Professional Practice Guidelines for the Treatment of Complex Posttraumatic Stress Disorders in Adults

A Joint Project of
Division 56 (Trauma Psychology) of the American Psychological Association
and
The International Society for the Study of Trauma and Dissociation (ISSTD)

Christine A. Courtois, PhD, ABPP, Chair
Paul A. Frewen, PhD, C. Psych, Co-Chair
Project Contributors:
Peter M. Barach, PhD, Bethany Brand, PhD, James Chu, MD, Marylene Cloitre, PhD, Constance Dalenberg, PhD, Nel Draijer, PhD, Victoria Follette, PhD, Julian D. Ford, PhD, Judith L. Herman, MD, Philip Kinsler, PhD, Ibrahim Kira, PhD, Andreas Laddis, MD, Ruth Lanius, MD, PhD, Sandra Paivio, PhD, C. Psych, Laurie A. Pearlman, PhD, Nnamdi Pole, PhD, Francine Shapiro, PhD, Joseph Spinazzola, PhD, Kathy Steele, RN, MSN, Joan A. Turkus, MD, with the assistance of Shannon Beattie, Alisa Breetz, PhD, and Jenney Zhu, BA.

INTRODUCTION

Exposure to traumatic life events is an unfortunately common human experience and a frequent cause of a wide variety of psychological and physical disorders that can express over the lifespan. When trauma exposure is defined as in the *Diagnostic and Statistical Manual 5* (DSM-5; American Psychiatric Association, 2013) as an event involving actual or threatened death, serious injury, or sexual violence, approximately two of every three persons worldwide will experience one or more traumatic events over their life course, and the majority will experience multiple exposures, averaging about five different traumatic stressors per person (Benjet et al., 2016). However, beyond the DSM-5 definition of trauma exposure, in recent decades different types of trauma occurring at various ages, in different contexts, and with different types of aftereffects have been identified. For example, the DSM-5 definition of trauma exposure has been faulted as being overly focused on *physical* forms of trauma to the exclusion of socioemotional or *relational* forms (e.g., abuse, abandonment, discrimination and oppression, death of significant others, betrayal, exploitation, and the use of various strategies to invoke fear, terror, cooperation, and dependency). Moreover, these relational and emotional forms of traumatization are thought to be especially impactful on children due to their accessibility, immaturity, dependence, and vulnerability, thus further constituting *developmental* forms of trauma (Anda et al., 2006; Dube et al., 2003; Finkelhor, 2008). Collectively, these emotional, relational, and developmental forms of trauma exposure have been termed *complex trauma* since Herman (1992b) coined the term in her now classic text *Trauma and Recovery*. The complex trauma formulation thus expands the definition of trauma from merely physical forms to include other ongoing, progressive, and entrapping interpersonal violence usually over the course of childhood but occurring at any age and having age and stage-related developmental and posttraumatic impact.

Further, just as research has suggested expanding the definition of trauma exposure beyond physical trauma alone, other research has expanded investigation of the mental health outcomes of complex trauma beyond the defining triad of symptom criteria of Posttraumatic Stress Disorder (PTSD), namely, reexperiencing, numbing, and hyperarousal (a fourth criteria, that of avoidance and cognitive changes was included in the *Diagnostic and Statistical Manual 5* [American Psychiatric Association, 2013]). The original three criteria were based on the study of combat trauma as experienced by late adolescent or adult males, i.e., at a stage of psychological maturation where their personalities were largely developed. This form of PTSD is now informally labeled “Classic” PTSD to distinguish it from a different form, labeled “Complex” PTSD (CPTSD) also suggested by Herman (1992a). The symptom criteria for CPTSD were based on the aggregated findings of the aftereffects of childhood trauma and other forms of domestic violence as experienced primarily by children and adult women. These included various forms of affect dysregulation and impulse dyscontrol, alterations in attention and consciousness including dissociative experiences, disturbances in self-perception and identity, relational problems including ambivalent attachment to abusers and vulnerabilities to revictimization, somatization, and broad existential impacts on the victim’s meaning-making systems (e.g., on their life goals, sense of purpose, or spirituality). The diagnostic formulation of CPTSD was proposed to the DSM-IV committee as a freestanding diagnosis, separate from PTSD. The committee voted on its inclusion, but the decision was later reversed at a higher level and it was included instead as an associated feature of PTSD, where it has remained through the most recent edition. However, the DSM-5, partly based on neurobiological research (e.g., Lanius et al., 2012), included a dissociative subtype of PTSD to account for brain changes associated with

early life versus later traumatization. Many believe that this dissociative subtype, along with the definition of complex PTSD as an associated feature of PTSD, represents where descriptions of complex PTSD are to be found in the DSM-5.

Despite the omission of a separate complex PTSD diagnosis in DSM-5, research on complex forms of trauma and PTSD continued and in 2018 a set of three simplified criteria based on latent class analyses comprised of 1) emotional dysregulation, 2) identity-based, and 3) relational/social concerns, collectively labeled *Disorders of Self Organization* (DSOs), were proposed for inclusion in the *International Classification of Diseases (ICD*-11) of the World Health Organization (WHO, 2018) Complex PTSD was accepted as a freestanding but "sibling diagnosis" to PTSD, requiring that the client meet the triad of criteria for PTSD, namely, re-experiencing, avoidance, and hyperarousal, in addition to DSO symptoms. CPTSD has been colloquially referred to as "PTSD plus" to account for these additional symptoms. Besides these aforementioned affective, interpersonal, and self-referential DSOs, research findings have also continued to accumulate that recognize that repetitive traumas—perhaps especially those occurring during childhood—additionally create transdiagnostic risk factors for various medical, somatic, and psychological disorders, especially dissociative conditions, and including mood, anxiety, and substance use disorders (e.g., Frewen et al., 2021), along with increased risk for self-harm, risk-taking, other forms of interpersonal violence, and suicide. In summary, complex trauma results in myriad and idiosyncratic consequences, many of which are synergistic and compounded. These symptoms quite often originated as defensive and protective responses to ongoing forms of traumatization that, while being adaptive and even life saving at the time of trauma, become maladaptive over time when used chronically outside of their original and pertinent context.

In recent years, several sets of Clinical Practice Guidelines (CPGs) developed specifically for the treatment of symptoms of classic PTSD have been published (APA, 2017a; Australia/Phoenix, 2013; Forbes et al., 2020; US DoD/VA, 2017). They were based on systematic reviews of randomized controlled trials of treatment efficacy regarding the remission or lessening of PTSD symptoms as the primary outcome. A comparison of the findings and methods of these can be found in Hamblen et al. (2019). All of these guidelines are in relative agreement in recommending a variety of cognitive (CT) and cognitive behavioral therapies (CBTs) along with eye movement desensitization and reprocessing (EMDR) identified as Trauma-Focused Treatments (TFTs) as "first line" efficacious treatments for the amelioration of PTSD symptoms. Further, for the most part, guideline authors at least implicitly assumed that the recommended treatments would be broadly applicable to most traumatized individuals, including those with CPTSD, regardless of type and extent of their trauma or their current readiness, preference, or emotional/life status. This assumption, however, has been challenged by many clinicians and researchers with experience treating persons with CPTSD. For example, some have questioned the applicability of the findings since people with the greatest degree of symptom severity and symptoms above and beyond those of classic PTSD (and who by extension are those most likely to have met criteria for CPTSD) were often excluded from the original efficacy studies. Many have also argued that most CPTSD patients require a period of stabilization and skill-building—with particular attention to emotional regulation--before directed trauma work of the sort required by most TFTs to avoid overwhelming and retraumatizing them in an iatrogenic way. Such clinicians have therefore continued to endorse a sequenced treatment model proposed by Herman (1992b) due to its more gradual approach built upon a hierarchy of tasks across three phases (described in more detail below).

Considerable and at times heated debate has occurred regarding the need for sequencing, with TFT proponents arguing that, based on study outcomes of their technique's efficacy, that initial attention to stabilization is not necessary and impedes trauma processing and resolution; it thereby offers no immediate relief and needlessly extends the patient's suffering (e.g., De Jongh et al., 2016). In contrast, the counter argument made by sequencing proponents is that traumatic memory processing should only occur after initial attention is given to patient safety and ability to regulate emotional responses so as not to be retraumatized (e.g., Cloitre et al., 2011). Many clinicians have had patients decompensate when they approached their traumatic memories before they had the skills to manage the strong emotional and physiological reactions that emerged. At present, while the "jury is out" in terms of whether sequencing is a necessary precursor in the treatment of complex trauma, in keeping with the principle of personalizing and customizing treatment to the needs and the capacities of individual patients, it is likely not necessary for all, but is still the general standard and will be important for many patients.

Despite the strong clinical consensus in favor of sequencing treatment for at least some patients, and lack of treatments being evaluated specifically for CPTSD rather than PTSD alone, no practice guidelines have been produced specifically for Complex PTSD to date. This absence primarily is due to the lack of available research on the efficacy of treatment for its additional symptoms (c.f., Karatzias et al., 2019). Obviously, the research is more difficult to conduct due to its many possible components and outcomes. Nevertheless, Karatsias et al. concluded their systematic review and meta-analysis of psychological intervention for ICD-11 complex PTSD symptoms as follows: "The development of effective interventions for SPTSD can build upon the success of PTSD interventions. Further research should assess the benefits of flexibility intervention selection, sequencing and delivery based on clinical need and patient preferences." At the present time, a variety of treatment efficacy studies have been undertaken and their preliminary findings are in publication.

In the absence of such an evidence-based Clinical Practice Guideline, a Professional Practice Guideline (PPG) on the treatment of CPTSD is especially relevant and timely. This guideline document has been developed jointly by the American Psychological Association (APA) Division 56 (Trauma Psychology) and the International Society for the Study of Trauma and Dissociation (ISSTD) to meet the need for guidance on the treatment of complex trauma that often includes dissociative processes. Since 1994, the ISSTD has produced a professional practice guideline for the treatment of Dissociative Identity Disorder--a severe form of dissociative complex traumatic stress disorder--that has been updated regularly. In fact, a new revision is currently underway. To date, it has been based on clinical consensus of experienced and expert clinicians and on available research findings.

