

Understanding Complex Trauma, Complex Reactions, and Treatment Approaches

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This article is written primarily for beginning therapists and practitioners. It provides an overview of what constitutes complex traumatization, common initial and long-term responses and symptoms and their diagnostic conceptualization as complex PTSD or DESNOS (Disorder of Extreme Stress Not Otherwise Specified). It also provides an overview of treatment sequencing and stages.

What is complex trauma and what makes it different from other forms of psychological trauma? *Complex trauma* generally refers to traumatic stressors that are *interpersonal*, that is, they are premeditated, planned, and caused by other humans, such as violating and/or exploitation of another person.

In general, interpersonal traumatization causes more severe reaction in the victim than does traumatization that is *impersonal*, the result of a random event or an "act of God," such as a disaster (i.e., a natural disaster such as a hurricane or tsunami, a technological disaster) or an accident (i.e., a motor vehicle or other transportation accident, a building collapse) due to its *deliberate versus accidental causation*. A third type of trauma, a *crossover* between the two, refers to accidents or disasters that have a human cause (i.e., technological disaster such as the recent Gulf oil leak or a transportation or building accident caused by human error, neglect, or malfeasance). Traumatic stressors of this type have been found to cause reactions that are more severe than those that are impersonal and less severe than those that are strictly interpersonal.

While interpersonal violence *can be a one-time occurrence* that takes place without warning and "out of the blue" usually perpetrated by a stranger (i.e., a robbery, a physical assault, a rape), when it occurs within the family between family members or in other closed contexts that involve significant roles and relationships, it is *usually repeated and can become chronic over time*. Child abuse of all types (physical, sexual, emotional, and neglect) within the family is the most common form of chronic interpersonal victimization. Such abuse is often founded on problematic and insecure attachment relationships (between parent and child or others who have primary caretaking responsibilities). Parents and other caregivers who abuse exploit a child's physical and emotional immaturity and dependent status to meet their own needs or do

so in response to their own inadequacies or distress, quite often their own history of unresolved trauma and/or loss.

Rather than creating conditions of protection and security within the relationship, abuse by primary attachment figures instead becomes the cause of great distress and creates conditions of gross insecurity and instability for the child including misgivings about the trustworthiness of others. When it occurs with a member of the family or someone else in close proximity and in an ongoing relationship with the child (i.e., a clergy member, a teacher, a coach, and a therapist), it often occurs repeatedly and, in many cases, becomes chronic and escalates over time. The victimization might take place on a routine basis or it might happen occasionally or intermittently. Whatever the case, the victim usually does not have adequate time to regain emotional equilibrium between occurrences and is left with the knowledge that it can happen again at any time. This awareness, in turn, leads to states of ongoing vigilance, anticipation, and anxiety. Rather than having a secure and relatively carefree childhood, abused children are worried and hypervigilant. The psychological energy that would normally go to learning and development instead goes to coping and survival.

Child abuse, occurring in the context of essential relationships, involves significant *betrayal* of the responsibilities of those relationships. In addition, it is often private and the child is cautioned or threatened to not disclose its occurrence. Unfortunately, when such abuse is observed or a child does disclose, adequate and helpful response is lacking, resulting in another betrayal and another type of trauma that has been labeled *secondary traumatization* or *institutional trauma*. It is for these additional reasons that complex traumatization is often compounded and cumulative and becomes a foundation on which other traumatic experiences tragically occur over the course of the individual's lifespan. Research studies have repeatedly found that when a child is abused early in life, especially sexually, it renders him/her much more vulnerable to additional victimization. Such child victims can become caught in an ongoing cycle of violence and retraumatization over their life course, especially if the original abuse continues to go unacknowledged and the aftereffects unrecognized and untreated.

Cumulative adversities faced by many persons, communities, ethno-cultural, religious, political, and sexual minority groups, and societies around the globe can also constitute forms of complex trauma. Some occur over the life course beginning in childhood and have some of the same developmental impacts described above. Others, occurring later in life, are often traumatic or potentially traumatic and can worsen the impact of early life complex trauma and cause the development of complex traumatic stress reactions. These adversities can include but are not limited to:

- Poverty and ongoing economic challenge and lack of essentials or other resources
- Community violence and the inability to escape/re-locate
- Homelessness

- Disenfranchised ethno-racial, religious, and/or sexual minority status and repercussions
- Incarceration and residential placement and ongoing threat and assault
- Ongoing sexual and physical re-victimization and re-traumatization in the family or other contexts, including prostitution and sexual slavery
- Human rights violations including political repression, genocide/"ethnic cleansing," and torture
- Displacement, refugee status, and relocation
- War and combat involvement or exposure
- Developmental, intellectual, physical health, mental health/psychiatric, and age-related limitations, impairments, and challenges
- Exposure to death, dying, and the grotesque in emergency response work

