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Treating Complex Trauma: Critical Interventions With Adults Who Experienced Ongoing Trauma in Childhood

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Complex trauma (CT) most often results from exposure to severe stressors that begin in childhood or adolescence, occur repeatedly, and take place within the caregiver system. Typically, CT involves repeated incidence of maltreatment over an extended period of time (i.e., months or years) that includes emotional abuse, physical abuse, sexual abuse, neglect, and witnessing family violence. These individuals experience lifelong difficulties related to self-regulation, relationships, psychological symptoms, alterations in attention and consciousness, self-injury, identity, and cognitive distortions. This article focuses on a limited number of interventions related to three clinical issues that are central in treating individuals exposed to CT: alliance repair, developing reflective functioning, and motivational enhancement. Each clinical issue and accompanying interventions includes (a) theoretical foundation and mechanism of change, (b) example verbatim clinical interchanges, and (c) supportive research.

Keywords: complex trauma, childhood abuse, alliance repair, reflective functioning, motivational enhancement

Complex traumatic experiences typically begin in childhood or adolescence and are perpetrated by caregivers and other adults who are expected to provide a safe, predictable, and secure environment (Courtois & Ford, 2013). Complex trauma (CT) involves repeated incidence of maltreatment over extended periods of time, including emotional abuse, physical abuse, sexual abuse, neglect, and witnessing family violence. Although CT experiences can occur at any age in highly oppressive contexts (e.g., partner violence, political and religious settings, acts of terrorism, refugee status, and war), it has its greatest impact in childhood.

CT that occurs in childhood within the caregiver system is associated with particularly severe symptoms, often related to survivor adaptations (e.g., self-harm behavior, social isolation, aggression, dissociation), adversely affecting normal and healthy development. These incidents often occur in an ongoing chaotic environment with extreme stress. In particular, a disruption in the caregiver–child relationship negatively impacts a secure attachment and a coherent and stable sense of self, leading to a general distrust of self and others. Lacking a sense of self-integrity, these individuals view themselves as bad, deserving of mistreatment, and undeserving of acceptance and love (Courtois & Ford, 2013). Along with self-regulation problems, these individuals have significant problems interpersonally. As a result, they may seek validation from others and yet anticipate and even facilitate their own rejection, or they may avoid relationships altogether by self-imposed social isolation. As a result, many of these individuals experience lifelong difficulties related to self-regulation, relationships, psychological symptoms, addiction, self-injury, alterations in attention/consciousness, identity, and cognitive distortions (Courtois & Ford, 2013).

Clients with these backgrounds present particular problems for therapists. They have an especially difficult time forming and maintaining a therapeutic relationship, which is both a goal of treatment and a necessary precondition for successfully addressing trauma-related issues (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004). Not surprising, they tend to struggle with attachment bonds. To be attached often means to be abused. Further, they often struggle with emotional regulation and interpersonal difficulties, often owing to low reflective functioning (RF; mentalization; Fonagy, Gergely, Jurist, & Target, 2002). RF is the ability to comprehend oneself and other's behavior in terms of mental states (feelings, intentions, desires, and beliefs; Fonagy & Target, 1997). Fonagy et al. relate RF to attachment such that insecure attachment is associated with low RF (i.e., unmediated evaluations of other's behavior), which in turn adversely affects relationships, especially trust. Predictably, these clients often are reluctant to address trauma-related issues, often owing to overwhelming sense of shame and anxiety, even though for many, this is why they sought psychotherapy. As a result, many of these clients have low expectations about their ability to change; thus, motivational enhancement is critical.

Interventions and Case Example

This article focuses on interventions related to three clinical issues that are central in treating individuals exposed to CT: alliance repair, developing RF, and motivational enhancement. The following case of CT will be the basis for the verbatim clinical exchanges in all three intervention sections below. The verbatim material includes a portion but not all the client–therapist interchanges for a particular segment of the original

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session. Client identifying information has been changed for purposes of confidentiality.

