CHAPTER 1

Complex Trauma and Traumatic Stress Reactions

Individuals with complex trauma histories pose some of the most difficult challenges and dilemmas faced by therapists and other helping professionals. The traumas they first experienced often date back to the earliest days of childhood, and the problems they experience in their current lives may have been relatively continuous from that time, may have emerged periodically and then remitted, or were mostly absent and emerged in delayed fashion in response to triggering events, experiences, or feelings. These clients typically have coped with several forms of interpersonal trauma—including abuse, neglect, exploitation, betrayal, rejection, antipathy, and abandonment—committed by other human beings. When their primary caregivers (such as parents, other relatives, health care providers, child care workers, or others in positions of authority) were the ones who engaged in these behaviors and mistreated them, the traumatic experiences were a violation of the universal expectation that children should be able to count on their caregivers to be trustworthy, nurturing, and protective. Such betrayals (Freyd, 1994) undermine the child's healthy development by leading to starkly negative beliefs about self and others and to corresponding behavior patterns based on facing a life in which the main priority is to survive overwhelming threats without help or protection. When life is a test of survival from the earliest days of infancy or childhood, the child adapts by anticipating and being prepared for the worst. Thus survival-based beliefs and behavior patterns become symptoms when they persist, even when circumstances no longer warrant them.

Individuals with complex trauma histories often remain in a biological and psychological survival mode (Osterman & Chemtob, 1999), even when they are no longer subject to the same risk of danger. Quite routinely, what were initially "normal reactions and adaptations to abnormal and recurring traumatic circumstances and experiences" (American Psychiatric

Association, 1980, p. 238) become problems over the long term because survival defenses are incompatible with a less dangerous or stressed life. Yet research has demonstrated that adults with complex trauma histories are at considerable risk for retraumatization across the entire lifespan (Duckworth & Follette, 2011; Widom, Czaja, & Dutton, 2008). When victimization continues unabated or recurs, survival reactions become ingrained, leaving their imprint on the individual's physiological and personality development. Survival can come to define a person's entire sense of self and his or her ability to self-regulate and to relate well and intimately with others. These reactions then tend to spawn defenses and coping mechanisms—or what have been identified as *secondary elaborations* of the untreated original effects (Gelinas, 1983)—including such problems as addictions, self-injury, and suicidality, which, paradoxically, may have been first used in the interest of self-soothing.

Many survivors of relational and other forms of early life trauma are deeply troubled and often struggle with feelings of anger, grief, alienation, distrust, confusion, low self-esteem, loneliness, shame, and self-loathing. They seem to be prisoners of their emotions, alternating between being flooded by intense emotional and physiological distress related to the trauma or its consequences and being detached and unable to express or feel any emotion at all—alternations that are the signature posttraumatic pattern. These occur alongside or in conjunction with other common reactions and symptoms (e.g., depression, anxiety, and low self-esteem) and their secondary manifestations. Those with complex trauma histories often have diffuse identity issues and feel like outsiders, different from other people, whom they somehow can't seem to get along with, fit in with, or get close to, even when they try. Moreover, they often feel a sense of personal contamination and that no one understands or can help them. Quite frequently and unfortunately, both they and other people (including the professionals they turn to for help) do misunderstand them, devalue their strengths, or view their survival adaptations through a lens of pathology (e.g., seeing them as "demanding," "overdependent and needy," "aggressive," or as having borderline personality).

Yet, despite all, many individuals with these histories display a remarkable capacity for resilience, a sense of morality and empathy for others, spirituality, and perseverance that are highly admirable under the circumstances and that create a strong capacity for survival. Three broad categories of survivorship, with much overlap between them, can be discerned:

1. Those who have successfully overcome their past and whose lives are healthy and satisfying. Often, individuals in this group have had reparative experiences within relationships that helped them to cope successfully.
2. Those whose lives are interrupted by recurring posttraumatic reactions (often in response to life events and experiences) that

periodically hijack them and their functioning for various periods of time.

3. Those whose lives are impaired on an ongoing basis and who live in a condition of posttraumatic decline, even to the point of death, due to compromised medical and mental health status (Felitti, Anda, Nordenberg, Williamson, Spitz, et al., 1998) or as victims of suicide of community violence, including homicide.

At the present time, no percentages are available for these three categories, but it is clear that for many (if not the majority of complex trauma survivors), their lives are interrupted and encumbered on a periodic or ongoing basis, and many of them seek relief from their symptoms from medical and mental health professionals.

What can helping professionals do to assist these individuals (hereafter identified as "complex trauma survivors" or "survivor clients") to overcome the correspondingly complex traumatic stress symptoms that once helped them to survive and to capitalize on their strengths and add to their resources? This is the question we address in this book, fully acknowledging that any answer is at best partial given the complexity of the challenge and the limitations of the evidence base of practice for this population. We believe that despite the complexities and challenges involved in their treatment, with appropriate and knowledgeable assistance many of these wounded yet spirited individuals can move beyond the point of survival to develop a greater capacity for a satisfactory life.

We begin with two composite case descriptions (both of fictional individuals) that capture many of the challenges and dilemmas that face complex trauma survivors and the helping professionals who seek to support them. The starting point for recovery from complex trauma is an understanding of how crucial experiences (including but not limited to trauma) have uniquely shaped the life and self of each individual.

Doris Hurley

Doris Hurley, a Caucasian woman in her 40s, sought psychotherapy because her husband gave her an ultimatum: "If you don't find a therapist who can make you stop hounding me and driving me crazy, I'm going to leave." Doris has long been unable to trust anyone close to her, yet she also is terrified of being abandoned. She vacillates between being highly dependent on her husband, pursuing him for emotional and physical closeness, and distancing and pushing him away. His resulting confusion and frustration led him to withdraw, confirming her belief that she will never find anyone trustworthy—and her unspoken fear that she is unlovable. This pattern was not limited to her marriage. Doris has a history of first charismatically ingratiating herself with family members and acquaintances and then rejecting or alienating them. Anyone who tried to get to know her usually drifted (or ran) away after they tired

of her (largely unspoken) demands and "tests" and her anger. Over time, Doris became increasingly despondent, enraged, and desperate.

Doris's early experiences included numerous abandonments by her parents. From a young age, her mother was repeatedly in and out of state psychiatric hospitals, suffering from schizophrenia. During these periods, she and her siblings, individually or in pairs, were sent to stay with different relatives who were welcoming and emotionally available only to varying degrees. When her mother was at home, she was quite unstable and highly medicated and, as a result, was inconsistent in both her emotional states and parenting behaviors. Her father was sometimes attentive, but he used his wife's illness and protracted absences as an opportunity to rationalize his sexual abuse of the girls and physical abuse of the boys. Doris often witnessed her father's abusive episodes when he was drinking and tried to protect her siblings by "allowing" her father to abuse her rather than them. At times, her father treated Doris with loving care and attention and as his special confidante. Yet he also berated Doris for causing all of her mother's problems and told her she could never do enough to make up for her "sins." By age 11, Doris felt a deep sense of self-loathing and a guilty obligation to take care of her mother and siblings. She had no one (other than her sometimes responsive but abusive father) available to nurture, encourage, or protect her. Doris came to believe that she ruined every relationship and harmed every person she cared about and that she had to make up for this by denying her own needs and doing everything for other people because they could not be trusted to take care of themselves. She continues to feel unloved and unlovable, a source of anguish and mounting frustration, feelings that she sometimes manages with alcohol.

