of complex/developmental trauma and involves the family system.
Target population	Children and young adults ages 0 to 21 who have experienced chronic/complex trauma; caregivers.
Type and duration	The intensity and duration depends on client and type of settings. Treatment is typically delivered in a home-based or residential setting.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

ARC is organized around the core domains of attachment (e.g., building safe caregiving systems), regulation (e.g., supporting youth regulation across domains), and developmental competency (e.g., supporting factors associated with resilient outcomes). ARC treatment is designed to help children understand and gain control over their bodies and their feelings, and understand the links between those strong feelings and the experiences they may have had in the past. ARC also works to build and support important areas of developmental competency, such as being able to make good choices; finding activities and interests that are fulfilling and that support feelings of mastery and power; and being able to make and keep friendships and healthy relationships over time.

For children in a home setting, primary caregivers are a very important part of the treatment team. Caregivers may be supported in identifying strengths and challenges within their family system, learning more about their own emotional experience as relates to their child(ren) and to parenting, and improving the relationship between caregiver and child(ren).

Learn More:

ARC website: **https://arcframework.org/**

CEBC program information: **https://www.cebc4cw.org/program/attachment-regulation-and-competency-arc-client/**

[8] Interventions in this section have been designed specifically to treat complex trauma and have been recommended by the National Child Traumatic Stress Network. The rating "Not Able To Be Rated" indicates that not enough quality studies have been performed to enable the CEBC to rate the effectiveness of the treatment.

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)

Summary	Office-based therapy that addresses symptoms of complex/developmental trauma and is designed to adapt to the youth's changing needs.
Target population	Youth and young adults ages 12 to 21 who have experienced chronic/complex trauma.
Type and duration	Weekly 45 to 60 minute session, in an office-based or residential setting. Caregivers may have sessions as well. Treatment length varies.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

ITCT-A integrates treatment principles from complex trauma literature, attachment theory, the self-trauma model, affect regulation skills development, and components of cognitive behavioral therapy. It involves structured protocols and interventions that are customized to the specific issues of each client, since complex posttraumatic outcomes are notable for their variability across different individuals and different environments.

A key aspect of ITCT-A is its regular and continuous monitoring of treatment effects over time. The client's social and physical environment is also monitored for evidence of increased stressors or potential danger from revictimization or broader community violence.

Learn More:

ITCT-A website: **https://keck.usc.edu/adolescent-trauma-training-center/**

CEBC program information: **https://www.cebc4cw.org/program/integrative-treatment-of-complex-trauma-for-adolescents/**

Real Life Heroes (RLH): Resiliency-focused Treatment for Children and Families with Traumatic Stress

Summary	Home-based therapy that emphasizes empowerment and a child's "hero's journey." May be used in conjunction with other treatments.
Target population	Children ages 6 to 12 who show symptoms of complex trauma, including high risk behaviors and developmental delays. Includes caregiver and family system.
Type and duration	Weekly 30 to 90 minute sessions in a home-based setting, which may include separate caregiver sessions. Treatment typically continues for 25 to 40 weeks.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

RLH is a resiliency-focused treatment program for children and families with toxic stress and complex trauma. RLH provides practitioners with easy-to-use, tools including a life storybook, manual, multi-sensory creative arts activities, and psycho education resources to engage children and families in evidence-supported trauma treatment. Practitioners can use RLH to reframe referrals based on pathologies and blame into a shared 'journey,' a 'pathway' to healing and recovery focused on restoring (or building) emotionally supportive and enduring relationships and promoting development of affect regulation skills for children, parents and other caregivers. Creative arts, movement activities, and shared life story work provide a means for children and families to develop the safety, attunement and trust needed for re-integration of traumatic memories.

RLH focuses on "relational healing for relational traumas" and can be used to engage hard-to-reach children and families with principles of "the hero's journey" and tools that highlight child, parent/caregiver, and cultural strengths.

Learn More:

RLH website: **https://reallifeheroes.net/**

CEBC program information: **https://www.cebc4cw.org/program/real-life-heroes-rlh/**

Strengthening Family Coping Resources (SFCR)

Summary	Trauma-focused skill building intervention to increase coping resources for the family.
Target population	Caregivers and their children ages 0 to 17 living in traumatic contexts who are vulnerable to and show symptoms of trauma exposure.
Type and duration	Weekly two hour sessions in an office-based or community setting. Treatment typically continues for 10 to 15 weeks. Sessions may be individual family sessions or multifamily group sessions.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

SFCR is a trauma-focused, skill-building intervention designed for families living in traumatic contexts with the goal of reducing the symptoms of posttraumatic stress disorder (PTSD) and other trauma-related disorders in children and adult caregivers. SFCR provides accepted, empirically supported trauma treatment within a family format.