It should be acknowledged that this jointly produced guideline is not directed towards the treatment of dissociative disorders per se since they are diagnostically differentiated from CPTSD. Yet it provides valuable background information on the treatment of dissociation for the current document because dissociative process is a common component of CPTSD. It is a customary coping response in young children who are caught in situations of chronic inescapable trauma and is routinely utilized in other situations of extended and repeat traumatization at any age (van Dijke et al., 2015). The inverse also applies: this CPTSD guideline can serve as a foundation for the treatment of the dissociative disorders since the recommended sequence and treatment trajectory are similar. However, interventions for the dissociative disorders are

generally more technically complicated as they address various dissociative aspects and processes presented by the client. Rather, the current guideline addresses the more heterogenous, transdiagnostic outcomes of trauma exposure found in complex trauma patients as well as those specifically meeting criteria for the CPTSD diagnosis.

The term *guidelines*–as used in the present document–refers to statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists (APA, 2015). *Guidelines* differ from standards. *Standards* are mandatory and, thus, may be accompanied by an enforcement mechanism; guidelines are not mandatory, definitive, or exhaustive. *Guidelines* are aspirational in intent. They aim to facilitate the continued systematic development of the profession and to promote a high level of professional practice by psychologists (and other mental and behavioral health professionals). A set of *guidelines* may not apply to every professional and clinical situation within the scope of that guideline. As a result, *guidelines* are not intended to take precedence over the professional judgment of psychologists (or other licensed psychotherapists) that are based on the scientific and professional knowledge of their field or profession (see APA Ethics Code, Std. 2.04). Moreover, these guidelines are to be understood and practiced as fully consistent with the APA Ethics Code (APA, 2010). Finally, it is acknowledged that federal and state laws supersede these guidelines. In accordance with guidance from the American Psychological Association (2015) and standards for guidelines of the Institute of Medicine (2011a & b), this document is expected to require periodic revision, and is scheduled to expire on January 1, 2026. After this date, practitioners are encouraged to contact the APA Practice Directorate, the Practice Committee and Executive Council of Division 56 and the Board of Directors of the ISSTD to confirm that this document remains in effect.

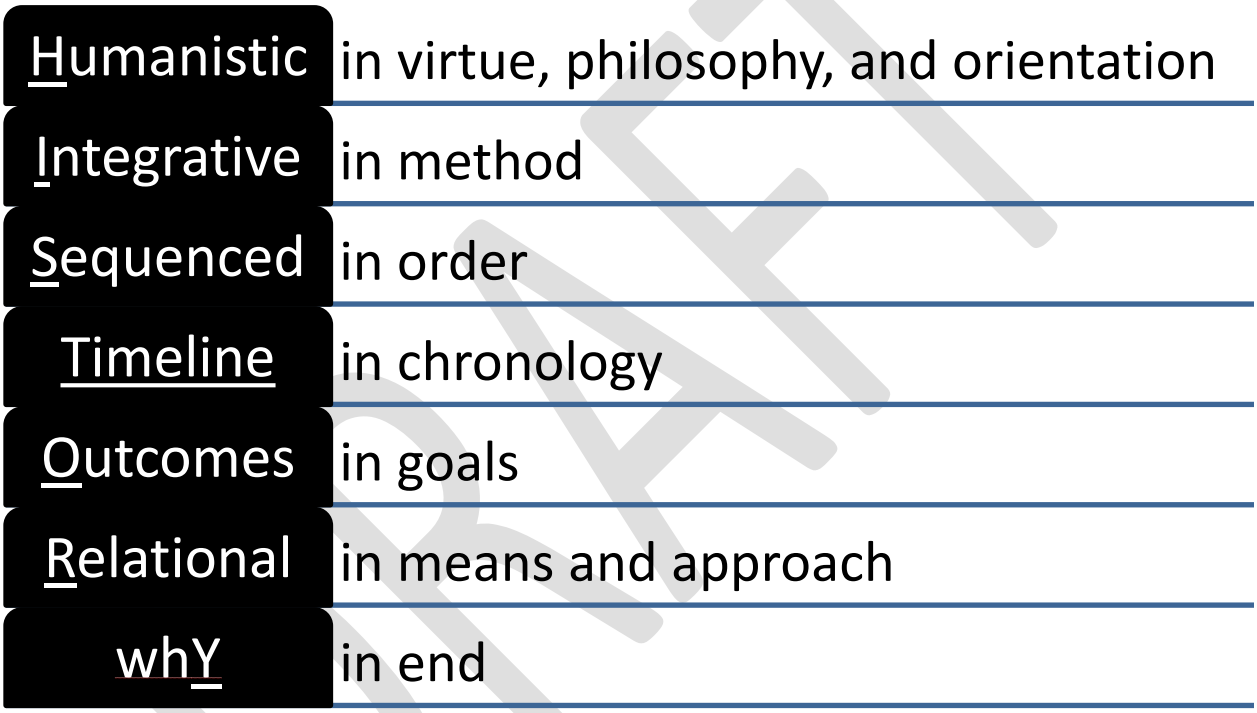
GUIDELINE RECOMMENDATIONS

Central to these guidelines are the findings of epidemiological studies that support the ubiquity and commonality of trauma in human experience and its wide array of potentially (and in many cases, highly likely) adverse and life-changing outcomes. This is especially the case when the trauma is interpersonal in causation and intentional, repetitive, developmental, and chronic over an extended period. It recognizes *complexity theory* as applied to the understanding of this condition discussed by Spinazzola and Briere (2020) who noted that inter-connections between cumulative exposure to interpersonal victimization and adaptations used to cope with it that later devolve into maladaptive behaviors. Due to this, cumulative interpersonal trauma exposure during childhood is found to contribute more significantly to adult symptom complexity and to predict more severe psychopathology than cumulative exposure during adulthood.

This guideline is further concordant with the philosophy of the Trauma Informed Care (TIC) (Classen & Clark, 2017; Harris & Fallot, 2001) movement, developed by trauma survivors and their supporters as a means of educating mental health and medical professionals that traumatized individuals make up a high percentage of those who seek treatment for a variety of physical and psychological concerns (e.g., Baker et al., 2020). It espouses using a “trauma lens” when assessing patients by asking about past and more recent experiences of trauma to assist in making accurate and differential diagnoses. It also focuses on traumatic stressors as etiological factors (i.e., *What happened to you?*) in comparison with focusing exclusively on diagnosis and symptomology (i.e., *What is wrong with you?*) to lessen the shame and stigma that often

accompany experiences of trauma and become intertwined with identity and self-esteem. Accordingly, the current guidelines have been developed to address complexly traumatized persons diagnosed with CPTSD and other transdiagnostic mental health problems using a trauma-informed philosophy. A set of 7 guidelines have been articulated to influence professional practice in treating persons with CPTSD and other serious mental health problems attributable to complex (emotional, sexual, relational, and developmental) trauma histories, including dissociation. The seven professional practice guidelines we articulate form the acronym *HISTORY* which we utilize as a convenient mnemonic for the approach articulated below.

Seven guidelines form the convenient acronym HISTORY:



1. **Psychologists strive to provide HUMANE treatment to complexly traumatized persons.**

Rationale

Complexly traumatized persons have suffered repeated and extensive harm and betrayal at the hands of others including family members and other relatives, peers, intimate partners, authority figures, and even designated helpers and organizations. *Chronic interpersonal trauma* often takes the form of severe human rights violations that dehumanize victims through means of emotional (e.g., antipathy and hatred, shaming, humiliation, harassment), physical (e.g., assault and interpersonal violence, discrimination, oppression, entrapment/imprisonment, pain, torture) and sexual violence (e.g., rape, child sexual abuse and incest, human trafficking). These *intentional* forms of violence and exploitation objectify victims and further deprive them of their ability to act in accordance with their moral and physical rights and freedoms. In the process, perpetrators lower self-worth, deform identity, and undermine

personal control and agency in their victims. Given this, it is a particularly grievous fact that victims are also often blamed by the society at large for their own victimization and its effects on them, or they blame themselves. Victims have often been misunderstood and stigmatized--including by healthcare providers and other ostensible helpers--for their complex posttraumatic symptoms, including their trauma-based modes of interaction (i.e., hypervigilance, avoidance, hostility, mistrust, etc.). This blame and shame have added "insult to injury" rather than providing for its amelioration and the restoration of the victim's integrity. Restoration of the sense of being human, of having self-esteem and of human dignity and agency, is therefore at the heart of the treatment outcomes for complexly traumatized persons to which psychologists and other mental health professionals aspire.

Application

Above all, psychologists and other mental health professionals have the ethical imperative to "Do no harm" in providing care to patients (APA, 2017b) which, in the case of the complexly traumatized person, extends to **"Do no *more* harm"** in recognition of the past harms they have already suffered at the hands of others (Courtois, 2015). On the one hand, psychologists may apply this principle by seeking to provide interventions that are aimed at undoing the harms of *past* inhumane treatment experienced by complexly traumatized persons. On the other, psychologists may apply this principle by helping complexly traumatized persons learn how to protect themselves against *present and future* harms such as from currently abusive relationships and any self-harming behaviors in which they may be engaged.

Psychologists seek to **instill dignity** within the complexly traumatized person's self-experience, aimed at combating trauma-related experiences of misunderstanding, dehumanization, guilt, shame, and self-loathing. Psychologists also **promote health** by seeking to *avoid* being unconditional about unhealthy behavior such as all forms of self-harming, excessive risk taking, and participation in abusive relationships. By contrast, psychologists communicate unconditional positive regard for the complexly traumatized person *as* a person.

Psychologists also seek to **foster agency** within the complexly traumatized person's experience of both treatment and in everyday living. Psychologists may apply this goal by seeking to enhance patients' motivation and engagement in treatment, including by educating them about trauma and its myriad consequences, the various intervention options available, and engaging them in collaborative decision-making about their preferences and choice of treatment goals and strategy. This stance aims at transferring modeled healthy forms of assertiveness outside the context of therapy, such as within the workplace and within interpersonal relationships with family, partners, and peers.

Finally, psychologists seek to **develop strength** in the complexly traumatized person's experience of themselves. Emphasis in treatment may be placed on recognizing the patient's resilience in surviving past trauma, and applying such capacities to self-regulation, recovery, and posttraumatic growth in the present. Such an emphasis aims to **support self-efficacy**, a newfound sense of confidence and even pride, relieving trauma-related experiences of shame, self-hatred, helplessness, and hopelessness.

