CHAPTER 1

Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders

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In this chapter, we first provide an overview of cutting-edge definition, theory, and research on complex trauma and complex traumatic stress disorders (CTSDs), then discuss the newly included diagnosis of complex posttraumatic stress disorder (CPTSD) in the latest edition of the *International Classification of Diseases* (ICD-11; World Health Organization, 2018) and the dissociative subtype of posttraumatic stress disorder (PTSD) in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). We identify key developments and controversies in the definition of complex trauma, CTSDs, and the diagnosis of complex PTSD and evolving practice guidelines including the distinction between clinical and professional practice guidelines, and best practices and consensus-based guidelines, along with evidence-based treatment. We then preview the chapters that follow, describing how each uniquely, and the entire set collectively, offer a picture of how the CTSD treatment field is evolving and its likely direction in the next decade and beyond. We begin by defining complex trauma.

Complex Traumatic Stressors: Evolving Definitions of an Elusive Concept

Stressors are events that require adaptation on the part of the affected individual in order to protect against a threat, solve a problem, or take advantage

of an opportunity—they may be experiences or events that are positive and growth producing (leading to *eustress*) or negative and growth-stunting and damaging events (leading to *distress*). *Traumatic stressors* "up the ante," so to speak. These are stressors—events, experiences, and exposures—that greatly exceed the individual's capacity to control, cope with, or withstand and that compromise the individual's psychophysiological equilibrium or stasis. Traumatic stressors have had many definitions over the past 150 years, but a recurrent theme is that they pose an imminent threat or actuality of death, or through other means cause fundamental and life-altering psychophysiological harm (*psychological trauma*) to the organism. Of note is that most of the definitions of traumatic stress refer to physical events personally experienced or witnessed (alone or in a group), and do not explicitly recognize emotional or psychological events and harms as traumatic per se, a stance that has been the subject of critique (DePrince et al., 2012). DSM-5 Criterion A describes traumatic stressors as "exposure to actual or threatened death, serious injury, or sexual violence" through direct experience, witnessing, learning about extreme harm to family or close friends, or experiencing repeated or extreme exposure to aversive details (American Psychiatric Association, 2013, p. 271). Additionally, although the consequences are acknowledged as possibly lifelong and extensive, traumatic exposure and experience do not receive much recognition in the DSM as being impacted or expressed by the victim's age/stage of development, except in the most general of ways (p. 279). A subtype of "PTSD in children age 6 years or younger" was included in this edition of the DSM; however, it is noteworthy that there is no separate diagnosis of PTSD in children after age 6.

Complex trauma refers to traumatic stressors with many additional complications. In our previous work, we identified several defining characteristics of *complex psychological trauma*: (1) interpersonal experiences and events that often involve relational betrayal; (2) repetitive, prolonged, pervasive, and in some cases, ongoing events; (3) involvement of direct attack, harm, and/or neglect and abandonment by caregivers or other adults who are responsible for responding to or protecting children and adolescents—this may extend to organizations and cultures that are disbelieving of the victim and deny the occurrence of the traumatic circumstance and so are unresponsive or that support or provide safe haven for perpetrators; (4) occurrence at developmentally vulnerable times in the victim's life, often beginning in early childhood (and sometimes in utero and in infancy); and (5) have great potential to compromise severely a child's physical and psychological maturation and development, and to undermine or even reverse important developmental attainments at any point in the lifespan (Courtois & Ford, 2019, p. 1; Ford & Courtois, 2014, p. 9). When abuse occurs in a family or other closed context or system (i.e., parish/synagogue/temple/ashram/mosque/church hierarchy; school, work, military command, team, or recreational setting) by a member of that group, escape is often difficult, if not impossible. Such a circumstance creates a condition of accessibility and captivity that makes recurrence and escalation much more likely. So, too, do intimidation tactics, including threats of abandonment

or violence or other coercion that are used to pressure victims into silence and nondisclosure, a process that, when successful, further entraps them and renders them susceptible to additional abuse.

Although much of the emphasis in our previous books (and in this one as well) is on complex trauma that occurs over the course of childhood and adolescence, it is now recognized that this form of trauma can continue or begin in adulthood in forms such as sexual harassment and assault, domestic violence, refugee status, racial, cultural, religious, or gender/sexual identity and orientation-based violence and oppression, geographical displacement, kidnapping, war, torture, genocide, personal or cyberbullying, human trafficking, and sexual or other forms of captivity or slavery. Moreover, complex trauma often occurs across generations (labeled as intergenerational, historical, or colonialism), fueled by the lack of acknowledgment or resolution of previous trauma and loss as well as recurring abuse. Complex trauma may be further based on unique characteristics of the individual and primary group membership and associated power or lack thereof. These characteristics may include ethnicity, skin color and other distinguishing features, gender, sexual identity and orientation, class, age, ability, and economic status. Prejudice and discrimination based on these characteristics can lead to the oppression and mistreatment of entire families, clans, tribes, nations, and those who hold different religious, cultural, and political beliefs, among other factors (Kira et al., 2011) over the course of generations, creating conditions of *historical cumulative individual trauma, as well as group or societal trauma*.

Most often, complex trauma occurs in a repeated and layered fashion that causes a compounding of the need for ongoing psychobiological defenses that ultimately alter the body and mind of the survivor. Such recurring and layered events and their multifaceted aftermath are referred to as *polyvictimization*. An additional element of this tragic trajectory is that it often creates ongoing risk for revictimization. Ford (2017a) summarized the dimensions of complex trauma that distinguish it from other forms into five "I's," to which we add several more: *Intentional interpersonal* acts that are *inescapable* and cause *injury* that is potentially *irreparable*. Additionally, complex traumatic stressors are highly *intimate, intrusive,* and *invasive* of the body and the self of the *individual*, often involving *imminent threat,* the totality of which results in deformations of *identity* (including the capacity to *integrate one's identity and experience and maintain one's integrity*) and disrupting *interpersonal capacity for intimate and other relationships*.

The first two "I's" are *intentional interpersonal acts* that violate the rights and integrity of others with the intent of meeting a particular need (e.g., among others, domination, power, sex, affection, sadism) of the perpetrator (i.e., the "evil that men [and women] do"). When people harm other people, it constitutes a desecration of the basic social contract, a willful disregard for and disrespect of the safety, dignity, integrity, and well-being of other human beings. In addition to creating fear/terror in relation to the perpetrator(s) (which can result in the PTSD symptoms of intrusive reexperiencing, numbing, avoidance,

and hypervigilance), such acts raise existential issues and call into question whether *anyone* can be trusted, whether there is *any* hope for the future, and whether there is something *fundamentally damaged or defective* about the survivor that made them[1] the target or victim of the trauma and possibly its cause (Herman, 1992a). Many CT survivors describe themselves, their existence, or their worlds as being a "void" or a "black hole filled with vileness." Moreover, when harm is perpetrated by individuals or institutions that should safeguard the welfare and rights of victim/survivors, this *betrayal* exacerbates the original betrayal involved in the trauma, causing additional fear and demoralization that can lead to a sense of shame and profound disconnection and alienation from self and others (Fisher, 2017; Smith & Freyd, 2014; see also Chapter 24).

When traumatic experiences actually are, or seem to be, *inescapable,* the sense of being *entrapped* and *helpless* can lead to a combination of conditioned defeat and learned helplessness in both children and adults (Hammack, Cooper, & Lezak, 2012). In extreme cases, such as when political or ethnic violence involves subjecting children (Gadeberg, Montgomery, Frederiksen, & Norredam, 2017) or adults (McDonnell, Robjant, & Katona, 2013) to captivity or torture, victims understandably can feel morally and mentally defeated and helpless to protect themselves, loved ones, and their community and institutions. Tragically, the core features of captivity and torture are not limited to these public forms of violence but also may occur in more disguised ways as a result of child abuse and domestic or intimate partner violence, and in single or repeated episodes of sexual assault, sexual harassment, or kidnapping. Much like the response of animals to inescapable danger when escape from a predator is impossible, human victims often go beyond the initial physiological fight-or-flight defensive response and move into a state of freeze and collapse (also known as *tonic immobility*—the body and mind shutting down) (Bovin et al., 2014, p. 721; Porges, 2011). This response, which appears to be an automatic self-protective reaction that occurs without conscious intent, ironically can later cause the victim to feel chronically guilty and ashamed for not having been better at fighting back or self-protection (Bovin et al., 2014), feelings that potentially set the stage for severe or complex PTSD symptoms.

