

Editorial:

The Challenges of Complex Trauma and the Promise of Supporting Strengths

Katherine Tyson McCrea, PhD, LCSW

We have known for some time that there is a pressing need for child welfare professionals worldwide to be trained in understanding and treating trauma. For this reason, initiatives such as the National Child Traumatic Stress Network in the United States (www.nctsn.org) have a decided emphasis on educating professionals throughout strategic planning and programming. Why is it evidently such a tall order to provide adequate services for severely traumatized children and youth?

First, our current knowledge indicates that many child and youth clients of public child welfare systems likely suffer not just from the effects of one type of trauma, but from a syndrome termed complex trauma. Complex trauma occurs when an individual experiences multiple, chronic, and/or sustained events that overwhelm the individual's coping capacity and have an adverse impact on development. Generally, the onset of complex trauma occurs early in life; common examples are sexual or physical abuse, war, community violence, and educational neglect (Cook et al., 2005; Spinazzola et al., 2005; van der Kolk, 2005). Essential to the nature of complex trauma are multiple, interacting traumatizing experiences, such as poverty, racial discrimination, community violence, familial abuse, and educational settings where children are retraumatized by the violence of peers and the disorganization and even hostility of some school staff.

Complex trauma massively impairs a child's functioning. It affects the child's brain development at the fundamental levels of memory acquisition and cognitive processing; creates heightened emotional reactions (especially anger, guilt, shame, and fear), hypervigilance, and sleep disorders; interferes with future orientation

and planning; builds in low self-esteem and inaccurate self-appraisal; and leads to destructive internalized relationship models (or schemas) that children reenact (Nelson, Furtado, Fox, & Zeanah, 2009; Perry, 2002; Pearlman & Courtois, 2005). Traumatized children's reenactments of traumatizing events often create further trauma for themselves or others. Examples are common in poverty-ridden schools, when children suffering from complex trauma fight each other, causing fear, physical harm, and the double humiliations of their educational failure and conflict with the law. With regard to the prevalence of complex trauma in public child welfare clients, the Illinois Department of Children and Family Services' 2009 research indicated that, of a sample of 8,131 clients in state custody, 97% were suspected of having had at least one traumatic experience. The majority were found to have had five or more different types of traumatic experiences, and this majority additionally had at least two types of multiple-incident trauma (Griffin, Martinovich, Gawron, & Lyons, 2009, p. 110).

Second, complex trauma has many consequences that were heretofore considered to be discrete mental disorders: learning disabilities caused by protracted dissociative reactions; hyperactivity caused by profound anxiety; school phobia (as children avoid settings that could re-trigger their distress); bullying (as children forced to identify with aggressors in their world reenact the hatred and antagonism of which they were victims); and, as the children mature, a proclivity to substance abuse to relieve or soothe their distress. Similarly, previous research about trauma has all too often focused on only one dimension of trauma. Although such research is valuable—for instance, in finding that victims of sexual abuse are more likely

to be at risk of child abuse than those who were not sexually abused (Craig & Sprang 2007)—research and service efforts heretofore targeted at only one of these problems could not be as effective, or as thorough, as is possible when the syndrome of complex trauma is studied and treated. For example, the interweaving of grief with trauma (for instance, loss of a parent due to violent death) can mean that a grief-stricken child has both posttraumatic stress disorder (PTSD) and grief symptoms. The PTSD symptoms of numbness and avoidance can significantly inhibit mourning. A child with PTSD may not be helped at all by a support group: rather than bringing relief through solidarity, the grief of other children may instead trigger posttraumatic reactions of unbearable distress and aggressive or avoidant behavior (Palardy et al., 2009). Another example stems from the fact that the most common trauma Illinois child welfare clients suffer from is neglect (Griffin et al., 2009)—but trauma treatment models that focus on processing of single events (as in treating victims of natural disasters) are not effective in helping victims of neglect. By comparison with the intrusive thoughts, avoidance, and dissociation of victims of episode-specific trauma, neglected children's experience of trauma is likely to be pervasive deprivation, stunting of their growth along multiple dimensions, and physical symptoms that have their own traumatic impact, especially in contexts of poverty where medical care tends to be inadequate (Nelson et al., 2009; Perry, 2002).

