A GUIDE FOR FAMILY & LOVED ONES

Complex PTSD (C-PTSD)

Understanding the deeper impact of prolonged or repeated trauma, supporting recovery and relationships, and safeguarding the wellbeing of everyone involved.

Why Complex PTSD needs its own guide

Complex PTSD includes the core symptoms of PTSD alongside additional difficulties with emotional regulation, a persistently negative sense of self, and relationships. These patterns are often linked with prolonged or repeated trauma from which escape was difficult or impossible. The person's reactions may therefore appear not only around obvious trauma reminders, but in everyday closeness, disagreement, dependence, trust and vulnerability.

PTSD and Complex PTSD: what is different?

Both can involve re-experiencing, avoidance and a persistent sense of current threat. Complex PTSD additionally involves what ICD-11 describes as disturbances in self-organisation: difficulty regulating emotions, deeply negative beliefs or feelings about oneself, and persistent difficulties sustaining relationships or feeling close to others.

This does not mean that somebody with C-PTSD is permanently damaged. These are understandable adaptations to prolonged threat. They may have helped the person survive environments where trust, safety or choice were limited. Recovery involves helping those survival responses become less necessary in the present.

Emotional flashbacks

Some people describe sudden states of fear, shame, helplessness, rage or abandonment that feel much younger or more intense than the present situation seems to explain. There may be no clear visual memory. The body and emotion can nevertheless respond as if an earlier relational danger is happening now.

A delayed message, disagreement, criticism, someone walking away, a closed door or unexpected touch can trigger an emotional state that feels absolute. The supporter may think, 'We were discussing something small - how did we get here?' Understanding emotional flashbacks can help both people pause before treating the current relationship as the whole cause of the intensity.

Shame and the negative sense of self

Prolonged trauma can shape beliefs such as 'I am bad', 'I am too much', 'I do not deserve care', 'everything is my fault' or 'people leave when they know the real me'. Compliments may be hard to absorb. A small mistake can trigger overwhelming self-attack. Reassurance may help briefly but cannot by itself rewrite a deeply learned self-concept.

Loved ones can avoid reinforcing shame while still addressing behaviour. 'What happened was not okay' is different from 'You are impossible.' Recovery needs accountability without humiliation and a gradual ability to experience worth that is not dependent on constant reassurance.

Trust, attachment and closeness

When danger came from people who should have been safe, closeness itself can become complicated. The person may long for connection and simultaneously fear it. They may become watchful for rejection, pull away after intimacy, struggle to ask for help or feel unsafe when dependent on somebody.

A partner may experience this as being pushed away and pulled back. The goal is not endless pursuit. Predictability, clear communication, consent and boundaries can create a relationship where closeness does not require either person to disappear.

Hypervigilance in relationships

C-PTSD can involve monitoring facial expressions, pauses, tone, silence or changes in routine for signs of danger. Neutral behaviour may be interpreted through an old threat template. Supporters can become hypervigilant too, monitoring every word to avoid a reaction. When both nervous systems are scanning each other, ordinary disagreement can feel dangerous.

Hold the present and the past together

Try: **'I can see this feels frightening and I wonder whether something older has been activated. I am here now, and we can deal with what is actually happening between us today.'** This validates intensity without pretending the present relationship caused all of it.

Dissociation, shutdown and disconnection

During overwhelm, the person may become numb, distant, unreal, unable to speak or disconnected from bodily sensation. Shutdown is not necessarily deliberate withdrawal. Reduce demands, orient gently to the present and ask what kind of contact helps. Do not crowd, shake or force eye contact.

If the person has an agreed grounding plan, follow it. Useful options may include naming the date and location, feeling feet against the floor, holding a textured object, noticing colours in the room or hearing a familiar voice. Grounding should increase choice, not become another demand to 'snap out of it'.

Anger and protective responses

Anger may have been unsafe or impossible during the original trauma and can emerge strongly later. It may protect against fear, shame or vulnerability. Understanding this can reduce moral judgement, but it does not make intimidation, threats, property damage or violence acceptable.

During escalation, keep language simple, lower stimulation and create space. Return to the content of the disagreement after both people are regulated. If you feel unsafe, prioritise safety rather than trying to complete a therapeutic conversation.

