MAY 2020, ISSUE 1

COMPLEX TRAUMA PERSPECTIVES

ISTSS Complex Trauma Special Interest Group Newsletter

EDITORS' CORNER

Kelly Pattison, MA, LMHC & Krista Engle, MA

Welcome to the first edition of *Complex Trauma Perspectives*, the International Society for Traumatic Stress Studies' Complex Trauma SIG newsletter! Through this publication, we hope to provide readers with novel and diverse perspectives on the experience, assessment, treatment, and understanding of complex trauma and its sequelae. We seek to highlight unique points of view, including those of clinicians, researchers, survivors, community partners, and professionals from a variety of disciplines, as we recognize that complex issues require complex solutions. We cannot expect to understand or address the multifaceted effects of complex trauma unless we listen to all of the voices that have gathered around the table. We hope that this and future editions of *Complex Trauma Perspectives* stimulate conversations, jumpstart ideas, and inspire action on the part of our readers and within the broader complex trauma professional community. *(cont.)*

WHAT'S INSIDE THIS ISSUE:

KELLY PATTISON, MA, LMHC
Kelly is currently pursuing her PsyD in Clinical Psychology (Traumatic Stress Emphasis) at Adler University, and she is a Student Co-chair for the CT SIG. Her previous experience includes working with survivors of complex trauma as a licensed mental health counselor and an advocate. She is interested in the treatment of Complex PTSD and dissociative disorders.

KRISTA ENGLE, MA
Krista is currently pursuing her PhD in Clinical Psychology (Trauma Track) at UC Colorado Springs, and she is a Student Co-chair for the CT SIG. She is interested in the role of cognitive flexibility in the development and maintenance of Complex PTSD symptoms.

EDITORS' CORNER (CONT.)

Kelly Pattison, MA, LMHC & Krista Engle, MA

In this first edition, we give you a first look at some exciting developments in the complex trauma publication world with a glimpse into the new edition of Ford and Courtois' book *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models* and a selection of abstracts from the *Journal of Traumatic Stress* highlighting issues relevant to complex trauma. In an effort to feature a variety of perspectives, we also include a clinician's perspective on the benefits and dimensions of trauma sensitive yoga; a deep look into the role of shame in relational trauma and Complex PTSD; a call to action to create accessible resources for those with CPTSD; and a survivor's experience navigating the complex world of Dissociative Identity Disorder and the healing that can occur through art.

In this fast-paced and ever-changing world, it is often difficult to keep up with every new development that happens in and outside the world of trauma studies, and even more difficult to flexibly incorporate new ideas and findings into our everyday practice and work. We therefore hope through each edition of *Complex Trauma Perspectives* to provide you with a timely, digestible, and engaging summary of some of our field's most recent advancements of particular interest to members of the Complex Trauma SIG.

Thank you for taking the time to read this inaugural edition of the newsletter. We look forward to serving you and your educational pursuits through this publication in the months to come!

Sincerely,

The *Complex Trauma Perspectives* Editors, Kelly & Krista

ANNOUNCEMENTS

In each edition of *Complex Trauma Perspectives*, we look forward to featuring upcoming events and recent publications of interest to the CT SIG community.

CT SIG BIBLIOGRAPHY

The Co-Chairs of the CT SIG are in the process of gathering resources of major relevance to the CT SIG community to post as a bibliography on the CT SIG website. **If you have published or know of articles, books, or other resources that you would like to see included in this list, please send them to Lori Herod at herod_lori@yahoo.ca with "CT SIG Bibliography" in the subject line.**

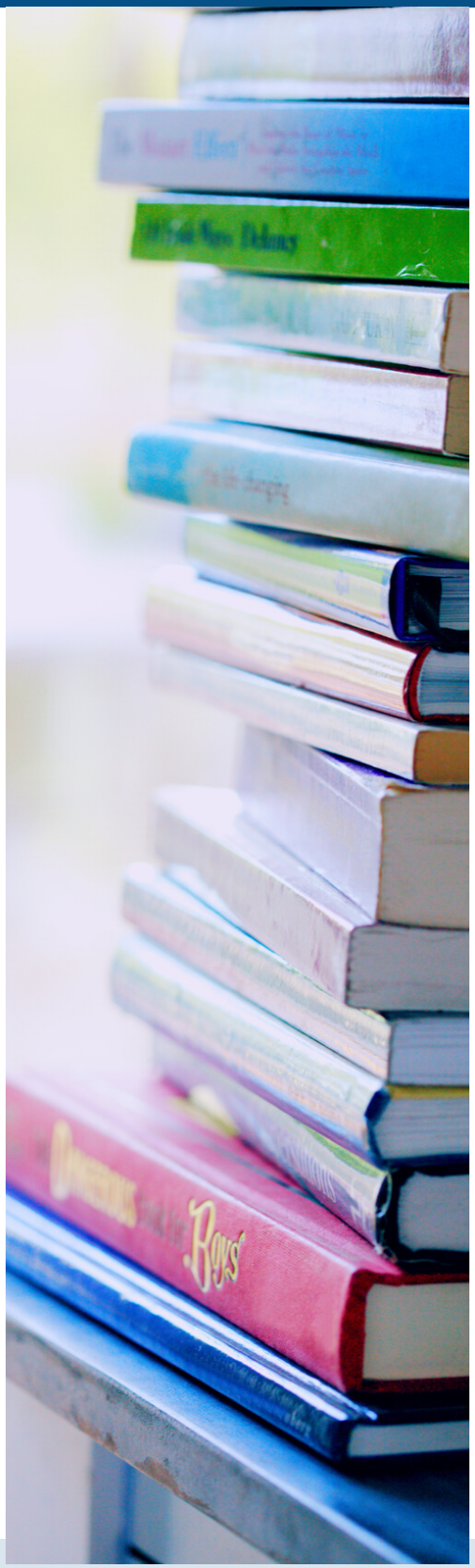
SEEKING EDITORIAL ASSISTANCE FOR CT PERSPECTIVES

We are seeking help with the production of future editions of this newsletter. If you have any interest in becoming more deeply involved with the CT SIG and the production of Complex Trauma Perspectives, please contact us at CTSIGPerspectives@gmail.com. No experience necessary!

BOOK RELEASE

Drs. Julian Ford and Christine Courtois are proud to announce the release of the **second edition of their book *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models*.** Ford and Courtois have curated information about the most recent advances in the field of complex trauma treatment, resulting in more than 75% new material in this newest edition. The volume presents cutting-edge theory and research about ways to understand, engage, assess, and treat adults with complex trauma histories, whose symptoms often include but may go well beyond those of PTSD - a conundrum with which many of us are familiar.

The *First Look* section of this newsletter includes a brief excerpt from the first chapter. For ordering information, please visit https://www.guilford.com/books/Treating-Complex-Traumatic-Stress-Disorders-in-Adults/Ford-Courtois/9781462543625.



If you have an upcoming event or publication that you would like to be considered for the Announcements section of *CT Perspectives*,
please send a short description of the announcement and your contact information to CTSIGPerspectives@gmail.com.

A FIRST LOOK AT THE SECOND EDITION OF FORD & COURTOIS' TREATING COMPLEX TRAUMATIC STRESS DISORDERS IN ADULTS: SCIENTIFIC FOUNDATIONS AND THERAPEUTIC MODELS

Julian D. Ford, PhD, ABPP & Christine A. Courtois, PhD, ABPP

The following is a brief section from the opening chapter of the second edition of Ford and Courtois' book *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models*. For free access to the entire first chapter and ordering information, visit https://www.guilford.com/books/Treating-Complex-Traumatic-Stress-Disorders-in-Adults/Ford-Courtois/9781462543625.

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Adapting Evidence-Based Treatments for PTSD to Complex PTSD: What's a Therapist to Do?

Since the early 1990s, paralleling the development of CTSD [complex traumatic stress disorders] psychotherapy best practices, several evidence-based treatments for adult PTSD (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Cusack et al., 2016) have shown promise in treating adolescents and adults with childhood sexual or physical abuse histories (Chard, 2005; Cohen et al., 2016; Foa, McLean, Capaldi, & Rosenfield, 2013; McDonagh et al., 2005; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013; Resick, Nishith, & Griffin, 2003; Resick, Suvak, & Wells, 2014; Steuwe et al., 2016). The issues involved in these applications were the subject of our previous books (Courtois & Ford, 2013; Ford & Courtois, 2014), where we explicitly suggested that caution was warranted in approaching trauma memory processing (TMP) too quickly with these clients due to what is often their emotional and environment instability, multiple presenting problems and comorbidities, severe difficulties with dissociation, and lack of ability to maintain safety or to manage their emotions or their actions.

(cont.)

THERAPISTS AND CLIENTS WITH CTSDS... HAVE CHOICES REGARDING HOW TO PROCEED AND WHAT STRATEGIES TO USE, BASED ON ONGOING CLINICAL ASSESSMENT, CLINICAL JUDGMENT, AND CLIENTS' GOALS, PREFERENCES, AND RESOURCES.