Hector Alvarez

Hector Alvarez is a 21-year-old Latino male, the oldest of three children. When he was 4 years old, his parents sought asylum in the United States from their home country in Central America, where his father had been tortured for his political beliefs. As his next of kin, the family fled the country fearing for their lives. Once in the United States, Hector's parents took low-income jobs that required both to work full time and long hours. He began kindergarten the year they immigrated and learned to speak English reasonably quickly. As a result and as often happens in immigrant families, his parents came to rely on him to serve as their interpreter. They also relied on him to care for his two siblings when they were working—he was essentially a full-time after-school babysitter for both siblings by the time he was 7 or 8 years old.

Hector's father suffered from terrible nightmares of his torture experience that would routinely awaken family members. He was often irritable due to lack of sleep and would take his anger and irritability out on Hector and his mother, both of whom he regularly physically assaulted, especially after he had been drinking (he drank more and more heavily over the years, in a futile effort to make the nightmares go away). Hector tried to protect his mother but to no avail, and both often had cuts and bruises that they hid from outsiders.

Hector's mother was very passive and deferential in response to her husband, suffered from major depression, and coped by turning to her Catholic faith or by sleeping, while Hector took care of his siblings.

Hector was a shy child who was quiet and reserved at school—he never "made waves" and was not rambunctious like the other boys in his class. Over time, other boys made fun of him, taunting him for being a "teacher's pet" and a "sissy" (and worse) and for always having to go home right after school instead of being able to play. They also teased him about being Latino and for his shabby clothing. Over time, he became more and more isolated and seemed to his teachers to be "in his own world." Some teachers tried to connect with him but found him frustrating because he was so hard to reach. His school performance was subpar, and some of his teachers wrote him off as being slow.

Hector was dutiful in his religious studies, mostly in an effort to spend time with his mother and to get her approval. In seventh grade, his attentiveness and piety were noticed by the parish priest, who began to think Hector might have a religious calling. The priest befriended him and gave him extra attention, something that made him feel better about himself even as it brought more derision from his peers. The priest began to visit his home and became friends with both of his parents, who were thrilled to have the attention of "God's representative on earth." They often invited him to share a meal with them and to spend his free time at their home. Over time, this priest became someone Hector could share his problems with and someone who intervened with his parents on his behalf. In efforts to foster Hector's vocation, the priest offered to take him on trips to visit various seminaries. Some of these trips required overnight stays. During these trips, the priest encouraged Hector to sleep in his bed and over time began to sexually molest him. Hector liked the attention but was confused about the sexual contact; he didn't know what it was, though he knew it was wrong when the priest told him not to disclose "their little secret," but he also knew it felt good. Over time, he came to dislike it, especially when it involved anal intercourse and not just mutual fondling and fellatio. The relationship and the abuse continued until Hector graduated from high school. He never told anyone what was happening with the priest, but the amount of time they spent together was noticed and whispered about. The priest had warned him that no one would understand their "special relationship from God" and that he would be punished by God if he ever disclosed it to anyone.

When Hector turned 18, instead of going to the seminary, as had been the plan, he joined the military to get away from his family and from the priest. Both his parents and the priest were furious with him, feeling let down and betrayed by what they described as "his selfishness." His mother grieved that he had given up his faith and his true vocation. His father railed that he had joined an arm of the government that would engage him in killing and torturing others, as he had been tortured. Hector went to boot camp, where he did well. He was deployed to Iraq, where he killed civilian combatants (including women and children) and witnessed the deaths and dismemberments of several other soldiers. While deployed, he was sexually gang-raped by a group of soldiers

who had noted that he did not have a girlfriend and therefore assumed him to be gay. Again, Hector told no one. Afterward, he became verbally abusive and started getting into physical brawls, as well as using drugs when he could get them. Hector returned home from his first tour of duty a changed man. At first, he was depressed and withdrawn, not wanting to tell anyone about his military duties. He was ashamed at the homecoming reception, believing himself to be "a monster" and "disgusting." He started drinking heavily. He became disruptive in his unit and was ordered to get a mental health evaluation. When he was diagnosed with depression and posttraumatic stress disorder (PTSD), as well as alcoholism, he was separated from his unit and the military, leaving him even more bereft and betrayed. He was also isolated from his family, who felt they no longer knew him and kept their distance. Over time, he became homeless and relied on military buddies for a place to stay and for support. They would routinely dry him out and keep an eye on him when he became suicidal. One day, they dropped him off at the Community Mental Health Crisis Center, where he was evaluated and admitted to an inpatient unit, where he reluctantly began treatment.

These two very different cases illustrate what is often the case for complex trauma survivors: the shock of multiple, repeated, and overlapping victimizations and traumatic exposures beginning in childhood in insecure and/or abusive attachment relationships; the child or adolescent's initial reactions that were either unrecognized or given no explanation, support, or intervention; longer term reactions in late adolescence or adulthood that occurred in conjunction with the age and life stage issues of the individual; and the development of coping mechanisms and defenses (including cognitions and beliefs rooted in the trauma) that then created additional problems for the individual. What was often life-sustaining or life-saving at the time of the repeated trauma (e.g., dissociation, denial, repression, forced silence) paradoxically interfered with the later ability to function in life and to relate to others in ways that are healthy and satisfactory.

This book is designed to provide practicing psychotherapists and clinical researchers with detailed information about complex traumatic stress disorders, along with state-of-the-art best practices and protocols for conceptualization, assessment, treatment, policy, and research. In the remainder of this chapter, we provide additional description of what has come to be known as *complex trauma* or *complex traumatic stressors*, including those that begin early in life, those that occur in adulthood, and those that overlap and are cumulative over the lifespan. Adult-onset complex trauma can occur in an individual without a previous history yet nevertheless cause complex reactions. More commonly, adult traumatic stressors consist of additional exposures and victimizations that build on, add to, or exacerbate the effects of earlier traumas. In Chapter 2, we describe how, over time, these adaptations to exposure to complex trauma can become persistent *complex posttraumatic reactions, adaptations, and disorders*. Many

of these problems have long gone unrecognized or untreated in mental health (and medical) practice, usually because the most apparent symptoms were treated without regard to the posttraumatic origin and adaptations that contributed to or perhaps even caused them (Gelinas, 1983).

Available clinical consensus (supported by emerging empirical data) endorses the use and sequencing of treatment strategies that go beyond those that have proven effective in treating the symptoms of "classic" PTSD as currently defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000; Adults Surviving Child Abuse, 2012; Arnold & Fisch, 2011; Chu, 2011; Cloitre et al., 2011; Courtois, 1999, 2010; Courtois & Ford, 2009; Courtois, Ford, & Cloitre, 2009; Ford, Courtois, Van der Hart, Steele, & Nijenhuis, 2005; Herman, 1992a, 1992b; Ogden, Minton, & Pain, 2006; Paivio & Pascual-Leone, 2010; Van der Hart, Nijenhuis, & Steele, 2006). As discussed in the Preface, these additional strategies include a preliminary focus on safety, increased life stabilization, and the development of emotional regulation and life skills (among others) offered in a progressive and hierarchical sequence and applied according to the client's emotional capacity and resources.

