Tamara McClintock Greenberg

Treating Complex Trauma

Combined Theories and Methods

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Preface

Despite significant increases in the numbers of therapeutic treatments offered to the public, people who have experienced complex trauma struggle to find relief from debilitating symptoms. Complex trauma or complex post-traumatic stress disorder (cPTSD) differs substantially from a diagnosis of PTSD. Complex PTSD impacts the identity of people afflicted and is thought to be more difficult to treat. Common symptoms of cPTSD include relationship difficulties, suicidality, physical symptoms, substance use, dissociation, difficulty regulating and modulating emotions, and a sense of meaninglessness. These latter three experiences (referred to in some literature as disturbances of self-regulation) often co-occur with what we think of as traditional PTSD symptoms, such as hypervigilance, re-experiencing traumatic events, psychic numbing, and avoidance. Though many people who have experienced trauma can appear to have lives that are well-adjusted, some are so impacted by symptoms they have not been able to develop careers or have meaningful relationships.

As I will argue throughout this book, complicated clients need multiple and flexible approaches to help them get better. I think we can help people who have been impacted by severe trauma, but it requires viewing them through a different lens. This starts with considering developmental adaptations required of trauma survivors and that some of the labels we have ascribed, especially ideas that they have personality disorders, no longer suit us or the people we care for.

I think the recent rise in interest of complex trauma is a healthy reaction to decades of pathologizing clients and worse, leading people to believe their conditions are beyond help. Current research and clinical observations support the idea that a trauma-informed approach to treatment provides hope for clients who may have not had the benefit of a more empathic and comprehensive understanding. It's not just minds that are impacted by trauma, bodies are too. Many of the symptoms we can find difficult and vexing often have neurobiological underpinnings, meaning clients who often want to have different kinds of lives feel forced into patterns they cannot help but repeat. Dissociation is common in people who have cPTSD, which means that clients have built-in defenses that can challenge our assessment and intervention skills. People who have survived repeated trauma need us to adapt and

shift in order to accommodate where someone lives emotionally at a given point and time. This includes willingness to be flexible with and knowledgeable of different therapeutic techniques and methods.

This volume will focus on several aspects of therapeutic treatment for persons who have experienced complex childhood and adult trauma. It will focus on what we know, which is that empathy and the stability of the therapeutic relationship explain therapeutic outcome more than any other variable. However, while our relationships are vital, treatment with people who have cPTSD also requires clinicians who can think in a flexible and moment-to-moment way about what clients need. Some therapists emphasize one or two main approaches and then assume or hope that these approaches can apply to the many diverse clients that present for help. While advocates of different theories claim they have the right answer, therapeutic technique accounts for only roughly 15% of the variance of therapeutic outcome. Adding to the confusion, there is no one superior theory for treating trauma. All empirically validated approaches have roughly equal efficacy. Clinicians, who have become increasingly tribal in the wars on theory, have failed to utilize combined approaches, which I'll argue is a great tragedy for the people who need our help.

In this book, I will provide a framework for helping the most complicated and challenging people we face as clinicians. Despite a large number of therapeutic theories and modalities within our field, there is confusion among even very skilled clinicians about how to be helpful. However, what concerns me most is the trend among some to advocate one or two theories and accompanying techniques and then to apply these techniques to most or all clients that seek treatment. Such an approach is limited. There is no one-size-fits-all approach to the treatment of complex trauma.

There was a time when clinicians were taught multiple ways to help people and were encouraged to use all available "tools in the toolbox." A person needing help walked in the door and the clinician decided which approach would work best based on symptoms and presentation, including DSM diagnoses, values and beliefs, cognitive and learning style, coping skills, behaviors, character structure, current and past relational attachments, and family history. While many approaches may still be taught in graduate programs, the current climate of psychotherapy research and practice is akin to a horse race. Clinicians have a curious investment in proving that they have the best theory and technique, as opposed to thoughtfully considering which approaches work best for whom and, most importantly, what techniques the client can tolerate.

