

# Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders

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As the research and clinical knowledge base relevant to the treatment of clients with complex trauma histories continues to evolve, we expect that the exact features characterizing complex traumatic stress disorders and the relevant assessment and treatment protocols also will change dynamically. However, the core problems of affect dysregulation, structural dissociation, somatic dysregulation, impaired self-regulation, and disorganized attachment patterns are likely to remain the foundation for clinicians working with survivors of complex trauma, regardless of the specific diagnoses or assessment and treatment methodologies in use. Thus, the approaches to conceptualizing, assessing, and treating clients with complex trauma histories, and the guidelines for professional practice management and self-care presented in this book can provide a lasting foundation for clinicians and researchers well into the future.

We define *complex psychological trauma* as resulting from exposure to severe stressors that (1) are repetitive or prolonged, (2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and (3) occur at developmentally vulnerable times in the victim's life, such as early childhood or adolescence (when critical periods of brain development are rapidly occurring or being consolidated; see Ford, Chapter 2, this volume). *Complex posttraumatic sequelae* are the changes in mind, emotions, body, and relationships experienced following complex psychological trauma, including severe problems with dissociation, emotion dysregulation, somatic distress, or relational or spiritual alienation, hereafter referred to as *complex traumatic stress disorders*.

Complex psychological trauma represents extreme forms of traumatic stressors due to their nature and timing: In addition to often being life-threatening or physically violating, terrifying, or horrifying, these experiences are typically chronic rather than one-time or limited, and they compromise the individual's personality development and basic trust in primary relationships. Therefore, complex traumatic stress disorders go well beyond the classic clinical definition of what is traumatic, and beyond the triad of criteria (intrusive reexperiencing of traumatic memories, avoidance of reminders of traumatic memories and emotional numbing, and hyperarousal) that make up the diagnosis of posttraumatic stress disorder (PTSD) in the text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000). Complex traumatic stress disorders often include a combination of other DSM-IV-TR Axis I and Axis II (personality) disorders and symptoms, Axis III physical health problems, and severe Axis V psychosocial impairments. As a result of the complex traumatic antecedents, and the traumatic stress symptoms and impairments that are involved, complex traumatic stress disorders tend to be difficult to diagnose accurately and treat effectively.

## DEFINING COMPLEX TRAUMA

The word *trauma* has multiple meanings, referring alternatively to medical/physical injury or psychological injury, as well as to the events that cause this injury. Physical and psychological trauma often co-occur, but we follow the tradition of the field of traumatic stress in focusing on the latter, psychological trauma. Of note, it is often difficult to find a clear definition of psychological trauma, even in books on the topic. According to Weathers and Keane (2007):

Achieving a consensus definition of trauma is essential for progress in the field of traumatic stress. However, creating an all-purpose, general definition has proven remarkably difficult. Stressors vary along a number of dimensions, including magnitude (which itself varies on a number of dimensions, e.g., life threat, threat of harm, interpersonal loss . . . ), complexity, frequency, duration, predictability, and controllability. At the extremes, i.e., catastrophes versus minor hassles, different stressors may seem discrete and qualitatively distinct, but there is a continuum of stressor severity and there are no crisp boundaries demarcating ordinary stressors from traumatic stressors. Further, perception of an event as stressful depends on subjective appraisal, making it difficult to define stressors objectively, and independent of personal meaning making. (p. 108)

The English word *trauma* originates from the ancient Greek word for “injury” or “wound.” It originally “connotes a physical injury and parallels

the psychic wounding that can potentially follow a traumatic episode” (Dass-Brailsford, 2007, p. 3). *Trauma* is often used interchangeably (and confusingly) to refer to (1) the *traumatic stressor event(s)* including *the individual’s experience during exposure to the stressor(s)*, or (2) the individual’s *response*, whether *peritraumatic* (occurring during or in the immediate aftermath of the experience) or *posttraumatic* (occurring weeks, months, or years afterwards) (McFarlane & de Girolamo, 1996; Weathers & Keane, 2007). We refer to the stressor event(s) as *psychological or psychic trauma*, the *traumatic stressor*, or *complex trauma*, and to the response or aftermath as *posttraumatic reactions and disorders* or *complex traumatic stress disorders*.