DEFINING COMPLEX TRAUMA

Traumatic events as defined in DSM-IV-TR involve death and threat of death, exposure to the grotesque, or violation of bodily integrity. In the proposed forthcoming new version of the DSM—DSM-5—the definition of traumatic stressors has been streamlined by dropping the requirement that the individual must experience intense subjective distress (i.e., fear, helplessness, or horror) during or soon after the event (*www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=165*). This change is consistent with research indicating that those subjective reactions exclude some peritraumatic responses that are associated with PTSD (e.g., amnesia and dissociation; O'Donnell, Creamer, McFarlane, Silove, & Bryant, 2010) and are better understood as "risk factors rather than diagnostic requirements for PTSD" (Karam, Andrews, Bromet, Petukhova, Ruscio, et al., 2010, p. 465). Two other proposed changes in the DSM-5 definition of traumatic events are that they may include (1) learning of a violent or accidental death or threat of death that happened to a close relative or close friend or (2) "repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse)." These two additions are consistent with a more complex view of traumatic stressors that includes a relational component—the traumatic impact of an actual or potential loss of a primary attachment relationship or the vicarious impact of learning of something terrible happening to key people or to other vulnerable persons, such as children.

In addition to those classic criteria, complex traumatic stressors involve relational/familial and interpersonal forms of traumatization and exposure that are often chronic and include threats to the integrity of the self, to personal development, and to the ability to relate to others in healthy ways. They include abandonment, neglect, lack of protection, and emotional, verbal (including bullying), sexual, and physical abuse by primary caregivers or others of significance or loss of these primary attachment figures through illness, death, deployment, or displacement of some sort. Although these stressors more commonly occur during childhood and adolescence, some occur in adulthood in such forms as domestic violence, kidnapping, war, torture, genocide, human trafficking, and sexual or other forms of captivity or slavery.

Additionally, complex trauma may be based on and associated with the victim's very identity, including such immutable characteristics as race, ethnicity, skin color, gender, genetic and medical conditions and physical limitations, family/tribal/clan background and history, and other factors, such as religious and political orientation, class, economic status, and resultant power or lack thereof (Kira et al., 2011). Traumatic victimizations based on these characteristics can literally begin pre-birth and be life-long or can occur primarily in adulthood. They may result in both individual victimization and in the persecution of entire communities or populations who share characteristics that lead their members to be deemed suspect, inferior, or of sufficient threat to warrant their eradication. Kira and colleagues (2011) have described the violence perpetrated in the name of these types of prejudices or political and economic motives as "identity trauma" because they are based on the intent to discredit and destroy the personal and cultural identity of victims.

Complex trauma, whatever its type or whenever it begins, is usually not a one-time occurrence. Instead, it is most often recurring, escalating in severity over its duration. One type of trauma may "layer" on top of another, a pattern found in family abuse victims who are multiply victimized in the family by more than one member (poly- or multiple victimization) and who are more vulnerable to abuse outside of the family (revictimization) in many life domains such as school, work, the military, religious congregations and groups, and so forth. The result is what has been identified by Ford and Courtois (2009), Duckworth and Follette (2011), Follette, Polusny, Bechtle, and Naugle (1996), and Kira and colleagues (2010) as cumulative forms of trauma and retraumatization that deprive victims of their sense of safety and hope, their connection to primary support systems and community, and their very identity and sense of self. Such compounded stressors are the norm rather than the exception for any number of complex trauma survivors. Treatment must therefore be correspondingly complex, multifaceted, and yet individualized in order to fully address the scope of the traumatic experiences and their multiple life impacts (Briere & Lanktree, 2011; Courtois, 2004; McMacklin, Newman, Fogler, & Keane, 2012).

COMPLEX TRAUMA IN CHILDHOOD

Child psychiatrist Lenore Terr distinguished two main types of children's exposure to psychological trauma that also apply to adults (Terr, 1991). "*Type I" single-incident trauma* refers to a one-time or short-term event that occurs suddenly and "out of the blue" and is thus unexpected and profoundly shocking: a traumatic motor vehicle accident; a natural disaster; a terrorist bombing, an episode of abuse, assault, or rape; a sudden death or displacement; or the witnessing of violence or something overwhelming that is highly out of the ordinary. In terms of causation, this type of trauma may be *impersonal* (i.e., not caused by another person but rather a true random event or accident, often labeled an "act of God") or it may be *interpersonal* (i.e., caused or carried out by another person or persons, sometimes with intention, other times not). In contrast, *"Type II" repetitive or complex trauma* refers to ongoing physical, sexual, and emotional abuse and neglect and other forms of maltreatment in the nuclear or extended family (or quasi-family); domestic violence; community danger and violence; cultural, gender, political, ethnic, illness and religion-based oppression, violence, and physical and geographic displacement; refugee status; terrorism; torture; war; and genocide. These are all interpersonal, involving intentional acts by, or the failure to act by, other human beings.

Although Type I traumatic stressors are typically one time or very time limited, they can range from relatively mild to those of high-magnitude intensity that cause enough distress in the short-term aftermath to meet criteria for what is listed in DSM-IV-TR as acute stress disorder (ASD) and PTSD, acute type (American Psychiatric Association, 1994, 2000). On average, children are more easily stressed or traumatized than adults due to their immaturity and dependence on adults for response and protection. Children place their own age-related interpretations on events especially when they receive no explanation or soothing. Yet, both children and adults have an easier time recovering from Type I traumas (even of high intensity) than from those of the Type II variety. This is especially true when Type I traumas (such as a weather event or other natural disaster or an industrial, ecological, or transportation accident) occur within and affect an entire community or country. They constitute public events that require public emergency response and that are openly discussed in the broader community. Type I traumas typically do not recur, at least not with the same unexpectedness or strength as the original event, or they do so after a period of relative calm, as in the case of recurrent natural or weather-related disasters. However, their influence may be felt for years and beyond. In consequence, Type I trauma victims may remain vigilant to the possibility of recurrence, a response that tends to (but does not always) diminish over time as life returns to normal or a "new normal" is established for individuals, families, and entire communities (Shapiro, 2012).

Although Type II trauma might be expected to be less common than

its Type I counterpart, it unfortunately appears to be much more common and prevalent than previously recognized, especially in children, adolescents, and others in conditions of dependency and disempowerment (such as females in patriarchal cultures; the politically oppressed; refugees and others who are displaced; the unemancipated, or those who lack basic resources; the emotionally, intellectually, or physically ill or disabled; the infirm and the elderly). Kaffman (2009) described childhood victimization as a "silent epidemic," and Finkelhor, Turner, Ormrod, and Hamby (2010) reported that children are the most traumatized class of humans around the globe. The findings of these researchers are at odds with the view that children have protected status in most families, societies, and cultures. Instead, Finkelhor reports that children are prime targets and highly vulnerable, due principally to their small size, their physical and emotional immaturity with its associated lack of control, power, and resources; and their related dependency on caregivers. They are subjected to many forms of exploitation on an ongoing basis, imposed on them by individuals with greater power, strength, knowledge, and resources, many of whom are, paradoxically and tragically, responsible for their care and welfare. These traumas are *interpersonal* in nature and involve personal transgression, violation, and exploitation of the child by those who rely on the child's lesser physical abilities, innocence, and immaturity to intimidate, bully, confuse, blackmail, exploit, or otherwise coerce.