Third, the multifaceted causes of complex trauma make it harder to remedy. At the individual level, symptoms of complex trauma cause clients to explicitly avoid therapeutic relationships and to reenact alienating behaviors in supportive services and foster care. Accordingly, workers and foster parents need to be trained to respond with compassion and professional caregiving to behavior that the caregiver may experience as rejecting or noncompliant, emotionally abusive, and even physically threatening. Moreover, it

is not uncommon for caregivers working with victims of complex trauma to risk vicarious trauma; such trauma is evident, when it is not prevented, in the withdrawal of professionals from therapeutic involvement, or hostile antagonism toward victims (for instance, blaming the children for their symptoms by labeling them as uncooperative with service efforts). More intensive supervisory support and education are needed to assist caregivers who help children suffering from complex trauma (Bussey, 2008; Osofsky, 2009).

Several causes of complex trauma inhere in factors at the societal level, such as poverty and underresourced educational and mental health systems, that cannot be addressed by individually oriented therapies. If they are to have lasting effects, efforts must be multifaceted and targeted to aid children throughout their developmental process. Moreover, because complex trauma by definition involves locally specific community and cultural forces, it cannot be treated in a cookie-cutter fashion. Therapeutic and community change efforts must be “glocalized,” applying general and even global knowledge to local cultural conditions. Helping a child prostitute in Thailand who believes that her prostitution is the only way to save her family from starvation clearly requires different efforts than helping a victim of trafficking in Lithuania or a neglected child terrorized by gangs in the urban United States.

A final reason why complex trauma is so difficult to remedy is that victims of complex trauma initially find it difficult to verbalize what they have endured, either for fear of re-triggering distress, or because of numbness or denial. In societally induced traumas, whether due to corrupt housing authorities, abusive prison officials (Fine & Torre, 2006), or genocidally oppressive political systems (Lykes, 1994), trapped victims may fear retaliation, and so a pervasive culture of silence accompanies victimization. It is virtually impossible to mobilize public will and educate professionals to change a social

problem that is cloaked in silence.

Despite these challenges, there are distinct clues for planning and carrying out effective treatments on which we can build. The National Child Traumatic Stress Initiative documents several treatment protocols with demonstrable effectiveness, and there are now centers all over the country specializing in the treatment of complex trauma and important books providing in-depth applied insights (Courtois & Ford, 2009; van der Kolk, McFarlane, & Weisaeth, 1996).

An important large-scale approach to treating complex trauma is sustained focus on developing resilience by supporting children's strengths. We know that trauma is often reproduced because it interferes with compassion. So, for instance, researchers in Rwanda found that victims of genocide were less likely to participate in community-based efforts at restoring justice and peace (Pham et al., 2004). In Spain, researchers found that parents at risk of abuse are known to have more difficulty than other parents in empathizing with their children's distress (Perez-Albeniz & de Paul, 2003). We also know that societies can create national programs of mourning and recognition to correct these problems (Herwitz, 2005). Communities can develop projects focused on restoring empathy; these have with documented effectiveness in helping children and youth to develop their empathy and use that empathy to regulate their aggression (Gordon, 2009). Therapeutic efforts require partnerships between service providers, community leaders, and trauma-educated mental health providers that respectfully draw from the strengths of indigenous cultural traditions (Lykes, 1994; Zeanah et al., 2006).

We have other clues springing from research here in Illinois, which was "one of the first state child welfare systems to switch to a trauma-informed, public health approach to working with its children. In 2004, the state began its program, collecting

trauma, behavioral health, and risk behavior data on all children entering custody" (Griffin et al., 2009, p. 107). The resulting research demonstrates and documents that children suffering from complex trauma are more able to forego risk-taking behaviors when their strengths are developed and supported.

