

**IAAP Interview- Professor Sylvia Marotta-Walters**  
**Learning about “Complex Trauma”**



1. *As an expert on the field, can you briefly explain what is a complex trauma and what are its differential characteristics compared with non-complex trauma?*

Complex trauma does not currently exist as a diagnostic category in the DSM system though it is in the ICD. It is a term that is used to encompass chronic or long term trauma that develops over a period of time and/or at an early stage of life, rather than a single extreme exposure. It is also called developmental or attachment-related trauma. Historically it evolved from what was called DESNOS, or disorders of extreme stress not otherwise specified. When comparing complex trauma to posttraumatic stress disorder, there are some overlaps and some distinct features. For example, there can be re-experiencing or avoidant phenomena, but in addition there are also alterations in the ability to self-regulate emotions, alterations in attention, and alterations of meanings. Complex trauma is also increasingly associated with chronic and unexplained medical conditions.

2. *In the last APA manual of psychiatric diagnostics (DSM-5), complex trauma has not been recognized as a category on its own right. Do you agree with this decision? Do you think this resolution has any implication in the treatment of these patients?*

The DSM is a living system that depends on data derived from the field. One of the reasons why the numbering system changed from Roman to Arabic was so that it could be continuously updated. While complex trauma itself was not recognized, in DSM-5 there is recognition of a dissociative subtype of posttraumatic stress disorder, which in my mind shows that eventually, as the data accumulate, there will be a category for complexity. There is currently a privately funded field project to explore developmental trauma in children. The primary implication that I see in terms of treatment is that people with complex trauma are frequently treated for co-morbid disorders such as anxiety or depression, which then delays the focus of treatment on the underlying etiologies of these if they are trauma or neglect focused.

3. *A paradigmatic example of complex trauma is the one of children having suffered repeatedly sexual abuse. What kind of consequences does this continued abuse have on development and on the configuration of the final structure of these children personality?*

Depending on the age at which the repeated trauma or sexual abuse develops, we now know that there are actual anatomical and physiological changes to the brain that affect things such as emotional regulation and memory. Disrupted attachments, when sexual abuse happens within the family, can result in boundary problems with subsequent interpersonal relationship difficulties. The lack of mirroring of appropriate self-regulatory strategies from parents who are deficient due to their own mental health issues also disrupts the capacities of the self, such as consistency of self image, and the ability to take initiative on one's own behalf. With better imaging technology, we are able to measure some of these changes to brain structure and function but it is still too early to know specifically the linkages between such changes and future behaviour. One important aspect of psychoneurophysiology is that we now know how incredibly plastic the human brain is, and from a treatment perspective we also know that children's response to trauma treatment can be amazingly quick. Human beings are still very adaptive to all kinds of environmental pressures.

4. *Some other paradigmatic example of this complex trauma concept makes reference to refugees or victims of torture. Have they got some special characteristics?*

Traumatologists have long known that there are more difficult consequences of exposure to trauma when those trauma experiences are caused by other human beings as opposed to natural occurrences. That situation results in the special characteristic of refugees and/or victims of torture having to change their entire worldview based on such terrible experiences. Additionally, when one loses one's cultural identity and in the case of refugees, even their country of origin, there is the natural human need for adequate food, shelter, and safe living conditions. All of these are disrupted for refugees, and sometimes for torture victims those very natural needs are manipulated to cause further pain and suffering.

5. *Manuals of good clinical practice recommend treating this kind of patients with the same well-established treatments usually employed with non-complex trauma (for example, psychological treatment focused on trauma), only adding, if necessary, more sessions to cope with extra symptoms such as emotional deregulation or risky behaviour. Could you precise more which kind of techniques or strategies it is important to take into account in the treatment of complex trauma?*

I think every clinician should have training in one of the evidence based treatments for trauma. There are several models, such as trauma-informed CBT, EMDR, prolonged exposure, cognitive processing therapy. All of these can be used within a phase based treatment strategy, with a primary consideration being an ongoing assessment of how the individual is tolerating the treatment. There is a window of tolerance that the clinician needs to monitor, being sure that safety and stabilization are present during the trauma reprocessing phases of treatment. I don't think of adding sessions so much as I think of ensuring that there is a collaborative

process with the patient, during which timing, pacing, and reconsolidation of traumatic material all have an active role.

6. *More specifically, what should they be the specific strategies to intervene with children with complex trauma? Do parents or main carers have to participate in treatment?*

I don't treat children directly so I'm probably not the best person to answer that question. However, many of the adults I treat are exhibiting the knowledge and skill deficits that one would expect of children precisely because of those deficient early childhood environments we were talking about before. It is not unusual for a 40ish person to have the emotional coping skills of a teenager, and that is why ongoing assessment is so important for the trauma therapist to do. In order to teach an anger management skill, for example, one has to assess whether the patient can identify an anger response at all. Regarding parents in treatment, I do know of some trauma narrative approaches that have good success with parents narrating the traumatic experience for their child under the guidance of a therapist, while providing a secure base for the child during the therapy. I also think it is important to provide training in trauma informed care strategies for people in positions where they work with children in non-therapy settings.

7. *Do you identify distinctive abilities that therapists should have in their approach to people with complex trauma?*

Several years ago I wrote about refugees and their specific treatment needs and I coined the term 'unflinching empathy' then. I think it's important for therapists who work with people who have experienced trauma to know themselves and their own cultural biases, to maintain a supportive neutrality in terms of their boundaries and those of their patients, and most of all, to be fully present to those with whom they work. It is in the re-telling of a trauma story to someone who won't flinch from the pain of the story, that one finds the foundation of healing.

8. *If you consider necessary, please, add whatever extra commentary to specify, complete or explain some of the previous points or some other new.*

The last thought I will leave with you is that human beings remain the most adaptable, and therefore the most resilient, of organisms in our world. While many people get exposed to trauma, the vast majority of people will heal.

THANK YOU SO MUCH!!