Mental health professionals in recent years have begun to speak of complex traumatic stress or complex psychological trauma (Courtois & Ford, 2009), complex posttraumatic stress disorder (Herman, 1997, 2009), and complex trauma (Warshaw, 2010) that can result from prolonged and repeated abuse, especially if the abuse began in early childhood or came from multiple sources.

Some experts distinguish between “Type I” trauma – resulting from a single incident such as a serious car accident, a natural disaster, or a one-time episode of abuse or assault – and “Type II” complex or repetitive trauma resulting from child physical or sexual abuse, severe domestic violence or community violence that is ongoing and chronic (Courtois & Ford, 2009).

The histories of people with complex trauma generally include a variety of abusive experiences across the life cycle rather than a single act of abuse (Warshaw, 2010). That is, they live in chronically abusive environments that combine varied types of abuse and neglect. As children they often experienced combinations of emotional, physical and sexual abuse; parental substance abuse; being a witness to domestic violence; having a parent or parents with psychiatric illness; and/or incarceration of a parent (Kinsler, Courtois & Frankel, 2009).

Social marginalization and oppression are likely to exacerbate or complicate complex trauma symptoms (Briere & Spinazzola). Courtois and Ford (2009) list several cumulative adversities faced by individuals, communities, ethnocultural minority groups and societies that may lead to – as well as worsen the impact of – complex trauma. Some of these include living in an impoverished neighborhood; incarceration; homelessness; having physical, developmental, intellectual or psychiatric disabilities; being sexually or physically re-victimized as children or adults; and victimization through political repression, genocide, “ethnic cleansing,” torture or displacement.

Judith Herman (2009) emphasizes two major points about complex trauma:

• Such trauma is embedded in a social structure that permits the abuse and exploitation of subordinate individuals or groups.

• Such trauma is relational. It takes place when the victim is in a state of captivity, under the control and domination of the perpetrator.

Effects of complex trauma

Because of its extreme nature, complex trauma can have a profound impact on an
individual’s personality development and basic trust in primary relationships (Courtois & Ford, 2009; Warshaw, 2010). Herman (1997, 2009) lists several common long-term effects of complex trauma on survivors:

- **Emotion regulation problems.** People with complex trauma often experience difficulty managing their emotions. They may experience severe depression, have thoughts of suicide, or have difficulty controlling their anger. They may experience numbing, or an absence of emotions other than anxiety, guilt, shame and sadness.

- **Changes in consciousness.** Following exposure to chronic trauma, a person may repress memories of the traumatic events, experience intrusive flashbacks, or experience dissociation.

- **Somatization.** Survivors of complex trauma may experience unexplained physical pain or medical problems.

- **Changes in expectations regarding personal relationships.** People who have been repeatedly traumatized often expect to be assaulted, betrayed, exploited or abandoned by significant others, or people to whom they turn for help, because this has been their lifetime experience.

- **Spiritual alienation.** People exposed to chronic or repeated traumatic events may develop a fundamental sense of alienation from themselves, other people, and spiritual faith as a result of feeling permanently damaged. They may experience existential or spiritual changes in their view of the world, including loss of faith in humanity or a sense of hopelessness about the future.

A survivor shares her experience with dissociation:

“I was being sexually abused from as far back as I remember. My first memory of sexual abuse was when I was three, when my father raped me. At the point that I felt overpowered by him, I panicked, and my mind automatically and instinctively separated itself from my body. I dissociated. I went up to the ceiling. I went as far away as I could from what was going on and watched, as if it was happening to someone else. It looked like me, but it wasn’t me. So I didn’t feel the panic. I didn’t feel the physical pain or the emotional pain.”

