Greetings complex trauma colleagues,

Welcome to the fifth edition of Complex Trauma Perspectives, the International Society for Traumatic Stress Studies’ Complex Trauma SIG newsletter! Through this publication, we hope to promote understanding of complex trauma and its sequelae by centering unique perspectives on the assessment, treatment, and conceptualization of complex trauma from various points of view, ranging from that of clinicians and researchers, to survivors, community partners, and interdisciplinary professionals.

As our first issue of 2022, we are excited to highlight the World Health Organization’s (WHO) 11th version of the International Classification of Diseases (ICD-11). The ICD-11 was released in 2018, adopted by the 72nd World Health Assembly in 2019, and came into effect for member states at the beginning of 2022. New to the ICD-11 is a diagnosis for complex posttraumatic stress disorder, also known as Complex PTSD, or CPTSD, which is discussed throughout this issue. Many of you likely know this is a significant milestone many years in the making and represents a momentous international undertaking by complex trauma clinicians, researchers, survivors, and advocates. (cont.)
With this edition of Complex Trauma Perspectives, we hope to stimulate discussion about the CPTSD diagnosis, explore the implications of its inclusion in the ICD-11, and inspire future conversations about complex trauma assessment, treatment, and more.

To begin the discussion on the ICD-11 Complex PTSD diagnosis and its implications, we asked lead researchers to share their thoughts on the diagnosis in our new feature section, "Commentary Corner". We invite CT SIG members and Complex Trauma Perspectives readers to continue this conversation in the next issue of our newsletter by submitting a response to these comments, or your own commentary on the ICD-11 CPTSD diagnosis, to CTSIGPerspectives@gmail.com with “Commentary Corner CPTSD Diagnosis” in the subject line. This will be an ongoing feature and the discussion on the CPTSD diagnosis will continue for as long as we receive submissions. A special thanks to Marylene Cloitre, Julian Ford, and Thanos Karatzias for getting this important conversation started.

The Complex Trauma Perspectives team would additionally like to announce a transition of leadership to two new editors: Morgan McCowan and Aubrie Munson, who also double as the student co-chairs of ISTSS’s Complex Trauma SIG. We are excited to move into the leadership roles for this newsletter and extend much gratitude to Kelly Pattison and Krista Engle, the original editors of this newsletter, both for getting this publication started and for their immense support in the transition of leadership.

Thank you to all Complex Trauma SIG members, our SIG co-chairs, article contributors, and article editors!

Sincerely,
Complex Trauma Perspectives Editors, Morgan & Aubrie

MORGAN MCCOWAN, MA
Morgan is a 4th-year student at Adler University in Chicago, pursuing a PsyD in Clinical Psychology with an emphasis in Traumatic Stress Psychology. Specializing in complex and continuous forms of trauma, including systemic, institutional, and intergenerational traumas, Morgan is a therapist at the Chicago Center for HIV Elimination. She is passionate about providing affirming, community-based trauma-informed care to the LGBTQIA+ population. Morgan's research centers Black sexual minority men and their experiences of intersectional identity trauma related to race/ethnicity and sexuality. She will begin her doctoral internship at a community center in Chicagoland area in the fall. In her free time, she enjoys going for walks and doing art.

AUBRIE MUNSON, BA
Aubrie is currently a 2nd-year MS psychology student at Arizona State University. Her research focuses on individuals with a history of interpersonal trauma and their current touch behaviors and attitudes. She’s interested in learning whether individuals with complex PTSD symptomatology differ from those with PTSD symptomatology, as it pertains to current touch behaviors, attitudes towards touch, and relationship quality. Aubrie also plans to incorporate moral injury into future studies. After pursuing a doctorate, Aubrie plans to become a clinician-researcher at a Veteran Affair Hospital. In her free time, Aubrie volunteers for Crisis Text Line and volunteers for a search and rescue team; she also trains her dog for search and rescue missions.

CONTACT THE COMPLEX TRAUMA SIG CO-CHAIRS THROUGH THE SIG WEBPAGE* TO JOIN NEW OR ONGOING SIG PROJECTS

CONTACT THE COMPLEX TRAUMA PERSPECTIVES EDITORS BY EMAILING CTSIGPERSPECTIVES@GMAIL.COM

*Throughout the issue underlined text represents a clickable link for access to additional resources*
Complex PTSD has now been accepted into the World Health Organization’s (WHO) 11th version of the International Classification of Diseases (ICD-11; World Health Organization, 2018). Complex PTSD, or CPTSD, is a sibling diagnosis to PTSD under the general parent category of ‘Disorders Specifically Related to Stress.’ Consideration of the distinction between these two types of traumatic stress disorders in ICD-11 initially came from two sources. First, a survey of 3,222 mental health providers from 35 countries indicated that CPTSD was the most frequent diagnosis suggested for inclusion in ICD-11 (Robles et al., 2014) with clinicians reporting that a distinction was needed to better account for the different characteristics and consequences of exposure to chronic, sustained, and multiple forms of trauma. Second, a series of early investigations applying person-centered quantitative analyses (latent class analyses) to trauma-exposed populations indicated that individuals fell into at least two different groups, with one displaying a CPTSD profile and the other a PTSD profile. This result was consistently observed across clinical, community, and epidemiological samples and across different cultures and countries (Cloitre, 2020). These differences, with some refinement, evolved into the diagnostic criteria for PTSD and CPTSD in the ICD-11. The introduction of a clear definition of CPTSD, its acceptance in a diagnostic system, and the development of a reliable measure (Cloitre et al., 2018), have led to substantial growth in research exploring risk factors, correlates, and implications for treatment.

Notably, there are several ways in which ICD-11 CPTSD differs from the earlier conceptualization on which it is based (Herman, 1992), a result of evolving and continuing research. First, exposure to chronic and multiple forms of trauma is a risk factor, not a requirement, for the CPTSD diagnosis. Some individuals with single incident traumas but psychological and/or environmental vulnerabilities (e.g., substantial ACEs) may develop CPTSD. Alternatively, individuals with chronic trauma exposure have been shown to develop PTSD rather than CPTSD. This flexibly considers genetic and environmental risk factors, as well as protective elements. Ultimately, the diagnosis is based on symptom profile not trauma history. A second difference concerns the symptom profile of CPTSD. The symptom clusters of both PTSD and CPTSD in ICD-11 are streamlined and limited in number (see infographics description). The WHO guidelines for the development of diagnoses highlighted the importance of organizing symptoms according to a limited number of essential or core features that would be applicable across different populations, cultures, and languages. The PTSD diagnosis is comprised of three symptom clusters: re-experiencing, avoidance, and sense of threat. This triad is well-established, empirically supported, and is associated with a dominant explanatory construct in PTSD termed “fear conditioning.” The CPTSD diagnosis includes the three PTSD symptom clusters and three additional (cont.)
symptom clusters describing disturbances in self-organization (DSO): emotion dysregulation, negative self-concept, and relational difficulties. Each DSO reflects a fundamental category of human experience that is disturbed by severe or chronic trauma. Lastly, as may be self-evident, a person can be diagnosed with either PTSD or CPTSD; if a person is diagnosed with CPTSD, they cannot also have PTSD.