Since most families living in traumatic contexts contend with on-going stressors and threats, SFCR is also designed to increase coping resources in children, adult caregivers, and in the family system to prevent relapse and re-exposure. SFCR builds the coping resources necessary to help families boost their sense of safety, function with stability, regulate their emotions and behaviors, and improve communication about and

understanding of the traumas they have experienced. SFCR's therapeutic strategies promote contextual change within the family milieu through encouraging positive modifications in important aspects of daily life and home environment.

SFCR has the dual goals of reducing the symptoms of trauma-related disorders in any family member and increasing coping resources in children, caregivers, and in the family system. SFCR is designed to build the skills necessary to help families boost their sense of safety; function with stability; co-regulate their stress reactions, emotions, and behaviors; and make use of support resources.

Learn More:

SFCR website: **https://www.sfcresources.org/**

CEBC program information: **https://www.cebc4cw.org/program/strengthening-family-coping-resources/**

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

Summary	Group therapy that uses the principals of cognitive behavioral therapy to increase resiliency and enhance strengths.
Target population	Adolescents with a history of exposure to trauma who are still living with ongoing stress and are in unstable environments. Suitable for youth who may not meet the criteria for PTSD but who are experiencing behavior problems.
Type and duration	Weekly one hour group sessions in an office-based or residential setting. Treatment consists of 16 sessions.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

SPARCS is designed to address the needs of adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning. This can include difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life, as well as worldviews that make it difficult for them to see a future for themselves.

SPARCS is based primarily on cognitive-behavioral principles and teaches skills to foster resilience and enhance group members' current strengths. Experiential activities and discussion topics have been specifically developed for use with adolescents, and are designed to capitalize on developmental considerations that are particularly relevant for teenagers (e.g., issues related to autonomy and identity). It should be noted that SPARCS is a present-focused intervention, and is not an exposure-based model. Although there is no direct exposure component (e.g., no construction of a trauma narrative), traumas are discussed in the context of how they relate to the adolescents' current behaviors and to their understandings of their problems and difficulties in the here and now.

The curriculum, which draws from the core components of complex trauma treatment, incorporates techniques from Dialectical Behavioral Therapy (DBT), Trauma and Grief Components Therapy (TGCT), and early versions of Trauma Adaptive Recovery Group Education and Therapy (TARGET). These techniques are utilized with participants throughout many of the group sessions.

Learn More:

National Child Traumatic Stress Network: **https://www.nctsn.org/interventions/structured-psychotherapy-adolescents-responding-chronic-stress**

CEBC program information: **https://www.cebc4cw.org/program/structured-psychotherapy-for-adolescents-responding-to-chronic-stress/**

CAREGIVER EDUCATION, TRAINING, AND RESOURCES

For a child to recover from complex trauma, caregiver involvement is critical. Experts agree that healing depends upon a child developing a secure attachment to a caregiving figure. Best outcomes occur when that caregiver understands how complex trauma has affected the child in their care and when the caregiver is trained in techniques to create healthy attachment and manage behavior issues.

USEFUL WEBSITES

California Evidence-Based Clearinghouse (CEBC) for Child Welfare

https://www.cebc4cw.org/

The CEBC is a searchable database of evidence-based treatments, programs, and practices for children with mental health treatment needs. The CEBC is an excellent resource to learn more about evidenced-based mental health treatments.

Child Welfare Information Gateway

https://www.childwelfare.gov/

The Child Welfare Information Gateway promotes the safety, permanency, and well-being of children, youth, and families by connecting child welfare, adoption, and related professionals as well as the public to information, resources, and tools covering topics on child welfare, child abuse and neglect, out-of-home care, adoption, and more. Their resource, **"Factsheet" Parenting a Child Who Has Experienced Complex Trauma"** is available here: **https://www.childwelfare.gov/pubPDFs/child-trauma.pdf**.

Complex Trauma Resources

https://www.complextrauma.org/

This website contains "a curated collection of books, videos, articles and more to educate consumers, caregivers, and professionals about complex trauma." The resource is offered by the Boston nonprofit, the Foundation Trust.

Empowered to Connect

https://empoweredtoconnect.org/

Empowered to Connect (ETC) is an attachment rich community focused program that exists to support, resource, and educate caregivers. ETC's resources and trainings are especially helpful for caregivers of children who have experienced adverse childhood experiences (ACEs), toxic stress, and maltreatment. ETC relies heavily on the model of Trust Based Relational Intervention (TBRI). Information about local trainings and trainers is available on the ETC website, as are other resources, such as the ETC podcast, blog, and educational resources.