There is much still to be learned about how best to provide therapeutic services for victims of complex trauma, and which strengths it is most helpful to support and develop. We need much more fine-grained understanding of the nature and impact of complex trauma for individuals and its impact on the treatment process. For instance, it is very likely that short-term models tend to not be sufficient for people suffering from complex trauma, precisely because the trauma is not only ongoing but also anticipated to continue into the future. Until such persons can permanently extricate themselves from the traumatizing conditions, they need intensive, gentle, and empowering ongoing support to be able to develop psychologically. The services needed would give victims refuges where their physical and emotional safety are ensured, help them voice their experiences and provide the comfort of an enduring therapeutic partner in overcoming the effects of trauma, and support the professionals rendering those services. The public needs to be informed about the causes of complex trauma and given hope that, with investment, it can be treated and prevented.

In this issue there are several articles that advance our understanding of helping children and families suffering from multifaceted problems, including complex trauma.

From Kaunas, Lithuania, Jonas Ruskas and Darius Garulaitis address the problem that many parents of special-needs children are not involved in the plans schools make for their children's education. Using a participatory action approach to research,

Ruskas and his colleague found that they could not only study how to involve parents and teachers together in planning for the children, but also contribute to parents' involvement. The most satisfying outcome was that the involved parents created their own support network to keep the experience of involvement growing.

In a context where research is increasingly indicating the developmental risks of sustained nonparental care during early childhood (Belsky 2001), Andrew Guilfoyle, Margaret Sims, and Trevor Parry contribute an important paper that deepens their research about using the very simple and nonintrusive serum cortisol level test to evaluate how public day care affects the stress levels of 3- to 6-year-olds in Australia. Investigating children in 63 public community-based day care centers, they individualized children's cortisol levels and then evaluated how day care centers influenced those levels, relating the children's cortisol levels to the relationship-based principles used to evaluate the programs. High-quality programs that provided more intensive relationship support to the children were associated with significant reductions in the children's levels of stress. This important study indicates that no matter where the children start, providing supportive relationships in the day care setting can help children with stress management—and also that, regardless of where they start, children are just as vulnerable to nonsupportive day care environments. In short, “caring relationships matter.”

Coming to us from Paderborn, Germany, Ferdinand Sutterluty's insightful article takes the brave step of seeking to understand youths' experience of their own violence from a perspective of the youths' inner life. He offers a corrective to sociological theories that conceptualize motivation for violence in terms of rationality and incentives, contending that such models cannot do justice to the serious problem of youth violence. His article is important in offering

insights that, though horrifying at times, are also most important for practitioners, policymakers, and researchers to consider when seeking to effectively assist youth prone to violence.

Although researchers, service providers, and policymakers have long been concerned about the mental health needs of children in foster care, meeting those needs has remained a significant and insufficiently studied challenge. Theodore Cross and Christina Bruhn compared an Illinois sample of children in foster care with a national sample, finding that the mental health needs of that Illinois sample mirror those of their national counterparts: more than half have clearly defined mental health needs. Although children in foster care with diagnosed mental health care needs seem to receive care more often than children with mental health needs who are not in foster care, there are still large numbers of children in foster care whose mental health needs are not being met. In Illinois, mental health needs of children in foster care are met at rates much lower than occurs nationally. Why is this? In a second paper, Theodore Cross analyzes some of the obstacles to foster children's receipt of mental health care. Probably the most significant is problems with timely state reimbursement to providers. Providers who typically have to wait months to be paid for rendering services find that they simply cannot make ends meet if they make a commitment to mental health care for children whose insurance is Medicaid. Resolution of this tragedy requires, as Cross notes, a coalition of advocates, as it necessitates change at the statewide policy level before changes can occur at level of individual and community service provision.

