SIU MEDICINE

The Complexity of Complex Trauma: Understanding the Brain, Behavior, and the Path to Healing

CHILDREN'S MEDICAL & MENTAL HEALTH RESOURCE NETWORK

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Nothing To Disclose

Objectives:

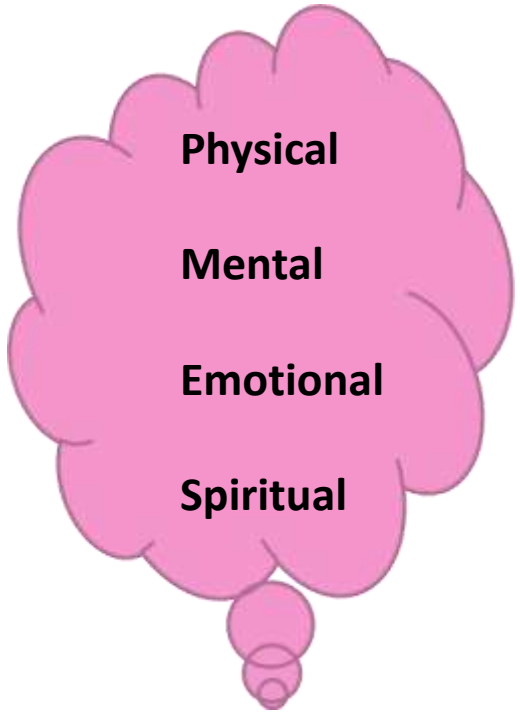
At the conclusion of this session, participants will be able to:

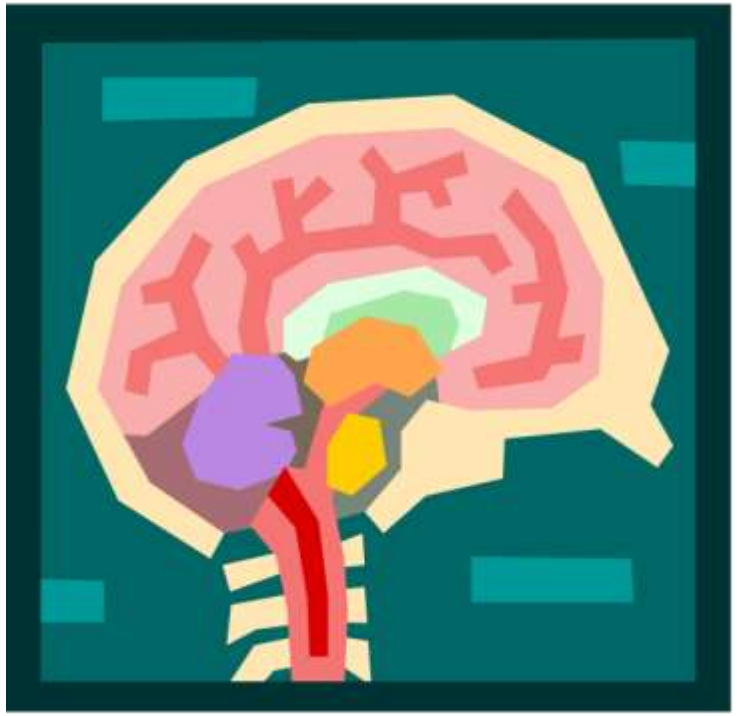
- Describe the neurobiological and developmental impacts of complex trauma and early childhood adversity.
- Recognize common trauma adaptations in children and adolescents, including dysregulation, dissociation, behavioral challenges, attachment difficulties, and somatic symptoms.
- Differentiate trauma responses from traditional psychiatric and behavioral diagnoses to improve assessment and treatment planning.
- Apply trauma-informed and healing-centered principles that promote safety, regulation, connection, and resilience across clinical, educational, and medical settings.

Remembering Trauma

Families today

Human Body is Complex





Childhood Trauma

Toxic stress -- repeated adverse experiences, such as child abuse or neglect, parental substance abuse and maternal depression -- that cause strong, frequent, or prolonged activation of the body's stress response systems in the absence of the buffering protection of a supportive, adult relationship.

Traumatic experiences – threaten the life or physical integrity of a child or of someone important to that child (parent, grandparent or sibling); cause an overwhelming sense of terror, helplessness and horror; and produce intense physical effects.

Psychological maltreatment -- a repeated pattern of damaging interactions between parent and child, such as belittling, rejecting and terrorizing, that becomes typical of the relationship.

Complex trauma – describes exposure to multiple or prolonged traumatic events, including the conditions mentioned above, which typically begins in early childhood within the care-giving system, and the impact of this exposure on the child's development.

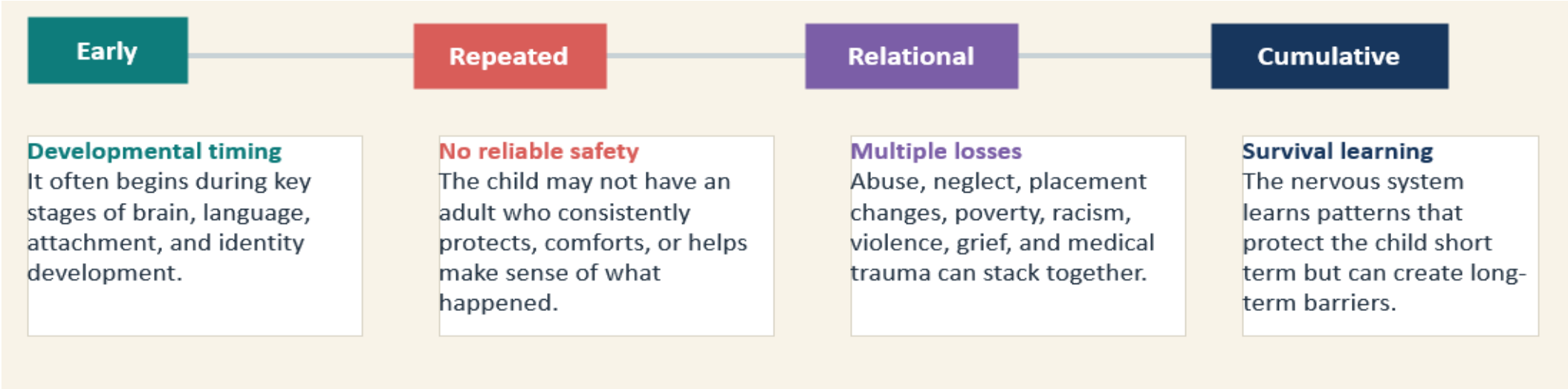
Normal Life, Bad Things

PTSD

Complex Trauma

What makes trauma “complex”?

Complex trauma is repeated, relational, and often begins before a child has the skills or power to protect themselves.



Complex Trauma changes what feels safe, what feels possible, and how a child understands themselves and other people.

