Empowerment and Resilience Treatment Structure

A vehicle to enhance clinical excellence

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Stage One: Preparation & Relationship-Building

Goals:

1. Client/s will feel safe physically, emotionally, and psychologically
2. Client/s will be indoctrinated about how treatment is delivered
3. Client/s will experience an increased confidence/faith in positive treatment outcomes.

Objectives:

To accomplish the three goals above through (orienting to the treatment process to build positive expectancy and "faith" in a desirable outcome, completing the formal and informal assessment process)

Orientation:

This is the mechanism for delivering information; building hope and expectancy in a future positive outcome; as well as building capacity, normalize therapy experiences, grounding the client/Client; creating transparency, and engagement.

A. Introduction of Healing Process
   1. Treatment structure explained *(It is essential to be explicit in orienting the client/Client from first contact if we are wanting to create a safe predictable process. To build hope and positive expectancy, we convey clearly that we have a plan and system that works and talk about what is contained in each stage. For example, "We will start by describing the orientation and what will be covered, then we will talk about the assessment process including formal and informal assessments that are likely to be used...." Providing an explanation of each portion on a broad scale and narrowing the plan to more specific as the time grows closer. Allow choice whenever possible. For example, "Would you like to do this section or this section first?" or "Would you prefer option 1or option 2?" When describing the treatment stage, discuss the possible models of intervention that can be used, briefly and again let them know when it is time you will revisit them and as much as possible let them choose which model of treatment they will be able to benefit the most from). State and define the ultimate goal of the therapeutic process as resilience and ending services. There is a beginning, middle, and end.*
      a. Why a structured process --- *human beings are naturally sensitized to learn from the environment as their first and perhaps their most effective process, however learning from the environment is usually non-directive and much of what is learned environmentally is assigned meaning and value to fit the metal architecture as it already exists. This means that durable habituated negative reactions, unsuccessful and painful attachment patterns, mental templates or schemas formed early in life*

and the protective reactive behaviors associated with adapting to or mitigating emotional wounds are frequently the dominate ones in operation. Learning new ways to navigate the world then would require an intentional and deliberate attuning to the environment. Operating on a treatment structure allows the healer the advantage of creating a learning and experiential environment for the client.

b. **What is the real benefit of the structure of treatment** --- *in order for the healer to create intentional and deliberate transformation in the lives of those that are served, increasing not only a freedom of psychological and emotional pain but to also propel clients toward a future of choice and personal integrity? Without a structure it is difficult produce consistent results that can be reproduced. Having a structure empowers the therapist to build their own believability for the client. Structure supports and enhances a co-created, intentional learning and experiencing environment that speeds the emergence of transformational change in the life of the client rather than the slower or incremental change process often associated with the average counseling process.*

2. **What is the healing process?** (*This has to go in order: Describe the process that people move through healing in EXQUISITE detail, as an example...when people first start in therapy they have some concerns about is this going to work, and they are often afraid that their situations is so awful that nothing can be done, they sometimes worry if they are up to the task, and if they fail or fail again what does that mean about them...then as they progress through the work these fears and concerns begin to lesson and a confidence begins to build.....you want to lay out the process that people will likely move through therapy emotionally, psychologically, what their bodies will likely experience, how their perceptions may change, relational changes and growth, etc) lay it out the first time from beginning to end...then go back through it and describe what it looks like when it is done fast from beginning to end, and then go back through it and describe what it looks like when it is done slowly from beginning to end. Complete each one from beginning to end before moving to the next one)*

a) Integrate the "Theory of the Somes." *(give detailed examples of how people move through treatment...some people move through counseling and it looks like this – DESCRIBE THE AVERAGE PACE...; some others do it like this – DESCRIBE THE FAST PACE...; and some do it like this – DESCRIBE THE SLOW PACE. We do not know how you will move through this process, but we are confident that where it is...recap the paces, you will move through exactly in the way that is best for you)*

- ✓ What are you conveying with the three somes? *That they are right regardless of how they move through things. We are confirming that we believe in their capacity to be successful. That therapy is an organic process that cannot be short changed.*

b) Acknowledge value of individuals or families --- *moving at their own pace, the healer, therapist and counselor generally has a drive to prove their own value to themselves or supervisors by pushing the therapy too quickly. This is often supported by the demand of dysregulated individuals and systems of care to be fast and rapid in the resolution of behavior that is generated by reactive adaptations and mitigations. It must be remembered that human beings are organic systems and must follow reasonable organic processes in preparing and then successfully moving through the development of health. Removal of pain is not health.*

c) Underscore and increase choices --- *As highly detailed descriptions of the entire process of therapy, it allows for a number of choice-points, a choice point is the creation of multiple options that have been adequately explained and have had examples delivered in such a fashion as to allow a client or Client the ability to choose a course of action. This also generates knowledge that more than one course or direction is possible, and that if this choice doesn't work that they have chosen, they are still OK and can move forward with some other choice that can lead to positive and beneficial outcomes.*

d) Highlight transparency of process --- *There is no doubt that professionals have an obligation to inform the client about treatments and processes so that they can make an informed choice. However, this is often only seen as a legal obligation rather than a solid and significant part of the treatment process.*

e) Assume capacity for health and wholeness --- *by giving choice and explain the process of healing the healer is assuming that the client has the ability to choose and execute choice in their daily life. That they have the capacity to be self-reflective and self-aware enough to make intentional choices and follow through on those things selected.*

f) Beginning, Middle, and End of therapy, *with a goal of being finished and having skills so that you should not need to return to therapy in the future, at least as it relates to the issues worked on here.*

3. **How we will know we are transitioning** *(describe in detail the points of transition that are normal...ties this back to what you have covered in the healing process, describe in detail the things that show movement and progress, and that as people achieve these...this is what we see emotionally, psychologically, what their bodies will likely experience, how their perceptions may change, any relational changes and growth)*

B. What is it like to work together?

1. **What is it like to work with me?** *(Expose your weaknesses, biases and tendencies. Explore with them, modeling what it looks like to recognize these. You will focus extra attention on learning what works best for them, because you have a goal of being 5 times better in five sessions than now, and in 10 sessions you want to be 10 times better at making everything*

tailored to them, even those this is my goal I will sometimes fail or slip up....when that happens I will pause and get me back in order)