Another survivor talks about feelings of being “damaged”:

“The first time I was abused sexually, my parents went to a convention, and had some friends babysit us. I was the oldest. I remember there was drinking and it was two males. They were brothers. I remember waking up and the man’s hand was touching me, and I took his hand off, and it wasn’t too hard to get away because he was almost passed out. I don’t know why I did this, but I grabbed the rest of my brothers and sisters. And I remember my younger brother, who was out in the kitchen with this other man, was being abused sexually. So I remember taking them
all and going to a neighbor’s house. I don’t remember anyone telling me not to say anything, but the neighbor came in and they cleaned everything up, put the booze out of the house, picked up all the cans, cleaned up the house. So I don’t know if that gave me the message that I wasn’t supposed to say anything, or it was my fault. So I had that happen, and I attribute that to the way I felt about myself – like I was dirty, or it didn’t matter anymore.”

People with a history of complex trauma have a higher risk for medical conditions, substance abuse and mental illness (Pease, 2010). Physical problems such as irritable bowel syndrome or fibromyalgia are also common, but often dismissed by physicians as “not real” or “all in one’s head” (Leal-Covey, 2011).

A lack of response or protection, secrecy, denial or victim blaming from people in a position to help the victim can severely exacerbate the impact of trauma. This circumstance has been labeled the second injury or betrayal trauma (Courtois & Ford, 2009). Strengths and resilience factors can mitigate these effects.

Resilience is the capacity for successful adaptation despite challenging or threatening circumstances (Warshaw, 2010). Resilience factors may include having the support of caring adults or peers, ability to engage other people, and ability to access resources (Pease, 2010). The response of caring adults can play a large role in the degree of resilience an individual develops. A survivor shares:

“My next-door neighbor, because we lived in a duplex, could hear that my father was hurting us. She’d hear my father yelling at us. She’d hear us crying and screaming. So when my mom went to work, instead of leaving me at home with my father, she arranged for me to go next door and stay with this 72-year-old woman. She had very little education. She grew up in the fields of El Salvador. She was totally a gift, and she would never, ever have known that. She was an incredible influence on my life. She let me know that she could hear what was happening in our home, and she let me know that what my father was doing was wrong.”

Barriers to service

Survivors of complex trauma face particularly tough barriers when they try to get the right kind of help from the social service system:

- Because of the number and complexity of their symptoms and issues, survivors of complex trauma often receive services that are fragmented and incomplete. All too commonly, neither the provider nor the person seeking help recognizes the link between the presenting issues and the history of chronic trauma (Herman, 2009).

- Certain behavior may pose challenges for advocates and other providers. Because of their characteristic difficulties in close relationships, survivors of complex trauma are particularly vulnerable to revictimization by caregivers. They may become engaged in
SAFETY ISSUES: COMPLEX TRAUMA

Herman (1997) identifies several safety concerns that providers should be aware of when working with survivors of complex trauma:

- A tendency to dissociate may make it difficult to form conscious and accurate assessments of danger.

- Survivors often have great difficulty protecting themselves in the context of intimate relationships because of difficulty establishing safe and appropriate boundaries with others. A tendency to denigrate themselves and to idealize those to whom they become attached may further cloud their judgment.

- Unconscious habits of obedience established during years of abuse can make survivors vulnerable to anyone in a position of power and authority.

- An empathic attachment to the wishes of others and an automatic, often unconscious wish to relive the dangerous situation and make it come out right may lead the survivor into reenactments of the abuse. The risk of rape, sexual harassment or battering, though high for all women, is approximately doubled for survivors of childhood sexual abuse.

- Survivors of complex trauma often feel unsafe in their bodies. Their emotions and their thinking may feel out of control, and they may also feel unsafe in relation to other people in general. A survivor shares:
  
  “I do have an eating disorder and I’m not in control of myself when I eat. Definitely my coping mechanism has been food and then my physical body looks as unhealthy as my emotional body.”