The Karyn Purvis Institute of Child Development

https://child.tcu.edu/#sthash.nmnyIr2O.dpbs

The home of Trust-Based Relational Intervention (TBRI), developed by Dr. Karyn Purvis, this website has information and resources related to complex trauma, as well as information about TBRI, an attachment-based intervention designed to help caregivers parent children affected by complex trauma.

National Child Traumatic Stress Network (NCTSN)

https://www.nctsn.org/

The NCTSN website is an excellent resource for all caregivers of children who have experienced trauma. Its website contains comprehensive resources for caregivers parenting children who have experienced complex trauma. Some features include:

- Detailed information about various types of trauma, including complex trauma
- A comprehensive list of treatments and interventions for trauma disorders
- Educational materials, including resource guides, webinars, and videos. Some notable resources include the following:
  - For caregivers: "Complex Trauma: Facts for Caregivers" **https://www.nctsn.org/sites/default/files/resources/complex_trauma_caregivers.pdf**
  - For teens: "What is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them" **https://www.nctsn.org/sites/default/files/resources/what_is_complex_trauma_for_youth.pdf**
- Online training for caregivers and others in the form of webinars and e-learning courses **https://www.nctsn.org/resources/training**

Zero to Three

https://www.zerotothree.org/

Trauma resources: **https://www.zerotothree.org/resources?topic=trauma-and-stress&type=**

Zero to Three is an organization that supports major efforts to address children's mental health, maltreatment, and the impact of trauma on infants and toddlers. Its website contains more than 130 resources and services related to trauma and stress.

VIRGINIA-BASED ORGANIZATIONS AND WEBSITES

ChildSavers

https://www.childsavers.org

Child Savers is a nonprofit organization in Virginia that uses a prevention and intervention model to assist with children's mental health. This prepares the children for future learning and helps them move on after a traumatic event.

Formed Families Forward (FFF)

https://formedfamiliesforward.org

FFF is a non-profit organization dedicated to supporting foster, kinship, and adoptive families of children and youth with disabilities and other special needs in the Northern Virginia area.

Greater Richmond SCAN (Stop Child Abuse Now)

http://grscan.com/

Greater Richmond SCAN (Stop Child Abuse Now) is a local nonprofit organization dedicated solely to the prevention and treatment of child abuse and neglect in the Greater Richmond area. Greater Richmond SCAN is part of the Virginia trauma-informed community network. Its website has information about parent resources and local trainings.

HopeTree Family Services

http://hopetreefs.org/

HopeTree Family Services is a faith-based organization that offers services and support for at-risk children and youth and their families across Virginia. Services include as private foster care, residential services, and community-based resources.

NewFound Families

https://newfoundva.org/

NewFound Families is the Virginia adoptive, foster, and kinship family association. They provide educational, advocacy, and support services to families caring for children unable to live with their birth parents. Their website provides a wealth of information about resources and supports for foster, adoptive, and kinship families.

SCAN of Northern Virginia (Stop Child Abuse Now)

https://www.scanva.org/

SCAN of Northern Virginia works to develop effective child abuse and neglect prevention programming for children and families. Its website includes a list of family programs, a parent resource center, and other online resources.

UMFS (United Methodist Family Services)

https://www.umfs.org/

UMFS is a nonprofit agency that provides a comprehensive array of programs to meet the needs of parents and high-risk children to enable them to overcome challenging circumstances and succeed. UMFS offers a network of flexible community-based services, such as intensive care coordination, parent support partners, community respite, supervised visitation, and community-based clinical support. Their website offers resources and educational information for foster, adoptive, and kinship families.

Virginia's Kids Belong

https://www.vakidsbelong.org/
Facebook: **https://www.facebook.com/vakidsbelong/**

Virginia's Kids Belong mobilizes government, faith-based, business, and creative leaders around the goal of permanency and belonging for every child. Through community partners, it promotes wrap-around support services for foster parents and other caregivers in need and hosts trauma trainings through local partners. Its Facebook page offers information about local events and resources for foster parents and other caregivers. Contact the organization through its website for more information.

Virginia's Trauma-Informed Community Networks

Throughout Virginia, there are more than 19 trauma-informed community networks (TICNs). These networks share common characteristics: spreading awareness, conducting training, and implementing new trauma-informed practices in schools, courts, and community services. Caregivers may be able to access local resources or trainings by contacting a TICN near their locality.