2. **Why does it take time to set treatment goals, and achieve those goals?** *(Often it helps to talk about the fact that we as human beings are organic organisms, meaning just like a seed can't go from being a seed to a fully blossoming plant overnight. Neither can we change that quickly in most cases. However, when we are in a state of arousal, we are always going to want to have the quick and immediate resolution, sometimes that desire is so strong it allows us to engage in magical thinking, which is common to all human beings. Normalize this, and draw several experiences from their own history that illustrate this "magical thinking", use a few humorous ones of your own as a starter for examples).*
3. **What is the format of the sessions**? *This is an important because it builds in routine, ritual and expectancy. Remember you always start each session with a review of the feedback from the prior session, which you have looked at and YOU have suggestions how YOU can improve what you are doing for the client or Client. Improving our intentionality as healers will look like spending the beginning of a session reconnecting from last session and prioritizing movement through the therapy process. Checking in on what has happened between sessions can often ignite the crisis of the week. Make sure that you address the rationale for concurrent documentation, and explain how it is designed to help the client and you know what was most important and so they can KNOW what is in their client record. This models transparency and allows opportunities for any conflicts in perception to be identified and processed on the spot.*
    a. *Prior session feedback, with several possible things that the helper can do to improve*
    b. *Provide the things that can be done to improve and let the client/Client choose which one they think would be beneficial*
    c. *Talk about how you will implement that in the future*
    d. *Talk about the kinds of things that will be accomplished*
    e. *Discuss the concurrent documentation process...giving multiple examples of the kinds of things people my say about what they have done in therapy that day*
    f. *Setting of the next appointment*
    g. *Feedback paperwork*
4. **How can I do the best job possible; Feedback informed treatment?**
    a. Introduce SAS feedback forms (or) SRS, ORS forms *(go through them and give examples of neutral, positive and critical feedback, multiple examples of each are most helpful)*
    b. Feedback helps me be better each time we meet *(I will review your feedback, and when you come into the next session, I will be able to tell you how I will be changing to fit your needs and Client culture better)*

c. What is our goal with feedback? --- *"In five sessions I want to be five times better tailoring what we do to you, at 10 sessions I want to be 10 times better at working with you effectively than I am today"*

5. **What can get in the way?** *This is a good place to go back and tie in the magical thinking explanation given before, and then address other situations that sometimes challenge moving forward. It is important for the helper/therapist to own the challenges...an example of what is meant by owning the challenges might me... "Sometimes in the process of therapy, clients experience fear in what they are being asked to do, or think, or see differently. I have come to notice that the road block is me, the therapist. I have not been focusing on their unique situation enough and that may cause me to push them to move a little fast, and I am not designing things well enough for them. If that should happen, I will always apologize and make certain that I improve my focus and attend more."*

6. **Can the place we meet have an effect?**

Organizational structure and culture greatly influences the environment where services are provided. In understanding that many agencies experience limited space, the healer's role is to create as much safety as possible. This means predictability and an understanding that unpredictability could be a part of that process. An example of how to phrase this when working with a client/Client would be, "I will do my best to make sure we have the same room. If that is not possible, I will let you know as soon as I know of any changes." It can be helpful when working with clients/families who are more sensitive, to provide a tour of the facility and show them where the rooms are and what they look like. The healer might schedule the room with the next appointment, when possible. Other notes to improve the consistency in care include the rooms to be laid out exactly the same with the same furnishings, color and decoration so that the familiar and safe are always present.

a. *For those meeting in a home environment, make sure to discuss how to best benefit from your coming into the home to provide services. Some of the items that need to be discussed is that this process needs to have predictability and that chaos make therapy more difficult. Ask the Client to reduce the following:*
   - ✓ *Not answering the door*
   - ✓ *Not answering the phone or texting during the session (with most smart phones they can know who it is and know if it is likely to be an emergency or not*
   - ✓ *No friends or neighbors unless they are going to participate in all sessions*
   - ✓ *Decide on the room that will be used each time*
   - ✓ *Discuss no TV or stereo*
   - ✓ *If you are working with children, that the Client (parent/s will need to be in attendance in the room and be participative, not off in another room)*

b. *If you cannot get agreement on (a) above then it is likely that the environment of the home will not be conducive to treatment, and it is clinically sound to discuss this with the client, or even to turn down the in-home option.*
   - ✓ *Case managers and other non-clinical healers may choose to be less formal about the environment though the expectation of providing consistency must be considered*
   - ✓ *Modeling setting both personal and professional boundaries is part of good clinical practice. When the healer fails at this task, it is an opportunity to model. This might sound like, "Wow did you see how I reacted so quickly? I was so dysregulated there." Model a self-regulation activity and follow up with, "Ok now that I'm back in order...." Discuss the process of the failure and what you will do in the future to prevent it.*

c. *It is suggested that you bring with you laminated signs for the door. Or other materials that can help the Client manage the environment more effectively.*

d. *When the organizational structure is not conducive to the creation of a safe environment, then be sure to address this in supervision*

7. #1 Rule: We only say what we choose to say

Formal and Informal Assessments

As you move through assessment you will be discovering daily and Client dynamic patterns and habituated behavior patterns. This is where you begin to use subtext and build capacity and identify strengths. The focus is on the client's process and patterns in physiological responses- not the content of what happened to them. Remember assessment tools **are not purely to collect data**, they are important relationship building tools.