- FORD & COURTOIS

A FIRST LOOK (CONT.)

Julian D. Ford, PhD, ABPP & Christine A. Courtois, PhD, ABPP

We also discussed differential application based on client readiness and attachment history, as well as therapist training. We still believe that caution is warranted due to evidence of increased rates of premature termination by individuals with childhood abuse histories in these evidence-based treatments, particularly in the trauma processing phase (McDonagh et al., 2005; Resick et al., 2014). However, we do agree that when TMP is decided as a treatment strategy it optimally should occur as soon as is feasible according to the client's readiness and willingness and based on choice of treatment. A novel framework for TMP has been proposed, in which the intentional recall of trauma memories in therapy is understood as paradoxically facilitating the capacity to intentionally suppress awareness of trauma memories and thereby escape the vicious cycle in which intrusive reexperiencing is perpetuated by self-defeating attempt to avoid (Ford, 2018). TMP thus involves developing and purposefully employing the necessary cognitive and emotion regulation capacities to choose to pay attention to trauma memories in order to find self-relevant meaning in them (Harvey, 1996). This is the exact opposite of a futile attempt to avoid paying attention to trauma memories or reminders—a strategy that backfires by increasing the intrusive reexperiencing of trauma memories instead of facilitating recovery from them. From this perspective, TMP can serve as a vehicle not merely for reducing PTSD-related avoidance but moreover for enhancing the very self-capacities that are disorganized or diminished in DSOs and CTSDs.

As described in several chapters in this book, adaptations to evidence-based treatments for PTSD that facilitate safe and effective therapeutic trauma-processing when CTSDs complicate their implementation have been proposed, developed, and researched (Chard, 2005; Harned, Korslund, & Linehan, 2014). Moreover, recent studies showing that interpersonal psychotherapy (IPT; Chapter 16) and present-centered therapy (PCT; Foa et al., 2018) achieve comparable outcomes to prolonged exposure in reducing PTSD symptoms have important implications. They suggest that ***intensive review of trauma memories is not necessary in all cases, and that other forms of trauma-focused or present-centered, client-centered, and interpersonal forms of treatment that do not require intensive trauma memory processing may be equally effective as evidence-based treatments for adult PTSD*** *(Ford, 2017b; Hoge & Chard, 2018; Markowitz, Petkova, Neria, Van Meter, Zho, Hembree, et al., 2015). Therapists and clients with CTSDs thus have choices regarding how to proceed and what strategies to use, based on ongoing clinical assessment, clinical judgment, and clients' goals, preferences, and resources.*

Practice Guidelines for PTSD Psychotherapy: Applicable to CTSDs?

As noted earlier and described in more detail in subsequent chapters in this book, there is evidence that ***adaptations of evidence-based treatments for PTSD may be safe and effective for clients with*** *CTSDs, especially when applied after a period or phase of assessment and stabilization and the development of the treatment relationship, including an alliance between therapist and client. However, there also is evidence that many clients with CTSDs have been screened out of the research studies testing those therapies (e.g., due to suicidality, self-harm, addiction, or severe affective lability or personality disturbance) (Spinazzola, Blaustein, & van der Kolk, 2005). Other clients with CTSDs do not benefit from evidence-based treatments for PTSD—or find the form or intensity of treatment sufficiently distressing to choose to "vote with their feet" by discontinuing treatment before achieving meaningful improvement. The research evidence also is almost exclusively based on treatment that is delivered for, at most, 4–5 months (i.e., 12–20 or fewer sessions), which is only half the length of time described by expert clinicians as optimal for Phases 1 and 2 of complex PTSD therapy (i.e., 9–12 months) (Cloitre et al., 2011).While these estimates are approximate and not research-based, even if Phase 1 was truncated or entirely eliminated as recommended by some (De Jongh et al., 2016), the third phase of integration of treatment gains into day-to-day life, relationships, and functioning is not addressed—or at best is left to a few sessions at the end of formal treatment or in posttherapy booster/check-in sessions. Current clinical practice guidelines for PTSD treatment generally do not provide clinicians with guidance about how to conduct therapy when clients either do not agree to follow an evidence-based treatment protocol for PTSD or do not benefit from it, or how to help clients with CTSDs integrate treatment gains into sustained positive changes in their day-to-day lives—let alone how to prevent or manage severe impairments (cont.)*

A FIRST LOOK (CONT.)

Julian D. Ford, PhD, ABPP & Christine A. Courtois, PhD, ABPP

or crises related to extreme states of bodily, affective, relational, or identity distress or confusion.

Other PTSD practice guidelines are either silent regarding complex trauma and CTSDs or cite the unavailability of research to determine the safety and effectiveness of PTSD evidence-based treatments for this population. The 2018 NICE PTSD Guideline is an exception, cogently stating that treatment for "people with additional needs, including those with complex PTSD" (p. 17) should directly address dissociation and emotion dysregulation. The NICE guidelines also recommend providing sufficient treatment duration to support these clients in fully engaging and developing a sense of trust, as well as increasing "the number of trauma-focused therapy sessions according to the person's needs" and making provisions to support "return to everyday activities and ongoing symptom management."

In response to these and related concerns, the American Psychological Association recently convened a working group to develop a "Professional Practice Guideline on Key Considerations in the Treatment of PTSD/Trauma." The work group is in the process of developing recommendations for clinicians in practice that is designed to complement the 2017 American Psychological Association Clinical Practice Guideline for PTSD in Adults evidence-based recommendations with information on responsible client-centered PTSD psychotherapy, including management of the many challenges that often accompany this treatment population. Most telling of all, this work group will articulate the importance of therapist empathy, congruence, and positive regard, and a therapeutic alliance based on collaborative treatment planning and evaluation by the client and therapist as partners (Elliott, Bohart, Watson, & Murphy, 2018; Eubanks, Muran, & Safran, 2018; Farber, Suzuki, & Lynch, 2018; Flückiger, Del Re, Wampold, & Horvath, 2018; Friedlander, Escudero, Welmers-van de Poll, & Heatherington 2018; Gelso, Kivlighan, & Markin, 2018; Karver, De Nadai, Monahan, & Shirk, 2018; Nienhuis et al., 2018).

In summary, although the research evidence base for models of PTSD psychotherapy has grownsufficiently in the past decade to warrant major updates in clinical practice guidelines, there continues to be insufficient outcome research on CTSD psychotherapy to support the designation of evidence-based treatments or the recommendation of practice guidelines. Notably—despite admirable efforts to adapt PTSD evidence-based treatments across cultures and populations (Chen, Olin, Stirman, & Kaysen, 2017; Schnyder et al., 2016), even the most comprehensive PTSD clinical practice guidelines cannot recommend how best to individualize treatment to clients with different PTSD symptoms, comorbidities, personal characteristics, life experiences, and preferences, or in different cultural, community, or family contexts that also attends to client preference and therapist training. Thus, at this point, we believe the real-world delivery of evidence-based treatments and practice guidelines for both PTSD and CTSDs still rest upon the "standards of care" foundation provided by expert clinicians' best practices. These continue to evolve with emerging research findings from the neurosciences and other fields and the resultant development of innovative clinical approaches. Of note: some of these (most of which are body-based such as acupuncture, thought field therapy, mantra-based meditation, yoga) have a preliminary evidence base and a designation as emerging (Metcalf, Varger, Forbes, Phelps, Dell, DiBattista et al., 2016; see Chapter 26).

The remainder of this book is devoted to a summary of the most up-to-date best practices for CTSD psychotherapy and their basis in neurobiopsychosocial clinical research and theory, followed by detailed descriptions of specific approaches to CTSD psychotherapy that are adaptations of PTSD evidence-based treatments or innovative approaches designed specifically for the treatment of CTSDs.

More information about the authors can be found on Guilford Press's website.

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RESEARCHERS' CORNER: HIGHLIGHTING THE JOURNAL OF TRAUMATIC STRESS SPECIAL SECTION ON COMPLEX PTSD

Introduction by Marylene Cloitre, PhD

In December 2019, the *Journal of Traumatic Stress 32(6)* included a Special Section on Complex PTSD (CPTSD). The JTS special section provides an overview of some of the latest developments in research and treatment for CPTSD. We are grateful to JTS editor Patricia Kerig for allowing us to highlight these articles and their abstracts in our Researcher's Corner. We have also included a brief introduction to this section written for *Complex Trauma Perspectives* by Dr. Marylene Cloitre. The full articles can be accessed at https://onlinelibrary.wiley.com/toc/15736598/2019/32/.

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Introduction by Dr. Marylene Cloitre

The JTS articles all share in the announcement and description of the new ICD-11 diagnosis of complex PTSD (CPTSD). This advance will allow clinicians to diagnose CPTSD and bill for care using empirically supported interventions, as the clinician and patient see fit, as relevant to the disorder of CPTSD. Worldwide, including in the United States, insurers, hospitals, clinics, and community mental health centers will be required to begin implementing this diagnosis starting on January 1, 2022. This is a boon to clinicians working with complex trauma. It provides formal recognition by the professional community in mental health; indeed, in all disciplines, that complex PTSD is a "real disorder" and needs to be taken seriously.

