

Working with Complex Trauma

Blue Knot Foundation fact sheet for health professionals

1 Childhood trauma, which falls in the category of complex trauma, has not been well understood within the mental health sector. Unlike 'single incident' trauma (i.e. PTSD) complex trauma is cumulative, underlying and interpersonally generated. Many health problems, conditions and disorders are increasingly recognised as trauma-related, with their origins in unresolved adverse experiences from childhood.

2 Prior to release of the nationally and internationally endorsed Blue Knot Foundation [Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Service Delivery](#) guidelines for trauma treatment related to single- incident PTSD. The impacts of complex trauma (also called 'complex PTSD') are more extensive than those for (single-incident) PTSD and require a different treatment path.

3 Childhood ('complex') trauma occurs in many forms. It includes sexual, emotional, physical abuse and neglect. It can also occur in the absence of abuse, for example if caregivers are unable to meet the emotional needs of children due to their own unresolved trauma histories.



4 If unresolved and unprocessed, traumatic experience/s impede a wide range of functioning. Unable to process and 'move on', the traumatised person remains on 'high alert' and is easily triggered by seemingly minor stress. *Childhood coping mechanisms become adult symptoms of ill health if overwhelming stress experienced in childhood is not resolved.*

5 Clinical and neuroscientific research is leading to new insights about the nature and optimal treatment of complex traumatic stress. It is vital that this information is available to health professionals, because many survivors 'have been retraumatised by [health professionals] who had inadequate understanding and skills to treat complex trauma-related problems' (van der Hart et al, 2006).

6 Treatment for complex childhood trauma should occur within an overall context which is 'trauma informed'. The paradigm of trauma-informed care and service delivery (TIC; see the second set of [Blue Knot Foundation Practice Guidelines](#))* is now being introduced in diverse human service settings. Its core principles are safety, trustworthiness, choice, collaboration and empowerment, which form the foundation for all interaction with survivors of complex trauma.

*NB The [Blue Knot Foundation Guidelines](#) originally comprised two sets. Both of those sets have now been updated. They are [Clinical Guidelines for Complex Trauma Guidelines](#) (embed link) and [Organisational Guidelines for Trauma-Informed Service Delivery](#) (embed link) i.e. non-clinical

7 'Health professionals' include diverse skill bases, qualifications and levels of contact with survivors. Thus specialist knowledge for direct clinical work (i.e. individual counselling and psychotherapy) is not applicable to all. What is applicable to all health professionals – from caseworkers to psychiatrists – is a mode of operating which is 'trauma informed' (i.e. which does not compound existing problems, which recognises the potential for re-enactment of trauma dynamics and takes steps to prevent this, and which 'does no harm').

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- 8** It is possible to recover from complex trauma. Research shows that even severe early life trauma can be resolved. It also shows that resolution of childhood trauma in adults intercepts transmission of trauma to the next generation and has positive effects on the children survivors have or may go on to have. *Optimism about the possibility of recovery from childhood trauma is warranted and should be conveyed to clients.*
- 9** Client behaviour should be regarded as adaptive attempts to cope with life experiences (i.e. what has happened to the person rather than what is 'wrong' with the person). All interaction and intervention should be respectful, empathic and non-escalating, with emphasis on client resourcing and skill-building.
- 10** Current best practice treatment for complex trauma is phased treatment. Phase 1 is safety and stabilisation, Phase 2 is processing, and Phase 3 is integration. Safety and stabilisation (i.e. Phase 1) underlies all therapeutic work and is the precondition for effective treatment.
- 11** Trauma cannot be processed (Phase 2) much less 'confronted' in the absence of ability to tolerate affect (Phase 1). The importance of Phase 1 cannot be overstated, and has not been well understood in standard trauma treatments. Unless you provide medium to long-term counselling/psychotherapy, most of your work will be confined to Phase 1 (i.e. restoration or acquisition of self-regulatory skills).
- 12** Therapy for complex trauma must always assist the client to stay within the optimal arousal zone in which feeling can be tolerated. If the client becomes hyperaroused (visibly agitated) and/or hypoaroused (dissociated or 'spaced out') interaction ceases to be therapeutic and retraumatisation may occur. The zone of optimal arousal is called 'the window of tolerance'.
- 13** Hypoarousal (emotional shut-down) has been less well understood than visible agitation (hyperarousal) and is sometimes mistaken for depression. Attempts to elicit a visible reaction from clients who are hypoaroused are anti-therapeutic and potentially retraumatising. Both hyper and hypoarousal are trauma responses, and clients in either/both state(s) are overwhelmed and at the limits of their coping capacity. In both cases they should be assisted to return to 'the window of tolerance' via appropriately tailored self-regulatory skills (i.e. the tasks of Phase 1).

- 14** Therapy for childhood (complex) trauma should be 'bottom up' as well as 'top down'. This means attentiveness to all three levels of cognitive, emotional, and sensorimotor processing (i.e. physical sensations, responses, and movement). Survivors of childhood trauma are particularly vulnerable to overwhelm from lower brain stem – 'bottom up' – responses (hence the importance of Phase 1 self-regulatory skills).
- 15** Standard psychotherapeutic modalities (including both insight-based and cognitive behavioural) require addition and supplement for working with complex traumatic stress (see [Blue Knot Foundation Practice Guidelines](#) and Pt. 17 below).
- 16** Therapy for childhood trauma should be grounded in knowledge of research in the neurobiology of attachment and therapists should expect and be able to work with complex transference and countertransference reactions. In this context, maintenance of their own self-care is critical to management of the risks of vicarious trauma.
- 17** Health professionals who work clinically with survivors should undertake ongoing professional development. Blue Knot Foundation offers both foundational and advanced workshops for health professionals. Professionals may claim CPD hours/credits/points as a pre-approved or self-directed learning activity. Clearly articulated learning outcomes for each program and Certificates of Attendance help support your reporting obligations. For more information, please refer to your professional association or the AHPRA website.