Remember to move into subtext when talking about the data being collected in assessments

1. **Assume that behavior has a developmental history that makes the behavior physiologically correct.**
2. **Assume that behavior that is being maintained has strengths that can be identified.**
3. **Assume that a pattern exists that reflects fluctuations and differences within behavior.**
4. **Understand that all behavior is purposive and that most problem behaviors have to do with dysregulated environments or failures to regulate self adequately**
5. **Assume that understanding patterns, history and purpose will increase effective outcome for the one seeking help**

Orient clients to assessments

When a preparing to administer an assessment (formal or informal) it is likely that the client/s will have hesitation and concerns about the responses. This is why we always move through assessments relationally rather than in a cold or flat administration process that is primarily focused on the collecting of data. Several things can enhance the use of assessments with clients, and they are listed below:

1. Explain in detail the following things for each assessment:
    a. Name
    b. How long it has been used
    c. How sound it is as an assessment
    d. When it is generally used
    e. The primary focus of the assessment
    f. Discuss the process of the assessment, and how people move through it
2. Explain the focus of the assessment and the kinds of useful information you are using it to discover.
3. After explaining several of the assessment possibilities, ask the client to choose one. If you are in a program that requires certain assessments to participate, and there is more than one, give the client the choice of which order they are administered.
4. Never collect data that you do not use actively with the client, engage them in the scoring if possible, or use the discussion of the responses to build capacity and empower the client. Always tie your interactions back to the purpose or focus of the assessment as you have explained it to the client.

Treatment Goals in phase 1

In this stage of treatment goals are not as collaborative as they will become in each stage following. *Remember dysregulating systems are not good at logic or reasoning, so let's not add to the discomfort of early treatment by demanding they have a goal. Make the first goal to accomplish the orientation and assessments. Explain to the client that once these are done you will collectively work at determining what needs to happen next and look at strategies to achieve this.*

- *Review the treatment structure to build commitment to treatment*
- *Orientation and acculturation around the therapy process*
- *Creating Safety (felt and real) as well as predictability in the therapy process by being transparent and descriptive about the process to increase client involvement, choice and enhance decision making ability*
- *Discovering capacities and strengths associated with behaviors, thoughts and emotions currently in practice and develop redeployment strategies*
- *Completing formal and informal assessments, and identify the possible ones that will be choose from*
- *Assessing patterns that are persistent and repeated that interfere with developmentally appropriate functioning, and times when they are not used, and when they are used more often than normal*

Many organizations have a lack of sensitivity about the process of developing treatment goals. They often seem to be overly focused on the removal or reduction of behaviors or thoughts that are deemed

problematic. It is not unusual for organizations to put demands for logic and reason on the client when they start treatment that can add extra stress to an already aroused system.
For example

a. *Soliciting a life-role goal at the very beginning of treatment planning, may seem like a great idea. If you are dealing with a cognitive, and rational, regulated individual. However, most clients initiating treatment or not operating in the logical mind, but are in the chaotic and reactive brain of survival and reactivity.*
b. *Pushing to identify a specific goal is a process that will require collaboration, and in early treatment trust and safety haven't been developed adequately to engage in this process. When done prematurely then the helper ends ups suggesting possibility after possibility to the client, until the client picks one. This is overly directive and not truly collaborative.*
c. *Using a set of basic goals allows you to assure the client by the time they get this to the point of moving to stage 2 of treatment they will be adequately prepared to not only choose a goal, but have increasing capacity to succeed in obtaining that goal*
d. *Having too many goals may feel overwhelming to the person and may make the treatment plan overly complicated and unwieldy, so start with basics, and engage the client through stage one.*

<u>Stage 2: Psychoeducation and Self-Regulation Skill Building</u>

Transition information –

Clients who have experienced traumatic stress often enter therapy in crisis, feeling overwhelmed and demoralized. Years, sometimes generations of failed attempts to manage their symptoms, they express despair that their pain will never be alleviated. Creating predictability and increasing safety is established by explaining the therapeutic process through Stage One. A key element of Stage One is the prioritization of self-regulation. The healer begins by modeling, referring back to the orientation phase as a reference point. The healer then identifies their own body's response to stress and expresses their process of transitioning to a more relaxed body. This includes elaborating on how thinking is changing and how feelings of being grounded increase. After modeling the benefits of their own emotional regulation, the client will have a reference point of how to move through transitioning from a stressed to a relaxed body, increasing hope that it is possible to regulate one's self. Once the client has moved through stage one with repeated modeling, they develop preparedness for being instructed and have trust to benefit from that instruction.

Goals:

1. **Create an understanding that behavior is congruent with aroused physiology**
2. **Normalize Problem behaviors as being reasonable when a client or Client are in a state of Sympathetic system dominance (SD)**
3. **Relate everyday interactions to (SD) and help client connect thinking, behaviors and perceptions in daily life to (SD)**

4. **Increase motivation to engage in the treatment process**
5. **Increase client belief in the effectiveness of treatment**

Objectives

1. **Teach the mechanics of the threat response system**
2. **Creating a common language to enhance ease of discussion and relational connection**
3. **Teach the impact of environment on behavior, thinking and perception**
4. **Convert discussions of anger, sadness, fear etc, to physiological dysregulation of Sympathetic system dominance (SD)**
5. **Normalize internal negative messages**
6. **Normalize perceptions of self, significant relationships and the world view**

Motivate based on what you have learned about the client or Client in stage one.
Example statements follow:

- The hard part of your life is over. You survived! The rest of this is just cleaning it up. Therapy is not difficult compared to what you have already accomplished. *(use your subtext to build capacity, believability, validate their efforts and consolidate their choices – you remember how you felt when you were struggling to decide to come into treatment, what is the first positive difference you see between that struggling you and this you sitting here today?)*
- Healing trauma is simple...it sometimes is not easy but it is always simple. You only have to complete two things to resolve your symptoms. These are: (1) learn to get and keep the muscles in your body and, once you have developed this skill, then (2) tell the stories of your trauma(s) to me while keeping a relaxed body. *Use subtext to build capacity and strengthen their belief in a future without the problem*
- You are in the top 10% of resilient people on this planet. I know that because you are here! You are not dead. You are not in jail. You are not actively drug-addicted. *Use subtext to build capacity and strengthen their belief in a future without the problem*
- The absolute hardest part of recovery from trauma is the stopping of avoidance and trying to run away from it. Look at you sitting here in my office ready to confront one of the most frightening things of your life. *Use subtext to build capacity and strengthen their belief in a future without the problem. What was the first thing you learned about yourself that allowed you to choose to recovery from suffering?*
- Throughout this therapy process, I promise that I will do my best to keep a pace that allows for identification and exploration of skills. You will be able to lessen your symptoms to a point of comfort and find a new way to live that is not ruled by fear once skills are brought to awareness and mastered through practice. *Use subtext to build capacity and strengthen their belief in a future without the problem*