Journal of Traumatic Stress, Volume 32, Issue 6
Special Section on Complex PTSD
Abstracts

Karatzias, T. & Levendosky, A. A. (2019). Introduction to the special section on complex posttraumatic stress disorder (CPTSD): The evolution of a disorder. Journal of Traumatic Stress 32(6), 817-821.

The inclusion of complex posttraumatic stress disorder (CPTSD) in the 11th revision of the *International Classification of Diseases* is an important development in the field of psychotraumatology. Complex PTSD was developed as a response to a clinical need to describe difficulties commonly associated with exposure to traumatic stressors that are predominantly of an interpersonal nature. With this special section, we bring attention to this common condition following exposure to traumatic stressors that only recently has been designated an official diagnosis. In this introduction, we review the history of CPTSD as a new condition and we briefly introduce the papers for the special section in the present issue of the Journal of Traumatic Stress. It is our hope that the work presented in the special section will add to an ever-expanding evidence base. We also hope that this work inspires further research on the cultural validity of CPTSD, its assessment, and treatment.

Liddell, B. J., Nickerson, A., Felmingham, K. L., Malhi, G. S., Cheung, J., Den, M., *(cont.)*

[IMPLEMENTATION OF THE COMPLEX PTSD DIAGNOSIS] PROVIDES FORMAL RECOGNITION BY THE PROFESSIONAL COMMUNITY IN MENTAL HEALTH; INDEED, IN ALL DISCIPLINES, THAT COMPLEX PTSD IS A "REAL DISORDER" AND NEEDS TO BE TAKEN SERIOUSLY.

- CLOITRE

RESEARCHERS' CORNER (CONT.)

Askovic, M., Coello, M., Aroche, J., & Bryant, R. A. (2019). Complex posttraumatic stress disorder symptom profiles in traumatized refugees. Journal of Traumatic Stress 32(6), 822-832.

Although it is well documented that exposure to severe, cumulative trauma and postdisplacement stress increases the risk for posttraumatic stress symptom disorder (PTSD), less is known about the representation and predictors of complex PTSD (CPTSD) symptoms in refugee populations. We examined PTSD and CPTSD symptom profiles (co-occurring PTSD and disturbances in self-organization [DSO] symptoms)and their premigration, postmigration, and demographic predictors, using latent class analysis (LCA), in a cohort of 112 refugees resettled in Australia. The LCA identified a four-factor model as the best fit to the data, comprising classes categorized as: (a) CPTSD, exhibiting high levels of PTSD and DSO symptoms (29.5%); (b) PTSD only (23.5%); (c) high affective dysregulation (AD) symptoms (31.9%); and (d) low PTSD and DSO symptoms (15.1%). Membership in the CPTSD and PTSD classes was specifically associated with cumulative traumatization, CPTSD *OR* = 1.56, 95% CI [1.15, 2.12], and PTSD *OR* = 1.64, 95% CI [1.15, 2.34]; and female gender, CPTSD *OR* = 14.18, 95% CI [1.66, 121.29], and PTSD *OR* = 16.84, 95% CI [1.78, 159.2], relative to the low-symptom class. Moreover, CPTSD and AD class membership was significantly predicted by insecure visa status, CPTSD *OR* = 7.53, 95% CI [1.26, 45.08], and AD *OR* = 7.19, 95% CI [1.23, 42.05]. These findings are consistent with the *ICD-11* model of CPTSD and highlight the contributions of cumulative trauma to CPTSD and PTSD profiles as well as of contextual stress from visa uncertainty to DSO symptom profiles in refugee cohorts, particularly those characterized by AD.

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.

The primary aim of this study was to provide an assessment of the current prevalence rates of *International Classification of Diseases* (11th rev.) posttraumatic stress disorder (PTSD) and complex PTSD (CPTSD) among the adult population of the United States and to identify characteristics and correlates associated with each disorder. A total of 7.2% of the sample met criteria for either PTSD or CPTSD, and the prevalence rates were 3.4% for PTSD and 3.8% for CPTSD. Women were more likely than men to meet criteria for both PTSD and CPTSD. Cumulative adulthood trauma was associated with both PTSD and CPTSD; however, cumulative childhood trauma was more strongly associated with CPTSD than PTSD. Among traumatic stressors occurring in childhood, sexual and physical abuse by caregivers were identified as events associated with risk for CPTSD, whereas sexual assault by noncaregivers and abduction were risk factors for PTSD. Adverse childhood events were associated with both PTSD and CPTSD, and equally so. Individuals with CPTSD reported substantially higher psychiatric burden and lower levels of psychological well-being compared to those with PTSD and those with neither diagnosis.

Vang, M. L., Menachem, B., & Shevlin, M. (2019). Modeling patterns of polyvictimization and their associations with posttraumatic stress disorder and complex posttraumatic stress disorder in the Israeli population. Journal of Traumatic Stress 32(6), 843-854.

Although evidence is accumulating for the conceptual validity of the *ICD-11* proposal for posttraumatic stress disorder (PTSD) and complex PTSD (CPTSD), our understanding of the specificity of trauma-related predictors is still evolving. Specifically, studies utilizing advanced statistical methods to model the association between trauma exposure and ICD-11 proposals of traumatic stress and differences *(cont.)*

RESEARCHERS' CORNER (CONT.)

in profiles of trauma exposure are lacking. Additionally, time since trauma and a clear memory of the trauma are yet to be examined as predictors of PTSD and CPTSD. We analyzed trauma exposure as reported by a general population sample of Israeli adults (*N* = 834), using latent class analysis, and the resultant classes were used in regression models to predict PTSD and CPTSD operationalized both dimensionally and categorically. Four distinct groups were identified: child and adult interpersonal victimization, community victimization–male, community victimization–female, and adult victimization. These groups were differentially related to PTSD and CPTSD, with only child and adult interpersonal victimization consistently predicting CPTSD and disturbances in self-organization. When modeled dimensionally, PTSD was associated with the child and adult interpersonal victimization and adult victimization groups, whereas only the child and adult interpersonal victimization group was predictive of PTSD when operationalized categorically. The roles of time since trauma and a clear memory of the trauma differed across PTSD and CPTSD. These findings support the use of trauma typologies for predicting PTSD and CPTSD and provide important insight into the distribution of trauma exposure in the Israeli population.

Hyland, P., Karatzias, T., Shevlin, M., & Cloitre, M. (2019). Examining the discriminant validity of complex posttraumatic stress disorder and borderline personality disorder symptoms: Results from a United Kingdom population sample. Journal of Traumatic Stress 32(6), 855-863.

Complex posttraumatic stress disorder (CPTSD) was added to the diagnostic nomenclature in the 11th revision of the *International Classification of Diseases* (*ICD-11*). Although considerable evidence exists supporting the construct validity of CPTSD, the distinguishability of CPTSD symptoms from those of borderline personality disorder (BPD) has been questioned. The present study examined the discriminant validity of CPTSD and BPD symptoms among a trauma-exposed population sample from the United Kingdom (*N* = 546). Participants completed self-report measures of CPTSD and BPD symptoms, and their latent structure was assessed using exploratory structural equation modeling (ESEM). A three-factor model with latent variables reflecting PTSD, disturbances in self-organization (DSO), and BPD symptoms provided the best fit of the data, $\chi 2(399, N = 546) = 1,650$, $p < .001$; CFI = .944; TLI = .930; RMSEA = .077, 90% CI [.073, .081]. We identified multiple symptoms distinctive to individual constructs (e.g., disturbed relationships and suicidality) as well as symptoms shared across the constructs (e.g., affective dysregulation). The PTSD, $\beta = .24$; DSO, $\beta = .23$; and BPD, $\beta = .27$, latent variables were positively and significantly associated with childhood interpersonal trauma. The current findings support the discriminant validity of CPTSD and BPD symptoms and highlight various phenomenological signatures of each construct as well as demonstrate how these constructs share important similarities in symptom composition and exogenous correlates.

Fyvie, C., Easton, P., Moreton, G., McKeever, J., & Karatzias, T. (2019).

The rivers centre in Scotland: An attachment-based service model for people with complex posttraumatic stress disorder. Journal of Traumatic Stress 32(6), 864-869.

The Rivers Centre in Edinburgh, Scotland (United Kingdom) operated for nearly 20 years as a traditional specialist trauma service, delivering psychological therapies to an adult population affected by trauma. Embedded in a health and social care system whose characteristics were unhelpful for people with histories of insecure attachment experiences, the Rivers Centre aimed to find a different way of working, and in January 2017, it relaunched with a new model of service. The aim of this paper is to describe the new service *(cont.)*

RESEARCHERS' CORNER (CONT.)

model from an organizational perspective in the context of attachment theory. At the heart of the model is the premise that to be effective, a trauma service needs to provide people with an alternative model of attachment. Early signs from service audit data indicate that an attachment-based way of working can improve engagement and can provide a supportive and responsive environment in which people can learn to recover.