Intimacy, touch and body safety

Prolonged trauma can affect body ownership, sexual safety and the ability to remain present during intimacy. The person may freeze, dissociate or become distressed by touch that is objectively affectionate. Ask rather than assume. Consent can change at any point.

Partners also have emotional and relational needs. Rebuilding intimacy may involve non-sexual closeness, explicit consent, slowing down, stopping without blame and specialist therapeutic support. Nobody should be pressured to provide sexual contact to prove love, and nobody should be shamed for trauma-related limits.

Control, choice and everyday decisions

If earlier life involved coercion or powerlessness, being told what to do can trigger disproportionate threat. Offer meaningful choices where possible. At the same time, a household cannot function if every request is interpreted as control. When calm, agree how responsibilities, money, parenting and shared decisions will be handled.

People-pleasing and the fawn response

Some survivors protect themselves by appeasing, agreeing quickly, over-caring or suppressing needs. Families may mistakenly assume the person is comfortable because they rarely say no. Encourage honest preferences and make disagreement safe. A 'yes' given from fear is not the same as genuine choice.

Parenting and intergenerational patterns

Parents with C-PTSD may be deeply committed to giving children a safer childhood and still find noise, dependency, conflict or boundary-testing activating. Shame can make ordinary parenting mistakes feel catastrophic. Support should strengthen reflective parenting rather than telling the parent they are destined to repeat the past.

Children must not become emotional regulators for adults. They need predictable routines, age-appropriate explanations and other dependable adults when a parent's symptoms are severe. If trauma responses are frightening children or affecting their safety, seek professional support early.

Friends, siblings and adult children

Siblings may carry different memories of the same family. Adult children may have spent years managing a parent's emotions. Friends may feel unsure whether to ask questions or give space. Each relationship deserves its own boundaries; being trauma-informed does not mean every relative must provide the same kind or amount of support.

Emotional flashback plan

When calm, record: **How do I know an emotional flashback may be starting? What do I fear is happening? What is actually happening now? What words help? What words intensify shame? Touch or space? Which grounding helps? What can my loved one realistically do? What must I do for myself? When should professional help be involved?**

Assessment and treatment

Complex PTSD is recognised in ICD-11. Assessment should explore PTSD symptoms plus emotional regulation, self-concept and relational difficulties, while considering depression, anxiety, dissociation, substance use, physical health and other possible or co-occurring conditions. Trauma history should be approached sensitively and without forcing unnecessary detail.

Treatment needs to be individualised. Trauma-focused CBT and EMDR are established treatments for PTSD symptoms and may be used within care for people with complex presentations. Some people need additional work on safety, emotional regulation, relationships or dissociation. Treatment pacing matters; moving too quickly into trauma processing can be destabilising for some people.

Stabilisation and pacing

Stabilisation is not about proving the person is 'ready enough' or delaying therapy indefinitely. It can involve building enough present-day safety, coping capacity, crisis planning and emotional regulation to engage in treatment. The amount needed differs between people and should be decided collaboratively.

Families can support routines, predictability and practical stability, but should not become responsible for delivering a clinical stabilisation programme. Skills need to belong to the person rather than depending entirely on one relationship.

Trauma-focused CBT and EMDR

Trauma-focused CBT helps people process trauma memories and meanings, reduce avoidance and rebuild a life no longer organised around danger. EMDR uses a structured therapeutic protocol that includes recalling aspects of traumatic experiences while engaging in bilateral stimulation. Both require appropriately trained practitioners.

For complex presentations, therapy may also address shame, attachment, emotional regulation, dissociation and relationship patterns. The exact approach should follow individual assessment rather than a one-size-fits-all sequence.

Medication and co-occurring difficulties

There is no medicine that erases complex trauma. Medication may be used for co-occurring depression, anxiety, sleep or other clinical needs after assessment. Medication decisions belong with qualified prescribers. Alcohol or recreational drugs may be used to numb distress but can complicate sleep, mood, risk and therapy.

What recovery can look like

Recovery can mean noticing an emotional flashback before it takes over, tolerating disagreement without expecting abandonment, feeling safer in the body, reducing shame, setting boundaries without panic, experiencing closeness without losing self, developing a more stable identity and building a future that is larger than survival.