Teach the mechanics of the threat response system- Explain "Exactly Right"

- You are a normal person having normal reactions to a traumatic past. You are perfectly adapted to the historical traumas of your life. The problem is that your adaptions have remained at the same level that was necessary to survive in your past. You no longer need that level of sensitivity and vigilance. You are not sick but rather "over-adapted" for a life where there are not as many demands upon you as there once were. The following are the items that are covered to support the above statement:
    1) Autonomic nervous system functioning and its purpose
    2) Primary components of the autonomic nervous system (Parasympathetic – cool and the Sympathetic – hot)
    3) Trauma is usually related to a state of sympathetic dominance (SD)
- Symptoms of traumatic stress are evidence of a system that is attempting to heal itself from a wound (trauma). With the fear that you have lived in since the traumas of your past, you have prevented your system from completing healing. What we are going to do is help you manage your physiological fear response and allow this process to complete.
    1) Discuss what the body experiences
    2) Discuss the overwhelm and accumulative harm effect of trauma on the body
    3) Discuss the normal behaviors that will emerge when the body is in a state of sympathetic dominance
    4) Discuss behavior is built on the body system that is in charge
    5) Have individual or Client come up with personalized names for the science materials that are explained. *It allows you to talk about it through a verbally unique bond that will strengthens relationship*
- What would any normal/healthy/rational person with your history likely believe about themselves? Their world? Relationships?
    1) Give multiple examples of what would be common everyday reactions to being in a state of SD. *Then go back through their own history, pick little things like an argument with a friend sometime in the past. Help the client see that in those moments of SD they behaved irrationally and reactively. Tie as many personal life examples as possible to each point before moving on to the next example. This effectively normalizes behavior, removes stigma, and reduces shame.*
    2) Draw on examples from multiple domains of their personal life. *Tie as many personal life examples as possible to each point before moving on to the next example. This effectively normalizes behavior, removes stigma, and reduces shame. As it relates to self-image, relationships, and world view, suggest that they identify differences that they have experienced when they were in SD and when they were not, and make their behavior while sometimes unfortunate completely congruent with the system that they are dominated by in the moment*

- Anytime a human being has a painful learning experience, a prescient is set for what to expect the next time they encounter a situation that is in any way similar to the previous learning experience. They perceive threat and what happens inside of a body that perceives threat... *(you have been modeling self-regulation up to this point for the client, now you are ready to teach the client how to regulate themselves. See Tools for Hope). Remember to identify benefits that you have received through the practice that you have done live with them in sessions---*
    1) With a relaxed body you are stronger, faster, and smarter.
    2) Begin practicing "relaxed vigilance" instead of reactive hypervigilance.
    3) Skills for stabilizing clients, including sensory grounding, envelope containment, postural grounding, motivational interviewing and positive expectancy, Thought Field Therapy/Emotional Freedom techniques, and more.
    4) Skills clients can use to recover their sense of personal safety include multiple techniques for self-regulation and anxiety reduction, such as interoception, mindfulness and "body-fullness," diaphragmatic breathing, guided visualization, peripheral vision, and core relaxation.
    5) Psychoeducational and cognitive restructuring tools that empower trauma survivors to catalyze their natural resilience by overcoming their "victim mythology." Shifting clients from an external to an internal locus of control enables them to regain a sense of self-efficacy and focus on solutions rather than problems.
    6) Learning how trauma is more accurately understood as an injury rather than an illness and why the underlying biological and neurological mechanisms must be addressed before proceeding to treatment using cognitive and behavioral techniques. Practitioners and clients jointly explore the nature and functioning of the human threat detection system, the polyvagal response, and the roles these systems play in the development and maintenance of posttraumatic symptoms and adaptations (e.g., addiction).

2. Create a common language to enhance ease of discussion and relational connection.
    a. *Building a common language with the client or Client helps empower quicker and more thorough understanding of concepts, increases utilization of concepts, and improves communication in general throughout the therapy process. Also, this common language lends functionality implementation of strategies for intervention.*
    b. *The principle of developing a common language among members of any community to empower effective communication is well established. Examples can be seen in all walks of life including healthcare, manufacturing, entertainment, sports, religion, politics, and military or police. Similarly, developing a common language among between therapist/mental health providers and clients that is not stigmatizing or pejorative is essential for effective communication.*

c. *Develop self-regulation activities based in the language of the Client...instead being calm, we might say "defeating that sneaky rage monster."*

3. Teach the impact of environment on behavior, thinking, and perception
    a. *Relate common everyday behavior to the environment. An example, "Have you ever walked into a room and felt tension there? Where in your body did you notice it first...second....third? Did this shift require any conscious or intentional action on your part?" "When have you had someone make a careless comment, and even though you knew it wasn't their intent to be rude, found you emotions firing off?"*
    b. *It is suggested that if you are working with an individual, you draw out 6-8 examples of how environment effects the body, emotions, thinking and reactions. If the client is a Client, then 2-3 per member should be sufficient.*
    c. *The influence of the environment can exert and influence on our physical and mental health in very complex ways. Some of these may be modulated by our genetic make-up, psychological factors, and by our perceptions of the risks that they present. Use examples of people who smoked during pregnancy that have had low birthweight children, or being in place where the noise level begin to generate a headache.*
    d. *Identifying the environment as a provocative agent empowers can empower the client, increasing normalization and empowerment, reducing shame and stigma. The client is not an awful person. The environment was in some activating their autonomic nervous system.*
    e. *Teach regulation skills that relate to management of the self in a provocative environment*
4. Build capacity by converting discussions of anger, sadness, fear, etc, to physiological dysregulation of Sympathetic system dominance (SD)
    a. *Many of the problem behaviors that bring people in to treatment are congruent with the system that is in charge at the time, which has become habituated and sometimes dominant through life experience.*
    b. *Poor behavior reduces automatically when the body is not in a state of (SD)*
    c. *When an expression of anger or frustration emerge...then it is an opportunity to tie it back to the information that has been delivered about physiology and (SD), so that people see the need to regulate even when is a foreign concept to them and their history*
    d. *This is a place where the instruction of self-regulation skills for the body can be easily plugged into the discussion with the client*
5. Normalize internal negative messages
    a. *The critical inner voice is a well-integrated pattern of destructive thoughts toward ourselves and others. The nagging "voices," or thoughts, that make up this internalized dialogue are at the root of much of our self-destructive and maladaptive behavior. Normalize how this is an (SD) response set. Relate this idea back to the point of activation discussion where worrisome fantasies were discussed.*

