

Complex Trauma:

Facts For Directors, Administrators, and Staff in Residential Settings



Katie is a 16-year-old who has been in residential treatment for six months. She has a long history of physical and sexual abuse and neglect. Her mother struggled with depression and was an active substance abuser, and her father sexually and physically abused her. He abandoned the family when Katie was three years old, at which time she was taken into DCF custody. Katie spent the next three years moving between foster placements because no one could “handle” her. She was finally adopted by a loving family at age six. However, due to her many transitions, she had trouble trusting adults and forming secure attachments. She became aggressive towards her parents when they tried to set limits and eventually started running away from home. Having never learned in early childhood how to manage difficult feelings, she relied on ineffective strategies like “spacing out,” going to sleep, and eventually cutting herself. Katie’s parents worked with several mental health professionals to obtain help for Katie, but nothing seemed to work. Her adoptive parents eventually decided that they could not keep Katie safe, so they pursued residential treatment. The residential program staff quickly felt overwhelmed and confused by Katie. One minute she would act like a “typical” teenager, and the next minute she would try to run away or hurt herself. At other times, she acted much younger than her chronological age, throwing temper tantrums and sometimes even wetting herself. Katie seemed to want to be friendly with staff, but then would push them away. Staff members had a hard time figuring out what was triggering Katie and often felt helpless and ineffective to intervene when she lost control of her emotions.

As Katie’s story shows, residential treatment centers are often an “end of the road” placement for youth who have not been helped in less intensive settings. The majority of youth in residential settings (as many as 71 percent, according to Briggs and colleagues in 2012) have histories of ongoing interpersonal trauma. They have been exposed to neglect and emotional, physical, and sexual abuse, and as a result often present with severe and complex symptoms. In addition to complex trauma, youth in residential settings have often experienced multiple transitions and disruptions in care. They are more likely to have co-occurring psychiatric diagnoses including ADHD, behavior disorders, PTSD, mood and anxiety disorders, and psychotic disorders. They also tend to display greater functional impairment in school and community settings, and with peer groups. Youth in residential settings are more likely to display self-harming and suicidal behaviors as well as risk-taking behaviors—substance abuse, problematic sexualized behaviors, delinquency, running away, and violence—that are directly related to their trauma histories. Most have been involved with the child welfare system and come from families with a number of other adversities such as substance abuse, psychiatric problems, domestic violence, unemployment, and incarceration. These stressors contribute to their placement in residential care and, at the same time, complicate the course of their treatment.

Because of their complex presentations, youth in residential treatment require more intensive and longer-term intervention. Though they may demonstrate a similar pattern of response to treatment as youth in other placement settings, the gains are often not sustainable by the end of typical residential treatment. Over 30 percent of youth in residential treatment continue to display clinically significant functional impairment after discharge. To make a difference in the treatment course for these youth, it is important to understand and address the role of complex trauma in their lives.

WHAT IS COMPLEX TRAUMA?

The term complex trauma describes both children’s exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term impact of this exposure. These events are severe and pervasive, such as abuse or profound neglect.

These adversities usually begin early in life and can disrupt many aspects of the child’s development and the formation of a self. Since they often occur in the context of the child’s relationship with a caregiver, these adversities interfere with the child’s ability to form a secure attachment bond. Many aspects of a child’s healthy physical and mental development rely on this primary source of safety and stability.

Complex trauma can have devastating effects on a child’s physiology; emotions; ability to think, learn, and concentrate; impulse control; self-image; and relationships with others. Across the lifespan, complex trauma is linked to a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors, and other psychiatric disorders.

HOW COMPLEX TRAUMA AFFECTS YOUTH IN RESIDENTIAL FACILITIES

From a very early age, Katie learned that adults, who are supposed to keep you safe, will hurt you or let you down. She was never taught how to identify her feelings or how to cope when things got stressful, so when she got upset she shut down and became withdrawn. When she felt threatened or cornered, Katie could become violent and lash out.

Youth with complex trauma present with a host of symptoms, many of which may be exacerbated by living in a residential setting and can make treatment programs particularly difficult to implement. Youth may present with confusing and conflicting symptoms which change depending on the circumstances. They may shift from being angry, sullen, and elated, to a relational style that is at times clingy, avoidant, aggressive, or ambivalent. Their symptoms may not be best captured by any one diagnosis or treatment technique. As the following list of emotional, cognitive, and physical challenges reveals, they may require a range of interventions depending on their state at any given moment.