In the worst-case scenario, a parent or other significant caregiver directly and repeatedly abuses a child or does not respond to or protect a child or other vulnerable individual who is being abused and mistreated and isolates the child from others through threats or with direct violence. Consequently, such an abusive, nonprotective, or malevolently exploitive circumstance (Chefetz [personal communication] has coined the term "attack-ment" to describe these dynamics) has a profound impact on the victim's ability to trust others. It also affects the victim's identity and self-concept, usually in negative ways that include self-hatred, low self-worth, and lack of self-confidence. As a result, both relationships and the individual's sense of self and internal states (feelings, thoughts, and perceptions) can become sources of fear, despair, rage, or other extreme dysphoria or numbed and dissociated reactions. This state of alienation from self and others is further exacerbated when the occurrence of abuse or other victimization involves betrayal and is repeated and becomes chronic, in the process leading the victim to remain in a state of either hyperarousal/anticipation/hypervigilance or hypoarousal/numbing (or to alternate between these two states) and to develop strong protective mechanisms, such as dissociation, in order to endure recurrences. When these additional victimizations recur, they unfortunately tend to escalate in severity and intrusiveness over time, causing additional traumatization (Duckworth & Follette, 2011).

In many cases of child maltreatment, emotional or psychological coercion and the use of the adult's authority and dominant power rather than physical force or violence is the fulcrum and weapon used against the child;

however, force and violence are common in some settings and in some forms of abuse (sometimes in conjunction with extreme isolation and drugging of the child), as they are used to further control or terrorize the victim into submission. The use of force and violence is more commonplace and prevalent in some families, communities, religions, cultural/ethnic groups, and societies based on the views and values about adult prerogatives with children that are espoused. They may also be based on the sociopathy of the perpetrators.

Unfortunately, Type II traumas such as childhood sexual or physical abuse, neglect, and family violence frequently occur concurrently or in succession. Such "cumulative trauma" (Cloitre et al., 2010; Kira et al., 2010) or polyvictimization (Finkelhor, 2008; Finkelhor, Ormrod, Turner, & Hamby, 2005) is associated with particularly severe and complex symptomatic problems (Arnold & Fisch, 2011). In such cases, survival adaptations can become habitual and persistent, interwoven in complex ways with the child's developing body, emotions, personality, mental processes, and relationships (Ford, 2005).

Type II trauma also often occurs within a closed context—such as a family, a religious group, a workplace, a chain of command, or a battle group—usually perpetrated by someone related to or known to the victim. As such, it often involves a fundamental betrayal of the relationship between the victim and the perpetrator and within the community (Freyd, 1994). It may also involve the betrayal of a particular role and the responsibility associated with the relationship (i.e., parent–child, family member–child, therapist–client, teacher–student, clergy–child/adult congregant, supervisor–employee, military officer–enlisted man or woman). Relational dynamics of this sort have the effect of further complicating the victim's survival adaptations, especially when a superficially caring, loving, or seductive relationship is cultivated with the victim (e.g., by an adult mentor such as a priest, coach, or teacher; by an adult who offers a child special favors for compliance; by a superior who acts as a protector or who can offer special favors and career advancement). In a process labeled "selection and grooming," potential abusers seek out as potential victims those who appear insecure, are needy and without resources, and are isolated from others or are obviously neglected by caregivers or those who are in crisis or distress for which they are seeking assistance. This status is then used against the victim to seduce, coerce, and exploit. Such a scenario can lead to *trauma bonding* between victim and perpetrator (i.e., the development of an attachment bond based on the traumatic relationship *and* the physical and sexual contact), creating additional distress and confusion for the victim who takes on responsibility and guilt for what transpired, often with the encouragement or insinuation of the perpetrator(s) to do so.

It is for all of these reasons that Type II or complex forms of trauma that involve interpersonal violation and disregard have been found to be associated with a much higher risk for the development of PTSD (acute, chronic, and delayed variants) than Type I trauma (e.g., 33–75+% risk vs.

10–20% risk, respectively; Copeland, Keeler, Angold, & Costello, 2010; Kessler, Sonnega, Bromer, Hughes, & Nelson, 1995) and to result in additional effects beyond the standard criteria for PTSD (Cloitre et al., 2009; Finkelhor, 2007). Thus polyvictimization or complex trauma are "developmentally adverse interpersonal traumas" (Ford, 2005) because they place the victim at risk not only for recurrent stress and psychophysiological arousal (e.g., PTSD, other anxiety disorders, depression) but also for interruptions and breakdowns in healthy psychobiological, psychological, and social development. Complex trauma not only involves shock, fear, terror, or powerlessness (either short or long term) but also, more fundamentally, constitutes a violation of the immature self and a challenge to the development of a positive and secure self, as major psychic energy is directed toward survival and defense rather than toward learning and personal development (Ford, 2009b, 2009c). Moreover, it may influence the brain's very development, structure, and functioning in both the short and long term (Lanius et al., 2010; Schore, 2009).

Complex trauma often forces the child victim to substitute automatic survival tactics for adaptive self-regulation, starting at the most basic level of physical reactions (e.g., intense states of hyperarousal/agitation or hypoarousal/immobility) and behavioral (e.g., aggressive or passive/avoidant responses) that can become so automatic and habitual that the child's emotional and cognitive development are derailed or distorted. What is more, self-integrity is profoundly shaken, as the child victim incorporates the "lessons of abuse" into a view of him- or herself as bad, inadequate, disgusting, contaminated, and deserving of mistreatment and neglect. Such misattributions and related schema about self and others are some of the most common and robust cognitive and assumptive consequences of chronic childhood abuse (as well as other forms of interpersonal trauma) and are especially debilitating to healthy development and relationships (Cole & Putnam, 1992; McCann & Pearlman, 1992). Because the violation occurs in an interpersonal context that carries profound significance for personal development, relationships become suspect and a source of threat and fear rather than of safety and nurturance.

In vulnerable children, complex trauma causes compromised attachment security, self-integrity, and ultimately self-regulation. Thus it constitutes a threat not only to physical but also to psychological survival—to the development of the self and the capacity to regulate emotions (Arnold & Fisch, 2011). For example, emotional abuse by an adult caregiver that involves systematic disparagement, blame, and shame of a child ("You worthless piece of s—t"; "You shouldn't have been born"; "You're the source of all of my problems"; "I should have aborted you"; "If you don't like what I tell you, you can go hang yourself") but does not involve physical or sexual violation or life threat is nevertheless psychologically damaging. Such bullying and antipathy on the part of the primary caregiver or other family members, in addition to maltreatment and role reversals that are

found in many dysfunctional families, lead to severe psychobiological dysregulation and reactivity (Teicher, Samson, Polcari, & McGreenery, 2006).