Although much is written about evidence-based approaches to improve child welfare practice, the nature of the evidence that can result in improvement tends to be insufficiently considered. Practitioner case records often provide considerably more data from a perspective that is uniquely

close to the complexities of the clients' lives, and accordingly has the potential for better ecological validity, than data gathered solely for research purposes. In their important study conducted in concert with public child welfare administrators and practitioners, Tobi Hamilton, Keri Batchelder, and Marc Winokur examined 200 case files and created recommendations for change derived directly from this careful examination of actual practice. Among their most important findings are that, despite the fact that 56% of the youth under care had serious behavioral symptoms, only 33% had been referred for a mental health evaluation; moreover, in 45.5% of the cases, maltreatment was chronic, indicating that significant numbers of youth under public care do not even receive evaluations for the mental health effects of the maltreatment they have suffered. Finally, in a context where maltreated children experienced the central trauma of instability in their core family, the children under care experienced a change in caseworker every 9.5 months. This highlights yet again that caseworker turnover is a central problem for child welfare systems, which must be addressed to prevent retraumatizing clients. Practitioners and policymakers need such information in order to plan for the fact that almost half of the families they see will need sustained help for problems that tend to be protracted rather than occasional. It is vital that public child welfare systems solve the problem of caseworker attrition and plan for stability and quality in the caregiving relationships the systems provide, so that they can avoid retraumatizing clients who are already psychologically scarred by maltreatment and loss in important relationships.

In that regard, to focus on the important issue of attracting and retaining quality foster parents, Tara Cavazzi, Andrew Guilfoyle, and Margaret Sims report on in-depth interviews with foster parents in Australia. They focused on foster parents' experiences of support and satisfaction in their roles. Their findings point to issues that child welfare program administrators

can readily seek to resolve: improving information provided to foster parents about children's histories, needs, and strengths; and paying close attention to the foster parents' attachment to the children in their care so that foster parents will be supported if they experience separation issues when the foster children return to the birth parents. Clearly, foster parents are the front-line caregivers for traumatized children, and thus need the depth of support that mental health care providers are now recognized as needing to prevent vicarious traumatization.

Addressing the need to unify communities to better care for orphaned children and orphans with special needs in particular, Gail Kenyon describes the extremely successful approach of community building. After describing the theoretical principles of this approach in depth, she then lays out how she applied them in a poor county in eastern North Carolina. With results beyond what she and the participants individually could have hoped for, they were able to mobilize considerable community awareness and support to enhance adoption resources and services in a county where needs were great and resources were scarce. This is a model program for workers seeking to improve child welfare resources with shoestring budgets but abundant motivation.

Joann Beathea draws from decades of experience in teaching and practicing cultural competency to provide practitioners with many insights about culturally competent practice with ethnic minority and disadvantaged child welfare clients. Articulating the experience of "invisible presence" that so often alienates ethnic minority clients from schools and human services, she explores why this occurs and also how professionals can prevent it. Beathea offers the important practical vision that helping professionals can experience resilience and "bouncing forward" from the difficulties and challenges of cross-cultural practice, and then help their clients

acquire resilience and the ability to “bounce forward” in the face of obstacles as well.

In her paper offering a way for caseworkers to document their practice, Daphne Stephenson-Valcourt recognizes the multiplicity of skills and roles that go into providing good child welfare practice. Because the way in which one’s practice is documented offers an occasion for reflection that can improve the quality of practice, as she notes, it is important to have a framework for documentation that facilitates reflection and optimizes outcomes. She outlines a useful and readily available framework in her 8-frame window model.

Ultimately, the outcomes of youth under state care are the most important indicators of the degree to which state care offers legitimate alternatives for maltreated youth. Hence, it is vital that we keep these indicators on our radar screen. As the Illinois Department of Children and Family Services prioritizes meeting the needs of youth aging out of foster care, this issue’s annotated bibliography responds to that important topic. Noriko Ishibashi Martinez comprehensively reviews evidence about the effectiveness of child welfare interventions for youth aging out of foster care. She covers both the complexity of attempting to measure positive outcomes, the diversity of outcomes to consider, and the varieties of theories and approaches to research one can employ to address this question.