b. *Use examples of when the client or Client experience the inner critic, helping them see it as part of the activation sequence of becoming (SD)*
c. *Teach the client or Client how to regulate themselves when the inner critic is speaking to them or through them.*

6. Normalize perceptions of self, significant relationships and the world view
   a. *What would any reasonable rational human being come to believe about **themselves** (intellectually, emotionally, spiritually, psychologically, physically, socially, and academically) from having these things occur in their life? How has your personal history of (SD) contributed to this view of the self*
   b. *What would any reasonable rational human being come to believe about **important relationships** (intellectually, emotionally, spiritually, psychologically, physically and socially) from having these things occur in their life? How has your personal history of (SD) contributed to this view on relationships*
   c. *What would any reasonable rational human being come to believe about **the world at large** from having these things occur in their life? How has your personal history of (SD) contributed to this view of the world*
   d. *Teach self-regulation as it would relate to balancing the views of self, relationships and of the world. These views are likely quite binary and through self-regulation they can be broadened out a bit. Relate back to the collapsed categories of the over activate ACC*
7. Now go through daily, common experiences that the client has and tie it in to the activation of (SD) and practice self-regulating imaginally through those activating moments.
   a. *It is suggested that this be done most of one session, or give the client at least the opportunity to regulate between 8-10 before while in recall of aversive experience*
   b. *When they struggle to be successful at degree of activation in (SD), make them correct, and that maybe more practice is needed.*
8. This is a great place to bring the timeline into the discussion...begin to work on it
   a. *Explain now that they have a better capacity to regulate themselves you would like to get a better understanding to help them prepare for treatment in stage 3 more effectively.*
   b. *Explain that a time line is a list of positives and negatives that have happened to each person in the Client:*
   c. *Give examples of both positive and negative things and then how you would summarize them into small 3-4 word statements*
   d. *Start with the oldest to the youngest*
   e. *Remind them of the first rule*
   f. *Begin with the safe items:*
   g. *Foster parents or adoptive parents also need to be able to create a timeline.*
   h. *Then compare if their timeline is different or similar to the child and what might those similarities or differences lead to?*

i. *AS YOU GO THROUGH THE TIMELINE YOU ARE USING SUBTEXT TO CONSOLIDATE THE GAIN IN SELF REGULATION.*

SAFETY & STABILIZATION

SAFETY AND TRAUMA RESOLUTION

The lynchpin that connects treatment of both traumatic stress and addiction is the development and maintenance of safety and stability. Without the ability to self-rescue, one is at great risk for being overwhelmed by memories or resuming addictive behaviors. A good analogy to use for this phenomenon is the idea of firemen being trained to control fires. The first thing they learn is what to do when the fire begins to control them. Any fireman needs to know when it is time to step back from the fire in order to maintain safety and in the end, conquer vs. be conquered. The same is true with the trauma survivor. Without the ability to self-regulate their own anxiety and arousal, the trauma survivor is at risk of being overwhelmed by memories without the ability to induce a feeling of safety. At this point, the traumatic material renders the survivor once again with the feeling of entrapment, with no way to "survive" other than resuming the addictive behavior.

What is Safety?

Gentry (1996) attempts to define and operationalize the concept of "safety" into three levels, relative to the treatment of trauma survivors. These three levels of safety are as follows:

Level 1.
RESOLUTION OF IMPENDING ENVIRONMENTAL (AMBIENT, INTERPERSONAL AND INTRAPERSONAL) PHYSICAL DANGER;
Removal from "war zone" (e.g., domestic violence, combat, abuse)
Resolving active addiction
Behavioral interventions to provide maximum safety;
Address and resolve self-harm.

Level 2.
AMELIORATION OF SELF-DESTRUCTIVE THOUGHTS & BEHAVIORS
(i.e., suicidal/homicidal ideation/behavior, eating disorders, persecutory alters/ego-states, process addictions, trauma-bonding, risk-taking behaviors, isolation)

Level 3.
RESTRUCTURING VICTIM MYTHOLOGY INTO A PROACTIVE SURVIVOR IDENTITY by development and habituation of life-affirming self-care skills (i.e., daily routines, relaxation skills, grounding/containment skills, assertiveness, secure provision of basic needs, self-parenting)

Therapists are taught from the first days of clinical training to "above all do no harm (*primum non nocere),*" which makes it logical to assume that the more safety and stability that we, as clinicians, can impress in the lives of our clients, the better for their treatment – right? This may not always be the case and in many instances, the clinician's focus on safety is more about their own apprehension and may actually escalate the crisis of the client.

So, how safe do you have to be and how do you get there? Destabilization tends to be precipitated by client behaviors and thoughts in response to the bombardment of intrusive symptoms (nightmares, flashbacks, psychological and physiological reactivity). Therefore, being able to manage these symptoms safely is imperative. There are no hard and fast criteria for safety, but we will discuss various techniques to help establish safety and stabilization and discuss reference points that can be useful to help you decide. A clinician's best intervention to optimize safety is a non-anxious presence along with an unwavering optimism for the client's prognosis.

Firemen who only stay in the firehouse practicing what to do in the event of a fire never gain mastery over fighting fires. Clients should develop the minimum ("good enough") level of safety and stabilization and then address and resolve the intrusive symptoms by enabling a narrative of the traumatic experience. This is often counter-intuitive and usually anxiety producing for the clinician. However, the client will be much better equipped to change his/her self-destructive patterns (e.g., addictions, eating disorders, abusive relationships) with the intrusive symptoms resolved because s/he will have much more of their faculties available for intervention on their own behalf.