Recent research has suggested that the presence and organization of CPTSD symptoms are relatively invariant across cultures (Knefel et al., 2019), that CPTSD and borderline personality disorder are distinct disorders (Frost et al., 2020), and that the distinction between PTSD and CPTSD is applicable to pediatric populations (Haselgruber et al., 2020). Significant work remains to be done. The relationship between CPTSD, dissociative disorders, other trauma-generated symptoms, and related problems needs further investigation. PTSD and CPTSD symptoms should be adapted for application with children and adolescents, taking into account developmental processes. Lastly, and of great interest, are the implications for treatment planning. It remains to be seen whether devising and matching treatments to these specific diagnoses will improve outcomes, increase patient satisfaction, and advance the efficient use of limited global mental health resources. (See https://www.traumameasuresglobal.com/ for more information on CPTSD research around the world).

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The development and validation of a complex PTSD (CPTSD) diagnosis is a landmark accomplishment by an international consortium of clinician-researchers. The inclusion of CPTSD in the ICD-11 is the culmination of a second major paradigm shift in the mental health field that has resulted in formal recognition of the unique and crucial contribution of posttraumatic stress reactions to psychopathology. The first paradigm shift was the definition and incorporation of PTSD as a diagnosis in the DSM-III in 1980. Soon thereafter, clinicians, scientists, and survivors of interpersonal trauma and betrayal were calling for a complex variant of PTSD in order to account for posttraumatic symptoms that extend beyond the initial core PTSD symptoms of intrusive re-experiencing, avoidance and emotional numbing, and hyperarousal and hypervigilance (Freyd, 1994; Herman, 1992). A formulation of Disorders of Extreme Stress Not Otherwise Specified (DESNOS) was developed and validated (van der Kolk et al., 2005), but was only included as a set of associated features in DSM-IV PTSD. Several symptoms in DSM-5’s revised PTSD (especially in the new PTSD Criterion D, “alterations in cognitions and mood,” and the expanded Criterion E hyperarousal symptoms) are similar to the DESNOS symptoms of trauma-related alterations in affect and impulse regulation, memory and attention, and systems of meaning. However, it was not until the current formulation of CPTSD that the complex posttraumatic sequelae (i.e., the Disturbances of Self Organization [DSO]: affect dysregulation, alterations in relationships, and negative self-concept) were finally aligned as a co-equal partner to the classic PTSD symptoms in a hierarchical structure with PTSD and DSO as correlated but distinct domains in a formally recognized psychiatric diagnosis.

As Dr. Cloitre notes, there is still work to be done in determining where to place other trauma-related symptoms represented in DESNOS in relation to CPTSD. Although, there are encouraging new findings, for example, in regard to dissociation and CPTSD (Jowett et al., 2021). It also will be important to define trauma-related alterations in somatic, attentional/cognitive, and behavioral domains, such as impulsivity and oppositionality. Symptoms of co-dependency and maladaptive attachment, in addition to a tendency to focus on detachment and withdrawal, will need to be explored in relation to CPTSD. Furthermore, recognition of a sense of self as damaged, feeling like a failure, and feelings of worthlessness in relation to CPTSD needs to be included in additional research. Progress in these areas is being made with the validation of a Developmental Trauma Disorder syndrome for children and adolescents (Ford et al., 2022). As I said in a recent commentary on a special issue of the Journal of Traumatic Stress, CPTSD is “still going strong after all these years” (Ford, 2019). For that, we have to thank the many clinicians and clinical researchers who have persevered in ensuring that CPTSD is finally a recognized and widely respected diagnosis.

References
The inclusion of Complex PTSD in the ICD-11 has probably been the greatest development in the area of psychotraumatology since the inception of PTSD as a mental health condition. We have observed the CPTSD profile in our clinics for years, but in the absence of a suitable diagnosable syndrome to capture our patients’ symptom profile, people have been given alternative diagnoses, such as depression and anxiety disorders. These diagnoses do not account for CPTSD’s full symptomatology, which has resulted in limited access to appropriate, effective therapies. The additional DSO symptoms of CPTSD are cross-diagnostic and can be observed in many other conditions; however, in the case of CPTSD, these symptoms are the result of traumatic stressors. DSO symptoms co-occur with re-experiencing, avoidance, and sense of threat, creating a specific and well-integrated symptom profile. It is now widely established that this set of symptoms can affect not only mental health but also physical health and longevity (Ho et al., 2021). The new diagnosis will undoubtedly allow more people to access appropriate treatment and support. This is quite important considering that CPTSD seems to be a more prevalent condition compared to PTSD following exposure to traumatic events (Karatzias, Hyland et al., 2019). Paradoxically, this is despite the requirement of having to endorse six clusters of symptoms in the case of CPTSD compared to three in PTSD.

Traditionally, more complex forms of traumatization have been associated with childhood and interpersonal traumatic life events but, as Cloitre suggests, the type of stressor is a risk factor for the condition and not a prerequisite. However, childhood trauma and polytraumatization are more strongly associated with CPTSD compared to PTSD (Karatzias et al., 2017). Although there is ample evidence that existing therapies can be useful for complex traumatization (Foa et al., 2010), emerging evidence suggests that the type of traumatic stressor not only can affect the symptom profile of CPTSD with regard to symptom prominence (Karatzias et al., 2020); it can (cont.)


**RESEARCH SUPPORT FOR COMPLEX PTSD AS A DISTINCT DIAGNOSIS**

**Different Symptom Profiles**

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PTSD and Complex PTSD share the same "Gate" Criterion of exposure to a traumatic stressor.

According to the ICD-11, PTSD and Complex PTSD are two independent disorders with different patterns of symptom presentation.