Implications for Toxic Stress on the Brain

How a child's brain develops though early experiences

https://www.youtube.com/watch?v=hMyDFYSkZSU

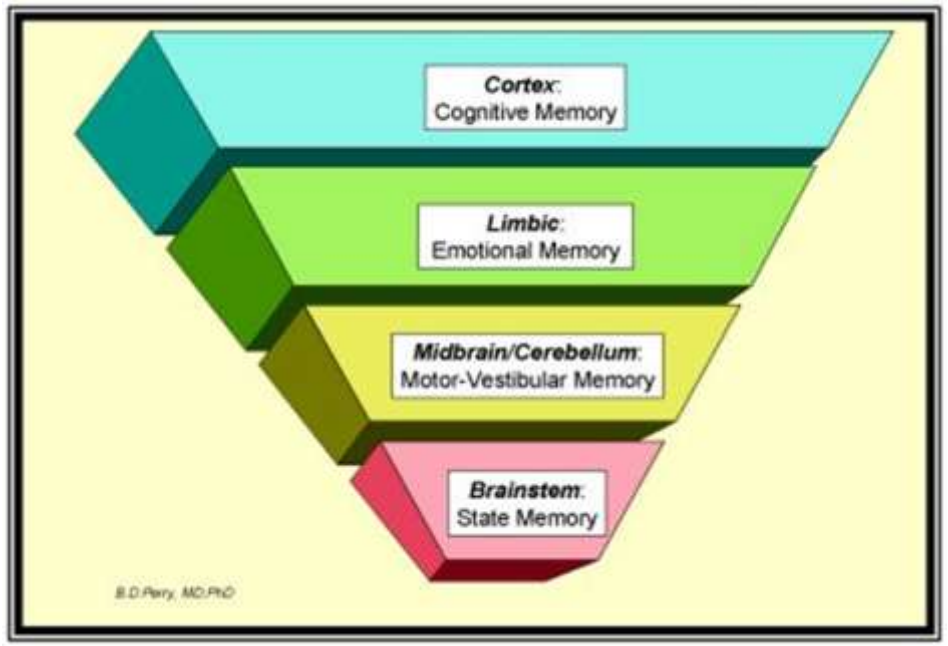
"A child's brain changes in a use dependent way." Bruce Perry

Most of the brain's growth occurs within the first 2-3 years of life

Age Range	Relative Victimization Risk	Key Characteristics
0–3 years	**Highest**	Highest rates of substantiated maltreatment; infants are at the greatest risk of abuse and neglect due to complete dependence on caregivers. ChildStats +1
4–7 years	High	Rates decline from infancy but remain elevated. Neglect is the most common form of maltreatment. ChildStats +1
8–11 years	Moderate	Victimization continues, with increasing reports of physical and sexual abuse compared with younger children. ChildStats
12–15 years	Moderate–High	Greater rates of sexual abuse and psychological maltreatment are reported. Adolescents may also experience increased family conflict and mental health concerns. ChildStats +1
16–18 years*	Lower overall rate than younger children, but still significant	Older adolescents have lower overall substantiated maltreatment rates than younger children, although sexual abuse and exploitation remain concerns. National data are typically reported through **ages 16–17**. ChildStats +1

"A child's brain changes in a use dependent way." Bruce Perry

- The brain develops from the bottom up.
- From lower centers to higher center.
- Brainstem to cortex.
- 100 million to 100 billion neurons with tens of thousands of connections to other neurons.

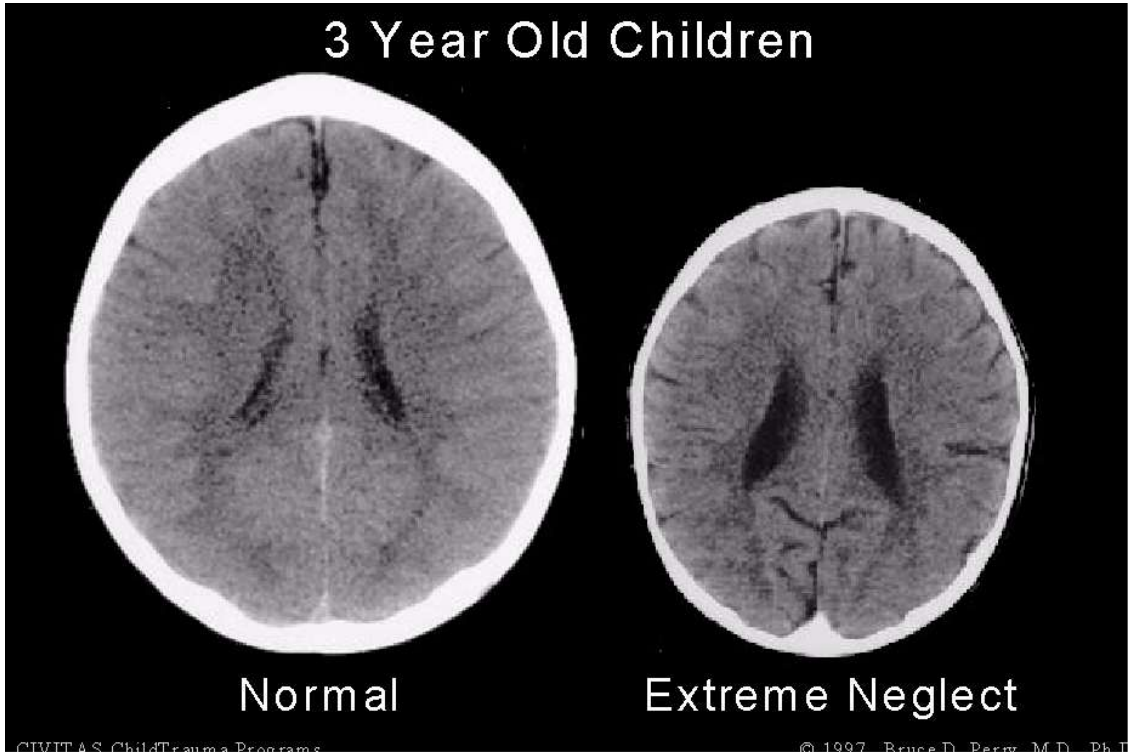


Why is Trauma so detrimental to a child's developing brain?

- Trauma in childhood can "turn on" certain genes that might otherwise have remained "off".
- Trauma can create chaotic biochemical changes that interfere with the maturation of the coping systems in the brain.
- Epinephrine, norepinephrine, dopamine, serotonin.
- This leads to problems with emotional regulation, relationships and identity formation.

The Impact Trauma on the brain

- Trauma can change brain structure:
- And can change the endocrine system responses:
  - Cortisol
  - Neurotransmitters
  - Immune function



There is a story behind every behavior….two common factors:

1. Feeling Unsafe
2. Fear of Failure

Behavior is communication

Like a fever to an illness:

- Symptoms are normal responses to abnormal things that happen
- Symptoms are adaptations
- Anxiety and Depression are normal responses to abnormal things that happen.

"What Looks Like Misbehavior Is Often Survival"

- Complex trauma changes how children respond to the world.
- Children exposed to chronic abuse, neglect, violence, or caregiver instability develop adaptations that helped them survive unsafe environments.

The Question Changes

From: "What's wrong with this child?“

To:

- "What happened to this child?“
- "How did their brain learn to survive?“
- "What does this behavior communicate?"