Psychological trauma was originally considered to be an abnormal experience (i.e., “outside the range of normal human experience” in DSM-III (American Psychological Association, 1980), but as epidemiological evidence accumulated to demonstrate that a majority of adults (e.g., Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and a substantial minority of children (e.g., Costello, Erklani, Fairbank, & Angold, 2002) are exposed to traumatic events, there has been a shift to defining psychological trauma without any qualifications about its normality or abnormality. Generally, people who have not experienced traumatic events do not expect trauma to occur in their (or their families’ or communities’) lives, but once psychological trauma has occurred, he or she is both more likely *objectively* to experience subsequent traumatic events and more prone *subjectively* to expect trauma to be a possibility. With the increasing diffusion of virtually instantaneous information through the many forms of electronic and other media—not only in Westernized societies but also in socioeconomically underdeveloped countries—people’s awareness of traumatic events has been greatly heightened, even if these events never happen to them or to anyone they know personally (e.g., the Silver, Holman, McIntosh, Pulin, & Gil-Rivas [2002] national U.S. survey on the effects of the September 11, 2001, terrorist incidents).

Traumatic events take many forms. Terr (1991) distinguished between “Type I” single-incident trauma (e.g., an event that is “out of the blue” and thus unexpected, such as a traumatic accident or a natural disaster, a terrorist attack, a single episode of abuse or assault, witnessing violence) and “Type II” complex or repetitive trauma (e.g., ongoing abuse, domestic violence, community violence, war, or genocide). Type II trauma is more prevalent than typically recognized (i.e., affecting as many as 1 in 7 to 1 in 10 children), more often occurs in combination or cumulatively (i.e., “polyvictimization”; Finkelhor, Ormrod, & Turner, 2007), and usually involves a fundamental betrayal of trust in primary relationships, because it is often perpetrated by someone known by or related to the victim. Complex or Type II trauma not only is associated with a much higher risk for the development of PTSD than is Type I trauma (e.g., 33–75+ % risk vs. 10–20% risk, respectively; Copeland, Keeler, Angold, & Costello, 2007; Kessler et al., 1995) but it also may compromise or alter a person’s psychobiological and socioemotional development when it occurs at critical developmental periods. Such “developmentally adverse inter-

personal traumas” (Ford, 2005) are “complex” because they place the person at risk for not only recurrent anxiety (e.g., PTSD; other anxiety disorders) but also interruptions and breakdowns in the most fundamental outcomes of healthy psychobiological development: the integrity of the body; the development of a healthy identity and a coherent personality; and secure attachment, leading to the ability to have healthy and reciprocal relationships (Cook et al., 2005; van der Kolk, 2005).

Therefore, complex trauma is a subset of the full range of psychological trauma that has as its unique trademark a compromise of the individual’s self-development. The timing of its occurrence—in critical windows of development during childhood, when self-definition and self-regulation are being formed and consolidated—and its very nature—the disruption or distortion of fundamental attachment security due to betrayal of the developing child’s security and trust in core relationships—distinguish complex trauma from all other forms of psychological trauma. Thus, complex trauma involves not only the shock of fear but also, more fundamentally, a violation of and challenge to the fragile, immature, and newly emerging self. Complex trauma often leaves the child unable to self-regulate (i.e., to control his or her feelings, cognitions, beliefs, intentions, and actions), to achieve a sense of self-integrity (i.e., the feeling and belief that one is a unique, whole, coherent, and worthy individual), or to experience relationships as nurturing and reliable resources that support self-regulation and self-integrity.

As a result of compromising self-regulation, self-integrity, and attachment security, complex trauma constitutes objective threats not only to physical survival—but also to the development and survival of the self. The nature of the objective threat involved in complex traumas often encompasses features that go beyond obvious instances of a threat of death or violation of bodily integrity as currently defined in Criterion A1 of the PTSD diagnosis in the DSM-IV-TR (American Psychiatric Association, 2000). For example, emotional abuse by an adult caregiver that involves systematic attacks upon the psychological integrity and the very selfhood of a child may not be immediately life threatening and may involve no violent or sexual violations of the child’s bodily integrity, but it may nevertheless lead to the long-standing severe problems with self-regulation that are associated with psychobiological stress dysregulation and reactivity (Teicher, Samson, Polcari, & McGreenery, 2006). Thus, the threat to self-integrity posed by developmentally adverse interpersonal stressors, particularly when interwoven into a developing child’s primary family/caregiver relationships, may induce both long-term biological and psychosocial stress reactivity even in the absence of life threat or violation of bodily integrity (Ford, 2005). Consistent with these findings, a proposed *developmental trauma disorder* (DTD; van der Kolk, 2005) requires exposure to “developmentally adverse interpersonal trauma” (e.g., abuse, betrayal, abandonment, threats to bodily integrity) as its objective (A1) criterion.