Complex PTSD accounts for changes in self-organization (DSOs), which are not included in PTSD criteria.

**Distinctions in Self-Organization (DSOs)**

- Re-experiencing
- Avoidance
- Sense of Threat
- Affect Dysregulation
- Negative Self-Concept
- Disturbed Relationships
- Functional Impairment

**Distinct Trauma Populations**

Individuals seeking trauma treatment were empirically distinguishable based on different patterns of symptom endorsement. Three groups emerged: those with low symptoms overall, those with typical PTSD symptoms, and those with Complex PTSD symptoms (typical PTSD symptoms + DSOs).

![Diagram of Distinct Trauma Populations](image)

**Theorized Differences in Trauma History**

Evidence suggests that Complex PTSD is often associated with histories of chronic/repeated trauma, particularly childhood abuse, whereas PTSD is more associated with single-incident trauma.

Based on a study of New Yorkers seeking treatment for trauma...

- Child abuse is predictive of Complex PTSD symptoms.
- Exposure to the 9/11 terrorist attacks in 2001 was predictive of PTSD symptoms.

77% of individuals who reported child abuse as their worst trauma had a Complex PTSD symptom profile.

80% of individuals who reported 9/11 as their worst trauma had a PTSD symptom profile.

**Distinction Supported Across Multiple Studies**

Over 40 studies across 15 different countries consistently demonstrated the distinction between PTSD and Complex PTSD, according to the key symptoms associated with each disorder in the ICD-11.

A meta-analysis of current evidence regarding the distinctiveness of PTSD from Complex PTSD found that 9 out of 10 studies reviewed supported a distinction between PTSD and Complex PTSD.

In the same meta-analysis, 5 out of 5 studies identified different levels of impairment between those with PTSD and those with Complex PTSD.

**References**


**Commentary Corner (Cont.)**

Karatzias

also moderate the treatment outcome (e.g., childhood trauma; Karatzias, Murphy et al., 2019). The inclusion of CPTSD in the ICD-11 opens up the possibility of exploring how helpful existing therapies can be for CPTSD and to experiment with new treatment paradigms (Karatzias & Cloitre, 2019). Our group is currently undertaking several projects which explore treatment of CPTSD, and we hope to be able to report on findings within the next few months. The inclusion of CPTSD in the ICD-11 has created the possibility to explore the efficacy of existing and novel therapies for this very debilitating condition. 

Information curation and infographic design by: Morgan McCowan, MA
Complex post traumatic stress disorder (CPTSD) was first proposed as a diagnosis by Dr. Judith Herman (1992): The existing diagnostic criteria for PTSD are derived mainly from survivors of circumscribed traumatic events. They are based on prototypes of combat, disaster, and rape. In survivors of prolonged, repeated trauma, the symptom picture is often more complex.... I propose to call it complex post-traumatic stress disorder. (p. 119)

Since 1992, the diagnosis has been the subject of ongoing debate by mental health clinicians and researchers, despite the fact that many have accepted its efficacy. According to van der Kolk (2019), a committee was created by the American Psychiatric Association (APA), at the urging of numerous professionals, to determine if CPTSD was a credible diagnosis. Although it was clear to the committee that CPTSD was indeed credible, and 19 to 2 voted in favour of accepting it into the Diagnostic and Statistical Manual of Mental Disorders (DSM), it was not included in the DSM’s newest edition, the DSM-5 (APA, 2013). Van der Kolk refers to the decision as “political” and, as I wrote in a previous article for this newsletter, this was viewed by many as a form of “institution betrayal” of CPTSD survivors, perpetrated by the APA (Smith & Freyd, 2014).

It was not until 2018, when the World Health Organization (WHO) announced CPTSD would be included in the eleventh edition of its International Classification of Diseases (ICD-11) that the CPTSD diagnosis became official. The ICD-11 became available for use in nine member states this year, nine years after the APA declined to include it in the DSM-5 and thirty years after it was first proposed by Dr. Herman (1992). It has been a very long wait for survivors in desperate need of validation, treatment, services, and support.

Although very much welcomed by survivors, the ICD-11 CPTSD diagnosis is not without problems. The ICD-11 definition of CPTSD adopted by the World Health Assembly in 2019 reads as follows:

Complex post traumatic stress disorder (CPTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met. In addition, CPTSD is characterised by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

The first distinction regards the nature of complex trauma, which typically involves ongoing/repeated traumatic stress versus a single event. It is the accumulation of traumatic stress that leads to the development of CPTSD, while a single incident is more likely to produce PTSD. This is an important distinction to make in terms of understanding the difference between CPTSD and PTSD, especially in terms of treatment.

Second, the events leading to the development of ICD-11 CPTSD are characterized as “extremely threatening or horrific” such as “torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse.”
The effects of trauma are indeed just that—effects of an event—and as such are causally related to the trauma and not to the harmed individual. … when psychology and mental health professionals draw that causal path incorrectly, when the field fails to place the dysfunction solidly on the shoulders of individual and societal wrongdoing, survivors of trauma … end up shouldering the burden. This, in essence, is pathologizing—the assumption that because individuals exhibit certain sets of symptoms, they are themselves disordered. (Rosenthal et al, 2015, pp. 131-137)

There is no mention of more covert/subtle but no less damaging forms of trauma such as emotional abuse/neglect (e.g., narcissistic abuse, coercive control). Sadly, many relational trauma survivors subjected to these more covert forms of traumatic stress often encounter dismissive attitudes and downright rejection of their pain. This must change.

Third, the wording of the diagnosis itself is problematic, starting with the word “disorder”. For survivors and professionals alike, it is stigmatizing and pathologizing:

The effects of trauma are indeed just that—effects of an event—and as such are causally related to the trauma and not to the harmed individual. … when psychology and mental health professionals draw that causal path incorrectly, when the field fails to place the dysfunction solidly on the shoulders of individual and societal wrongdoing, survivors of trauma … end up shouldering the burden. This, in essence, is pathologizing—the assumption that because individuals exhibit certain sets of symptoms, they are themselves disordered. (Rosenthal et al, 2015, pp. 131-137)

It is crucial that the wording of the diagnosis reflects the fact that survivors’ symptoms are normal/natural responses to trauma versus due to a character defect, lack of resilience, and/or weakness. Far too often, survivors face a “blame the victim” attitude, much like veterans before PTSD became more widely understood. This change will impact how survivors are viewed by medicine, mental health, social work, courts, and the public.