Self Regulation: As Katie’s story shows, youth with complex trauma have a hard time managing their feelings and often rely on ineffective, or even dangerous, coping strategies. They may have deficiencies in identifying, safely expressing, and modulating their emotions. As a result, they may exhibit rapid shifts between withdrawal and isolation to explosive, emotional volatility (such as crying one minute, screaming the next). To cope with trauma-related memories or nightmares, they may rely on unusual strategies aimed at maintaining safety at night, such as sleeping on a couch versus in a bed. Like Katie, they may also display other uncommon or age-inappropriate behaviors such as hoarding food or other items, bed wetting, or poor hygiene.

Attachment and Relationships: Katie’s history of multiple disrupted attachments and her “push/pull” relationship style with adults are all too common among youth with complex trauma. Youth may worry about their own and others’ safety, or they may struggle with separation anxiety because they are no longer with their families. On the other hand, because youth with complex trauma have often been hurt most in their home environments, the residential setting may cause emotional conflict for them.



Living in a residential setting may stir up memories or reminders of their homes and the traumas that occurred there. As a result, even though they may desire a close relationship with adults, connection may not feel safe. This may make it difficult for youth to connect with staff or to engage in treatment. Healthy and appropriate boundaries can be particularly difficult to manage given the close quarters of residential settings. Poor physical, emotional, and sexual boundaries are frequently noticed in these youth, as well as an inability to accurately interpret social cues.

Behavioral Control: Having never been taught effective ways of eliciting support from others, youth often employ maladaptive methods to meet their needs. In an attempt to maintain safety, seek love, or acquire emotional support, youth may be sexually or aggressively provocative. They may be prone to emotional and physical outbursts towards both other residents and staff. Youth may require external assistance to regulate emotions, but have poor skills to seek assistance. When unable to control her emotions, Katie engaged in self harm, running away, and temper tantrums. Poor impulse control may manifest as attentional difficulties and impulsive risk-taking behaviors like stealing, swearing, substance abuse, and risky sexual behaviors.

Physical Symptoms: Children often lack the words to express their internal pain. Their emotional pain may be expressed instead as physical aches and pains such as stomachaches or headaches which have no direct biological origin. (This is called somatization.) Additionally, because trauma also affects physiological systems, biologically-based physical challenges (such as compromised immune functioning or digestive issues) may develop from the toll the stress response takes on the body.

Dissociation: Katie's strategy of "spacing out," or dissociating, to escape uncomfortable feelings and sensations is common among complex trauma survivors. To outside observers, youth exhibiting dissociation may appear as if they are staring into space, zoning out, or not paying attention. Dissociation may also manifest as difficulty remembering events or a complete loss of consciousness. Clients may describe dissociation as feeling numb or unreal, or they may have no awareness of being in that state at all.

Self-Concept: Youth may be out of touch with their wants and needs and may need others to help articulate them. They often have an underdeveloped sense of who they are and take on different personalities or identities in different times and situations in an attempt to figure it out. Particularly when they are triggered, youths' emotions and behaviors may not match their chronological age. Like Katie, youth may act much younger when they are upset or overwhelmed. At other times, they may act older, exhibiting parental, provocative, or sexualized behaviors.

Cognition: Youth who have experienced complex trauma may encounter cognitive challenges in their ability to anticipate, plan for, and solve problems. This may contribute to poor impulse control and use of ineffective coping mechanisms. These youth may struggle to sustain attention because they are preoccupied with threat and always on high alert. They often have deficits in language development, abstract reasoning, and executive functioning, and demonstrate distorted thought processes, all of which may make it difficult for them to retain and utilize coping skills.

RECOMMENDATIONS FOR WORKING WITH YOUTH WITH COMPLEX TRAUMA

For Residential Directors and Administrators

Follow the four “R’s”:

Ensure that all staff as well as all youth and families have the knowledge, tools and resources needed to:

- Realize the adverse impacts of complex trauma
- Recognize the role of trauma-related reactions and survival coping in youths’ behavioral, emotional, and social problems.
- Respond in a manner that enhances youths’ safety and ability to achieve their full potential through developing a healthy lifestyle, skills, and relationships.
- Prevent re-activation of complex trauma reactions.