Creating a safe environment may require survivors to make major changes in their lives, and may entail difficult choices and sacrifices. Herman (1997) elaborates:

“Without freedom, there can be no safety and no recovery, but freedom is often achieved at great cost. In order to gain their freedom, survivors may have to give up almost everything else. Battered women may lose their homes, their friends and their livelihood. Survivors of childhood abuse may lose their families. Political refugees may lose their homes and their homelands. Rarely are the dimensions of this sacrifice fully recognized.”

ongoing, destructive interactions, in which the medical or mental health or social service system replicates the behavior of the abusive family (Herman, 2009).
• Individuals with a history of chronic, long-lasting trauma are frequently misdiagnosed in the mental health system, and often accumulate many different diagnoses before the underlying problem of a complex trauma syndrome is recognized. Three particularly troublesome diagnoses, according to Herman, have often been applied to survivors – somatization disorder, borderline personality disorder, and multiple personality disorder:

“Patients, usually women, who receive these diagnoses evoke unusually intense reactions in caregivers. Their credibility is often suspect. They are frequently accused of manipulation or malingering. They are often the subject of furious and partisan controversy. Sometimes they are frankly hated” (Herman, 2009).

• Because of encouragement by perpetrators and others to blame themselves for ongoing and repeated abuse, complex trauma victims may not seek help in situations where others would do so. A survivor shares:

“I remember my father being very violent. He would come home and have two days off from work. He was like a bear in a cage. The more he would drink, the more rage would come out, and then he would get out the belt. That was just kind of his normal routine. I think because he never taught me the importance of love and affection and respect for my mom and respect for myself, when I was sexually assaulted in high school, I was so ashamed of it and I was so fearful of him knowing that this happened, that I kept it to myself. He had trained me that when you misbehave the punishment is violence, so when I was assaulted I automatically assumed it was due to my bad behavior. It kept me from seeking help, and reporting it, and feeling like a crime happened. I felt like I had gotten into trouble and I needed to hide it the best that I could for as long as I could. Telling only meant more danger.”

• Victims of violence who are coping with several issues simultaneously may also feel immobilized due to the complexity of their situation. A survivor shares:

“My PTSD response was to become immobilized. The freezing thing – a couple of times I might have asked for help, had I not had the PTSD-conditioned response. To this day, there are still some times that, let something come at me sideways that’s unexpected, and I can go into a downward spiral. And then I think, ‘Oh my gosh, I don’t know what to do.’ So I can’t do anything.”

Empowering people with complex trauma

Here are some ways suggested by mental health professionals to empower people who are survivors of complex trauma:

• Educate survivors about trauma. Information about trauma and its impact may help individuals understand their reactions and develop increased self-compassion (Courtois, Ford & Cloitre, 2009).
Allow individuals to be in charge their own recovery. No intervention that takes power away from traumatized people can foster their recovery, no matter how much it appears to be in their immediate best interest (Herman, 2009). The goal of advocates or other providers is to be allies of the people they serve, placing all the resources of their knowledge, skill and experience at the disposal of the people who seek their help.

Resist the urge to rescue. In their desire to be helpful, some advocates and other professionals may get in the habit of assuming too much personal responsibility for the people they serve and doing everything for them, rather than assisting people in doing things for themselves. This may inadvertently send a message that we don’t believe people are capable of acting on their own behalf, and may feel patronizing and disempowering (Herman, 2009).

“We need to be empowering, not overbearing, not handing things to them, but have them do things independently,” says Daisy Barrera (2009), an advocate from Bethel, AK. A survivor shares:

“It took independence for me to be a very strong woman, to have that strength. I’m a firm believer: Somewhere, somehow inside, every person has strength. I’m here because of my strength, because of what I was willing to take a look at, what I was willing to do. It just boils down to individuality. Not dependency, but individuality.”

Practice humility. When we are wrong, we should promptly admit it. A sign of true competence is the willingness to acknowledge errors, blunders, and imperfections. Individuals who have survived interpersonal trauma are often not accustomed to relationships with people who admit errors and foibles, which makes repairing mistakes on the part of helping professionals both difficult and incredibly helpful (Kinsler, Courtois & Frankel, 2009).

