APA GUIDELINES for Working with Adults with Complex Trauma Histories

DIVISION 56 (TRAUMA PSYCHOLOGY) OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION
AND THE INTERNATIONAL SOCIETY FOR THE STUDY OF TRAUMA AND DISSOCIATION (ISSTD)

APPROVED BY APA COUNCIL OF REPRESENTATIVES
AUGUST 2024

AMERICAN
PSYCHOLOGICAL
ASSOCIATION

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Suggested Citation
American Psychological Association (2024). Guidelines for Working with Adults with Complex Trauma Histories.
Retrieved from https://www.apa.org/practice/guidelines/adults-complex-trauma-histories.pdf

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Introduction

Trauma can be defined in various ways. Both the American Psychiatric Association (2022) and the World Health Organization (2021) define traumatic events as experiences involving actual or threatened death or serious injury or sexual violence or events that are extremely threatening or horrific in nature. Using these definitions, research shows that at least two of every three persons worldwide will experience at least one traumatic event over their lifetime, with many experiencing multiple events (Benjet et al., 2016). Exposure may vary across nations, with a national sample of US adults finding lifetime exposure rates as high as 90%, and that exposure to multiple traumatic event types was the norm (Kilpatrick et al., 2013).

When a person reports that one or more traumatic events have occurred, they may be further assessed for the presence of posttraumatic stress disorder (PTSD) and complex PTSD (CPTSD). PTSD is a condition in which traumatic memories are intrusively re-experienced in various ways, and accompanied by avoidance, negative thoughts and emotions, and hyperarousal (American Psychiatric Association, 2022). Complex PTSD (CPTSD) is a condition involving the same criteria to PTSD (per ICD-11 criteria), coupled with additional problems labeled as Difficulties with Self Organization (DSO), namely problems with affect dysregulation, negative self-concept, and relational disturbance (World Health Organization, 2021).

Yet there may be limitations to the above approach to defining trauma exposure and posttraumatic responses, and the conduct of professional practice in psychology in turn. These limitations include: (1) *heterogeneity* within the category of traumatic life events; (2) *inattention to contexts* surrounding occurrences of traumatic events; (3) *exclusion of psychological forms of trauma* from the category of traumatic events; and (4) *overemphasizing specific diagnoses*, particularly PTSD.

First, research has shown that there is much heterogeneity within the category of traumatic life events, and traumatic events may differ in various key characteristics. For example, factor analysis has revealed differences between collective violence, the causing or witnessing of bodily harm, interpersonal violence, intimate partner and sexual violence, accidents, injuries, and other heterogenous events, with different sub-categories of traumatic events having different lifetime prevalence rates and conditional risk for PTSD (Benjet et al., 2016; Liu et al., 2017). Such findings raise the question of whether *people who have experienced different types of traumatic events may differ in other important ways,* and thereby require different approaches to intervention (Kip et al., 2023).

Second, inattention to contextual factors surrounding the occurrence of traumatic events risks masking further important differences between different types of traumatic events. For example, while standard measures such as the LEC-5 (Contractor et al., 2020; Stevenson et al., 2023; Weathers et al., 2018a, 2018b) routinely inquire to a limited extent about the context of trauma history, such as by assessing whether a person experienced events directly (first-hand) or indirectly (e.g., witnessed, learned about, transgenerational), information is rarely collected

regarding how *often* the traumatic events occurred, *who* was involved or attributed blame, or whether coercive control was exerted, or *when* or *where* the traumatic event occurred, as well as regarding cultural, ethnic, and other significant contextual elements. Importantly, these contextual factors may relate to risk of trauma occurring in the first place, the intensity of aftereffects, and to a person's understanding of how and why the trauma occurred. These omissions may be a problem as far as contextual factors surrounding trauma history are known to moderate risk for PTSD and CPTSD (Vallières et al., 2021), and may establish additional meaningful sub-categories of trauma history.

For example, considering *who was involved* in the traumatic event can distinguish between *interpersonal and non-interpersonal events*, with the former known to have higher risk for both acute (Geoffrion et al., 2022) and chronic posttraumatic stress (Brewin et al., 2000). Further, considering *to whom (if anyone) persons attribute blame* for the traumatic event makes possible additional sub-categorizations of events, such as between *intentional* vs. *accidental* events, *morally injurious* vs. *non-injurious* events (e.g., self-blame)(Griffin et al., 2019; Houle et al., 2024; McEwen et al., 2021), and events involving or not involving deep *betrayals of trust* (e.g., infidelity, intimate partner violence, and incest/sexual assault/abuse)(Babcock and DePrince, 2012; Salim et al., 2023). Finally, asking about *when* traumatic events occurred may meaningfully distinguish between events that occurred earlier in life (e.g., early middle childhood or adolescence) vs. later in life, which may also have different effects on psychological development across the life span (Dunn et al., 2017a, 2018a, 2020; cf., Dunn et al., 2017b, 2018b). Finally, the impact of transgenerational trauma may also be relevant in understanding a person's trauma history.