Karatzias, T, & Cloitre, M. (2019). Treating adults with complex posttraumatic stress disorder using a modular approach to treatment: Rationale, evidence, and directions for future research. Journal of Traumatic Stress 32(6), 870-876.

ICD-11 complex PTSD (CPTSD) is a new condition, and, therefore, there are as yet no clinical trials evaluating interventions for its treatment. In this paper, we provide the rationale for a flexible multimodular approach to the treatment of CPTSD, its feasibility, and some evidence suggesting its potential benefits. The approach highlights flexibility in the selection of empirically supported interventions (or a set of interventions) and the order of delivery based on symptoms that are impairing, severe, and of relevance to the patient. The approach has many potential benefits. It can incorporate the use of interventions for which there is already evidence of efficacy allowing the leveraging of past scientific efforts. It is also consistent with patient-centered care, which highlights the importance of patient choice in identification of the problems to target, interventions to select, and outcomes to monitor. Researchers on modular treatments of other disorders have found that, compared to disorder-specific manualized protocols, flexible multimodular treatment programs are superior in resolving identified problems and are associated with greater therapist satisfaction and reduced patient burden. We briefly identify types of interventions that have been successful in treating trauma-exposed populations as well as emerging interventions that are relevant to the particular problems associated with exposure to complex trauma. We conclude with examples of how such treatments can be organized and tested. Research is now urgently needed on the effectiveness of existing and new intervention approaches to *ICD-11* CPTSD treatment.

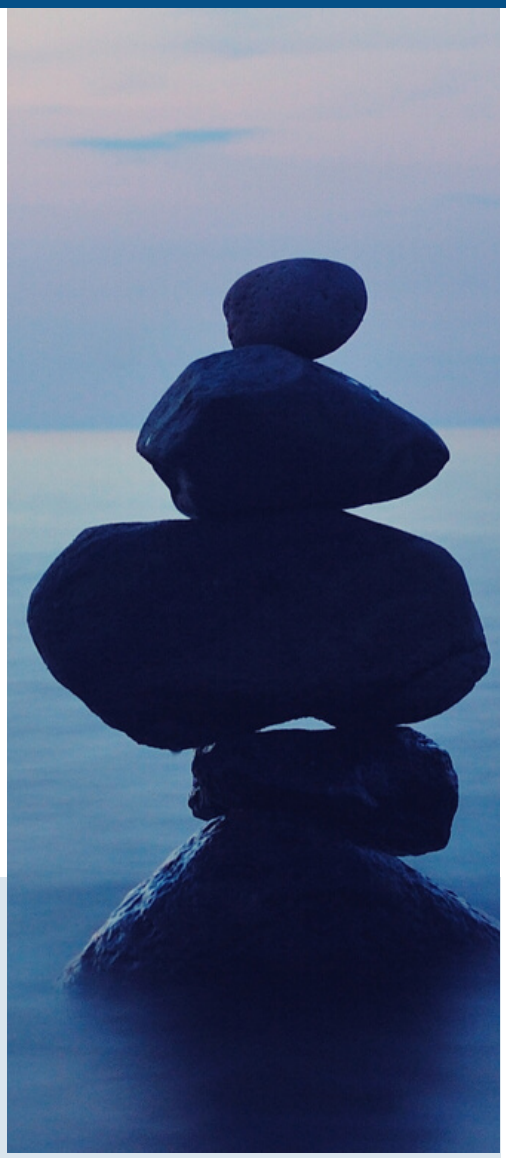
Ford, J. D. (2019). Commentary on the special section on complex PTSD: Still going strong after all these years. Journal of Traumatic Stress 32(6), 877-880.

Posttraumatic stress disorder (PTSD) is inherently complex, yet a growing evidence base indicates that a complex variant (CPTSD) can be distinguished from classic PTSD based on evidence of clinically significant affect, interpersonal, and self/identity dysregulation. This Commentary to the *Journal of Traumatic Stress* special section on CPTSD reviews the results of four new studies that empirically tested the structure, traumatic stressor antecedents, and construct validity of CPTSD in relation to PTSD and borderline personality disorder (BPD). Based on these and prior empirical findings, a reconceptualization of PTSD, CPTSD, and BPD as posttraumatic threat, betrayal, and rejection disorders, respectively, is proposed. Implications for treatment of trauma survivors are discussed in relation to articles in this special section, which describe a modular framework for CPTSD treatment and an innovative attachment and self-regulation focused on the redesign of a traditional outpatient mental health clinic.

JOURNAL OF TRAUMATIC STRESS

JTS, the official publication for the ISTSS, is an interdisciplinary forum for the publication of peer-reviewed original papers on biopsychosocial aspects of trauma. Papers focus on theoretical formulations, research, treatment, prevention education/training, and legal and policy concerns. Journal of Traumatic Stress serves as a primary reference for professionals who study and treat people exposed to highly stressful and traumatic events (directly or through their occupational roles), such as war, disaster, accident, violence or abuse (criminal or familial), hostage-taking, or life-threatening illness. The journal publishes original articles, brief reports, review papers, commentaries, and, from time to time, special issues devoted to a single topic.

For more information about the journal and submitting manuscripts for consideration, visit https://onlinelibrary.wiley.com/page/journal/15736598/homepage/productinformation.html.



CLINICIANS' CORNER: MOVING BEYOND TRAUMA-SENSITIVE YOGA WITH THE TRAUMA CENTER TRAUMA SENSITIVE YOGA MODEL (TCTSY)

Jennifer Marchand

In this paper, I place the Trauma Center Trauma Sensitive Yoga model (TCTSY) within the overarching framework of trauma-informed care (TIC) in order to distinguish it from other trauma-sensitive yoga models. I argue that TCTSY is a practice that moves *beyond* sensitivity and into trauma-specific treatment for complex trauma.

My hope is that placing yoga practice into the framework of TIC offers more differentiation between the terms "trauma-informed," "trauma-sensitive" and "trauma-specific" yoga, and what they offer survivors in terms of outcomes and benefits. As the framework of TIC becomes more woven into our systems and society, it will become increasingly important that we use language that is consistent with the three levels of TIC so that service users (and potential trauma survivors) can make informed choices regarding which type of yoga class or offering might best suit their needs.

Recognizing Complex PTSD as a separate diagnostic classification necessitates the development of treatments that safely meet the needs of complex and vulnerable clients. Integrating trauma-sensitive yoga practice into the structure of trauma-informed care, we see that it can be offered as a trauma-specific treatment for complex trauma and CPTSD.

Yoga on the Level of Trauma-Informed Services

(cont.)

RECOGNIZING COMPLEX PTSD AS A SEPARATE DIAGNOSTIC CLASSIFICATION NECESSITATES THE DEVELOPMENT OF TREATMENTS THAT SAFELY MEET THE NEEDS OF COMPLEX AND VULNERABLE CLIENTS.

- MARCHAND

CLINICIANS' CORNER (CONT.)

Jennifer Marchand

Trauma-informed care is the first and broadest level of the TIC model. Its aim is making all types of services that may be essential or beneficial to trauma survivors safe and accessible; in other words, it is not a clinical treatment for trauma to reduce trauma symptoms, but supports recovery by making services accessible.

Trauma-informed yoga practices are generally non-clinical offerings made to the general public, and should therefore adhere to the concept of universality, adapting practices based on the assumption that anyone accessing classes may be a trauma survivor. These classes are primarily yoga-focused while reducing potential triggers and increasing choice where possible. It can be applied to any style of yoga.

