

Interview: Does Complex Trauma Exist? A “Long View” Based on Science and Service in the Trauma Field

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Origins of the Concept of Complex Trauma

I'm very happy to share some thoughts about this topic. For a long time I have been following the professional dialogue about posttraumatic stress disorder (PTSD), psychological trauma, domestic violence, interpersonal violence, and then the emergence of a condition called *complex trauma*.

I believe that one of the very first places that Judy Herman discussed complex trauma was in my living room in Brookline, as part of the Harvard Study Group on Trauma. That group comprised 25 to 30 people who consistently attended a monthly meeting in Boston, starting in the mid-1980s and continuing until my sabbatical year in 1993 when, for a variety of reasons, it never picked up again. This group gathered people who were doing some of the foundational work on psychological trauma. It included colleagues in Boston at many of the key academic and clinical institutions, some who were visiting Boston for one reason or another, and some whom we would invite from elsewhere in the country to talk with our group about concepts of psychological trauma. Over time the people who comprised the Harvard Study Group on Trauma and those who presented to that group emerged as some of the leading figures in the field, including some who defined key concepts related to psychological trauma. Initially, the group met at the home of Henry Murray's¹ wife (Nina). Their home was in the shadows of Harvard's William James Hall—a particularly wonderful place to have a conversation about a disorder that was not well-accepted by mainstream psychology and psychiatry. Bessel van der Kolk also hosted the group at times in his beautiful South End row house.

One evening Judy Herman spoke about her concerns about the issues of PTSD and the very different patient population she was seeing at the Victims of Violence program at Cambridge Hospital. Her take on it was that many of the people who were given diagnoses of personality disorders were really people who suffered considerable domestic violence, child physical abuse, child sexual abuse, and neglect in ongoing ways. The nature of the distinction was that these were *ongoing* psychological traumas—ongoing oppression, ongoing stress associated with living in abusive situations, whether it was the spouse, or the parents, or the uncle, or whomever. It was this ongoing nature of it, the sense that “there is no safety,” “no place where anything is safe,” that I think led her to think a bit differently about what conventionally was called personality disorders (borderline being one, but not the only one). She gave birth to the notion of complex trauma and it received a great deal of attention from lots of people at the time who were seeing patients with this same set of problems. I would characterize the patients being discussed as those with dysregulated emotion, cognition, and behavior. The common thread was the existence of this background of ongoing, abusive environments. Interestingly, the syndrome

Lisa M. Najavits conducted an interview with Terry Keane on November 20, 2012. Terry Keane is solely responsible for the content and reviewed it to verify that it represents his views. It was videotaped, transcribed, and edited by Lisa Najavits to create headings, organization, and editing for grammar and flow.

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¹Harvard psychologist known for his work on personality theory.

wasn't just present among children; it could also be ongoing abusive violence with adults, such as spousal abuse, that led to this same type of symptomatology.

She published some papers on the topic and other people picked up the mantle, but there were a lot of other people who resonated with this notion that there's a whole other patient cohort out there who are coming for help that we know very little about, and we need a name for this. The label came to be known as "complex trauma."

Does "Complex Trauma" Exist?

There was, in relation to the Diagnostic and Statistical Manual of Mental Disorder Fourth Edition (DSM-IV) an effort to understand *disorders of stress not otherwise specified* (DESNOS). But I think that for people who study diagnostic nomenclature, the empirical findings were really not systematic, nor were they organized in the way in which we could readily make sense of the findings. In other words the symptoms weren't forming clusters that were homogeneous, internally consistent in terms of the statistical modeling of them, and predictive over time. It just wasn't working.

Now fast forward another 15 years or so, and there still isn't enough fundamental research on this patient population that would be compelling to senior clinicians, scientists, or policymakers to suggest that this is a coherent syndrome. This is particularly important to me, frankly, because a lot of the same concerns were raised about the diagnosis of *PTSD* in the early 1980s.

At a very early stage in my career, I was invited to give a lot of lectures on *PTSD*, in part because very senior researchers had read some of the articles that our group published in the early 1980s. We had published some of the first scientific work on *PTSD*, some of the very first empirical studies. So people wanted to "test the metal" and understand what it was we were seeing in the combat veteran population. It was then that I learned about what was necessary to provide convincing evidence that *PTSD* was a cohesive set of symptoms that was associated with considerable dysfunction; I was compelled to do so not because I had a burning interest in learning psychometrics or classification science, but because I was grilled on the topic. Sometimes the grilling was very hostile and sometimes I was invited to lecture just so that people could pick me apart.