Another word in the diagnosis that is problematic for survivors is the word “post.” It suggests that the trauma is in the past and yet for many (or most) it continues (e.g., ongoing emotional abuse in relational trauma, ongoing racism in collective trauma, ongoing natural disaster trauma of COVID-19). Wording such as “Complex Traumatic Injury” would more accurately reflect the enduring nature of both the trauma and survivors’ symptoms.

Finally, an important omission from the ICD-11 definition is the negative, lasting and often life-threatening impact of ongoing traumatic stress on physical health, particularly when it begins in childhood. The Adverse Child Experiences (ACE) study conducted from 1995 to 1997 by Kaiser Permanente in the United States revealed the serious health consequences of childhood trauma in adulthood. As Herman (2015) writes “the results were stunning”:

….higher ACE scores were strongly correlated with great incidence of the ten leading causes of death in the United States, including heart, disease, lung disease, and liver disease…smoking, obesity, alcoholism, risky sexual behaviour….injection drug use….clinical depression and suicidal behavior. (pp. 257-258)

In addition to improving the definition by capturing the physical impact of traumatic stress, it is suggested that incorporating a clear distinction between relational abuse/neglect and other forms of complex trauma that result in CPTSD (e.g., collective/group trauma such as racism; the trauma of natural disasters such as the COVID-19 pandemic) would be beneficial. This would lead to a more nuanced understanding of CPTSD as developing in response to various types of ongoing/repeated traumatic stress that threatens one’s physical and/or psychological self. (cont.)
CPTSD exacts a high physical and psychological toll on both individuals and, in turn, societies. Despite this, governments, medical/mental health care, justice, and other service sectors are slow to acknowledge and address its lasting and costly impact:

…even though the consequences of adverse childhood experiences constitute the largest public health problem in the United States (Fellitti et al., 1998), and likely world wide, there is enormous resistance to place the care and feeding of developing human beings where it belongs: at the forefront of our attention. (Ford & Courtois, 2020, p. 606)

We need to work together to bring those of us suffering from the debilitating symptoms of CPTSD to the forefront in the minds of those in the professional, governmental, and public spheres. As a start, let’s ensure the diagnosis is a compassionate and accurate contextual reflection of how and why symptoms develop. No doubt once there is a wider understanding of just how prevalent CPTSD is, and the extent to which it impacts people and societies around the world, the better prepared we will be to prevent, intervene, and/or treat it effectively.

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### References

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**LORI HEROD, EDD**

Dr. Lori Herod is a retired professor of Adult Education who is a survivor of complex trauma. In 2014, she founded an information website and discussion forum for survivors of relational trauma -- Out of the Storm (OOTS) -- after learning she suffers from CPTSD. In addition to teaching, Herod has worked and volunteered in many sectors including violence against women in Ontario, adult literacy in Ontario and Manitoba, restorative justice in Alberta, and recently, program development with the Canadian Centre for Inquiry. Herod is also Co-Chair of the Complex Trauma Special Interest Group at ISTSS and is the spouse of a retired Canadian military officer.
WHAT IS CLEAR IS THAT TRAUMA PREDICTS BOTH INTERNALIZING AND EXTERNALIZING SYMPTOMS AMONG YOUTH; AND, YOUTH EXHIBITING THE MOST TROUBLING EXTERNALIZING BEHAVIORS ARE MORE LIKELY TO BE DiAGNOSED WITH A CONDUCT DISORDER

—BREND, COLLIN-VÉZINA, & MILOT

RESEARCHERS’ CORNER I: CONFRONTING THE SPECTRE OF ANTISOCIAL PERSONALITY DISORDER AND PSYCHOPATHY AMONG JUSTICE-INVOLVED YOUTH

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Département de psychoéducation, Université du Québec à Trois-Rivières

In recent decades, there has been an expansion of knowledge regarding the impacts of adversity on children and youth. Early life stressors, particularly in the context of attachment relationships, have been shown to undermine emotional and somatic, attentional and behavioural, self- and relational capacities (Ford, 2021). Sweeping changes have been proposed to better capture the symptoms that can result from extreme stress in early life. A new diagnosis, developmental trauma disorder (DTD) was proposed (van der Kolk, 2005) as a parsimonious option for children and youth with complex presentations that do not meet the criteria for posttraumatic stress disorder (DePierro et al., 2019). Given the potential for early adversity to impact multiple domains of development, Teicher and colleagues (2021) have also advocated that those individuals with early life stress or maltreatment histories be recognized as an ecophenotype. As such, a specifier could be added regardless of diagnosis, to enable clinicians in their efforts to understand and treat individuals belonging to this distinct sub-group. Teicher and colleagues refer to research that demonstrates that people with maltreatment (cont.)
RESEARCHERS’ CORNER I (CONT.)

Brend, Collin-Vézina, & Milot

histories are less responsive to treatment across several diagnoses including depression, psychosis, substance use, and personality disorders, demonstrating how the impacts of developmental trauma might be a pervasive risk and prognostic factor. Dysfunction and treatment challenges may result from developmental injuries comorbid with, or rather than, individual pathology.

In addition to the relationship between early life adversity and treatment efficacy, Copeland et al. (2018) found that “childhood trauma casts a long and wide-ranging shadow, showing associations with elevated risk for adult psychiatric status [in general]” (p.7). Indeed, there are diagnoses that appear to be overwhelmingly given to people belonging to this ecophenotype. For example, people diagnosed with borderline personality disorder are up to 13.91 times more likely to report developmental trauma than non-clinical controls and 3.15 times more likely than other psychiatric groups (Porter et al., 2020). Antisocial behaviour has also been associated with maltreatment among both children and adults (Braga et al., 2017; DeLisi et al., 2019). This is of particular concern as antisocial personality disorder (ASPD) is strongly associated with criminal behaviour, and justice settings have been particularly slow to adapt services to meet the needs of developmental trauma survivors (Levenson & Willis, 2019). Given the results of recent research, it appears that one strategy to ensure that youth justice settings promote the well-being of developmental trauma survivors is to reappraise the etiology of behavioural problems among justice-involved youth.