Yoga on the Level of Trauma-Sensitive Services

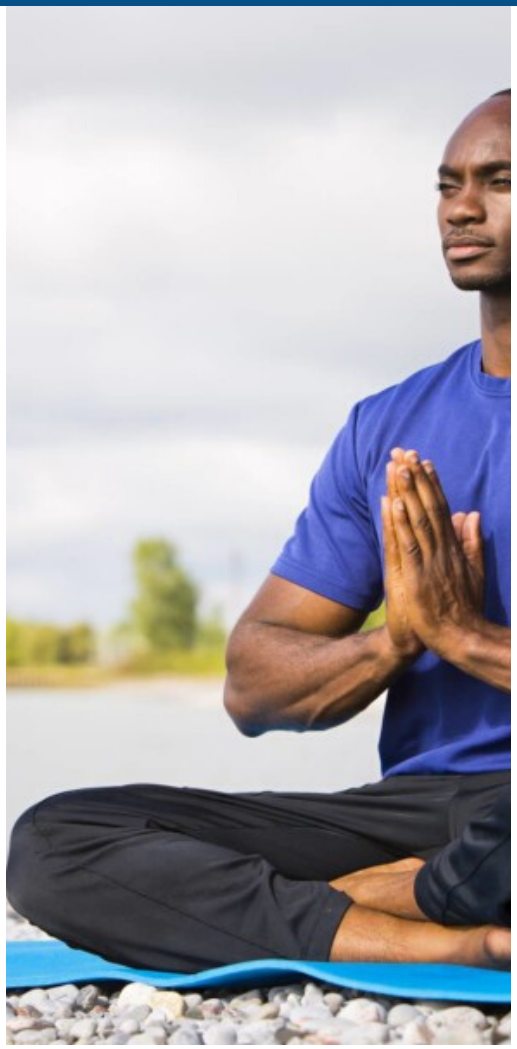
The second level of TIC is where we find trauma-sensitivity. Integrating yoga on this level aims to directly benefit those with a history of trauma and adversity, narrowing the focus slightly more than trauma-informed services while still being a primarily yoga-based practice. It may be offered to populations with a high exposure to trauma, but who may not necessarily be seeking treatment for trauma symptoms; rather, they may be seeking access to the potential benefits of yoga, such as calming the mind, increasing strength and flexibility in the body, and gaining self-regulation skills.

Trauma-sensitive yoga models often use tools derived from yoga practices, drawing upon asanas (postures) and pranayama (breathing) techniques to achieve specific results in the body, such as regulation of the nervous system and an inner state of calm. Some examples include alternating nostril breathing to intentionally activate the parasympathetic nervous system, using postures for relaxation and tension release, or to experience strength and power in the body.

Yoga on the Level of Trauma-Specific Services

On this level of TIC, services move beyond sensitivity and into evidence-based, empirically-validated methods that reduce specific trauma symptomatology. Integrating yoga into this level of trauma-specific services separates it from trauma-sensitive and trauma-informed yoga approaches. I argue that Trauma Center Trauma Sensitive Yoga (TCTSY) is best placed on this level of the TIC framework to highlight how it extends beyond sensitivity through its specific treatment purpose of increasing interoceptive capacity.

TCTSY is an empirically validated, adjunctive clinical treatment for survivors of complex trauma, complex PTSD and relational violence. TCTSY was developed and researched at the Trauma Center in Brookline, Massachusetts with David Emerson and Bessel van der Kolk at the forefront. It was originally referred to simply as trauma-sensitive yoga (TSY), including in the clinical studies done through the Trauma Center; however, as trauma-sensitive yoga programs and approaches began to emerge in North America and internationally, it became clear that it needed a name to differentiate it from other TSY models. TCTSY was chosen to pay homage to its roots in the development and research at the Trauma Center, which began in 2002,



although it is now run through the Center for Trauma and Embodiment at the Justice Resource Institute.

In TCTSY, simple yoga forms and movements provide concrete, present-oriented opportunities for participants to engage in the process of interoception, which can be defined as “the process of receiving, accessing and appraising internal bodily signals” (Daubenmier et al, 2015). By moving through different forms, participants practice noticing and interacting with what is happening in the body in order to rebuild neural and physiological interoceptive pathways. This allows survivors of complex trauma to experience having a body that is their own, which is the basis of having a tangible sense of self (“I sense, therefore I am”), and the ability to make choices and take effective action based on their internal world.

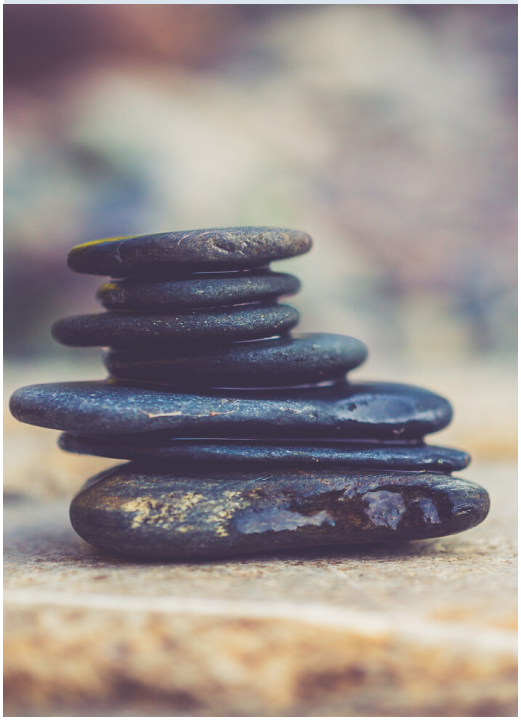
We have distinct interoceptive pathways that help us sense *(cont.)*

CLINICIANS' CORNER (CONT.)

Jennifer Marchand

what is happening in our internal world, and those pathways can be compromised by experiences of trauma (Emerson, 2014). Many survivors of complex trauma are conditioned to be acutely attuned to the external world, adaptively scanning and responding to cues of threat from the environment, including the overt or subtle non-verbal communication of others. The long-term impact of this survival strategy is an erosion of interoceptive capacity; as in, a disruption in the ability to effectively sense into one's present-moment experience and pick up cues from the internal world. As is often the case with complex trauma, sensations arising from the body can also be a source of unbearable pain that can cause the past to be re-experienced in the present without context or narrative, causing them to lose orientation to the present moment. Continuously being attuned to external rather than internal cues is an adaptive survival strategy in the face of chronic threat, but over time it can lead to a loss of self, loss of ability to make choices and take action based on needs and physiological states, and, in essence, the loss of one's sense of having a body.

The focus of TCTSY is concretely on the body, and on the "feelable" experiences happening within the body from moment-to-moment as a specific treatment for somatic dissociation and compromised interoception. This is different from the goal of many trauma-sensitive yoga models that employ yoga forms and breathing techniques to achieve self-regulation and an internal state of calm. In TCTSY, yoga is not used to regulate an internal state, but to bring awareness and connection to concrete sensations happening within the body (such as muscle dynamics) through mindful and present self-observation, regardless of what those sensations are. Calling attention to the breath is done with the goal of increasing



interoception by consciously noticing and experiencing the movement of the muscles associated with breathing, the temperature of the breath, and any other concrete sensation associated with breathing. Repeated experiences of noticing what is happening in specific areas of the body in a contained and concrete way becomes interoceptive training for the brain, making it easier overtime to stay oriented to the present moment without becoming overwhelmed or flooded by what is happening in the body. This enhances the ability of complex trauma survivors to interact with sensations in ways that are helpful and useful to their needs. Self-regulation can thus be seen as something that may naturally occur as a result of interoception, but it is not the primary objective or treatment goal of TCTSY (Emerson, 2014).

TCTSY facilitators are trained to remove cues of threat from the environment as much as possible so that the participant can have access to enough external safety to begin to go inward, connect to what is happening in their bodies, and practice choice-making in the moment (within each yoga form and movement). Creating external safety involves removing any unnecessary cues from the environment that are nonessential to the process of building and strengthening interoception. *(cont.)*

CLINICIANS' CORNER (CONT.)

Jennifer Marchand

JENNIFER MARCHAND

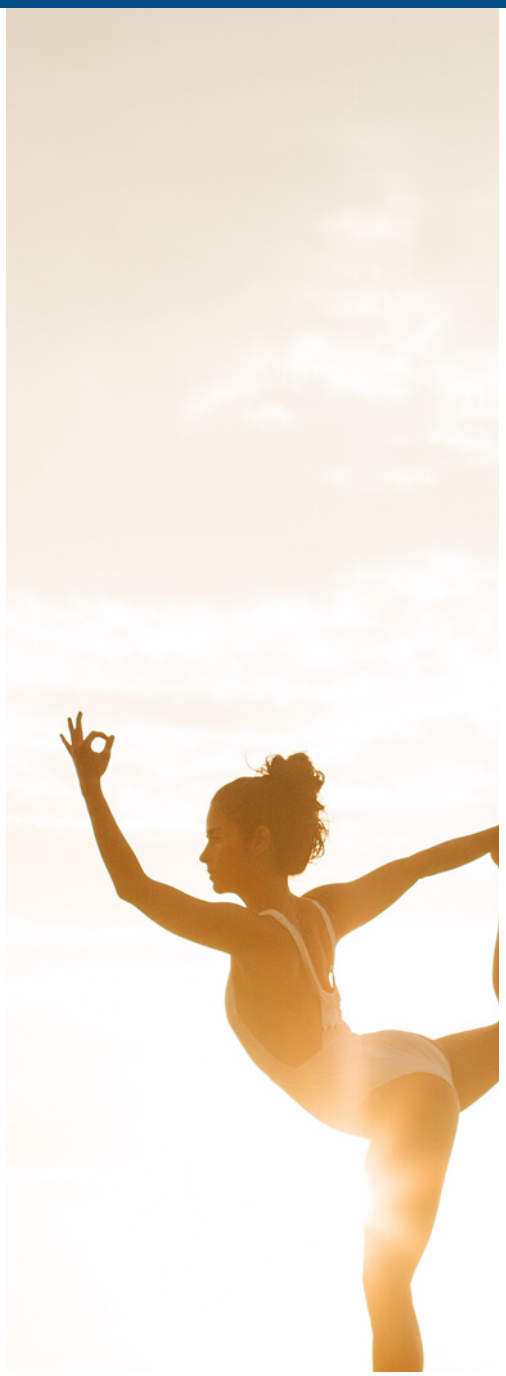
Jennifer is a certified EMDR therapist and TCTSY facilitator currently working as a trauma advisor and trainer for an international women's organization called Medica Mondiale. She works with health professionals in conflict-affected countries - such as Iraq and Afghanistan - on the implementation of trauma-sensitive health care for survivors of war rape and gender-based violence. Her focus is on developing culturally-responsive and safe approaches to clinical work in non-Western contexts, inspired by years of work with Canadian Indigenous populations and in Southeast Asia.