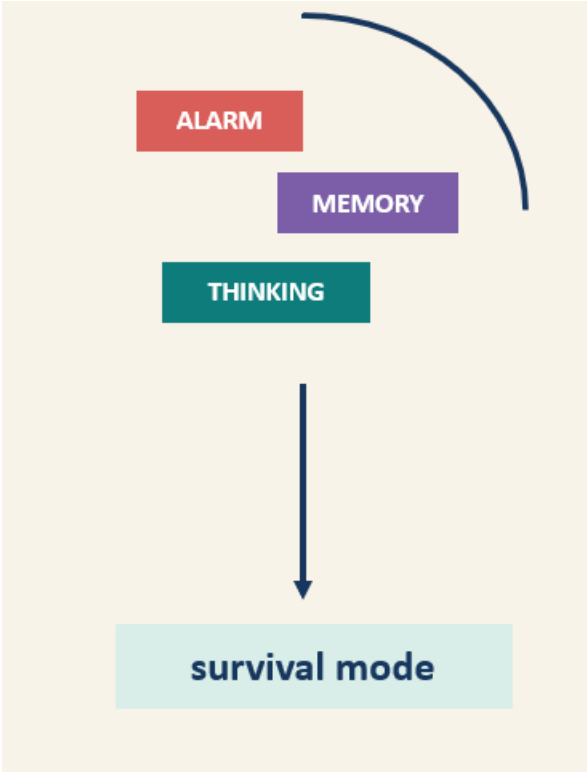
Understanding Complex Trauma

Complex trauma is not just one hard event. It is repeated, layered exposure to threat, loss, neglect, or unsafe relationships - especially when it happens during development.

The brain adapts to survive

Behavior communicates need

Healing happens in safety



The Brain Learns Survival

When trauma is repeated, the brain begins to expect danger.

The Amygdala
- •Detects threat
- •Activates rapidly
- •Remains on high alert
- •Planning becomes difficult

The Prefrontal Cortex
- •Decision making decreases
- •Impulse control weakens

The Hippocampus
- •Learning and memory suffer
- •Time sequencing becomes difficult

Stress Hormones
- •Cortisol and adrenaline remain elevated
- •The body stays prepared for survival instead of learning

"The behaviors that frustrate us today may be the very behaviors that kept this child alive yesterday. When we understand trauma adaptations, we stop asking children to prove they are safe—and we begin showing them they are."

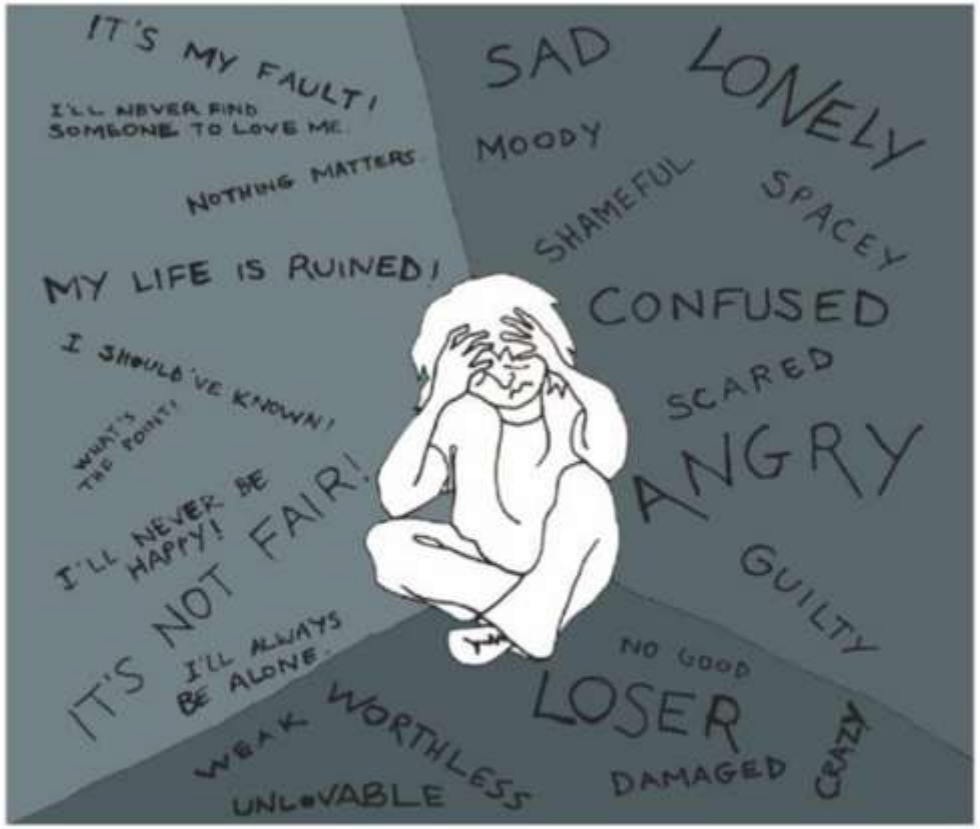
Trauma Behaviors Are Survival Strategies

A child's behavior often reflects an adaptation that once increased safety.

These behaviors developed because they worked in an unsafe environment.

Behavior We See	Survival Adaptation
Aggression	"If I strike first, I won't get hurt."
Withdrawal	"If no one notices me, I'll stay safe."
Lying	"The truth has been dangerous before."
Controlling behavior	"Chaos is less frightening if I'm in control."
Hypervigilance	"Danger can happen at any moment."
Perfectionism	"Maybe I'll be loved if I never make mistakes."
People pleasing	"Keeping everyone happy keeps me safe."

Beliefs about Self	Feelings	Body Messages
I am… Weak, Worthless, Broken, Pathetic.	I feel… Sad, Moody, Angry.	I feel… Tense, Jumpy, Amped, about to Blow.
A Liar, a Sneak, a Suck-Up, a Hypocrite, a Coward, a Bully.	… Spaced Out, Distracted, Numb.	Nothing at all. I don't notice when I cut or hurt myself.
… Nobody, a Failure, a Loser, a Freak, a Skank, Trash.	… Lonely, Afraid, Ashamed.	… Like I'm floating outside my body.
… No Good, Psycho, Messed up, Crazy.	… Helpless, Hurt, Furious.	My head aches. I'm always… in Pain, Sick to my stomach, Nauseous, Fidgety, Restless, Exhausted.
… I can't do anything right.	… Confused, Insecure, Unsure.	I can't stand bright lights, loud noises or tags on my clothes.
… Stupid, School is not for me.	… Scared of myself and what happens when I lose control.	I can't make eye contact with most people.
I have to … Be Perfect, Fool Everyone, Convince Them to Love Me.	… Like I don't care anymore what happens to me or anyone else.	I can't deal with people standing too close to me or wanting to touch me.



What is Complex Trauma? A Resource Guide for Youth
The National Child Traumatic Stress Network
www.NCTSN.org

What happens in the brain and body?

Under chronic threat, the stress response can become the child's default operating system.

Amygdala: alarm system

Scans for danger and can trigger fight, flight, freeze, or fawn before the child can think it through.