Similarly, in complex trauma, the individual’s subjective reactions during stressful experiences extend beyond those that define psychological trauma in

DSM-IV-TR PTSD Criterion A2 (i.e., extreme fear, helplessness, or horror). Complex PTSD (Herman, 1992) or disorders of extreme stress not otherwise specified (DESNOS; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) were proposed for DSM-IV. Although ultimately included as associated features of PTSD, DESNOS was empirically shown to be related to exposure to interpersonal psychological trauma in childhood (van der Kolk et al., 2005). The proposed DTD diagnosis for children with complex traumatic stress symptoms is even more specific in identifying “rage, betrayal, fear, resignation, defeat, and shame” as the subjective (A2) criterion for childhood complex traumatic stress disorders (van der Kolk, 2005, p. 405).

This description of the subjective components of complex trauma offers a more nuanced and phenomenologically specific elucidation of the global descriptors provided for Criterion A2 in traditional PTSD. For example, “resignation” and “defeat” might be cognates for helplessness, as might “rage” or “betrayal” be for horror. However, the DTD A2 criterion provides more than just a better detailed operationalization of the subjective sense of traumatization than that used in the traditional definition of PTSD. DTD’s more complex subjective reactions articulate aspects of psychological shock that are not clearly implied by fear, helplessness, or horror. The inclusion of betrayal is derived from clinical and theoretical work on the distinct phenomenology and clinical sequelae of “betrayal trauma” (Freyd, DePrince, & Gleaves, 2007). Including shame also expands the clinician’s focus from fear or anxiety to the sense of a damaged self (Feiring, Taska, & Lewis, 2002). Including rage is consistent with research suggesting that children exposed to traumatic victimization may be defiantly oppositional and victimizing toward others, as well as anxious (Ford et al., 2000).

Thus, identifying complex trauma as a distinct subset of psychological traumas provides the clinician and researcher with a basis for identifying individuals who have experienced not only the shock of extreme fear, helplessness, and horror but also disruption of the emergent capacity for psychobiological self-regulation and secure attachment. In addition to hyperarousal and hypervigilance in relation to *external* danger, complex trauma poses for the person the *internal* threat of being unable to self-regulate, self-organize, or draw upon relationships to regain self-integrity.

Cumulative adversities are faced by many persons, communities, ethnocultural minority groups, and societies that may lead to—as well as worsen the impact of—complex trauma (Vogt, King, & King, 2007):

- Economically impoverished inner city ethnoracial minority persons.
- Incarcerated individuals and their children and families.
- Homeless persons and their families.
- Sexually and physically revictimized children or adults.
- Victims of political repression, genocide, “ethnic cleansing,” torture, or displacement.

- Developmentally, intellectually, or psychiatrically challenged individuals.
- Civilian workers and soldiers harassed and assaulted on the job or in the ranks.
- Emergency responders who are repeatedly exposed to grotesque death and suffering.

Another unfortunate reality concerning complex trauma is related to its interpersonal nature. The closer the relationship between perpetrator(s) and victim(s) and their group memberships (e.g., in a family, religion, gender, political party, institution, chain of command), the more likely they are to face conditions of divided loyalty. As a self-protective strategy, the group may coalesce around silencing, secrecy, and denial. As a result, victims *do not receive* the help they expect and need when the victimization is disclosed or otherwise exposed. This circumstance has been labeled the *second injury* (Symonds, 1975) or *betrayal trauma* (DePrince & Freyd, 2007). A lack of response or protection—or victim blaming—is betrayal of the victim’s trust and the helper’s responsibility that can severely exacerbate traumatic victimization. In the worst case scenario, a caregiver directly and repeatedly abuses a vulnerable child or does not respond or protect the child from abuse by others. Young children exposed to betrayal trauma by caregivers often develop a *disorganized/dissociative* attachment style in childhood and an adult attachment style described as *fearful/avoidant/dissociative* (Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006). Children, more than adults, are prone to use dissociation to cope with such overwhelming circumstances (Putnam, 2003), and it is now hypothesized that this style transforms the personality, preventing the integration of the traumatization across all aspects of the child’s and later the adult’s self. The result is a person who maintains a “front” or an “as if” or “apparently normal” personality that seems functional but is numb to and even unaware of the trauma, and an “emotional” personality that is incapacitated psychosocially by the knowledge of the trauma (see Steele & van der Hart, Chapter 7, this volume).

## **CONCEPTUALIZING COMPLEX TRAUMATIC STRESS DISORDERS**

*Complex traumatic stress reactions* are those that are most associated with histories of multiple traumatic *stressor exposures and experiences*, along with severe disturbances in primary caregiving relationships. PTSD alone is insufficient to describe the symptoms and impairments that follow exposure to complex trauma. The combination of PTSD with other DSM-IV-TR Axis I and II disorders and Axis III medical problems would be a more parsimonious solution to the dilemmas posed by complex trauma than to postulate an entirely new “complex traumatic stress disorders” diagnosis or syndrome. However,

existing diagnoses, including PTSD, cannot fully account for or guide the treatment of the sequelae of complex trauma.

