JUNE 2023, ISSUE 7

COMPLEX TRAUMA PERSPECTIVES

CO-CHAIRS' CORNER - A MESSAGE FROM THE OUTGOING CT SIG CO-CHAIRS

Lori Herod, EdD, Rebecca Ohler, LPC LMHC, Morgan McCowan, MA, & Aubrie Munson, MS

Greetings complex trauma colleagues,

We've been doing a bit of spring cleaning in the CT SIG and have some new leadership members to introduce and several to say farewell to. It's always sad to say goodbye but Rebecca, Lori, Aubrie, and Morgan have stepped down as Co-Chairs/Student Co-Chairs; however, Morgan will remain on as Newsletter Editor. We'd like to thank them for all the time and effort they put into expanding the CT SIG in terms of membership, projects, and outreach. You will be missed!

Our new CT SIG Co-Chairs are Krista Engle, Philip Katner, and Kayleigh Watters, and our new Student Chair is Carine Leslie. The new leadership team is looking forward to working with all of you on the various projects the SIG has undertaken. Stay tuned - next issue we will introduce each of the new co-chairs. (*cont.*)

WHAT'S INSIDE THIS ISSUE:

QUICK LINKS:

COMPLEX TRAUMA TRAININGS LIST
click here to comment

MENTORSHIP PROGRAM
click here to sign up

PUBLIC ACCESS FOLDER
click here to view

EMAIL NEWSLETTER AT
ctsigperspectives@gmail.com
TO SUBMIT YOUR RECENT PUBLICATIONS OR TO INFORM US OF RECENT ACHIEVEMENTS

CO-CHAIRS' CORNER (CONT.)

Complex Trauma SIG Project List

Current CT SIG projects are listed below; please note we have two new projects!

ICD-11 Complex PTSD Diagnosis - Member Survey & Critique

The ICD-11 Complex PTSD diagnosis is available to World Health Organization member states. The goal of this project is to hear from clinicians, researchers, and other ISTSS members about their experience of using this new diagnosis - what works, what might be missing, and more. We are incorporating input from Round 1 of the feedback we have received and will send updates to the Listserv.
Thank you to Sue Brown for heading this project!
Project status: Incorporating Round 1 Input
What we need: We will send updates via the Listserv and next newsletter.
How you can help: Stay tuned to the Listserv and newsletter!

Complex Trauma Training List - Resource for Professionals

Complex Trauma trainings are increasingly available from professional organizations around the world. We now have a list of current Complex Trauma professional trainings (not including doctoral/postdoctoral programs), including details for each, such as training cost and target audiences.
Thank you to Philip Katner for getting us started by compiling this list!
Project status: Complex Trauma training list has been compiled
What we need: Feedback about these trainings - if you are familiar with them, pros/cons of the training, and any other information that would be helpful for others who may be interested in enrolling for these trainings
How you can help: Follow this link Trauma Training List and add comments to the spreadsheet - see column N for instructions on how to comment

Mentorship Program

We have developed a program in which later-stage professionals can provide mentorship to students and early-stage professionals. If you have not yet expressed interest, but would like to participate as a mentor or mentee, please fill out our survey stating your interest. If you have any questions, email student co-chair/project lead, Carine.
Thank you to Aubrie Munson for her work on this and to Carine Leslie for taking over as project lead!
Project status: Mentorship program is up and running
What we need: Those interested in being a mentor/mentee can still sign up here
How you can help: Sign up as a mentor or mentee and/or recommend the program to others - we are in particular need of additional mentors!

Uplifting Complex Trauma SIG Members' Achievements & Publications

To support CT SIG members in sharing achievements and publications with the rest of the SIG, we will continue our "kudos" section of the newsletter to list recent achievements. We also have a public folder with all newsletter issues and a "Supplementary Content" folder to include CT SIG members' recent publications and/or additional content for distribution to the SIG. Access the folder here: CT Perspectives Public Access
Thank you to CT SIG members for the requests for public access to the newsletter and the idea to share additional publications! (cont.)

CO-CHAIRS' CORNER (CONT.)

Uplifting CT SIG Members' Achievements & Publications *(cont.)*
Project status: Public folder available & Kudos Corner is an ongoing feature
What we need: Achievements and publications from CT SIG members
How you can help: Email achievements/publications to Newsletter Editor, Morgan

Complex Trauma Treatment Core Competencies List
We are in the process of compiling a list of core competencies for Complex Trauma treatments/trainings. This list is based on existing guidelines and articles Chris Courtois circulated to the CT SIG in 2022 and will be further expanded based on member feedback. Cited pieces are accessible here: CT Perspectives Public Access in the "Supplementary Content" folder [See: Cloitre, Courtois, et al. (2011); Cook & Newman (2014); Dyer & Corrigan (2021)]
Thank you to Chris Courtois for initiating this important project!
Thank you to Luca Hartman and Brianna Domaceti for agreeing to be project leads!
Project status: Brianna and Luca have compiled an initial list of core competencies and are compiling feedback.
What we need: Thank you to those who have already provided feedback! We will seek another round of feedback from the CT SIG once the next draft is completed.
How you can help: Stay tuned to the Listserv and newsletter!

***NEW* Developmental Trauma Bibliography Project**
Julian Ford and his colleagues are working to have the Developmental Trauma Disorder (DTD) diagnosis accepted officially. Like Complex PTSD, we hope that having an evolving bibliography of relevant research will help with their efforts.
Thank you to Scott Uhler for agreeing to head up the bibliography project! And to Julian Ford for facilitating collaboration between advocates for the DTD and Complex PTSD diagnoses.
Project status: Scott is in the process of updating the bibliography to make it more accessible
What we need: Feedback when ready
How you can help: Stay tuned to the Listserv and newsletter!

***NEW* Consultation Groups Project**
Former CT SIG Co-Chair, Rebecca Ohler, is heading a project to hold clinical consultation groups to support clinicians working with clients who are presenting with complex trauma histories and/or symptomatology.
Our thanks to Rebecca as she gets this off the ground!
Project status: Rebecca's project proposal has been approved
How you can help: Stay tuned to the Listserv and newsletter for more info

Thank you again for your support of the CT SIG over the past few years. We have all so enjoyed being part of the leadership team and look forward to the next phase of the organization!

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

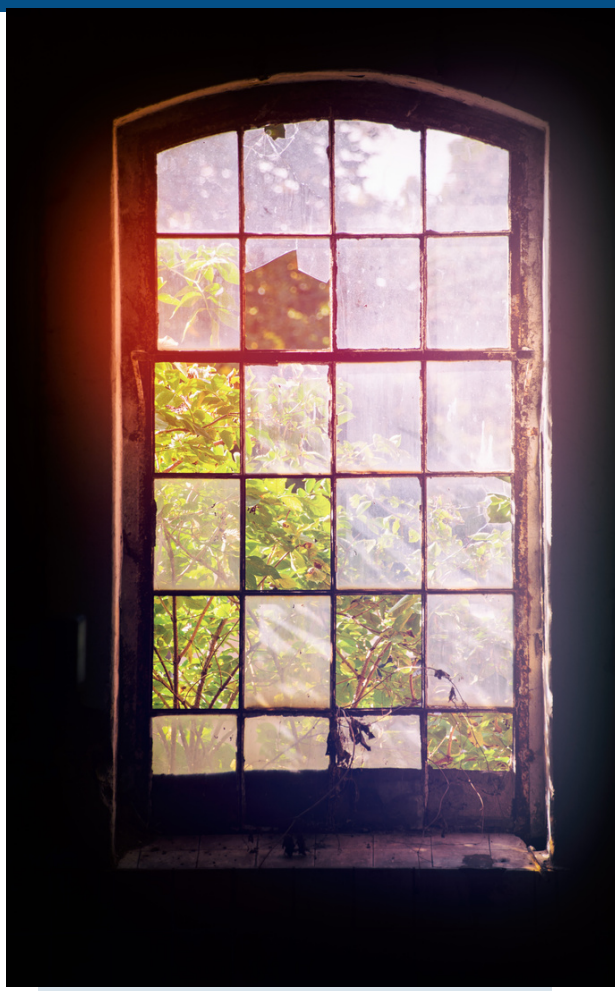
JOIN US AT OUR NEXT MONTHLY SIG MEETING on Friday, August 18, 2023 at 11am ET/10am CT /9am MT/8am PT

CONTACT THE *COMPLEX TRAUMA PERSPECTIVES* EDITORS BY EMAILING
CTSIGPerspectives@gmail.com

Throughout the issue underlined text represents a clickable link for access to additional resources

RESEARCHERS' CORNER —
THE THREE TRUTHS OF COMPLEX TRAUMA: PERSPECTIVES FROM A MALE SURVIVOR OF CHILD SEXUAL ABUSE

Malachi Ananda Gillihan



A Cognitive Dissonance

Dear Reader – when I offer the following word pairings to you, what happens in your thoughts, in your feeling state in the body, and even in your sense of interest in this article? Please note what happens after reading each pairing.

> "Male" and "Vulnerable."
> "Masculine" and "Weak."
> "Man" and "Helpless."

Regardless of how you identify along the gender spectrum, the chances of you pairing these words together on your own might be unusual. Some might suggest it would be more likely to pair "male," "masculine," and "man," with words like ego, toxicity, patriarchy, ambition, and domination. Reading the above pairings may create an experience of cognitive dissonance.

Hello, my name is Malachi Gillihan, and if this is the first time we have met, I usually introduce myself in "professional" or "academic" circles as a trauma specialist and survivor-practitioner. (When I write as a "survivor," I also tend to write more conversationally, although please hang in there as I promise to speak APA. It's just casual APA; but check my citations, they are flawless.) I call myself a "trauma specialist" because, well, trauma is my specialty (and because I associate that liminal space between five and 15 years of dedicated work experience to be the realm of the "specialist," while "expert" is reserved for those beyond 15 years in the field). "Practitioner" because I have a small private practice working with survivors, in efforts to restore a sense of safety in the body as well as safety with other bodies (also referred to as safety in relationships); and, to support a sense of both healing and growth. In addition, "practitioner" because I am a PhD researcher evaluating the application of ritual and rites of passage to group-based approaches for male survivors of sexual trauma. Finally, as a "survivor," I am a male survivor of child sexual abuse. I have lived with the symptoms of post-traumatic stress and complex trauma for more than 30 years.