MINIMUM STANDARDS OF SAFETY

1. RESOLUTION OF IMPENDING ENVIRONMENTAL (AMBIENT, INTERPERSONAL AND INTRAPERSONAL) PHYSICAL DANGER.

Level One of Safety includes the resolution of environmental danger. When treating an addicted survivor, environmental danger may manifest itself in unsafe situations such as those of domestic violence, living with an active addict or self-destructive behaviors. **Traumatic memories will not resolve if the client is in active danger.**

Active addiction IS active danger. The addicted survivor must arrest active addiction before treatment for recovery to be effective. This needs be clearly communicated to the addicted survivor and may be articulated as: *"Safety is the requirement for resolving both your addiction and your traumatic stress. This safety will require that you bring your using behavior under control (i.e., abstinence) and that you develop ways of effectively regulating your own anxiety, without the use of chemicals or self-destructive behaviors."*

2. ABILITY TO DISTINGUISH BETWEEN "AM SAFE" VERSUS "FEEL SAFE."

Many trauma survivors feel as if danger is always lurking around every corner. In fact, the symptom cluster of "Arousal" is mostly about this phenomenon. It is important for the clinician to confront this distortion and help the client to distinguish, objectively, between "outside danger" and "inside danger." Outside danger, or a "real" environmental threat, must be met with behavioral interventions designed to help the survivor remove or protect her/himself from this danger. Inside danger, or the fear resultant from intrusive symptoms of past traumatic experiences, must be met with interventions designed to lower arousal and develop awareness and insight into the source (memory) of the fear.

Addicted survivors of trauma are used to resolving internal danger with mood altering substances. Not feeling safe is often a precursor to impulsive behavior. As noted above, Dayton (2001) discusses the phenomenon of emotional literacy. It is not necessary that a trauma survivor be fluid in their emotional literacy in order to resolve traumatic material yet they do need to be able to distinguish when they are not feeling safe. With addicts, it may be useful to develop a few words for the feelings of discontent that predispose the individual to turning to mood altering substances and behaviors. For instance, a client may not be able to articulate feelings of powerlessness or vulnerability but they may be able to distinguish an internal cue that tells them that things are "not right." An example of this may be a commitment to tell someone when feeling "irritable" or "uncomfortable."

3. **DEVELOPMENT OF A BATTERY OF SELF-SOOTHING, GROUNDING, CONTAINMENT AND EXPRESSION STRATEGIES AND THE ABILITY TO UTILIZE THEM FOR SELF-RESCUE FROM INTRUSIONS.**

Addicted survivors of trauma are accustomed to using mood altering substances and behaviors to self-soothe. The ability to use alternative methods of self-soothing is often a turning point for the survivor as they move from engulfment by the traumatic material to feeling a sense of empowerment over it.

When dealing with the traumatic material, the client must be able to identify to what extent they may explore the material before needing to retreat and return to the safety of the present. Just as with a fireman, before s/he can learn how to self-rescue, they need to be able to identify when it is warranted. One method of teaching the client how to determine this is by utilizing the Subjective Units of Distress Scale (SUDS). This is a scale from zero to ten that indicates what level of discomfort a client is experiencing. Traumatic material will inevitably produce discomfort, but the trauma survivor must practice leaning into the resistance without being overwhelmed. With a SUDS scale, the client can identify their own limits and when self-rescue is necessary. A SUDS rating of 10 would indicate the most discomfort a survivor could imagine feeling. This may be indicated during a flashback. A SUDS rating of 0 or 1 would indicate no discomfort. By using this scale, the client is then able to gain a sense of awareness as to what extent they may safely explore the traumatic material, without becoming overwhelmed.

It is useful to ask the client to begin to narrate the traumatic experience(s) and as their emotions intensify, the clinician may challenge the client to rescue themselves from these

overwhelming feelings by implementing the skills above. This successful experience can then be utilized later in treatment to empower the client to extricate him/herself from overwhelming traumatic memories. It is also a testament to the client now being empowered with ***choice*** to continue treatment and confront trauma memories.

4. POSITIVE PROGNOSIS AND CONTRACT WITH CLIENT TO ADDRESS TRAUMATIC MATERIAL.

The final important ingredient of the Safety Phase of treatment is negotiating the contract with the client to move forward to Phase II (Trauma Resolution). Remember the importance of mutual goals in the creation and maintenance of the therapeutic alliance. It is important for the clinician to harness the power of the client's willful intention to resolve the trauma memories before moving forward. An acknowledgment of the client's successful completion of the Safety Phase of treatment coupled with an empowering statement of positive prognosis will most likely be helpful here (i.e., *"I have watched you develop some very good skills to keep yourself safe and stable in the face of these horrible memories. Judging from how well you have done this, I expect the same kind of success as we begin to work toward resolving these traumatic memories. What do you need before we begin to resolve these memories?").*

SKILLS FOR DEVELOPING, MAINTAINING & ENHANCING SAFETY

In order to fully resolve traumatic material, feelings of empowerment must mitigate the victim role. These skills are meant to be suggestive and may not work for every survivor. It is important that the client be able to identify what works for them. Some clients experience a feeling of failure if they attempt to lower their SUDS scale and it does not work. It is important that we as clinicians normalize trial and error and instill hope in the trauma survivor.

Remember that the goal of these skills is to take the client out of the fight or flight option and back into intentionality where they control their internal and external world. It is helpful to use the term staying "intentional" vs. being rendered "reactive." When we are intentional, we have the ability to act out our intentions. When we are in a reactive state of mind, we react to situations without thought or insight. A reactive state is fear driven and impulsive.