Hippocampus: memory + context

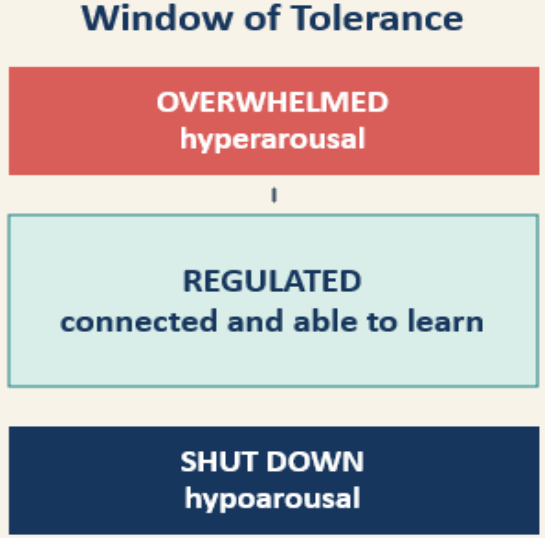
Stress can fragment memory and make it hard to sort past threat from present safety.

Prefrontal cortex: thinking brain

Planning, impulse control, flexible problem solving, and decision making can go offline under stress.

Stress hormones

Cortisol and adrenaline help in danger, but repeated activation wears down sleep, mood, attention, and health.



Complex trauma can shrink the window.

Neuroception

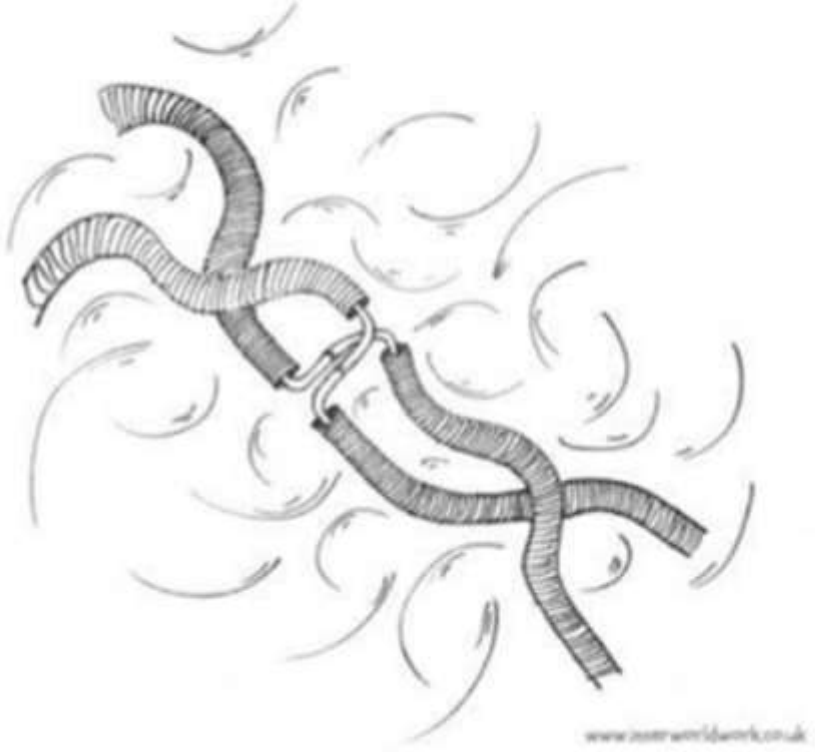
The nervous system constantly asks: "Am I safe?" Children with complex trauma may detect danger even when adults believe everything is fine.

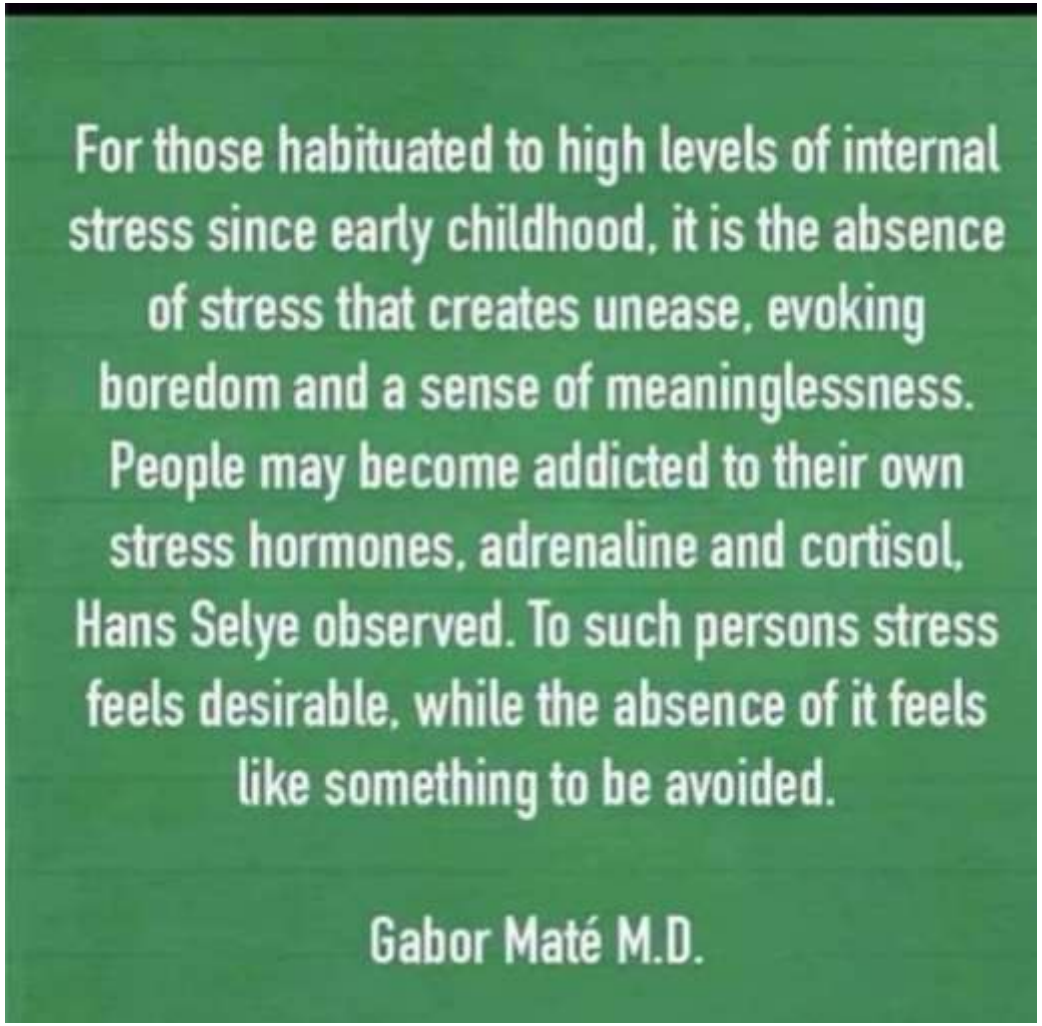
New baseline

High toxic stress can become familiar. Calm may feel unfamiliar, boring, or unsafe until trust is built over time.

When I was little, some wires got connected to the wrong places in my brain. Often I think and feel like I'm under attack even when I'm actually very safe. My brain activates survival mode to protect me.

I don't even know that I have gone into survival mode, I can't even tell you what feels wrong. It happens so often that this part of my brain is really strong and rules over the calm part of my brain. I can't turn it off by myself.