"Oh, God, I'm so screwed."

I still remember the conversation I had with a therapist during one of my first EMDR sessions. During our check-in before the treatment she said, "Malachi, you have complex trauma. That's why this is so hard." I remember feeling my body go cold while I thought to myself, "Oh, God, I'm so screwed." I already experienced a sense of isolation and loneliness being a male survivor. I already wrestled with feeling broken and flawed as a result of my hypervigilance and moodiness. I also struggled with fear and hopelessness that I would ever be able to glimpse "the other shore," that conceptual, mythic place where people enjoyed a warm, cozy, safe and secure life *after trauma.*

I knew I had trauma. The symptoms spoke for themselves. Complex PTSD (CPTSD) sounded like a whole different story, and hearing those words scared the hell out of me. *(cont.)*

I USUALLY INTRODUCE MYSELF IN "PROFESSIONAL" OR "ACADEMIC" CIRCLES AS A TRAUMA SPECIALIST AND SURVIVOR-PRACTITIONER.

- GILLIHAN

RESEARCHERS' CORNER (CONT.)

Gillihan

The Three Truths of Sexual Trauma

Some of the ironies and cruelties of the traumatic experience are feeling *as if* we are alone, *as if* we are broken, and *as if* we will never be able to heal or grow. What I discovered through my own experience was just the opposite, and that each of these beliefs had a roundabout way of pointing towards what I now call the "Three Truths of Sexual Trauma."

I Am Not Alone
I Am Not Broken
I Can Heal and Grow

How did I learn I am not alone? At first, I learned through psychoeducation. The statistics spoke for themselves. Several recent studies (Cook et al., 2018; Ellis et al., 2020) contend that, for male survivors alone, there are approximately one billion men and boys who have or will experience sexual trauma in their lifetime. If we integrate data on female survivors, the number surges to between three to four *billion* individuals *currently existing*, who have or will experience sexual trauma in their lifetime (Levine & Kline, 2008; Smith, 2018). That is nearly half the planet; and yet, regardless of how many countless others there are, these individuals often live for decades with a crushing sense of isolation. Trauma *feels* lonely.

The second way I learned I was not alone was more embodied. I *experienced* "I am not alone," by being with other male survivors in healing circles and support groups. Later, in my research, I discovered a statistical confirmation of what I had observed and experienced myself: the primary healing support male survivors seek is peer support (Ellis et al., 2020). Men with histories of sexual trauma are seeking other men with similar experiences.

Judith Herman, one of the pioneers of the CPTSD field, affirms this in her own writing and research. Herman (2015) argues that trauma recovery *requires* relationship, and ideally among individuals with shared histories. Her methods in group-based research affirms this (Herman et al., 2018; Mendelsohn et al., 2011).

Healing is relational, and survivors, including myself, discover the deepest healing arguably happens through safe connection with other survivors.

The truth of "I am not broken" came through psychoeducation as well. I recall bursting into tears the first time I read Stephen Porges' *The Polyvagal Theory* (2011). It described my experience. More important, the theory lifted shame and self-judgement I had been carrying for years, feeling and believing that I was fundamentally flawed as a result of my experiences. While I continue to struggle with thinking, "God, what is *wrong (cont.)*

THERE ARE APPROXIMATELY ONE BILLION MEN AND BOYS WHO HAVE OR WILL EXPERIENCE SEXUAL TRAUMA IN THEIR LIFETIME.

- GILLIHAN

RESEARCHERS' CORNER (CONT.)

Gillihan

with me?" from time to time, I recognize now that this thinking occurs when I have shifted into a sympathetic or dorsal state. I have learned that "story follows state," and that regardless of how much recovery or healing I have done, when anyone shifts into a different state of consciousness, then the range of thoughts, beliefs, and behaviors dramatically shifts as well – and, perhaps most importantly, that *it is not my fault* (Porges, 2017; Dana & Porges, 2018). I do not have to accept the thought that I am broken, that I am flawed, and that I am to blame.

Finally, the idea that I can heal and grow also came from direct experience first, and later through research such as the growing field of post-traumatic growth. For most of the 30-plus years of living with trauma, recovering safety in the body seemed hopeless, and I accepted a kind of fatalism towards relationships. When I began to grow in ways I could not have imagined, it contradicted this long-held belief, and in conjunction with other survivors, I came to realize that personal transformation is possible.

SO HOW DO WE ARRIVE AT THESE TRUTHS OURSELVES? WE HAVE TO STUDY, TO SEEK, TO BE WITH OUR OWN DOUBT AND INSECURITY. WE HAVE TO DISCOVER WHAT IS "VULNERABLE," "WEAK," AND "HELPLESS" WITHIN US.

- GILLIHAN

The Three Truths of Complex Trauma

I contend that these three truths are just as applicable to CPTSD, regardless of the source of trauma. When it comes to complex trauma, survivors are not alone, they are not broken, and they can not only heal, they can grow. Getting diagnosed with complex trauma can be scary. Your 'garden variety' PTSD is more than enough to besiege a person for a lifetime. To literally make trauma *more complicated* is like throwing fuel on the fire. It can feel overwhelming to an already overwhelmed system.

On the other hand, it is possible that when a client feels stuck, haunted, or held back, receiving a diagnosis of CPTSD may alleviate some of the self-judgement or expectations they may be placing on themselves for not being able to "hack it" the way others may be able to. When they learn that their experience is literally more difficult, it can not only feel scary, it can feel like, "Of course that's why this is so hard! Of course, this is why I have struggled for so long. Of course!" Perhaps it gives them *(cont.)*

RESEARCHERS' CORNER (CONT.)

Gillihan

permission to go easier on themselves, to take care, to be gentle. Perhaps it invites more vulnerability, more permission to be with the sense of weakness or helplessness that may have accompanied being overpowered or sexually humiliated. Perhaps, through the diagnosis, we can even find a way to connect to a source of strength, possibility, tenderness, and hope.

Implications for Practice

In order for us as healing professionals to offer to others that these ideas can be true *for them*, they must be real *for us*. Clients pick up on platitudes and lack of conviction immediately. They sense it through their traumatic transference or through our traumatic counter-transference (Herman, 2015; Quatman, 2015). They know when it is not true for us.

So how do we arrive at these truths ourselves? We have to study, to seek, to be with our own doubt and insecurity. We have to discover what is "vulnerable," "weak," and "helpless" within us. As the second passage of the mystical *Gospel of Thomas* suggests (Leloup & Rowe, 2005), when we find what we seek, our world might be shaken; and, following a ground-breaking insight, we may then marvel and be in awe.

Realizing that we are not alone, that we are not broken, and that we can heal and grow is a marvel. For survivors, it can feel like an awe-inspiring revelation. Given the variety of experiences that we somehow survived that led to complex *(cont.)*

MALACHI GILLIHAN, PHD

Dr. Malachi Gillihan is a trauma specialist, yogi, and spiritual counselor. As a male survivor of child sexual trauma, Malachi has integrated his lived experience with PTSD and complex-PTSD with his studies in East-West approaches to trauma recovery, healing, and growth. Having taught more than 1000 classes, in addition to writing and speaking about trauma recovery and spirituality, he maintains a small private practice, working with male survivors, teaching yoga and meditation, and leading retreats. Malachi earned his Masters in East-West Psychology along with his certification as a Spiritual Counselor from the California Institute of Integral Studies (CIIS) in San Francisco, CA, and is currently completing his PhD, focused on group-based interventions for survivors of sexual trauma. He has trained under teachers including Dr. Dan Siegel, Judith Lasater, Sean Feit-Oakes, Deb Dana, and Michael Brian Baker in areas including yoga instruction and yoga for trauma, interpersonal neurobiology, the Polyvagal Theory, mindfulness-based stress reduction, Buddhist approaches to counseling, breathwork, and insight meditation. Malachi has been practicing yoga and meditation for 20 years.

RESEARCHERS' CORNER (CONT.)

Gillihan

trauma, it is a marvel to come face to face with the possibility that it does not have to have the last word. The other shore exists. Perhaps it is not the fantasy world of a place with no problems, no difficulties, no sadness, depression or loss; but the real world, the human and more-than-human world, is reachable. We can come home.

The chasm of complex trauma can be crossed through relationship. That relationship may be in a circle with peers who share a similar history, and it might be us, meeting with a client once a week in some office park in the middle of nowhere. ∎

WHEN IT COMES TO COMPLEX TRAUMA, SURVIVORS ARE NOT ALONE, THEY ARE NOT BROKEN, AND THEY CAN NOT ONLY HEAL, THEY CAN GROW.

- GILLIHAN

References

- Cook, J. M., Anderson, C., Simiola, V., & Ellis, A. E. (2018). Top Ten Questions Male Sexual Abuse Survivors Want to Know from Health Care Research. *Journal of Aggression, Maltreatment & Trauma, 27*(8), 867-882. 10.1080/10926771.2018.1446481
- Dana, D., & Porges, S. W. (2018). *The Polyvagal Theory in Therapy* (First edition ed.). W.W. Norton & Company.
- Ellis, A. E., Simiola, V., Mackintosh, M., Schlaudt, V. A., & Cook, J. M. (2020). Perceived helpfulness and engagement in mental health treatment: A study of male survivors of sexual abuse. Psychology of Men & Masculinities, 21(4), 632-642. 10.1037/men0000313
- Herman, J. L. (2015). Trauma and recovery. Basic Books, a member of the Perseus Books Group.
- Herman, J. L., Kallivayalil, D., & and Members of the Victims of Violence Program, and Members. (2018). Group Trauma Treatment in Early Recovery. Guilford Publications.
- Leloup, J., & Rowe, J. 1. (2005). The Gospel of Thomas: the gnostic wisdom of Jesus. Inner Traditions.
- Levine, P. A., & Kline, M. (2008). Trauma-proofing your kids: a parents' guide for instilling confidence, joy and resilience. North Atlantic Books.
- Mendelsohn, M., Herman, J. L., Schatzow, E., Coco, M., Kallivayalil, D., & Levitan, J. (2011). The Trauma Recovery Group. Guilford Publications.
- Porges, S. W. (2011). The polyvagal theory: neurophysiological foundations of emotions, attachment, communication, and self-regulation (1st ed. ed.). W.W. Norton.
- Porges, S. W. (2017). *The pocket guide to polyvagal theory: the transformative power of feeling safe* (First edition. ed.). W. W Norton & Company.
- Quatman, T. (2015). *Essential Psychodynamic Psychotherapy.* Routledge. 10.4324/9781315750095
- Smith, M. D. 1. (2018). *Encyclopedia of rape and sexual violence.* ABC-CLIO, an Imprint of ABC-CLIO, LLC.

