Complex Psychological Trauma and Its Consequences on Mental and Physical Health

Axis One (Important Terms in Traumatic Psychology)

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Abstract:
Experiences beyond an individual's control that cause physical, psychological, or emotional distress affecting their ability to cope are referred to as "trauma." The effects of trauma can be short-term or long-lasting. Understanding how the human survival instinct impacts our body's systems, along with our early life experiences, is key to addressing our experience and helping individuals deal with traumatic experiences. Experiencing a traumatic event does not always lead to Post-Traumatic Stress Disorder (PTSD), although individuals may suffer from one or more symptoms immediately after the event, known as Acute Stress Disorder. With proper support and space to process these experiences, these symptoms typically diminish over time. When someone faces a series of repeated traumatic events from an early age, it is referred to as Complex Trauma (CPTSD). The impact of complex trauma symptoms is usually more enduring and often requires long-term support for the individual to process and recover over time. The study and treatment of trauma effects must be approached with an understanding of the dimensions of each type of these disorders and an analysis of their concepts, which is the aim of this paper.

Keywords: Trauma, Post-Traumatic Stress Disorder (PTSD), Complex Psychological Trauma (C-PTSD), Acute Stress Disorder (ASD).

Introduction:

Human history is not only a story of art, science, and culture but also involves war, interpersonal violence, oppression, and numerous disasters, both natural and man-made. Indeed, most people in society will experience one or more potentially traumatic events during their lives. Among them, a significant number will suffer lasting psychological distress, ranging from persistent mild anxiety to symptoms that interfere with nearly all aspects of life. Trauma is defined as a severe psychological and physical response to stressful events and painful experiences that exceed an individual's ability to adapt and cope. This response may manifest in a range of psychological symptoms, most notably anxiety, depression, isolation..., and physical symptoms such as high blood pressure, diabetes... Individuals react

differently to psychological trauma, making it difficult to predict the resulting psychological and physical effects.

The concept of psychological trauma and its treatment are crucial for ensuring appropriate support for affected individuals. This understanding requires deep assimilation of psychological trauma concepts from a multidimensional perspective that considers the biological, psychological, social, and cultural factors contributing to trauma development.

Research Problem:

Psychological trauma and post-traumatic stress disorders (PTSD) are psychological phenomena that transcend cultural and societal boundaries, making them a subject of utmost importance. These phenomena manifest as a result of painful and stressful experiences that exceed an individual's capacity to endure and adapt, leading to a diverse range of psychological and physical symptoms that exhaust the individual and society, impacting their mental and physical health.

Based on the aforementioned, the main research problem was formulated in the following primary question:

How can important terms in traumatic psychology be unified and defined to ensure diagnostic and therapeutic accuracy and effectiveness, while considering the cultural and linguistic diversity of individuals?

To achieve accurate answers, the following sub-questions were formulated:

1. What is the concept of psychological trauma?
2. What is the concept of a traumatic event?
3. What are the post-traumatic psychological disorders?
4. What is the concept of complex psychological trauma and developmental traumatic disorder?
5. What are the differences between developmental and complex trauma?

Importance of the Study:

This study derives its importance from its focus on highlighting psychological trauma concepts and associated pre- and post-traumatic disorders. It addresses multiple approaches combining psychological, social, and biological theories for a more comprehensive and effective understanding of psychological trauma, post-traumatic stress disorders, and enhancing the ability to define related concepts.

Objectives of the Study:

This study aims to:

1. Highlight precise and integrated definitions of psychological trauma, post-traumatic stress disorder, developmental trauma, and complex trauma, emphasizing their differences and overlaps.

Research Methodology:

To achieve the study's objectives, the analytical descriptive methodology was employed, gathering information from original sources and processing them objectively.

Conceptual Framework:

Historical Overview of the Term "Psychological Trauma":

The history of terms used to discuss psychological trauma is relatively recent, with Post-Traumatic Stress Disorder (PTSD) only entering common language in the late twentieth century. However, the history of studies on these concepts has not been tranquil, and the terms we use today are the product of conflicting opinions and perspectives on how to define these terms for a diverse audience. Influences emerged from social, political, psychological, and medical arenas, each drawing from different philosophical traditions to inform their views. The emergence of PTSD as a distinct category within DSM-III was a turning point where it became an "official medical psychological reality."