From juvenile behaviour to adult pathology

Justice-involved youth are distinguished by the relationship between mental health and justice professionals’ perceptions and observations of their behaviour in childhood and adolescence and the adult diagnosis of ASPD. Indeed, how those perceptions and observations are documented form the prerequisite of the adult ASPD diagnosis. The Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-5-TR) states: “The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood” (American Psychiatric Association [APA], 2013, 2022). Therefore, children and youth who are perceived to be manifesting such conduct can be understood to potentially be developing an antisocial personality. Further, the DSM-5-TR definition of ASPD explains that “this pattern has also been referred to as psychopathy...” (APA, 2022). Thus, although this diagnosis is distinct from the label “psychopath,” the two constructs have been used to identify the same clinical population (Miller et al., 2019). While the DSM does not make a diagnosis of ASPD available for minors, psychopathy can be assessed with the Hare psychopathy checklist: Youth version (Forth, 2005), which has facilitated its use in research and practice.

There are several criticisms of such labels being applied to children and youth. Ribeiro da Silva and colleagues (2020) summarized these critiques, including that some of the characteristics embodied in the construct of psychopathy are developmentally appropriate in these age ranges. They also drew focus to the highly plastic nature of child and youth personality. Further, “the validity and temporal stability of psychopathic traits; the pejorative characterization of the term and its implications for children/youth and their families; the implications to the legal context; the potential stigmatization that may occur to these youth; and the triggering of potential Pygmalion/Golem effects” suggest these concepts might not accurately capture child and youth personality traits, and might harm children, youth, and their families (p.2). It is worth noting that, despite sharing many characteristics, ASPD and psychopathy are distinct concepts (Smith et al., 2021). Both represent a constellation of traits with clinical and social importance but lacking in “validity as a true syndrome in nature with a single common etiology” (Crego & Widiger, 2015, p. 674). (cont.)
Psychopathy, although described as “one of the more well-established personality disorders” (Crego & Widiger, 2015, p. 665) has not been validated as a diagnosis by the APA. This is also true in the International Classification of Diseases, 11th edition (ICD-11; World Health Organization [WHO], 2019/2021) in which neither ASPD nor psychopathy are included (Mulder, 2021). Thus, even for application among adults there is a lack of consensus about how to understand and treat this phenomenon.

In 2020, Cochrane published two meta-analyses regarding treatment efficacy for ASPD. The conclusion Gibbon and colleagues (2020) reached regarding the existing psychological interventions was that there was insufficient evidence to either recommend or reject any of them. Similarly, regarding the extant pharmacological treatments, Khalifa et al. (2020) determined that there was not “enough evidence to determine whether or not medication is a helpful treatment” for people with ASPD (p. 32). Recent findings from a meta-analysis examining psychopathy found that it is neither predictive of treatment and rehabilitation outcomes nor the individual trait of lack of conscience (Larsen et al., 2020). Conclusions that refute accepted beliefs about psychopathy and demonstrate that the concept fails to be associated with meaningful change (Larsen et al., 2020). These meta-analyses were conducted using data from adult populations, without the above-mentioned caveats associated with juvenile populations.

DeLisi and colleagues (2021) investigated the interrelationship between psychopathy and trauma exposure among young offenders. They concluded that “interventions that serve to reduce exposure to trauma in children’s lives can not only reduce delinquency and related antisocial behaviours, but also reduce the incidence of personality pathology that makes such conduct more likely” (p. 287). This conclusion is amplified by several large-scale studies (Fox et al., 2015; Trulson et al., 2016). Research investigating ASPD or psychopathy has identified the presence, if not the critical importance, of childhood histories of maltreatment or ongoing traumatic experiences (Ribeiro da Silva et al., 2020; Yalch et al., 2021). The exact causal mechanisms of violent offending and the influence of childhood maltreatment remain unclear (Connolly, 2020). What is clear is that trauma predicts both internalising and externalising symptoms among youth; and, youth exhibiting the most troubling externalising behaviours are more likely to be diagnosed with a conduct disorder (Baker et al., 2007; Farley et al., 2021; Frensch & Cameron, 2002; Kearney et al., 2010). A diagnosis that opens the door for them to be perceived as psychopathic or in the preliminary stage of ASPD.

**Treating injury not pathology**

The diagnosis of complex posttraumatic stress disorder (CPTSD), introduced in the ICD-11, describes the potentially debilitating impacts of “exposure to events of an extremely threatening or horrific nature” (World Health Organization [WHO], 2019/2021, para. 1). Children and adolescents are acknowledged as being at greater risk of developing CPTSD and several of the expected symptoms are consistent with (cont.)
a lack of regard for, or behaviour that violates, the rights of others. The items that comprise the Hare Psychopathy Checklist: Youth Version are consistent with developmental presentations of CPTSD as outlined in the ICD-11, which also states, “[c]hildren and adolescents with Complex Post-Traumatic Stress Disorder often report symptoms consistent with … Oppositional Defiant Disorder [and] Conduct-Dissocial Disorder…” (para. 21). The WHO cautions that “co-occurring diagnoses should only be made if the symptoms are not fully accounted for by Complex Post-Traumatic Stress Disorder and all diagnostic requirements for each disorder are met”.

Justice-involved youth, as a group, suffer extremely elevated rates of trauma exposure (Wolpaw & Ford, 2004). Baglivio et al. (2014) measured adverse childhood experiences (ACEs) among 64,0329 juvenile offenders. “Only 3.1% of the males and 1.8% of the females reported no ACEs. Approximately 10% of the males reported just one ACE compared to 7.6% of the females” (p. 9). Given that behaviours symptomatic of developmental trauma may result in conduct disorder diagnoses, trauma exposure among justice-involved youth must be consistently and rigorously considered at all levels of youth justice systems involvement. Trauma-specific treatments have been implemented among justice-involved youth and are showing promise (Marrow et al., 2012). Through a systematic review of the literature, Baetz et al. (2021) found that “trauma-specific treatments significantly reduced PTSD symptoms, co-occurring mental health symptoms, and justice-related outcomes” (p. 1). The exact mechanisms of delinquent behaviours remain unclear. Consensus across juvenile-justice services about the compatibility of trauma-informed approaches with ASPD or psychopathy remains to be achieved. The multiple and complex impacts of child abuse and deprivation are clear, and evidence supports treatment to mitigate the impacts of developmental trauma (Pane Seifert et al., 2021; Spinazzola et al., 2021; Teicher et al., 2021). Traumatic experiences in childhood play a significant role in the presence and the complexity of symptoms in adulthood (Cloitre et al., 2009). Culturally appropriate, trauma-informed care offers a promising alternative lens for juvenile-justice services.