Complex Trauma in Infancy

When trauma occurs in infancy, the immediate aftereffects are consistent with the developmental conditions of this earliest phase of life, as well as the infant's limited capacities for response (Scheeringa & Zeanah, 2001). The infant's sense of self is somatosensory and preconscious and is based on developing the capacity to organize the flood of sensory inputs and whatever support and security are available. The infant's interactions with caregivers, such as reciprocal gazing, the physical sensations of being held, fed, clothed, toileted, and communicated with through vocalizations and gestures, are critical to the organization and management of this sensory input. Emotion regulation is largely derived from caregiver responses that provide physical contact and soothing with emotional comforting and the identification of emotional states. Competent caregiver behaviors balance the amounts of pleasurable or dangerous multisensory stimulation that the infant is exposed to and function as outside regulators. Over time and with repeated experiences of modulation by and with the caregiver, the infant begins to learn self-regulation of physical and emotional states and develops security with the caregiver.

When traumatic stressors occur during infancy, they are often due to neglect and lack of appropriate and needed care resulting in understimulation on the one hand, to gross exposure and overstimulation with inadequate response or protection on the other, or to physical injury (or all of the above). It takes little to traumatize an infant due to his or her physical and psychic immaturity and extreme state of helplessness and dependence on caregivers for food, shelter, protection, nurturance, response, and stimulation. In consequence, infants are traumatized more readily and by less intense events than are older children or adolescents. The infant's reactions to trauma may emerge as problems in achieving core developmental milestones, such as nursing or bottle feeding (and, later, eating), speech, and a regular sleep cycle. Or they may appear in the form of unpredictable fussiness or insatiability, as well as difficulties in nutrition and digestion. Toileting may be delayed or complicated by excessive or restricted elimination or emotional distress in response to needing or having diaper changes or (later) encouragement to independently "use the potty." The traumatized infant may have emotional outbursts such as rageful protests, a separation cry, inconsolable crying, or withdrawal and despair. If the traumatic circumstances persist and if help or comfort is not forthcoming, the infant may "fail to thrive" and detach from and appear indifferent to the external world, even when caregivers are available. If traumatic injury, emotional intrusion, and neglect/lack of stimulation are of sufficient severity or duration, the infant is at risk of becoming physically ill and even of dying.

Because these self-regulatory, behavioral, social, and emotional problems can occur for many reasons in infancy and early toddlerhood, they should not be assumed to be necessarily or exclusively due to trauma. Yet trauma may be involved—for example, due to direct exposure to physical violence or intrusions (including but not limited to physical and sexual molestation) or to indirect exposure (seeing or hearing family violence, war violence, a natural or human-made accident or disaster) or to profound neglect or sudden catastrophic loss of a primary caregiver (or all three). Under conditions of great danger and insecurity, survival replaces the exploration and growth experiences associated with secure attachment and relational security. Rather than seeking out stimuli, as seems to be the hardwired tendency for most infants, the trauma-exposed infant or young child is likely to experience stimuli as terrifying and overwhelming, anxiety-provoking, painful and frustrating, or confusing and meaningless. This is true of both internal stimuli (such as bodily feelings or newly emerging emotions) and external stimuli (such as new sights, sounds, smells, and touch). What ordinarily would be exciting opportunities to explore, organize, and gain a sense of mastery in relation to one's own body and the external world instead become experienced as threats, as a condition of psychic discomfort and pain, and as confusing and indecipherable "noise." The self-regulatory, relational, and emotional problems that emerge are the direct result of having the developing body and brain's self-protective stress response systems hijacked by the basic imperative—survival—in the absence of adequate nurturing and soothing.

Complex Trauma in Toddlerhood through the Elementary School Years

As the child grows, he or she develops a foundation of basic identity and sense of self, self-regulatory capabilities, and the ability to use language to verbally organize and orchestrate these core capacities. When complex forms of traumatic victimization or loss begin in this stage, the impact can still be severe. This is especially the case if the traumatic shock or the sudden loss of primary attachment figures overwhelms the child's ability to sustain organized self, relational, and emotion regulation, disrupting normal developmental tasks and causing symptoms of distress. As an example: a toddler who has well-developed self-regulatory skills and a consistently responsive and available caregiver may recover from some traumatic experiences without lasting aftereffects or harm. On the other hand, if that same toddler experiences prolonged exposure that extends over many months or years, and if either the toddler's or the caregivers' (or both) ability to self-regulate and maintain relational security are overwhelmed, then the child is likely to develop bodily, behavioral, emotional, or social problems that reflect regression to an earlier level of functioning similar to that of a traumatized infant.

Furthermore, when a toddler or even an older (early elementary school-age) child has not developed a sense of optimism, agency, and security in primary relationships, that child is particularly at risk for experiencing profound "regression" in self-regulatory capacities if subjected to any type of abuse, violence, neglect, or loss. This may not actually be regression as commonly understood, but instead an unfortunate highlighting and exacerbation of the child's poorly developed self-regulatory and relational capacities. Any residual deficits might not become apparent until many years later, especially if caregiver relationships and the environment provide consistency and security and the child does not experience additional traumatic stressors; these children are often identified as asymptomatic. The deficits often become apparent when the normal challenges of adolescence or young adulthood trigger reminders of the trauma or overwhelm self-regulatory or relational capacities. The deficits are akin to a "crack in the foundation" or a "fault line," a vulnerability that can lead to a major loss of personal psychosocial functioning. Thus it is understandable that a child or adolescent who seemed to be well adjusted could develop problems with self-regulation that seem "infantile," such as bedwetting, encopresis, temper tantrums, difficulty delaying gratification, depression, major fears and anxiety, and reactive attachment disturbances involving withdrawal from close relationships after exposure to a reminder of the original trauma(s).

The initial reactions of victimized toddlers and school-age children also involve newly developed or intensified problems with emotion regulation and sense of self. Feelings (such as anxiety, terror, confusion, guilt, rage, shame, despair, or loss and grief reactions) and predominantly negative self-perceptions (such as a sense of being abnormal, bad, stupid, ugly, or deserving of mistreatment and nonresponse) may develop in the aftermath of abuse. Yet, in some cases, feelings such as these may be absent especially when the abuse involves grooming and seduction of the child into a special relationship involving excessive attention that over time, includes sexual activities. In relationships involving *traumatic bonding*, the child's attachment system is invoked, and the resultant feelings of being special are likely to continue and compound over time. This may also occur when the child has been misled or blamed by a perpetrator or a misguided caregiver.

Even when a perpetrator is excessively cruel or uncaring toward the victimized child, the child may still seek contact due to the need for attachment and attention. This paradoxical response is likely when the child needs and depends on the perpetrator even in the face of the abuse or believes that this is a person who, by virtue of his or her authority or status, should be mollified or even loved or respected. Moreover, the child may feel a sense of protectiveness, loyalty, and devotion to the perpetrator that can effectively split the child's awareness into structurally dissociated mental states: simultaneously or alternately feeling loved and special or loyal, responsible, and guilty while also feeling terrified or enraged (Freyd, 1994; Van der

Hart, Nijenhuis, & Steele, 2006). If other children or loved ones (e.g., a battered parent) are victimized, the child may develop a similar dissociation between feeling developmentally appropriate fear and helplessness and feeling an age-inappropriate parentified sense of responsibility (and failure) to protect loved ones, including, in some cases, the perpetrator.