2. Psychologists aspire to be INTEGRATIVE in their approach to intervention with complexly traumatized persons.

Rationale

While clinical practice guidelines for PTSD recommend certain specific treatments, specifically prolonged exposure therapy, cognitive therapy, cognitive processing therapy, and

eye movement desensitization and reprocessing therapy (APA, 2017a), less is known concerning the efficacy of psychological treatments for CPTSD or other transdiagnostic mental health problems experienced by complexly traumatized persons. Many different psychological interventions have been applied or adapted for the treatment of this population, providing defensible grounds for a flexible, eclectic, and individualized approach to treatment planning that aligns with specific presenting problems, goals, and preferences. As it now stands, treatment of response to complex trauma is not readily or accurately reducible to prescriptive recommendations or to designations of most treatment models or components as "evidence-based" (or not). Rather, an integrative approach may be advisable in broad keeping with and cross-referenced and validated in both the scientific and clinical evidence base (Ford & Courtois, 2020; Karatsias & Cloitre, 2017; McFetridge et al., 2017; Keselman & Stavroupolous, 2012, 2019). Accordingly, when it comes to psychotherapy and other interventions for complexly traumatized persons, professional consensus is that "one size does *not* fit all" (Cloitre, 2015; Courtois, 1999; Greenberg, 2021). Instead, treatment is appropriately multi-dimensional, multi-component, and integrative. As a result, psychotherapy treatment goals are ideally individually determined according to the needs, desires, preferences, capacities, and resources of each patient within their socio-ecological, cultural, and intersectional context. Informed by the principles of psychotherapy integration, psychologists strive to be competent in the delivery of a diverse range of effective interventions to complexly traumatized persons.

Application

An ever-growing variety of methods, interventions, and tools are now being developed and touted for the treatment of traumatized persons, some of which will be more legitimate and researched than others. Thus, psychologists appropriately err toward a healthy skepticism and caution especially about novel methods that are advertised as the "one and only" or "instant cure" for trauma recovery. As noted above, cognitive-behavioral therapies such as prolonged exposure therapy, cognitive therapy, cognitive processing therapy, and eye movement desensitization and reprocessing therapy are among the most evidence-based interventions for PTSD to date, followed by interpersonal, narrative exposure, emotion-focused, and psychodynamic psychotherapies. However, most of these treatments have not yet been as thoroughly evaluated among persons with CPTSD or other transdiagnostic mental health problems experienced by this population. When clinical practice guidelines are not available, psychologists strive to **select evidence-based, supported, or informed treatment approaches** consistent with the individual patient's needs, expectations, and choice. This includes understanding the theoretical and empirical basis for various techniques and methods, including expert consensus concerning their best application to what population and for what clinical presentation.

One way in which psychologists may aspire toward integration is to **augment traditional psychotherapy** with other treatments to the extent that evidence supports doing so. Augmentation strategies may include various mind-body therapies (including somatosensory-based, movement, expressive arts, and mindfulness-based psychotherapies) and neuroscience-informed treatments (Lanius et al., 2018) including neurofeedback, non-invasive brain stimulation and medical and psychedelic therapies. Many of these modalities are thought to be based on procedures and mechanisms of action that may also be helpful (if different) from those associated with traditional talk therapy for trauma. Moreover, a recent review of the newest research not yet included in clinical practice guidelines for PTSD treatment found that certain novel treatments (e.g., acupuncture, mindfulness, yoga) have developed clinical consensus and enough research support to have been identified as emerging (Metcalf, Varker, Forbes, Phelps,

et al., 2016; e.g., studies in veterans: Chopin, Sheerin, & Meyer, 2020; Davis et al., 2020). As one example, Ford (2020) presented a preliminary algorithm for how various adjunctive strategies might be selected and applied according to the patient's symptoms and their severity, goals, preferences, and resources. In any case, psychologists strive to **obtain training and supervision** at appropriate levels in those intervention methods that they deliver directly to patients.

Beyond psychological interventions, an integrative approach may also include psychopharmacology and medication management as needed. The most detailed guidelines for pharmacotherapy of PTSD were outlined by the US DOD/VA (2017) although their applicability to the CPTSD population remains to be determined empirically. Psychologists aim to **manage medication** in collaboration with physicians and other psychopharmacologists with requisite expertise in treating CPTSD and other transdiagnostic outcomes of complex trauma. Such work aims to ensure coordination of treatment and decrease risk of over or undermedication, as well as self-medication and substance abuse. For example, while cannabis is often used by patients, whether self-administered or prescribed, research has not yet clearly substantiated that the potential benefits for anxiety reduction outweigh possible adverse effects, and further research is needed (Dagan & Yager, 2020).

3. Psychologists endeavor to SEQUENCE treatment to complexly traumatized persons based on client-centered readiness, ability to self-regulate, and preference.

Rationale

It is understood that not all complexly traumatized persons experience the same aftereffects on the same timetable, but rather their expression can be highly variable over time and in intensity. Nor do they heal or recover in the same way, to the same degree, or on the same schedule. Some present with intrusive traumatic memories and related symptoms as the most pronounced while for others different symptoms are more disabling. For some, it is other life issues and symptoms and for still others all are prominent and intertwined. Some patients may be in high distress and make a multi-problem presentation while at a lower level of emotional regulation capability, life stability, and safety to be able to engage in psychotherapy. Others, in contrast, have the emotional wherewithal, attachment style, and life stability from early in the treatment to move forward more readily. Some present in highly avoidant, dissociative, or disorganized states with major mistrust of authority figures and little by way of personal support, while others are eager and stable enough to engage and have adequate levels of trust and outside support to do so.

Not uncommonly, clients enter treatment in a state of crisis or distress that requires immediate attention to risk, stabilization, and safety planning, and possibly more intensive or collateral treatment (i.e., an in-patient stay, an out-patient PHP or specialized residential treatment program). Among those who are experiencing continuing victimization and revictimization, the establishment of current safety from which to work against ongoing acute trauma normally takes precedence (e.g., those experiencing relationship violence, adult rape and other community violence, prostitution and sex trafficking, sexual and other forms of harassment and bullying, and those who are engaged in dangerous self-injury or risk-taking or are actively suicidal at the outset of treatment or over its course). Additionally, some clients suffer from chronic collateral conditions that impede their ability to do more than engage in ongoing stabilization with the therapist's support. The early stage of treatment devoted to these issues is often the most long-lasting, and some patients may never develop enough emotional or life stability to proceed to formal trauma resolution. Nevertheless, this stage, through the provision of active therapist care and personal stabilization, identified as present-centered,

person-centered, or contextual treatment (Gold, 2020) has a developing evidence-base. However it is that the tasks of this stage are accomplished and if therapist and client agree on the need for exposure to the trauma, it is the stepping stone to the second stage focused on trauma memory processing aimed at resolution.

Application

Based on the original sequenced model of trauma treatment developed more than a century ago by French neurologist Pierre Janet to treat his dissociative traumatized patients, Herman (1992) articulated a **sequenced model that includes a variety of treatment tasks that are hierarchically organized into three main phases**. The first phase involves present-centered safety and crisis resolution, psychoeducation and other cognitive interventions, life and personal stabilization and other skill-building (especially in emotional regulation, ability to self-reflect, and life skills), and development of the therapeutic alliance. The second involves trauma processing aimed at resolution that is carefully titrated to the capacities of the client and that utilizes skills learned in the prior phase. The second phase is also directed towards issues of complicated bereavement arising from the recognition of personal betrayal and exploitation by significant others and other personal and life losses entailed in the victimization. The recommended evidence-based trauma-focused treatments (TFTs) for memory processing and complicated bereavement are most applicable in this phase of treatment, selected by the patient after learning about them from the therapist. Finally, the third phase involves re-connection to life apart from and less encumbered by the trauma. This stage involving the application of the learning from the treatment and a life that does not revolve around posttraumatic and other symptoms. Instead, other different life and relationship issues may emerge that can extend the length of the treatment. Above all, this model is consistent with the aspiration to sequence interventions in a way that is appropriate to client readiness (Procheska, Norcross, & DiClemente, 2005), and may require delay of past-centered (traumatic-memory) focused interventions until a patient is in a position of requisite emotional stability and interpersonal safety to manage the distress that may be generated by such treatments.

Although this model is presented in linear format, it is not static and lockstep. Instead, its implementation is more like a recursive spiral that dynamically moves back and forth between the stages as needed. This non-linearity is in keeping with the literature on models and mechanisms of change, the expected occurrence of relapses and remissions, the emergence of new life stressors and those resulting from co-occurring conditions (e.g., addictions, compulsions, self-injury, suicidality, major depression, panic, and other anxiety symptoms) over the course of treatment. The emergence or expression of these conditions may require adjustment of the treatment plan and concurrent or sequential treatment. For example, although it seems counterintuitive, it is often only after treatment is well-underway that a client's dissociative symptoms, addictions, or self-harm behaviors are disclosed or otherwise become apparent. Their emergence may then require additional assessment and determination of supplementary treatment goals and strategies.

When any other adjunctive treatment is added, the primary therapist seeks to **engage in active collaboration with the provider of the additional treatment**. There are many reasons for this, among the most important are communication between providers enabling the provision of coordinated and consistent care and the avoidance of splitting which may re-create conditions of the client's past relationships with significant others.

Researchers have substantiated the role of **various present-centered and person-centered treatments**, that is, those which help clients with present day skills, concerns, and interactions as compared to past-centered treatments (Hoge & Chard, 2018) and those that

accommodate the client's unique personality, needs, intersectional issues and other life circumstances. Nevertheless, the **therapeutic resolution of past traumatic memories has long been considered a cornerstone of effective interventions for the resolution of all types of trauma** but particularly for complexly traumatized persons. Such processing can occur using a variety of modalities, primarily through verbal (e.g., exposure therapy, narrative exposure therapy, cognitive processing therapy) or non-verbal means (e.g., expressive writing, art therapy, movement therapy, somatosensory approaches) or a combination (e.g., role play, psychodrama, theatre) and with or without the use of psychotropic medication or other medical interventions.

Many complexly traumatized individuals benefit from **gradual exposure versus prolonged exposure techniques**, given that they may have many instances of trauma and many different emotional responses to process. **Complicated bereavement** often emerges during the processing as clients come to terms with the betrayal and objectification involved in their victimization, as well as major losses (e.g., loss of childhood, loss of good parenting, loss of self and potential, loss of significant relationships through abandonment, separation/divorce, and death, among many others). This too may take additional time and require specialized strategies to process. Finally, complex trauma clients may begin to address whether they want to take any type of action with regards to their perpetrators or others (e.g., re-engagement or disengagement; boundary and limit setting; confrontation/discussion; separation or divorce; criminal, legal, or administrative action, and so on). These issues are best undertaken after the client has completed the main part of their trauma processing and are mostly asymptomatic and therefore are not prone to the re-activation of posttraumatic responses or the re-emergence of symptoms. These issues often extend into the third and final stage as well.