To summarize: *complex traumatic events and experiences can be defined as stressors that are:*

(1) repetitive, prolonged, or cumulative (2) most often interpersonal, involving direct harm, exploitation, and maltreatment including neglect/abandonment/antipathy by primary caregivers or other ostensibly responsible adults, and (3) often occur at developmentally vulnerable times in the victim's life, especially in early childhood or adolescence, but can also occur later in life and in conditions of vulnerability associated with disability/ disempowerment/dependency/age /infirmary, and so on.

Such complex stressors are often extreme due to their nature and timing: some are actually life-threatening due to the degree of violence, physical violation, and deprivation involved, while most threaten the individual's emotional mental health and physical well-being due to the degree of personal invalidation, disregard, deprivation, active antipathy, and coercion involved. Many of these experiences are chronic rather than one-time or time-limited and they can progress in severity over time as perpetrators become increasingly compulsive or emboldened/entitled in their demands, as trauma bonds develop between perpetrator and victim/captive, and/or as their original effects become cumulative and compounded and the victims increasingly debilitated, despondent, or in a state of adaptation, accommodation, and dissociation. Because such adversities occur in the context of relationships and are perpetrated by other human beings, they involve interpersonal betrayal and create difficulties with personal identity and relationships with others.

Complex Reactions

It is now understood that ongoing abuse or adversity over any developmental epoch but especially over the course of childhood can have major impact on the individual's development in a variety of ways and involve all life domains. In fact, recent studies have documented that abuse and other trauma result in changes in the child's neurophysiological development that, in turn, result in changes in learning patterns,

behavior, beliefs and cognitions, identity development, self-worth, and relations with others, to name the most common. Although some individuals who were traumatized as children manage to escape relatively unscathed at the time or later (often due to personal resilience or to having had a restorative and secure attachment relationship with a primary caregiver that countered the abuse effects), the majority developed a host of aftereffects, some of which were posttraumatic and met criteria for Posttraumatic Stress Disorder (PTSD). But the PTSD diagnosis as currently defined in the *Diagnostic and Statistical Manual IV-TR* of the American Psychiatric Association (American Psychiatric Association, 2000) (the mental health "Bible" that therapists and others use to make diagnoses) does not account for many of the aftereffects seen in children and later in adults abused as children, and is not, in fact, a diagnosis for childhood PTSD. As of yet, no such diagnosis has been included in the *DSM*, although a proposal for a Developmental Trauma Disorder (DTD) has been proposed submitted for its inclusion in the next edition (van der Kolk, 2005)

In recognition of this omission and the misfit encountered in applying many of the complex trauma reactions to the criteria of "standard" PTSD, a review of the most common aftereffects of chronic childhood abuse resulted in their organization into seven criteria sets that were included in a new diagnostic conceptualization labeled Complex PTSD or DESNOS (Disorders of Extreme Stress Not Otherwise Specified) (Herman, 1992 a & b). Complex PTSD was suggested as a means of organizing and understanding the often perplexing array of aftereffects that had been identified into one comprehensive and overarching diagnosis. Moreover, the diagnosis was a way to de-stigmatize aftereffects and symptoms by acknowledging their origin as outside the individual and not due to the character (or character defect) of the individual.

Unfortunately, these negative points of view have been held by many mental health practitioners over the years that impacted their compassion for and treatment of traumatized individuals. Sadly, Complex PTSD was not included as a freestanding mental health diagnosis in the *DSM IV* and was instead considered as an associated feature form of PTSD, although this might change in the future revisions with additional research findings. In the meantime, many therapists who treat children and adults with complex trauma histories and complex trauma reactions use this conceptualization because it matches what they see in their clients' presentations and helps them to explain and organize the symptoms and to further organize their treatment. In fact, Complex PTSD/DESNOS was immediately accepted and used by a wide variety of clinicians treating patients with complex trauma histories because it had face validity in that it matched the varied presentations made by their clients and was a more parsimonious and less stigmatizing way to understand and diagnose the symptom constellation they presented.