We are fortunate to have a number of options for helping people. In this book I will focus on my nearly 30 years of experience of helping clients, what I have learned from them, as well as supervising and teaching younger colleagues eager to learn about the variety of ways to alleviate human suffering. This book will be a guide for therapists who may not have had the benefit of learning multiple approaches. For people who are new to the field, I hope to provide examples of how to think in ways that move beyond just techniques and that my explanations of my missteps can be useful and informative. It may also be helpful to well-seasoned

clinicians who are looking for additional ways to think about the multiple avenues we can use to help clients with cPTSD. I'll offer client examples, ideas for interventions, and explanations regarding what I say to clients and why. I'll introduce the concept and technique of clinical hypothesis testing and how constant evaluation of people in our care can lead us to choose or alter treatment approaches; often this is necessary in just one session. I'll discuss ways to provide ongoing assessment of clients and ideas for when specific therapies should be used or avoided.

It was as gratifying as it was challenging to weave in multiple theories and methods for treating complex trauma, many of which literally have different languages and typologies to describe the impact of the many terrifying experiences faced by the people we are trying to help. There are many important ideas about how to help people who have survived repetitive and multiple traumas. But no theory can do it all, and I learned as I talked with talented clinicians and researchers that we all can learn a lot from each other.

In this book I will offer a number of overarching themes about what seems to make therapy work for people who have endured trauma. These include the therapeutic relationship, clinical hypothesis testing, the use of several and flexible approaches, and the importance of mentalizing and the imagining of psychic experience as key aspects of facilitating therapeutic change. At times, I will express my preference for various CBT approaches; at others. I might imply my use of modern psychodynamic methods that focus on the present and current relational functioning. I assume the reader of this book already has ideas about how to help people with their own preferred methods. My disclosure of what techniques I use and when is not meant to be implemented in a rigid way. I trust the reader can determine for herself or himself what works best for whom and when. My main goal is just to implore us to think about how we need to use many techniques to help people. Flexibility is what I am advocating for here.

I will address the most challenging aspects of care. After describing the benefits and limitations of multiple empirically validated approaches, I will focus on how to help clients feel safe, including the important aspects of neurobiology and physiological responses that work together with psychological constructs to reinforce that the world is a dangerous place. I'll emphasize the importance and clinical utility of thinking about, imagining, and managing fear. I will address suicidality early on in this book as suicide and deaths of despair are at near-epidemic levels in the United States and elsewhere. Following that, I will describe the important phenomena of dissociation and how understanding this process is vital to clinical work. I will discuss substance use in detail and the variety of ways we can think about and help people who need to excessively numb themselves from their own thoughts and feelings. As trauma often lands in the body, an entire chapter is devoted to physical concerns among trauma survivors. Another problem that has both physical and psychological etiology is aggression and anger. I'll describe ways to provide support and safety among clients who simply cannot control more aggressive aspects of their behavior, as well as the devastating impact of anger when turned on the self. As we increasingly realize that cultural and systemic aspects of racism and other forms of discrimination are important contributors to mental health and can be

traumatic, I will describe research and clinical experiences impacting people who have historically been negated and minimized. Finally, I will discuss the very real impact of vicarious trauma and self-care in the trauma therapist and ways we can consider how to take care of ourselves while taking care of others.

A few notes about how I describe clinical material and emotionally charged topics. A lot of trauma books go into details about specific kinds of abuse, victimization, and traumatic events. Since I am assuming that the reader is aware of the many kinds of traumas people experience, I am going to limit details of traumatic events. In my experience as a reader of books on trauma, I sometimes find detailed discussions of horrific events to be unnecessary. Additionally, since statistics suggest that a number of people reading this book might have histories of trauma, I'd like to keep the material from being too overstimulating. It's not that I don't discuss difficult material, but I do so with the least amount of information possible, so that I can still get my point across. This is also to protect confidentiality. And on that note, although cases are described in this book, they are heavily and judiciously composite. Any details have been additionally disguised to protect privacy.