The *irreparable injury* that is caused by *intentional and inescapable* acts of harm and *personal intrusion* primarily is psychological and spiritual (Walker, Courtois, & Aten, 2015), although certainly it causes physiological alteration and damage as well. *Moral injury* initially was thought to occur when a survivor committed acts in traumatic events that violated personal values, but it also has been found to be associated with being violated psychologically and spiritually by other person(s) (Hoffman, Liddell, Bryant, & Nickerson, 2018). Moral injury sustained as a result of one's own or others' actions often leads to guilt, shame, anger, and depression, as well as PTSD, but when injury results from the actions of others (i.e., especially when they involve betrayal of some sort and violate the terms of a relationship or an agreed-to commitment, duty,

[1] "They," "their," "them," and "themselves" have been used in this chapter and our other chapters (Chapters 2, 3, 4, 18, 19, 21, and the Epilogue) to represent nongendered pronouns.

or responsibility), the PTSD symptoms are often the most severe and complex. Moral injury caused by others' acts also tends to be associated with a sense of having been not only harmed but also essentially damaged in ways that seem *irreparable,* and this can lead to severe problems with feeling disillusioned with and alienated from others, alienated from self, grossly defective, and deserving of mistreatment and lack of assistance. Dissociation, self-harm, multiple forms of addiction, and suicidality can occur in response to these feelings (Ford & Gomez, 2015) and as means of self-management and tension reduction, and paradoxically as self-soothing and self-repair (Briere, 2019).

Although *intentional, inescapable, and irreparably injurious* acts occur both in public and in private, in either case they are *intimate, intrusive,* and *invasive,* since they violate the survivor's physical, psychological, and spiritual *integrity* and boundaries. Because complex trauma is the opposite of safe, respectful, mutual, and self-determined intimate encounters or relationships, it calls into question the safety, sanctity, and even the very possibility of being a unique and *integrated individual* who can be *intimately involved* with other human beings. When experiences involve psychological or physical (or both) domination, oppression, and intrusion, the sense of subjugation and exploitation intensifies the survivor's sense of *inescapable* and *irreparable injury,* often identified as self-alienation, that occurs in conjunction with problems of self-integration (Fisher, 2017; see also Chapter 24). This, in turn, leads to estrangement and withdrawal from contact with others, identified as other-alienation and involving profound mistrust (see Chapters 20 and 21). The result is severely dysregulated emotions and actions, potentially including depression, panic and other anxiety conditions and disorders, guilt, shame, anger and rage, addiction, disorders of eating or sexual involvement, psychosomatic or autoimmune illness, borderline personality disorder, psychosis, or suicidality. These are cardinal features and adaptations—not *disorders* but complex stress *reactions and expressions of distress/symptoms*—that are found in CTSDs.

CTSDs: Controversy and Innovation

Complex Traumatic Stress Reactions and Adaptations

The ongoing and repetitive exposure to and experiencing of complex traumatic stressors without relief typically result in stress reactions that are, in parallel form, more complex. The findings of child psychiatrist Lenore Terr, a pioneer researcher of childhood trauma, indicated a distinct pattern of response when the trauma was what she termed Type I (single event or very short term, usually of an *impersonal* nature and occurring quite suddenly and unexpectedly) as opposed to Type II (recurrent and prolonged/pervasive *interpersonal* trauma including physical/sexual and emotional intrusion that comes to be anticipated and dreaded) (Terr, 1991). While both types have the potential to cause symptoms of acute stress disorder (ASD) and PTSD in their aftermath, Type II has additional dimensions that cause reactions and symptoms above and beyond those of standard or classic PTSD. According to Terr, survivors

of Type II trauma must find ways to emotionally and physically fend off or defend against repeated acts of aggression and intrusion, whether these occur regularly or on a more intermittent basis.

Ford (2005) labeled Type II trauma as "developmentally adverse interpersonal traumas" in recognition of their capacity to interfere with and interrupt the victim's healthy physical and psychological development. As we wrote in the first edition of this text, "Complex trauma often forces the child victim to substitute automatic (i.e., implicit or nonconscious defensive and) 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 response) that can become so automatic and habitual that the child's emotional and cognitive development are derailed or distorted" (Courtois & Ford, 2013, p. 14). Polyvagal theory (Porges, 2007) has given a psychophysiological explanation for the freeze and collapse that is often involved in repeated abuse, as has research findings that dissociation (i.e., escape where there is no escape; floating above and seeing it happen to him or her; "not me") is a quite common response in repeatedly abused children (Putnam, 2009). Furthermore, we noted that "in vulnerable children, complex trauma compromises 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" (Courtois & Ford, 2013, p. 14). This finding accords with a deformation of the developing self and loss of a sense of positive identity that occurs when PTSD gets intertwined with the child's physical and emotional maturation and developing personality (Herman, 1992a).

As discussed previously (Ford, 2009) and in more detail in Chapter 2, the immediate responses to stressors—whether traumatic or not—are *psychophysiological stress reactions* that mobilize the body to fight or flee and occur instantaneously, automatically, and out of conscious awareness (implicitly), directed by areas in the more primitive midbrain and lower brain that operate on reflex and habit and so do not require thought or reflection. However, as areas become activated in the brain's outer layer (cortex), cognitive processes enable the individual to ascertain the degree of danger and consciously (explicitly) and intentionally modify and redirect the automatic stress reactions (i.e., executive function). The classic example is the instinctual alarm response in reaction to seeing an object that looks like a snake and connotes imminent danger. The alarm system spontaneously activates, but when the perceptual information reaches the cortex and it determines that the "snake" is actually a stick, the alarm reaction downshifts and the body returns to its normal state. However, when the alarm reaction is the result of actual severe danger or harm (i.e., acute traumatic stressors, the instinctual reaction can dominate and override the reflective cognitive reappraisal), leading to extreme and potentially persistent and impairing stress reactions and an ASD (Bryant, 2017).

The severity, and especially the ongoing or ambient recurrence of complex or Type II trauma, can, as Terr (2000) noted, evoke stress reactions that

are so powerful that they override or shut down any subsequent conscious or self-reflective stress response. These reactions often involve dissociation and a splitting of the self from the stressor that, over time, become an autonomic and automatic mechanism that initially or exclusively occurs in response to anticipating and coping with ongoing threat. This type of response can generalize to other situations or stimuli that serve as triggers to the same response, even when the situation is neutral and benign rather than dangerous. Such responses are often observed in the clinical setting and can involve reexperiencing phenomena, hyperarousal and hypervigiliance on one hand, or hypoarousal, numbing, alexithymia, and dissociation on the other. The latter reactions can at times lead to physical and emotional shutdown and ultimately to collapse and inability to respond.

Thus, *complex traumatic stress reactions,* like other reactions to ordinary and traumatic stressors, involve states of heightened or diminished (i.e., hyper- or hypo-) arousal. This involves a sequence of responses of freeze, fight, flight, and immobility that was first identified in the study of animals caught in situations of inescapable danger. In the *fight* response, stress reactions manifest as aggression directed toward the source of the threat or the environment (e.g., fighting back, hitting, kicking, attacking, raging, screaming). In the *flight* response, the victim tries to physically escape the dangerous person or environment through whatever means are available (e.g., making a run for it, calling for help). If fight and flight fail to resolve the danger or provide an escape, the *immobility* response involve physical collapse and a paralysis-like state. Like that of a captured animal about to be attacked and even killed, this response involves analgesia and anesthesia to lessen the pain and physical immobility that can appear to a predator as if the prey is severely injured or dead. The immobility response also involves a psychological shutdown, including feelings such as intense despair, defeat, resignation, and helplessness, and depersonalization, derealization, and dissociative fragmentation of the self (e.g., "It's not happening, it's not happening to me, I'm not in the picture"; Ford, 2017a; Porges, 2011).