Recovery does not require forgiving perpetrators, reconciling with unsafe relatives or telling the whole trauma story. The person has a right to choose what healing means for them.

Relationship repair

Trauma can explain why a conflict became intense, but both people still need repair. Ask: What happened in the present? What older fear was activated? What impact did the behaviour have? What does each person need acknowledged? What boundary or skill would help next time?

Avoid using trauma as a weapon - 'You're only saying that because of your childhood' - or as a reason that nothing can be discussed. Present-day relationships deserve present-day accountability.

Supporting therapy without becoming therapy

Ask what practical support helps: quiet after sessions, transport, childcare, a meal, or not asking questions. Do not demand disclosure of therapy content. Partners and relatives should remain partners and relatives. When one person becomes the full-time regulator, therapist and crisis service, intimacy and equality often suffer.

Reclaiming ordinary life

Healing also happens in ordinary experiences: cooking, walking, learning, working, laughing, friendships, rest and hobbies. Not every conversation needs to be about trauma. A relationship needs shared life as well as understanding.

Setbacks and anniversaries

Stress, anniversaries, family contact, medical procedures or major transitions can reactivate old patterns. A difficult period does not erase progress. Review what changed, restore supportive routines and seek clinical help if symptoms are significantly worsening.

Safeguarding yourself as a supporter

Complex trauma can draw loved ones into a powerful care-taking role. You may become responsible for reassurance, sleep, appointments, finances, social contact, conflict prevention and emotional regulation. Because the person's history is painful, saying no can feel cruel. Over time, however, a relationship with no room for the supporter becomes unsustainable.

Your needs are not evidence that you lack empathy. You are allowed privacy, sleep, work, friendships, money that is protected, time alone and feelings that are not immediately turned into somebody else's trauma response.

Walking on eggshells

If you constantly rehearse sentences, hide ordinary feelings or avoid reasonable boundaries because you fear triggering shame, shutdown or abandonment, notice what has happened to the relationship. Trauma-informed communication should increase safety for both people, not require one person to become invisible.

Boundaries and predictable return

A useful boundary may include connection: 'I am too overwhelmed to continue this safely. I am taking forty minutes and I will come back at 7 pm.' This is different from disappearing without explanation. Predictable return can reduce threat while preserving the supporter's right to pause.

Other boundaries may be: 'I cannot be shouted at.' 'I will not discuss this while either of us is intoxicated.' 'I can listen, but I cannot be your only support.' 'I will not give access to my private accounts.' 'I will ask before touching you, and I need you to respect my no as well.'

Support versus rescue

Support helps the person use their own skills, treatment and network. Rescue repeatedly removes every consequence, cancels the supporter's life, takes over tasks the person can do or assumes that another adult's emotions must be prevented at any cost. Rescue often comes from love and fear; it can still create dependence and burnout.

Secondary trauma and carer fatigue

Hearing trauma material, witnessing repeated crises and living in chronic alertness can affect supporters. You may experience sleep problems, intrusive images, anxiety, numbness, irritability, reduced concentration or loss of pleasure. These reactions deserve support in their own right.

Supporter wellbeing check-in

Ask: **Am I safe? Am I sleeping? Can I have needs without feeling guilty? Do I still recognise my own life? Am I becoming responsible for another adult's regulation? Are children affected? Are my finances and privacy protected? Who supports me? What boundary would make this relationship more sustainable?**

When trauma and harmful behaviour coexist

Most trauma survivors are not abusive. Do not equate C-PTSD with danger. But if actual behaviour includes violence, threats, coercive control, stalking, sexual pressure, property destruction or financial exploitation, respond to the behaviour. A trauma history may provide context; it does not remove another person's right to safety.

You do not need to stay in an unsafe relationship in order to prove that you understand trauma. If children or vulnerable adults are exposed to frightening or dangerous behaviour, their welfare must be considered.

Crisis and urgent support

Seek urgent professional help for suicidal intent, serious self-harm, inability to remain safe, severe deterioration, dangerous substance use or another immediate risk. If there is immediate danger to life, call 999 or attend A&E.; NHS 111 can provide urgent health advice. Follow any existing crisis-team or care plan. Samaritans can be contacted on 116 123 in the UK and ROI.

Calling professionals when a situation exceeds what a family can safely hold is not rejection. It protects the person in crisis and the people around them.