Those kinds of experiences actually forged steel because I got to understand what the nature of the scientific study of psychopathology really was. Although I already had all the courses and I had done perfectly well in those courses, they were meaningless until I had to stand up and defend the things that we were seeing and doing in the clinic and in the laboratory—what we were studying, seeing, and observing—in Vietnam combat veterans with *PTSD*. This led to a whole sequence of studies, including a publication around 1985 in which we utilized Eli Robins' and Sam Guze's "recipe" for understanding whether something really was a disorder or not, their strategy for verifying the validity of a construct like *PTSD*, depression, or borderline personality disorder. We did studies using that as a framework, and then wrote a review article that covered a wide range of the literature that had emerged by the mid-1980s, indicating that there was coherency in the *PTSD* diagnosis.

And then a lot of the acrimony began to shift. I don't know whether it shifted because, at that same time, I moved to Boston and was a bit older, but also I was no longer from Jackson Mississippi (which I think may have contributed to some of the acerbic remarks about our work because it was coming from a place nobody had ever heard of before). In the field of psychopathology within behavior therapy circles, everybody knew who we were, but in the more mainstream field of psychopathology world, they didn't, and so this information was coming from a place that I think people couldn't trust. But once I moved to Boston and occupied a position in a top rank academic medical center in the country's leading research city, the tenor of the debate changed. And there were now measures, methods, and models, all of which could be applied to *PTSD*.

I give you this background only because it's my view that a lot of that foundational work on *PTSD*, which took many, many years of my career and other people's careers—many years of concerted effort—I don't think has yet been done for the notion of complex trauma. The few times that I've seen projects on it, including the DSM field trials, it hasn't worked very well. That

doesn't mean it doesn't exist. It doesn't mean there isn't an entity out there. It just means that the scientific community isn't conceiving of it correctly. Now, maybe PTSD was easy, maybe it was just waiting to be done. But we did the right studies, we created the right assessment tools, we did the right analyses, and then it was hard to argue with the data. But the data are the data. These data continue to speak volumes for the validity of the PTSD concept.

I remember one time going to a storied Midwestern university that housed a very hard-nose scientific, psychopathology crowd. They were ready to just string me up and shoot me. My brother, who was a professor at the University School of Medicine at the time, was in the audience. He had come over to the psychiatry department for this lecture and he was just appalled at the way they treated me. I just thought this was common, that this is what happened to visitors to this place. But the fact that I was responding with the *data* convinced the people at the university that we were onto something. People who were very skeptical suddenly were thinking, "Well, maybe the next study would be this," "Maybe the next thing to do was that," "Maybe we can use this." And the fact that we had data that we hadn't yet published on the Minnesota Multiphasic Personality Inventory (MMPI) was really very important. A lot of these people were very actively involved in using the MMPI, and that we had a large sample of patients upon whom we had validated and cross-validated a scale on the MMPI made a big impression on them. Plus, we did the work with considerable methodological rigor. Suddenly the conversation was turning in our favor.

There were a lot of other things that happened in the mid- to late 1980s that led to dramatic changes in the discussion. I don't think that these conversations about complex trauma have been had yet because these data aren't there yet. The quality of the studies isn't there yet. There isn't somebody who is associated with the notion of complex trauma who is as hardheaded as my colleagues and I were with PTSD. There isn't anyone who is doing methodologically rigorous sequences of studies to prove its existence. I haven't seen it emerge yet. There are a lot of people who talk, there a lot of books that have been written. But there isn't somebody with that single-minded focus with access to patient populations, with access to a research environment, all of which I had, and which would really take the field forward. I think that's unfortunate. I'm actually quite neutral about the whole matter in part because I was part of another generation of people who were arguing, against the zeitgeist of the time, that PTSD is a *real* disorder, is very consistent, and is observable across different types of trauma. And of course that was what happened—the diagnosis of PTSD was eventually accepted. It was because people came to understand that there was a database, there was scientific strength behind the work that we were all doing and the arguments we were making.

So what has to happen for complex trauma to receive the same attention? First, I never personally liked the name "complex trauma." It implies that the other things that we see in clinics represent "simple trauma" and that's hardly the case. The premise of complex trauma is *many trauma exposures*, recurring over time. But, of course, war is the exact same way. War is actually long-standing experiences (sometimes years) without safety, and with many traumatic events occurring. We have now had 11 years of war with military people serving multiple tours. If they leave the war zone, they may return to safety, but many of these people never *feel* safe again. So maybe the idea that complex trauma is about multiple traumas is not really the right way to construe it. So, if multiple traumas will not be the organizing factor for complex trauma, what else is? Perhaps it's interpersonal violence. But war, too, is fundamentally about interpersonal violence. War is about betrayal—it's all about betrayal, just as is abuse by someone in a parenting role, a teaching role, and so on.