### **Complicated, Chronic, or Axis I Comorbid PTSD**

PTSD was first codified in DSM-III as a formal diagnosis to identify individuals who had experienced extreme stressors (especially in combat) and were more than transiently (i.e., at least 1 month) troubled by anxiety associated with those stressor exposures. PTSD was designed to be distinct from another diagnosis attributable to exposure to stressors: *adjustment disorder*, which involves time-limited (i.e., less than 6 months) difficulties with distress or behavioral coping following adverse life events within “the normal range of human experience” (e.g., divorce, job loss, interpersonal conflict, financial problems, bereavement). Similar to adjustment disorders, PTSD involves not only symptoms of anxiety, dysphoria, and emotionally based behavioral problems (e.g., irritability, detachment from relationships) but also includes intrusive reexperiencing (unwanted memories and reminders, behavioral reenactments), avoidance (of unwanted memories or reminders of them), and hyperarousal (startle and jumpiness) and hypervigilance symptoms not included in adjustment disorders.

PTSD has been found to have variable expression and duration, ranging from relatively short-term acute responses to those that are chronic and do not remit, even with treatment. Some cases of PTSD also go dormant for periods of time, emerging episodically, usually in response to triggers of one sort or another that set off the psychobiological PTSD response that in turn cascades into physical and psychological symptoms. Noteworthy for our discussion is that the symptoms required for the diagnosis of PTSD, as it is currently defined, do not cover the full range of posttraumatic impairments. PTSD does not include emotion dysregulation (i.e., extremely intense or absent emotions other than anxiety or dysphoria, e.g., guilt, shame, sadness) and associated dysregulation of consciousness (e.g., dissociation), physical reactions and functioning (e.g., somatization), information processing (e.g., schemas or attention processes that are biased toward expecting to be assaulted, betrayed, exploited, or abandoned), and existential and spiritual adjustment (e.g., a fundamental sense of alienation from oneself, other people, and spiritual faith as a result of feeling permanently damaged) (Herman, 1992).

PTSD was designed to be distinct from (Summerfield, 2001) but potentially to occur comorbidly with other DSM Axis I disorders that involve chronic (episodic or continuous) problems with anxiety (e.g., phobias, generalized anxiety, panic, obsessions, or compulsions), mood (e.g., major depression or dysthymia, mania), or self-regulation (e.g., schizophrenia, dissociative disorders, eating disorders, substance use disorders). In addition, PTSD was designed to be distinct from childhood psychiatric disorders, including both “externalizing” disorders (e.g., attention-deficit/hyperactivity disorder [ADHD], conduct disorder) and “internalizing” anxiety and mood disorders. Epidemiological

studies show that anxiety and mood disorders often are comorbid with PTSD among adults (Kessler et al., 1995; Kessler, Chiu, Demier, Merikangas, & Walters, 2005), and with childhood internalizing and externalizing disorders (Copeland et al., 2007). PTSD also has been shown to be comorbid with severe Axis I psychiatric disorders in as many as one-third to almost one-half of cases (e.g., bipolar disorder, major depression with psychotic features, schizophrenia spectrum disorders; see Mueser, Rosenberg, Goodman, & Trumbetta, 2002). Substance use disorders also often are comorbid with chronic PTSD (Kessler et al., 2005). *Psychoform* and *somatoform* (i.e., medically unexplained physical problems) dissociative disorders also are overrepresented among persons with PTSD (Sar, Aküyz, & Dogan, 2006).

### PTSD and Comorbid Axis II Personality Disorders

Axis II personality disorders also are intended to be distinct from PTSD, but they frequently occur comorbidly (in 25–33% of PTSD cases, e.g., chronic PTSD and borderline personality disorder [BPD]), schizotypal disorder, and antisocial personality disorders; Yen et al., 2002). When PTSD is accompanied by Axis I or II disorders, the extent of biopsychosocial impairment exceeds that which is attributable to PTSD alone (Kessler et al., 1995). For example, in a study of a low-income community health care sample of women, major depression, dissociative disorders, and BPD were the most common comorbidities of PTSD, and when any of these disorders was comorbid with PTSD, the risk of major physical illness was significantly increased over the already high level of risk conferred by PTSD alone (Seng, Clark, McCarthy, & Ronis, 2006). Patients diagnosed with PTSD have been found to have more severe somatic problems and intrusive reexperiencing symptoms (Ford, 1999), and suicidality and impulsiveness (Zlotnick et al., 2003) when they have comorbid complex traumatic stress disorders or BPD, respectively.