At the opposite end of the spectrum, when victimization is sudden in onset and forcefully committed by a stranger or by someone with no tenderness or desire to cultivate a pseudo-relationship, the child is likely to experience a more immediate sense of shock, disbelief, fear, terror, anxiety, and helplessness (as described earlier as Type I trauma; Terr, 1991). Whatever the case, the child will probably show effects at the time, such as emotional shock and a look of being stunned or distracted and withdrawn. If the traumatic abuse or violence continues or if the child feels too frightened or confused to seek help, the initial shock and fear reactions tend to metastasize psychologically, spreading into many areas of the child's psyche and emotional and interpersonal life. Within a matter of weeks, this can lead to the development of severe symptoms of depression (emotional numbing, dysphoria), anxiety (including behavioral regressions, phobias, panic, obsessive rumination), dissociation, hypervigilance and startle reactions, and related debilitating feelings of shame, guilt, and worthlessness. Family members and others, such as teachers or friends, often notice such changes. However, in the absence of disclosure by the child and without actually witnessing or having other evidence of the victimization (or because of naivete about, minimization of, or unwillingness or inability to believe that a traumatizing event—especially abuse by a family member—could have occurred), they may not understand these reactions or what they represent.

Thus, children's posttraumatic responses may show up in a number of symptoms that frequently are not recognized as being driven by the anxiety, fear, or terror associated with victimization/trauma. These can include:

- Compulsive or ritualized behavior and phobias.
- Sleep disturbances, such as nightmares, night terrors, and fear of sleeping or of sleeping alone, refusing to sleep in a bed, sleeping in a closet or on the floor between the bed and the wall, sleeping with lights on or in layered clothing.
- Excessive worry about family's or loved ones' safety.
- Perceptual distortions, such as hearing sounds and feeling physical sensations.
- Dissociative reactions, such as losing time, personal discontinuity, splitting from or disowning reality, going into a trance, or feeling like several different persons.
- Difficulty recalling events or information, mood swings, sudden episodes of apparent paralysis ("frozen watchfulness").
- Emotional "meltdowns" or "blow-ups"; a tendency to be defiant

and oppositional; or, at the other end of the spectrum, to be excessively detached, passive and compliant with the demands and wishes of others, especially authority figures.

None of these problems is intrinsically associated with trauma, but all of them reflect adaptations that may result from experiencing traumatic threats or harm in the absence of adequate protection or caring. When these patterns begin during complex trauma exposure in childhood and are not recognized or treated, they unfortunately tend to persist into adolescence and adulthood as pervasive difficulty with identity development and self-worth, with the regulation of bodily functions, emotional states, and mental processes, and with maintaining healthy relationships. Thus the common denominator across all developmental epochs is a loss or distortion of normal self-regulatory abilities. Early childhood and preadolescence are crucial developmental periods for the consolidation of these abilities—ideally to provide the child with a solid foundation on which to create a positive and organized sense of self and an integrated personality during the next tumultuous developmental period, adolescence.

COMPLEX TRAUMA IN LATENCY AND ADOLESCENCE

When traumatic victimization or other traumatic exposure begins, continues, or remains unresolved in latency and adolescent years, the youth's immediate reactions tend toward desperate attempts to cope, a despairing sense of shame and self-blame, or angry protest and resistance. Briere and Elliott (2003) helpfully point out that although many activities (e.g., substance use, bingeing and purging, self-mutilation, suicidal attempts, impulsive and high-risk behavior, and indiscriminate sexual behavior) are counterintuitive, as they seem to be self-destructive, they often serve to maintain a sense of self by serving as *tension-reduction behaviors*. These behaviors usually begin in later childhood or adolescence as attempts to distract from, reduce, or manage the emotional pain and confusion elicited by victimization. They offer a short-term solution to overwhelming emotional distress by providing a sense of physical or emotional relief, or escape. Some behaviors may amplify physical arousal, whereas others may numb it, and both may be needed by the adolescent in the throes of polarities of reexperiencing/hyperarousal and numbing/dissociation. These strategies are generally effective in providing some relief or a sense of being in control rather than helpless. Moreover, as adolescents get physically bigger and stronger and have more opportunities for independence, they may engage in behaviors that were not possible previously, such as fighting back, resisting, running away, and so on. Although frequently labeled as "acting-out" or "externalizing" behaviors driven by impulse or addiction, in this population, these

tactics are more helpfully seen as attempts at problem-solving and emotional regulation in the face of painful emotions. As effective (but problematic) coping strategies, these also can be defined as secondary elaborations of the original untreated effects that were mentioned earlier, first identified by Gelinas (1983). In other words, these are new development-related problems that have emerged in an attempt to cope with the traumatic aftermath that often require treatment above and beyond the direct posttraumatic aftereffects.

A primary task of the adolescent years is the development of personal identity and a sense of self-worth. Not surprisingly, it is in adolescence that previous feelings and thoughts about what being victimized says about "who I am as a person" may take center stage and result in the development of a negative identity and exceedingly low self-esteem. The seeds for such pervasive and damning self-perceptions may be found in earlier victimization; in adolescence, self-scrutiny and self-awareness become so developmentally urgent that any lasting sense of helplessness, complicity, guilt, shame, or failure can expand into a full-blown view of oneself as dirty, disgusting, worthless, stupid, deformed, or otherwise shameful and permanently damaged. Traumatized adolescents often feel different from their peers and like outsiders who do not fit the norm. Some develop secondary sex characteristics earlier than their peers, also making them look and feel different from others in their peer group (Trickett, Kurtz, & Noll, 2005).

In contrast, some adolescent survivors describe feeling special, powerful, and sometimes entitled. This is especially true of those for whom excessive attention was part of the abuse relationship by virtue any power they held over the abuser or members of the family—especially their mothers in some cases of father–daughter incest—and of any affection or sexual pleasure they experienced. All of these feelings can coexist with self-loathing and shame or might alternate with them. Some victims experience this power as personally affirming, resulting in feelings of grandiosity, whereas others believe themselves to be malignantly powerful and defective. As children, these victims may have developed the belief that they could willfully manipulate others and "make or break" the family or their peer group (or the broader community setting) with their terrible powers or the secrets they hold. In adolescence these largely implicit ideas no longer manifest mainly or only as the egocentrism associated with early childhood. A more pervasive form of narcissistic entitlement and power and an apparently callous indifference to and contempt for others can lead to conduct disturbances and the victimization of others. Many individuals with apparent sociopathic tendencies and conduct disorders were victimized as children. Such individuals at some point had the capacity for respect, empathy, and genuine social responsibility that was lost and corrupted in the struggle to survive, to make sense of, and to remove themselves from the receiving end of victimization. Identification with the perpetrator and the victimization

of others is specifically included as a core feature of complex PTSD (see the following sections). Thornberry, Henry, Ireland, and Smith (2010) discussed the causal impact of early maltreatment on early adulthood adjustment. (For a highly descriptive and moving discussion on the impact of complex trauma on development, see Arnold and Fisch [2011]).

COMPLEX TRAUMA IN ADULTHOOD AND ACROSS THE LIFESPAN

Complex trauma that begins in adolescence or adulthood may have a profound impact, but in a different way than does repetitive and untreated trauma over the course of childhood. By later adolescence and adulthood, the individual has matured in body, personality, identity, and ability to relate to others and so has many more resources than the immature, developing child. Nevertheless, experiences of complex trauma during these later years can have great impact and can even break down key developmental achievements at any point in the lifespan. For example, an individual who had a fairly sheltered life and security of attachment growing up may become caught in community or political violence up to and including genocidal conflicts as an adult. Thereafter, he or she may become phobic about being out in public and withdraw from interactions with others. Whatever their origin, the common thread that makes these traumas complex is that they are overwhelming in their threat or harm, not only to the individual's personal safety but also to his or her identity, relationships, and overall security and that they negatively impact or reverse the individual's development.