CLINICIANS' CORNER — WHAT IS CPTSD REALLY?

Ed Sibley, MA

Preface

My thanks to the Complex Trauma SIG for this opportunity to introduce myself and to present an innovative approach to psychotherapy that I have successfully used to help others. My journey of accomplishment began with the necessity to help myself as a victim-survivor of both complex trauma and what I experienced during and immediately after my 25 years in the military.

From my experience, I believe that aside from what people learn through trial and error, success or failure is mostly contingent on what we learn from others. Consequently, I use a non-threatening, "top down" approach -- much like Dr. Janina Fisher's trauma-focused, nurture-based psychotherapy (Fisher, 2017) --that allows the client to decide when to revisit past trauma issues without being distracted while absorbing critical recovery information. Simply put, I teach, to give my clients the tools to understand the why and the how to figure out their trigger and coping issues on their own. In achieving a sense of self-worth, they reduce the suicidal ideations and strive to learn more about a healthy path forward.

Further, it is my contention that everyone faces some level of distress, however mild or severe, throughout the life cycle. Moreover, in our Western Culture we are conditioned to avoid distress/evil and focus solely on the eustress/good perspectives. Such an approach results in a distorted learning process that fails to address how to survive a severe trauma experience. The key to my psychotherapy approach can be found in what I have come to recognize as Psychological Stress Theory (PST). PST, for all intents and purposes, is based on the concept of using nature to understand and apply nurture in overcoming PTSD/CPTSD (DTD). The key to that understanding is in the knowledge that trauma is the trigger, and "PTSS-Disorders" are the symptoms. But, what is not understood is that the disease is distress; as basically defined by Hans Selye in 1936 (Britannica, 2022). This article is an introduction to what I have come to identify as Psychological Stress Theory (PST).

What is PTSD/CPTSD, Really?

When I was in graduate school, for my master's in counseling psychology, among the guidelines being taught, was to never be judgmental. Strange as it may be, that principal was somehow too difficult for some of my professors to abide by, especially in my case. Even in today's mental health work environment, I have found this anomaly to be true with too many professionals. Indeed, it seems to be prevalent throughout our Western Culture.

IN OUR WESTERN CULTURE WE ARE CONDITIONED TO AVOID DISTRESS/EVIL AND FOCUS SOLELY ON THE EUSTRESS/GOOD PERSPECTIVES. SUCH AN APPROACH RESULTS IN A DISTORTED LEARNING PROCESS THAT FAILS TO ADDRESS HOW TO SURVIVE A SEVERE TRAUMA EXPERIENCE.

- SIBLEY

As a survivor of complex trauma (developmental trauma), I have come to recognize the consequence of such an early-life experience, where both good and bad survival lessons are learned, and those lessons became the basis for how I entered adulthood. *(cont.)*

CLINICIANS' CORNER (CONT.)

Sibley

Overcoming the learned bad behaviors was often an unguided journey of stumble, fumble and fall. Indeed, as Albert Einstein is reported to have commented about what many would call common sense, that it is nothing more than prejudices learned before the age of eighteen that need to be unlearned (Barnet, 1948, pg. 48). Unfortunately, clarity of purpose based on healthy behavioral examples often does not occur until a mid-life crisis if it happens at all.

The following poem exemplifies my experience of how complex trauma conditioning plays out over the life span. I use it as an aide in my work to help my clients...

UNDERSTANDING WHY

My parents have always been good people.
They did the best they could.
Sometimes each was successful in his or her own way.
And, I learned well from what they did.

At other times there were failures
and my hurt was deeply felt.
Yet I survived.
The anger buried deep within me.
And, another lesson became inscribed.

Influenced further by clan, tribe, and society all.
In time I found myself living what I had absorbed.
Successes and failures both.
And, with the experience, a realization
that my freedom to choose
depends so much on my basis of choice.

A beginning, an understanding, compassion and more.
To know forgiveness for being human
without having to praise or condone what is done.
To embrace the past, both good and bad.
And, with it all, the ability to move on.

Like my parents and their parents before them,
I can strive to improve on what has been taught.
To know there is more, where better is possible,
because even the good is not enough.
But, like so many before me, I too will never be "perfect."
At least, not now... not in this life.

In any search for understanding on how to achieve a healthier mentality and overall sense of wellness, it might very well be necessary to begin by stating the obvious, that everyone faces some level of distress, however mild or severe, throughout the life cycle. In the realm of nurture, it is the nature of the universe that there will always be a positive eustress that will, if embraced, provide answers for whatever negative distress *(cont.)*

CLINICIANS' CORNER (CONT.)

Sibley

challenges might occur. A simple reminder of this truth can be found in the Buddhist Proverb: *Obstacles do not block the path; they are the path.*

In the poem, the first stanza is a depiction of eustress-type behavior whereas distress-type involvement is depicted in the second stanza. Using the natural eustress elements of healthy boundaries (intellect) and unconditional love (emotion), as expressed in stanzas three and four respectively, are how to achieve balance and a sense of wellness based on the lessons learned, or not. The goal, as noted in the last stanza, is to go further than what has been taught – whether eustress related or distress-based complex trauma – during attachment, the developmental or adolescent years, or beyond.

Although not explicit in stanza five, it certainly is implicit that the ultimate outcome for such a journey of enlightenment is to achieve a sense of awareness, self-regulation, and self-actualization. The most significant insight and lesson to learn from a healthy nurturing process or one that is self-taught is how to trust and to be trusted (Janoff-Bulman, 1992, pgs. 12-21). Moreover, in the first line of stanza five I have also tried to at least suggest there is a search for beginnings. The question of where human behavior has its origins has always been at the forefront of psychological research. In the search to identify a first causality for human behavior – what Sigmund Freud and colleagues called metapsychology, circa 1914 (Gay, 1988, pg. 362) – I would offer that one natural science take-away from this poem is that in nurturing there are only two categories of emotions that govern all human behavior: love-based eustress and fear-based distress.

The poem also exposes the Western Cultural singularity aspect of thinking that is based on what is commonly referred to as the Abrahamic religious belief of an *oppositional dualistic* nurture-based viewpoint. This type of thinking is a form of conditioning that can be observed in what has *(cont.)*

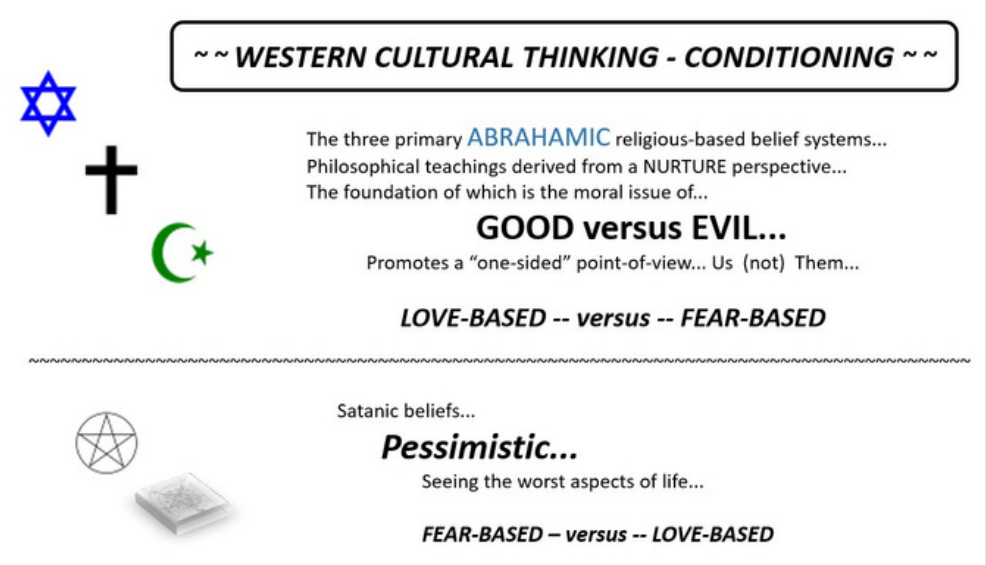


FIGURE 1

FIGURE 2

OBSTACLES DO NOT BLOCK THE PATH; THEY ARE THE PATH.

- BUDDHIST PROVERB

CITED BY SIBLEY

CLINICIANS' CORNER (CONT.)

Sibley

become known as the struggle between good (love-based eustress) and evil (fear-based distress) as found in any number of folk stories about creation and the human experience (Campbell, 1972, pgs. 268-274).

The alternative to counter such a mythological struggle and its one-sided conditioning is what forms the starting point for what I would identify as Psychological Stress Theory (PST). Conceptually, in PST, to understand more fully the *why* of human behavior, it is necessary to combine nurture's empirical and philosophical viewpoints with the terms and procedures associated with the laws of nature. The concept of evil then becomes just another fear-based obstacle, not for fear of being emulated, but simply to be overcome as the means to improve our sense of self-worth. It can also be said that *oppositional dualistic* conditioning and its resulted thinking is the basis for he "us and them" fear-based societal thinking and any subsequent related dysfunctional behaviors.