Before PTSD was established in 1980 as an official mental health disorder, several alternative descriptive labels were used to refer to what we now consider symptoms associated with psychological trauma. During World War I (1914-1918), British military physicians coined the term "shell shock" to explain the confused state and disturbed behavioral and psychological responses of soldiers during combat. These symptoms were attributed to physiological damage caused by exposure to exploding artillery shells. In 1916, "shell shock" was officially adopted by the British Army as a classification recognized as a legitimate war injury, responding to the large numbers of soldiers being diagnosed. However, by the end of World War I, controversy persisted over whether shell shock was physiological or psychological. This is logical given that psychology and psychiatry were relatively emerging disciplines, finding their place in the diagnostic medical system. At that time, some still viewed psychological treatments with suspicion and concern that they might "encourage morbid introspection and selfishness, increase suggestibility, and exacerbate existing deficiencies in willpower." Thus, the debate continued to divide physicians favoring a physiological explanation from those arguing for a psychological formulation of the symptoms observed in war returnees. Despite its common use in World War I, by 1939 in Europe at the start of World War II (1939-1944), the term "shell shock" was discouraged. It

appeared that senior military personnel perceived this type of "war neurosis" was more likely to affect psychologically weaker individuals, leading to decisions by U.S. draft boards to screen out "psychologically weaker" individuals during recruitment. Consequently, over a million potential new recruits were deemed "psychologically unfit for combat."

Trauma in Language:

Trauma originates from the Greek word meaning "wound." It was originally used in medicine for a severe physical injury but is now widely used to refer to emotional shock after a stressful event or a deeply painful experience. The American Heritage Dictionary defines trauma as a serious injury or shock to the body, as from violence or an accident, which comes to mind when thinking of "trauma care" or "trauma unit." This chapter focuses on the second part of this definition: "a wound or emotional shock that creates substantial, lasting damage to a person's psychological development, often leading to neurosis, and an event or situation causing significant distress and disruption." (Atchison & Diane K., 2012, p. 324)

The word trauma is used to describe a situation where a person experiences a difficult event that wounds them psychologically. Recently, awareness has grown that individuals exposed to events like attacks suffer not only physical injuries but also psychological harm. These are trauma victims. (Al-Nuwaysiah, 2013, p. 99)

The Dictionary of Social Work Terms states that trauma is a physical condition resulting from a sudden accident, with symptoms including weak pulse, irregular breathing, chills, dizziness, fainting, general weakness, as well as shock, terror, and fear. (Hamid, 2012, p. 259)

Trauma is an emotional response to a horrific event such as an accident, rape, or natural disaster. (APA, 2023)

This definition by the American Psychological Association (APA) summarizes the breadth of trauma's impact. Two individuals experiencing the same traumatic event will not exhibit identical response patterns—a factor extremely difficult to account for in trauma's aftermath. For example, during a natural disaster, survivors often report feeling "guilty" for not being as psychologically affected as others. The concept of survivor guilt is well-documented, and we see it here at the start of our journey as a crucial part of how we judge our ability (or inability) to cope with life's difficulties. Immediately after the event, shock and denial are typical. Long-term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea.

This additional aspect of APA's definition begins to suggest a range of emotional and physical symptoms that can be present during trauma exposure, highlighting the complexity of these phenomena. The UK government (November 2023) defines trauma as follows:
"Trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening. While traumatic experiences are unique to the individual, they can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional, or spiritual well-being." (Farrington & Alison, 2024, p. 5.4)

Conceptual Origins of Trauma Definitions:
Different definitions of trauma primarily stem from psychodynamic and behavioral traditions, and early work on the biological basis of the stress response. Each will be briefly explored in the following sections:

Psychodynamic Analysis:
In psychodynamic writings, centrally based on definitions by Sigmund Freud (1920) and Anna Freud (1964), trauma is defined in terms of stimulation exceeding the individual's coping capacity. Freud (1920) famously spoke of traumatic stress resulting from "a massive breach in the protective shield against stimuli," a rupture of the interface between the survivor's inner and outer world. Thus, from a psychodynamic perspective, a negative event can sometimes be considered traumatic.