San Francisco, CA, USA Tamara McClintock Greenberg

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Finally, though, if it were not for my clients who entrusted me with their care, this book would not be possible. It is from them I have learned and continue to learn how to heal trauma. This book is because of them and for them. I hope it speaks to their experience and to the many lost voices and identities that trauma has attempted to take away.

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Chapter 1
The Need for Utilizing Multiple Approaches for Complex PTSD: No Theory Has It All

Introduction: Complex Clients Need Multiple Approaches

Despite significant increases in the numbers of therapeutic treatments offered to the public, people who have experienced complex trauma struggle to find relief from debilitating symptoms. Complex trauma or complex post-traumatic stress disorder (cPTSD) differs substantially from a diagnosis of PTSD. Introduced by Herman (1992) and expanded upon most notably by Van der Kolk (e.g., 1994, 1996; Van der Kolk et al. 2012) and Courtois and Ford (2009, 2013), cPTSD impacts the identity of people afflicted and is difficult to treat. Common symptoms include relationship difficulties, suicidality, physical symptoms, substance use, dissociation, difficulty regulating and modulating emotions, and a sense of meaninglessness. These latter three experiences (referred to in some literature as disturbances of self-regulation, or DOS) often co-occur with what we think of as traditional PTSD symptoms, such as hypervigilance (that may co-occur or be misconstrued as hypomania; I'll speak to this more in subsequent chapters), re-experiencing traumatic events, psychic numbing, and avoidance. Though many people who have experienced trauma can appear to have lives that are well-adjusted, some are so impacted by symptoms they have not been able to develop careers or have meaningful relationships. Consider the following case example:

Melanie is a 30-year-old woman who came to therapy after a partial hospitalization program. She landed in San Francisco a few years ago after getting her "dream job" as a software engineer at a start-up. Though she was excited about moving from another part of the country, by the time we met, she had been fired from her third job. She could not tell me exactly why she was let go from her previous positions, though was able to say that she didn't like her most of her co-workers or bosses. After she lost her third position, Melanie became increasingly anxious, with frequent panic attacks. She thought in these moments she was dying. Her anxiety, however, was equally matched by severe episodes of depression, and she had days where she could not get out of bed. Eventually she thought a lot about suicide and

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on the eve of a visit from her family emailed her mother and told her she was going to kill herself. Her panicked mother called the police and Melanie was brought to a hospital for evaluation. She denied being suicidal and said she did not even remember sending the email. The psychiatrist assessing her was concerned but did not feel he had enough evidence for a mandatory psychiatric hold but convinced Melanie to enter into a partial hospitalization program, which she attended for 3 weeks.

When we met, Melanie appeared to be very astute psychologically. Though she initially told me this was her first time having difficulties, I eventually learned that she started therapy in college and had seen "six or eight" therapists before myself. She couldn't tell me much about her life, except that she knew she needed to find a job and she worried about what her parents might think if she remains unemployed. She had a boyfriend, but it was hard to get a sense of how serious the two were, as they had been dating roughly 3 months. Regarding her upbringing, she reported stoically that her parents were "good to her" with very vague details about their lives and careers, and she denied any difficulties growing up that might contribute to her current situation. She said she kept thinking if she could just find the right job, with people who understood her abilities, then everything would be okay. When asked if she had thoughts about starting therapy again, she looked at me blankly and said, "Well, if this helps, that would be good. I don't know if it will."

