The term complex trauma describes the dual problem of children's exposure to multiple traumatic events and the impact of this exposure on immediate and long-term outcomes. Typically, complex trauma exposure results when a child is abused or neglected, but it can also be caused by other kinds of events such as witnessing domestic violence, ethnic cleansing, or war. Many children involved in the child welfare system have experienced complex trauma.

Often, the consequences of complex trauma exposure are devastating for a child. This is because complex trauma exposure typically interferes with the formation of a secure attachment bond between a child and her caregiver. Normally, the attachment between a child and caregiver is the primary source of safety and stability in a child's life. Lack of a secure attachment can result in a loss of core capacities for self-regulation and interpersonal relatedness. Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and other difficulties, including psychiatric and addictive disorders, chronic medical illness, and legal, vocational, and family problems. These difficulties may extend from childhood through adolescence and into adulthood.

The diagnosis of posttraumatic stress disorder (PTSD) does not capture the full range of developmental difficulties that traumatized children experience. Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria for depression, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety disorders, eating disorders, sleep disorders, communication disorders, separation anxiety disorder, and/or reactive attachment disorder. Yet each of these diagnoses captures only a limited aspect of the traumatized child's complex self-regulatory and relational difficulties. A more comprehensive view of the impact of complex trauma can be gained by examining trauma's impact on a child's growth and development.

**Impact on Development**

A comprehensive review of the literature suggests seven primary domains of impairment observed in children exposed to complex trauma. Each of the seven domains is discussed below.

**Attachment**

Complex trauma is most likely to develop if an infant or child is exposed to danger that is unpredictable or uncontrollable, because the child's body must devote resources that are normally dedicated to growth and development instead to survival. The greatest source of danger and unpredictability is the absence of a caregiver who reliably and responsively protects and nurtures the child. The early caregiving relationship provides the primary context within which children learn about themselves, their emotions, and their relationships with others. A secure attachment supports a child's development in many essential areas, including his capacity for regulating physical and emotional states, his sense of safety (without which he will be reluctant to explore his environment), his early knowledge of how to exert an influence on the world, and his early capacity for communication.

When the child-caregiver relationship is the source of trauma, the at-

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The early caregiving relationship provides the primary context within which children learn about themselves, their emotions, and their relationships with others.
idi controlled behavior patterns, including compulsive compliance with adult requests, resistance to changes in routine, inflexible bathroom rituals, and rigid control of food intake. Childhood victimization also has been shown to be associated with the development of aggressive behavior and oppositional defiant disorder.

An alternative way of understanding the behavioral patterns of chronically traumatized children is that they represent children’s defensive adaptations to overwhelming stress. Children may reenact behavioral aspects of their trauma (e.g., through aggression, or self-injurious or sexualized behaviors) as automatic behavioral reactions to trauma reminders or as attempts to gain mastery or control over their experiences. In the absence of more advanced coping strategies, traumatized children may use drugs or alcohol in order to avoid experiencing intolerable levels of emotional arousal. Similarly, in the absence of knowledge of how to form healthy interpersonal relationships, sexually abused children may engage in sexual behaviors in order to achieve acceptance and intimacy.

Cognition

Prospective studies have shown that children of abusive and neglectful parents demonstrate impaired cognitive functioning by late infancy when compared with nonabused children. The sensory and emotional deprivation associated with neglect appears to be particularly detrimental to cognitive development; neglected infants and toddlers demonstrate delays in expressive and receptive language development, as well as deficits in overall IQ. By early childhood, maltreated children demonstrate less flexibility and creativity in problemsolving tasks than same-age peers. Children and adolescents with a diagnosis of PTSD secondary to abuse or witnessing violence demonstrate deficits in attention, abstract reasoning, and problem solving.

By early elementary school, maltreated children are more frequently referred for special education services. A history of maltreatment is associated with lower grades and poorer scores on standardized tests and other indices of academic achievement. Maltreated children have three times the dropout rate of the general population. These findings have been demonstrated across a variety of trauma exposures (e.g., physical abuse, sexual abuse, neglect, and exposure to domestic violence) and cannot be accounted for by the effects of other psychosocial stressors such as poverty.

negative affect than nontraumatized children. In preschool, traumatized children are more resistant to talking about internal states, particularly those they perceive as negative. Traumatized children have problems estimating their own competence. Early exaggerations of competence in preschool shift to significantly lowered estimates of self-competence by late elementary school. By adulthood, they tend to suffer from a high degree of self-blame.

Family Context

The family, particularly the child’s mother, plays a crucial role in determining how the child adapts to experiencing trauma. In the aftermath of trauma, family support and parents’ emotional functioning strongly mitigate the development of PTSD symptoms and enhance a child’s capacity to resolve the symptoms.

There are three main elements in caregivers’ supportive responses to their children’s trauma:

1. Believing and validating the child’s experience,
2. Tolerating the child’s affect, and
3. Managing the caregiver’s own emotional response.

When a caregiver denies the child’s experiences, the child is forced to act as if the trauma did not occur. The child also learns she cannot trust the primary caregiver and does not learn to use language to deal with adversity. It is important to note that it is not caregiver distress per se that is necessarily detrimental to the child. Instead, when the caregiver’s distress overrides or diverts attention away from the needs of the child, the child may be adversely affected. Children may respond to their caregiver’s distress by avoiding or suppressing their own feelings or behaviors, by avoiding the caregiver altogether, or by becoming “parentified” and attempting to reduce the distress of the caregiver.