Freud assumed psychological trauma was always sexual, resulting from seduction—i.e., a child being seduced by an adult. He indicated that trauma requires two conditions: first, a seduction incident involving an immature individual in a passive position without preparation; second, the triggering factor

or dimension through which the trauma acquires its meaning. (Moussi & Radwan, Terrorism Violence Against Childhood and Adolescence, 2008, p. 39)

Biological Analysis of the Stress Response:
On the biological front, early researchers were influenced by the work of Hans Selye (1956), who first coined the term "stress" and postulated that stress responses were mediated by the hypothalamic-pituitary-adrenal (HPA) axis. Selye described the General Adaptation Syndrome, which he considered healthy, viewing traumatic neurosis as a result of chronic or severe stress exposure. Thus, the gross stress reaction, an early diagnosis for Acute Stress Disorder (ASD) and PTSD that appeared in DSM-I (American Psychiatric Association, 1952), was defined as occurring in those who were normal but responded to overwhelming fear. The reaction was defined as subsiding within days or weeks; otherwise, another diagnosis was needed. (This condition also aligned with the psychodynamic position.) Selye's work led to the study of individuals biologically vulnerable to traumatic responses due to abnormal HPA axis function, as well as studies of brain catecholamines and corticotropin-releasing factor in trauma-exposed individuals (Yehuda, 1998). Unlike the analytic tradition, the biological tradition inspired animal models and soon merged with research traditions of those studying the fight-or-flight response to threat or aggression. (Gold, APA Handbook of Trauma Psychology, 2017, p. 15.16)

Behavioral Analysis:
The third tradition is behaviorism, specifically the classical conditioning model popularized by Ivan Pavlov (1902). Behavioral theories provided the first empirical treatments for phobias, an anxiety disorder that can follow a frightening experience. These treatments could be designed and implemented without needing to describe the client's experience as fear, helplessness, or horror. As with biological traditions, animal research played a significant role in advancing behavioral theories, notably with researchers like Watson and Rayner (1920).

Strong arguments can be made for the evolutionary benefits of processes that activate the fear network (and associated behaviors) in novel, dangerous situations. Experiments were applied to humans to establish links between specific experiences (e.g., sudden severe illness or unexpected injury) and the events or circumstances surrounding them (Davey, 1992). Behaviorism also provided mechanisms for understanding fear extinction and the conditions under which fear is renewed or reinstated, even after extinction. (Gold, Joan M., & Constance J, APA Handbook of Trauma Psychology, 2017, p. 15)

Although behavioral models apply to individuals regardless of predisposition, substantial evidence has accumulated that fear conditioning occurs more easily in some individuals than others, partly due to brain structure differences like amygdala volume. Fear responses also appear to be more readily activated by stimuli deriving threat potential from evolutionary emergencies.

These three traditions provide a rich foundation for trauma studies that emerged in recent decades. However, differences in these traditions partly explain the definitional quagmire lamented in the trauma literature.

Definition of Trauma:
We define psychological trauma as follows: An experience is traumatic if (1) it is sudden, unexpected, or non-normative; (2) it exceeds the individual's perceived capacity to meet its demands; and (3) it disrupts the individual's frame of reference and core psychological needs and related schemas. The first part of the definition serves to exclude chronic life difficulties, which, while important and sometimes severe, must be distinguished from trauma if the construct is to serve any heuristic purpose, as Anna Freud (1967) and Henry... (McCANN & LAURIE ANNE, 2015, p. 10)

Traumatic Event:
The Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM-IV-TR) (APA 2000) defines a traumatic event as an event posing a significant risk of death or serious injury and evoking fear, helplessness, or horror. This definition is restrictive in that the event must pose a significant threat, but it is broad in that any variety of events may be traumatic as long as they are perceived as posing a significant threat and clearly resulting in traumatic outcomes. At the time this definition was formalized, debate existed in the literature over whether certain events were sufficient to qualify as a traumatic experience. Generally, individuals are affected differently based on the event type, whether they were directly or indirectly exposed to the event, the event's impact level, and the event's societal characteristics.