- A list of TICNs and contact information is maintained by Voices for Virginia's Children and can be found here: **https://vakids.org/trauma-informed-va/trauma-informed-community-networks**
- Details about the activities of various TICNs across Virginia can be found here: **https://vakids.org/wp-content/uploads/2019/04/Virginias-Trauma-Informed-Community-Networks-PDF.pdf**

Voices for Virginia's Children

https://vakids.org/
Trauma resources: **https://vakids.org/trauma-informed-va/for-professionals-and-families**

Voices for Virginia's Children is Virginia's only independent, multi-issue child policy and advocacy organization. Their website contains information of use to caregivers, including links to Virginia's Trauma-Informed Community Networks.

VIRGINIA'S KINSHIP NAVIGATOR PROGRAMS AND SUPPORT PROGRAMS

Kinship navigator programs help kinship caregivers find services, resources, and support. In addition, we suggest that you check with your local department of social services for information on any supports that they provide to kinship families.

City of Virginia Beach Kinship Care Portal (Virginia Beach)

https://hs.virginiabeach.gov/social-services/kinship-care

This site provides information on the regional kinship navigator pilot program in Virginia Beach and surrounding areas.

Kinship Care – Family Engagement Program (Fairfax)

Kinship Resource Line: (703) 324-4534

Fairfax County Department of Family Services offers a dedicated resource line that caregivers can call to get help with issues and services related to kinship care. In addition, the Department offers a virtual "Parent Café" each week where parents and caregivers can discuss parenting issues. More information about Parent Café can be found here: **https://www.fairfaxcounty.gov/familyservices/community-corner/parent-cafe-provides-community-of-support**

Kinship Care Support – Fairfax County Public Schools (Fairfax and surrounding areas)

https://www.fcps.edu/resources/family-engagement/kinship-care-support

Fairfax County Public Schools has collected county and state resources on their website to help kinship caregivers. Resources include educational materials and links to support groups and community agencies.

Kinship Connection of Chesterfield Virginia (Chesterfield and surrounding areas)

https://www.chesterfield.gov/199/Kinship-Connection

Kinship Connection is a program of the Aging & Disability Services office that offers two monthly support groups and resources for grandparents and other kin who are raising a child. The program is free and open to any grandparent (or other relative raising a child) in the area.

Kinship Navigator of Central Virginia (Central Virginia)

https://kinshipnav.org/

This site provides a selection of links to services throughout Central Virginia.

CAREGIVER TRAINING

Due to the coronavirus pandemic, many state-sponsored, in-person foster parent trainings were disrupted. The following organizations offer online trainings in complex trauma designed to help caregivers and the children in their care. Many trainings are fee based, but most websites offer free videos and educational materials.

Please note that the Virginia Commission on Youth has not evaluated these trainings and cannot attest to their effectiveness.

The Attachment Trauma Center Institute
https://www.atcinstitute.com/parents/parent-class/

The Center for Adoption Support and Education
https://adoptionsupport.org/

Child Trauma Academy
https://www.childtrauma.org/

ChildSavers Trauma Training
https://childsavers.org/trauma-basics/

Empowered to Connect
https://empoweredtoconnect.org/training/

Foster Care & Adoptive Community
http://www.fosterparents.com/

Foster Care Institute
https://www.drjohndegarmofostercare.com/

Foster Parent Academy
https://fostercareacademy.thinkific.com/

Foster Parent College
https://www.fosterparentcollege.com/

Institute of Child Psychology
https://instituteofchildpsychology.com/product/childhoodtrauma_online/

National Child Traumatic Stress Network (NCTSN)
https://www.nctsn.org/resources/training

UDEMY.com
https://www.udemy.com/

Trust-Based Relational Intervention (TBRI) Online
https://child.tcu.edu/tbri101/#sthash.7ELfcRTh.o7S8AUYq.dpbs

Appendix 1: How Complex Trauma Can Affect Children's Thoughts, Beliefs, and Behaviors[9]