In her excellent book, "The Body Remembers" Rothschild (2000) encourages clinicians to teach clients how to put the "brakes" on when beginning trauma therapy. She uses the analogy of teaching a new driver to be really comfortable with the braking system in a car before "accelerating". In the same manner, she finds methods for teaching client's how to "brake" before becoming deeply involved in trauma work. In this way, the client moderates the trauma work. A client can begin to work beyond the fear once they have learned that they need not be stuck in fear forever. Once an individual learns that they can touch just the surface of their experience and then return to a safe or neutral ground it is empowering and affords them the knowledge that they can master their own discomfort.

<u>Progressive Relaxation</u>

Ehrenreich (1999) provides a simple script for Progressive Relaxation that can be expanded or contracted with just a minimum of effort. Begin this exercise by instructing the individual to focus on lengthening and deepening the breath. Focus on the inhalation and exhalation making the breath smooth and deep.

Now tighten both fists, and tighten your forearms and biceps ... Hold the tension for five or six seconds ... Now relax the muscles. When you relax the tension, do it suddenly, as if you are turning off a light ... Concentrate on the feelings of relaxation in your arms for 15 or 20 seconds ... Now tense the muscles of your face and tense your jaw ... Hold it for five or six seconds ... now relax and concentrate on the relaxation for fifteen or twenty seconds ... Now arch your back and press out your stomach as you take a deep breath ... Hold it ... and relax ... Now tense your thighs and calves and buttocks ... Hold ... and now relax. Concentrate on the feelings of relaxation throughout your body, breathing slowly and deeply (Ehrenreich, 1999, Appendix B).)

Autogenics

A favorite script for Autogenic Relaxation comes from "Mastering Chronic Pain" (Jamison, 1996). Although written for a different audience, it is applicable to the addicted survivor. Autogenics is a process of using internal dialogue to self-soothe. It is NOT hypnosis. The client is in control the entire time. It begins by encouraging the client to find a relaxing place and position. Focusing on their breath allows it to soften, lengthen, and deepen. The internal dialogue can then begin.

> Jamieson (1996) begins with:
> "Now slowly, in your mind, repeat to yourself each of the phrases I say to you. Focus on each phrase as you repeat it to yourself" (p. 73).
>
> I am beginning to feel calm and quiet
> I am beginning to feel quite relaxed.
> My right foot feels heavy and relaxed.
> My left foot feels heavy and relaxed.
> My ankles, knees, and hips feel heavy, relaxed, and comfortable.
> My stomach, chest, and back feel heavy and relaxed.
> My neck, jaw, and forehead feel completely relaxed.
> All of my muscles feel comfortable and smooth.
> My right arm feels heavy and relaxed.
> My left arm feels heavy and relaxed.
> My right hand feels heavy and relaxed
> My left hand feels heavy and relaxed
> Both my hands feel heavy and relaxed.
> My breathing is slow and regular.
> I feel very quiet.
> My whole body is relaxed and comfortable.
> My heartbeat is calm and regular.
> I can feel warmth going down into my right hand.

It is warm and relaxed.
My hands are warm and heavy.
It would be very difficult to raise my hands at this moment.
I feel very heavy.
My breathing is slow and deep.
My breathing is getting deeper and deeper
I am feeling calm.
My whole body is heavy, warm, and relaxed.
My whole body feels very quiet and comfortable.
My mind is still, calm, and cool.
My body is warm and relaxed.
My breathing is deeper and deeper.
I feel secure and still.
I am completely at ease.
I feel an inner peace.
I am breathing more and more deeply (Jamieson, 1999, p.73-74).

Now encourage the client to bring their attention back into the room in which they are relaxing. Suggest that they can bring feelings of relaxation into their regular waking day simply by focusing in the same manner as they have during this exercise.

It can be very empowering for the client to develop their own script which they can then read when they are feeling overwhelmed or in need of self-rescue. This can also assist the client in becoming more creative and proactive in resolving their traumatic material.

Diaphramatic Breathing

If we watch an infant sleep, we will see the rhythmical movement of deep belly breathing. This is the ideal breathing for relaxation and the nourishing of the body with the breath. Again, it is important for the addicted survivor to recognize when they are in need of an exercise to self-soothe. For instance, many addicted survivors can relate feelings of anxiety to a "lump in their throat" or a "pain in their chest." These somatic experiences will act as a cue that feelings of safety may need to be addressed.

When we feel upset or anxious about something our breathing is often the first thing to change. It is likely to become shallow, rapid and jagged or raspy. If on the other hand, we were to practice an intentional diaphragmatic breathing, we would be more able to consciously regulate our breathing when we became upset.
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Find a comfortable, unrestricting position to sit or lie in. Place your hands on your belly as a guide to the breath. Begin to consciously slow and smooth out the breath. Just noticing the rhythm of the breath through the inhalation and exhalation. Is it smooth, deep and full or jagged, shallow and slight? Now focus on bringing a deeper breath into the belly. Let a full

breath be released on the exhalation. Inhale fully, not holding the breath at any time. On the exhalation release completely and pause, counting to 3 after the exhalation is complete. Then inhale slow full and deep. Continue to focus in this manner on the breath.

Gentry (2002), suggests placing one's clasped hands behind the neck. This opens the chest through the lifting and spreading of the elbows. As this occurs, breath moves much more freely deep into the belly, thus allowing an excellent alternative (to hands on the belly) for those just learning deep breathing exercises.

At first, the individual is taught to deep breath in sets of 5. Then this is increased to 10 inhalations and exhalations. Finally, an instruction is given to practice 2 times each day for 5 minutes per day. In this way, the individual is learning to relax through deep breathing.

3-2-1 Sensory Grounding

This technique assists the trauma survivor in developing the capacity to "self-rescue" from the obsessive, hypnotic and numinous power of the traumatic intrusions/flashbacks. It is based on the assumption that if the survivor is able to break his/her absorbed internal attention on the traumatic images, thoughts and feelings by instead focusing on and connecting with their current external surroundings through their senses (here-and-now), the accompanying fight/flight arousal will diminish. This technique will assist the survivor in understanding that they are perfectly safe in their present context and the value of using their sensory skills (sight, touch, smell, hearing, and even taste) to "ground" them to this safety in the present empirical reality.