Although Axis I and II disorders commonly co-occur with PTSD, reliance on them leads to a confusing plethora of comorbidity combinations that do not cohere as a syndrome. To the extent that this Babel of comorbidities reflects common underlying problems in posttraumatic self-dysregulation and attachment disorganization, reliance on PTSD plus comorbidities deprives the clinician of an efficient organizing system for assessment and treatment planning. Rather than addressing the core psychobiological adaptations that are sequelae of complex trauma, the clinician must instead focus assessment and treatment on the symptoms of multiple disorders. This may undermine clinical efficiency and effectiveness. It also burdens therapists with shifting their clinical protocols to address each new type of comorbidity.

PTSD can literally get lost in the shuffle, leading to a focus on “mental illness” (rather than on posttraumatic adaptation) that can be stigmatizing for clients. One of the core elements in the original rationale for a distinct diagnosis of complex PTSD was to reduce the stigma on clients (and families), and to increase the willingness and ability of clinicians to examine carefully the cli-



ent's history and presentation to determine whether clinical impairments may constitute forms of trauma-related self-dysregulation (Herman, 1992). When symptoms (e.g., mood swings, internal voices, hallucinatory reexperiencing symptoms, dissociative reenactments) are assumed a priori to be due to other psychiatric disorders, the role of trauma-related adaptations in self-regulation, self-integrity, and attachment disorganization are likely to be ignored in treatment planning and outcome monitoring. Many complex traumatic stress disorder symptoms parallel or mimic those of other psychiatric diagnoses; thus, differential diagnosis is necessary in order not to assign causality falsely to an existing disorder, without consideration of the potential role of adaptation to complex trauma. This was a primary *raison d'être* for the development of the original PTSD diagnosis; therefore, it warrants careful consideration with complex trauma.

Although simply classifying impaired complex trauma survivors as PTSD plus comorbid BPD may seem to be a straightforward solution, the high likelihood of stigma faced by persons (especially women) diagnosed with BPD has led some clinicians and researchers to seek a way for clients diagnosed with PTSD and BPD to be "extricated from the diagnosis of borderline personality disorder and subsumed under that of complex PTSD" (MacLean & Gallop, 2003, p. 369). Effective treatments have been developed for BPD, but even the most efficacious ones (e.g., dialectical behavior therapy) primarily have shown evidence of enabling people to cope with the intense emotional and interpersonal distress and dysregulation associated with that disorder—but not of remediating traumatic stress symptoms (Wagner & Linehan, 2006).

## PTSD and Comorbid Dissociative Disorders

Another possible solution to comorbidity is to treat the impaired complex trauma survivor as having comorbid PTSD and a dissociative disorder. When structural dissociation is a prominent problem (e.g., dissociative disorder not otherwise specified [DDNOS] and dissociative identity disorder), treatment modalities such as those described in this book (Steele & van der Hart, Chapter 7; Fosha, Paivio, Glesier, & Ford, Chapter 14; Schwartz, Schwartz, & Galperin, Chapter 17) provide means to address dissociative symptoms as posttraumatic adaptations. In addition, thorough assessment of dissociative symptoms is crucial when clients present with complex trauma histories (Courtois, Ford, & Cloitre, Chapter 4, this volume), in order not to overlook or misclassify (e.g., manic or psychotic symptoms) dissociative aspects of clinical cases involving complex trauma histories.

However, structural dissociation is not inevitably observed clinically as an impairment for clients with complex trauma histories. Dissociation is particularly likely to occur when complex trauma involves sexual abuse (Putnam, 2003), but complex trauma involving physical or emotional violence or victimization without sexual violation may be associated with extreme forms of affect/interpersonal dysregulation that do not always include structural dis-

sociation. Relying solely on existing dissociative disorders might inadvertently lead to their overdiagnosis and to treatment that does not address the full range of complex, trauma-related impairments.

## PTSD Subtypes

Another approach to the clinical/scientific conundrum of classifying and treating complex traumatic stress disorders has been to identify subtypes of PTSD. A rational approach based on research on the high level of persistence of PTSD that occurs for more than 6 months, particularly when it occurs over many years or decades, is to separate acute and chronic PTSD (not to be confused with acute stress disorder, which can last no longer than the shortest possible duration of PTSD, 30 days, and must begin within a month after a traumatic event).