For those habituated to high levels of internal stress since early childhood, it is the absence of stress that creates unease, evoking boredom and a sense of meaninglessness. People may become addicted to their own stress hormones, adrenaline and cortisol, Hans Selye observed. To such persons stress feels desirable, while the absence of it feels like something to be avoided.
Gabor Maté M.D.

Behavior often reflects adaptation

A behavior that is unsafe or disruptive may still be a learned survival strategy.

FIGHT	FLIGHT	FREEZE	FAWN
Arguing, aggression, control, refusing help	Running, skipping school, avoiding tasks	Shutting down, blank stare, no response	People-pleasing, over-apologizing, masking distress

Ask "What is this behavior protecting?" before asking "How do we stop it?"

- ✓ Need for control may reflect past powerlessness.
- ✓ Defiance may reflect threat detection, not disrespect.
- ✓ Withdrawal may reflect overwhelm, not lack of motivation.

Common Trauma Adaptations

Children may become:

Fight

- Aggressive
- Defiant
- Explosive
- Controlling

Flight

- Restless
- Avoidant
- Running away
- Constant movement

Freeze

- Emotionally shut down
- Quiet
- Dissociated
- Unable to respond

Fawn

- Overly compliant
- Parentified
- Caretaking others
- Unable to say "no"

These responses are automatic nervous system responses—not conscious choices.

Children never, ever CHOOSE the meltdown, or any anxiety related behaviour, in the same way that YOU would never, ever choose to have a meltdown in front of your family, colleagues or friends! A meltdown is not a choice, its a byproduct of a brain that isn't coping with something. And that brain needs to be showered in love, compassion and safety. Not punishment, fear or shame.

www.allisondavies.com.au

How Brain Changes Affect Functioning

When the survival system is activated:

- Attention shifts toward possible threats.
- Decision-making becomes narrow and immediate.
- Working memory decreases.
- Language and problem-solving abilities may temporarily decline.
- The child has difficulty identifying feelings and communicating needs.
- Minor stressors may create disproportionately strong reactions.
- The child may move outside the Window of Tolerance quickly.

How Brain Changes Affect Functioning

Inside the Window of Tolerance

The child can:

- Think
- Learn
- Communicate
- Accept help
- Regulate emotions
- Consider choices

Outside the Window of Tolerance

The child may become:

Hyperaroused: angry, impulsive, anxious, aggressive, or restless

Hypoaroused: withdrawn, numb, disconnected, sleepy, or unresponsive

Regulation must occur before reasoning and learning are possible.

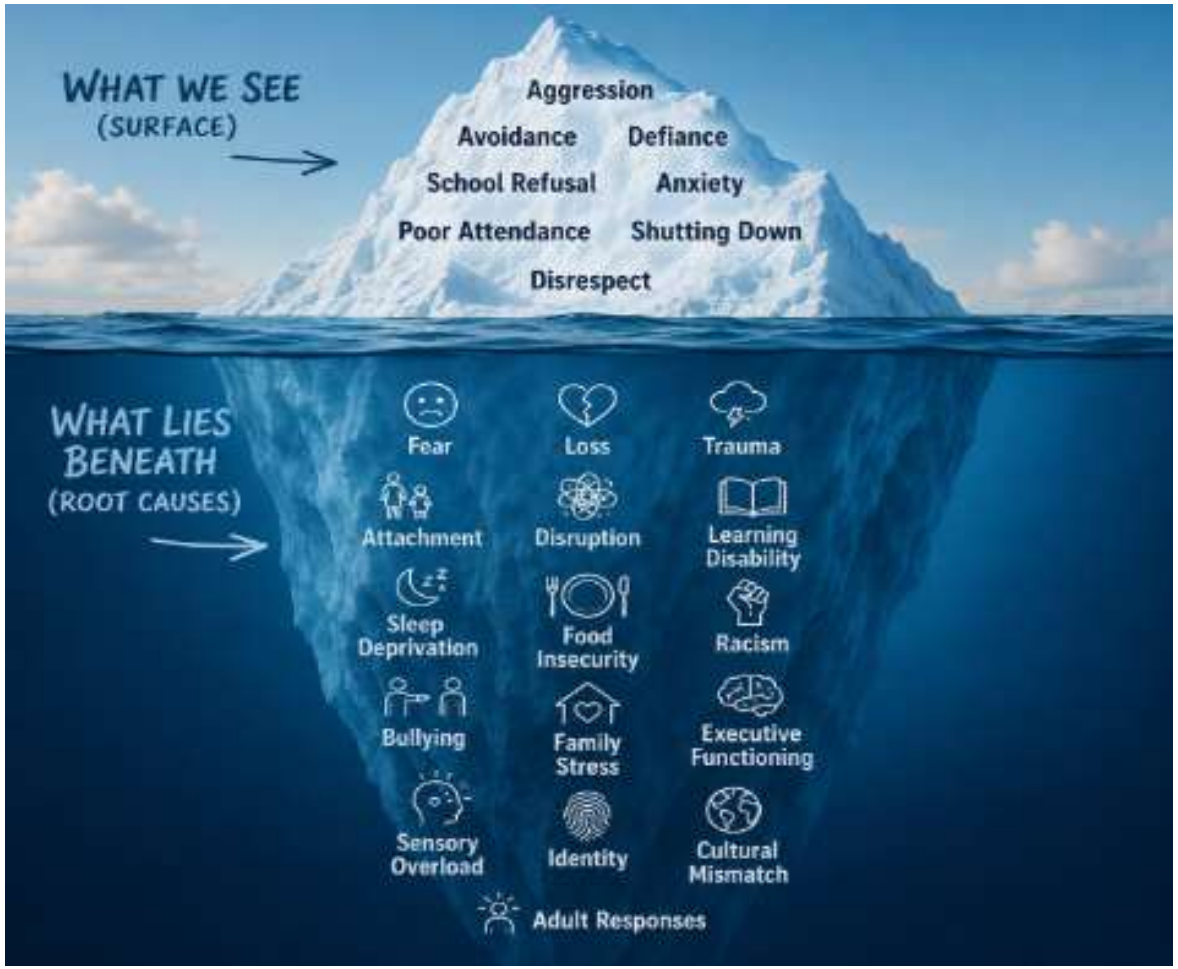
THESE CUPS REPRESENT A STUDENT'S CAPACITY FOR STRESS OR DIFFICULTIES THEY EXPERIENCE AT SCHOOL.

Student A comes to school with her cup already full. At home, she may experience hunger, violence, or abuse. Small difficulties or challenges at school may send her over the edge.

Student B comes to school with her cup almost empty. At home, she experiences support, a loving family, and security. She can handle difficulties and challenges at school without being sent over the edge.

COUNSELOR CHELSEY

How Brain Changes Affect Functioning



How complex trauma shows up

Complex trauma can affect learning, language, health, and relationships at the same time.

School + learning
Attention shifts toward safety. Working memory, processing speed, attendance, and task initiation can decrease.

Speech + language
A child may lack the words to explain feelings, needs, sequence, or cause and effect - especially under stress.