This case involves a 25-year-old female whose earliest memory was being sexually abused by an uncle at the age of 5. Subsequently, she was sexually abuse repeatedly by other male extended family members over a long period of time. As a result, she became involved in ongoing serial sexual activity that began in her early teens and extensive drug use until recently. Many of these relationships involved physical and sexual abuse. She initiated therapy because of problems with her daughter but eventually sought individual treatment for relationship problems, PTSD symptoms, and other symptoms commonly associated with CT (e.g., significant mistrust, dissociation, emotional dysregulation, impaired memory, and addiction).

Alliance Repair

Insecure or disorganized attachments characterize most adults with histories of CT (Lyons-Ruth & Jacobovitz, 1999). Ironically, the context for hurt, betrayal, and distrust—a relationship—is the same context for healing. To the degree therapists can provide a safe, consistent, and caring relationship, survivors can alter ingrained relationship patterns based on insecurity, mistrust, and manipulation. The importance of the therapeutic relationship is common knowledge in the psychotherapy literature, but it is especially important in treating CT survivors (Courtois & Ford, 2013). Of particular importance is ongoing repair of alliance ruptures.

With survivors of early exposure to CT, the predominate view of the world and people is one of danger, mistrust, and a foreboding sense that they deserve abuse and pain. Such clients will not easily be won over by empathy, warmth, and genuineness. In fact, these conditions may create the opposite response—greater mistrust, intense emotional dysregulation, and hostility (Courtois & Ford, 2013). Even the most competent therapist may be misinterpreted or the target of the client's negative transference. Further, both moving toward and away responses may occur in tandem (e.g., extreme interpersonal demand together with withdrawal and dissociation). Changing these responses are goals of treatment (e.g., acquiring emotional regulation skills), but they are most effectively addressed within the context of a strong alliance. Owing to ingrained mistrust, alliance repairs are an ongoing process in treatment.

In a general sense, alliance repair parallels the process of attachment development between parent and child: attunement, disruption, and repair. The repetition of this process in the natural course of parent–child interaction facilitates the development of a secure attachment and the expectation that disruptions in relationships will occur and can be repaired. Although more circumscribed in therapy, this same process between the client and therapist facilitates the reworking of client's internal working model of relationships and provides the opportunity to examine and enhance self-capacities (i.e., affect tolerance, self-worth, and inner connection to significant others; Courtois & Ford, 2013).

Two themes subsume most types of ruptures: withdrawal (e.g., compliance, withdrawal) and confrontation (e.g., blaming, criticizing, or demanding; Safran, Crocker, McMain, & Murray, 1990). Resolution for both involves addressing underlying fears and self-criticism. Several repair elements are particularly relevant for ruptures with CT clients: (1) acknowledge the rupture; (2) therapist awareness of his/her own feelings; (3) therapist accepts responsibility for his or her part in rupture; (4) empathize with client's experience; (5) clarify any misunderstandings; and (6) explore themes associated with rupture (Safran et al., 1990; Safran, Muran, & Eubanks-Carter, 2011).

The following verbatim exchange include several, but not all, of the above repair elements (see corresponding numbers in parentheses).

Client: I got involved again even though I said I wouldn't. You know what I do when I get lonely.

Therapist: Yes. Loneliness is a trigger for you. Some regret? Can you talk about it?

Client: No. You don't really want to hear it. I mean, we've talked about how bad it would be if I got with another guy. I really debated whether or not to tell you about it. I don't know why I did.

Therapist: Would you be willing to talk about why you told me even though you didn't want to?

Client: (looking away) *Ok, can you just leave it alone* (angrily).

Therapist: Sure. I can tell you are a little angry with me (1).

Client: No. I'm not really angry. Well, maybe some. I'm feeling sick (avoidance).

Therapist: I can understand why you might be angry with me (4). *You said you didn't want to talk about it and it felt like I pushed it a little* (3).

Client: Sometimes you can be just like a lot of other people in my life who say they care but they don't respect my noes. As usual I can't keep my mouth shut. I'm a F. . .ing idiot. I'll never learn!