However, individuals exposed to any major event may suffer a variety of symptoms reflecting physical and psychological responses to events clearly classified as traumatic (e.g., combat trauma; psychological trauma; physical trauma). Thus, the literature on the health effects of traumatic events includes a wide range of potentially traumatic events systematically studied. This breadth in the research literature informs the literature on stress responses and the specific health effects of certain traumatic events. Additionally, similarities and differences between the different types of events studied provide confidence in the nature of

the observed effects and help inform future research and clinical applications aimed at mitigating adverse effects. (Contrada & Andrew, 2011, p. 373)

Traumatic Events:

Large-scale traumatic events include events like natural disasters and industrial accidents, notably today, terrorist attacks. They can profoundly impact group and individual functioning. (BYRON & SUZANNE, 2002, p. 896)

Yerzano (1994) indicates that traumatic events are serious, confusing, and sudden, characterized by their extreme intensity, causing fear, anxiety, withdrawal, and avoidance. Traumatic events are also high in intensity, unexpected, and non-recurring, varying in duration from acute to chronic. They can affect an individual alone, such as a car accident or a violent crime, or an entire community, as in an earthquake or hurricane. The stress response occurs when an individual is exposed to a distressing or painful traumatic event. The response to traumatic stress can be immediate or delayed. (Sharifa, p. 13)

Psychological Trauma:

Psychological trauma involves a range of antecedents and consequences, including witnessing situations of death, life threat, limb loss, or head injury, all considered causes of acute and chronic psychological disorders. Although these disorders result from a specific traumatic event, this event alone is insufficient to explain such a disorder. Despite every person experiencing a life-threatening traumatic event and being affected to some degree, only some people, based on their psychological traits and environmental characteristics, develop the specific symptoms of this disorder. Orsano et al. (1994) indicate that traumatic events are serious, confusing, and sudden, characterized by their extreme intensity, causing fear and anxiety. (Majid, 2007, p. 249)

Ferenczi views psychological trauma as involving the collapse of the sense of self, the capacity for resistance, and defensive behavior and thinking. Alternatively, the organs involved in self-preservation atrophy or reduce their function to the maximum possible extent. In this sense, it is a dissolution and loss of original form, with easy acceptance without resistance to a new form. Psychological trauma always emerges unprepared, preceded by self-confidence. The traumatic event shatters this confidence in the self and the external environment. Before the event, the person believed this would not happen to them, only to others. He also sees that trauma can be purely physical, purely psychological, or both physical and psychological. Physical trauma is always psychological as well, with anxiety being its direct result. It involves a feeling of inability to cope with significant distress resulting from the suddenness characterizing psychological trauma. Thus, the

person cannot install realistic defenses against harm or produce perceptions that act as antidotes against distress and pain. (Moussi & Radwan, 2008, p. 48)

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013) defines trauma as:
"Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) Witnessing, in person, the event(s) as it occurred to others; (3) Learning that the traumatic event(s) occurred to a close family member or close friend—in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). (Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.)" (Briere & Catherine, 2015)

Acute Stress Disorder (ASD):
Acute Stress Disorder has symptoms almost identical to PTSD. It is usually diagnosed when symptoms appear immediately after a traumatic event, and if they persist, the diagnosis is revised to PTSD. Symptoms must last at least 3 days (though they typically appear immediately after trauma), but if they persist for 1 month or longer, the diagnosis changes to PTSD. Diagnostic criteria for ASD include exposure to actual or threatened death, serious injury, or sexual violation. Witnessing the trauma; learning of trauma affecting a close friend or family member; or repeated or extreme exposure to trauma (as with first responders or police). The individual must have at least nine symptoms reflecting intrusion (e.g., recurrent intrusive thoughts or distressing dreams), negative mood, dissociative symptoms (e.g., altered sense of reality or inability to remember aspects of the event), avoidance symptoms, or arousal symptoms (e.g., sleep disturbance, irritability or anger outbursts, hypervigilance, difficulty concentrating), causing significant distress or impairment. ASD is diagnosed if symptom duration is 3 days to 1 month post-trauma. If symptoms persist beyond 1 month, the diagnosis changes to PTSD. (Bonder, 2022, p. 9)

Complex Psychological Trauma (C-PTSD):
Complex Psychological Trauma (C-PTSD) is defined as resulting from exposure to severe, repeated, or prolonged stress, involving harm or abandonment by caregivers or other ostensibly responsible adults, occurring during developmentally vulnerable periods in the victim's life, such as early childhood or adolescence