Acknowledge that everyone on staff—clinicians, administrators, educators, and auxiliary personnel (e.g., kitchen; maintenance; transportation)—is a member of the intervention team.

- Every member of the program has an opportunity to promote healing. To help youth heal, directors and administrators need to adopt a holistic approach that empowers all staff members to actively engage with youth in a trauma-informed way.

Take care of staff, and encourage staff to take care of themselves.

- Due to the complex symptom presentations encountered in residential programs, the risk for secondary traumatic stress and vicarious trauma is high.
- Consistent training, supervision, and self-care are necessary to reduce staff burnout and turnover.
- Helping staff to manage their own emotional reactions will help prevent burnout. Staff training should focus on self-regulation and affect management in order to maintain staff wellness, attunement to youth, and balance between consistency and predictability with warmth and compassion.

Because trauma matters, ensure that residential policies are trauma-informed.

- For youth with complex trauma, standard rules and protective measures such as seclusions, restraints, and other behavioral management strategies may be perceived as threats and authority figures as potential perpetrators. Administrators should limit residential policies that may trigger trauma responses for youth with complex trauma.
- In order to help youth internalize a sense of control in the face of outside stressors, residential policies should attempt to shift from the use of external controls, such as restraints, time-outs, PRNs, and redirection, to the use of self-regulation and problem-solving skills.

Because development matters, ensure that schools emphasize social and emotional development of youth. In that way, they may better take advantage of educational opportunities.

- Trauma-informed education should undergo a paradigm-shift from curriculum-driven inflexibility to identifying and addressing trauma-related barriers to learning.
- Teachers should make efforts to increase classroom engagement by integrating clinical goals into the classroom such as trust and community building, coping skills, and identifying and differentiating actual, current threats to safety versus “false alarms” triggered by reminders of past traumatic experiences).

For Residential Staff

It's about trauma. Understand behavior through a trauma lens.

- Maintain a nonjudgmental attitude about youths' behaviors. Consider the way in which behaviors can serve as survival mechanisms that developed in the context of dangerous or otherwise unsafe environments.
- The goal of any intervention should be to first understand the function of the behavior and to help the youth figure out more adaptive alternative behaviors.



It's about the relationship, but relationships take time. Be patient.

- Staff should take time to build trust with youth with complex trauma. The therapeutic relationship can be healing for youth with complex trauma, but it can be slow to develop due to their past experiences in unsafe relationships.
- “Home” and “family” are loaded concepts for many complexly traumatized youth who have become “allergic” to relationships. Residential settings and staff may be a more tolerable alternative for some youth to develop new patterns of attachment because there is more structure and less intimacy. However, they need time to settle into this new way of relating to others.
- Mis-attunements will happen; it's what you do about them that matters. Seek opportunities for therapeutic repair, which is healing for the child, but also beneficial to your own learning process.

It's NOT about you.

- Strive to make interactions with youth responsive, not reactive. When youth are triggered they are responding to events from the past, so don't take things personally. Instead, invoke your curiosity and trauma lens to understand what happened.
- Emphasize “teachable moments.” Every interaction with a client is a potential clinical intervention point. The goal of interactions with youth should be to support them in identifying and utilizing opportunities to engage in clinical skills on an ongoing basis, across a variety of contexts.

CONCLUSIONS

Children exposed to trauma have learned to wear many masks to survive their experiences and navigate dangerous, exploitative, or unpredictable relationships and circumstances. When we get caught up in their behavioral presentations, we lose sight of the vulnerable people behind the masks who desperately need our patience, our understanding, and our help to develop more adaptive ways to safely express themselves and get their needs met.

Residential treatment is often considered a “last chance” for many youth. Staff must be careful not to take on their clients’ hopelessness and despair. Instead, residential treatment facilities must maintain their central focus: to support the development of youth’s strengths, competencies, and pre-existing internal capacities.

When in doubt, return to the 4 R’s: Provide the knowledge, tools, and resources needed to **realize** the adverse impacts of complex trauma, **recognize** the role that trauma-related reactions and survival coping play in youths’ behavioral, emotional, and social problems, **respond** in a manner that enhances youths’ safety, and prevent **re-activation** of complex trauma reactions.

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