The "traditional" or "classical standard" criteria that make up the original diagnosis of PTSD in the *DSM IV-TR* (American Psychiatric Association, 1980) were derived from the study of war trauma and adult soldiers and included: (1) intrusive re-experiencing of

traumatic memories, (2) emotional numbing and avoidance of reminders of the trauma, including memory loss, and (3) hyperarousal, in addition to various associated features such as depression and anxiety and other co-morbidities. Complex traumatic stress disorders routinely include a combination of additional *DSM-IV TR* Axis I and Axis II (developmental/personality) disorders and symptoms, Axis III physical health problems, and severe Axis V psychosocial impairments. Due to the complex traumatic antecedents (in the distant past as well as in the present) and the resultant array of traumatic stress symptoms and other impairments, complex traumatic stress disorders tend to be difficult to diagnose accurately and treat effectively. It would be useful to have a diagnostic conceptualization that is encompassing to understand and organize the various aftereffects.

The seven categories of additional aftereffects include the following:

1. *Alterations in the regulation of affective impulses*, including difficulty with modulation of anger and of tendencies towards self-destructiveness. This category has come to include all methods used for emotional regulation and self-soothing, even those that are paradoxical such as addictions and self-harming behaviors;

2. *Alterations in attention and consciousness* leading to amnesias and dissociative episodes and depersonalization. This category includes emphasis on dissociative responses different than those found in the *DSM* criteria for PTSD. Its inclusion in the CPTSD conceptualization incorporates findings that dissociation tends to be related to prolonged and severe interpersonal abuse occurring during childhood and, secondarily, that children are more prone to dissociation than are adults;

3. *Alterations in self perception*, predominantly negative and involving a chronic sense of guilt and responsibility, and ongoing feelings of intense shame. Chronically abused individuals (especially children) incorporate abuse messages and posttraumatic responses into their developing sense of self and self-worth;

4. *Alterations in perception of the perpetrator*, including incorporation of his or her belief system. This criterion addresses the complex relational attachment systems that ensue following repetitive and premeditated abuse and lack of appropriate response at the hands of primary caretakers or others in positions of responsibility;

5. *Alterations in relationship to others*, such as not being able to trust the motives of others and not being able to feel intimate with them. Another "lesson of abuse" internalized by victim/ survivors is that other people are venal and self-serving, out to get what they can by whatever means including using/abusing others. Abuse survivors may be unaware that other people can be benign, caregiving, and not dangerous;

6. *Somatization and/or medical problems*. These somatic reactions and medical conditions may relate directly to the type of abuse suffered and any physical damage

that was caused or they may be more diffuse. They have been found to involve all major body systems and to include many pain syndromes, medical illnesses and somatic conditions;

7. Alterations in systems of meaning. Chronically abused and traumatized individuals often feel hopeless about finding anyone to understand them or their suffering. They despair of being able to recover from their psychic anguish.

Research has shown that individuals who have symptoms that meet criteria for the complex trauma diagnosis may or may not have the additional symptoms associated with standard forms of PTSD (Ford & Kidd, , 1998); that is, they may have all of the complex trauma criteria but may or may not have PTSD symptoms, per se.

Of note, many of the major characteristics resemble the symptom picture of emotional lability, relational instability, impulsivity, unstable self-structuresense of self, and self-harm tendencies most associated with borderline personality disorder (BPD; American Psychiatric Association, 1994). The BPD diagnosis has carried enormous stigma in the treatment community where it continues to be applied predominantly to women clients in a pejorative way, usually signifying that they are irrational and beyond help. In recent years, this diagnosis that has come to be understood as a posttraumatic adaptation to recurrent and severe childhood abuse, attachment trauma, and personal invalidation, giving therapists another way to understand and treat it. We Conceptualizing and understanding BPD from a complex trauma perspective can assist the clinician in being more empathic towards the client and more even-handed in terms of treatment and personal reactions (countertransference and vicarious trauma).

Complex Treatment

Despite these shifts in orientation understanding the aftereffects and their origins, the individuals with CPTSD/DESNOS (or BPD) diagnosis can be a difficult population to treat. Psychotherapy is fraught with many complications (Chu, 1992; Linehan, 1993) due to the number of issues symptoms the client might experience, issues with personal safety, and deficiencies in the ability to regulate affect and to apply other life skills.; Exposing these patients clients too directly to their trauma history in the absence of their ability to maintain safety in their lives or to self-regulate strong emotions can lead to retraumatization, and associated decompensation, and inability to function. .

In recent years, treatment for patients with the "classic" form of PTSD has increasingly emphasized the use of cognitive-behavioral interventions (CBT), including prolonged exposure (PE) and cognitive restructuring (CR), techniques for which empirical research support has become available (Foa, Friedman, Keane, Friedman, & Cohen, 2008). The research substantiation of the effectiveness of these techniques in ameliorating the often refractory symptoms of PTSD is laudable. Unfortunately, the wholesale application use of CBT exposure techniques to in patients with CPTSD/DESNOS (even those who

clearly have PTSD symptoms) may be problematic if applied too early in treatment and before the client is stable and safe.