Stage three is the least researched as it tends to involve a wide range of issues and strategies that make assessment difficult. The **reintegration tasks** to be tended to may include literally learning to live a life devoid of trauma symptoms, reactivity, and life chaos; the changing of or readjustment of major relationships and attachments; developing intimacy and sexual healing and development;, learning and applying healthy parenting skills; vocational choice and career development; financial management and other self-care strategies; making complaints or reports of their victimization for purposes of adjudication or restitution; developing survivor missions, and many more. Therapists must be aware of the challenges of this phase and be prepared to offer assistance or referrals for adjunctive treatment as required.

As these issues are well-underway, **termination** is also considered. It **should be carefully planned** as it may stimulate reactions to previous losses in the client's life requiring additional time to accomplish. **Therapists avoid encouraging any form of dual relationship throughout the course of treatment and after treatment ends**. In the latter case, such attention makes it possible for the client to return as needed, whether for a check-in, check-up, or a resumption of treatment. Herman (1992b) was explicit in acknowledging that for some clients, treatment occurs on an episodic rather than a straightforward basis. Some need time to process previous treatment gains before returning while others may leave treatment for other reasons including changes in resources or refocusing on life outside of treatment where they apply what they learned.

4. **Psychologists aim to conceptualize trauma exposure over the course of a chronological TIMELINE.**

Rationale

It is well-recognized that trauma exposure can occur literally from pre-birth and through infancy/early childhood in the form of attachment and relational disturbances with caregivers that may then continue through latency and beyond. As previously discussed, early life adversities dramatically increase the risk that additional traumatic life events will occur over the entire life course, creating a cumulative developmental and posttraumatic burden on the individual (e.g., Copeland et al., 2018). Repeated childhood trauma has been found to delay or disrupt development in cognitive, affective, relational/social, self-development, and (neuro)biological domains (e.g., Teicher & Samson, 2016). It can also interrupt sensitive periods of development, leading to functional and maturational deficits that can accumulate with time partly depending on the age at first exposure and later life events (e.g., Dunn et al., , 2016). These then intertwine with adaptations made to cope with ongoing or ambient abuse, neglect, and violence to create a complicated and nested set of posttraumatic and developmental aftereffects. If that were not enough, any more recent and acute adult-onset traumas and victimizations then can add additional layers to the cumulative impact. Moreover, beyond traumas that a person experiences directly, the concept of intergenerational trauma recognizes the burden of risk of trauma exposure to children that comes about via parents' and other relatives' past personal and historical trauma exposure, harms that may also require treatment interventions for the next generation (e.g., identification and processing of traumas experienced by one's parents or grandparents). Even further, traumas occurring to entire cultures may also bear effects that require addressing in individual persons, for example, those relating to longstanding racial prejudices, discrimination, and systematized oppression (e.g., indigenous communities in colonized countries and in racially enslaved, oppressed, trafficked marginalized communities) and the extremes of genocidal practices (e.g., Holocaust survivors).

Application

Psychologists strive toward ***developmental* case conceptualizations that assess chronologically** the person's trauma exposure in such a way as to establish not only *what* happened to a person but also *when.* Such an assessment includes queries about both recent and lifetime-cumulative trauma as well as intergenerational and historical traumatization. Whether conducted in forward or reverse order, aspiring to gather a comprehensive lifeline or chronology of traumatic events, from pre-birth (as may be relevant) onward, can provide a way to understand the context of patients' presenting problems. Psychologists require an understanding that clients may initially be reluctant or unable to fully disclose their experiences of trauma, requiring them to be both receptive and patient on an ongoing basis. It is not unusual for assessment to be ongoing over the entire course of treatment, resulting in the potential requirement to make collateral adjustments in the treatment plan. Thus, **therapists seek to understand the impact of the wide variety of ordered and layered traumatic exposures that may have occurred for an individual by undertaking an initial wide-ranging psychosocial assessment at the outset of treatment that includes attention to a variety of adversities and family and life issues, and a lifespan focus including attention to historical precedents and developmental milestones**. Assessment of pre-birth traumas in particular can also provide further historical perspective and may establish likely meanings and impacts of specific traumatic events within the overall context of person's broader familial circle and cultural ancestry. While address of earlier childhood trauma and neglect is often critical, **the importance of assessing not only physical trauma exposure but also other adverse events in adulthood is also emphasized** (e.g., Mersky, Plummer Lee, & Janczewski, 2020). **Occasional re-assessment** is undertaken in order to assist in any needed updating and revision of case conceptualization and treatment plan.

Having conducted a thorough assessment, psychologists aim to understand the relative impact of recent versus early life stressors on current functioning and **prioritize present- vs. past-centered therapies** according to the acute vs. longer term needs of the patient. This determination is based on the present level of distress and disability attributable to each experience. Traumatic memory-focused treatments often proceed rationally in forward-chronological order, that is, processing earlier experiences first. Further, in cases where assessment is suggestive of development-based knowledge and skill deficits, psychologists may undertake to provide whatever compensatory education and skills training is necessary to restore functional capacities and self-regulation.

Of course, present day and acute trauma exposure generally requires immediate attention and intervention, and psychologists strive to abide the principle of **current safety first**. As a result, psychologists aim to conduct not only early preliminary but ongoing risk and violence assessments to ascertain the patient's status, with the purpose of assuring patients' own and others' safety throughout and following the conduct of treatment. In this context, safety is defined broadly to include attention not only to the physical environment and outside circumstances of the patient's life - including interpersonal relationships - but also the concern that patients may represent a danger to themselves (e.g., self-harm, suicidality) or others (including the therapist) through their engaging in excessive risk-taking, in the form of access to weapons, threat or perpetration of violence to others, or litigiousness, addictive behaviors, and other various symbolic means by which they may seek to "repeat the trauma" or "revenge the trauma" through reenactment. Ensuring the immediate safety of the patient and others thus takes precedence over other long-term issues in treatment planning, with the introduction of a **collaboratively derived safety plan** (rather than a time-limited safety contract) that the client agrees to implement on an ongoing basis ideally constructed as soon as possible to be applied on an ongoing basis.

5. **Psychologists seek to advance heterogenous positive OUTCOMES in their interventions with complexly traumatized persons.**

Rationale

Complexly traumatized persons can generally be regarded as a heterogenous group, such that no single diagnosis is likely to fully explain the range of psychological, behavioral, and somatic outcomes of chronic exposure to interpersonal traumatic stressors, be it PTSD, CPTSD, or otherwise (Ford & Courtois, 2020). As discussed previously, research and theory substantiate that, beyond the core symptoms of "classic" PTSD, complexly traumatized persons frequently experience additional difficulties in affective, negative self-referential, and interpersonal domains of functioning constituting the diagnosis of CPTSD. Moreover, other theory and research suggests that many persons with complex trauma histories report or exhibit additional signs and symptoms of psychological and somatoform dissociation, psychosomatic symptoms, substance use problems, and may engage in various forms of risk-taking, self/other-harm, and suicidal behaviors, to name just a few. As a result, the potential targets of individualized treatment are manifold and typically transdiagnostic.

Application

Psychologists working with this population **understand that, by its very nature, complex trauma involves a broad diversity of what can be confounding and confounded symptoms and presentations**. When they have this understanding, they are less likely to be overwhelmed or immediately discouraged. They also understand that complexly traumatized clients have

survived harrowing experiences resulting in their having strengths and resources that can be capitalized on in treatment. Therapists therefore apply this principle by aspiring to **individualize treatment** targets based on comprehensive, dimensional, and transdiagnostic assessment. They also understand that the client is responsible for their own healing and that motivation enhancement may be needed on an ongoing basis. Beyond the assessment and treatment of the various core symptoms of PTSD and CPTSD, psychologists strive to undertake thorough and ongoing assessment of severe emotion dysregulation, dissociative experiences, psychosomatic symptoms, substance use, and self-harming behaviors, so as to **treat each identified problem directly** as needed.

Traumatized persons often experience a high degree of distress, whether on a continuous or episodic basis, and they are often highly reactive to stimuli reminiscent of previous traumatic events observed in their surrounding physical and social environments. As a result, psychologists seek to help patients **manage physiological reactivity and emotion regulation**, including in developing skills for identifying, self-monitoring, and regulating aversive psychophysiological arousal states at the extremes of *hyper*-arousal – e.g., panic, impulsive risk-taking, hypervigilance, rage, aggression, structural dissociation – and *hypo*-arousal – e.g., emotional numbing, detachment, alexithymia, anhedonia, hopelessness/despair, as well as any behavioral manifestations of dysregulated arousal such as tonic immobility, fainting and physical collapse, feigned death, exhaustion, or paralysis, any of which are potentially indicative of functional defensive states. Somatosensory-based interventions and techniques for emotional modulation and self-soothing may be helpful in modulating reactivity to minor as well as major stressors (Ogden & Fisher, 2015; Ogden, Minton, & Pain, 2006).

Often but not always related to experiences of emotion dysregulation, psychologists also strive to help patients **reduce dissociative reactions and processes** that may constitute a dissociative subtype of PTSD and CPTSD. Dissociative experiences may range from relatively mild and normalized instances of inattention or brief "spacing out" to more obvious trauma-related alterations in consciousness such as symptoms of depersonalization and derealization. These may be decreased with identification and recognition by therapist and client and the application of grounding techniques such as sensory awareness and other mindfulness practices. Dissociative symptoms including amnesia, identity confusion and identity fragmentation or alteration and voice hearing may also be present, and different therapeutic approaches and techniques have been developed to address such problems that work in compatible ways but with different methods (e.g., Bromberg, 2006; Kluft, 1999).

Psychologists also strive to **alleviate psychosomatic pain** that is a prominent posttraumatic sequela in some patients. Diffuse pain syndromes and other medically unexplained symptoms may be addressed through the provision of education and resources and collaboration with medical and other behavioral health practitioners. This is optimally achieved through a trauma-informed approach to physical symptom management that avoids client-blaming and shaming (i.e., "It's all in your head"; Clark et al., 2015). Such trauma-informed approaches to medical management are especially important because many complexly traumatized persons initially present their concerns and symptoms to medical rather than mental health providers.