Chronic PTSD is more persistent, refractory to treatment, and more impairing than acute PTSD (Norris & Slone, 2007). Even after years of intensive treatment, it is subject to what Wang, Wilson, and Mason (1996) termed *cyclical decompensation*. However, the comorbid psychopathology that typically accompanies chronic PTSD, rather than chronicity per se, may account for the exacerbated symptoms and impairments (e.g., Ford, 1999; Ford & Kidd, 1998).

An empirical approach to identifying PTSD subtypes has been undertaken by Miller, Kaloupek, Dillon, and Keane (2004), replicating a prior study by using Minnesota Multiphasic Personality Inventory—second edition (MMPI-2) data for over 700 military veterans with clinically diagnosed PTSD. Three subtypes were identified: (1) a “low pathology cluster,” with MMPI-2 scores in the nonclinical range; (2) an “internalizing cluster,” characterized by severe anxiety and negative affect, low levels of positive affect, and high rates of panic disorder and major depressive disorder; and (3) an “externalizing” problems cluster, characterized by high levels of impulsivity, aggression, anger and other negative emotions, antisocial personality traits, and alcohol use problems. Cases classified as externalizing subtype tended to have the most chronic PTSD, the most numerous and severe psychiatric comorbidities, and the most severe psychosocial impairment. Complex trauma histories were not reported in this study, but the externalizing PTSD subtype includes most of the major features associated with a history of complex trauma (with the possible exception of dissociation, which was not reported).

Thus, it is possible that complex traumatic stress disorders may be an externalizing subtype of PTSD. Yet this approach to classification may not be a good fit, because it requires the addition of many symptoms not currently included in the PTSD diagnosis, essentially comprising a new or expanded diagnostic classification rather than purely a subtype of PTSD. The question of how best to define the features of a hybrid form of severe, chronic externalizing PTSD would therefore remain no less an issue than if a complex traumatic stress disorder formulation were used.

## Disorders of Extreme Stress Not Otherwise Specified

The first systematic conceptual/clinical model describing complex traumatic stress disorders was formulated by Herman (1992) and van der Kolk and colleagues (2005) as complex PTSD or disorders of extreme stress not otherwise specified. DESNOS has been assessed by structured interview (Pelcovitz et al., 1997) in college (Ford, Stockton, Kaltman, & Green, 2006) and in midlife and older adult community samples (van der Kolk et al., 2005); in inpatient (Ford, 1999; Ford & Kidd, 1998) and outpatient samples (van der Kolk et al., 2005); and in substance abusing (Ford & Smith, 2008), seriously mentally ill (Ford & Fournier, 2007), and incarcerated (Scoboria, Ford, Lin, & Frisman, in press) samples. DESNOS involves persistent alterations in seven aspects of self-regulation following exposure to traumatic stress: (1) affect and impulse regulation (i.e., persistent distress; risky behavior or self-harm); (2) biological self-regulation (i.e., somatization, e.g., pain or physical symptoms or impairments that cannot be fully medically explained); (3) attention or consciousness (i.e., dissociation); (4) perception of perpetrator(s) (e.g., idealization, preoccupation with revenge); (5) self-perception (e.g., self as damaged or ineffective, profound shame or guilt); (6) relationships (e.g., inability to trust, revictimization, avoidance of sexuality); and (7) systems of meaning or sustaining beliefs (e.g., hopelessness, loss of faith). PTSD is an anxiety disorder, but DESNOS involves a broader set of self-regulatory impairments that takes the form of profound and enduring problems with overwhelming emotional distress, dissociation, loss of relational trust and spiritual faith, and chronic unexplained health problems. In civilian clinical samples (Ford et al., 2006; Ford & Fournier, 2007; Ford & Smith, 2008; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; van der Kolk et al., 2005) and military clinical samples (Ford, 1999), DESNOS has been shown to be most likely to occur following (1) trauma in *early childhood*, when many self-capacities are formed or malformed, and (2) *interpersonal violence or violation*.

## Posttraumatic Personality Disorders

Other formulations of complex traumatic stress disorders include the “enduring personality change after catastrophic experience” diagnosis in the World Health Organization (WHO; 1992) *International Classification of Diseases* (ICD-10; Beltran & Silove, 1999), Parson’s (1997) traumatic stress personality disorder (TrSPD), and posttraumatic personality disorder (PPD; Classen, Pain, Field, & Woods, 2006). The ICD diagnosis closely parallels DESNOS, differing primarily in defining dissociative features in greater detail. TrSPD is postulated to occur when PTSD becomes a chronic focus for the individual’s life and involves (1) hypervigilance, (2) “self-preoccupation and social ambivalence or withdrawal,” (3) “persistent fears or terror over the return of dissociated elements of the past,” (4) “work inhibitions,” (5) “existential reactions of despair, emptiness, and lack of meaning in life,” and (6) chronic maladaptive inflexible