So, what are the organizing principles for the notion of complex trauma? And how can we work with it in a way that helps us to describe this population of patients? Apparently, it's a huge number of people who are coming in with something that experienced therapists are saying looks a lot like one another. But what is it? What are the organizing principles? Can't we measure it? Can't we look at its internal consistency? Can't we see how these symptoms all hang together? Can't we create clusters? Can't we observe physiological differences between people who do and don't possess the condition? Can't we do the scientific work that will speak for itself? That's what I'm advocating for in complex trauma. This is what the proponents of complex trauma are asking for—the scientific community is asking for the fundamentals. Unfortunately, when people

talk about complex trauma, it turns into you're "with them or against them" and that's never a comfortable dialogue to me. I really want to say, "Okay, these are the next five things that I would do if I were studying this patient population."

Then there are other people who feel that it doesn't make much difference whether we call it complex trauma or not—if there's a trauma history, then the treatment is the same regardless. I don't know that there are good data on that either. The studies are never powered correctly (i.e., have enough subjects for appropriate statistical analyses) to be able to answer that question. Some of these data I've seen in presentations by other people will say that people with and without features of complex PTSD do equally well, but it's never powered properly, it's simply a post hoc examination of findings.

So, I think the studies still need to be done. But who will do them? I don't really know. Sometimes it has been put in front of me, but my plate is really full, and I have a lot of questions that I want to ask regarding war veterans, so I haven't turned my attention to this area at all, to be honest. But I do try to read, I do try to keep up with it. I don't spend a lot of time on people's opinions. I spend much more time on data, concepts, theoretical models, and constructions of the condition. First and foremost, it is ultimately all about the scientific information substantiating the condition of complex trauma, which is, I think, still modest.

The Need for Trauma Training in Clinical Psychology

The idea historically in our country is that if you have a PhD in clinical or counseling psychology and you are confronted with a case—whether it's simple, straightforward, or complex—you have the background to know what to do. Nothing could be further from the truth. Our training programs do not teach us about every disorder, its evaluation, and its care. We don't learn that way as psychologists. Rather, we learn in broad strokes, a broad swath of information about all of psychopathology is what is provided to us, and then we focus over time. And psychologists usually focus pretty quickly as they go through internship and fellowship; eventually most psychologists get increasingly focused. So, the idea that one can go into a broad-based clinical practice and be prepared to take care of patients of all types—personality disorders, substance use disorders, schizophrenia, bipolar disorder, PTSD, social anxiety, adjustment to medical conditions—is just not possible.

Training on Trauma in the Department of Veterans Affairs (VA)

In my 35 years in the field, I have never before seen a healthcare system committed to educating and training its mental health workforce as the VA is doing currently. It's never before happened in America. It is happening, too, to some extent in the United Kingdom and Australia, and perhaps elsewhere. But it's not happening in major health systems outside of Veterans Affairs centers. The VA has taken upon itself the task of trying to educate the workforce in the interest of providing patients the best available mental health care. But it's a very big workforce to educate. Will it fall short? Of course. But it's a constantly evolving thing and I hope we will keep moving in that direction. We need to learn how to take care of families, how to do marital therapy, how to comfort people who have lost a child or a loved one, how to do grief therapies, how to do all evidence-based PTSD therapies. It's not easy to learn different approaches to therapy. But the VA system has taken it upon itself to do this. It will fall short, but the good news is that it's trying. There's no other system that I know in healthcare in America that's trying to do this on such a large scale in the mental health arena. The stakes are very high and we need to do it as well as we possibly can.

There is a real need for people who are experienced, who understand what the problems are, and who will help educate in whatever form—whether it's giving a lecture, writing a book chapter or journal article, or addressing some pressing concern nationally. These are the things that we do as professional people committed to the field. That's the commitment to being a VA researcher, or being a VA clinician: We try to do the best we possibly can for the people who are coming in for care, whose lives, as far as I'm concerned, were irrevocably changed as a result of the experiences they had in these war zones. We owe it to them to try to do the best we possibly

can. I have tried to do my part of it too. It's a small part, but you do whatever you can do to try to make the healthcare system work.

The Effect of War

First and foremost, in my opinion, is that service in the military has done more *to help* the lives of the people who have served than anything else imaginable. Our country has, ever since George Washington and Abraham Lincoln, committed itself to provide opportunities for people who engaged in military service. Those opportunities are college and graduate education opportunities, less expensive loans, guarantees of loans, helping people get started in business, helping people acquire jobs, and helping people to keep jobs. These are the things that I think are really the foundation of the incredible America of our lifetime. The post-World War II “boomer” generation had access to the best universities in all the world and in all of history because of the collaboration between the government and universities. And universities and the research environment drove corporations, and these then drove education. It was all premised on helping this country move forward after the terrible wars in Europe and Asia. The fact that we still have the finest universities in all the world is a tribute—it's now more than 70 years duration—and a sign of something very special and very important about the role of the military in our country.