Compared with other clinical issues, we know relatively little about cPTSD. For example, the diagnosis was not included in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, though it will be included in the ICD-11 (Brewin 2019). Part of the reason for the DSM omission and the relative lack of attention paid to this diagnosis may be because cPTSD symptoms overlap with other symptoms of mental illnesses. For example, researchers have noted overlap between cPTSD and borderline personality disorder (e.g., Ford and Courtois 2014). Among many clinicians, cPTSD is a euphemism for personality disorders. I was recently talking with a younger clinician finishing his fourth year of graduate school. When I told him I was writing a book about complex PTSD, he said, "Oh, so personality disorders." I'll discuss this issue in much more detail in the next chapter, but the complexity of treating people who have experienced severe, repetitive traumas, I think, has led to difficulties involving both inaccurate and compassionate diagnoses. Some people, especially those who have more symptoms of disturbances of self-regulation, may seem *personality disordered* to some clinicians. What is often meant by this moniker is that patients seem brittle in their defensive structure, they may have little external support due to social isolation (presumably because they have difficulty with relationships), they may be prone to suicidal thoughts and/or excessive use of substances, they may appear overly concrete or literal in their thinking (suggesting to some clinicians that they may not appreciate symbolic or abstract interpretations), and sometimes, we feel uncomfortable in their presence. Maybe they seem angry, or perhaps they are envious or hesitant to be dependent on us and trust our authority. Suspicious people often fall into the category of "difficult" and are certainly not sought after as patients. And yet, many of these symptoms are common among people with cPTSD.

Some people with cPTSD have been viewed as being too challenging to help, as their character styles are already baked in. Childhood trauma does impact how or if we develop a cohesive sense of self, as well as our personality style, the capacity to tolerate stress, the ability to form healthy relationships, etc. Adult trauma can shake the foundation of self-structure, at times causing it to collapse (Boulanger 2007).

No matter how we theorize it, these clients are often complex and vexing. Some of us also worry these clients will be aggressive and may be unable to form a good working relationship, and for those who use structured cognitive behavioral therapies, worries abound that the client will not be compliant. Yet despite the challenges, there's something just not quite right and a bit unfair regarding how some of these clients have been viewed. One problem with the ways we've focused on maladaptive personality traits is that if we begin treatment with the idea that someone is "characterologically disturbed," we tend to lack sympathy. Some may also worry that these clients cannot be helped, a hangover from the older teachings on the treatment of people with personality disorders. Conversely, if we think of someone as having survived trauma, we generally tend to not only have more empathy, but we may try harder to help. Additionally, we may rightly assume that it will take the client a long time to trust us, and our expectations regarding compliance and the development of therapeutic alliance could be more tempered. As we will see throughout the course of this book, we often have to be creative and flexible in order to help some of the clients who show up in our offices. My main point is that if we think of people through a trauma-focused lens, we are often more able to access empathy and our own motivation as helping professionals. Indeed, no matter what kind of therapy we practice, no matter what kind of techniques we prefer, we are often treating coping mechanisms that originate from something that worked at some point before they met us. If we start with that premise, we may be more inspired to find ways to help.

I think the recent rise in interest of complex trauma is a healthy reaction to decades of pathologizing clients and worse, leading people to believe their conditions are beyond help. Modern research and clinical observations support the idea that a trauma-informed approach to treatment provides hope for clients who may have not had the benefit of a more empathic and comprehensive understanding. It's not just minds that are impacted by trauma, bodies are too. Many of the symptoms we can find difficult and vexing often have neurobiological underpinnings, meaning clients who often want to have different kinds of lives feel forced into patterns they cannot help but repeat. Dissociation is common in people who have cPTSD, which means that clients have built-in defenses that can challenge our assessment and intervention skills. People who have survived repeated trauma need us to adapt and shift in order to accommodate where someone lives emotionally at a given point and time. This includes willingness to be flexible with and knowledgeable of different therapeutic techniques and methods.