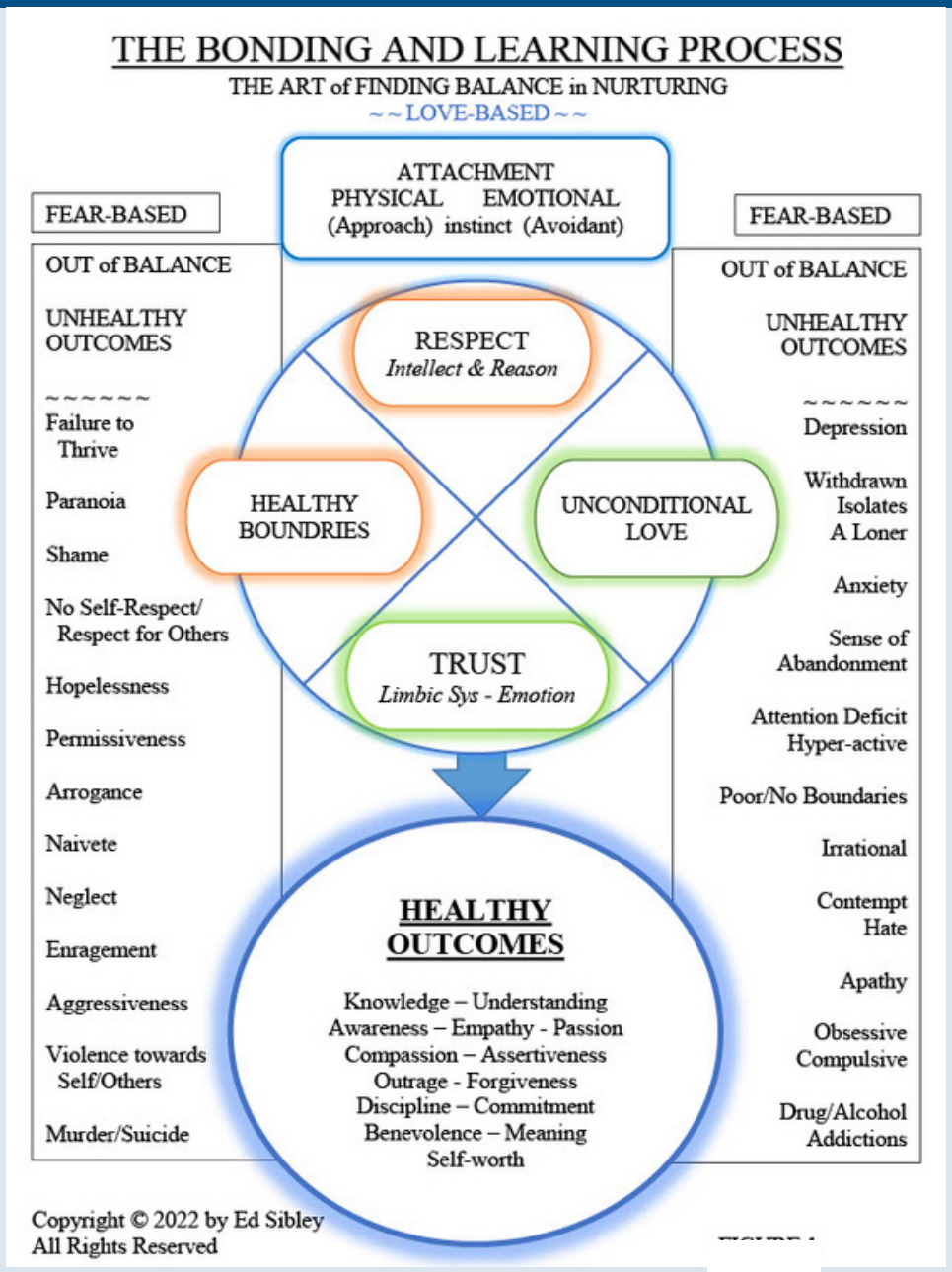


FIGURE 3

To narrow the search in understanding the psychology of human behavior, it stands to reason that the universe in which we exist has some form of an impact on our ability to function. Some of the natural science principles that underscore nurture in PST include but are not limited to the physiology of the human body, the overriding understanding of Einstein's mathematical insights, Quantum Theory and in particular Newton's Laws of Motion (Janoff-Bulman, 1992; Lipton, 2009; Britannica, 2022). Indeed, when the Laws of Motion are extrapolated and applied to psychology, we can establish the very nature of what constitutes psychological stress.

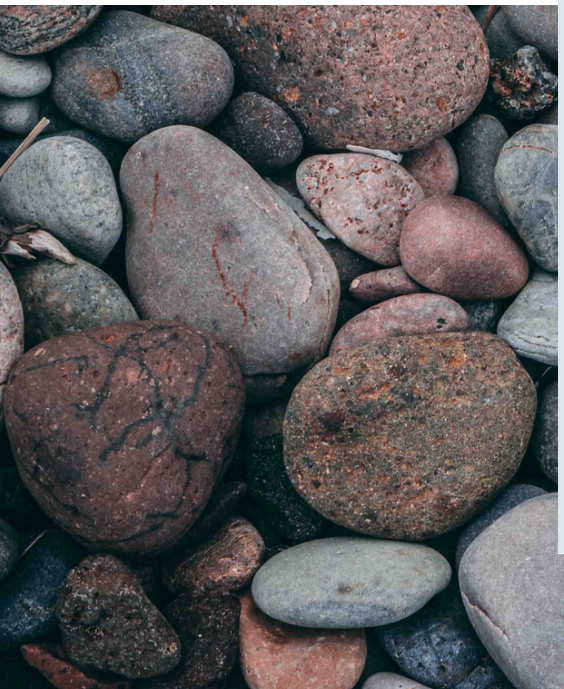
Further insights where nature is involved can be obtained from *(cont.)*

CLINICIANS' CORNER (CONT.)

Sibley

the wisdom inherent in the 6,000-year-old Chinese philosophy of the Pa Kua/ the eight changes and the I Ching/the first book of the five classic books of Confucianism based in large part on the Pa Kua. The Pa Kua is a cult belief – attributable to two mythical figures, Fu I/the "Heavenly Emperor" and Shen Nung/the "Earthly Emperor" – that teaches the non-oppositional dualistic concept in the language of Yang and Yin (i.e., nature's elements of sky and earth respectively) (Culling, 1965, pg. 9; Campbell, 2004, pg. 292). This basic view of natural science provides significant insight that helps to explain nature's role in nurture that remains valid to this day. This same information may also be found in the current teachings of Taoism/The Way, Shintoism, Buddhism and even in Sun Tzu's *The Art of War* (Denma, 2001).

Moreover, when the science of nature is combined with the artfulness needed in applying nurture's *(cont.)*