Caregivers who have had impaired relationships with attachment figures in their own lives are especially vulnerable to problems in raising their own children. Caregivers with histories of childhood complex trauma
may avoid experiencing their own emotions, which may make it difficult for them to respond appropriately to their child’s emotional state. Parents and guardians may see a child’s behavioral responses to trauma as a personal threat or provocation, rather than as a reenactment of what happened to the child or a behavioral representation of what the child cannot express verbally. The victimized child’s simultaneous need for and fear of closeness also can trigger a caregiver’s own memories of loss, rejection, or abuse, and thus diminish parenting abilities.

Ethnocultural Issues

Children’s risk of exposure to complex trauma, as well as child and family responses to exposure, can also be affected by where they live and by their ethnocultural heritage and traditions. For example, war and genocide are prevalent in some parts of the world, and inner cities are frequently plagued with high levels of violence and racial tension. Children, parents, teachers, religious leaders, and the media from different cultural, national, linguistic, spiritual, and ethnic backgrounds define key trauma-related constructs in many different ways and with different expressions. For example, flashbacks may be “visions,” hyperarousal may be “un ataque de nervios,” and dissociation may be “spirit possession.” These factors become important when considering how to treat the child.

Resilience Factors

While exposure to complex trauma has a potentially devastating impact on the developing child, there is also the possibility that a victimized child may function well in certain domains while exhibiting distress in others. Areas of competence also can shift as children are faced with new stressors and developmental challenges. Several factors have been shown to be linked to children’s resilience in the face of stress: positive attachment and connections to emotionally supportive and competent adults within the family or community, development of cognitive and self-regulation abilities, and positive beliefs about oneself and motivation to act effectively in one’s environment. Additional individual factors associated with resilience include an easygoing disposition, positive temperament, and sociable demeanor; internal locus of control and external attributions for blame; effective coping strategies; a high degree of mastery and autonomy; special talents; creativity; and spirituality.

The greatest threats to resilience appear to follow the breakdown of protective systems. This results in damage to brain development and associated cognitive and self-regulatory capacities, compromised caregiver-child relationships, and loss of motivation to interact with one’s environment.

Assessment and Treatment

Regardless of the type of trauma that leads to a referral for services, the first step in care is a comprehensive assessment. A comprehensive assessment of complex trauma includes information from a number of sources, including the child’s or adolescent’s own disclosures, collateral reports from caregivers and other providers, the therapist’s observations, and standardized assessment measures that have been completed by the child, caregiver, and, if possible, by the child’s teacher. Assessments should be culturally sensitive and language-appropriate. Court evaluations, where required, must be conducted in a forensically sound and clinically rigorous manner.

The National Child Traumatic Stress Network is a partnership of organizations and individuals committed to raising the standard of care for traumatized children nationwide. The Complex Trauma Workgroup of the National Child Traumatic Stress Network has identified six core components of complex trauma intervention:

1. Safety: Creating a home, school, and community environment in which the child feels safe and cared for.

2. Self-regulation: Enhancing a child’s capacity to modulate arousal and restore equilibrium following disregulation of affect, behavior, physiology, cognition, interpersonal relatedness and self-attrition.

3. Self-reflective information processing: Helping the child construct self-narratives, reflect on past and present experience, and develop skills in planning and decision making.

4. Traumatic experiences integration: Enabling the child to transform or resolve traumatic reminders and memories using such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.

5. Relational engagement: Teaching the child to form appropriate attachments and to apply this knowledge to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social em-
6. **Positive affect enhancement:** Enhancing a child’s sense of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure.

In light of the many individual and contextual differences in the lives of children and adolescents affected by complex trauma, good treatment requires the flexible adaptation of treatment strategies in response to such factors as patient age and developmental stage, gender, culture and ethnicity, socioeconomic status, and religious or community affiliation. However, in general, it is recommended that treatment proceed through a series of phases that focus on different goals. This can help avoid overloading children—who may well already have cognitive difficulties—with too much information at one time. A phase-based approach begins with a focus on providing safety, typically followed by teaching self-regulation. As children’s capacity to identify, modulate and express their emotions stabilizes, treatment focus increasingly incorporates self-reflective information processing, relational engagement, and positive affect enhancement. These additional components play a critical role in helping children to develop in positive, healthy ways, and to avoid future trauma and victimization.

While it may be beneficial for some children affected by complex trauma to process their traumatic memories, this typically can only be successfully undertaken after a substantial period of stabilization in which internal and external resources have been established. Notably, several of the leading interventions for child complex trauma do not include revisiting traumatic memories but instead foster integration of traumatic experiences through a focus on recognizing and coping with present triggers within a trauma framework.

Best practice with this population typically involves adoption of a systems approach to intervention, which might involve working with child protective services, the court system, the schools, and social service agencies. Finally, there is a consensus that interventions should build strengths as well as reduce symptoms. In this way, treatment for children and adolescents also serves to protect against poor outcomes in adulthood.

### References

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