Finally, psychologists aim to **address addictive behaviors** that are common comorbidities in complexly traumatized persons, often attributed to as a secondary coping mechanism for primary symptoms (i.e., self-medication). Increasingly the literature is pointing to the viability of conducting simultaneous treatment for persons with PTSD and comorbid substance use or other addictive/compulsive disorders that may also be a pragmatic approach to CPTSD treatment, but this requires empirical validation. It is also important to recognize

addictions may present not only in the forms of alcoholism and illicit substances but also to stimuli reminiscent of the trauma in the form of sexual and other behavioral addictions such as sexual promiscuity and pornography consumption, and addiction to video games, social media, and various forms of violence.

6. **Psychologists prioritize the therapeutic RELATIONSHIP as the principal foundation and context of intervention with complexly traumatized persons.**

Rationale

Individuals with a long history of unsafe and insecure relationships involving loss, rejection, abuse, violence, and betrayal from a young age, familial or otherwise, are likely to have difficulty establishing meaningful and healthy relationships later in life. Such individuals' personal boundaries have been violated and they have been repeatedly betrayed and exploited within the context of relationships with significant others, whether in biological and extended families, in communities, organizations, and in fiduciary relationships. In many ways, dual or multiple relationships may have been and continue to be the norm for such persons, who as a result are at high risk for abuse and re-abuse, both in and outside of therapy (Pope & Bouhoutsos, 1986; Gabbard, 2017). Alternately, many complexly traumatized persons have become socially alienated from and avoidant of others in response to repeated breaches of trust, betrayal, and exploitation. As a result, many consequently lack a support network or have one that is inadequate and/or dysfunctional and unhealthy.

By contrast, safe attachment figures may allow for the development of "earned secure" attachment styles that strengthen the individual's identity and self-worth and the potential to develop meaningful relationships with trustworthy others outside of psychotherapy. In virtually all schools of psychotherapy, the relationship between therapist and client has the greatest degree of endorsement as an empirically supported treatment strategy (evidence-based relationship) and "a deep synergy between treatment methods and the therapeutic relationship" is recognized (Norcross & Lambert, 2018). Research studies routinely find that elements of the relationship potentiate treatment techniques and interventions, including with interpersonally traumatized persons with CPTSD (Cloitre et al., 2004). Indeed, Ellis et al., (2017) systematically reviewed and synthesized the empirical literature on the effects of evidence-based relationship variables in the psychological treatment of adults who had experienced trauma-related distress. They found that the therapeutic alliance was predictive of or associated with a reduction in various trauma-related symptoms. The treatment relationship is thus understood to be both therapeutic context and catalyst for what are often termed trauma-based reenactments and for the upgrading of relationship skills (Kinsler, Kinsler, Courtois & Frankel, 2009).

Application

Relationship skills are routinely taught in therapy training programs as essential to the engagement of the client and the success of the treatment. **In no therapy is the relationship and alliance between therapist and client more important than in the treatment of those who have been interpersonally and complexly traumatized.** However, as discussed above, those individuals typically have many difficulties in relationships with others based on their formative experiences with significant attachment figures, involving betrayal and exploitation. Perpetrators of complex trauma in fact use the relationship to engage and ensnare their victims, in the process corrupting the bond between them. As a result, relationships with others can become fraught with the baggage of abuse such that even individuals who are benign and

intend no harm are mistrusted and tested repeatedly. It is also a fact that many trauma survivors have had difficult, if not retraumatizing interactions with professionals charged with helping them. Therefore, **it is imperative that therapists who treat complex trauma clients be aware of the many difficulties these individuals have in both trusting others and relating to them, especially those in positions of actual or perceived authority**. Survivors' interpersonal attachment styles and strategies may range from avoidance and distrust on the one hand to over-engagement and preoccupation on the other to a confusing combination of approach-avoid behaviors. In this relational context, through their engagement and attunement to the client, **therapists must seek to both identify and develop an understanding of the origin of these styles as adaptations and as learned behavior**. **They also seek to remain emotionally attentive and regulated in their interactions with these clients**, whatever their style of engagement, to engender security of attachment.

Psychologists strive to ensure therapeutic boundaries as another ethical imperative, avoiding the development of dual relationships of any sort with patients with complex trauma histories. They aim to educate clients about the necessity and utility of healthy and appropriate interpersonal boundaries and to teach skills for developing and maintaining them in interactions with others. Psychologists also strive to convey information about boundaries in fiduciary relationships and act in accordance so that the therapeutic relationship might serve as a model of such boundary maintenance. In practice, this may include limiting the number of sessions per week to one or two, limiting most interactions with clients to scheduled appointments, and steadfastly avoiding extra-therapeutic contacts other than for communication purposes or when a crisis might justify them. Further, while at times it may be necessary for boundary crossings (versus violations) to occur (e.g., the therapist who attends a medical appointment with a phobic client as a means of in vivo exposure, who then continues to help the client to manage anxiety for the next visit, undertaken alone or with another support person). These would be decided according to the client's specific needs, would be expected to be infrequent and based on clinical judgment and consultation as to necessity, and discussed with and explained to the client as an exception to normal practice.

Whenever a rupture in the alliance develops, **therapists strive to note it and respond non-defensively while inviting the client to discuss it and to collaboratively problem solve solutions**. As this type of notice and negotiation is unlikely to have occurred in families that operate from an insecure/unresponsive or disorganized style, relational repair affords a unique opportunity for misunderstandings and miscommunications to be discussed and rectified. It can be a most, if not the most, significant intervention of all.

Beyond adherence to these basic concerns, **psychologists seek to develop a physical, emotional, and relational "safe haven" for their clients, which provides security of attachment, a "learning laboratory" for safe exploration of self and others**. This in turn often facilitates behavioral change in the context of interpersonal relationships outside of therapy (Brown & Elliott, 2016; Hopper, et al., 2019; Kinsler, 2017). Traumatic reenactments occurring in the transference can make explicit otherwise implicit and unconscious relational patterns that may have been established in consequence of the trauma. It facilitates their identification, mentalization, and reformulation, first through process observations that incrementally "invite clients to notice" aspects of themselves and their views of and interactions with others (Fisher, 2017; Wallin, 2007). This can start with the therapist, ultimately and ideally encouraging more healthy relational patterns and the therapeutic resolution of interpersonal traumas.

Although these issues have been historically the domain of psychoanalytic/psychodynamic psychotherapies, they have been imported into most trauma treatment for complex trauma and its resultant personal and interpersonal injuries. Moreover, although material that is outside of

conscious awareness (implicit knowledge) has also primarily been the domain of psychoanalysis/psychodynamic treatment, its broad recognition in the treatment of individuals with complex trauma histories (undertaken from any theoretical perspective or treatment approach) is of critical importance. Such material tends to present implicitly as a traumatic transference, enactment, and through other behavioral and interpersonal manifestations. These typically involve a projection onto the therapist and the treatment relationship based on past traumatic experiences and relationships.

The treatment benefits from the **therapist's attention to the patient's predominant attachment style and to the attunement of their interactions to their style while identifying and gently challenging those styles by teaching and modeling alternative ways of understanding self and others**. The goal is to help the client become more secure in style with regards to identity, self-worth, and interactions with others ("earned security") based on the relational and identity changes experienced in the context of treatment (Muller, 2010, 2017; Wallin, 2007). A wide array of "treatment traps" (Chu, 1988; Chu, 2011 a & b) has been identified as treatment for this population has become more developed and sophisticated. **Therapists are advised to anticipate these kinds of reactions and issues, so they do not encounter them from a position of unfamiliarity**. While they are not expected to foresee all possibilities, having a general awareness assists them to manage from a position of cognizance rather than surprise. It is also of considerable importance that therapists routinely avail themselves of continuing education and of consultation and supervision in providing this treatment.

The relationship dimension of the treatment is foundational and extremely important to its success as both context *and* technique; however, it is not the sole treatment. Rather, **treatment of trauma requires a range of strategies and approaches** as discussed above, especially those that are evidence-based and informed or those that are based on strong clinical consensus and recommendation. This said, **psychologists strive to approach their clients from a position of openness and support in recognition that they are seeking assistance for emotional distress and other difficulties, not uncommonly related to experiences of past or present trauma**. Psychologists recognize that they serve as important relational and attachment figures for their clients and strive to provide them a "safe haven" from which they can engage in self-exploration and experiential learning. They teach and model healthy relational interactions, including relational repair when misunderstandings or other breaches occur.

7. Psychologists aspire to help complexly traumatized persons arrive at adaptive interpretations of the reasons WHY trauma occurred.

Rationale

Research has long supported that survivors' subjective appraisals and attributions concerning what occurred during and in response to complex trauma is more predictive of longer-term outcomes than are objective event characteristics (e.g., Brewin, Andrews, & Valentine, 2000). Survivors' perceptions concerning their own and known others' intentional or accidental roles in what took place are highly influential in determining risk for chronic posttraumatic stress in both trauma-exposed children and adolescents (Mitchell et al., 2017) and in adults (Gomez et al., 2019). Unfortunately, survivors' appraisals of reasons for the occurrence of such misfortunate events are often erroneous and high in self-blame and shame (Hoppen, Heinz-Fischer, & Morina, 2020). Not surprisingly, these viewpoints are frequently promoted by perpetrators who project blame and shame onto the victim as a means of rationalizing or excusing their own culpability. Recently research has turned to examination of

specific kinds of posttraumatic appraisals, for example, those provoking feelings of self- and other alienation (McIlveen et al., 2020), feelings of betrayal (DePrince, Chu, & Pineda, 2011), and those impacting sense of personal and narrative coherence (Schäfer et al., 2019). Further, appraisals of the meaning of the traumatic event are a relevant factor in various types of traumatization, including for experiences of childhood maltreatment (Wiseman, Hamilton-Giachritsis, & Hiller, 2021).

Application

Psychologists strive to explore the "Why?" and "Why me?" among many other pertinent and personalized existential questions with their clients in order to assist them to **adaptively re-appraise** the meanings they have made of what happened to them. This includes addressing systematic biases or inaccuracies in cognitive appraisals concerning what occurred and replacing them with more adaptive, realistic, and healthy viewpoints. A non-specific outcome of various effective trauma treatments typically involves the reappraisal of maladaptive cognitions and beliefs that underlie meaning-making regarding traumatic life events--including the relationship with the perpetrator. Regardless of whether such newfound understandings come about through direct interventions such as cognitive therapy or psychoeducation or more indirectly as a secondary effect of discussion of these issues or other approaches, a more accurate and adaptive understanding regarding what took place during traumatic events is often a critical step to resolution and recovery.