How I May Feel

Beliefs About Self	Feelings	Body Messages
I am … weak, worthless, broken, pathetic. I am … a liar, a sneak, a suck-up, a hypocrite, a coward, a bully. I am … nobody, a failure, a loser, a freak, a skank, trash. I am … no good, psycho, messed up, crazy. I can't do anything right. I am … stupid, school is not for me. I have to … be perfect, fool everyone, convince them to love me.	I feel … sad, moody. I feel … angry, furious. I feel … spaced out, distracted, numb. I feel … lonely, afraid. I feel … helpless, hurt. I feel … confused, insecure, unsure. I feel … scared of myself and what happens when I lose control. I feel … ashamed. I feel … like I don't care anymore what happens to me or anyone else.	I feel … tense, jumpy, amped, about to blow. I feel … nothing at all. I don't notice when I cut or hurt myself. I feel … like I'm floating outside my body. My head aches. I'm always … in pain, sick to my stomach, fidgety, restless, exhausted … I can't sleep. I can't stand bright lights, loud noises, or tags on my clothes. I can't make eye contact with most people. I can't deal with people standing too close to me or wanting to touch me.
Thoughts	**Relationships**	**Beliefs about the Future**
It's not fair! I don't understand why everyone treats me this way. Everything I touch gets ruined. I want to … hurt myself, run away, die … I can't take it anymore. I can't get my thoughts to stop spinning. I get lost in my head. I don't understand why I do some of the things I do. Sometimes I just lose it.	I can't trust anyone. I trust the wrong people. Nobody wants me. Nobody likes me. I shut everyone out. I just want to be left alone. I can't make or keep friends. Relationships aren't worth it: there's always too much drama. Everyone I care about dies, betrays me, or leaves. I hurt everyone I love.	My life is ruined. It doesn't matter. What's the point? I'm never going to become anything. I don't see a future. I'll be dead or in jail by the time I'm 25. I'll never be good enough. I don't deserve to be happy. Happiness is for other people, not me. I'll never have a job. I'll never be a success. I'll never be good at anything.

[9] From the National Child Traumatic Stress Network (NCTSN). https://www.nctsn.org.

What I May Do

Situation	What I may do to cope	How it can cause problems for me
Physical Violence or Abuse	Pay really close attention to what others feel or want and try hard to make sure they are happy.	I put the needs of others ahead of my own. Sometimes others use this to take advantage of me.
	Learn to fight really well and always be ready to fight.	I get into a lot of fights. I think others want to fight me even when they really don't.
	Learn not to feel pain so I can "take it" and just wait for it to be over.	Sometimes, I can't feel anything at all—painful or good feelings.
Sexual Abuse	Get "out of" my body.	I flirt a lot and try to get others to have sex with me. I use sex to get friends or approval. At times, people use this to take advantage of me.
	Learn to use sexual feelings or sex to make myself feel better.	I touch myself sexually a lot, even when I'm not in private. Or, I have sex with a lot of people. People use this to take advantage me. I have caught diseases because of it.
	Learn to use affection or physical contact to comfort myself and try to get people to love and care for me.	I hug people I've just met. When I make a new friend, I want to touch and hug and tell them I love them a lot. Sometimes people start to avoid me or complain, and I get in trouble for having "bad boundaries."
	Keep my distance from others to avoid getting intimate or sexual.	I avoid relationships with others that may lead to anything sexual so that I won't be taken advantage of again. I feel lonely a lot.
Neglect	Get whatever I can when it is available and hold on to it.	I get in trouble because I steal, sometimes even when I don't need or want to.
	Take care of myself and don't rely on others to meet my needs.	I have a very hard time asking for help or accepting help.
	Develop ways to keep myself from feeling lonely, like watching a lot of TV. Do things by myself a lot.	I have a hard time making friends or relating to people. People sometimes think I'm "weird" or "different."
	Develop "imaginary friends" to comfort me when I'm hurt or upset.	I sometimes have trouble separating my "imaginary" world from the "real" world.
	Eat as much as possible.	I eat too much or when I'm not hungry.
Lots of Different Kinds of Trauma	Use drugs or alcohol to not feel or to feel better.	I sometimes do things that I later regret, or I don't do things I'm supposed to do.
	Take on the responsibility to care for or protect a parent, a sibling, or a friend.	I try to keep people safe but cannot. I try to help and care for people but end up failing and letting them down. I get blamed when things go wrong. I am attacked and pushed away when I try to keep the people I care about from making bad choices.
	Engage in extreme risk-taking to feel alive, in control, tempt fate, or take charge of "what's inevitably going to happen anyway."	I injure myself. I experience a temporary high or rush, then I crash, experience a huge letdown, and get really depressed and hopeless. This leads me to seek out the next, bigger risk.
	Hurt myself.	I damage my body to punish myself, to show others my pain, to make myself feel better, or to distract myself from emotional pain.
	Hurt others.	I ruin relationships because I'm afraid to get close to someone and risk getting hurt. I hurt others to deliver justice, to make me feel less helpless, or to show them how it feels.

The Collection of Evidenced-Based Practices for Children and Adolescents with Mental Health Treatment Needs, 10th Collection

Virginia Commission on Youth, 2025

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