Medical health
Sleep problems, headaches, stomachaches, asthma flares, appetite changes, and chronic pain may increase.

Relationships
Trust can feel risky. Children may test adults, reject closeness, cling, control, or expect rejection.

Common multidisciplinary question

"Are we seeing willful behavior, skill gaps, nervous-system activation, unmet needs, or all of the above?"

Look for patterns across:

- ✓ sleep, appetite, sensory needs
- ✓ attendance and transitions
- ✓ triggers, strengths, and safe adults

Trauma Changes Relationships

Children with complex trauma often believe:

- Adults cannot be trusted.
- Relationships are unpredictable.
- Love always comes with pain.
- Asking for help is unsafe.
- I must depend on myself.

As a result they may:

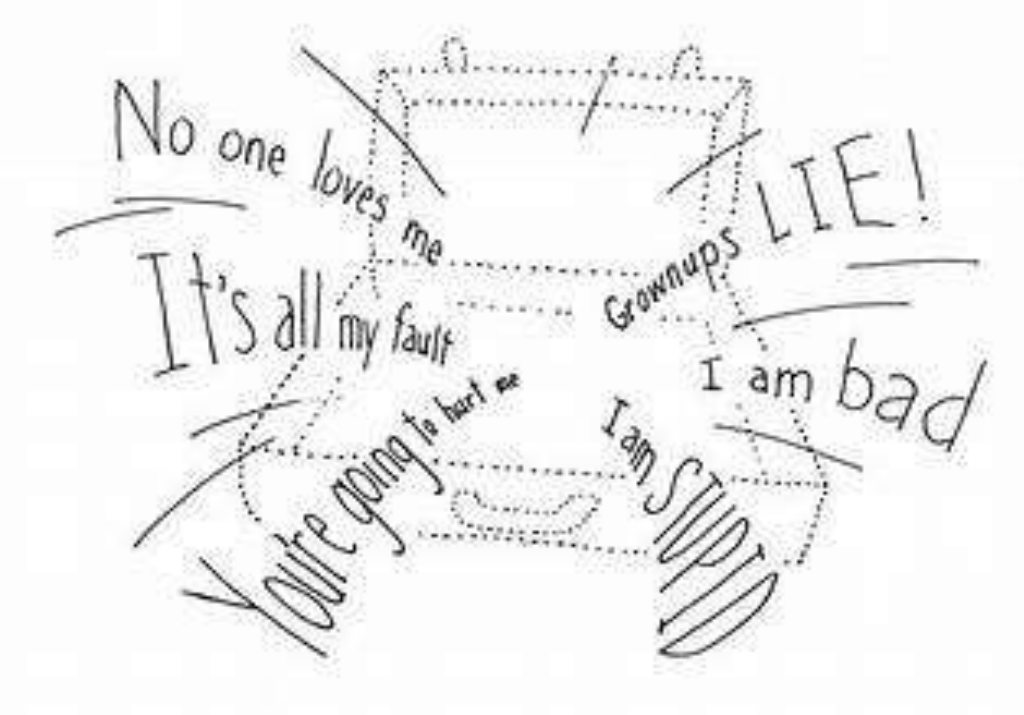
- Reject kindness
- Test adults repeatedly
- Push caregivers away
- Become clingy or overly independent
- Expect rejection

Connection—not punishment—is the pathway to healing.

The Invisible Suitcase

Trauma shapes the child's beliefs and expectation:

- About themselves
- About the adults who care for them
- About the world in general



Bruce Perry

"A confident well regulated adult can take a child out of a fire and have less trauma than an anxious dysregulated adult conveying fear to a child who falls off his bike."

From Survival to Resilience

Trauma adaptations are not permanent.

With consistent support, children can develop:

- Emotional regulation
- Secure attachment
- Executive functioning
- Healthy relationships
- Confidence, Hope, Resilience

Our role is not to ask children to stop surviving. Our role is to create environments where survival is no longer necessary.

Healing Happens Through Relationships

Children heal through:

- ✓ Safe adults
- ✓ Predictable routines
- ✓ Emotional co-regulation
- ✓ Opportunities for success
- ✓ Positive peer relationships
- ✓ Trauma-informed schools
- ✓ Mental health treatment
- ✓ Stable caregiving

Every positive relationship becomes a corrective experience.

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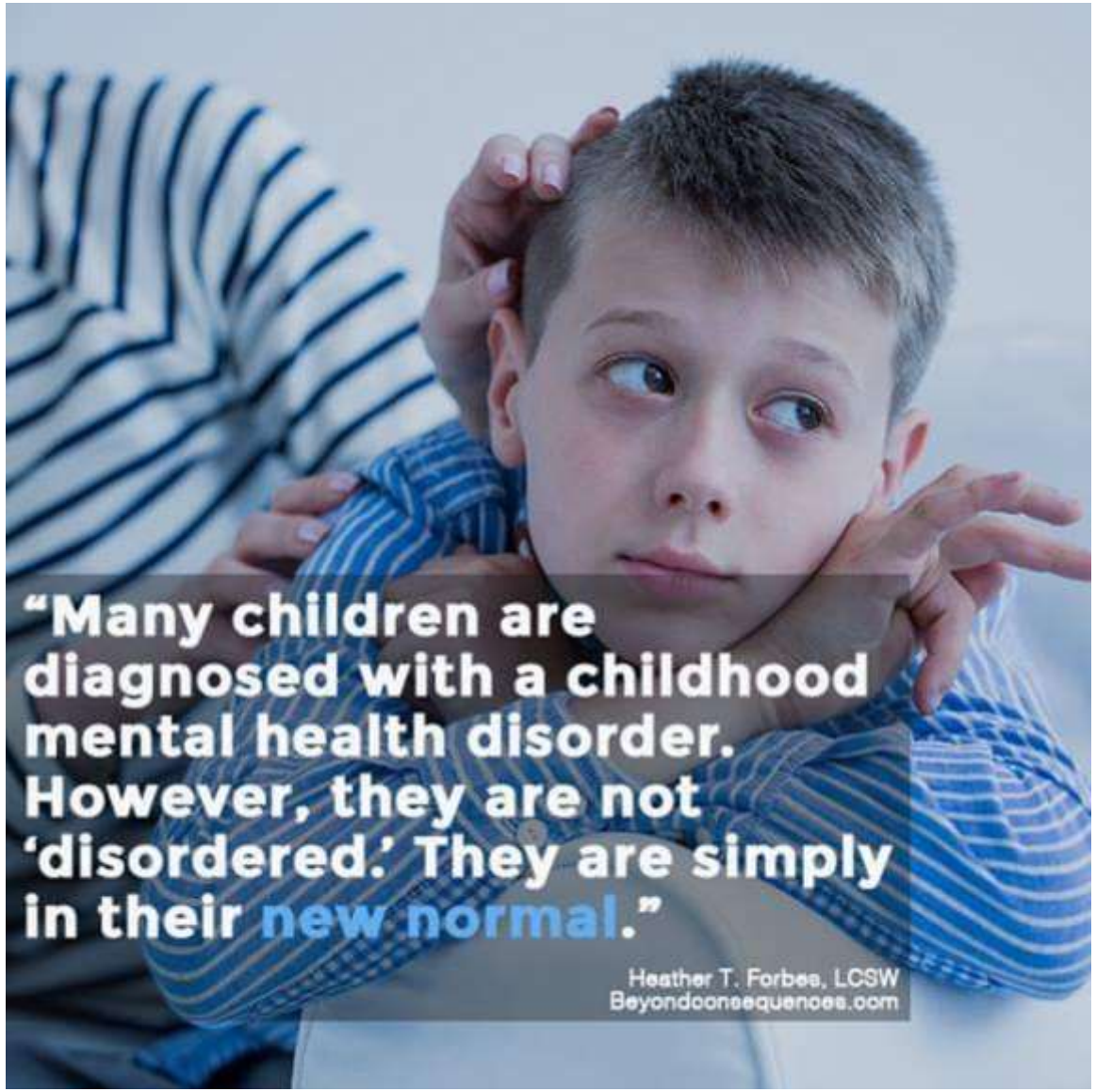


When danger is frequent and unpredictable, the child's brain organizes around survival rather than exploration, connection, and learning.