Therapist: You've shared something hard to talk about. That's a big step. But you feel like I took advantage of you, like other people in your life (4). *Maybe a little mad at yourself for telling me.*

Client: Yeah, it's really hard. I don't do this very well. I just want to leave . . . but I'm not.

Therapist: Thanks for staying. This is different than usual for you. How does it feel for you to stay and work on resolving our issue, and not walking out or shutting down (6)?

The resolution of this conflict was seen by the client as a catalyst for approaching and resolving conflicts rather than avoiding or attacking. This was a reoccurring theme. The repair process was repeated throughout treatment, although less frequent toward the end of treatment.

In general, rupture repairs are significantly related to positive treatment outcomes (Safran et al., 2011). There is less research on alliance repair with CT clients. A study by Dalenberg (2004) involved interviews with 132 former clients who had completed long-term treatment ($M = 27.4$ months) for trauma. Participants reported the most and least helpful therapist responses to their anger. The least satisfactory was "no response" (3.4 on 10-point scale), followed by "extreme angry response to client" (4.0). Outcomes tended to be poor if the therapists provided "no response." The most satisfactory therapist response was "openly showed sadness or discomfort and discussed" (7.09). Clients were more satisfied if the therapist took some responsibility for the rupture, than if clients were blamed. Note, these results include several above repair elements (e.g., acknowledge the rupture, therapist assumes some responsibility for the rupture).

Reflective Functioning

Individuals with extensive CT backgrounds often struggle distinguishing their subjective internal world from external realities, especially interpersonal dynamics, and thus, are more likely to possess low RF (Fonagy et al., 2002). They have difficulty forming a functional internal representation of the mental state of another person and thus struggle with considering another person's perspective, greatly limiting a collaborative interaction. High RF enables people to consider that others have different thoughts and feelings, and thus enhances interpersonal skills.

RF has important implications for psychotherapy with CT clients. High RF enhances one's ability to anticipate and predict other's behavior, communicate dialogically, adapt more readily to new situations, and enhance resiliency when faced with trauma and hardship (Fonagy et al., 2002). Therapists' ability to verbalize client's thoughts, feelings, and intentions, especially the relationship between behaviors and intentions, enhances clients' RF (Holmes, 2010). Further, the therapist's ability to distinguish clients' thoughts and behaviors from their own, models RF. Finally, Holmes (2010) suggests the importance of establishing an alliance to provide a substrate on which a secure attachment can be developed and in turn strengthen RF.

The following verbatim includes interventions (i.e., verbalizing client thoughts and client examination of his/her own thoughts about other's behaviors) to enhance RF in the context of the client's well-established avoidance responses (e.g., confusion).

Therapist: Thanks for staying. This is different than usual for you. How does it feel for you to stay and work on resolving this issue, and not walking out or shutting down?

Client: I don't know (long silence). *What, what did you say—I'm confused I guess.* (long silence)

Therapist: It's hard to get a focus. Take your time.

Client: Yeah, I kinda zoned out for a second (mild dissociation).

Therapist: Can you talk about what just happened?

Client: Ok. I think I got angry and scared—with you. I didn't want to tell you about the guy.

Therapist: Maybe you thought it would disappoint me. But then you felt defensive and then angry when it seemed like I pushed you talk about it? (verbalizes client's thoughts and relationship to behavior)

Client: Yeah—something like that. I don't usually feel bad about finding someone, but I guess telling you I wasn't, I did. I don't think I really thought about it like that, I mean all together.

Therapist: Ok, so you were in a situation where you felt lonely and your first reaction was to look for a guy, somebody to be with at that moment, and you found someone. And this tends to happen when you're lonely? (invitation to examine her thoughts related to a pattern of behavior)

Client: Yeah—I was lonely. Also I get scared or antsey or something when I'm alone.

Therapist: Makes sense. Maybe you experience some level of anxiety or uncertainty—like you're looking for someone or someplace safe or something to calm you.

Client: Yeah, I'm definitely not comfortable alone and so then I look for someone. I'm trying not to but it's hard (verbalizes understanding of her thoughts in relationship to her behavior).