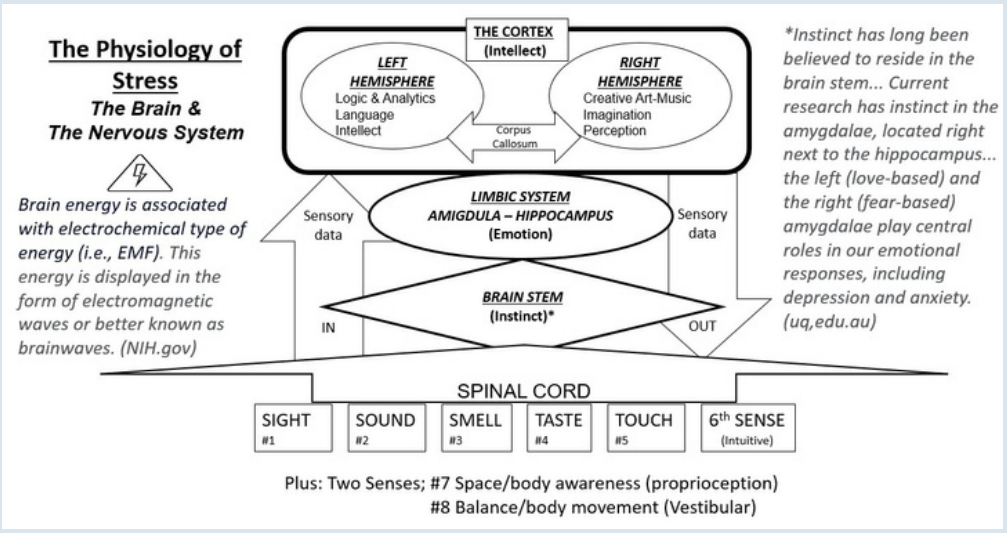


FIGURE 4

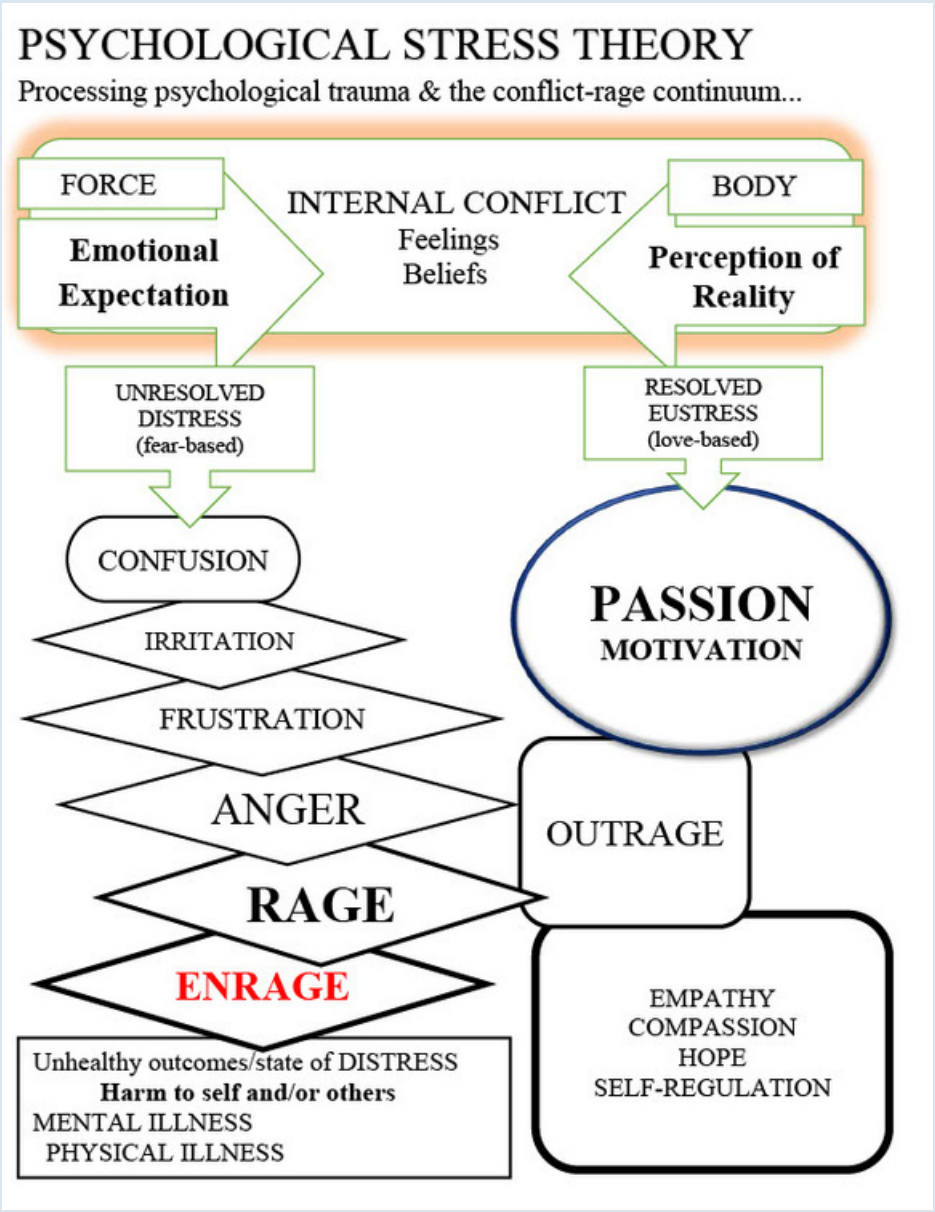


FIGURE 5

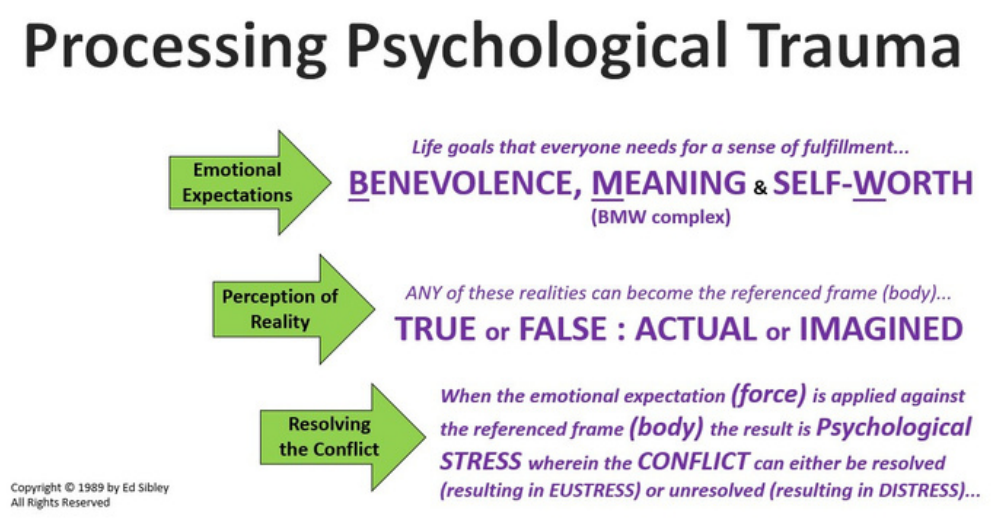


FIGURE 6

empirical findings and philosophical concepts, the diagnoses and thus the outcomes of the recovery process can be much improved. And, with such a recovery, the prejudice inherent in judgmental behavior can be transformed into a healthier journey in life wherein understanding nature becomes the means to overcome the admonition, "do as I say, not as I do" especially for anyone in the role of a parent, teacher, mental health caregiver and/or law and order professional. (See figures 1 through 6 for graphic representations of the above concepts.) ∎

References

- Barnett, L. (1948). *The Universe and Dr. Einstein*. Time Inc.
- Britannica, The Editors of Encyclopedia (2022). *Hans Selye*. Encyclopedia Britannica. https://www.britannica.com/biography/Hans-Selye.
- Campbell, J. (1972). *The Hero with A Thousand Faces.* Princeton University Press.
- Culling, L. T. (1965). *The Incredible I Ching.* Helos Book Service (Publications) Ltd.
- Denma Translation Group, The (2001). *The Art of War -- Sun Tzu.* Shambhala Publications, Inc.
- Fisher, A. (2017). *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation.* Taylor & Francis Company.
- Gay, P. (1988). Freud, A Life for Our Time. W. W. Norton & Company.
- Isaacson, W. (2007). *Einstein.* Simon & Shuster.
- Janoff-Bulman, R. (1992). *Shattered Assumptions: Towards A New Psychology of Trauma.* Free Press.
- Lipton, B .H. (2009). *The Biology of Belief* (fifth edition). Hay House, Inc.

ED SIBLEY, MA

Ed Sibley has an MA in Counseling Psychology from Massachusetts State University at Framingham and a BSEd from Massachusetts State University at Fitchburg. Ed has been a member of STSS/ISTSS since 1985. He is semi-retired with past memberships in the American Academy of Experts in Traumatic Stress, International Critical Incident Stress Foundation and an associate member of The National Council of Juvenile and Family Court Judges. He enlisted in the Marines in 1959, was promoted to Sergeant, and in 1968 was commissioned, eventually obtaining the rank of Major in which he served until 1985. Ed is the Founder and Director of Intra-family Trauma Resource Network, Inc. (ITRN). Since 1984, ITRN has been involved in child and family advocacy and outreach work dealing with intra-family psychological distress through individual and group support activities. Ed is available for lectures and group interactive presentations and can be reached by email at ed.sibley.itrn@gmail.com, by telephone at (508) 752-0122 or by USPS at ITRN, Inc., 1178 Main St., Suite #4, Worcester, MA 01603-2048.

SURVIVORS' CORNER — IT'S NEVER TOO LATE: TREATING SENIORS IN CARE WITH A HISTORY OF COMPLEX TRAUMA

Lori Herod, EdD

I am a survivor of relational trauma and recently spent two months in hospital in an inpatient treatment program for seniors with anxiety and depression. During my treatment, none of the professionals evaluating/treating me (including three psychiatrists) brought up the topic of past trauma. I brought it up with them, but it did not resonate that my childhood abuse still impacts me greatly as a senior as an important factor with respect to my current health, well-being, and treatment. One reason for this is likely due to the lack of trauma training many mental health clinicians (and medical professionals) receive according to Kumar et al (2022). In their study, "68% of participants reported feeling inadequately trained to assess trauma and 75% felt inadequately trained to treat trauma." It was with great interest, therefore, that I read Monica Cations' (2023) article "Growing Old with Trauma: Elder Care Through a Trauma-Informed Lens" in ISTSS's Stress Points in which she discusses the importance of providing trauma informed care (TIC). Finally, here was research recognizing the importance of understanding and providing appropriate care for seniors with a history of complex trauma.

An earlier article by Cations and her colleagues (2021) states, "To our knowledge, this is the first research study aiming to examine the impact of TIC in geriatric inpatient care settings." I was surprised by this because there is a proliferation of data about childhood abuse/neglect which clearly demonstrates that there are both mental and physical health effects of trauma and they commonly extend to late in life (Afifi et al., 2016; Buhrmann & Fuller-Thomson, 2022; Cation, 2023; Dye, 2018; Felitti et al, 1998; Pfluger et al). I personally can attest that trauma does not simply fade or go away with time and does indeed follow one over the course of one's lifespan if not recognized and treated effectively. I am not alone in this. I run a web site and forum (Out of the Storm) which I started with 3 members in 2014 and now has almost 11,000 survivors registered from 68 countries. Many are seniors who, like me, did not realize they suffer from Complex PTSD until later in life and have not received the treatment they need. Unfortunately, the lack of trained professionals, accessible care (cost-wise or geographic), and misdiagnoses are common complaints by these members.

It was in 2014 that I read about Complex PTSD and realized that my mental health issues went beyond chronic depression and anxiety, and that I had been underdiagnosed and undertreated for decades. As Brand (2016) suggests, it essential for those providing care to recognize the lasting impact of Complex Trauma and provide effective treatment:

> It is critical that clinicians are trained in the assessment and treatment of trauma-related reactions, and in particular, dissociative reactions. If dissociation and DD are not recognized, many of these patients will not be referred to psychotherapy, and even if they are referred, they are unlikely to optimally respond to treatment until the role of trauma in creating and maintaining their distress is addressed.

At least part of the lack of recognition/treatment of trauma in seniors may be because Complex PTSD was not recognized as an official diagnosis by the World Health Organization until 2018 and many, perhaps most, went untreated or were misdiagnosed and treated for other mental health issues such as dementia, borderline personality disorder, and/or anxiety and *(cont.)*

SURVIVORS' CORNER (CONT.)

Herod

depression (Bailey & Brown, 2020; Powell, 2019). It is only recently that Complex PTSD has become more widely known allowing survivors to finally put a name to what has been plaguing them and to seek professional help and support from one another. Powell (2019) describes finally receiving a diagnosis of Complex PTSD from her therapist after years of looking for answers: "She took her time getting to know me for weeks before she suggested any diagnosis, and when she finally did, it was complex PTSD. As she explained what it is to me, I sobbed. Finally, someone understood me and, even more, I finally understood myself."

According to Cations (2023), TIC is not about treatment of trauma, but providing an environment that is as safe and non-triggering as possible. I was fortunate that, although the inpatient program I spent time in did not provide trauma-specific treatment, they did incorporate TIC and this allowed me and my fellow patients to feel safe and valued. We had relationships with the staff that were very caring and supportive and that in and of itself was healing to a degree. The atmosphere in the program I attended was much like de la Perrelle, et al (2022) describe in their study:

> Staff behaviours demonstrated respect, fostered trust, and anticipated needs without unnecessarily imposing care. Staff consistently offered choices, used residents' names, sought permission before providing care, and offered reassurance. Staff reported high morale with a commitment to delivering high quality care, and feedback to management. Effective communication promoted information sharing and trust among staff.

I am left to wonder, however, just how much more recovery and healing would have taken place if the focus of the program was on the treatment of trauma with the same TIC approach.

MANY [MEMBERS OF OUT OF THE STORM, A WEB FORUM FOR COMPLEX PTSD SURVIVORS] ARE SENIORS WHO, LIKE ME, DID NOT REALIZE THEY SUFFER FROM COMPLEX PTSD UNTIL LATER IN LIFE AND HAVE NOT RECEIVED THE TREATMENT THEY NEED.
UNFORTUNATELY, THE LACK OF TRAINED PROFESSIONALS, ACCESSIBLE CARE (COST-WISE OR GEOGRAPHIC), AND MISDIAGNOSES ARE COMMON COMPLAINTS BY THESE MEMBERS.