The repeated and escalating nature of traumatic circumstances that involve intentional harm by perpetrator(s) known to or related to a dependent, accessible, and vulnerable victim in a closed environment (i.e., ongoing incestuous abuse in a family, sexual harassment in the workplace, domestic violence in the home, torture in a prison) may result in an automatic overriding of the fight–flight phases of the stress response and feigned compliance and almost immediate immobilization. The victim may have learned that fight–flight is useless because it results in escalation of the danger rather than its cessation. This is especially the case if resistance or attempted escape enrages a perpetrator who views it as a challenge to their domination and control. Victimized individuals may also superficially comply (or feign compliance) with their perpetrators in an attempt to mollify them or decrease their dangerousness. It may also be more self-protective to go into a state of collapse and associated analgesia and anesthesia in order to blunt awareness and pain. CTSDs involve chronic

and extreme reactions that are virtually identical to the immobility phase of the stress response, at times interspersed with hyperarousal symptoms. Both therefore represent unsuccessful attempts at fight or flight.

Complex Traumatic Stress Disorders

CTSDs in Adulthood

Complex PTSD (Herman, 1992a) or disorders of extreme stress not otherwise specified (DESNOS; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) were first proposed as psychiatric diagnoses more than 25 years ago. Since then, these and other models of adult CTSDs have spurred important advances in clinical research (Ben-Ezra et al., 2018; Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Ford, 2015; Karatzias et al., 2017a, 2018; Krammer, Kleim, Simmen-Janevska, & Maercker, 2016; Murphy, Elklit, Dokkedahl, & Shevlin, 2018; Palic et al., 2016; Sachser, Keller, & Goldbeck, 2017; Van Dijke, Ford, Frank, & van der Hart, 2015; Van Dijke, Hopman, & Ford, 2018) and practice (Briere & Lanktree, 2012; Cloitre, 2015; Cloitre et al., 2011; Courtois & Ford, 2013; Ford & Courtois, 2014; Herman, 2012; Schnyder & Cloitre, 2015). Although still controversial as a diagnosis (Bryant, 2012; Goodman, 2012; Herman, 2012; Resick et al., 2012), CTSDs represent a psychobiologically based metamodel for psychopathology that overarches several main responses and diagnoses and is person centered (Jenness & McLaughlin, 2015) and adaptation and resilience focused (McLaughlin & Lambert, 2017).

A core construct has emerged to distinguish CTSDs/complex PTSD from PTSD and other psychiatric disorders: *disturbances of self-organization* (DSOs; Cloitre, Garvert, Brewin, et al., 2013; Shevlin et al., 2017, 2018) or what Herman (1992a) identified as *deformations of the self* and Smith and Freyd (2014) as betrayal-trauma from recurrent traumatic exposure and the need for the victim to mount extensive psychological defenses in response. This stands in contrast to the adaptations used to cope with fear resulting from a loss of safety due to external (and even extreme danger) that characterize PTSD responses. In contrast, DSOs involve developmental, maturational, and self-adaptations to cope with the confusion and demoralization resulting from repeated exposure to trauma and the associated recurrent loss of personal control. DSOs also entail the loss of an integrated and stable identity due to the internal emotional turmoil resulting from ongoing and inescapable interpersonal traumatic stress, usually with no recourse for protection and intervention. Both PTSD and DSOs are the results of attempts to cope with an existential threat, but whereas the driver for PTSD is the threat of physical destruction or death, DSOs are driven by the disruption of essential developmental relationships that poses a threat of profound relational loss or psychological disintegration of the self. DSOs have three core components that parallel but differ substantially from the core criteria for a diagnosis of PTSD, which are (1) intrusive reexperiencing; (2) numbing; (3) active avoidance and changes in beliefs and cognition in the interest of

avoidance; and (4) physiological hyperarousal and hypervigilance. In contrast, DSOs involve (1) emotion dysregulation in the form of either extreme emotional turmoil (e.g., terror, rage, incapacitating shame) or profound emotional shutdown and alexithymia (e.g., pervasive feelings of emptiness, numbing, depersonalization, detachment, dissociation); (2) interpersonal dysregulation in the form of intensely conflictual, enmeshed, detached, or chaotic relationships; and (3) self-dysregulation, in the form of self-loathing, viewing oneself as irreparably damaged or contaminated, or the absence of self as a separate and unique individual.

In PTSD, emotional, mental, and relational turmoil occur as a byproduct of coping with fear/terror and complicate the other fear-related symptoms (Kaczkurkin et al., 2017). However, in DSOs, psychological and relational turmoil have become unmanageably extreme, such that the person's very psychophysiological integrity and identity are threatened, as is trust in the ability of others to be benign, caring, and nonexploitive. In DSOs, the sense of a coherent, acceptable self ("who I am"; "what makes me unique"; "what makes me worthwhile and worthy") is unstable, tenuous, and at times entirely undeveloped or lost, which tragically is an expectable result of repeated mistreatment and associated lack or response, soothing, or protection.

Thus, DSOs can be understood as a psychological and biological exacerbation and amplification of the externally focused fear that drives PTSD. However, in addition to fear, DSOs involve a blockage, disruption, or distortion of the victim's developmental trajectory. Caught in either an emotional maelstrom or a black hole, trapped in either victimizing/invalidating relationships or in a state of extreme relational isolation, it is understandable that complex trauma survivors would have difficulty in developing a coherent and authentic identity and sense of self. DSOs represent the dilemma experienced by many complex trauma survivors as a result of having been unable to develop the capacities for emotion regulation and interpersonal involvement that are the essential foundations for an integrated personality, accurate self-knowledge, and a sense of self-integrity. Despite all, many survivors of complex trauma who experience DSOs are remarkably resilient and courageous individuals faced with making emotional, relational, and physical survival a higher priority than their own personal development. The extremity of their struggle to come to terms with their emotions, relationships, and confusion about their identity reflects the enormity of the adversity they have survived, but it is not a measure of the capacities and potential they possess.

Although complex PTSD was not included as a discrete diagnosis in DSM-5 (American Psychiatric Association, 2013), neurological research that demonstrated biological, structural, and psychological differences in PTSD symptoms when they were complicated by severe dissociation (often due to chronic child abuse without relief) resulted in the inclusion for the first time of a dissociative subtype of PTSD (Frewen, Brown, Steuwe, & Lanius, 2015; Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012; Nicholson et al., 2015, 2017; Steuwe, Lanius, & Frewen, 2012). The dissociative PTSD subtype is not

a separate diagnosis but a variant of PTSD that includes additional clinically significant symptoms of depersonalization or derealization. The dissociative subtype tends to involve states of hypoarousal, in contrast to the hyperarousal that is more characteristic of classic PTSD. This psychophysiological shutdown or sequestering of emotions, thoughts, somatic reactions, and other persons may produce states of severe dysregulation of emotions (including *alexithymia,* the absence or nonrecognition of emotions), relationships, and identity that parallel the core features of complex PTSD. However, the two paradigms are not synonymous, because dissociative PTSD often involves only a state of profound biopsychosocial shutdown—without the extreme heightening of arousal and distress that also is a hallmark of complex PTSD.