TCTSY facilitators are careful not to assume that any stimuli—such as smells, chants, props, music, lyrics, language, candles, imagery, metaphors, ways of breathing—are relaxing or calming for a participant, as any type of stimuli can be triggering based on individual experience of trauma.

Another technique is offering non-hierarchical choice for each yoga form where no one choice is communicated as being better than another; for example, the choice of making bigger movements is not presented as being better than making smaller movements – choices can therefore be made based on what feels most helpful for the participant in that moment. The facilitator also invites a shared authentic experience by being simultaneously engaged in the movement process and staying connected into their own interoceptive experience. This makes the facilitator available as a real presence that can provide relational safety and resonance.

Conclusion

TCTSY is not about remembering, creating a narrative of the trauma story, or about assigning meaning to the past. It is an embodied, non-dual awareness practice of being fully in the present in order to feel and tolerate what is happening in the body moment-to-moment. This is what helps us treat some of the most common injuries of complex trauma: eroded interoception, lack of ownership over the self, and difficulties being in the present.



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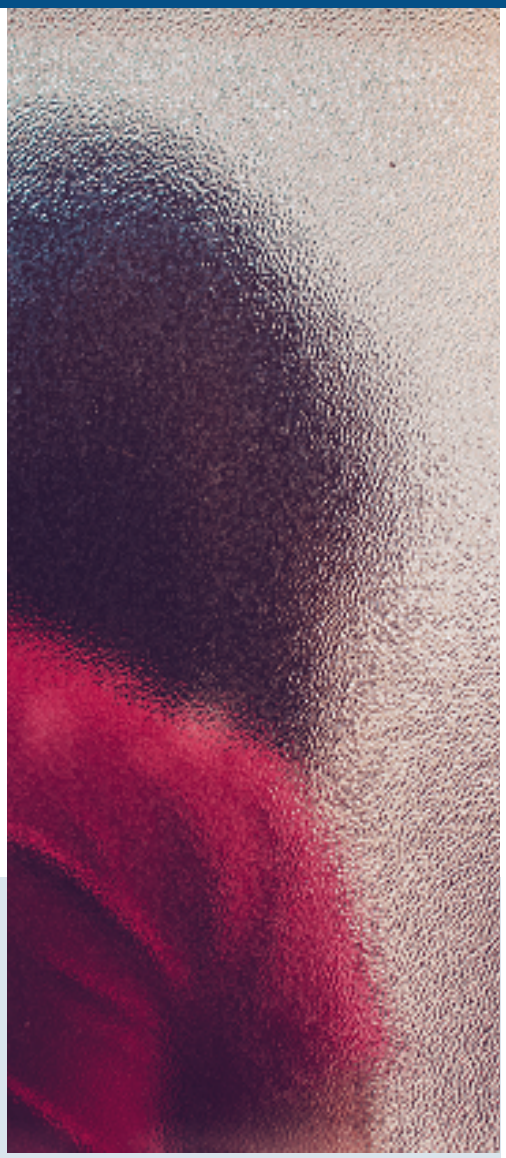

BROADENING PERSPECTIVES ON TRAUMA: CONSIDERING THE ROLE OF SOCIAL AFFECTS AND SHAME IN COMPLEX PTSD

Fabiana Franco, PhD

Complex post-traumatic stress disorder (CPTSD) is considered to be a particularly challenging form of post-traumatic stress disorder (PTSD). While PTSD is usually caused by a single or series of traumatic events (defined as experiencing a real or imagined threat to one's life or bodily integrity), CPTSD is often caused by repeated and ongoing exposure to trauma. In most cases, this trauma occurs within a relational context such as child abuse or neglect (Courtois, 1988; van der Kolk, 2017). However, a longitudinal study investigating prisoners of war (POWs) found CPTSD can also occur as a result of exposure to captivity during wartime (Zerach, Shevlin, Cloitre & Solomon, 2019).

This article will discuss the implications of how social affects and close relationships influence the development and maintenance of CPTSD symptoms. The relationship between the social environment and CPTSD is examined through the lens of a model developed by Maercker and Horn (2013). Finally, implications for future research will be discussed.

Social-interpersonal Framework of PTSD

Maercker and Horn (2013) developed a framework to illustrate how traumatic stress can be either mitigated or intensified by the various layers of interactions that occur between the person and the social environment. The authors describe the first layer *(cont.)*

CLINICIANS AND RESEARCHERS NEED TO TAKE INTO ACCOUNT THE POWERFUL ROLE OF SHAME, ESPECIALLY FOR THOSE SUFFERING FROM CPTSD.

- FRANCO

THE ROLE OF SOCIAL AFFECTS AND SHAME IN COMPLEX PTSD (CONT.)

Fabiana Franco, PhD

as *social affects,* defined as emotional reactions that occur in relation to other people such as shame, guilt, anger, or revenge. These intense negative emotions are part of the interaction styles of traumatized individuals.

The second layer of the model concerns the nature of close *relationships* of survivors. If a survivor is able to share their traumatic experiences with others who are supportive, they are more likely to experience greater psychological wellbeing (Maercker & Horn, 2015). The implications of this model are important, as close relationships offer social support, a factor that is consistently shown to be a factor in the recovery of trauma survivors (Brewin, Andrews, & Valentine, 2000).

The third layer, *culture and society*, consists of aspects such as the collective experience of trauma, social acknowledgment of victim or survivor, and cultural values.

Social-interpersonal Implications for CPTSD

Shame and guilt, in particular, are important for those suffering from CPTSD due to the nature of the cause of trauma. When we consider the relationship between the victim and the social environment, there are important differences in the nature of trauma for PTSD and CPTSD. PTSD is often caused by an incident that is not personal in nature, such as a natural disaster or a car accident.

For the person suffering from CPTSD, the trauma is often relational and therefore deeply personal. When abuse occurs in the home, even young children implicitly understand that what is occurring should not be talked about with people outside the family. In cases of sexual abuse, the abuse tends not to be discussed internally, with other members of the family. As a result, the victim and the family hide the abuse. Secrecy and the sense that something is wrong or different in the family can lead to feelings of shame, self-blame, and guilt. These implications are important as shame is known to cause social withdrawal and interpersonal avoidance (Street, Gibson & Holohan, 2005).

The Powerful Role of Shame

Clinicians and researchers need to take into account the powerful role of shame, especially for those suffering from CPTSD. Shame can amplify negative outcomes, creating a negative spiral as the person withdraws and loses access to social support. People with CPTSD have reported lower levels of perceived social support (PSS) (Simon, Roberts, Lewis, van Gelderen, & Bisson, 2019). Those who present with CPTSD often do not have the social support they need. They may also have a difficult time disclosing and discussing past trauma, even with their therapist. Shame, blame, and guilt deserve special consideration when working with CPTSD.

In treatment, clinicians have found difficulties in using cognitive behavior therapy (CBT) with individuals experiencing profound shame and shame flashbacks as a result of trauma. Individuals with CPTSD have difficulty shifting their perspective in a way that is helpful to changing their perception of the experience and feeling better.

In a study by Rogers, therapists reported that individuals with *(cont.)*

THE ROLE OF SOCIAL AFFECTS AND SHAME IN COMPLEX PTSD (CONT.)

Fabiana Franco, PhD

CPTSD stated they could understand they were not to blame, yet they still feel shame, and felt that they are to blame because they were born bad or have always been different (Rogers, 2012).

In other populations, such as individuals suffering from social anxiety disorder, researchers have found CBT to be effective in reducing shame (Hedman, Ström, Stünkel, & Mörtberg, 2013). The different response to CBT suggests that individuals with CPTSD may be dealing with a deeper level of trauma stemming from the relational roots of the trauma.

These findings make sense given the impact of repeated trauma during critical childhood stages on the development of sense of self and early attachment relationships. Early caregiver-child interactions are known to play an important role in the child's development of the *internal working model of self* (Schore, 2003). This understanding is neurological and unconscious. In the case of CPTSD and child maltreatment, the child grows up with a distorted sense of self. The child may develop an understanding that the world is a dangerous place and he or she is not deserving of love and care. This understanding is deep and can be difficult to shift with CBT.