- HEROD

Most of the psychoeducation groups in the program were about positive skills/resiliency building (e.g., Cognitive Behavioural Therapy, assertiveness, relationship building), all good but tough trauma related topics (hypervigilance, dissociation and avoidance, low self-esteem, abandonment and rejection, isolation, and relationship/ intimacy difficulties) were not addressed.

I learned from several of my fellow patients that they had been in the program previously and I wondered if the reason was the treatment *(cont.)*

SURVIVORS' CORNER (CONT.)

Herod

EVEN SENIORS WHO HAVE EXPERIENCED PAST COMPLEX TRAUMA AND ARE COPING WELL MAY BECOME INCREASINGLY DISTRESSED AS AGING BRINGS ABOUT DIFFICULT EVENTS.

- HEROD

provided only dealt with part of the problem. I personally felt lost and anxious after being released from the program as I went from a lovely, safe, bubble of care to struggling with my trauma symptoms on my own again.

According to the Jewish Centre on Aging and Trauma (n.d.), even seniors who have experienced past Complex Trauma and are coping well may become increasingly distressed as aging brings about difficult events.

> Traumatic stress symptoms can persist and re-emerge in older adulthood as this is a phase of social, financial, and physical change. These changes can trigger a traumatic stress response even for those who had previously been coping well. As trauma survivors age, their trauma symptoms can resurface and evolve as a result of major life changes such as retirement, emergence of health problems, loss of independence, loss of loved ones.

In that many (most?) patients in the program I was part of had experienced Complex Trauma in childhood/youth, it seems a natural evolution of TIC to include the identification and treatment of trauma which extends beyond Cognitive Behavioral Therapy. My own reaction to this “golden standard of treatment” and others (Dalal, 2018) was that it is insufficient on its own to process the deep wounding that results from Complex Trauma. The addition of more compassionate focused therapy seems warranted (Beaumont et al, 2016; Hoffart et all, 2015; Irons & Lad, 2017). It might initially drive the cost of the program up because professionals with more extensive trauma training would be required (i.e., psychologists versus occupational therapists), and treatment would take longer, but in the long run would likely cost less because the same survivors would not return to the program a second or even third time (which was the case for several patients).

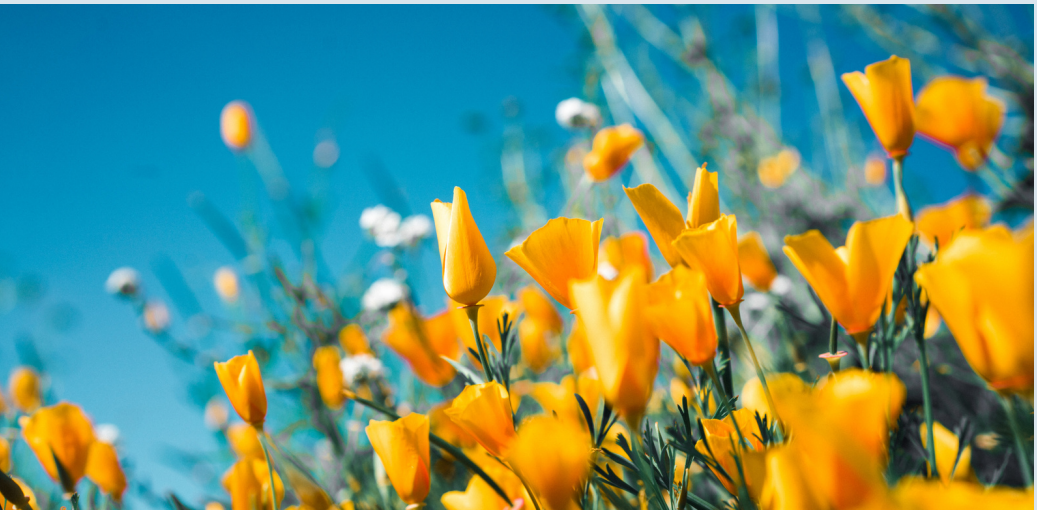
As a senior of 66 years, I would welcome trauma focused in-patient treatment. Given I may (hopefully) live another 15 to 20 years I would like to do so with a greater degree of healing and peace in my later years. Dealing with Complex Trauma symptoms is not only emotionally exhausting, but physically detrimental as so much of the data have demonstrated, beginning with the Kaiser *(cont).*

SURVIVORS' CORNER (CONT.)

Herod

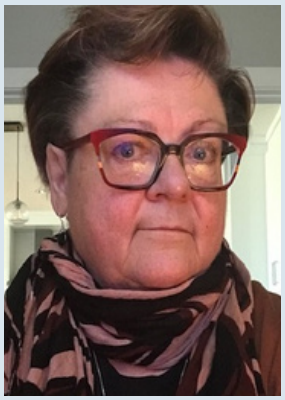
Permanent Adverse Childhood Events (ACEs) study in the 1990s (Felitti et al, 1998). This well-known study demonstrated “a strong dose response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults”. Researchers continue to learn about the lifelong consequences for physical health which need to be considered when treating seniors with mental health issues (Afifi et al, 2016).

TIC is important in that it provides safety, a sense of being valued, and having a say in one’s care. Beyond *care*, however, is the need for compassionate, trauma-focused *treatment* (Beaumont et al, 2016; Hoffart et all, 2015; Irons & Lad, 2017) to help with the deeply emotional symptoms associated with past abuse and neglect and, where possible, the adverse impacts to physical health. It is never too late to help seniors live out their remaining years in less distress and in better health. ∎



LORI HEROD, EDD

Dr. Lori Herod is a retired professor of Adult Education who is a survivor of complex trauma. In 2014, she founded an information website and discussion forum for survivors of relational trauma -- Out of the Storm -- after learning she suffers from CPTSD. In addition to teaching, Lori has worked and volunteered in many sectors including violence against women in Ontario, adult literacy in Ontario and Manitoba, restorative justice in Alberta, and recently, program development with the Canadian Centre for Inquiry. Lori was also Co-Chair of the Complex Trauma Special Interest Group at ISTSS for three years and is the spouse of a retired Canadian military officer.



References

- Afifi, O. et al. (2016). Child abuse and physical health in adulthood. *Statistics Canada Health reports, 27*(3), pp. 10-18. https://www150.statcan.gc.ca/n1/pub/82-003-x/2016003/article/14339-eng.pdf
- Bailey, T.D., Brown, L.S. (2020). Complex Trauma: Missed and misdiagnosis in forensic evaluations. *Psychological Injuries and Law, 13,* 109–123. https://doi.org/10.1007/s12207-020-09383-w
- Beaumont, E., Durkin, M., McAndrew, S., & Martin, C. (2016). Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service personnel suffering with trauma-related symptoms. *The Cognitive Behaviour Therapist, 9,* E34. https://doi.org/10.1017/S1754470X16000209
- Brand, B. L. (2016). The necessity of clinical training in trauma and dissociation. *Journal of Anxiety and Depression, 5*(4). https://doi.org/10.4172/2167-1044.1000251
- Buhrmann, A. & Fuller-Thomson, E. (2022). Poorer physical and mental health among older adults decades after experiencing childhood physical abuse, *Aging and Health Research, 2*(3), https://doi.org/10.1016/j.ahr.2022.100088
- Cations, M. (2023). Growing Old with Trauma: Elder Care Through a Trauma-Informed Lens, *Stress Points, 37*(1). International Society for Traumatic Stress Studies.
- Cations, M., Laver, K., Couzner, L., Flatman, S., Bierer, P., Ames, C., Huo, Y., & Whitehead, C. (2021). Trauma-informed care in geriatric inpatient units to improve staff skills and reduce patient distress: a co-designed study protocol. *BMC Geriatrics, 21*(1), 492. https://doi.org/10.1186/s12877-021-02441-1
- Dalal, F. (2018). *CBT: The Cognitive Behavioral Tsunami: Managerialism, Politics and the Corruptions of Science.* Routlege.
- de la Perrelle, L., Klinge, N., Windsor, T. D., Low, L. F., Laver, K., & Cations, M. (2022). Characterizing trauma-informed aged care: An appreciative inquiry approach. *International Journal of Geriatric Psychiatry.* https://doi.org/10.1002/gps.5802
- Dye, H. (2018) The impact and long-term effects of childhood trauma, *Journal of Human Behavior in the Social Environment, 28*(3), 381-392, https://doi.org/10.1080/10911359.2018.1435328
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://www.ajpmonline.org/article/S0749-3797(98)00017-8/fulltext
- Hoffart, A., Øktedalen, T., & Langkaas, T. (2015). Self-compassion influences PTSD symptoms in the process of change in trauma-focused cognitive-behavioral therapies: a study of within-person processes. *Frontiers in Psychology, 6.* https://doi.org/10.3389/fpsyg.2015.01273.
- Irons, C. & Lad, S. (2017). Using Compassion Focused Therapy to Work with Shame & Self-Criticism in Complex Trauma. *Australian Clinical Psychologist, 3*(1).
- Jewish Center on Aging and Trauma (n.d.). Aging and trauma. https://cdn.fedweb.org/fed-42/2/AgingAndTrauma_FactSheet_CenterOnAgingAndTrauma_2fdbr.pdf
- Kumar, S. A., Brand, B. L., & Courtois, C. A. (2022). The need for trauma training: Clinicians’ reactions to training on complex trauma. P*sychological Trauma: Theory, Research, Practice, and Policy, 14*(8), 1387–1394. https://doi.org/10.1037/tra0000515
- Pfluger, V., Rohner, S.L., Eising, C.M. et al. (2022). Associations Between Complex Trauma Exposure in Childhood/Adolescence and Psychopathology in Older Age: The Role of Stress Coping and Coping Self-Perception. *Journal of Child & Adolescent Trauma 15,* 539–551. https://doi.org/10.1007/s40653-021-00419-0
- Powell, T. (2019). Complex PTSD and misdiagnosis: It happens more than you know. *Healthy Place.* https://www.healthyplace.com/blogs/traumaptsdblog/2019/5/complex-ptsd-and-misdiagnosis-it-happens-more-than-you-know

STUDENTS' CORNER — STUDENT PERSPECTIVE ON ACADEMIA AND LEARNING ABOUT COMPLEX TRAUMA

Brianna Domaceti, BA,
Luca Hartman, BA, &
Jodie Maccarrone Ph.D.