More recently, complex PTSD has been included in the ICD-11 (World Health Organization, 2018), based on international research with a wide variety of populations that indicate DSO symptoms can be distinguished from symptoms of PTSD (Brewin et al., 2017; Hyland et al., 2017; Karatzias et al., 2016, 2017a, 2017b; Shevlin et al., 2017) and from the symptoms of self-disorganization that constitute borderline personality disorder (Cloitre, Garert, Weiss, Carlson, & Bryant, 2014; Ford & Courtois, 2014). The ICD-11 version of complex PTSD is both simpler and more complicated than the earlier complex PTSD/DESNOS models of adult CTSD. ICD-11 complex PTSD can be viewed as more parsimonious, including only six core symptoms (two each for the three features of emotion, interpersonal, and self-dysregulation, and not including the DESNOS features of dissociation, bodily dysregulation, or altered core beliefs and spirituality). On the other hand, ICD-11 complex PTSD adds the requirement of at least one symptom from each of the classic PTSD domains of intrusive reexperiencing, avoidance, and hyperarousal, *in addition to* the DSO symptoms.

Ford (2017a) identified several similarities and differences in a recent review of adult CTSDs. The prevalence of current CTSDs is comparable to that of PTSD in nonclinical (i.e., 1–5%) and psychiatric or other high-risk (16-45%) adult populations. CTSDs are characterized by a history of chronic exposure to interpersonal traumatic stressors (e.g., family or community physical or sexual violence or abuse), often (but not always, e.g., when adults experience domestic violence or other types of traumatic captivity or torture) beginning in childhood and exacerbated by neglect and nonprotection, and revictimization in adolescence and adulthood. Complex PTSD often co-occurs with PTSD and may occur separately, but it is associated with more severe psychiatric comorbidity (e.g., depression, anxiety and all types of phobias, addictive, or personality disorders) and psychosocial impairment (e.g., interpersonal conflict or isolation, relationship difficulties, educational or work problems and failure, self-harm or suicidality) than PTSD alone. Consistent with the ICD-11 complex PTSD formulation, dissociation and bodily dysregulation (i.e., somatization) occur often in conjunction with DSOs; however, DSOs equally can occur *without* dissociation or somatization. For example, profound neglect due to caregivers providing a child with minimal emotional

responses and little if any help in identifying, modulating, and discriminating emotions, may lead to DSOs that are characterized by a sense of the self as empty and emotionless (Lowe et al., 2016). The risk of self-harm and revictimization also are elevated in complex PTSD, although this is primarily the case in a subgroup for whom extreme emotion and self-dysregulation is accompanied by severe dysphoria, dissociation, or addictive disorders and may be prompted when disregard and antipathy expressed by primary caretakers is reenacted by the victim, often unconsciously. Thus, adult CTSDs are indeed complex, with a variety of core and associated symptoms and impairments that vary for each person and require thorough individualized assessment and treatment planning.

CTSDs in Childhood: Risks for the Lifespan

Beginning as early as in utero or infancy/toddlerhood, exposure to complex traumatic stressors in childhood (especially with no preventive or therapeutic intervention or other relief or support) can lead to neurobiopsychosocial problems all along the lifespan (Briggs-Gowan et al., 2010), persisting or worsening in the elementary or middle school years (Briggs-Gowan, Carter, & Ford, 2012), in adolescence (Dierkhising, Ford, Branson, Grasso, & Lee, 2019; Ford, Elhai, Connor, & Frueh, 2010a; Grasso, Dierkhising, Branson, Ford, & Lee, 2016), and into middle and late adulthood (Horan & Widom, 2015a, 2015b; Young & Widom, 2014). A study with adolescents who were receiving treatment for persistent traumatic stress reactions identified those who had experienced complex traumatic stressors in one or more of three developmental epochs (Grasso, Dierkhising, et al., 2016): (1) early childhood (i.e., ages 0–6 years) primarily involved intrafamilial maltreatment (including neglect and emotional abuse) or physical violence associated with dangerous/impaired/addicted/absent/unresponsive caregivers, and parental/caretaker substance dependence and addictions are commonly involved, although not always; (2) in middle childhood (i.e., ages 7–12 years), extrafamilial sexual abuse and community/school violence (e.g., assault, in-person, and cyberbullying) increasingly were reported as contributors to complex trauma both apart from, and in combination with, past and ongoing intrafamilial maltreatment and violence; and (3) in adolescence complex trauma exposure became still more complex, increasingly involving sexual and physical assault and community/school violence in addition to/on top of family abuse and violence. Finkelhor (2008) labeled such a history as poly-victimization, describing this as a common as well as tragic layering of exposure to multiple types of trauma and adversity over many years and often an entire lifetime (often referred to as revictimization).

Although the specific nature of complex trauma exposure changed across the developmental epochs, youth who had been exposed to complex trauma in early childhood tended to experience additional (or continued and compounded) complex trauma exposure in middle childhood and adolescence (Dierkhising et al., 2019). Tellingly, youth who reported exposure to complex

trauma *only* in early childhood (i.e., not in middle childhood or adolescence) were twice as likely to be described by a parent as having clinically significant emotional and behavioral problems, compared to those who had experienced other, more impersonal traumas (e.g., severe bereavement or accidents) but were never exposed to complex trauma in early life. This suggests that early attachment security and parents/caregivers who are responsive to the child's emotional needs may provide a form of inoculation to the development of later distress. And youth who reported experiencing complex trauma in all three developmental epochs, from birth and early childhood through adolescence, were twice as likely as other youths to have not only emotional and behavioral problems but also clinically significant PTSD and complex PTSD symptoms (Dierkhising et al., 2019).

So, by the time they reach early adulthood, those individuals who experienced complex trauma in early life are at risk for a range of severe emotional, relational, and behavioral problems. Unfortunately, many receive treatment that does not address their problems as traumatic in origin, particularly if mental health providers do not screen for a history of trauma or do not recognize its significance and its possible connection to symptoms when a trauma history is reported. Since it is only those who have had chronic exposure to complex trauma continuing throughout childhood and adolescence who are likely to develop classic PTSD symptoms that are possibly recognized as such, other symptoms may not be viewed as having any association with past trauma. Due to the temporal disconnection of symptoms from the traumatic stressor origins(s), both victims and clinicians may misunderstand or misattribute the origin and meaning of symptoms, making complex PTSD more difficult to recognize. Yet, clearly, more than PTSD is occurring for these adolescent and young adult survivors—problems with their developing identity and associated emotion dysregulation and conflict in or withdrawal from relationships and additional experiences of victimization may impede their success in school, work, and other life pursuits long into adulthood.

As noted earlier, although there is as yet no freestanding diagnosis for PTSD in children in any edition of the DSM, modifications to the PTSD diagnosis in the form of a subtype for young children were included in the latest revision in order to prevent children who present with only a few of the symptoms—but symptoms that are severe enough to cause serious impairment—from being excluded from PTSD treatment (Scheeringa, Myers, Putnam, & Zeanah, 2012). The "before age 6 subtype of PTSD," as the name implies, applies only to children age 6 years and younger and not to school-age children or adolescents. Its criteria include intrusive reexperiencing symptoms not only as they present verbally but also in reenactments of traumatic events in play. Only one symptom of either avoidance of reminders or emotional distress/numbing is required, since young children typically do not develop as many of these symptoms as do older children or adults.

In addition, as discussed, children and adolescents who experience com-

plex trauma often have symptoms that persist into adulthood and extend beyond those of classic PTSD, which alone (and especially if unrecognized and unaddressed) can alter the course of a child's entire life. Moreover, complex traumatic stress reactions can lead children to receive multiple psychiatric diagnoses that can follow them in complicated and unique ways, causing symptoms and related stigma that damages their developing and possibly already fragile identities and relationships, and can be lifelong. Among the disorders that often are diagnosed in children who have complex trauma histories are reactive attachment disorder (RAD); generalized or phobic anxiety, panic, or obsessive–compulsive disorders; bipolar disorder, psychotic or dissociative disorders; eating, body image, or sexual disorders; disruptive behavior disorders (e.g., attention-deficit/hyperactivity disorder; oppositional defiant or conduct disorders), and traits of personality disorders (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). While childhood exposure to complex trauma and complex traumatic stress reactions may not be the sole, or even primary, cause of the additional symptoms of these disorders, when they contribute to and exacerbate the complex symptoms, standard treatments for those disorders may be ineffective or iatrogenic, since they do not remediate the unrecognized role of past trauma or CTSDs.