One of the most fundamental reappraisals is to accurately **attribute responsibility** for what happened. Complexly traumatized persons often engage in unwarranted self-blame and responsibility for what transpired, leading to guilt, shame, and experiences of moral failure and moral injury. These can involve manifestations of ambivalent attachment to and traumatic bonding to perpetrators and others. A more accurate attribution concerning responsibility for what happened can undermine the basis for internalizing posttraumatic symptoms and negative self-attributions, serving as a release of associated depression, anxiety, and other consequences (e.g., addictions, self-harm, suicidality). By contrast, external attributions may also sometimes be inaccurate, leading to blaming and seeking vengeance against persons who were not clearly at fault; alleviating these concerns may also be a means of reducing externalizing problems such as anger and hatred toward certain persons or groups.

As these posttraumatic appraisals can be highly impacted by a client's family history and ethno-cultural, religious/spiritual, and political beliefs and influences, therapists seek to identify them as a means of deepening their understanding of the client as they seek to assist them with resolution. In some cases, these issues can negatively influence the patient's meaning making systems while, in others, they might provide sources of solace and healing. Psychologists **encourage and engage in existentially-and spiritually focused discussions** with the patient with the goal of exploring, identifying, and understanding existential and spiritual issues and dilemmas which might be "stuck points" for their recovery. They support meaning-making regarding the value of relationships, spirituality, and other factors with the aim of encouraging posttraumatic resolution and growth.

Concluding Summary

Beyond striving to adhere to these professional practice guidelines, psychologists, among other health professionals, providing care to complexly traumatized persons strive to be informed by the scientific and clinical literature on appropriate care and treatment. Developing and maintaining competency can be challenging as clinical practice curricula in

psychology and other mental health professions may not include focused study of trauma in general, and much less so in terms of complex forms of trauma or dissociation (Courtois & Gold, 2009). As a result, core competencies for the treatment of PTSD have been published by the American Psychological Association to specify the minimal knowledge and skills all psychologists require in providing care to traumatized persons (APA, 2015; Cook et al., 2014) and the Council of Social Work Education has published its own set of competencies and curricula at various levels of expertise in the training of social workers (CSWE, 2015). Beyond this, specialized competencies may also be required to provide professional practice to complexly traumatized populations and additionally to sub-populations and for various comorbid disorders (e.g., survivors of repeated child abuse, human trafficking, torture survivors, dissociative processes and disorders, and so on). These remain to be researched.

It is especially important to be explicit about the need for specialized training in the treatment of trauma in general but especially as it pertains to complex trauma. As has been suggested in these guidelines, this population presents additional complications, challenges, and risks in a number of domains, areas for which generic clinical training is not likely adequate to address. In addition, it is especially important to acknowledge that clinicians seeking to utilize specialized techniques, whether trauma-focused or not, require specialized training in that technique before using it with clients (APA, 2017b) and seek supervision and consultation in the use of new technical applications.

There is now a broad--and growing--authoritative literature on the treatment of complex trauma and dissociation from a variety of different therapeutic orientations that clinicians and students can refer to. Any therapist working with this population but especially those at expert levels seek to stay abreast of the latest research and clinical developments to apply in their work. As examples, somatosensory and expressive approaches, interpersonal neurobiology applications, and medical use of psychedelics are all cutting edge and evolving treatments for this population. They do not yet have an adequate evidence base but, in the interim, they can be applied following the training of the practitioner, careful clinical consideration optimally with consultation, and with the consent of the client.

Additional clinical resources may be secured through membership in professional societies (e.g., APA Division 56, the ISSTD, the ISTSS), reading peer-reviewed journal articles (e.g., those published in the flagship journal of the ISSTD, *The Journal of Trauma and Dissociation;* the flagship journal of the ISTSS, *The Journal of Traumatic Stress;* the APA Division 56 journal *Psychological Trauma: Research, Treatment, Practice and Policy*) and others such as the *European Journal of Psychotraumatology* and volumes (e.g., the *Handbook of Dissociation* (Dell & O-Neill, 2009) and the *APA Handbook of Trauma Psychology* (Gold, 2017). They also strive to regularly attend conferences and continuing education workshops established by these professional organizations (as well as organizations that provide professional continuing education) to learn to apply the latest evidence and techniques to their practice. Some of these training offerings have developed to the point that they offer certification in their distinctive technique, some with ongoing supervision and at different levels of expertise. **Therapists also strive to obtain ongoing professional support and mentoring when treating complexly traumatized persons in the form of expert supervision and consultation.**

Further, it is understood that psychologists adhering to the current professional practice guidelines would in so doing attend to all forms of diversity and intersectionality. These issues, including, but not limited to, ethnicity/culture/race/tribe/nationality, community, family, gender, sexual and gender identity and orientation, age, ability, spirituality/religiosity and political beliefs and groups, among the most evident, are indeed embedded in or interact with the experience of traumatization and its adverse sequelae (Brown, 2008; Hays, 2011). In

fact, it is helpful for therapists to understand that personal characteristics and/or membership in a group or community and its associated beliefs and traditions may be the reason for or rationalization of violence and additional forms of traumatization. Recently, there is greatly increased recognition of the intergenerational transmission of trauma in contexts such as racial discrimination and oppression and other colonial/genocidal/collective trauma and in experiences of harassment and humiliation by others.

As such, **a general goal beyond the presently described 7 guidelines is for therapists to be cognizant of these issues and to seek to learn more about them/understand them from the client's perspective**. They may also strive to learn as much as possible about any cultural norms and traditions around such events, any related idioms of distress, and any healing rituals or personnel. **Psychologists may seek to achieve this by becoming attuned to their own responses, conscious and unconscious biases, and lack of information (often identified as having "cultural humility")** (Hook et al., 2013) and, in addition to gaining information directly from the client, seeking out educational resources and consultation/supervision as needed. This may also be addressed by social or community interventions rather than by only providing treatment to individuals (Alpert & Goren, 2017; Staub, Pearlman, Gubin, Hagengimana, 2005; Saul, 2014). A socioecological perspective that takes sociocultural and other diversity/intersectionality factors and contexts into account is thus generally recommended.

Finally, psychologists and other psychotherapists have an **ethical imperative to maintain their own emotional and mental health to be optimally relationally available and attentive in treating clients with complex trauma histories.** Further, given that the quality of the relationship in conjunction with the application of various techniques predict treatment efficacy, psychologists treating persons with complex trauma histories strive to understand that their relational styles and interactions are a core component of treatment that are likely to put additional emotional demands on the therapist. Therapists whose attachment style is secure or "earned secure" (the latter the consequence of having healed from any traumatic relational experience or histories of their own), will be more able to maintain emotional equilibrium and **model emotional regulation for their clients to emulate.**

Psychotherapists can be affected vicariously by both their clients' experiences and disclosures and their styles of interacting that can result in the development of symptoms of secondary traumatic stress. *Vicarious trauma,* possibly a variant of countertransference, involves changes in therapists' schema about self and others resulting from their exposure to and work with traumatized clients (VT; McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996). Several related terms have been used to describe the psychological impact of the treatment of trauma survivors, including *compassion fatigue* (Figley, 2002), *secondary trauma* (Stamm, 1995) and *empathic strain* (Wilson & Lindy, 1994).

By contrast, treatment is now understood as having transformational potential for both client and therapist (Gartner, 2017; Hopper et al., 2018), **in both negative as well as positive ways**. Beneficial aspects of vicarious trauma, for example, might include the therapist being better able to face and overcome both personal and professional problems. Responses of this sort have been observed and described as *posttraumatic resilience* or *vicarious resilience* (Gartner, 2017; Hopper et al., 2018). On the other hand, therapeutic encounters with persons with complex trauma histories can also create personal hardship and distress for treatment providers and might exacerbate issues from their own histories. **It is therefore recommended that psychologists who treat complexly traumatized persons monitor their own mental and physical health, strive to engage in ongoing efforts at self-care and stress management, and seek out professional supervision and consultation and personal treatment as needed** (Saakvitne, 2017). Recent surveys of experienced therapists specializing in the treatment of the

complex trauma population found that participants expressed a major appreciation for the strength and perseverance shown by their clients in facing their adversities. Importantly, they expressed a deep sense of purpose and personal satisfaction in both the challenge and the work of helping clients resolve the complicated developmental and posttraumatic consequences of complex trauma. They too developed Posttraumatic Growth as a result of the work (Tedeschi & Calhoun, 2004).

APPENDIX

Introduction to the Joint Project

The intended audience of these guidelines is practicing psychologists, psychotherapists and other professionals involved in the psychological and behavioral health treatment of cPTSD and CPTSDs (henceforth discussed as CPTSDs in adults in recognition of the wide variety of presentations and symptoms that are possible and that have not yet been adequately catalogued) (Courtois & Ford, 2020). The development of recommendations for the treatment of CPTSDs in adults was proposed independently by the leadership of the Practice Committee of *Division 56 (Trauma Psychology) of the American Psychological Association* (Division 56) and the *International Society for the Study of Trauma and Dissociation* (ISSTD). Since both organizations have an interest in improving treatment for this population, the decision was made by the Executive Board of each to join forces and to cooperatively develop this document. In conjunction with other guidelines for the treatment of complex trauma, this document gives practicing psychologists, psychotherapists and other professionals guidance on the treatment of complex developmental posttraumatic conditions and disorders.

In order to produce a set of recommended practices that represent the current state of the science and clinical practice, working group members reviewed the research (the empirical evidence base—which at the time of this writing is increasing) and clinical literature (the practice consensus evidence base that is currently available and also growing) on the treatment of individuals who endure the many manifestations of complex traumatic stress disorders, as limited to current and seminal writings recognized in the field as important (see reference list for literature cited). Potential members of this guideline panel were identified by the Working Group Chair (Courtois) and the former Chair of the Practice Committee of Division 56 (Brand), along with the President of the ISSTD at the time (Steele) based on their research, clinical expertise, and authoritative writings on the topic and their willingness to participate in this project. Over several years, they volunteered their time and expertise and contributed to the drafting and several revisions of this document.