This volume will focus on several aspects of therapeutic treatment for persons who have experienced complex childhood and adult trauma. It will focus on what we know, which is that empathy and the stability of the therapeutic relationship explain therapeutic outcome more than every other variable. However, more than a

good relationship is needed for patients to get better. Our relationships are vital but also require clinicians who can think in a flexible and moment-to-moment way about what clients need. Some therapists emphasize one or two main approaches and then assume or hope that these approaches can apply to the many diverse clients that present for help. While advocates of different theories claim they have the right approach, therapeutic technique accounts for only roughly 15% of the variance of therapeutic outcome. Adding to the confusion, there is no one superior theory for treating trauma. All approaches have roughly equal efficacy. Clinicians, who have become increasingly tribal in the wars on theory, have failed to utilize combined approaches, which I'll argue is a great tragedy for the people who need our help.

In this book, I will provide a framework for helping the most complicated and challenging people we face as clinicians. Clients such as Melanie often bounce from one therapist to another looking for help. Despite a large number of therapeutic theories and modalities within our field, there is confusion among even very skilled clinicians about how to be helpful. However, what concerns me most is the trend in the field to advocate one or two theories and accompanying techniques and then to apply these techniques to most or all clients that seek treatment. Sometimes clients who see therapists who have only one or two tools in their toolbox can feel that they, as clients and trauma survivors, are broken and unfixable. This is often not true. There is no one-size-fits-all approach to the treatment of complex trauma. And the reality is that for people with cPTSD, during one session, a particular method may work. The next session, a whole new approach may need to be used. As one trauma expert described, "We need to be able to just sit in a room with clients before rushing in with our approach or technique." No matter which therapy we use, it's all about the relationship and relating to a client in a human and authentic way.

There was a time when clinicians who went to grad school were taught multiple ways to help people. A person needing help walked in the door and the clinician decided which approach would work best based on symptoms and presentation, including DSM diagnoses, values and beliefs, cognitive and learning style, coping skills, behaviors, character, and current and past relational attachments and family history. While many approaches may still be taught in graduate programs, the current climate of psychotherapy is akin to a horse race, in which clinicians have a curious investment in proving that they have the best theory and technique, as opposed to thoughtfully considering which approaches work best for whom and most importantly, what techniques the patient can tolerate. We are fortunate to have a number of options for helping people. In this book I will focus on my nearly 30 years of experience of helping clients, what I have learned from them, as well as supervising and teaching younger colleagues eager to learn about the variety of ways to alleviate human suffering. This book will be a guide for therapists who may not have had the benefit of learning multiple approaches. I'll offer client examples, ideas for interventions, and explanations regarding what I say to clients and why. I'll introduce the practice of clinical hypothesis testing and how constant evaluation of people in our care can lead us to choose or alter treatment approaches; often this is necessary in just one session. I'll discuss ways to provide ongoing assessment of clients and ideas for when specific therapies should be used or avoided.

The rest of this chapter will review the data on efficacy in psychotherapy and how overreliance on technique or theory neglects the most robust indicator of therapeutic success—the relationship between therapist and client. That being said, I will also briefly review the most common empirically validated therapies used to address PTSD and cPTSD. I'll discuss the controversies that exist in the field and challenges in the study of people with PTSD and cPTSD, and I'll introduce the notion of clinical hypothesis testing and how we can begin to apply that concept from the first meeting. First, let's think about trauma and what it actually means.

What Is Trauma and Who Gets to Define It?