Finally, Rachel Kibblesmith, who brings to her work a deep commitment to and experience with children with special needs and children suffering from profound poverty, reviews two series of recent books: one on school social work and providing mental health treatment in school contexts, and another on treating depression and symptoms of violence in children and youth. The books are important resources for child welfare professionals in educational, psychosocial, and legal settings.

We look forward to your reflections on these articles and to all that you, our readers, can contribute to these ongoing efforts to understand and help children and youth suffering from complex trauma.

References

- Belsky, J. (2001). Emanuel Miller lecture: Developmental risks (still) associated with early child care. *Journal of Child Psychology & Psychiatry*, 42(7), 845–859.
- Bussey, M. (2008). Trauma response and recovery certificate program: Preparing students for effective practice. *Journal of Teaching in Social Work*, 28(1), 117–144.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals* 35(5), 390–398.
- Courtois, C., & Ford, J. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. New York, NY: Guilford.
- Craig, C., & Sprang, G. (2007). Trauma exposure and child abuse potential: Investigating the cycle of violence. *American Journal of Orthopsychiatry*, 77(2), 296–305.
- Fine, M., & Torre, M. E. (2006). Intimate details: Participatory action research in prison. *Action Research*, 4, 253–269.
- Gordon, M. (2009). *Roots of empathy: Changing the world one child at a time*. New York, NY: The Experiment.
- Griffin, G., Martinovich, Z., Gawron, T., & Lyons, J. (2009). Strengths moderate the impact of trauma on risk behaviors in child welfare. *Residential Treatment for Children & Youth* 26(2), 105–118.
- Herwitz, D. (2005). The future of the past in South Africa: On the legacy of the TRC. *Social Research*, 72, 531–548.

- Lykes, M. B. (1994). Terror, silencing, and children: International multidisciplinary collaboration with Guatemalan Maya communities (pp. 1–22). Boston, MA: Center for Human Rights and International Justice, Center Affiliated Faculty Publications, Boston College.
- Nelson, C. A., Furtado, E., Fox, N. A., & Zeanah, C. H. (2009, May-June). The deprived human brain. *American Scientist* 97, 222–229.
- Osofsky, J. D. (2009). Perspectives on helping traumatized infants, young children, and their families. *Infant Mental Health Journal*, 30(6), 673–677.
- Palardy, G., Vonk, M. E., McClatchy, I. (2009). The prevalence of childhood traumatic grief: A comparison of violent/sudden and expected loss. *OMEGA—Journal of Death & Dying* 59(4), 305–323.
- Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress* 18(5), 449–459.
- Perez-Albeniz, A., & de Paul, J. (2003). Dispositional empathy in high- and low-risk parents for child physical abuse. *Child Abuse & Neglect*, 27(7), 769–780.
- Perry, B. D. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain & Mind* 3(1), 79–100.
- Pham, P. N., Weinstein, H., Longman, T. (2004). Trauma and PTSD symptoms in Rwanda: Implications for attitudes toward justice and reconciliation. *Journal of the American Medical Association*, 292(5), 602–612.
- Spinazzola, J., Ford, J., Zucker, M., van der Kolk, B. A., Silva, S., Smith, S., & Blaustein, M. (2005). Survey evaluates complex trauma exposure, outcome, and intervention among children and adolescents. *Psychiatric Annals*, 35(5), 433–439.
- van der Kolk, B. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401–408.
- van der Kolk, B., McFarlane, A., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York, NY: Guilford.
- Zeanah, C. H., Koga, S., Bogdan, S., Stanescu, A., Tabacaru, C., Fox, N. A., Nelson, C. A., & BEIP Core Group. (2006). Ethical considerations in international research collaboration: The Bucharest Early Intervention Project. *Infant Mental Health Journal*, 27(6), 559–576.