Unfortunately, such youth also may be identified as "antisocial," "aggressive," or "delinquent," and deemed unsuitable for therapeutic treatments despite having shown signs (often overlooked) of emotional distress related to complex trauma exposure earlier in their lives (Ford, Chapman, Connor, & Cruise, 2012). A study with psychiatrically and behaviorally impaired children revealed that a complex trauma history (physical or sexual abuse) was associated with reactive (but not proactive) aggression (Ford, Fraleigh, & Connor, 2010c) and low bodily reactivity to and a high threshold for physical pain (Ford, Fraleigh, Albert, & Connor, 2010b). This combination of aggression and reduced psychophysiological responsivity often leads youth to be labeled psychopathic, or "callous and unemotional." However, there is evidence that many may have developed a form of "acquired callousness," hypoarousal (i.e., shutting down physiologically), dissociation/detachment, and alexithymia as CTSD defenses rather than an intractable antisocial personality disorder (Bennett & Kerig, 2014; Porges, 2007).

Developmental Trauma Disorder

Despite the extensive evidence that children and adolescents who are exposed to complex trauma are at risk for potentially lifelong complex traumatic stress reactions, not until an expert group from the National Child Traumatic Stress Network was convened and generated data was there a call to action (D'Andrea et al., 2012) and a CTSD diagnosis for children formally proposed to the DSM-5 working group. Based on an international survey of child-serving clinicians (Ford et al., 2013) and a field trial study with a new structured interview

(Ford, Spinazzola, van der Kolk, & Grasso, 2018; Spinazzola, van der Kolk, & Ford, 2018; van der Kolk, Ford, & Spinazzola, 2019), developmental trauma disorder (DTD) was established as a framework of assessment and treatment planning with children who are dysregulated in three overarching domains: emotional; cognitive and behavioral; and identity and ability to relate to others (van der Kolk, 2005). The DTD dysregulation domains thus closely parallel (although not exactly duplicating), and may be the precursors of, the three domains of adult DSO/CTSDs, namely, complex PTSD.

The proposed structure for DTD that was validated in the field trial study is based on research on the development of self-regulation capacities and the adverse impact of exposure to complex trauma stressors in childhood (see Chapter 2). Since identity development occurs in the context of key relationships, those processes were included in a single DTD feature as opposed to separate distinct features in complex PTSD. Cognitive and behavioral self-control are in flux but highly interrelated in childhood; thus, they too comprise a single feature in DTD. The combination of emotion and bodily dysregulation as a single feature in DTD is consistent with the changes in children's bodies and emotions as they mature, and with the common finding that emotions often are expressed by children in behavior and symptoms rather than in words. Of note, although children and adolescents who showed dysregulation consistent with DTD in the interview study tended to have complex trauma histories involving multiple types of victimization in multiple life settings and relationships, DTD was best distinguished from PTSD by past exposure to both community and family violence and severely impaired primary caregivers and related attachment trauma (Spinazzola et al., 2018).

Although not accepted as a diagnosis in DSM-5 (Bremness & Polzin, 2014), DTD represents a promising clinical framework for identifying and guiding the treatment of CTSDs in children, not only to "unimpair" (and prevent the loss of) their childhood but also to avert future intergenerational transmission of CTSDs. In keeping with evidence that parents' own personal histories of trauma, neglect, and loss that are unresolved are associated with difficulties in providing secure attachment relationships for their own children (San Cristobal, Santelices, & Miranda Fuenzalida, 2017; van Ee, Kleber, & Jongmans, 2016), effective treatment for CTSDs with children and with parents (alone and together) may also prevent its transmission to future generations (Berthelot et al., 2015; Bowers & Yehuda, 2016).

Treatment Guidelines, Evidence-Based Treatment, and Clinical Best Practices Treatment Guidelines

Treatment guidelines, well-developed research-based scientific directives, are most associated with contemporary medical care. They offer the medical provider information on the efficacy and effectiveness of different treatments for different illnesses as a support for clinical decision making. In 2011, the

National Academies of Science Institute of Medicine (IOM) published a guide to treatment guidelines entitled *Clinical Guidelines We Can Trust*.[2] The report defined eight standards for developing trustworthy clinical practice guidelines, among them (1) transparency in both process and funding; (2) appointment of a multidisciplinary group of experts and public members and assessing and minimizing conflicts of interest; (3) use of a systematic review of evidence of comparative effectiveness research following standards set by the IOM; (4) provision of detailed and precise recommendations based on an appraisal of the quality, completeness, consistency, and gaps in both the research evidence and the input of values, opinion, theory, and clinical experience, along with ratings of potential benefits and harms; (5) provision of an opportunity for independent external review of draft guidelines; and (6) updating guidelines on a regular basis as new evidence is made available.

Due to a more limited research evidence base than that for many medical illnesses and treatments, treatment guidelines for psychology, psychiatry, and other mental health professions initially were largely based on expert consensus and available research findings. The increase in mental health research evidence in recent decades—developed with greater methodological rigor over time—has allowed adoption of IOM methodology and standards by the mental health professions, although this process has not been without difficulties. A primary challenge is that the evidence base in the mental health fields has been defined more broadly than that in medicine. Additionally, medical symptoms and illnesses tend to be more readily objectively defined than those in the psychological domain and are therefore more amenable to quantitative study as treatment outcomes.

In the early 2000s, the American Psychological Association convened a Task Force on Evidence-Based Practice, which stipulated that systematic evaluation of three criteria domains were necessary to justify rating a treatment as evidence based: (1) the best research evidence, (2) clinician expertise and judgment, and (3) client values and preferences (American Psychological Association, 2006). While mindful of the significance of research findings, treatment guidelines were viewed as requiring evidence that was not only solely and narrowly based on research but also included the perspectives of those involved in treatment, both clinicians and clients.

In 2015, the American Psychological Association followed up by publishing a document that defined and differentiated two main types of treatment guidelines: *clinical practice guidelines* (CPGs) and *professional practice guidelines* (PPGs). Both types of treatment guidelines serve three functions, specifically, to enable practitioners and professional organizations to (1) fulfill relevant legal, regulatory (and, we would add, funding/reimbursement) requirements, (2) provide services that are beneficial and safe to the public, and (3) deliver services based on the best available professional expertise and scientific

[2] *www.nationalacademies.org/hmd/reports/2011/clinical-practice-guidelines-we-can-trust/standards.aspx*

knowledge as to their efficacy and safety (American Psychological Association, 2015).

CPGs most closely resemble the medical field's treatment guidelines and emphasize the selection of evidence-based treatments based on research evidence derived from randomized clinical trial (RCT) research studies following the standards promulgated by the IOM in 2011.[3] In contrast, PPGs are based on reviews of the clinical and research literature *and* surveys of clinicians' or reviews of authoritative writing of those determined to be experts in the particular treatment under investigation *and* client preferences and values. Key features of this type of guideline are "to educate, to facilitate competence . . . , and to assist the practitioner in the provision of high-quality psychological services by providing well-supported practical guidance and education in a particular practice area" (American Psychological Association, 2015, p. 824).