The absence of specialized training for working with patients with complex trauma contradicts the dire need for mental health professionals competent in treating those affected by traumatic life events (Kumar et al., 2022). Recent surveys conducted by the World Health Organization (WHO) revealed that an estimated 48% of the world population will have experienced more than one traumatic event in their lifetime (Kessler et al., 2017). Research has shown that those who experience pervasive forms of trauma are at a greater risk for developing symptoms associated with complex post-traumatic stress disorder (CPTSD; Badour et al., 2015). Symptoms such as disturbances in self-organization, severe emotion dysregulation, and maladaptive interpersonal strategies are more characteristic of those with CPTSD (Frost et al., 2019). Additionally, CPTSD has been associated with more severe psychiatric needs and decreases psychological well-being when compared to post-traumatic stress disorder (PTSD; Cloitre et al., 2019). The apparent differences between CPTSD and PTSD, in addition to the prevalence of more complex forms of trauma, emphasize the need to distinguish between the treatment needs of those with CPTSD as compared to PTSD (Frost et al., 2019). Despite the prevalence of recurrent trauma exposure, few mental health training programs offer students opportunities to develop the necessary skills to provide services to this population (Courtois & Gold, 2009). The dissonance between the need for specialized trauma-informed care and the lack of trauma training calls into question the structure of current curricula for graduate-level training.

Fortunately, the current movement for establishing trauma psychology as a recognized specialty by the American Psychological Association highlighted the availability of resources for treating PTSD and less complex presentations of trauma (American Psychological Association [APA], 2022). Treating those affected by traumatic events requires a holistic view encompassing contextual factors and the intersectionality of trauma and pathology (Cook & Newman, 2014; Gold, 1998). The New Haven Trauma Competencies, outlined by a *(cont.)*

STUDENTS' CORNER (CONT.)

Domaceti, Hartman, & Maccarrone

committee of experts in treating trauma survivors, emphasize the specialized skill set required for clinicians working with those affected by trauma (Cook & Newman, 2014). Similarly, the Guidelines on Trauma Competencies for Education and Training (American Psychological Association [APA], 2015) provided psychology and counseling training programs with concrete guidelines to recalibrate curricula to aid trainees in developing trauma competencies. Despite the availability of educational resources, such as the Core Curriculum in Childhood Trauma, most training institutions do not prioritize trauma training among psychology trainees (Cook et al., 2019; Layne et al., 2011). Further, CPTSD was recently included in a diagnostic manual, namely, the International Classification of Diseases, 11th revision (ICD-11). However, CPTSD was not included in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, revised (DSM-5TR). Taken together, the relatively new status and exclusion of CPTSD from the DSM-5-TR may contribute to the considerably fewer resources that are available to psychology programs to cultivate training for clinicians working with populations affected by complex trauma (Karatzias et al., 2019). APA and related organizations have yet to outline explicit standards for training psychology and counseling students in the treatment of trauma. Consequently, most graduate-level trainees face the inevitable reality of treating patients with CPTSD symptoms without adequate preparation, training, or supervision. To illustrate, a recent study examined the prevalence of individuals who received complex trauma training in a sample of 195 licensed mental health professionals (Kumar et al., 2022). Only 26.09% of the professionals sampled indicated undergoing complex trauma training during their graduate program, and 10.14% reported receiving no training, even after they entered the professional space. The disparity in the accessibility of complex trauma training, especially in graduate training programs, results in the production of clinical professionals who are not equipped to work with a large majority of clients seeking treatment.

As the literature on trauma evolves, the difference in treatment needs among those with histories of adversity are becoming more evident (Courtois & Ford, 2009). The introduction of CPTSD in the ICD-11 reflects the fundamental differences between the experience of a *(cont.)*

THE DISSONANCE BETWEEN THE NEED FOR SPECIALIZED TRAUMA-INFORMED CARE AND THE LACK OF TRAUMA TRAINING CALLS INTO QUESTION THE STRUCTURE OF CURRENT CURRICULA FOR GRADUATE-LEVEL TRAINING.

- DOMACETI, HARTMAN, & MACCARRONE

STUDENTS' CORNER (CONT.)

Domaceti, Hartman, & Maccarrone

single-event trauma and repeated or prolonged trauma, termed complex trauma (WHO, 2019). The semantics of the latter necessitates an appreciation of the distinct features of complex trauma. Complex trauma often presents as symptoms encapsulated or explained by other mental health disorders and somatic conditions, thereby masking the precipitant or underlying cause of presenting symptoms. Successful treatment for this type of presentation requires a clinician who understands the multidimensional influence of complex trauma and how it may reveal itself differently depending on the individual. This requires knowledge beyond the existing clinical paradigm of post-traumatic stress disorder as well as a clinical acumen beyond the generally accepted diagnostic criteria defining post-traumatic stress reactions. In fact, the acquisition of these skills and competency necessitates intensive and specialized supervision and training (Ellis et al., 2019). Despite growing empirical evidence illustrating the specialized treatment needs for different types of trauma, psychology and counseling programs do not create training opportunities for those who aspire to treat the various presentations of trauma.

Trauma is a common source of mental health challenges that motivate individuals to seek psychotherapy. Literature shows that trauma can manifest in a myriad of forms, thereby emphasizing the need for expanded treatment models that incorporate individual, contextual, and ecological factors. Why training models are yet to reflect the needs of treatment-seeking populations and psychology trainees remains unclear. It is imperative that specialized training in the etiology, maintenance, and treatment of CPTSD be incorporated in the core curriculum of graduate programs to ensure the complex clinical needs of these clients are met. ∎

References

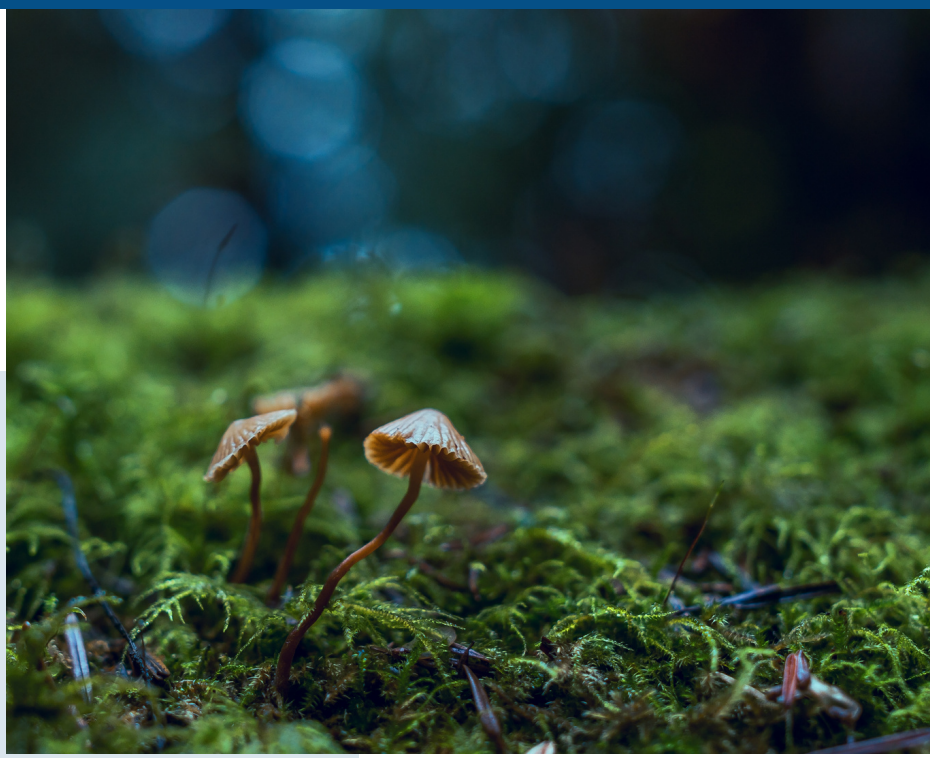
- American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787
- American Psychological Association, Division 56, Task Force on Specialty Status for Trauma Psychology. (2022). "Trauma Psychology Specialty Petition." https://apps.apa.org/CommentCentral2/attachments/Site110_Trauma%20Psychology%20Specialty%20Petition%20(New)%20(2).pdf
- American Psychological Association. (2015). Guidelines on trauma competencies for education and training. http://www.apa .org/ed/resources/trauma-competencies-training.pdf

IT IS IMPERATIVE THAT SPECIALIZED TRAINING IN THE ETIOLOGY, MAINTENANCE, AND TREATMENT OF CPTSD BE INCORPORATED IN THE CORE CURRICULUM OF GRADUATE PROGRAMS TO ENSURE THE COMPLEX CLINICAL NEEDS OF THESE CLIENTS ARE MET.

- DOMACETI, HARTMAN, & MACCARRONE

STUDENTS' CORNER (CONT.)

Domaceti, Hartman, & Maccarrone



BRIANNA DOMACETI, BA

Brianna Domaceti, BA (she/her) is a second-year clinical psychology student at Nova Southeastern University. Her research and clinical interests are in complex trauma and the therapeutic alliance. She is completing her first practicum at the Anxiety Treatment Center. She is also a member of the Trauma Resolution and Integration Program Research Team.

LUCA HARTMAN, BA

Luca Hartman, BA (she/her) is a second-year clinical psychology student at Nova Southeastern University. Her research and clinical interests are in childhood adversity, racial trauma and adult survivors of trauma. She is completing her first practicum at the Child and Adolescent Traumatic Stress Program in addition to working as a research co-coordinator of the Trauma Resolution and Integration Program.

JODIE MACCARRONE, PHD

Dr. Jodie Maccarrone (she/her) is a Postdoctoral Resident and adjunct professor in the College of Psychology at Nova Southeastern University. Her research interests focus on examining the bidirectional relationship between mental and physical health (specifically pain disorders) and trauma as an important risk factor, as well as the impact of psychological well-being on chronic health issues. She completed her predoctoral internship at Broward Health Medical Center working primarily in an inpatient consultation liaison role. Her previous clinical experiences include primary care and community health /behavioral health settings.