References


CULTURALLY APPROPRIATE, TRAUMA-INFORMED CARE OFFERS A PROMISING ALTERNATIVE LENS FOR JUVENILEJUSTICE SERVICES.

—BREND, COLLIN-VEZINA, & MILOT
Brend, Collin-Vézina, & Milot


DENISE MICHELLE BREND, MSW, PHD

Dr. Denise Michelle Brend is passionate about identifying and mitigating the ways in which exposure to potentially traumatic experiences can impact helping relationships, individuals, and communities. Currently an Assistant Professor at Université Laval and a Canadian Consortium on Child and Youth Trauma co-researcher, Denise’s research is focusing on the potentially harmful impacts of human services work in systems of care and control, workplace social support, and the implementation of effective social responses to trauma through social innovation.

DELPHINE COLLIN-VEZINA, PHD

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RESEARCHERS’ CORNER II: SYSTEMATIC PERSECUTION AND MISTREATMENT AS A COMPLEX TRAUMA OF SOCIETAL ABUSE

Elena Cherepanov, PhD, LMHC
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Trauma specialists have long been aware that interpersonal abuse can produce a particularly complex, severe, and chronic traumatic aftermath associated with long-term alterations in self-related and social cognitions. In my book *Understanding the Transgenerational Legacy of Totalitarian Regimes* (Cherepanov, 2021a), I argue that systematic persecution can shape a similarly complex collective trauma. This experience of abuse can determine future strength, resilience, and collective vulnerabilities. Furthermore, just like with interpersonal abuse, this experience can create cycles of societal revictimization in the future.

Persecution becomes systematic when instigated, encouraged, or supported by a person, institution, or group in power, which often is the government, administration, or local leaders. Systematic oppression, discrimination, or intimidation can be recognized both in low- or high-resource settings and anywhere belonging to a particular political, religious, racial, ethnic or sexual minority group, which makes people a target for deliberate societal victimization. Societal mistreatment is a form of collective abuse which aims to instill power and control over the behavior and often the mind of people.

Authoritarian, totalitarian, or nationalistic leaders use brainwashing, threats, and political violence to coerce people into obedience, foster divisiveness, and vilify the marginalized groups. In a violation of human rights, they fail to protect marginalized groups and set up institutional barriers to accessing vital resources.

The COVID-19 pandemic demonstrated that having trust in the government is essential for effective disaster management during crises. Abuse of power by the government and systematic persecution, on the other hand, creates a profound distrust of public officials which has become a barrier to implementation of public health anti-COVID-19 measures and accessing health care and mental health services (Cherepanov, 2021a).

Studies consistently demonstrate that even a brief exposure to abuse of power can contribute to a significant short- and long-term impact equally recognized in individuals, communities, and across generations (Cherepanov, 2020, 2021b). This experience tends to profoundly alter individuals’ and groups’ worldviews and affects the identity formation and core social beliefs about self and others (DeGruy, 2005).

Resultant political apathy, powerlessness, and learned social helplessness can discourage marginalized groups from taking responsibility and investing in the collective future. This mindset can increase vulnerabilities to societal abuse in the future.

The victimhood (see Hirschberger, 2018) can become deeply engrained into a cultural identity and is recognized in increased depression, hypervigilance, over-reactiveness, and self-destructive behavior such as an increase in substance use and suicides rates (Hamby et al., 2020; Gameon & Skewes, 2021). (cont.)
In addition, similarly to other traumas of abuse and mistreatment, systematic persecution creates profound impact not only on victims, but also erodes the souls of perpetrators as well as bystanders. No one is left untouched. Sooner or later, they or their descendants will have to come to terms with the fact that their ancestors participated in the persecution or allowed it to happen. Common strategies to edit a problematic discourse are “selectiveness” of the historical memory, omission of shameful facts, or blaming the victims for holding on to the memory of a past injustice.

When addressing the legacy of societal abuse, trauma specialists play an important role in supporting survivors, raising awareness of its consequences, and preventing future recurrences. Based on what is known about recovery following complex trauma from interpersonal abuse, overcoming historical trauma from systematic persecution will likely involve confronting and accepting the past, grounding in the present time, realizing available choices, empowering movement away from trauma-reactive mode to re-imagining a collective future, and making commitment for change in the future (Cherepanov, 2020).

Future directions: More research is needed. Supporting those affected by systematic persecution both nationally and internationally calls for a better understanding of the impact of ongoing and historic victimization. Recognizing its aftermath in people we serve, and in ourselves, will enable the development of responsible, effective, and contextually grounded strategies for intervention and prevention.

**References**
CLINICIANS’ CORNER I

TRAUMA DRAMA: HOW DO WE DEMONSTRATE THE IMPACT OF DRAMA ON HEALING

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For millennia, drama has been used to reintegrate traumatized people into society, yet theatre treatments are currently underutilized, perhaps because of barriers to quantification. As the complex trauma field coalesces around research agendas focused on the new CPTSD diagnosis in the ICD-11 (World Health Organization, 2018), it may make sense to examine traditional healing practices – like drama – since they naturally attract the injured, are well tolerated across cultures, and have been improved over generations. Throughout my life, when psychotherapeutic treatments have provided a partial remedy for personal traumas, I have found myself returning to drama as a reliable way to mop up residuals. In recent doctoral studies, I have heeded the charge to make a unique writer-specific contribution to the literature by conducting a dissertation study of Trauma Drama (TD; Spinazzola, 2019). TD is a manualized 18- to 24-session group intervention that synthesizes scenario-driven improvisational theatre with the expert-consensus treatment guidelines for complex trauma (Cloitre et al., 2012). TD is an evidence-informed intervention model adapted from Urban Improv, an improvisational theatre-based youth violence prevention program with some empirical support (Kisiel et al., 2006; Zucker et al., 2010). Although I studied TD in a complex-trauma-exposed residential-youth population, it is also offered through schools and community mental health agencies in the United States and Canada. TD utilizes a troupe composed of mental health providers and actors. It is a phased model. Phase I (weeks 1 to 5) utilizes improv games to cultivate emotional regulation skills and foster safe, trusting relationships among group members. Phase II (weeks 6 to 17) employs improvisational scene work based on pre-written scenarios that typify experiences of complex-trauma-exposed youth. Scenes are performed once through by troupe members and are rewound to pivotal decision points in the action. Participants are invited to brainstorm alternative decisions and act them out. Phase III (weeks 18 to 22) focuses on integrating lessons learned and application to everyday life.