Therapist: Yeah, It's automatic. It works on the short run. You're less lonely for a while.

Client: Yeah on the short run, but not the long run. They never work. I wanna stop but something just takes over and bam-I'm there again (client identifies the negative effects of this strategy).

Therapist: What's it like talking about this with me? (shifts context to relationship with therapist)

Client: Ok I think—maybe a little uncomfortable 'cause I don't talk like this to people.

Therapist: I can see it's uncomfortable for you. I wonder if there is a part of you that expects me to be critical of you? (verbalizes possible client thoughts about the therapist)

Client: Yeah, cause I said I wouldn't to you. I didn't want you to get angry and think I lied to you.

Therapist: It mattered to you what I thought of you.

Client: Yeah—really. It mattered.

Therapist: It matters to me too. How are we doing talking about it? (Invites client to evaluate their conversation, thus, indirectly challenging her expectations about the therapist.)

Client: Well, not bad. Different from what I thought—better. I'm relieved. (She becomes aware that her thinking about the situation was different from the therapist's and seemed relieved.)

The client went from confused and mildly dissociated, to increasingly engaged, and finally, talking about the importance of the therapist's opinion of her. Her longstanding manner of dealing with loneliness and anxiety (arbitrary involvement with men) as well as conflict avoidance were examined with respect to RF. The client–therapist relationship was strengthened as a result.

Research from relationship-based treatments (e.g., transference-focused therapy [Levy et al., 2006]) and mentalization-based treatment (Bateman & Fonagy, 2004) indicates that enhanced RF with borderline personality disorder (BPD) clients is significantly related to decreases in negative symptoms. Further, Fonagy et al. (1996) found that clients with abuse histories with low RF were more likely to be diagnosed with BPD than abused clients with high RF. RF may function as a protective factor with respect to BPD.

Motivational Enhancement

Survivors of CT often have difficulty maintaining therapeutic engagement and motivation to change. Many enter treatment in crisis and/or at someone's bidding and in either a precontemplation or contemplation stage of change (Courtois & Ford, 2013). Further, change talk and commitment to change often are short-lived. Many believe that regardless of their efforts or desire to change, the odds are against them. They have resigned themselves to being a victim and to a life of unhappiness and failure. In some cases, they believe that they deserve punishment. Thus, they make only half-hearted efforts to change or to remove themselves from harm's way. Motivation to change is an ongoing issue, not simply a goal in the early stage of treatment.

An adequate level of RF and an enhanced therapeutic alliance provide a substrate for motivational enhancement. However, they may be insufficient to sustain client engagement in the change process, even with an adequate level of trust. Low frustration tolerance, resulting from an ingrained/automatic "fight–flight–freeze" defensive posture, often cause clients to feel overwhelmed even with the slightest suggestion of change and or therapeutic engagement. In such situations, other types of interventions may be necessary in addition to overt relationship-based responses.

Interventions associated with motivational interviewing (MI; Miller & Rollnick, 2012) and strategic family therapies (Fisch, Weakland, & Segal, 1982) may be helpful.

These interventions support "no change" or "slow change" as desired outcomes. MI refers to such interventions as "rolling with the resistance," while strategic therapies use similar interventions called restraining strategies. Although some view such interventions as paradoxical directives that capitalize on the reactivity of the client against demands to change, supporting no or slow change can be a respectful and empathic manner of aligning with clients in their struggle with change, and validates their concerns and fears about change. Also, "go slow" messages ("Perhaps we were moving too fast. A slower pace might reduce the chance of relapse.") can lessen client's anxiety about change. Supporting slow change demonstrates faith in clients' choice of change rate and validates their willingness to trust themselves. These interventions facilitate therapists' alignment with clients' "fits and starts" style of change. Also, therapists can assume a one-down posture with clients (e.g., "Help me understand what it's like for you.") that positions the client as the expert and diminishes the stature of the therapist as a target for reactance.

This verbatim exchange highlights "rolling with resistance" and "go slow" responses.

Client: The anxiety really limits me. It's almost all the time. What can I do?