1. Begin by asking the client to tell part of their trauma narrative and allow them to begin to experience some affect (reddening of eyes, psychomotor agitation, constricted posture).
2. When they have begun to experience some affect (~ 5 on a SUDS Scale), ask them "would you like some help out of those uncomfortable images, thoughts and feelings?
3. If they answer "yes," ask them to describe, out loud, three (3) objects that they can see in the room that are above eye level. (Make certain that these are physical, not imaginal, objects).
4. Ask them to identify, out loud, three (3) "real world" sounds that they can currently hear sitting in the room (the sound can be beyond the room, just make certain that they are empirical and not from the traumatic material).
5. Hand them any item (a pen, notebook, Kleenex), and ask them to really feel it and to describe, out loud, the texture of this object. Repeat this with two additional objects.
6. Return to objects that they can see and ask them to identify now two (2) objects that they can see, above eye level. Do the same with things that they can hear and feel (instead of handing items to the client, ask them to reach out, touch, and describe the texture of two objects). Repeat this now with one object each for sight, sound, and texture.

When completed, ask the client "What happened with the traumatic material?" Most of

Safe-Place Picture with Anchoring & Transitional Object (alternative to Safe Place Visualization)

- Distribute paper and colored markers
- Tell client: *Draw a picture of a place that is safe and comfortable...it can be some place from your memory, that you been to before, or some place from your imagination, some place you've not yet been...just take the next five minutes to draw a picture that makes you feel safe and comfortable*
- Tell client "STOP" after 5 minutes
- Ask them: "May *I approach you?"*
- With permission, approach them and ask them to tell you about their drawing.
- Before they start hand them a polished stone and say to them: *"You know how you have memories and flashbacks of those BAD things that have happened to you? And how uncomfortable the feelings associated with those memories can be? Well some scientists found out several years ago that you can make flashbacks of GOOD memories also—so that you can call up to the present those positive feelings associated with this drawing in times when you are scared or overwhelmed. Would you like to give it a try?* If so, ask them: "Then *I would like for you to squeeze all those positive feelings from that drawing into that stone while you are telling me the story of that picture. Ready to start?"*
- Participate in the narrative...ask questions and provide support. When done ask how they are feeling.

Postural Grounding

- While the client is exhibiting the constricted and fetal posture, ask her/him, "How vulnerable to do feel right now in that posture?" You will usually get an answer like "very."
- Ask them to exaggerate this posture of constriction and protection (becoming more fetal) and then to take a moment to really experience and memorize the feelings currently in the muscles of their body.
- Next, ask them to, "stand up, and turn around and then to sit back down with an ADULT POSTURE—ONE THAT FEELS' IN CONTROL." [It is helpful for the clinician to do this with the client as demonstration].
- Ask them to exaggerate this posture of being IN CONTROL and to now really notice and memorize the feeling in the muscles of their body.
- Ask them to articulate the difference between the two postures.
- Ask them to shift several times between the two postures and to notice the different feelings, thoughts, and images associated with the two opposite postures.
- Indicate to the client that they are now able to utilize this technique anytime that they feel overwhelmed by posttraumatic symptoms— especially in public places.
- Discuss with the client opportunities where they will be able to practice this technique and make plans with them for its utility.

Containment with Envelope (Trauma Containment or Session Closure)

When a client is either overwhelmed by a trauma memory or has accessed some difficult material in the last 1/3 of a session you can use this technique to contain the traumatic material or safely bring a session to a close.

- (FOR SESSION CLOSURE) Give client paper and colored markers...ask them to draw what it feels like inside right now. 2 minutes only.
- (FOR TRAUMATIC CONTAINMENT) Give client paper and colored markers...ask them to draw what it feels like inside right now. 2 minutes only.
- After two minutes say: *STOP. Put your marker down and look at me.*
- While client has been drawing, retrieve a 9 x 12" envelope. Ask client to place their drawing in the envelope. Next, hand client a stapler and tell them: *Put as many staples in the top of this envelope as you need to make certain that this drawing stays in here.* Allow client to staple as many times as they wish.
- Say to client something like: *OK. You and I both know that you still have some work to do on this material and we'll get to it. However, therapy happens here, in my office, and life happens out there. If it is OK with you, I would like to hold on to this drawing and all the fear and feelings associated with it. I will keep it safe, locked in my filing cabinet. When you are ready to work on it, we will take it out and address it. But until then, will it be OK if I hold on to it?*
- Remember to show to client upon their first return to your office following this session and ask them if they wish to address this material today or wait until another day.

Self-Rescue from Abreaction

- Signs of abreaction: shaking leg, wringing hands, fetalization of posture, downward fixation of eyes, tearfulness, flat or pressured speech, describing trauma with present-tense verbs.

- If you have a spontaneous abreaction, go to step "c". If your client does not spontaneously exhibit an abreaction during the first few sessions, it will be important for you to attempt to elicit or trigger one. You can do this by asking you client: Tell me the worst part of that trauma (look/listen for the above signs).

- After about 5-10 seconds of you client exhibiting progressive signs of an abreaction, get their attention by whistling or waving your hands followed by saying their name out loud. Ask them: Would you like some help out of that place and to learn how you never again have to get stuck there...so you can always pull yourself back out? Elicit "yes" response from client.

- Ask client to describe, out loud, three (3) objects that they can see in the room that are above eye level. (Make certain that these are physical, not imaginal, objects).

- Ask them to identify, out loud, three (3) "real world" sounds that they can currently hear sitting in the room (the sound can be beyond the room, just make certain that they are empirical and not from the traumatic material).

- Hand them any item (a pen, notebook, Kleenex), and ask them to really feel it and to describe, out loud, the texture of this object. Repeat this with two additional objects.

- Return to objects that they can see and ask them to identify now two (2) objects that they can see, above eye level. Do the same with things that they can hear and feel (instead of handing items to the client, ask them to reach out, touch, and describe the texture of two objects). Repeat this now with one object each for sight, sound, and texture.

- When completed, ask the client: What is different than it was 90 seconds ago? Most of the time your client will describe a significant lessening of negative feelings, thoughts and images associated with the traumatic material.

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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