Kira (2010) discussed how some of the distinguishing and immutable characteristics of an individual's very being and identity can cause him or her to be targeted for ongoing persecution and even attempts at systemic eradication. Other personal characteristics or group affiliations that are not inborn or unchangeable but nevertheless are central to the individual's sense of self and community—such as religious or political affiliations, belief systems, and practices—may be used by adversaries to single them out for imprisonment, forced evacuation and relocation, torture, or other forms of violence and cruelty, including genocide.

Chu, Frey, Ganzel, and Matthews (1999) described the phenomenon of *chronic disempowerment* that so often accompanies ongoing victimization and entrapment. Violence that terrorizes or attempts to destroy a gender, culture, religion, or generation or that violates fundamental human values is disempowering because it destroys victims' core source of personal power: their sustaining beliefs, guiding principles, and essential hopes. Colonialism, torture, captivity, genocide, "gendercide," terrorism, and other atrocities are purposefully disempowering because they shatter victims' sense of personal safety, their identity, and the meaning and value of their lives and

their communities. In the face of such terror and the helplessness associated with ongoing entrapment, only survival may seem possible, and that may even seem of questionable desirability (Kira et al., 2010). The result is not just shock and anxiety but also the loss of trust in—or even the ability to recognize—oneself and the hopes that had been one's foundation and compass for years or even decades before the trauma. Thus complex trauma can destroy not only families, communities, and cultures but also the ability of each affected individual to maintain an intact personality, sense of self, and body and to maintain hope and a sense of agency.

Additional forms of complex traumas in adulthood can include:

- War and combat, as either a warrior or a noncombatant.
- Intractable poverty or homelessness.
- Inescapable exposure to community violence or terrorism.
- Political, ethnoracial, religious, gender, and/or sexual identity persecution.
- Incarceration and residential placement involving ongoing threat or actual assault.
- Human trafficking, forced prostitution, and sexual enslavement.
- Involvement in authoritarian groups or cults (some with a religious basis, others based in political or other closed beliefs), some involving mind control perpetrated by a charismatic leader and/or group influence and control mechanisms.
- Political repression involving genocide or "ethnic cleansing," and torture.
- Violence or exploitation due to displacement, refugee status, and relocation.
- Physical enslavement.
- Witnessing gruesome injury or death in the line of police and emergency response work.

Kira and colleagues (2010) suggested that these types of traumas constituted another two categories, in addition to the types identified by Terr (1991) described earlier in this chapter: *Type III*, having to do with one's identity, and *Type IV*, having to do with community membership. They also noted that complex traumas need not be of the catastrophic sort; rather, they may occur in the form of daily microaggressions that gradually break down an individual's (and a community's) spirit and the will to live and resist. Prior to Kira's suggestion, Solomon and Heide (1999) had suggested that *Type III* trauma consisted of multiple, pervasive, and violent events beginning at an early age and continuing over a long period of time. Both of these suggested types (III and IV) refer to the unfortunate fact that some victims routinely or sporadically experience all four types of victimization over their entire life course, making their traumatization that much more complex and compounded.

COMPLEX TRAUMA, COMPLEX TREATMENT

When psychotherapy begins, a therapist has no way of knowing what hidden forces are driving the individual to seek treatment. At first, the difficulties may seem clear-cut, especially when the therapist conducts a detailed psychosocial evaluation, when the individual is articulate in describing his or her past and current needs, or when a referrer or past therapist has not flagged anything out of the ordinary. Yet, as therapy progresses, it is not at all uncommon for therapists to discover that a client suffers from a range of symptoms such as those included in Table 1.1. This partial list is no doubt familiar to many therapists who may have been surprised by the extent of symptomatic distress suffered by some of their clients, even those who "present well" and are apparently well functioning. Whether these impairments emerge sporadically or are chronic, even without a readily discernible triggering event or exposure, it is important for therapists to consider that the client may be suffering from the effects of past or current psychological trauma. This stance is referred to as trauma-reformed orientation on the part of providers (Adults Surviving Child Abuse, 2012; Harris & Follot, 2001; Jennings, 2004; Saakvitne, Gamble, Pearlman, & Tabor, 2000).

Many clients who have had devastating and life-altering traumatic experiences are reluctant to disclose them at the start of therapy. There are a variety of reasons for this reluctance, among them: the painfulness and stigma surrounding them; loyalty to the perpetrator, family, or others; forced silence based on threat or terror; the belief that these experiences are irrelevant to current problems and symptoms; and, in a related vein, the individual's disconnection from the original trauma, lack of trust in the assessor or therapist, or lack of (or incomplete) memory about them. Of particular relevance are traumatic experiences that took place during developmentally formative periods of life (i.e., childhood through adolescence). These include all of the forms of childhood maltreatment and abuse described earlier in this chapter, as well as exposure to and experiencing of ongoing violence or bullying due to group membership (i.e., racial or ethnic group, religion) and exposure to community-based events (i.e., ongoing violence, gangs, war, political conflicts).

Profoundly injurious, terrifying experiences such as these are likely to be psychologically traumatic for any person who experiences them firsthand or who witnesses them. They are particularly likely to be traumatizing if they occur repeatedly and chronically and escalate in severity over time or if they involve multiple occurrences of intentional harm by one or more perpetrators. They can also create conditions of anticipatory anxiety and hypervigilance. As noted previously, the impact of trauma and social maltreatment on children and adolescents can be particularly severe due to their physical and psychological immaturity, and the fact that they are still in the process of personality development.

TABLE 1.1. Potential Sequelae of Exposure to Complex Trauma

- Extreme mood lability (unregulated and dysregulated extremes of emotions and/or cycling between states of manic-like hyper-arousal and severe depression and hypoarousal).
- Social isolation, alienation, and detachment from others.
- Excessive self-sufficiency and fear of intimacy and relationship.
- Excessive dependency, passivity, and superficial compliance with the wishes of others.
- Alcohol or other substance abuse.
- Addictions, including love, relationship and sexual contact.
- Compulsions, including eating disorders (anorexia, bulimia, bulimarexia, binge eating, restricting, and morbid obesity), overwork/workaholism, sexualizing, hoarding, and excessive exercise, gambling, shopping and spending.
- Impulsivity, high-risk behaviors or dangerous thrill-seeking, with disregard for personal welfare and that of others, including children and other dependents.
- Uncontrolled anger or aggression directed toward self or others.
- Episodes of cruelty toward others and toward animals.
- Self-injury ("accidental" or intentional).
- Suicidality (ranging from ideation to parasuicidal or lethal attempts) and parasuicidality.
- Social problems due to persistent suspicion and mistrust of others and lack of social skills.
- Dysfunctional and pathological relationships, including emotionally or physically harmful, exploitive, violent, cruel, and malicious relationships with parents, siblings, partners, peers, employers, mentors, strangers, authorities, or one's own children; sexual, physical, and psychological revictimization or perpetration of victimization.
- Persistent dissociation, including depersonalization, derealization, and loss of personal continuity and awareness, not limited to but potentially including identity alterations.
- Posttraumatic symptoms of intrusive reexperiencing and physiological hyperarousal, alternating with emotional numbing and avoidance of reminders of traumas.
- Medical conditions that cannot be diagnosed or that do not respond to medical treatment.
- Chronic medical conditions, especially autoimmune disorders.
- Chronic low self-esteem, up to and including self-loathing.
- An inability to tolerate or recover from even mild emotional distress.
- Self-blame and self-condemnation, shame, guilt, and unresolved bereavement.
- Primary attachment styles and relationships that are ambivalent, dismissive, dependent, conflicted, anxious, fearful, or disorganized/unresolved.
- Pervasive feelings of helplessness and ineffectiveness.
- Dysfluence and incoherence in discussing personal events and life history.
- Pervasive feelings of hopelessness and despair of ever being understood or of being able to view oneself or be viewed by others as "normal."
- Alienation from or rejection of spirituality and spiritual/religious beliefs.
- Information-processing problems, including attention deficit, failure to complete or perform consistent with one's innate ability key tasks in work or school, or the opposite, the ability to perform very well but with a sense of being an imposter who is actually incompetent.
- Conduct disorders, including oppositional defiant disorder and hyperactivity.
- Psychotic-like experiences of command hallucinations or intrusive negative voices or images that alternately threaten, denigrate, or urge self-harm or the harm of others.
- Psychosis and hallucinations.