As applied to the treatment of PTSD, the earliest guidelines were produced throughout the 2000s (Bernardy & Friedman, 2012; Foa et al., 1999; Foa, Keane, Friedman, & Cohen, 2009; Forbes et al., 2010; Stein et al., 2009; Ursano et al., 2004). The earliest PTSD treatment guidelines were of necessity consensus-based PPGs rather than CPGs, as efficacy research was just being undertaken and a research base had not yet fully developed. In the past decade, however, treatment guidelines for PTSD have become more methodologically sophisticated, tending to adopt the IOM standards. There are now at least 10 PTSD CPGs, including for adult PTSD by the American Psychological Association[4] and the National Institute for Health and Clinical Excellence (NICE),[5] as well as revised and updated guidelines from the Phoenix Australian Centre for Posttraumatic Mental Health[6] and the U.S. Department of Department of Defense/Veterans Affairs.[7] The International Society for Traumatic Stress Studies published PTSD clinical practice guidelines for children and adults, first in 2000 and now updated in 2009 (Foa, Keane, Friedman, & Cohen, 2009) and in 2019, with the latter based on the IOM methodology.[8] While all of these guidelines are specific to the symptoms of classic PTSD, several mention their application to complex PTSD (but with no specific guidance for CTSD treatment).

Evidence-Based Treatments

In identifying evidence-based treatments for PTSD, CPGs have adhered to IOM standards for research reviews that are transparent, systematic, and based on

[3] *www.nationalacademies.org/hmd/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx*

[4] *www.apa.org/ptsd-guideline/ptsd.pdf*

[5] *www.nice.org.uk/guidance/gid-ng10013/documents/draft-guideline-2*

[6] *https://phoenixaustralia.org/resources/ptsd-guidelines*

[7] *www.healthquality.va.gov/guidelines/mh/ptsd/vadodptsdcpgfinal012418.pdf*

[8] *www.istss.org/getattachment/treating-trauma/new-istss-prevention-and-treatment-guidelines/istss_preventiontreatmentguidelines_fnl.pdf.aspx*

independent peer review. However, public and client input has been obtained only in relation to general principles of collaborative and ethically sound treatment, and these are presented either as an addendum to the research-based specific recommendation of evidence-based treatments or not at all. By using evidence solely from research studies to identify evidence-based treatments and privileging results from rigorously controlled RCTs that are critically evaluated to meet certain research standards, the guidelines strengthen the scientific (internal) validity of their evidence-based treatment recommendations.

Yet because research was not sufficiently specific and of the highest methodological quality, and the preferences of a wide variety of public members and clients were not solicited in formulating evidence-based treatment recommendations, the crucial question of when and for whom different evidence-based treatment models or their components are recommended remains unanswered. The available PTSD CPGs consistently and explicitly caution (e.g., American Psychological Association, 2017, PTSD Guideline, p. 76) that the evidence is not yet available to recommend which treatments work best for which clients. Thus, the guidelines select evidence-based treatments that research suggest are effective, either explicitly stating or implying that "one size" (i.e., any effective evidence-based treatment for PTSD) is expected to fit all. However, this stance that has been sharply questioned for PTSD treatment, and especially as applied to CTSDs (Cloitre, 2015; Courtois, 2010; Courtois & Brown, 2019).

Drawing from these available treatment guidelines, across the civilian and military adult populations, the following three evidence-based treatments for psychotherapy for adult PTSD have been consistently strongly recommended as frontline treatments: prolonged exposure, cognitive processing therapy; and cognitive therapy. Four other evidence-based treatments are consistently recommended as well: eye movement desensitization and reprocessing therapy, narrative exposure therapy, and brief eclectic psychotherapy for PTSD and some forms of pharmacotherapy for adults with PTSD. These are described in detail as applied to CTSDs and complex PTSD in this book.

Current Best Practices for CTSD Psychotherapy

As noted earlier, until recently, the treatment of CTSDs in adults has been guided by complex trauma-based adaptations of clinician-formulated *best practices* and research-driven evidence-based treatment models for psychotherapy in general and for PTSD therapy specifically. Judith Herman's (1992b) prescient book *Trauma and Recovery* provided a synthesis of best practices for complex PTSD treatment based on the experience of complex trauma survivors and the writings of therapists over the course of the prior century, especially the treatment approach developed by French neurologist Pierre Janet (van der Kolk & van der Hart, 1989). Its cornerstone is a sequenced, three-phase framework that begins with a pretreatment assessment. Phase 1 explicitly focuses on the client's personal, relational, and environmental safety (i.e., safety to and from self and others); provides education about the nature and impact of traumatic

stressors over time and the process of recovery from traumatic stress disorders; develops or upgrades needed skills such as emotion regulation, self-reflection, and life skills; addresses comorbidities such as addictions, depression, anxiety, and self-injury/suicidality; and deliberately works on establishing a collaborative therapeutic relationship and alliance. As needed, based on the client's ability to function and symptom picture, Phase 2 involves a guided therapeutic exploration of the client's memories and emotions related to past experience(s) with traumatic stressors, and reflective processing as to their meaning (Harvey, 1996) including the impact that those experience(s) have had in relation to the client's self and life (i.e., trauma processing; Ford, 2018). Phase 3 concludes the treatment by helping the client to translate the knowledge and skills acquired in earlier phases into day-to-day life, shifting the focus from recovery from CTSD symptoms to the achievement of a life, lifestyle, relationships, and accomplishments that are personally meaningful and fulfilling.

The three-phase approach to complex PTSD psychotherapy has been elaborated in subsequent descriptions of best practices for CTSD treatment (Courtois & Ford, 2013; Courtois, Ford, & Cloitre, 2009). In the mid-2000s, The International Society for Traumatic Stress Studies (ISTSS) commissioned a Task Force on Complex Trauma, whose aim was to produce a consensus-based set of professional practice guidelines for adult complex PTSD based on an international survey of identified expert clinicians (half of whom were specialists in treatment of classic forms of PTSD and the other half who specialized in complex PTSD (Cloitre et al., 2011). Most (84%) of the 50 respondents from both the PTSD and complex PTSD domains endorsed a phased approach to complex PTSD treatment and suggested that interventions should be individualized and tailored to the needs of individual clients and target specific (and often idiosyncratic) problematic symptoms and circumstances, as well as personal/relational strengths and resilience (Cloitre et al., 2011).

Based on the survey and a review of nine research studies of complex PTSD psychotherapy outcomes, Best Practice Recommendations for the Treatment of Complex PTSD[9] were published in 2012. The guidelines explicitly recognized that treatment of complex PTSD may exceed the time allocated for completion by the standard evidence-based, trauma-focused treatments for PTSD. A Phase 1 of approximately 6 months was recommended to stabilize and prepare the complex PTSD client for trauma processing in Phase 2, in order to ensure personal, interpersonal, and environmental safety, and to teach or strengthen life skills and those needed for emotional self-regulation (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005) and initiate a therapeutic alliance (Ford, 2013). For Phase 2 trauma processing, at least 3–6 months were recommended, in which unresolved aspects of trauma memories were reviewed and reappraised, in order to "integrate [them] into an adaptive representation of self, relationships, and world" (p. 5). Finally, a Phase 3 of 6–12 months was

[9] *www.istss.org/istss_main/media/documents/istss-expert-consensus-guidelines-for-complex-ptsd-updated-060315.pdf*

recommended, with weekly sessions gradually titrated to less frequent contacts, to ensure "consolidation of treatment gains to facilitate the transition . . . to greater engagement in relationships, work or education, and community life" (pp. 5–6).

These 2012 ISTSS recommendations were entitled "Consensus Guidelines," because they were not based on a definitive research review (due to the small number of relevant studies), and did not include direct input from the public/clients and other professionals. Recently, more than 25 expert classic PTSD clinical researchers, including several of the PTSD experts from the 2011 survey, published a rebuttal that challenged the need for and the evidence to support this three-phase psychotherapy model (De Jongh et al., 2016). They cited the research supporting the efficacy of various cognitive-behavioral therapies (CBTs) that were applied as early as the first session in research studies of PTSD treatment without the formal Phase 1 period of preparation and stabilization. They also called into question whether therapists who adopted a phased treatment approach avoided engaging their clients in trauma processing due to their own personal avoidance/fears, thereby unnecessarily delaying or failing to provide evidence-based treatments and prolonging their treatment. Their critique was challenged as failing to consider the need to individualize PTSD treatment (Cloitre, 2015) and as prematurely rejecting potentially effective therapeutic approaches that are trauma-focused but do not require immediate intensive processing of trauma memories (Ford, 2017b). It has also been challenged by many practitioners experienced in the treatment of clients with CTSDs, particularly those who are highly dissociative and the most dysregulated, as creating an iatrogenic danger for decompensation when applied without first attending to safety, skill building, and self-regulation. However, partly in response to that critique, the most recent ISTSS PTSD treatment guidelines declined to include best practice recommendations for complex PTSD treatment (of children or adults), instead providing narrative descriptions of the gaps in, and need for, systematic research on methods and outcomes of PTSD treatment with adults and children (see below).