But there is also that minority of people whose lives are actually disorganized by their experiences in the war zones, experiences that are very dramatic and sometimes traumatic. They may not be able to take advantage of the many opportunities, educationally and otherwise, that are proffered by the government to help those who served. Those are people, broadly conceived, who suffered trauma and developed PTSD. When I first entered the field in the 1970s, there was considerable debate about whether the reason these young people returning from Vietnam were suffering was because “the worst went over and the worst came back.” That was part of the culture that existed in the 60s, 70s, even into the 80s until a transition occurred in mid-80s.

The notion that these people were already damaged, whether genetically or by their earlier life experiences, was very much on the table until the mid-80s. It was really the National Vietnam Veterans Readjustment Study that, I think, put to rest that conversation (not permanent rest but put to rest at that time) because that project was paid for by the government, by the VA. It was the first scientific study ever conducted to evaluate what the price was, psychologically and behaviorally, of sending people to war. No other country had ever done it. The United States did it. It was controversial. I was in the midst of the controversy, and sometimes I was in the cross hairs. It was partly because people really had strong beliefs about whether it was the *prewar* characteristics, the *war* characteristics, or the *postwar* characteristics that were responsible for the outcomes. Or, as many of us thought, it's an interaction of all three of course.

The National Vietnam Veterans Readjustment Study had a spectacular board of psychiatric epidemiologists, the likes of which I've never seen before or since—terrific people. I had the administrative oversight role for the government on this project; I was the government's spokesperson. I was the one who had to take ideas from the research team back to Washington and convey to the public policy leaders what I thought the recommendations were and what we as an institution should do, and that, of course, was also loaded with conflict because there were differences of opinion even at the highest level of public policy about what should be done. In the end, with the help of many talented VA researchers, we were able to learn about the relative weight of responsibility from premilitary exposures to stress, war zone stress, and post-war zone stress characteristics. And in the end, it was a combination of all three of these, but the greatest weight was on the military experiences themselves. This is not to diminish the pre-exposure or postexposure stressors, which were also related to outcomes, but the greatest power was the effect of military experiences.

So, these, to me, are some of the watershed moments in the field. They're really important for understanding PTSD. They're really important for understanding human resilience, and they're really important for understanding the effect of war. And now, here we are again. I never thought we'd be in the position of understanding the effect of so many deployments into a war zone, but we are 11 years into the current war, with over two and a half million Americans serving, many of them up to five, six, seven tours in these war zones. It's amazing. We don't know the

effect yet. It doesn't look good at this point, but maybe it'll be just fine over time. There is no shortage of interest in the psychological outcomes, there is no shortage of interest on the part of this country in making sure that those who served and are going back into the healthcare systems, whether DoD, the VA, or the private sector, are getting services that will mitigate the effect of these events on their adjustment. There are dedicated resources for the care of military veterans, their families, and their children, and the hope is that more can be done. There's a lot going on and it's very encouraging to see.

The Opportunity to Do Good Work in Trauma

I think we're in a very important business in clinical psychology and mental health. I've been doing this now for 35 years since my internship at the University of Mississippi Medical Center/Jackson VA. There is not a greater opportunity to do important good work than there is now in this field of psychological trauma. For me it's really all about the effect of war, how war changes people's lives, and what it does to individuals, families, communities, nations, and, more broadly, society. I have never had a day at work where I was bored. I've never said, "Well wouldn't it be interesting to see somebody who has a panic disorder, somebody who has depression." Since 1981 my career has been about PTSD. To me that's an indication of how important the work is and it keeps motivating me—it keeps me here working late at a computer—but it's in the interest of trying to reach large numbers of people who might read, who might think, who might be able to help people who are struggling. And so here I have been for 35 years and I don't have any end in sight for the work. I think it's work about which one can be very proud. I think at the end of the day, if there are enough of us who commit for very long periods of time to the scientific study of these problems, then the whole trajectory of mental health research and services will be altered. The fact is, it already has been, but it needs to be altered even more.

We now know at a basic level how genes work, how things get flipped on and flipped off, and what patterns might happen after the experience of adversity. We didn't know this 15 years ago. Then, it was much more seen as either on or off—you inherit it and you get it. But now we know that if somebody lives in a really stressful environment, then there will be an effect at the genetic level, which then leads to an effect at the protein, enzyme, cellular, tissue, or organ level, and then at the holistic level, and then at the family level, and then at the community level, and finally at the societal level. That may be how all of this works, but it will take some pretty large computers and some pretty detailed evaluation of measurement to get to the bottom of it. But when we get to the bottom of it, should we ever, the role of psychological trauma is going to be one of the variables, one of the factors that people are going to look at and say "Yes, we really need to try and reduce the amount of this that's happening in our society." There's no question in my mind that's coming. It may be sooner than I think.