We define "complex trauma" as traumatic attachment that is life- or self-threatening, sexually violating, or otherwise emotionally overwhelming, abandoning, or personally castigating or negating, and involves events and experiences that alter the development of the self by requiring survival to take precedence over normal psychobiological development. Note that traumatic events experienced in adulthood may have similarly complex adverse effects by severely damaging or destroying a person's previously formed self, beliefs, and perceptions, for example, when torture, genocide, or extended abusive captivity are inflicted on individuals or entire populations.

Although knowledge of details of the traumatic stressors (the "who, what, when, where," or the objective dimensions) can be very important in treatment, it is sometimes less important than understanding the immediate and longer term reactions, meanings, coping strategies, or survival tactics that currently persist (the subjective and personal dimensions) (Wilson, Drozdek, & Turkovic, 2006). The events may be of subjective importance to the survivor (so as to create a coherent narrative of "what happened to me"), but it is the survivor's biological, emotional, cognitive, behavioral, and relational adaptations that must be understood in order to help with recovery. Many traumatized individuals blame themselves for their survival strategies (often in response to blame or criticism from others) and incorporate beliefs about themselves along the lines of "This is just the way that I am, just the flaws in my personality or nature that I was born with and can never change . . . I'm too damaged, I'll never be any good . . . I'll never be loved . . . I'm not capable of love." They often cannot understand how these apparently troublesome and incapacitating reactions could ever make sense, except as a reflection of something repugnant *about them*. Just as most children egocentrically incorporate *what was done to them* as being *about them* and consequently develop a shamed identity, self-loathing, and illogical responsibility for being victimized, adults who experience trauma (especially involving interpersonal victimization by someone known to or related to them in some way) may similarly adopt a sense of self-blame because there seems to be no other reasonable explanation for its occurrence and for their continued suffering.

For some clients, symptoms such as those listed in Table 1.1 are a constant in their lives. For others, symptoms can emerge suddenly in response to one or more experiences or somatosensory states that serve as reminders of the trauma. These "triggers" can include positive as well as negative life events, such as single or accumulated life stressors, anniversaries, births and deaths, other significant transitions, and physical or emotional reactions that in some way serve as reminders of the original traumatic event or experience. Some individuals are adept at hiding these symptoms from others, functioning fairly well and appearing relatively intact, although a great deal of effort might go into producing this effect. Others are not so adept, or their symptoms are not so easily suppressed or disguised, becoming apparent at home or work in erratic or otherwise problematic behavior

and changed or charged emotional responses. In either case, the individual may feel as though he or she is going crazy. Although some seek treatment soon after the emergence of symptoms, others cope on their own by self-medicating or self-soothing in ways that can create additional problems (e.g., secondary elaborations such as addictions, workaholic behaviors, procrastination, sexual dysfunction or promiscuity, social withdrawal and personal detachment, eating disorders, compulsive shopping, financial mismanagement and chaos, ongoing self-injury, suicidal ideation or suicidality) and the relationship and family problems that accompany them.

Many complex trauma survivors describe having made multiple attempts at treatment over the years with only transient or negligible progress. Furthermore, they frequently report having been misunderstood, misdiagnosed, medicated (often to excess), and even institutionalized, then stigmatized when they did not get better. The individuals show remarkable perseverance, courage, and hope in making yet another attempt to get help from professionals, even as they might simultaneously hold a number of understandable biases toward treatment, including mistrust of the process and suspicions regarding the motives of the therapist or allied professional. For example, they may have developed a sense of chronic disempowerment and hopelessness—the feeling that nothing will help them and that they can do nothing to get better as they are beyond help—and a corresponding belief that authority figures, including therapists, family members, and friends, are not trustworthy and do not really care. Reactions such as these must be understood by the therapist as resulting from the additional "insult added to injury" that many survivors experienced repeatedly in their lives, whether in the context of therapy or with significant others. Initially, these biases may interfere with developing a therapeutic alliance or with other dimensions of the treatment, a further complication to the process. On the other hand, survivors who are newer to psychotherapy may not have had the same negative treatment history and may not be as jaded, but they are equally desperate for help in quelling their distressing symptoms.

Not every individual with an intractable psychiatric history or personality disorder suffers from a history of complex trauma. However, both clinical observations and research findings suggest that a substantial percentage of mental health clients (as well as persons seeking medical treatment) with a combination of the symptoms and difficulties listed earlier are likely suffering from the aftereffects of trauma exposure (in childhood or later in life, or both) and subsequent reactions. And unfortunately, in many of those cases, it is rare that the posttraumatic origin and nature of their problems have been recognized or addressed in psychotherapy. A posttraumatic or trauma-informed lens is helpful in conceptualizing the client and these symptoms: It is less pathologizing or stigmatizing but does not reduce the clinical relevance of other potential biological or environmental sources of distress or impairment. Instead, when symptoms are viewed as posttraumatic stress reactions in a context, they can be treated as cumulative

adaptations that an individual has made over time, largely or entirely without awareness, in order to survive repeated experiences of overwhelming harm, danger, or loss.

CONCLUSION

Complex trauma prevents, disrupts, or shatters the victim's ability to develop a sense of self and to trust self and others. Knowing when complex trauma occurred in a client's life can provide a basis for understanding—and helping the client to understand—how symptoms were developmentally appropriate and adaptations that were necessary or functional at that age and stage of development. If problematic symptoms can be traced back to how the individual coped with and survived trauma—and how those adaptations altered or disrupted healthy development—then therapy can provide clients with a basis for both empathy for themselves and for hope that it is possible to rework developmental challenges that were derailed or had to be abandoned to survive. This developmental reworking does not involve regressing to childhood; rather, it is designed to help clients draw on their strengths and capacities as adults in the interest of developing skills and diminishing symptoms. The reworking of trauma to the point of resolution is in the interest of healing past injuries and creating healthier present-day coping and relationships that are less imbued by trauma. It is clearly also in the interest of an improved future.

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