For the past 20 years, I have been a therapist, but for the 20 years prior (starting at age 5), I was an actor. Through the exploratory study of TD, I hoped that my “insider” actor/therapist knowledge might enable me to crack the tough nut of finding a way to study drama as a treatment for complex trauma. It seemed to me that if I could identify a simple matrix of relevant variables, with which to probe drama’s characteristics, processes, and effects, that standardized variable matrix might be able to be used by researchers across cultures and settings. Data from smaller (cont.)
samples could then be combined into larger data sets. Those larger data sets might support statistical modeling capable of revealing how and for whom drama facilitates complex trauma healing. Consequently, my mixed-method study of TD (Sullivan, 2021) cross-compared three levels of data: physiological heart rate variability data, eight standardized psychological questionnaires, and phenomenological interviews.

TD appeared to be what I call a Smart Intervention, meaning that TD appeared to partner with the innate healing potentials of the participant’s system to find hidden treatment targets and to dose challenges intuitively and in manageable chunks (Wickelgren, 1979). The conditions of TD’s group milieu activated a subliminal Seek and Find mechanism within participants, which was able to locate the diffuse, non-verbally encoded, preverbal somatic and emotional treatment targets that were most relevant to the particular individual. TD then appeared to find successive treatment targets in a sequence up the developmental ladder. Automatic personalization via the Seek and Find mechanism appeared to be TD’s potentially generalizable characteristic -- a developmental process (rather than a symptom outcome), which seemed to render TD capable of delivering differentially targeted personalized medicine in the group milieu. The International Trauma Questionnaire (ITQ [Cloitre, Bisson, et al., 2018; Cloitre, Shevlin, et al., 2018]), developed to evaluate the new CPTSD criteria and not available in time for the TD study, might provide evidence of change via the Seek and Find process. In addition, longitudinal brain imaging of the default mode network (DMN) at rest may show physical evidence that the Seek and Find has done its work. The DMN is a cortical network along the brain’s midline that is involved in self-referential and autobiographical memory and which, when people are at rest, is responsible for providing a stable and continuous sense of self. A recent series of papers has described lack of activation in the DMN of the brain, as revealed through fMRI that exists in conjunction with a lack of sense of self when at rest in survivors of childhood trauma (as opposed to healthy controls who exhibit the opposite patterns [Lanius et al., 2020; Terpou et al., 2019, 2020; Thome et al., 2019]). TD findings taken together with the findings of those papers suggest that participants impacted by TD might show progressively greater activation of the DMN at rest as they started to develop a greater sense of self through TD’s processes.

TD leveraged the handed-down folkways of theatre (egalitarian culture, skills, and beginning-middle-ending structure), along with theatre games and improvisations, to provide a predictably safe environment. Actors/facilitators and participants formed critical bonds that were trusting, behaviorally self-disclosing, and intimate, yet well contained within the special conditions of group time in the theatre space (apparently avoiding some of the relational confusion that might occur when working with complex-trauma-exposed populations [Courtois, 2021]). TD interspersed fun and play with serious topics. Troupe members and participants alike considered TD to be emotionally challenging work; they looked.

FIGURE 1 QUALITATIVE CONSTITUENTS & PROCESSES OF THE TRAUMA DRAMA EXPERIENCE
It’s not like a paperwork thing. It’s not something like, ‘I’m going to sit in an office for an hour and just talk about myself.’ No. You learn from current things, old things, things that are day-to-day, things that you might walk down the street and find. But no one gets hurt. No one’s in trouble. It might feel awkward and uncomfortable, but you’re learning and you’re growing. And that’s the therapy. You deal with it because you know you’re going to learn from it, and no one’s getting hurt. It’s dramatizing…not traumatizing. You just go there, and you have fun, and you come home. You don’t really think on it too much, but you know in the back of your head, okay, people are in the same shoes and we feed off each other and are able to learn together and teach each other. That’s kind of what this group is.

Another of TD’s processes that facilitated change was the Modification of Associations Process (MAP). The MAP appeared to modify, update, and diversify associations that had been previously fixated by trauma. Through repeated occurrences of the MAP and the consequent updating and expansion of previously fixated associations – participants pivoted away from Absence to a greater sense of Presence to self, others, and the world. Trauma-bound associations that had anchored a pervasively negative sense of self and isolation from self, others, and the world loosened and changed. The MAP may be thought of as leading people through the following seven steps: 1) grounding into the safe routine and ritual of the session; 2) up-regulating arousal during games or scenes; 3) being surprised by an activity or idea that challenged trauma-related associations to self, others, and the world; 4) risking thinking and/or acting differently because of the surprise; 5) discovering a new way of thinking/behaving as a result of having taken a risk; 6) down-regulating arousal in the wake of discoveries; 7) integrating new discoveries into everyday life (see Figure 2). I will apply the surprise, risk, and discovery steps to Taisha’s quote below.

I would feel very isolated. …I was actually very embarrassed and ashamed. I thought I was the only one that would go through really difficult things, and I would get my anger out on them. …I tried helping myself out, and I just got stuck. …But then I realized they’ve been through many situations that were similar to mine. Like I said earlier, I’m comfortable talking about situations like that [now] because I know that I’m not alone with it. You take the thing that’s still really sad …like I said; you still have people that help you through it. …You can actually help each other. …It’s really helpful because you might need that in life.

Taisha was surprised that she was not the only one to be embarrassed and ashamed. She risked identifying with others, and via that risk, she discovered that she was not alone and could get support from and give support to others. This represented a change in self, other, and worldview. The MAP weakened Taisha’s associations to negative self-perceptions. Connection and identification with helpful others became associated with the (cont.)
possible affordance of relaxation, comfort, and protection as opposed to being primarily associated with inherent danger.

Another clear finding of the TD study was the critical importance of the Phase I stabilization component of TD’s sequenced treatment in impacting Disturbances of Self Organization (DSO) and its factor clusters of emotion dysregulation, negative self-concept, and interpersonal problems as described by the new CPTSD diagnosis (Cloitre, 2020). TD’s Phase I, with its focus on trusting, egalitarian relationships and reciprocity, reduced participants’ negative sense of self, improved their perspectives on interpersonal relationships, and provided practice of emotional regulation skills via play. Participants named these gains as a prerequisite to their willingness to start TD’s Phase II, which more directly addressed CPTSD factor clusters. A multi-time-point longitudinal study, using the ITQ might help validate and legitimize phased treatment for CPTSD and might also help to assess the contribution of each treatment phase to outcomes.