Concurrently with the development of the ISTSS Complex PTSD Consensus Guidelines, in 2012, the Australian organization Adults Surviving Child Abuse (ASCA) (now renamed Blue Knot Foundation) published best practice recommendations for professionals, treatment program staff, and advocates working with adult survivors of childhood abuse.[10] Although entitled "practice guidelines," this document represents a synthesis of best practices derived from the experience of clinicians and clients with CTSDs, including comprehensive published recommendations (Courtois & Ford, 2013; Courtois et al., 2009). The ASCA guidelines recommend a three-phase model with several specific goals: (1) enhance affect regulation, (2) facilitate the acquisition or restoration of self- and relational capacities that were disrupted or never developed due to

[10] *www.recoveryonpurpose.com/upload/asca_practice%20guidelines%20for%20the%20treatment%20of%20complex%20trauma.pdf*

coping with the impact of complex trauma, (3) facilitate reappraisal of symptoms as adaptive reactions, (4) explain the normative bodily adaptations that occur in reaction to complex trauma, (5) encourage establishment or strengthening of support networks, (6) facilitate awareness and resolution of attachment insecurity and shame, and (7) facilitate awareness and modulation of extreme arousal states, dissociation, and sensorimotor expression of emotions.

A more recent review of the literature on the treatment of CTSDs (including the dissociative disorders) has resulted in several best practice recommendations that are in line with those of the Australian ASCA (Courtois & Ford, 2019). Treatment for CTSDs should not be limited to static interventions but instead should be based on systematic assessment and treatment planning (Briere & Scott, 2015). Methods and algorithms for deploying, sequencing, and evaluating strategies for selecting and sequencing treatment goals and interventions are currently under development (Grasso, Ford, & Lindhiem, 2016; Layne, 2011).

Uniquely, the ASCA guidelines also provide recommendations for

> trauma-informed care and service delivery . . . targeted at *organizations and their workforces* . . . [e.g.,] community managed mental health and human service sectors (drug and alcohol, sexual assault, child protection, housing, supported accommodation, refugee services, disability, advocacy, aged care, indigenous, . . . GBLTQI . . . private practice counselling, psychotherapy psychology, and psychiatry . . . primary and allied health care services . . . public and private hospitals . . . criminal justice . . . emergency . . . legal . . . policing . . . education, [and] employment [services]. (p. xxxiii, emphasis in original)

General principles of trauma-informed approaches to services for adult survivors of CT have been published,[11] but the ASCA guidelines are the most extensive and specific recommendations for policy, procedures, and extratherapeutic interactions with clients with CTSD who are receiving services. The ASCA trauma-informed care (TIC) service recommendations are also based on a synthesis of prior published principles (Bloom, 2013; Fallot & Harris, 2008) (i.e., trauma screening, safety, trustworthiness, choice, collaboration, empowerment, safe environment) that are mapped explicitly onto practitioner and organizational practices.

Two additional PPGs have been published more recently, one by the National Institute for Health and Care Excellence in the United Kingdom, and a comprehensive update of the Australian guidelines by the Blue Knot Foundation, published along with other documents outlining the treatment of complex trauma and the special issues related to traumatic memory and dissociation.[12] The United Kingdom document[13] most resembles the findings of the previously published PPGs while the Blue Knot document is more far-reaching and incor-

[11] *https://store.samhsa.gov/shin/content/sma14-4884/sma14-4884.pdf*

[12] *www.blueknot.org.au/resources/Publications/Practice-Guidelines*

[13] *www.nice.org.uk/guidance/ng116*

porates a great deal of new data from neuroscience and attachment research and what is termed the "neurobiological revolution in psychotherapy." The Blue Knot guideline espouses the use of body-based (or "bottom-up") techniques in recognition of the implicit encoding of traumatic stress in the body, rather than relying only on "top down" or cognitive-behavioral and psychodynamic approaches. The Blue Knot guidelines emphasize helping clients pay specific attention to their experience (both physiological and psychological) and learning emotion identification and means of modulation designed to disrupt autonomic entrenched survival mechanisms and defensive operations. They state it this way: "Many therapists still focus on a client's thoughts, feelings and beliefs without paying sufficient attention to their *experience*. This is not logical as physiological experience precedes reflection and subjectivity . . . and failure to acknowledge this in treatment can have destabilizing effects." (p. 3). They therefore emphasize the salience of the body and encourage greater use of body and brain-based treatments.

Moreover, the Blue Knot guidelines return attention to the issue of traumatic memory, especially the role of implicit (subcortical) memory and its difference from conscious, explicit memory. Both forms of memory are important in trauma memory processing (Ford, 2018), and several approaches to psychotherapy for complex traumatic stress disorders directly address implicit, body-based sensations and emotions (see Chapters 23–26). The Blue Knot guidelines challenge some of the more established recommendations for the treatment of complex traumatic stress disorders, encouraging therapists to be flexible, focused on the client's experience, and to "think outside the box." This body/brain-based approach stands in contrast to most current practice guidelines and evidence-based treatments for classic PTSD.

Adapting Evidence-Based Treatments for PTSD to Complex PTSD: What's a Therapist to Do?

Since the early 1990s, paralleling the development of CTSD psychotherapy best practices, several evidence-based treatments for adult PTSD (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Cusack et al., 2016) have shown promise in treating adolescents and adults with childhood sexual or physical abuse histories (Chard, 2005; Cohen et al., 2016; Foa, McLean, Capaldi, & Rosenfield, 2013; McDonagh et al., 2005; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013; Resick, Nishith, & Griffin, 2003; Resick, Suvak, & Wells, 2014; Steuwe et al., 2016). The issues involved in these applications were the subject of our previous books (Courtois & Ford, 2009, 2013; Ford & Courtois, 2013), where we explicitly suggested that caution was warranted in approaching trauma memory processing (TMP) too quickly with these clients due to what is often their emotional and environment instability, multiple presenting problems and comorbidities, severe difficulties with dissociation, and limitations in the ability to maintain safety or to manage their emotions or their actions.

We also discussed differential application based on client readiness and attachment history, as well as therapist training. We still believe that caution is

warranted due to evidence of increased rates of premature termination by individuals with childhood abuse histories in these evidence-based treatments, particularly in the trauma processing phase (McDonagh et al., 2005; Resick et al., 2014). However, we do agree that when TMP is decided as a treatment strategy it optimally should occur as soon as is feasible, according to the client's readiness and willingness and based on choice of treatment. A novel framework for TMP has been proposed, in which the intentional recall of trauma memories in therapy is understood as paradoxically facilitating the capacity to intentionally suppress intrusions of trauma memories and thereby escape the vicious cycle in which intrusive reexperiencing is perpetuated by self-defeating attempt to avoid (Ford, 2018). TMP thus involves developing and purposefully employing the necessary cognitive and emotion regulation capacities to choose to pay attention to trauma memories in order to find self-relevant meaning in them (Harvey, 1996). This is the exact opposite of a futile attempt to avoid paying attention to trauma memories or reminders—a strategy that backfires by increasing the intrusive reexperiencing of trauma memories instead of facilitating recovery from them. From this perspective, TMP can serve as a vehicle not merely for reducing PTSD-related avoidance but moreover for enhancing the very self-capacities that are disorganized or diminished in DSOs and CTSDs.