The child's nervous system adapts to the environment it experiences.

Sign or Symptom	Trauma / Traumatic Stress	ADHD	ODD	Conduct Disorder	Bipolar Disorder	PTSD
Difficulty concentrating	Common, especially when scanning for danger or emotionally overwhelmed	Core feature	May appear during conflict or unwanted tasks	May occur with school disengagement or comorbid conditions	Common during manic, mixed, or depressive episodes	Common due to intrusive memories, hyperarousal, or poor sleep
Restlessness or hyperactivity	May reflect hyperarousal, anxiety, or a need to escape	Core feature, particularly hyperactive-impulsive presentation	May occur when resisting demands	Possible but not defining	Increased activity may occur during mania	May reflect hypervigilance or physiological arousal
Impulsivity	Survival responses may occur before reflective thinking	Core feature	May appear during anger or defiance	Often associated with rule violations or aggression	May become pronounced during mania	Can occur during heightened arousal or perceived threat
Irritability	Very common	May result from frustration or emotional dysregulation	Core feature	Common, particularly with aggression	Can be severe during manic, mixed, or depressive episodes	Common alteration in mood and arousal
Anger or temper outbursts	Often triggered by reminders,	May follow frustration or overstimulation	Frequent temper and angry or resentful	May accompany aggression and	May occur during distinct mood episodes	May be triggered by reminders or hyperarousal

Sign or Symptom	Trauma / Traumatic Stress	ADHD	ODD	Conduct Disorder	Bipolar Disorder	PTSD
	fear, shame, or loss of control		behavior are characteristic	serious rule violations		
Defiance or refusal	May be an attempt to regain safety or control	May result from distraction, impulsivity, or difficulty completing demands	Central pattern involving authority figures	May occur alongside more serious rights violations	Possible during severe irritability, but not a defining pattern	May occur when a request feels threatening or resembles past experiences
Aggression	May represent a fight response	Can occur with poor impulse control but is not required for diagnosis	Verbal or relational aggression may occur	Repetitive aggression toward people or animals may be present	May occur during severe mania or irritability	Reactive aggression may occur when the child perceives danger
Emotional dysregulation	Common due to an overactive stress-response system	Common associated difficulty, though not a core diagnostic criterion	Often expressed through anger and argumentativeness	May appear as aggression or limited frustration tolerance	Significant mood and energy changes occur during episodes	Common, especially around reminders and perceived threats
Sleep problems	Nightmares, difficulty settling, or fear of sleeping may occur	Sleep difficulties may coexist but are not required	Not a defining feature	May occur because of lifestyle, substance use, or comorbid conditions	**Reduced need for sleep without feeling tired** may indicate mania; increased sleep may occur during depression	Nightmares, insomnia, and disrupted sleep are common
Poor academic performance	Stress may interfere with memory,	Common due to inattention, organization, and	Conflict and refusal may interfere with school participation	School absence, rule violations, and	Mood episodes can substantially	Concentration, avoidance, sleep loss, and intrusive

Sign or Symptom	Trauma / Traumatic Stress	ADHD	ODD	Conduct Disorder	Bipolar Disorder	PTSD
	language, attendance, and learning	task-completion problems		disengagement may contribute	interfere with functioning	symptoms may interfere
Difficulty following directions	Multi-step directions may overwhelm an activated nervous system	Common due to inattention, working-memory difficulty, or impulsivity	May actively refuse directions	May intentionally disregard rules	May occur during severe mood episodes	May occur when distracted by threat cues or intrusive memories
Forgetfulness or disorganization	Can result from chronic stress and impaired working memory	Core inattentive features	Usually not central unless another condition is present	Not a defining symptom	May appear during mood episodes	May occur because attention is captured by trauma symptoms
Withdrawal or shutdown	Freeze, collapse, dissociation, or avoidance may occur	Possible, especially after repeated failure or rejection	Less characteristic	Possible but not defining	Common during depressive episodes	Avoidance, emotional numbing, and detachment may occur
Anxiety or hypervigilance	Common; the child may constantly scan for danger	Anxiety may coexist but is not a core ADHD symptom	May appear when the child anticipates demands or consequences	Not defining, although anxiety or PTSD may coexist	Anxiety can occur during mood episodes	Central arousal feature; exaggerated startle and watchfulness may occur
Risk-taking behavior	May reflect impaired danger recognition, escape, numbing, or reenactment	May result from impulsivity	Possible but not defining	Serious rule violations and risky or unlawful behavior may occur	Markedly increased risky behavior can occur during mania	May occur through avoidance, substance use, or trauma reenactment

Sign or Symptom	Trauma / Traumatic Stress	ADHD	ODD	Conduct Disorder	Bipolar Disorder	PTSD
Lying or hiding information	May have developed as protection from punishment, harm, or rejection	May occur impulsively or to conceal incomplete work	May occur to avoid responsibility	Deceitfulness and lying for gain or avoidance can be characteristic	Possible during episodes but not defining	May conceal symptoms or events because of fear, shame, or avoidance
Blaming others	May reflect fear, shame, fragmented memory, or self-protection	May occur after impulsive mistakes	Characteristic pattern	May accompany limited accountability	Not defining	May occur when the child feels threatened or cannot integrate the event
Relationship difficulties	Mistrust, attachment disruption, rejection sensitivity, or controlling behavior may occur	Peer conflict may result from impulsivity or missed social cues	Conflict with authority figures is prominent	Rights violations, aggression, or limited empathy may affect relationships	Mood episodes may disrupt relationships	Detachment, mistrust, irritability, and avoidance may interfere
Mood changes	Often connected to triggers, relationships, reminders, or perceived danger	Usually brief and related to frustration or stimulation	Typically linked to conflict, rules, or demands	Not generally organized into distinct mood episodes	**Distinct episodes** of unusually elevated, expansive, or irritable mood with changes in energy, sleep, speech, and judgment	Mood changes may follow trauma reminders and coexist with avoidance or arousal symptoms