Upon hearing about this project, a few colleagues urged me to define trauma with specific concerns that this term has been overused and overapplied. At first I was a little defensive about these comments. I assumed that trauma and traumatic events were obvious. Then one of my colleagues showed me a flyer for a conference entitled, "The Trauma of Falling in Love." I started to get the point. At that time I wasn't aware that there have been calls for people in the mental health field to limit the use of the term trauma. One author noted that it's problematic for us to interpret adversity as trauma and describes this in the context of suffering as being integral to the human condition (Haslam 2016). In an opinion piece in the *Chicago Tribune*, Haslam describes the problem as when people describe trauma in response to "microaggression, reading something offensive without a trigger warning or even watching upsetting news unfold on television." He even refers to someone describing a "hair trauma" because she did not like the texture of her hair. I appreciate the point that Haslam and others have made about the overuse of the term trauma. I am also cognizant of the debates on college campuses, for example, regarding the request for "trigger warnings" when students are exposed to something that might be unpleasant. I can understand where it could go too far, the idea that people should be protected from certain facts because they make them uncomfortable. However, it also occurs to me that what may be described as traumatic by some has meaning that could be explored in a therapeutic relationship with a sense of curiosity about what specifically feels traumatic. Just because someone says they were upset by something they read or heard in a college class does not mean they have not been traumatized, though I would agree that the specific "trigger" may not be a trauma. However, triggers can feel traumatic as they can remind people of more severe and dangerous episodes in their lives. We should try to understand the meanings of people's concerns. In other words, I agree with the criticisms about the overuse of the word trauma and the way the word has lost some meaning in our lexicon. Yet, people do get triggered by material that reminds them of something terrible and frightening that happened to them. If we look at statistics, even just on how many people experience sexual assault, they are sobering. According to the Centers for Disease Control (Smith et al. 2018), more than one in three women and nearly one in four men have experienced sexual violence involving physical contact at some point in their lives.

Nearly 1 in 5 women and 1 in 38 men have experienced completed or attempted rape in their lifetimes. That's pretty striking. On the other hand, although 70% of the US population experiences at least one traumatic event in their lifetime, only approximately 6% develop PTSD (Breslau 2009; Pietrzak et al. 2011). This implies that we are incredibly resilient. Most of us do not develop PTSD from a single traumatic event. But traumatic events do have meanings that are woven into people's personalities. For example, I recall events in recent history in which public figures were accused of or actually admitted to sexual assault. Following those revelations I had many clients, some of whom I'd known for years tell me stories of similar things that had happened to them. They never considered themselves victims, they thought it was normal and that it happens to everyone, or they simply "forgot" about it. In fact, it's important to remember that many people who experience sexual assaults, abuse, and many other devastating traumatic events often don't advertise this. Shame quiets people.

As therapists, we should take an open and accepting stance about anything people want to describe, no matter how they label it. I also don't feel that we should define experiences for our clients. Although we may think of something as traumatic, we need to see if our clients feel that way. As I'll discuss in the chapter on dissociation, we have seen the damage done from therapists defining a client's experience before they are ready to fully understand their histories. Whenever we purport to know more than a client about their history, we engage in a kind of identity theft. A client's history is theirs to tell, understand, and think about, if they want to. Complex PTSD already robs people of their identities, and if we tell people who and what they are and how they came to be, it reenacts experiences of someone exploiting their power and control. Basing psychotherapy on a relational model allows therapists and client to discover together the meanings and nuances of different life events.

In writing this book and describing trauma, I am going to talk about people who have been repeatedly subject to traumatic and adverse experiences. As we'll see, childhood trauma predicts adult trauma because of a number of complex variables and mechanisms. I'll describe the plight of veterans who often have histories of childhood maltreatment or neglect and go on to multiple deployments based on extended wars and conflicts. I'll discuss the damaging nature of extended periods of neglect in childhood and how this can be a form of trauma in children who do not have the developmental capacity to handle demands associated with emotionally or physically caring for themselves. Likewise, physical and sexual assaults in both childhood and adulthood force people to confront terror, confusion, and helplessness. I'll describe the impact of traumas experienced by adults who work as first responders, police officers, and emergency workers after natural disasters or violent community events and by those in countries in which there is sectarian violence, as well as alienation and discrimination based on gender, sexual orientation, race, ethnicity, and religion.