(when critical periods of rapid brain growth or consolidation occur). (Courtois & Julian, 2009, p. 13)

C-PTSD is a more severe form of PTSD. It is distinguished from this known trauma syndrome by five of its most common and disturbing features: emotional flashbacks, toxic shame, self-abandonment, a vicious inner critic, and social anxiety. Perhaps emotional flashbacks are the most prominent and distinguishing feature of C-PTSD. Survivors of traumatic abandonment are highly susceptible to painful emotional flashbacks, which, unlike PTSD, typically lack a visual component. Emotional flashbacks are sudden, often prolonged regressions to overwhelming feelings of being an abused/abandoned child. These feeling states can include overwhelming fear, shame, alienation, anger, sadness, and depression. They also include unnecessary triggering of our fight/flight instincts. It is important to note here that emotional flashbacks, like most things in life, are not all-or-nothing. Flashbacks can range in intensity from subtle to horrific. They can also vary in duration, from moments to consecutive weeks, transitioning into what many therapists call regression. (Walker, 2013, p. 2)

Some terms, including the differences between developmental and complex trauma, are still being defined. Developmental trauma is used as a subset of a larger dynamic of complex trauma. While developmental trauma is based on relational disturbances during childhood affecting the child's sense of self, complex trauma is an umbrella term also encompassing later disturbances in one's sense of self. This can include adult experiences such as domestic violence, human trafficking, imprisonment and torture, or where escape from a toxic, abusive, or violent situation was impossible.

Complex trauma speaks to the way interpersonal relationships in dominant situations affect individuals in subordinate positions. Painful relationship dynamics can emerge when vulnerable individuals must depend on those in power for their survival and well-being. In attachment theory, the focus is on how this occurs between parents and children. But it is important to recognize how this also happens in larger ways beyond attachment failures in family systems.

Relational trauma also emerges from the oppression of communities, cultures, and nations. These relational systems of oppression and subjugation create and perpetuate complex trauma. We cannot separate an individual's developmental process from the society they grew up in. A growing movement in mental health addresses these larger concerns and seeks to broaden the inclusion of more culturally enlightened perspectives and models. In the trauma field, it is crucial to identify the historical legacy of brutality, oppression, and generations of complex

trauma that have deeply, and continue to, affect vulnerable individuals and cultures. (Heller & Brad, 2022, p. 12.13)

Post-Traumatic Stress Disorder (PTSD):
PTSD was first observed and treated as a disorder after World War I. Over subsequent years, most PTSD-related research focused on returning soldiers and war veterans, noting the recurrent and debilitating nature of their psychological distress. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V, APA, 2013)

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PTSD is a common reaction to experiencing something traumatic. (Raja, 2012, p. 15)

Based on the above, PTSD can be summarized as follows:
It is a psychological disorder affecting some people following exposure to trauma or acute physical injury, as occurs post-wars due to loss of loved ones or exposure to violent accidents or natural disasters. The most common crises preceding the disorder are the person or a loved one/close relative facing death, severe violent injury, or exposure to scenes of death, destruction, and devastation, as occurs in wars and natural disasters. The medical definition here restricts crises and disasters to those involving threat of death or severe physical injury. It does not include other misfortunes such as divorce, chronic illness, or severe social problems, as these have different psychological complications. This psychological disorder affects 1% of people, but in some groups like combat soldiers and disaster survivors, the infection rate rises higher.

Classification of Post-Traumatic Stress Disorder:
The World Health Organization's International Classification of Mental and

Behavioural Disorders (ICD-10) classifies PTSD under category F40-F48 for neurotic, stress-related, and somatoform disorders, placing it within the subcategory of reactions to severe stress and adjustment disorders. This includes five types:

1. Acute stress reaction
2. Post-traumatic stress disorder
3. Adjustment disorders
4. Other reactions to severe stress

This disorder appeared in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, 1994) under Axis I for anxiety disorders, which include phobias, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and PTSD. (Al-Nuwaysiah, 2013, p. 102)

Acute Stress Disorder and Post-Traumatic Stress Disorder:

Acute Stress Disorder (ASD) is a relatively recent addition to diagnostic systems used to describe stress reactions following trauma. It was introduced in 1994 in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV; American Psychiatric Association, 1994). It has been a controversial diagnosis as researchers questioned its conceptual basis, operational definition, and empirical support. Nevertheless, the emergence of the diagnosis led to a massive increase in interest in acute trauma reactions and a wealth of new research shedding light on how we understand post-traumatic stress responses occurring immediately or shortly after the traumatic event.