Sign or Symptom	Trauma / Traumatic Stress	ADHD	ODD	Conduct Disorder	Bipolar Disorder	PTSD
Dissociation or appearing "checked out"	May occur during overwhelming stress	Daydreaming or inattention may look similar	Not typical	Not typical	Severe mood symptoms may affect engagement, but dissociation is not defining	Can occur as a trauma-related response
Intrusive memories or reenactment	Possible after trauma	Not characteristic	Not characteristic	Not characteristic, though trauma may coexist	Not characteristic	Central feature: intrusive memories, nightmares, or trauma-related reenactment
Avoidance of reminders	Common	Not characteristic	Refusal may resemble avoidance but usually has a different function	Not characteristic	Not characteristic	Central feature involving avoidance of trauma-related thoughts, feelings, people, places, or situations
Violation of others' rights	Aggression may occur reactively, but repeated rights violations are not inherent to trauma	Not characteristic	ODD does not require serious rights violations	**Defining feature**, including aggression, destruction, deceitfulness, theft, or serious rule violations	Risky behavior may occur during mania, but persistent rights violations are not required	Not characteristic
Elevated mood, grandiosity, or	Not typical trauma features	Not typical	Not typical	Not typical	**Strongly suggestive of a manic episode**,	Not typical

Important Clinical Cautions

Similar behavior does not mean the same diagnosis.

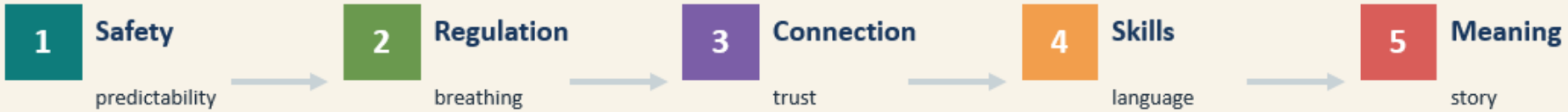
- A child who leaves a classroom may be impulsive, oppositional, frightened, overstimulated, avoiding a trauma reminder, or unable to understand the assignment.
- Trauma, ADHD, ODD, conduct disorder, bipolar disorder, and PTSD can **coexist**.
- A diagnosis should not be based on one behavior, one setting, or one informant.
- Assessment should include developmental history, trauma history, symptom timing, triggers, duration, functional impairment, sleep, medical conditions, learning and language needs, family history, and observations across settings.
- Bipolar disorder should not be inferred from ordinary moodiness or rapid reactions alone. A careful evaluation should identify distinct mood episodes and associated changes in sleep, energy, speech, thinking, and judgment.
- Children showing serious aggression, major rights violations, suicidal thinking, psychosis, extreme risk-taking, or a dramatic decline in functioning need prompt assessment by a qualified child mental-health professional.

Helpful Differential Questions

Assessment Question	What It May Help Clarify
Did the symptoms begin before or after trauma exposure?	Possible relationship between adversity and symptom onset
Are symptoms present across safe and unsafe settings?	Developmental condition versus context-dependent survival response
Are there identifiable trauma reminders or relational triggers?	Trauma-related activation or PTSD
Are attention difficulties constant or mainly present during stress?	ADHD versus trauma-related concentration problems
Does refusal reflect distraction, skill deficits, fear, or deliberate opposition?	ADHD, trauma response, learning difficulty, or ODD
Is aggression reactive and threat-based, or planned and goal-directed?	Trauma-related fight response versus possible conduct-pattern concerns
Are mood changes brief and trigger-related, or sustained for days with major changes in sleep and energy?	Emotional dysregulation versus bipolar mood episode
Does the child have nightmares, intrusive memories, avoidance, or exaggerated startle?	Possible PTSD symptom clusters
Are behaviors developmentally appropriate for the child's age and abilities?	Developmental variation, delay, or psychiatric concern
Could language, learning, sensory, medical, sleep, or substance-related factors be contributing?	Conditions that may mimic or worsen psychiatric symptoms

Healing through safety and repetition

Complex trauma is relationally shaped, and healing is also relationally shaped.



What helps teams respond well

- ✓ Prioritize regulation before correction.
- ✓ Use routines, previewing, and clear expectations.
- ✓ Coordinate school, medical, behavioral, and family supports.

Trauma-informed does not mean permissive. It means we pair accountability with safety, skill-building, and relational repair.

The Pathway to Healing

Trauma Exposure Can Lead To:

Repeated danger
→ Overactive stress response
→ Reduced access to thinking and language
→ Survival behavior
→ Punitive or rejecting adult responses
→ Increased fear and mistrust

Children do not heal simply because the danger has ended. They heal through repeated experiences of safety, regulation, connection, and trustworthy relationships.

Trauma-Informed Care Can Create:

Predictable safety
→ Supportive co-regulation
→ Increased access to the thinking brain
→ Improved communication and decision-making
→ Successful experiences
→ Trust, connection, and resilience

Evidence-Based and Evidence-Supported Trauma-Informed Treatments for Complex Trauma

Children with complex trauma often require treatment that addresses:

- Safety and stabilization
- Emotional regulation
- Attachment and relationships
- Trauma processing
- Executive functioning
- Identity development
- Caregiver involvement
- Skill generalization across settings

Treatment is most effective when interventions are individualized, developmentally appropriate, and involve caregivers whenever possible.

Evidence-Based and Evidence-Supported Trauma-Informed Treatments for Complex Trauma

Treatment	Evidence Strength	Primary Age
TF-CBT	★★★★★	3–18 years
CPP	★★★★★	Birth–6 years
PCIT	★★★★★	2–7 years
CBT	★★★★★	Children & Adolescents
EMDR	★★★★☆	Children & Adolescents
ARC	★★★★☆	All Ages
DBT	★★★★☆	Adolescents
Trauma-Informed Play Therapy	★★★★☆	Young Children
DDP	★★★☆☆	Children & Adolescents
TBRI	★★★☆☆	Foster/Adoptive Populations
IFS	★★★☆☆	Older Adolescents & Adults
Somatic Experiencing	★★★☆☆	All Ages
Sensorimotor Psychotherapy	★★★☆☆	Adolescents & Adults

Key Takeaways

- There is no single treatment that addresses every aspect of complex trauma.
- Phase-based care—beginning with safety, regulation, and relationships before intensive trauma processing—is widely recommended for complex trauma.
- Caregiver involvement, stable relationships, and trauma-informed environments are among the strongest predictors of positive outcomes.
- The best outcomes occur when evidence-based trauma treatment is coordinated with schools, medical providers, child welfare, and community supports.

Hope

"For a child with complex trauma, one regulated adult can change the trajectory of a lifetime.“

"Every time we respond with curiosity instead of judgment, connection instead of punishment, and regulation instead of reaction, we interrupt the cycle of intergenerational trauma.“

Children don't need perfect professionals. They need regulated professionals.Children don't need more punishment. They need more understanding.Children don't need us to rescue them. They need us to walk beside them while they learn that the world can be safe again.

Never Underestimate Your Influence

A calm voice.

A patient response.

A consistent relationship.

A moment of empathy.

A safe classroom.

A trusted therapist.

A compassionate physician.

A caring caseworker.

A believing teacher.

These moments may seem ordinary to us.
To a child with complex trauma, they can change the architecture of the brain... and the trajectory of a life.

"The opposite of trauma is not simply safety—it is connection." — Dr. Bruce Perry