CPTSD/DESNOS (even those who clearly meet criteria for PTSD) may be problematic and resurface some of the problems described in the previous paragraph. In response to this, the recommended course of treatment from those experienced in treating CPTSD (Chu, 1998; Courtois, 1999, 2004; Courtois, Ford, & Cloitre, 2009; Ford, Courtois, Van der Hart, Nijenhuis, & Steele, 2005) involves the *sequencing of healing tasks across several main stages of treatment*. These stages include (1) pre-treatment assessment, (2) early stage of safety, education, stabilization, skill-building, and development of the treatment alliance, (3) middle stage of trauma processing and resolution, and (4) late stage of self and relational development and life choice. There is overlapping therapeutic work throughout the stages and often a need to rework stabilization skills over the course of treatment. But as each stage builds on the previous work, the trauma survivor acquires growing control and mastery, which directly counteract the powerlessness of victimization and its continuing aftereffects.

The pre-treatment assessment should be comprehensive, with attention to diagnosis within the posttraumatic/dissociative spectrum, posttraumatic and other symptoms, safety, and comorbidity (particularly substance abuse, medical illness, eating disorders, and affective disorders). It is useful to complete all five axes of the *DSM*, with emphasis on current stressors and available resources for use in the development of a treatment plan. This is also the time to take a broad look at needs and resources, including available health care resources, which can so easily be limited by a client's disability or by managed care insurance coverage or by his/her own motivation or emotional capacity for treatment.

The *early stage* focuses on safety, stabilization, and establishing the treatment frame and the therapeutic alliance. Measured by mastery of the necessary skills and not by duration, this stage of treatment may be the most important since it is directly related to the clients' capacity to function. Education in complex trauma and elements of the human response to trauma provide a foundation for skill-building. Skills to be developed include healthy boundaries, safety planning, assertiveness, self-nurturing and self-soothing, emotional modulation, and strategies to contain trauma symptoms such as spontaneous flashbacks and dissociative episodes. Additionally, attention to wellness, stress management and any medical/ somatic concerns is needed. Medications such as antidepressants and anti-anxiety drugs are often helpful and should be considered to target posttraumatic symptoms and those associated with depression, anxiety, and sleep disorders.

The middle stage of treatment begins only after stabilization skills have been developed and are utilized as needed. This stage involves revisiting and reworking the trauma with careful processing to integrate traumatic material along with its associated but often avoided emotion. This stage typically involves the expression of pain and profound grief

but with the support and witnessing of the therapist. The re-working of trauma is always destabilizing, so the skills learned in the early stage of treatment provide the frame and skill-set needed to face and integrate the previously avoided traumatic material. A wide variety of techniques have been developed for processing trauma that are applicable to this treatment stage including prolonged or graduated exposure, cognitive processing therapy, cognitive restructuring, narrative exposure, and reprocessing, testimony, and Eye Movement Desensitization and Reprocessing, to name the most common.

The late stage of treatment involves identity and self-esteem development and concurrent development of improved relational skills and relationships. The important issues of intimacy, sexuality, and current life choices, including whether to continue certain relationships and vocational choices typically occurs in this stage, if they have not been addressed earlier. Additionally, clients at this stage often encounter an existential crisis associated with a new sense of self and must struggle with the meaning of the now integrated trauma memories and with the losses they have endured. Survivors at this stage often struggle to embrace life with renewed energy and hope for the future. For some, meaning-making may involve a commitment to make a difference in the world, particularly with respect to decreasing violence. This is sometimes referred to as a "survivor mission."

The course of treatment and its duration can vary quite dramatically and a variety of different treatment strategies might be used across the stages of treatment. Some clients stay in therapy for years (especially those with the most extensive trauma histories and those with insecure attachment styles) may never move beyond the first stage, while others move through the three stages in much less time, and still others only engage in treatment episodically as needed. Shorter-term and "hybrid" approaches (Cloitre, Cohen, & Koenen, 2006; Ford & Russo, 2006; Gold, 2000) are now under development. The important consideration is that new and different approaches to the treatment of complex trauma are now available and effective. Survivors who were once confused by their symptoms and who despaired of ever receiving understanding and assistance now have the opportunity to receive effective treatment, to heal, and to get their lives back and on track.

Christine A Courtois, PhD & Associates, PLC is a private practice that specializes in the treatment of adults experiencing the effects of childhood incest/sexual abuse and other types of trauma. Dr. Courtois has worked with these issues for 30 years and has developed treatment approaches for complex posttraumatic and dissociative conditions for which she has received international recognition.

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