Practical family coaching tools

1. Past-or-present check. What is happening now? What does my nervous system fear is happening? What evidence belongs to the present? What choice do I have now that I did not have then?

2. Emotional flashback card. My early signs are ____. The feeling is ____. I fear ____. Today is ____. I am with ____. Helpful words are ____. Touch: yes/ask/no. My grounding choices are ____. My next step is ____.

3. Two-person needs map. During conflict, what does the survivor need - safety, clarity, space, reassurance, choice? What does the supporter need - respect, time, sleep, safety, honesty, autonomy? Design a response that recognises both columns.

4. Relationship repair. What happened today? What older wound may have been activated? What impact did each person's behaviour have? What needs an apology or repair? What boundary remains? What would make the next conversation 5% safer?

5. Boundary and return plan. I need to pause when ____. I will say ____. I will return at ____. If the boundary is not respected, I will ____. If I feel unsafe, I will ____.

6. Reclaiming-self plan. Trauma taught me I am ____. The evidence for who I am now includes ____. Parts of my life I want back are ____. One small act of identity, pleasure, competence or connection this week is ____.

7. Supporter recovery plan. What have I lost to the care-taking role? What do I want back? Which responsibilities are genuinely mine? Which belong to the person or professionals? Who can hear my experience without making me feel guilty?

Common myths

'Complex PTSD is just severe PTSD.' It includes the PTSD pattern plus persistent difficulties in emotional regulation, self-concept and relationships. **'If somebody reacts strongly, the current partner must have caused it.'** Present events matter, but old threat learning can amplify current experience. **'Trauma-informed means never saying no.'** No; predictable boundaries can increase safety. **'Recovery means forgiving.'** No. **'The supporter should become the safe person for everything.'** Sustainable recovery needs a wider system.

Recommended reading

Trauma and Recovery - Judith Herman: a foundational exploration of trauma, safety and reconnection. **Healing the Fragmented Selves of Trauma Survivors** - Janina Fisher: a trauma-informed perspective on fragmentation, shame and survival responses. **Coping with Trauma-Related Dissociation** - Suzette Boon, Kathy Steele and Onno van der Hart: practical material for trauma-related dissociation. Books can be activating; readers should pace themselves and use them alongside professional support where appropriate.

UK and clinical resources

Complex PTSD is recognised in the World Health Organization's ICD-11. Useful UK starting points include NHS information on complex PTSD and PTSD, NICE guideline NG116 on PTSD, NHS Talking Therapies where appropriate, and Mind trauma information. Local trauma and specialist services vary by area.

Clinical note

This guide is educational and does not diagnose Complex PTSD or replace individual medical or psychological advice. Complex presentations can overlap with dissociative, mood, personality-related and neurodevelopmental difficulties. Treatment should follow an individual professional assessment, and significant risk requires appropriate clinical or emergency support.

A message from Maggie

Complex trauma can be difficult for families to understand because the past does not always stay neatly in the past. It can appear in a pause, a tone of voice, an argument, intimacy, a closed door or the feeling that somebody is moving away. The person may know logically that they are safe and still feel, in their whole body, that something terrible is about to happen.

Understanding that can change the way we respond. Instead of asking why somebody cannot simply move on, we can recognise a nervous system and a sense of self that learned survival over a long period of time. We can offer predictability, choice, respect and connection while the person learns that the present can be different.

But I also want to speak directly to the person beside them. You do not have to make yourself smaller to prove that you are safe. You are allowed boundaries. You are allowed to disagree. You are allowed to sleep, work, see friends, protect your finances and have parts of your life that are not organised around trauma.

The healthiest support is not one person endlessly regulating another. It is a relationship where both people can gradually become more themselves. Sometimes that means moving closer. Sometimes it means stepping back. Sometimes it means saying, 'I love you, and this needs professional help rather than more from me.'

What happened to somebody matters deeply, but it does not have to be the final definition of who they are or what their relationships can become. Recovery can create more safety, more identity, more choice and more ordinary life. My hope is that there is room for both the survivor and the supporter to breathe.

Maggie Learoyd
Space to Breathe Therapy

Final coaching question

What would a relationship look like if **the survivor did not have to live as though the past were still happening, and the supporter did not have to organise their whole life around preventing it?**