The only source of financial support has been the agreement to pay stipends by Division 56 and the ISSTD for administrative and research assistance. There are no conflicts of interest to report in the development of these guidelines other than royalties for books published by members of this panel and honoraria for workshops on the topic under discussion here.

References

Alpert, J. L., & Goren, E. R. (Eds.). (2017). *Psychoanalysis, trauma, and community: History and contemporary reappraisals*. New York, NY: Routledge, Taylor & Francis Group.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th Ed.). Washington, DC: Author.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* III. Washington, DC: Author.

American Psychological Association. (2017a). *Clinical practice guidelines for the treatment of PTSD in adult*s. Washington, DC: Author.

American Psychological Association. (2017b). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). http://www.apa.org/ethics/code/index.html

American Psychological Association. (2015a). *Guidelines on trauma competencies for education and training*. Retrieved from: http://www.apa.org/ed/resources/trauma-competencies-training.pdf

American Psychological Association. (2015b). Professional practice guidelines: Guidance for developers and users. *American Psychologist, 70*(9), 823-831.

American Psychological Association. (2010). 2010 Amendments to the 2002 "Ethical principles of psychologists and code of conduct." *American Psychologist, 65*, 493. http://dx.doi.org/10.1037/a0020168

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186. doi:10.1007/s00406-005-0624-4

Australian Centre for Posttraumatic Mental Health (2013). *Australian guidelines for the treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*. ACPMH: Melbourne, Victoria. Retrieved from http://phoenixaustralia.org/wpcontent/uploads/2015/03/Phoenix-ASD-PTSD-Guidelines.pdf

Baker, C. N., Brown, S. M., Overstreet, S., Wilcox, P. D., & New Orleans trauma-informed schools learning collaborative (2020, December 10). Validation of the Attitudes Related to Trauma-Informed Care Scale (ARTIC). *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. http://dx.doi.org/10.1037/tra0000989

Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., Shahly, V., … Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine, 46*(2), 327-343.

Bonn-Miller, M. O., & Rousseau, G. A. (2017). *Marijuana use and PTSD among veterans*. Washington, DC: US Department of Veteran Affairs, National Center for PTSD.

Bortz, J. J., Summers, J. D., & Pipe, T. B. (2007). Mindfulness meditation: Evidence of decreased rumination as a mechanism of symptom reduction. *Journal of Neuropsychiatry and Clinical Neurosciences, 19*, 217-218.

Bouso, J. C., Doblin, R., Farre, M., Alcazar, M. A., Gomez-Jarabo G. (2008). MDMA-assisted psychotherapy using low doses in a small sample of women with chronic Post-traumatic Stress Disorder. *Journal of Psychoactive Drugs*; *40***,** 225–36.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for Post-traumatic Stress Disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68*(5), 748–766. doi.org/10.1037/0022-006X.68.5.748

Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys*. Analytic Press.

Brown, D. P. & Elliott, D. S. (2016). *Attachment disturbances in adults: Treatment for comprehensive repair*. W. W. Norton.

Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. American Psychological Association.

Brown, P. J., Stout, R. L., & Mueller, T. (1999). Substance Use Disorder and Posttraumatic Stress Disorder comorbidity: Addiction and psychiatric treatment rates. *Psychology of Addictive Behaviors, 13*(2), 115-122. http://dx.doi.org/ 10.1037/0893-164X.13.2.115

Carswell, J. & Frewen, P. (2017). Experiences of psychopathology distract from focused attention during mindfulness meditation: Assessment in relation to Meditation Breath Attention Scores in mental health help-seeking participants. *Mindfulness, 8*, 943–948. doi.org/10.1007/s12671-016-0670-1

Chabrol, H., & Oehen, P. (2013). MDMA-assisted psychotherapy found to have a large effect for chronic post-traumatic stress disorder. *Journal of Psychopharmacology, 27*, 865–66.

Chopin, S. M., Sheerin, C. M., & Meyer, B. L. (2020). Yoga for warriors: An intervention for veterans with comorbid chronic pain and PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(8), 888-896. http://dx.doi.org.proxy1.lib.uwo.ca/10.1037/tra0000649

Chu, J. A. (2011a). Pharmacology for trauma-related disorders. In J.A. Chu, *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders* (2nd Ed.) (pp. 246-254). Wiley.

Chu, J. A. (2011b). *Rebuilding shattered lives: Treating Complex PTSD and dissociative disorders*, (2nd Ed.). Wiley. doi: 10.1002/9781118093146

Chu, J. A. (1988). Ten traps for therapists in the treatment of trauma survivors. *Dissociation, 1*, 4, 24-32.

Clark, C., Classen, C. C., Fourt, A. & Shetty, M. (2015). *Treating the trauma survivor: An essential guide to trauma-informed care*. Routledge, Taylor & Francis Group.

Classen, C. C., & Clark, C. S. (2017). Trauma-informed care. In S. N. Gold, J. M. Cook, & C. Dalenberg (eds.). *APA Handbook of Trauma Psychology (pp. 515-542).* American Psychological Association.

Cloitre, M. K. (2015). The "one size fits all" approach to trauma treatment: should we be satisfied? *European Journal of Psychotraumatology 6*: 27344.

Cloitre, M. K., Courtois, C. A., Ford, J. D., Green, B. L., Alexandre, P., Briere, J., Herman, J. L., … van der Hart, O. (2012). *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*. Retrieved from http://www.istss.org.

Cloitre, M. K., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., et al., . . . (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress*, *24*(6): 615-627.

Cloitre, M. K., Stovall-McClough, C., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related Post-traumatic Stress Disorder. *Journal of Consulting and Clinical Psychology, 72*(3): 411-416.

Cook, J. M., Newman, E., & the New Haven Trauma Competency Work Group. (2014). A consensus statement on trauma mental health: The New Haven Competency Conference process and major findings. *Psychological Trauma: Theory, Research, Practice and Policy, 6*, 300-307.

Copeland WE, Shanahan L, Hinesley J, et al. (2018). Association of childhood trauma exposure with adult psychiatric disorders and functional outcomes. *JAMA Net Open,*1(7):e184493. doi:10.1001/jamanetworkopen.2018.4493

Council on Social Work Education (2015). *Educational Policy and Accreditation Standards.* Retrieved from https://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx

Cougle, J. R., Bonn-Miller, M. O., Vujanovic, A. A., Zvolensky, M. J., & Hawkins, K. A. (2011). Posttraumatic Stress Disorder and cannabis use in a nationally representative sample. *Psychology of Addictive Behaviors, 25,* 554-558. doi: 10.1037/a0023076

Courtois, C. A. (2015). First, do no *more* harm. In D. Walker, C. A. Courtois, & J. Aten, (Eds.), *Spirituality oriented psychotherapy for trauma* (pp. 55-76). American Psychological Association Press.

Courtois, C. A. (1999). *Recollections of sexual abuse: Treatment principles and guidelines*. W. W. Norton.

Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. Guilford Press.

Courtois, C. A., & Ford, J. D. (2013). *Treatment of complex trauma: A sequenced, relationship-based approach.* Guilford Press.

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 3-23.

Dagan, Y., & Yager, J. (2020). Cannabis and Complex Posttraumatic Stress Disorder: A narrative review with considerations of benefits and harms. *The Journal of Nervous and Mental Disease, 208*(8), 619–627. https://doi.org/10.1097/NMD.0000000000001172

De Jongh, A. D., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., Foa, E. B., Bicanic, I. A. E., et al., … (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33*, 359-369.

Dell, P. F., & O'Neil, J. A. (2009). *Dissociation and the dissociative disorders: DSM-V and beyond*. Routledge, Taylor & Francis Group.

DePrince, A. P., Chu, A. T., & Pineda, A. S. (2011). Links between specific post-trauma appraisals and three forms of trauma-related distress. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*, 430–441. https://doi.org/10.1037/a0021576

Descilo, T., Vedamurtachar, A., Gerbarg, P. L., Nagaraja, D., Gangadhar, B. N., Damodaran, B., … Brown, R. P. (2010). Effects of a yoga breath intervention alone and in combination with an exposure therapy for PTSD and depression in survivors of the 2004 South-East Asia tsunami. *Acta Psychiatrica Scandinavica, 121*, 289-300.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences Study. *Pediatrics, 111*(3), 564-572.

Ellis, A., Simiola, V., Brown, L. S., Courtois, C. A., & Cook, J. M. (2017). Effect of evidence-based therapy relationships on treatment outcome for adults with trauma: A systematic review. *Journal of Trauma &Dissociation, 16*:1-29. doi: 10.1080/15299732.2017. 1329771

Figley, C. R. (2002). *Treating compassion fatigue*. Brunner-Rutledge.

Finkelhor, D. (2008). *Childhood victimization: Violence, crime, and abuse in the lives of young people*. Oxford University Press.

Fisher, J. (2017). *Healing the fragmented selves of trauma survivors: Overcoming internal self-alienation*. Routledge, Taylor & Francis Group.

Fisher, J., & Ogden, P. (2009). Sensorimotor psychotherapy. In C. A. Courtois & J. D. Ford (eds.), *Treating complex posttraumatic stress disorder: An evidence-based guide.* (pp, 312-328). Guilford Press.

Forbes, D., Bisson, J. I., Monson, C., & Berliner, L. (Eds.). (2020). *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies* (3rd ed.). Guilford Press.

Ford, J. D. (2021). Progress and limitations in the treatment of Complex PTSD and Developmental Trauma Disorder. *Curr Treat Options Psych 8*:1–17. doi: 10.1007/s40501-020-00236-6

Ford, J. D. & Courtois, C. A. (Eds.). (2020). *Treating complex traumatic stress disorders in aduls: Scientific foundations and therapeutic models.* (2nd ed.). Guilford Press.

Frewen, P. A. & Lanius, R. A. (2015). *Healing the traumatized self: Consciousness neuroscience treatment*. W. W. Norton.

Gabbard, G. O. (2017). Sexual boundary violations in psychoanalysis: A 30-year retrospective. *Psychoanalytic Psychology, 34*(2), 151-156.

Gapen, M., van der Kolk, B. A., Hamlin, E., Hirshberg, L., Suvak, M., & Spinazzola, J. (2016). A pilot study of neurofeedback for chronic PTSD. *Applied Psychophysiology & Biofeedback, 40*(4), 1-11. DOI 10.1007/s10484-015-9326-5.