Throughout successive iterations of the PTSD diagnosis in DSM, there was a one-month limitation post-trauma exposure on how quickly this diagnosis could be made. This condition was imposed due to concerns that prematurely labeling maladaptive stress responses would pathologize standard, transient stress reactions. This perspective was discussed in the period preceding DSM-IV (American Psychiatric Association, 1994) when commentators felt this situation created a diagnostic gap preventing accurate identification of individuals suffering from acute distress. One primary reason for this concern was that in the U.S. healthcare system, access to care could be jeopardized if a person lacked an officially recognized diagnosis. Thus, it was suggested that a diagnosis describing acute stress reactions would facilitate healthcare pathways within a month of trauma exposure. Additionally, a secondary goal for the new ASD diagnosis was proposed: identifying individuals with acute trauma who would later develop PTSD. As we will discuss, many people will exhibit acute distress in the first few days' post-

trauma, and this distress can extend into the first or second week. However, many of these individuals will not develop PTSD. Therefore, the primary challenge for early intervention has always been distinguishing individuals in the acute phase exhibiting a transient stress response from those showing early signs of a chronic PTSD course. It was suggested that ASD might offer a solution, at least partially, to this problem. (Gold, APA Handbook of Trauma Psychology, 2017, p. 161)

However, PTSD does not only arise when someone is in physical danger. Oppressive or abusive work conditions can also lead to symptoms, such as nurses in hospitals exposed to high levels of bullying from doctors, patients, or even other nurses. Prolonged exposure to such environments can lead to numerous strains like burnout and PTSD. (Levy, 2017, p. 631)

Differences Between Developmental and Complex Trauma:
Developmental trauma is used as a subset of a larger dynamic of complex trauma. While developmental trauma is based on relational disturbances during childhood affecting the child's sense of self, complex trauma is an umbrella term also encompassing later disturbances in one's sense of self. This can include adult experiences such as domestic violence, human trafficking, imprisonment and torture, or where escape from a toxic, abusive, or violent situation was impossible.

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Developmental Trauma:
The term developmental trauma is used for several reasons. During childhood, the brain develops, grows, and organizes at an incredible rate. With a child's soft brain like a sponge, it constantly absorbs new experiences and is shaped by its

environment. Therefore, when trauma occurs during this critical sensitive window, it is likely to impact the child's neurobiological, social, emotional, sensory, physiological, moral, and cognitive developmental trajectory. These children will not have a safe experience and will likely need to invest more energy in their survival rather than being able to be in their learning/thinking brain (the neocortex controlling higher-level processes like logic and reasoning) and fully master age-appropriate competencies. At its core, fear and safety constrain the expansion of learning and relationships. Thus, due to these developmental vulnerabilities, the child's social, emotional, and developmental age may differ from their chronological age. (Treisman, 2017, p. 10)

The need for both relational and cognitive-behavioral interventions in treating chronic and/or complex PTSD is not particularly surprising, especially when examining real-world clinical practice. Arguably, all good trauma therapy is cognitive-behavioral to the extent that it involves exploring painful sources (exposure) within a safe relationship (therapeutic alliance) where the client is encouraged to feel and think about what happened to them (emotional and cognitive activation and processing). On the other hand, the most effective therapy for the effects of complex trauma is also relational and "dynamic," involving the effects of active attachment relationships and intrapsychic processes. Ultimately, the complex interrelationships between exposure to negative events, biology, psychology, culture, social support, and symptoms mean that no two trauma survivors are clinically identical. The natural consequence of this reality is that the therapy required to intervene in post-traumatic outcomes will necessarily differ from case to case, as a function of a wide range of variables. This implies that trauma therapy must be flexible, inclusive of different perspectives, relevant to the specific issues and concerns of the traumatized person, and responsive to their specific relational context. In some cases, it may also include selected and monitored psychotropic medications. Coupled with the remarkable resilience of individuals with psychological trauma, this therapy can be a powerful factor in psychological recovery.

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