Although TD provided some potentially generalizable process outcomes across participants, it produced symptom outcomes that differed by particular physiological subtypes/phenotypes. I found three subtypes by examining shifts in nervous system balance over time as reflected through high frequency heart rate variability (HF HRV) electrophysiological data. The first subtype, Calming Down, showed arousal at pretest and nervous system balance at posttest. The second subtype, Waking Up, exhibited an immobilizing level of calm at pretest and an awakened level of arousal at posttest. The third subtype, Sowing Seeds, exhibited nervous system balance at pretest and an excessive calm at posttest. Each subtype showed unique and somewhat unanticipated patterns of symptom change over the course of the intervention. To illustrate, I will describe the symptom pattern of the Calming Down subtype – which, although carrying the highest cumulative trauma load – achieved the greatest nervous system balance of the three subtypes by the end of the TD treatment and was responsible for most of the statistically significant decrease in depression. Yet Calming Down showed a worsening in executive function symptoms. That mixed picture of recovery-in-progress makes sense. If, as my study suggests, TD diversified previously stuck patterns of neural connectivity, a messy period of more chaotic thinking might precede the settling down of the brain to a new order. It could be that patterns of improvement in certain symptoms, as well as an exacerbation (or transient exacerbation) in other symptoms, might be indicative of a growth/recovery trajectory and these patterns might differ by subtype/phenotype.

Naturalistic interventions like drama appear to have the potential for treating complex trauma. They are simple yet complex in their capacity to interact differentially according to a person’s specific needs. As such, drama as a treatment has previously defied systematic and methodical study. I have begun to identify a simplified matrix of variables and a method that may be used across cultures and treatment settings (cont.)
in order to aggregate a larger data set on which statistical modeling can be used: a) to refine variables for the study of naturalistic treatments, b) to uncover different typological healing paths, and c) to identify helpful components of naturalistic treatments that might be added to existing therapies in order to increase effectiveness. In order for drama interventions to be broadly disseminated and funded, it is necessary to produce legitimate evidence of effect.

As I finish this article, Putin has invaded Ukraine, and refugees are streaming across borders. This reminds me that not only do we need adaptable, effective, and non-pathologizing CPTSD treatments for developmental trauma, but also for refugee populations affected by complex trauma. ■

References

ED SIBLEY, MA, MHC/PSYCH-TRAUMA

Ed Sibley has an MA in Counseling Psychology and completed his Master Thesis on “Psychological Stress Theory: A Metapsychology & Objective Argument for a First Cause Construct.” Sibley enlisted in the Marines in 1959, became a Sergeant in 1968, eventually obtaining the rank of Major, in which he served until 1985. Sibley is the Founder and Director of Intra-family Trauma Resource Network, Inc. (ITRN) in Worcester, MA., a 501(c)(3) non-profit. Since 1985, ITRN has been involved in child/family advocacy and outreach work dealing with intra-family psychological distress (i.e., trauma/abuse) issues, including facilitation of an incest survivors’ support group for women and men. Sibley’s approach to clinical work begins with a distress diagnosis followed by a top-down teaching approach using nature to explain nurture’s failings and how to move beyond the fear-based developmental misconceptions. Unlike the soft-science of trauma focused nurture therapy alone, he also uses the laws of the universe (e.g., the hard-science of stress as defined in Newton’s Laws of Motion) as applied in a first causality reality-based therapy. How the formula of addressing psychological stress plays out begins with identifying the conflict between expectation and reality. For each of Sibley’s clients, individually or as a group, addressing the issue of understanding why requires a balance of top-down with bottom-up love-based awareness and application. Sibley measures successful recoveries by the number and strength of the client’s “Ah-Ha” reactions.

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CONCLUDING COMMENTS

Complex Trauma SIG Co-Chairs & Student Co-Chairs
Lori Herod, Rebecca Ohler, Morgan McCowan, & Aubrie Munson

CT SIG PROJECT ANNOUNCEMENTS

• ISTSS has now updated their publicly searchable Clinician Database to include specialties for "Complex Trauma" and "CPTSD"
  o Please consider opting into the clinician database - this is an important resource for complex trauma survivors, as few other available databases list Complex Trauma or Complex PTSD
  o To add these specialties to your ISTSS clinician profile, navigate through the following steps: click “My Membership” ➔ “Edit Your Profile” ➔ “Opt into Clinician Directory” ➔ “Special Interests” ➔ tick off the appropriate fields under “Fields to Display in Directory” (which is just above “Opt into Clinician Directory”)

• Roadmap to Resilience Podcast, a project done in collaboration with the ISTSS Moral Injury SIG, is now available!
  o This podcast features experts in the field of child stress and trauma who delve into research-based strategies for building resilience in children of all ages
  o Check it out wherever you get your podcasts

• Looking for other trauma podcasts? Try The Trauma Talks Podcast
  o This podcast examines the challenges of living with trauma, investigates current work in the field, and shares practical coping strategies
    ▪ None of the episodes go into detail about traumatic events
    ▪ Designed for information sharing, education, and support
  o *Note* The CT SIG was not part of creating this podcast, but recommends it to those who desire more audio content regarding trauma!

QUESTIONS OR COMMENTS ON THE NEWSLETTER?

Please email Complex Trauma Perspective editors with any feedback, contributions, or interest in helping with future issues

If you are interested in submitting commentary regarding the ICD-11 CPTSD diagnosis, please email with subject heading "Commentary Corner CPTSD Diagnosis"

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Thank you to our article editors:
Leisha Beardmore, Mimi Sullivan, Hannah Zioowski, Miranda Galbreath, Christie Iribarren, & Brett Stallone-Dwyer

Sincerely,
The Complex Trauma SIG Leadership Team
Lori & Rebecca (Co-Chairs)
Morgan & Aubrie (Student Co-Chairs)

CONTACT THE COMPLEX TRAUMA SIG CO-CHAIRS THROUGH THE SIG WEBPAGE TO JOIN NEW OR ONGOING SIG PROJECTS

THANK YOU SO MUCH FOR READING THE FIFTH ISSUE OF COMPLEX TRAUMA PERSPECTIVES, THE OFFICIAL NEWSLETTER OF THE ISTSS COMPLEX TRAUMA SIG!