- Badour, C., & Adams, T. (2015). Contaminated by trauma: Understanding links between self-disgust, mental contamination, and PTSD. In P. Overton, J. Simpson, & P. Powell (Eds.), *The revolting self: Psycholog- ical and clinical perspectives on self-directed disgust* (pp. 127–149). Karnac Books.
- Cloitre, M., Hyland, P., Bisson, J. I., Brewin, C. R., Roberts, N. P., Karatzias, T., & Shevlin, M. (2019). ICD-11 posttraumatic stress disorder and complex posttraumatic stress disorder in the United States: A population-based study. *Journal of Traumatic Stress, 32*(6), 833-842. https://doi.org/10.1002/jts.22454
- Cook, J. M., Simiola, V., Ellis, A., & Thompson, R. (2017). Training in trauma psychology: A national survey of doctoral graduate programs. *Training and Education in Professional Psychology, 11,* 108–114. http://dx.doi.org/10.1037/tep0000150
- 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. Afifi, O. et al. (2016). Child abuse and physical health in adulthood. *Statistics Canada Health reports, 27*(3), pp. 10-18. https://www150.statcan.gc.ca/n1/pub/82-003-x/2016003/article/14339-eng.pdf
- Courtois, C., Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for adults. In C. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide.* Guilford Press.
- Ellis, A. E., Gold, S. N., Courtois, C., Araujo, K., & Quinones, M. (2019). Supervising trauma treatment: The contextual trauma treatment model applied to supervision. *Practice Innovations, 4*(3), 166-181. https://doiorg.ezproxylocal.library.nova.edu/10.1037/pri0000095
- Frost, R., Hyland, P., McCarthy, A., Halpin, R., Shevlin, M., & Murphy, J. (2019). The complexity of trauma exposure and response: Profiling PTSD and CPTSD among a refugee sample. *Psychological Trauma: Theory, Research, Practice, and Policy, 11*(2), 165-175. https://doi.org/10.1037/tra0000408
- Gold, S. N. (1998). The need for a contextual framework for intervention training.*Psychotherapy in Private Practice, 17*(1), 29-42. The Need for a Contextual Framework for Intervention Training
- 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
- Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E. J., Cardoso, G., Degenhardt, L., de Girolamo, G., Dinolova, R. V., Ferry, F., Florescu, S., Gureje, O., Haro, J. M., Huang, Y., Karam, E. G., Kawakami, N., Lee, S., Lepine, J., Levinson, D., . . . Koenen, K. C. (2017). Trauma and PTSD in the WHO World Mental Health Surveys. *European Journal of Psychotraumatology, 8*, 1353383. https://doi.org/10.1080/20008198.2017.1353383
- Kumar, S. A., Brand, B. L., & Courtois, C. A. (2022). The need for trauma training: Clinicians' reactions to training on complex trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 14*(8), 1387-1394.
- Layne, C. M., Ippen, C. G., Strand, V., Stuber, M., Abramovitz, R., Reyes, G., . . . Pynoos, R. (2011). The core curriculum on childhood trauma: A tool for training a trauma-informed workforce. *Psychological Trauma: Theory, Research, Practice, and Policy, 3,* 243–252. http://dx.doi.org/ 10.1037/a0025039
- World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

KUDOS CORNER — UPLIFTING COMPLEX TRAUMA SIG MEMBERS' ACHIEVEMENTS

Please join us in celebrating the below achievements of our Complex Trauma SIG members!

Krista Engle, PhD — New Complex Trauma SIG Co-Chair
Kayleigh Watters, PhD — New Complex Trauma SIG Co-Chair
Philip Katner, LMSW — New Complex Trauma SIG Co-Chair
Carine Leslie, MS — New Complex Trauma SIG Student Co-Chair
We would like to wish Krista, Kayleigh, Philip, and Carine a warm welcome to the Complex Trauma SIG Leadership Team! We know you will do an amazing job and look forward to each of your offerings to the SIG. Stay tuned, in our next issue we will be doing a feature on each new leadership member, and their hopes for the SIG.

Morgan McCowan, MA — Successful Defense of Doctoral Dissertation
Doctoral Dissertation — *Continuous Intersectional Identity Traumas: Profiles of Type III Trauma and Coping in Black Sexual Minority Men (BSMM)*
The purpose of this person-centered quantitative dissertation was to explore intersectional identity trauma as it manifests in BSMM by utilizing the Stigma Induced Identity Threat Model (Major & O'Brien, 2005), and its recent application with intersectionality (Remedios et al., 2020) to identify contextual variables likely to impact BSMM's exposure to trauma, experience of symptoms, and coping adaptations, and to conduct a latent profile analysis to identify emergent subgroups within the study sample. Study results supported that BSMM's development of trauma symptoms and coping behaviors varied by contextual variables related to identity stigmatization, underscoring the importance of taking contextual factors, such as the impact of oppressive systems of power, into account when diagnosing and treating traumatic stress disorders, particularly in multiply marginalized populations.

EMAIL NEWSLETTER AT

CTSIGPERSPECTIVES@GMAIL.COM

TO INFORM US OF YOUR RECENT ACHIEVEMENTS

EDITORS' CORNER:
CONCLUDING COMMENTS

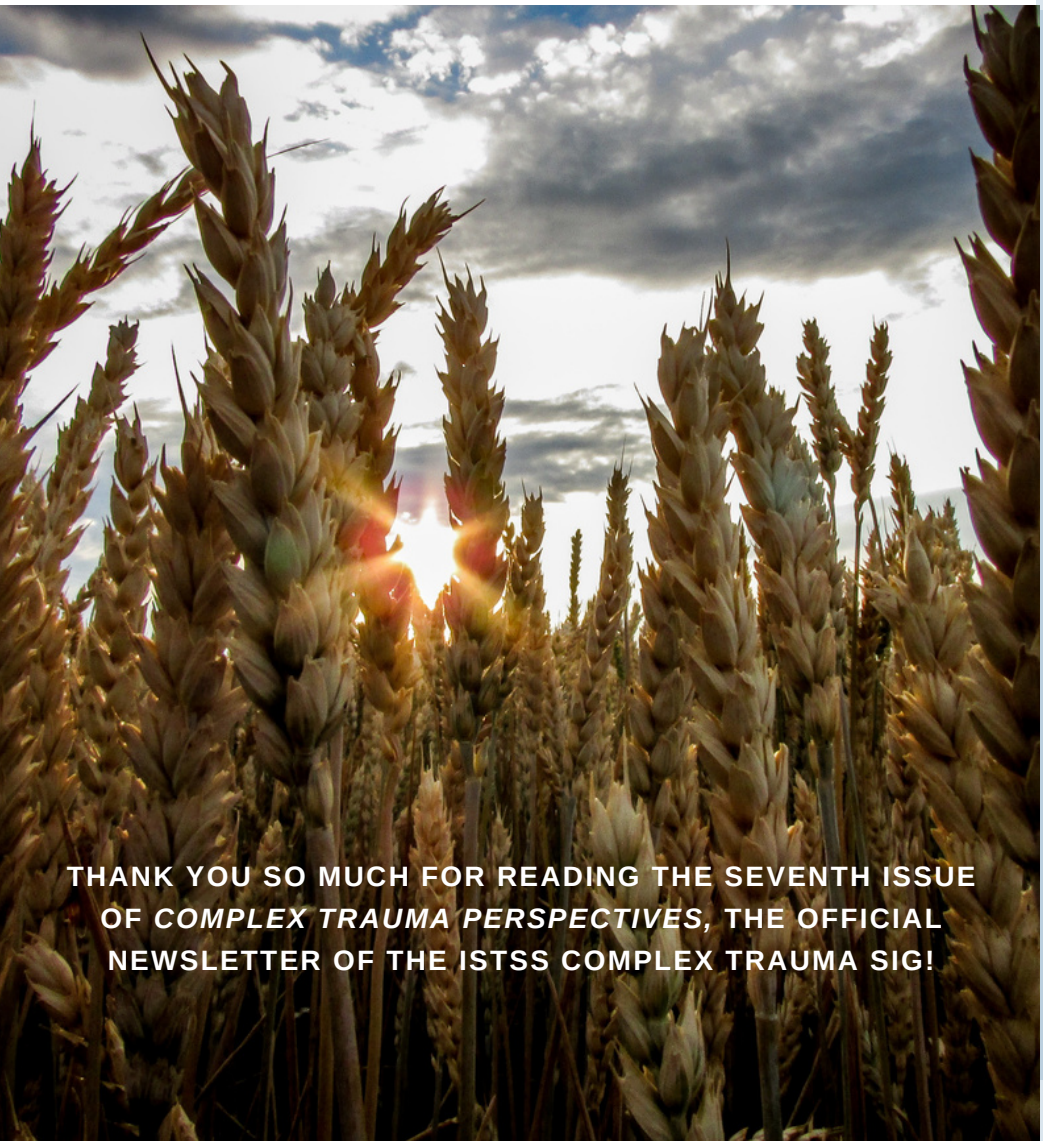
Morgan McCowan, MA & Aubrie Munson, MS

As mentioned in our previous issue, please feel free to share this newsletter with whomever you would like, on social media, etc.! We just ask that you share the newsletter in its entirety (rather than isolated pages), so that everyone gets credited appropriately. Additionally, feel free to share the link to our previous issues: CT Perspectives Public Access. This link will work for anyone, including those who are not ISTSS members.

This is Aubrie's last issue as co-editor for the newsletter. We are sad to see her leave but are so excited for her next steps. Thank you for all your efforts the past few years and sublime organization skills, Aubrie!! We also want to extend a special thank you to Lori Herod for all her help with this issue! Morgan is staying on as Newsletter Editor and is excited to continue in this role!

Thank you to our article editors for this issue:
Elizabeth Marston &
Danielle Ciccone-Coutre

Sincerely,
The *Complex Trauma Perspectives* Newsletter Editors
Morgan McCowan & Aubrie Munson ∎∎



QUESTIONS OR COMMENTS ON THE NEWSLETTER?

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

View past newsletter issues and supplementary content here: CT Perspectives Public Access

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

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

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