behavior patterns (Parson, 1997; p. 333). Thus, TrSPD includes some, but not all, of the features of PTSD and complex traumatic stress disorders. PPD is postulated to be a sequela of childhood abuse with two subtypes. The disorganized PPD subtype is similar to the abuse/attachment model of complex traumatic stress disorders described by D. Brown in Chapter 6, this volume. The organized type of PPD involves self-dysregulation similar to that of DESNOS, and social avoidance but no fundamental loss or fluctuations in trust and security in primary relationships. PPD's disorganized type includes more profound disturbance in core attachment working models, such that rage, pathological mourning, and self-harm are predominant features. PPD is distinguished from BPD, in that BPD often derives from significant attachment failures, without a severe history of psychological trauma such as childhood sexual abuse. BPD has more prominent features of emotion and relational dysregulation, and a lesser degree of dissociation than PPD.

Whereas both TrSPD and PPD offer clinicians an approach to conceptualize and assess chronic characterological problems associated with exposure to developmentally adverse interpersonal trauma, neither formulation specifies diagnostic criteria in the detail provided by DESNOS. The distinction between organized and disorganized PPD highlights the importance of identifying the effects of compromised attachment security in combination with traumatic experiences such as childhood abuse, as noted in several chapters in this book—and most specifically by Brown's (Chapter 6, this volume) conceptualization of attachment/trauma disorders. It also suggests the possibility that the contribution of self-dysregulation and attachment disorganization to complex traumatic stress disorders may be distinct even though they often co-occur. However, the utility of distinguishing PPD from BPD based on severity of abuse exposure is unclear given findings that DESNOS and BPD are commonly comorbid and difficult to distinguish in psychiatric samples (McLean & Gallop, 2003). PPD is defined as PTSD plus DESNOS (Classen et al., 2006), and DESNOS addresses the core features of BPD, while adding a focus on potentially alterable traumatic stress underpinnings. Therefore, DESNOS appears to be the most efficient and well-articulated approach to describing the sequelae of complex trauma as a single syndrome for adults.

## Developmental Trauma Disorder

DESNOS has not been formally extended to describing complex traumatic stress disorders among children. However, the complex trauma work group of the National Child Traumatic Stress Network (NCTSN) has advanced a potential new diagnosis for complexly traumatized children to complement the existing childhood anxiety, affective, behavioral, and attachment disorders in the next (fifth) edition of the American Psychiatric Association's DSM. As noted earlier, DTD identifies developmentally adverse interpersonal trauma and subjective reactions that include not only fear but also self-related (e.g., shame) and defensive (e.g., rage) subjective reactions as a specific traumatic

stressor criterion. DTD was designed to enable clinicians and researchers to treat and study traumatized children who display symptoms similar to those that lead to diagnoses of (1) severe mental illnesses, such as bipolar disorder or schizoaffective disorder; (2) disruptive behavior disorder conditions, such as conduct disorder or oppositional defiant disorder; or (3) dissociative or reactive attachment disorders.

DTD includes two primary features. The first DTD feature is stressor-triggered dysregulation that occurs when trauma-related cues occur. Dysregulation may occur in one or more domains (Ford, Hartman, Hawke, & Chapman, 2008) including emotions (e.g., extreme lability or numbing), cognitions (e.g., dissociation, preoccupation with threats), somatic functioning (e.g., unexplained pain or medical problems), relationships (e.g., oppositionality, dependency), behavior (e.g., reenactments of traumatic experiences, self-injury), or self-attributions (e.g., self-hatred). The second DTD feature involves beliefs that are altered by persistent experiences with abandonment, betrayal, and other forms of victimization that potentially influence the child's personality development. These altered beliefs include an expectation of being victimized, unprotected, or denied justice, and a related sense of distrust of others and self-blame. Finally, DTD involves serious functional impairment in peer or family relationships, school or work, or legal (e.g., juvenile justice) domains.