Recommendations for Future Research

It has been widely documented that CPTSD is often a result of ongoing relational trauma. We also know that early child maltreatment and abuse often causes feelings of shame and self-blame in the victim. Given that shame and guilt are associated with social withdrawal and CPTSD often causes difficulties in relationships (Giourou, Skokou, Andrew, Alexopoulou, Gourzis, & Jelastopulu, 2018), special attention should be devoted to the potential lack of social support for persons suffering from CPTSD. Future research should investigate potential therapeutic interventions in which the focus is on healing shame and enhancing capabilities to access social support for individuals suffering from CPTSD.

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FABIANA FRANCO, PHD

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RELATIONAL TRAUMA SURVIVORS WITH COMPLEX PTSD: AN UNDERSERVED POPULATION

Lori Herod, EdD

In 2014 I founded the online web site and forum group Out of the Storm (OOTS) for trauma survivors with Complex PTSD (CPTSD). (As I write this there are over 7600 registered members.) I did so because at the time there was little if any public information about CPTSD despite it having been on the radar for almost thirty years (Herman, 1992). I personally learned about it when I read the book "CPTSD: From Surviving to Thriving" (Walker, 2013). For the first time I recognized what I had been dealing with for most of my life. I was in my mid fifties and had been to many therapists over the years.

One apparent reason for the lack of information was that CPTSD was not an official diagnosis in either of the two most widely used diagnostic manuals, the APA DSM or WHO ICD. Despite a growing body of research and recognition of this more complex form of trauma, inexplicably in 2015 a bid to include CPTSD in the DSM-IV failed:

> *In response to our lobbying, the American Psychiatric Association funded a field trial for a new diagnosis: complex PTSD or DESNOS. After that study was completed, the PTSD committee voted 19 to 2 to create a new diagnosis in the DSM. But to our amazement, that diagnosis was eventually left out of the DSM-IV, despite overwhelming research evidence for a much more complex developmental response to trauma (van der Kolk, 2019).*

This meant PTSD was the only diagnosis available to mental health/medical professionals, insurers, government health funders and others providing treatment, services and supports. In turn, this left a sizable population of people dealing with the debilitating and lasting effects of relational trauma underserved:

> *PTSD was a pretty good diagnosis for war veterans, but it was clear that there's a much larger population of traumatized people. For every vet who comes back messed up, there are at least 30 kids who get abused, molested, abandoned, and neglected at home (van der Kolk, 2019).*

Three years later in 2018, CPTSD was accepted as a diagnosis in the ICD-11 by the World Health Organization. While this was a step forward, many professionals and providers use the DSM and as a result, survivors with CPTSD are still being treated as though they have PTSD. As research continues to demonstrate, however, there are major differences between PTSD and CPTSD (Hyland et al., 2017; Karatzias et al., 2017).

PTSD involves short term/single incident, non-relational trauma (natural disasters, crime) and results in three major symptoms (which CPTSD shares): AV - Avoidance of Traumatic Reminders; RE – re-experiencing the past; SOT - persistent sense of threat. CPTSD results from *ongoing* trauma which is predominantly *relational* in nature (abuse/neglect) and results in *three additional symptoms*: AD – affective dysregulation; NSC – negative self-concept; and, DR – disturbed relationships (Hyland et al., 2017).

IT HAS BECOME ABUNDANTLY CLEAR THAT WE STRUGGLE TO FIND EFFECTIVE, ACCESSIBLE AND AFFORDABLE TREATMENT AS WELL AS SERVICES AND SUPPORT FOR COMPLEX PTSD.
- HEROD

Treatment for CPTSD must necessarily address additional symptoms that develop in the face of the cause (relational) and ongoing nature of the trauma (Karatzias, et al., 2019; Karatzias & Cloitre, 2019). In the six *(cont.)*

RELATIONAL TRAUMA SURVIVORS WITH CPTSD: AN UNDERSERVED POPULATION (CONT.)

Lori Herod, EdD

LORI HEROD, EDD
Dr. Herod is a survivor of relational trauma and the founder of the online website and forum group *Out of the Storm* (OOTS) for trauma survivors with Complex PTSD. She is also a Co-Chair of the ISTSS Complex Trauma Special Interest Group.

years since I started OOTS, however, it has become abundantly clear that we struggle to find effective, accessible and affordable treatment as well as services and support for CPTSD. Given that the vast majority of OOTS members are from first world countries, this points to a larger and problematic issue: we are an underserved trauma population everywhere.

There is a pervasive lack of knowledge about/training to identify and treat CPTSD in all of the countries OOTS members are located. The few professionals who do know about and treat CPTSD are typically in private practice in large cities. Private sessions cost between $180 and $225 per session, making them unaffordable for most survivors. There are long waiting lists for any publicly funded care which is predominantly for PTSD; treatment for CPTSD is simply not available.

We are underserved and yet there are many more of us than those with PTSD (van der Kolk, 2019). We must consider why this is still the case some thirty years after Judith Herman (1992) identified CPTSD. Perhaps there are politics involved as van der Kolk suggests (2019). Whatever the case, it seems only logical that the solution is for survivors with CPTSD to be identified and treated as a trauma group distinct from those with PTSD.

Toward this end, ISTSS/CT SIG members could collaborate to: 1) have CPTSD included in future editions of the APA DSM; 2) educate mental health, medical and other CPTSD; and 3) to influence governments, insurers and other providers to increase funding for treatment, services and supports.

The COVID-19 global pandemic is causing ongoing traumatic stress to millions around the world. Now more than ever, it is crucial to recognize how pervasive CPTSD is, and actively begin to assess what research, treatment, services and supports are needed. Those of us with CPTSD and at risk of developing it deserve no less; it's time.

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SURVIVORS' CORNER

'IDENTITY/S': THE SIGNIFICANT ROLE OF CHANGING PEOPLE'S MINDS

Becky Newell

The buzz in the room made it feel special. Not because on the stark, freshly painted walls hung four years worth of paintings; not because there was an air of acceptance I had never experienced in my life before. Nor was it because as many of my friends and family, who could make it to London, were there! It was enormously important, to me, for all of these reasons and because Kim Noble had offered a hand of friendship and exhibited with me. To Kim Noble, an already well established artist with D.I.D who has had many exhibitions, written a best selling book about the subject, and appeared on the Oprah Winfrey show, this was all routine.

Filled with our experiences, Kim and mine, the room was separated into two, and then separated again and again as each of our personalities took their place on the walls. Shocking? Possibly in its uncompromising honesty. Each of the pieces painted privately and quietly at home now pulled together looked fierce to me. Definitely triggering when put together with the box-like room, bright lights, and crowd.

Extraordinarily, four particular people stood in the room. Each one of us utterly different, each utterly able to function within this sea of triggers, noise and colour. I have only met one person with D.I.D before but here four of us stood, all living with D.I.D. Each of us had achieved something, given ourselves direction in one way or another, we had learned in extraordinary and different ways to live balanced and wonderful lives. My favourite quote is from Fredrich Nietzsche "To live *(cont.)*

THE NEED FOR EDUCATION AT EVERY LEVEL COULD NOT BE MORE CLEAR. A SIGNIFICANT SHIFT IN THE PUBLIC'S AWARENESS OF D.I.D. IS REQUIRED, NOT AS A LUXURY, BUT AS AN EMERGENCY.

- NEWELL

SURVIVORS' CORNER (CONT.)

Becky Newell

is to suffer, to survive is to find some meaning in the suffering," and it seemed fitting for our coming together.

I was enormously humbled to be in this particular room. I had gotten there by a series of wonderful accidents, and to end up hanging my work with Kim Noble's exemplary pieces and making a speech after Valerie Sinason! Valerie Sinason, founder of the Clinic for Dissociative Studies and on the Board of Directors for ISSTD, required no introduction, and since the beginning of my recovery, she had been a voice of encouragement, until now, from afar. After three very intense months planning every detail of the night, 'Identity/s' was finally happening. I had even given thought to the aftermath; I had needed to. Previous experience had taught me that there was a small chance of feeling suicidal, and I needed to be aware and plan for the risks.

So why were we all there and why was it all so important?

As I sit up here in my attic studio, cat warming herself virtually atop the radiator, I must admit I am trying to filter that question through myself. There were so many things that were important, and when you work as we do in my inner family, everyone has a different set of priorities.

There's the sales; the recognition of my art! The whole business of writing both campaign letters and my story! There's the whole question of finding justice and who to contact, write to, and chase up about that.... not just for myself but for those who are still being Ritually Abused. If I'm honest, for a while I had thought of Ritual Abuse only in a historical context. It was with mounting horror and urgency to act that I realised this is happening to a child now, in my town and in yours, too. To reflect on a personal level, meeting other people who believe us -

allowing the impact of that to filter in. There's the big idea that I don't need to apologise for having D.I.D. because I have been.... I've been so grateful for acceptance anywhere I've found it! Of course, meeting three other people, radically different, all who have D.I.D. was enlightening! It confirmed to me there is no 'one way'. The idea that 'integration' is the gold star of healing was repugnant to me when I first heard it on a training video. To be honest, it frightened the life out of me. I was terrified I would be destroyed, all of our 'who' would be amalgamated and lost. The idea left me grief stricken! For us .... it is not the way! And that was the point confirmed ...'for us'.