Therapist: So the anxiety gives you the most problems. Maybe this is what you want to focus on?

Client: Yeah. I really do. I need to do something. (She agrees to focus on her anxiety.)

Therapist: One tool that many find helpful to control anxiety is mindful breathing. Many people find it helps calm them so they can get refocused. Maybe a place to start?

Client: Well, it sounds good, but I think I've tried breathing before and it just doesn't work. I may even get more anxious. I need to do something though, nothings working.

Therapist: So the breathing just didn't work for you. Just to make sure I'm not missing something (One-down), *would you mind walking me through what happened when you tried the breathing?*

Client: It's not gonna help. I mean, I tried it and it didn't work. Don't you believe me?

Therapist: I can see your point. It makes sense you wouldn't want to try something that didn't work before (Aligns with client) *and if you feel I am pushing you, it just makes the anxiety worse. The breathing may not be best for you at this point* (Validates client choice but leaves option open).

Client: Well, it's not that I don't want to try things to help, it's just that, maybe it won't work again and then I'd just feel hopeless (Reverses defensiveness and shares underlying concern).

Therapist: That makes sense. If you try the breathing again and it doesn't work, then you wonder if anything will work. We can move slow on this and make sure we've examined all options first (Aligns with client apprehension and encourages going slow).

Client: Yeah, slower sounds better. But I do want less anxiety. I'm just not sure where to start.

Therapist: Maybe we can step back and look at a smaller piece of this.

Client: Yeah. Well, I can't even sleep a lot of the time. I mean my mind starts going real fast and I just can't stop it. I just lay there and keep thinking; sometimes about a lot of nothing (Reengages).

Therapist: So if you could slow down the thinking some, that might be a place to start?

Client: Yeah, really. Just to sleep some. Relax a bit or something (Resumes focused change talk).

An attempt to explore the client's effort to implement mindful breathing was dismissed. The therapist then assumed a more empathic, collaborative, and one-down posture and joined with the client's apprehension. This led to a softening by the client, revealing her underlying fear of failure, and ultimately a refocus on a client-chosen anxiety-related issue. Confronting her likely would have exacerbated her anger and defensiveness.

Research overwhelmingly supports the effectiveness of MI with a wide range of clinical issues (Burke, Arkowitz, & Menchola, 2003). Although MI is used with clients who have trauma backgrounds, few studies have been conducted with CT populations. One study with female survivors of domestic violence indicated that women receiving MI plus treatment as usual (TAU) were significantly more motivated for change than women receiving TAU only (Rasmussen, Hughes, & Murray, 2008). Further, women receiving MI plus TAU reported greater self-efficacy about ending violence and avoiding violent relationships in the future. Whether or not these women were exposed to CT was not indicated. However, MI with trauma populations appears promising.

Conclusion

CT experiences create major disruptions in survivors' lives. Owing to past abuse and exploitation, they have significant interpersonal problems related to trust. Of little surprise, developing and maintaining a therapeutic alliance is challenging; thus, the ability to repair alliance ruptures is critical. Further, some have attributed interpersonal deficits to an underdevelopment of RF (Fonagy et al., 2002). People with low RF are prone to misinterpret the actions of others and respond in ways that fail to consider underlying intentions of the sender. Finally, survivors of CT often have difficulty maintaining therapeutic engagement and motivation to change. These three clinical issues are critical in the treatment of CT survivors.

Alliance repair, developing RF, and motivational enhancement, and their respective interventions, overlap in at least two areas: the centrality of the therapeutic relationship and the process nature of the interventions. Because of the importance of these two areas in treating CT survivors, the three clinical issues likely will be common threads throughout treatment as stand-alone essentials of healing (Courtois & Ford, 2013). Further, the three enhance the effectiveness of cognitive–behavioral interventions that are necessary in teaching self-regulation skills and to process trauma memories and accompanying emotions (Cloitre et al., 2004). A therapist's ability to recognize and skillfully address these issues is critical in successfully working with survivors of CT (Courtois & Ford, 2013; Fonagy et al., 1996).

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