DTD is similar to DESNOS in describing an organized and specific set of alterations in the person's ability to self-regulate when confronted with reminders of traumatic experiences (i.e., the emotion/impulse dysregulation, dissociation, and somatization features of DESNOS, and the dysregulation feature of DTD) and in fundamental guiding beliefs (i.e., traumatically distorted expectations concerning self and relationships). The specific forms of dysregulation identified in DTD include behavioral and relational problems that are more common in childhood than among adults (e.g., oppositional defiant behavior; extreme dependency). The domain of altered systems of meaning (e.g., loss of spiritual faith) described in DESNOS is not identified in DTD, because those existential changes are less evident (e.g., more likely to be expressed indirectly in behavior or in generalized distrust of self or others) in traumatized children than in adults. However, DTD and DESNOS together provide a potential lifespan framework for conceptualizing the sequelae of complex trauma as a unified clinical syndrome, complex traumatic stress disorders. The approaches described in this book for clinical assessment and psychotherapy with children or adults who have experienced complex trauma and have clinically significant psychosocial impairment address both PTSD and DESNOS (for adults) or DTD (for children).

## The Challenge and the Opportunity Facing Us

In making a distinction between types of posttraumatic disorders, *we are in no way diminishing the complexity that is inherent in the criteria for "traditional" PTSD*. PTSD itself is a complex and dynamic biopsychosocial spectrum disorder.

der with numerous personal and interpersonal manifestations and ramifications for those so diagnosed, and it may appear in different structural configurations at different times (Wilson, Friedman, & Lindy, 2002). PTSD has symptoms and impairments that overlap with those of other Axis I psychiatric disorders, but it has syndromal integrity (Elhai, Grubaugh, Kashdan, & Frueh, 2007). Careful attention to the diagnostic criteria for PTSD and other disorders therefore permits accurate differential diagnosis without overlooking or overdiagnosing PTSD. However, in the absence of a formal diagnosis for complex traumatic stress disorders, there is the potential mis- or overdiagnosis of severe disorders (e.g., bipolar or schizophrenia spectrum disorders, BPD, conduct disorder).

According to experts on complex traumatic stress disorders, a sophisticated trauma-based approach to conceptualizing and classifying these disorders is essential to prevent complexly traumatized clients from being burdened with stigmatizing diagnoses and to provide these clients with treatment that is informed by current scientific and clinical knowledge bases (Herman, 1992, and Foreword, this volume; van der Kolk, 2005, and Afterword, this volume; van der Kolk et al., 2005). Whether complex traumatic stress disorders should be consolidated into a single diagnosis (or two complementary diagnoses for adults and children, such as DESNOS and DTD) or be viewed as a set of distinct clinical features that do not necessarily have to co-occur in every unique case (e.g., emotion dysregulation, structural dissociation, somatic dysregulation, disorganized attachment working models; see Briere & Spinazzola, D. Brown, and Steele & van der Hart, Chapters 5–7, respectively) remains open to debate and empirical testing by clinicians, researchers, and theoreticians. The critical domains of complex traumatic stress disorders have been demarcated (i.e., the alterations in mind, emotion, body, and relationships that cut across every conceptual model of the sequelae of complex trauma). Now the critical challenge to clinicians and researchers is to understand each domain well enough to be able to do the following:

- *Accurately assess each core domain* (i.e., to recognize core forms of self-regulation and dysregulation when they are present, without being distracted, confused, or misled by diagnostic or conceptual presumptions, blinders, habits or biases).
- *Understand how dysregulation in each domain has resulted from complex trauma* (i.e., to grasp the person's way of being in the world well enough to see the whole person in context—specifically, to distinguish between the adaptive components of experience and personality from the pathological accommodations that traumatic disruptions of development and attachment have required the survivor to make).
- *Plan and carry out interventions that enable the person to develop capacities for self-regulation in each domain* (i.e., to utilize evidence-based or evidence-informed [American Psychological Association, 2006] ways of interacting therapeutically and approaches to modeling and teaching skills that replicate [not replace] developmental opportunities that the

person missed or that were altered as a result of having to survive and cope with complex trauma [Ford, Courtois, van der Hart, Nijenhuis, & Steele, 2005]).

Thus, in the psychotherapy (and pharmacotherapy; see Opler, Grennan, & Ford, Chapter 16, this volume) of complex traumatic stress disorders, there is no disjuncture between the therapeutic relationship/alliance and therapy “interventions,” because each simply is a different lens for seeing and understanding a ubiquitous therapeutic process: the repair and restoration of the person’s adaptive self-development (Wilson, 1989). This is not a fuzzy “feel good” endeavor; rather, it is a very delicate, deliberate, precise, and mindful intervention with a person whose life both figuratively and literally hangs in the balance. The opportunity to assist another human being in engaging in the most fundamental acts of learning and psychological growth, after that person has been denied that opportunity by fate and trauma, also is a sacred trust that requires the extraordinary mental, emotional, spiritual, and ethical dedication from both therapist and client. It is our hope that clinicians and trainees will find the guidance they need and deserve for this task in the subsequent chapters in this book.

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