Too much, too many individuals trying to run with different priorities at once with only one body and 24 hrs! The consistent frustration for those of us with D.I.D. because on top of that, we have children, little ones, that must have their time. Exercise routines that if left too long will turn into eating problems. It is all enough to drive one back to the bottle of whisky sitting, half drunk, on my desk! Underneath, of course, are the shadows that are dug up and looked at gently once a week, which ultimately have become a driving force behind this splintered overload. A search for some balm to soothe a roar of injustice.

So why an exhibition about identity? Why was it so important? I guess because the singular cruelest moment for me to understand was that at 46, I had absolutely no identity that had not been manipulated into 'being' in some way. That I had felt like an *(cont.)*

SURVIVORS' CORNER (CONT.)

Becky Newell

outsider and the weirdo at school, college and drama school because I had been manipulated into secrecy and controlled. I suddenly felt a huge weight recognising my nothingness. I had not been allowed to express a thought or feeling of my own since my birth. However it didn't mean that I hadn't thought about those feelings, it didn't mean that I was dead, somewhere my creativity was keeping hold of my voice. Finding and giving myselves voice has been a slow and difficult journey, but having found ways of communicating, what did I want to say?

As I have learned to live multiply, I have found many joys. I have seen as much humanity as I saw inhumanity. However, I have also recognised with a sickening clarity the apathy that exists in the world, the inability for people to embrace what they are fearful of. I have lost family and friends and any faith in any 'system' if I ever had it before!

The need for education at every level could not be more clear. A significant shift in the public's awareness of D.I.D. is required, not as a luxury, but as an emergency. Without the understanding of D.I.D, there will be no convictions, no justice, no awareness to help current victims, no treatment for trauma, misdiagnoses, the list just goes on and on. This isn't an insignificant 'extra'. It is something that underpins many other problems that affect society. Recently, the U.K. Prime Minister Boris Johnson said he couldn't see why we were 'spaffing' money on all this 'malarkey' when referring to historical abuse cases. Our House of Lords has members who have confessed to covering up child abuse in their professional careers. It is clear then that it is the public's awareness that must be changed and that begins in small ways. That begins in the small steps of awareness that I experienced as I began to live multiply - becoming aware of what had happened to me and of the distinct individuality I live with. Whilst films such as 'Split' can be seen as infuriating, they do open a door to discussion and we have to begin the conversation somewhere. Using the arts as a medium to begin the conversation is an important part of that process.

So many people have asked me 'was your exhibition successful? Did you sell much?' I have to admit I sold some pieces and would probably have been richer if I had got a pound every time someone told me they had heard of Kim but not of me! But yes! The exhibition was successful; we spoke out! We have been speaking out to people who would not normally hear or ask about D.I.D. ever since. It may be a small step, but I know from my own experience that small steps eventually get you a long way. It was also successful because, on a *(cont.)*

I CANNOT PUT WORDS, YET, TO THE DARKNESS I EXPERIENCED, BUT I CAN PUT SHAPE AND COLOUR. THAT CAN BE THE BEGINNING OF A CONVERSATION OR THE BEGINNING OF AN EXHIBITION, ARTICLE, CAMPAIGN, DOCUMENTARY, BOOK, OR JUSTICE. THROUGHOUT HISTORY, ART HAS TOLD THE STORY OF ITS PEOPLE AND IT IS ENORMOUSLY IMPORTANT THAT WE ENCOURAGE THE WHISPERS.

- NEWELL

SURVIVORS' CORNER (CONT.)

Becky Newell

personal level, I didn't just learn there are others - I met them! That awful fraudulent feeling that is so common amongst us that live with D.I.D. was challenged and learning about others' experiences gave me courage and a reality that helped me make sense of my own identities. We, as an inner family, should not be unique in finding acceptance, briefly in a stark room, in London! Acceptance, justice, compassion and treatment should be a given for those who have survived the inhumanity that has caused D.I.D.

The arts have an important role to play in beginning a very necessary conversation. Particularly at a time when the world reacts to isolated living, we recognise how information presented creatively plays a significant role in society. Netflix documentaries are keeping half of the western world entertained, we have all heard about the fate of the 'Tiger King'. On a serious note from the initial whispers of creating something, we allow people to express something that they cannot in any other form. I cannot put words, yet, to the darkness I experienced, but I can put shape and colour. That can be the beginning of a conversation or the beginning of an exhibition, article, campaign, documentary, book, or justice. Throughout history, art has told the story of its people and it is enormously important that we encourage the whispers.

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#DIDlife
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BECKY NEWELL

Becky Newell is an artist, teacher, wife, mother and survivor of childhood Ritual Abuse which resulted in Dissociative Identity Disorder. Understanding 'Becky Newell' as an individual and as an umbrella term for many, She has several personalities that paint in diverse ways. Previously Becky has exhibited in Worcester, Cornwall, and Birmingham. Her work has been featured on magazine covers and C.D. covers. After experiencing Complex PTSD, 15 years after her sister, her work took on new and more meaningful roots. Previously criticised regularly for having diverse styles all became clear when she understood her personalities. Jack Newell, whilst running a successful business teaching adults art, paints large scale emotive acrylic pieces. He also works in 3D experimenting with many different materials. While language often fails for Jack, art rarely does. Fi however paints in ink and bleach. She is also experimental in her work but conjures up mystical worlds that are familiar to the inner family, particularly places of dissociation and images of dark woods and escapism.

Though it has been a long while since Becky herself has painted she is still represented with her ink and acrylic work. Words are also part of the creative element within this inner family. Stephen writes poetry, exhibiting with Jack and Fi. 'Campaign Girl' is exactly that, writing on behalf of Ritual Abuse and D.I.D awareness. Campaigne Girl is outspoken and keen to engage with the outside world. As part of that engagement, Becky has been involved with Dr Edith Eger's (author of 'The Choice') next book. 'Identity/s' was the first exhibition Becky took on exploring the nature of D.I.D. She was joined by the well established Kim Noble who also has D.I.D. The exhibition was supported by Valerie Sinason and sponsored by The Perspective Project. They hope it will be the first of many!

CONCLUDING COMMENTS

Kelly Pattison, MA, LMHC & Krista Engle, MA

In September of 2019, a small group of people from the ISTSS Complex Trauma SIG met over Zoom to discuss the possibility of creating a newsletter for our community. Together, we dreamed about what it would look like to have a unique space to highlight the valuable and diverse experiences of those who work with and/or have experienced complex trauma, so that we could learn from and honour the wisdom of one another. Over many months, we worked to transform our dreams and ideas into something concrete that we could produce, and thanks to the support and generosity of our community and contributors, we now conclude our first issue of *Complex Trauma Perspectives*.

What we never could have anticipated when we began this process is the context in which our inaugural issue would be published – in the midst of the collective trauma of a global pandemic. COVID-19 has impacted all of our lives in significant ways, and we are experiencing the physical, mental, emotional, spiritual, and social costs that this has on our daily lives. We are trying to find a balance of caring for ourselves and caring for others in the midst of an ever-evolving situation. We want to honor the work that each of us is doing – for our families, our communities, our students, our clients, and ourselves. In these difficult times, we are working to hold the disparities highlighted by this pandemic alongside the resiliency and strength of our communities. We are working to apply what we know of complex trauma so that we can create resources that will help all of us get through the pandemic as best we can. We are grateful for the foundations laid by pioneers in the field of complex trauma that have allowed us to address COVID-19 through this specific lens. For more information about ISTSS resources specific to COVID-19, visit https://istss.org/public-resources/covid-19-resources.

As we consider what it looks like to move forward into the future, we would like to invite you to be a part of the creative process for *Complex Trauma Perspectives*. We are currently looking for contributors to future issues of *Complex Trauma Perspectives*, feedback as to what you would like to see featured in those issues, and people who would like to be involved in the process of creating the newsletter. Our current goal is to publish the newsletter three times per year; thus, our next issue will likely be published in September 2020.

If you have any feedback, questions, potential contributions, or desire to be involved in the production of the next edition of *Complex Trauma Perspectives*, please contact us at CTSIGPerspectives@gmail.com.

Thank you to everyone who has supported us and contributed to the first edition of this newsletter, and we look forward to hearing from you with regard to the next one!

Sincerely,

The *Complex Trauma Perspectives* Editors, Kelly & Krista

Contact us at **CTSIGPerspectives@gmail.com** with questions, feedback, contributions, or interest in helping with the production of future issues of *Complex Trauma Perspectives*.