In other words, I will discuss situations in which the aggregate of hurtful, frightening, and out of control experiences leaves people with a variety of emotional problems that meet criteria for PTSD and cPTSD. I am not advocating a position of

people externalizing blame for their problems. Indeed, most people I see with backgrounds of trauma blame themselves. They feel responsible for the fact that they don't have better lives, that they have "let themselves" be victimized (which is not true, but a way to maintain a sense of agency and control). They feel confused about whether or not they are entitled to be treated well and they don't know if their thoughts and perceptions are realistic or not. I'm not too worried about clients overusing the term trauma largely because many people with complex trauma histories with PTSD want to avoid talking about what has happened to them. But when people do describe trauma, it's important to believe them, even though stories and feelings about trauma can shift over a lifetime and even over the course of treatment.

The remainder of this chapter will go on to distinguish differences between PTSD and cPTSD, and the rest of this book will describe the healing of wounds following multiple traumatic events.

Difficulties in the Study of Complex Trauma

Trauma survivors are an incredibly diverse group of people, and to use the language of researchers, heterogeneity is the enemy of clean research. Trauma experiences involve veterans in war scenarios, immigrants, and refugees who struggled to get to a safe country and spent time in camps, victims of childhood slavery and sex trafficking, and even those who, in some countries, experience violence related to being attacked for being part of some religious, racial, or sexual or gender minority groups. In addition, people who develop severe, life-threatening illnesses can experience PTSD symptoms, as well as people in traumatic accidents, victims of domestic violence, and people who were abused or neglected as children. This latter group may be the most complicated of all to treat and study for several reasons. First, people abused as children (and those with chronic traumatic experiences) are harder to treat with less successful outcomes. This makes sense, as childhood trauma can disrupt the ability to form a cohesive self that includes the ability to manage anxiety, stress, disappointment, and whatever adverse events that may be experienced throughout the lifespan. No matter what one's theoretical orientation, I think most of us agree that a safe and protected childhood, and one in which people feel loved, allows people to enter the world with a good ability to tolerate difficult emotions and the stress of life in general. I think of a secure childhood as creating a scenario for the development of a good relationship with one's mind and the presence of internal resources. Stress of any kind requires us to go inside of ourselves and to be able to know what we think and feel, as well as what we need. It also allows us to trust our feelings, an important skill especially in relationships, as it gives us confidence to be assertive and set limits. Trauma truncates our ability to think, but childhood trauma can create a paucity of internal resources and can limit the ability to recognize vital thoughts and feelings, and this creates a different starting place in psychotherapy. As I've argued (Greenberg 2016), we often expect that traumatized

clients have access to basic thoughts and feelings. If they do not, it can make psychotherapy more challenging.

Data supports these observations. Karatzias et al. (2019) reviewed the efficacy of interventions for cPTSD and found that childhood abuse was found to impact outcomes across all types of PTSD treatments, suggesting that "those with a history of childhood trauma may experience less improvement, and that current treatments for this patient population can be improved" (p. 10). Research suggests that the effects of trauma are cumulative. For example, Breslau et al. (1999) found that the development of PTSD symptoms from exposure to any traumatic event increased the risk that future trauma would result in PTSD. This finding has been explained as the stress sensitization hypothesis and supports that the cumulative effects of multiple traumas increase the likelihood of a more extreme response to future traumatic events (McLaughlin et al. 2010).

I'll talk a lot more about the influence of childhood abuse throughout this book. For now, however, it's also important to emphasize the sheer complexity of human adaptation and resilience, as well as the ubiquitous nature of traumatic experiences. That said, clinical research suggests that there is a continuum of PTSD and cPTSD, as we humans rarely fall into neat categories of diagnostic criteria. However, it's important we discern the distinction of PTSD and cPTSD and the clinical implications.