Avoid judgmental attitudes. People do not choose to develop complex trauma issues. Assume the attitude that people who seek your help are doing the best they can and want what is best for themselves and their families. Karen Foley, a Seattle-based behavioral health specialist, says, “I think it would be abnormal not to have the ability to function affected when somebody’s been through trauma” (Foley, 2010).
• “Normalize” responses to traumatic situations. Consider how certain behaviors and beliefs make sense or could be a reasonable response to prolonged or repeated trauma. Don’t ask, “Why is this person acting this way?” Instead ask, “What happened to this person to trigger this response?” Herman (2009) explains the need to look at behaviors through the experience and resulting logic of the person who has survived trauma:

“The ‘characterological’ features of complex PTSD start to make sense if one imagines how a child might develop within a relational matrix in which the strong do as they please, the weak submit, caretakers seem willfully blind, and there is no one to turn to for protection. What kind of ‘internal working models’ of self, other, and relationship would be likely to develop under such circumstances? This thought experiment turns out to be quite useful clinically. One begins to understand the survivor’s malignant self-loathing, the deep mistrust of others, and the template for relational reenactments that the survivor carries into adult life.”

• Be willing to discuss “taboo” topics. For example, many people don’t want to talk about it, but some sexual abuse victims feel pleasure during the assault and feel guilty about this. If someone shares this with you, affirm for them that this is a natural response. Olga Trujillo, Director of Programs at Casa de Esperanza in St. Paul, MN, says:

“Your mind is trained automatically, instinctively, to get you out of that situation in the best way possible. And that often is through pleasure. So you may feel pleasure at some point if you are sexually abused on a regular basis. Your body will do that. It is protection, and it is an automatic response for your body to feel pleasure” (Trujillo, 2009).

• Believe people who tell you about traumatic incidents. Do this, even if what they say seems to be “bizarre” or “paranoid.” A survivor shares:

“If I had to testify, I could never say that my father threatened my life. But my father threatened my life. My father killed all sorts of pets in our home, not always in front of us, but he put them in positions where we’d find them, and we’d know he was the one who killed them.”

Working with other providers

Intensive service coordination is crucial for people with complex trauma issues. Because of the cumulative nature of complex trauma, survivors are likely to have multiple issues needing attention and to have experienced difficulty accessing the right kinds of help. Keep these ideas in mind when working with other providers:

• Train mental health professionals about the dynamics of domestic violence, sexual assault and sexual abuse, and how victims may manifest the effects of these traumas.

• Refer to providers who understand complex trauma and dissociation, and emphasize
trauma-informed services (Trujillo, 2009). Trauma-informed care can be defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health care and other types of services (Huckshorn, 2004). Trauma-informed care provides a new paradigm under which the basic question is transformed from “What is wrong with you?” to “What has happened to you?” (NCTIC, n.d.)

• If possible, cultivate a pool of private practice therapists who are each willing to accept one or two people on a pro bono basis for long-term therapy. Because of the complexity of their issues, people who are survivors of complex trauma often require more intensive, longer-term therapy than publicly funded agencies can provide. For some survivors, treatment may last for years, whether provided continuously or episodically (Courtois, Ford & Cloitre, 2009). One survivor shares how important such long-term support was for her:

   “I would go to my therapist in the winter months and escape to seasonal summer work. I did this for five years and my therapist was supportive and understanding. This patience with me was what I needed. Without it I would not have completed my mental health therapy.”

References

Barrera, D. Advocate, Barrow, AK. Personal interview with Debi Edmund, November 2009.


Foley, K., Triple Play Connections, Seattle, WA. Personal interview with Debi Edmund, July 2010.

Herman, J.L. (1997). Trauma and recovery: The aftermath of violence from domestic abuse to political terror. New York: Basic Books.