As described in several chapters in this book, adaptations to evidence-based treatments for PTSD that facilitate safe and effective therapeutic trauma processing when CTSDs complicate their implementation have been proposed, developed, and researched (Chard, 2005; Harned, Korslund, & Linehan, 2014). Moreover, recent studies showing that interpersonal psychotherapy (IPT; Chapter 16) and present-centered therapy (PCT; Foa et al., 2018) achieve comparable outcomes to prolonged exposure in reducing PTSD symptoms have important implications. They suggest that *intensive review of trauma memories is not necessary in all cases, and that other forms of trauma-focused or present-centered, client-centered, and interpersonal forms of treatment that do not require intensive trauma memory processing may be equally effective as evidence-based treatments for adult PTSD* (Ford, 2017b; Hoge & Chard, 2018; Markowitz et al., 2015). Therapists and clients with CTSDs thus have choices regarding how to proceed and what strategies to use, based on ongoing clinical assessment, clinical judgment, and clients' goals, preferences, and resources.

Practice Guidelines for PTSD Psychotherapy: Applicable to CTSDs?

As noted earlier and described in more detail in subsequent chapters in this book, there is evidence that *adaptations of evidence-based treatments for PTSD may be safe and effective for clients with CTSDs, especially when applied after a period or phase of assessment and stabilization and the development of the treatment relationship, including an alliance between therapist and client*. However, there also is evidence that many clients with CTSDs have been screened out of the research studies testing those therapies (e.g., due to

suicidality, self-harm, addiction, or severe affective lability or personality disturbance) (Spinazzola, Blaustein, & van der Kolk, 2005). Other clients with CTSDs do not benefit from evidence-based treatments for PTSD—or find the form or intensity of treatment sufficiently distressing to choose to "vote with their feet" by discontinuing treatment before achieving meaningful improvement. The research evidence also is almost exclusively based on treatment that is delivered for, at most, 4–5 months (i.e., 12–20 or fewer sessions), which is only half the length of time described by expert clinicians as optimal for Phases 1 and 2 of complex PTSD therapy (i.e., 9–12 months) (Cloitre et al., 2011). While these estimates are approximate and not research-based, even if Phase 1 was truncated or entirely eliminated as recommended by some (De Jongh et al., 2016), the third phase of integration of treatment gains into day-to-day life, relationships, and functioning is not addressed—or at best is left to a few sessions at the end of formal treatment or in posttherapy booster/check-in sessions. Current clinical practice guidelines for PTSD treatment generally do not provide clinicians with guidance about how to conduct therapy when clients either do not agree to follow an evidence-based treatment protocol for PTSD or do not benefit from it, or how to help clients with CTSDs integrate treatment gains into sustained positive changes in their day-to-day lives—let alone how to prevent or manage severe impairments or crises related to extreme states of bodily, affective, relational, or identity distress or confusion.

To address these shortcomings, the 2017 American Psychological Association PTSD Guideline (pp. 80–83) included input from community members and clinicians in practice, and the Veterans Administration/Department of Defense PTSD Guidelines incorporated client focus group input. In contrast to the guidelines' recommendations of prepackaged evidence-based treatments, both laypersons and clinicians recommended a personalized approach to psychotherapy that is determined in the context of a culturally sensitive and collaborative therapeutic alliance by the client (and supporters) with a clinician who has specialized skill in treating PTSD with clients of similar background and clinical characteristics. Rather than any single evidence-based treatment, the preferred course was a variety of approaches to treatment, with a thoughtful and fully informed discussion of the process and pros and cons of different approaches, in order to fully inform client choice. Correspondingly, the use of PTSD practice guidelines in real-world clinical practice is inconsistent at best. For example, in contracted or direct services for military veterans with PTSD, evidence-based treatments are used by only half of all practitioners, and typically with little or no formal training or adherence to the protocols (Finley et al., 2019; Hepner et al., 2018).

Other PTSD practice guidelines are either silent regarding complex trauma and CTSDs or cite the unavailability of research to determine the safety and effectiveness of PTSD evidence-based treatments for this population. The 2018 NICE PTSD Guideline is an exception, cogently stating that treatment for "people with additional needs, including those with complex PTSD" (p. 17) should directly address dissociation and emotion dysregulation. The NICE

guidelines also recommend providing sufficient treatment duration to support these clients in fully engaging and developing a sense of trust, as well as increasing "the number of trauma-focused therapy sessions according to the person's needs" and making provisions to support "return to everyday activities and ongoing symptom management."

In response to these and related concerns, the American Psychological Association recently convened a working group to develop a "Professional Practice Guideline on Key Considerations in the Treatment of PTSD/Trauma." The work group is in the process of developing recommendations for clinicians in practice that is designed to complement the 2017 American Psychological Association *Clinical Practice Guideline for PTSD in Adults* evidence-based recommendations with information on responsible client-centered PTSD psychotherapy, including management of the many challenges that often accompany this treatment population. Most telling of all, this work group will articulate the importance of therapist empathy, congruence, and positive regard, and a therapeutic alliance based on collaborative treatment planning and evaluation by the client and therapist as partners (Elliott, Bohart, Watson, & Murphy, 2018; Eubanks, Muran, & Safran, 2018; Farber, Suzuki, & Lynch, 2018; Flückiger, Del Re, Wampold, & Horvath, 2018; Friedlander, Escudero, Welmers-van de Poll, & Heatherington, 2018; Gelso, Kivlighan, & Markin, 2018; Karver, De Nadai, Monahan, & Shirk, 2018; Nienhuis et al., 2018).

In summary, although the research evidence base for models of PTSD psychotherapy has grown sufficiently in the past decade to warrant major updates in clinical practice guidelines, there continues to be insufficient outcome research on CTSD psychotherapy to support the designation of evidence-based treatments or the recommendation of practice guidelines. Notably, despite admirable efforts to adapt PTSD evidence-based treatments across cultures and populations (Chen, Olin, Stirman, & Kaysen, 2017; Schnyder et al., 2016), even the most comprehensive PTSD clinical practice guidelines cannot recommend how best to individualize treatment to clients with different PTSD symptoms, comorbidities, personal characteristics, life experiences, and preferences, or in different cultural, community, or family contexts that also attends to client preference and therapist training. Thus, at this point, we believe the real-world delivery of evidence-based treatments and practice guidelines for both PTSD and CTSDs still rest upon the "standard of care" foundation provided by expert clinicians' best practices. These continue to evolve with emerging research findings from the neurosciences and other fields and the resultant development of innovative clinical approaches. Of note, some of these (most of which are body based such as acupuncture, thought field therapy, mantra-based meditation, and yoga) have a preliminary evidence base and a designation as emerging (Metcalf et al., 2016; see Chapter 26).

The remainder of this book is devoted to a summary of the most up-to-date best practices for CTSD psychotherapy and their basis in neurobiopsychosocial clinical research and theory, followed by detailed descriptions of specific approaches to CTSD psychotherapy that are adaptations of PTSD evidence-

based treatments or innovative approaches designed specifically for the treatment of CTSDs.

To bring closure to the book's review of best practices and evidence-based treatment models for CTSDs, a concluding chapter identifies past and new challenges facing the complex trauma/CTSD field. The book closes with an evocative and inspiring Afterword by Bessel van der Kolk, in which this key pioneer in the traumatic stress and CTSD field provides a cogent reprise of the past and an illuminating glimpse into the future of our field. In summary, we aim to chart a course forward for the next decade of innovation in clinical practice and research on complex trauma and recovery, so that in 10 years we have much good news to report in a third edition of this book. In the meantime, we invite you to join us in learning about the advances that have taken place in the past decade. We hope that they provide insights that you can apply to your work and studies with the resilient survivors of complex trauma whom you—and we, too—are honored to learn from and to serve.

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