PTSD vs. cPTSD: Important Distinctions

Although there is often overlap between PTSD and cPTSD diagnoses, the qualitative distinction between PTSD and CPTSD symptomatology has been supported in different groups (Brewin et al. 2017), including those experiencing interpersonal violence (Cloitre et al. 2013), rape, domestic violence, traumatic bereavement (Elklit et al. 2014), and refugees (Hyland et al. 2018). The distinction between PTSD and cPTSD has also been confirmed in samples of young adults (Perkonigg et al. 2016). The World Health Organization will likely include cPTSD as part of the 11th edition of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11). Based on the papers from the aforementioned authors, as well as Rosenfield et al. (2018), the general consensus is that cPTSD involves more severe symptoms; PTSD is often thought to involve "discrete traumatic events or set of traumatic events" (p. 364).

People who have experienced trauma exist on a continuum of "simple" PTSD to cPTSD, with the latter tending to reflect what we often consider as persons who not only have classic PTSD symptoms but with significant disorders of self-regulation, dissociation, depersonalization, suicidal behaviors, substance abuse, relational instability, and self-injurious behaviors. In terms of our diagnostic criteria, however, these lines are becoming blurry. Note that for the first time, the DSM-V included a category for people with PTSD who have dissociation (APA 2013). Given the complex nature of trauma, the ways people with trauma histories in childhood often go

on to experience trauma as adults, as well as complex factors included in adult development, it can be difficult to tell the difference between PTSD and complex PTSD. However, complex PTSD does seem to affect attachment and relational development in a way that PTSD does not. To put a finer point on this, let's consider a case of PTSD in someone who does not have symptoms of cPTSD:

Ted, 26, was injured as a passenger in a ride-sharing service car. He was on his way to work on a dreary and foggy Tuesday morning in San Francisco and he was in a rush. The car he entered did not have a working seat belt. He mentioned this to the driver and the driver said there was nothing he could do. Ted had to make a quick decision. Should he risk the relatively low probability of getting into an accident or be late for work where he had an important meeting? He chose to stay in the car. While coasting through a green light, his driver's vehicle was hit by another car racing through the intersection. Ted was hit and sustained damage to his bladder, ribs, and right lung, but after a brief hospitalization was discharged. When I met Ted, he was in a great deal of pain, but had gone back to work. He had nightmares about the incident and reported that he kept seeing the face of the driver whenever he felt relaxed. He noted he had become "jumpy," and though he began walking to work so he could avoid taxis or ride-sharing services, he felt "afraid all of the time" that he would get hit by a car. He noted he had never felt this "helpless" before. Yet, Ted reflected that his husband had been "incredibly supportive" and his family who resided in another state offered to fly to California to help him if he needed it. Regarding his upbringing, Ted said that he felt very loved by his mother and father, one of whom was a college professor. Although coming out was difficult for him, he found his parents supportive, as one of them had a sibling who was gay. He had experienced some bullying in high school, which he said may have been linked with his sexual orientation. However, he found his parents as well as a school counselor to be supportive, and he utilized their support during this time. He was receptive to therapy and said he would do whatever he needed to get better. In our first couple of sessions, I noted how terrifying his experience was and just how hard it must be to have felt so out of control and at the mercy of a random event. These conversations helped after just a few sessions. He still continued to have intrusive thoughts and nightmares, however, and I discussed a referral to a trusted colleague who does EMDR for people with acute PTSD. I explained that EMDR was a kind of exposure therapy and that he would be pushed to think about some of difficult thoughts he was experiencing, but at a pace he could handle, all while the therapist kept note of his level of distress. We agreed to keep meeting during his EMDR treatments. Our meetings did not last long. He noted after two sessions of EMDR that he felt much better and "stronger." He met with me a couple more times and the EMDR therapist just three times more and left treatment with few residual symptoms.

As is clear from Ted's case, he had PTSD (not cPTSD) and was able to utilize the internal and external resources available to him to help him move on. Of course, exposure therapy can take shape in many forms, including what we may think of as traditional psychotherapy where someone talks about his or her experience of the trauma. But Ted was eager to get help quickly and "get back to normal." He seemed safe and secure in his life before this accident and felt genuinely happy. He found