Gartner, R. B. (Ed.). (2017). *Trauma and countertrauma, resilience and counterresilience: Insight from psychoanalysts and trauma experts*. Routledge, Taylor & Francis Group.

Gold. S. N. (2020). *Contextual trauma therapy: Overcoming traumatization and reaching full potential.* American Psychological Association.

Gold, S. N., Dalenberg, C. J. & Cook, J. M. (Eds.). (2017). *APA Handbook of Trauma Psychology*. Washington, DC: American Psychological Association.

Gomez De La Cuesta, G., Schweizer, S., Diehle, J., Young, J., & Meiser-Stedman, R. (2019). The relationship between maladaptive appraisals and posttraumatic stress disorder: A meta-analysis. *European Journal of Psychotraumatology, 10*, 1620084. https://doi.org/ 10.1080/20008198.2019.1620084

Granath, J., Ingvarsson, S., von Thiele, U., & Lundberg, U. (2006). Stress management: A randomized study of cognitive behavioural therapy and yoga. *Cognitive Behaviour Therapy, 35,* 3-10.
.

Greenberg, T. M. (2020). *Treating complex trauma: Combined theories and methods*. Springer.

Hamblen, J. L., Norman, S. B., Sonis, J. Phelps, A., Bisson, J, Delgado Nunes, V., Megnin-Viggars, O., Forbes, D., Riggs, D., & Schnurr, P. P. (2019). A guide to PTSD guidelines. *Psychotherapy, 56*(3)*,* 359-373.

Harris, M., & Fallot, R. D. (Eds.). (2001). *Using trauma theory to design service systems*. Jossey-Bass.

Hays, P. (2011). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (3rd Ed.). American Psychological Association.

Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 3*, 377-391.

Herman, J. L. (1992b). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror* (2nd Ed.). Basic Books.

Hoge, C. W., & Chard, K. M. (2018). A window into the evolution of trauma-focused psychotherapies for posttraumatic stress disorder. *JAMA, 319,* 343-345. doi:10.1001/jama.2017.21880

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr., E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*®. doi:10.1037/a0032595

Hopper, E., Grossman, F., Spinazzola, J., & Zucker, M. (2020). *Treatment of adult survivors of childhood emotional abuse and neglect: Reaching across the abyss*. Guilford Press.

Institute of Medicine. (2011a). *Clinical professional practice guidelines we can trust*. The National Academies Press.

Institute of Medicine. (2011b). *Finding what works in health care: Standards for systematic reviews*. The National Academies Press.

International Society for the Study of Dissociation Task Force on Children and Adolescents (2003). *Guidelines for the evaluation and treatment of dissociative symptoms in children and adolescents*. McLean, VA: Author.

International Society for the Study of Trauma and Dissociation. (2011). [Chu, J. A., Dell, P. F., Van der Hart, O., Cardeña, E., Barach, P. M., Somer, E., Loewenstein, R. J., Brand, B. L., Golston, J. C., Courtois, C. A., Bowman, E. S., Classen, C. C., Dorahy, M., Şar, V., Gelinas, D. J., Fine, C. G., Paulsen, S., Kluft, R. P., Dalenberg, C. J., Jacobson-Levy, M., Nijenhuis, E. R. S., Boon, S., Chefetz, R. A., Middleton, W., Ross, C. A., Howell, E., Goodwin, G., Coons, P. M., Frankel, A. S., Steele, K., Gold, S. N., Gast, U., Young, L. M., & Twombly, J.]. *Guidelines for treating Dissociative Identity Disorder in adults*. McLean, VA: Author.

Karatzias, T. & Cloitre, M. 2017.Treating adults with complex posttraumatic stress disorder using a modular approach to treatment: Rational, evidence, and directions for future research. *Journal of Traumatic Stress, 32*, 6, 870-876.

Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., Hyland, P., Maercker, A., Ben-Ezra, M., Coventry, P., Mason-Roberts, S., Bradley, A., & Hutton, P. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. *Psychological Medicine, 49*(11), 1761–1775. https://doi.org/10.1017/S0033291719000436

Kezelman, C., & Stavropolous, P. (2019). *Practice guidelines for clinical treatment of complex trauma*. Melbourne, Australia: Blue Knot Foundation. www.blueknot.org.au

Keselman, C., & Stavropoulous, P. (2012). '*The last frontier': Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*. Adults Surviving Child Abuse.

Kinsler, P. J. (2017). *Complex psychological trauma: The centrality of relationship*. Routledge, Taylor & Francis Group.

Kinsler, P. J., Courtois, C. A., & Frankel, A. S. (2009). Therapeutic alliance and risk management. In C. A. Courtois & Ford, J. D. (eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 183 – 201). Guilford Press.

Kluft, R. P. (1999). An overview of the treatment of Dissociative Identity Disorder. *American Journal of Psychotherapy, 53*: 289-319.

Lanius, R. A., Brand, B., Vermetten, E., Frewen, P. A., & Spiegel, D. (2012). The dissociative subtype of posttraumatic stress disorder: Rationale, clinical and neurobiological evidence, and implications. *Depression and Anxiety, 29*(8), 701-708. https://doi.org/10.1002/da.21889

Lanius, R. A., Boyd, J. E., McKinnon, M. C., Nicholson, A. A., Frewen, P., Vermetten, E., Jetly, R., & Spiegel, D. (2018). A review of the neurobiological basis of trauma-related dissociation and its relation to cannabinoid- and opioid-mediated stress response: a transdiagnostic, translational approach. *Current Psychiatry Reports, 20*(12), 1–14. https://doi.org/10.1007/s11920-018-0983-y

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1): 131-149.

McFetridge, J., Swan, A. H., Heke, S., Karatzias, T., Greenberg, N., Kitchiner, N. et al… (2017). *Guideline for the treatment and planning of services for complex post-traumatic stress disorder in adults*. UK Psychological Trauma Society.

Mersky, J. P., Plummer Lee, C., & Janczewski, C. E. (2020). Toward the assessment of adverse adult experiences: An initial validation study of the adult experiences survey. *Psychological Trauma: Theory, Research, Practice, and Policy,* http://dx.doi.org.proxy1.lib.uwo.ca/10.1037/tra0000833

Metcalf, O., Varker, T., Forbes, D., & Phelps, A., et al. . . (2016). Efficacy of fifteen emerging interventions for the treatment of Post-traumatic Stress Disorder: A systematic review. *Journal of Traumatic Stress, 29*(1):88-92. http://doi: 10.1002/jts.22070

Miller, M., Mistry, D., Jetly, R., & Frewen, P. (2021). Meditating in virtual reality 2: Phenomenology of vividness, egocentricity and absorption-immersion. *Mindfulness, 12*(5), 1195–1207. https://doi.org/10.1007/s12671-020-01589-y

Muller, R. T. (2017). *Trauma and the struggle to open up: From avoidance to recovery and growth.* W. W. Norton.

Muller, R. T. (2010). *Trauma and the avoidant client: Attachment-based strategies for healing.* W. W. Norton.

Norcross, J. C., & Lambert, M. L. (2018). Psychotherapy relationships that work III. Special issue of *Psychotherapy, 55*(4): 4-8.

Ogden, P., & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment*. W. W. Norton.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. W. W. Norton.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* W. W. Norton.

Pope, K. S., & Bouhoutsos, J. C. (1986). Sexual intimacy between therapists and patients. In J. Worell (Ed.), *Encyclopedia of women and gender: Sex similarities and differences and the impact of society on gender* (2nd Ed.), (pp. 955-962). Academic Press.

Prochaska, J. O., Norcross, J. C., & DiClemente, C. A. (2005). Stages of change: Prescriptive guidelines. In G. P. Koocher, J. C. Norcross, & S. S. Hill. (Eds.), *Psychologists' desk reference* (2nd ed.), (pp. 226-231). Oxford University Press.

Saakvitne, K. W. (2017). Clinical consultation to help transform vicarious traumatization. In R. B. Gartner, (Ed.), *Trauma and countertrauma, resilience and counterresilience: Insight from psychoanalysts and trauma experts* (pp. 236-250). Routledge, Taylor & Francis Group.

Saul, J. (2014). *Collective trauma collective healing: Promoting community resilience in the aftermath of disaster*. Routledge, Taylor & Francis Group.

Schäfer, S. K., Becker, N., King, L., Horsch, A., & Michael, T. (2019). The relationship between sense of coherence and post-traumatic stress: a meta-analysis. *European Journal of Psychotraumatology, 10*(1), 156283- 1562839. https://doi.org/10.1080/20008198.2018.1562839

Spinazzola, J., & Briere, J. (2020). Evidence-based psychological assessment of the sequelae of complex trauma. In J. D. Ford & C. A. Courtois (Eds.). Treating complex traumatic stress disorders: Scientific foundations and therapeutic models (2nd Ed.). Guilford Press.

Stamm, B. (Ed.). (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: The Sidran Press.

Staub, E., Pearlman, L. A., Gubin, A., & Hagengimana, A. (2005). Healing, reconciliation, forgiving, and the prevention of violence after genocide or mass killing: An intervention and its experimental evaluation in Rwanda. *Journal of Social and Clinical Psychology, 24*, 297-334. doi: 10.1521/jscp.24.3.297.65617

Tedeschi, R. G. & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, *15*(1): 1-18.

Teicher, M. H., & Samson, J. A. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. *Journal of Child Psychology and Psychiatry, 57*(3), 241–266. https://doi.org/10.1111/jcpp.12507

US VA/DoD Clinical Practice Guidelines (2017). *Management of Posttraumatic Stress Disorder and Acute Stress Reaction*. Retrieved from https://www.healthquality.va.gov/guidelines/mh/ptsd/

Waller, M., Mistry, D., Jetly, R., & Frewen, P. (2021). Meditating in virtual reality 3: 360° video of perceptual presence of instructor. *Mindfulness*, *12*(6), 1–1437. https://doi.org/10.1007/s12671-021-01612-w

Wallin, D. J. (2007). *Attachment in psychotherapy*. Guilford Press.

Wiseman, H., Hamilton-Giachritsis, C., & Hiller, R. M. (2021). The relevance of cognitive behavioral models of post-traumatic stress following child maltreatment: A systematic review. *Trauma, Violence, & Abuse, 22*(1), 191–206. https://doi.org/10.1177/1524838019827894

World Health Organization (June, 2018). International statistical classification of diseases and related health problems (11th ed.). https://icd.who.int/browse11_2018-06/l-m/en#/http://id.who.int/icd/entity/585833559