Taken together, it may be argued that the complexity of an individual's trauma history increases with the degree to which traumatic events occurred repeatedly, were of an interpersonal and intentional nature, transgressed deeply held moral/ethical principles, and occurred early and across multiple developmental stages, and even across generations. This raises the question of whether *people who experience traumatic events repeatedly in interpersonal, moral, and developmental contexts are best served by person-centered approaches to professional practice that take such contextual complexities into account*.

Third, the conventional definition of traumatic events used in psychological practice, and in turn the assessment measures upon which it is based, notably excludes psychological stressors that may lack an explicit physical or sexual violation. For example, psychological trauma may occur in the context of emotionally abusive relationships between intimate partners, a parent's or caregiver's abuse of a child or between siblings, or bullying in peer relationships, and can cause similar or even greater levels of distress when compared with traumatic events that are of an explicitly physical or sexual nature (Humpreys et al, 2020; McKay et al., 2021). In the same regard, the conventional definition of trauma as an explicitly physical event may exclude discrimination based on identity or demographic factors such as sex, gender, race/ethnicity/culture (Bird et al., 2021; Kirkinis et al., 2021; Roach et al., 2023), sexual identity and orientation (Dürrbaum & Sattler, 2020; Jonas et al., 2022; Marchi et al., 2023; Wittgens et al., 2022), and ableness. Further, other forms of non-physical traumatization may result from an individual's transgenerational exposure. The exclusion of psychological forms of trauma from the definition of trauma arguably brings forward the concern that people who have experienced psychological trauma in the absence of physical or sexual trauma will not meet diagnostic criteria for PTSD. Embracing a broader notion of what constitutes trauma may therefore be necessary to help guide professional practice with persons who have experienced psychological forms of trauma.

Fourth, there is a concern that the more general, non-specific role for trauma history as a *transdiagnostic risk factor for all mental health problems* may be missed. Here, clinical practice guidelines (CPG) "provide specific recommendations about treatments for particular health conditions or diagnoses" (American Psychological Association, 2023). For example, the APA CPG for PTSD (American Psychological Association, 2017b, revision forthcoming) represents an excellent resource for guiding treatment specifically for PTSD. However, due to CPG addressing specific diagnoses, CPG may be less well suited to addressing the broader role that an individual's trauma history may have for professional practice more generally.

In this regard, it is important to recognize that trauma history may not only be a primary cause of PTSD but also a host of other mental health problems. Indeed, non-specific trauma histories (and perhaps especially childhood trauma history) may be a risk factor for the transdiagnostic outcomes of virtually *all* mental health conditions (e.g., Hogg et al., 2023). In fact, the role of trauma history as a risk factor is established for several mental health problems, including for depression and anxiety disorders across the life spectrum (Claxton et al., 2021; Fernandes and Osório, 2015; Li et al., 2023; Vibhakar et al., 2019; Kuzminskaite et al., 2021; Panagou and MacBeth, 2022), eating disorders (Örge and Volkan, 2023; Molendijk et al., 2017; Pignatelli et al., 2017), substance use and other addictive disorders (Hoffman & Jones, 2022; van den Berk-Clark & Wolf, 2017), psychotic disorders (Bailey et al., 2018; Bloomfield et al., 2020, 2021), dissociative disorders (Raison & Andrea, 2023), personality disorders (e.g., borderline personality disorder)(Jowett et al., 2020; MacIntosh et al ., 2015; Yuan et al., 2023), and non-suicidal self-injury and suicidality (Ford and Gómez, 2015). These findings are important, as far as treatments for these conditions that neglect a trauma-informed care lens and philosophy of practice that may lead to poorer outcomes. For example, treatment for eating disorders using a trauma-informed care

approach may often be appropriate (Day et al., 2024), as persons with eating disorders are known to often perceive an association between their trauma-related and eating disordered behaviors (Thornley et al., 2016). Similarly, persons with substance use disorders also tend to perceive that their substance use is linked to their posttraumatic symptoms (Boughner & Frewen, 2016), again suggesting the potential for integrated intervention (Roberts et al, 2015; Torchalla et al., 2012). Accordingly, it is important that professional practice in psychology include assessment of risk and resiliency factors for all presenting problems, including trauma history.

Need and Purpose of Guidelines

In 2017, the American Psychological Association Council of Representatives approved and published CPG on the treatment of PTSD in adults (APA, 2017b, revision forthcoming). This CPG was developed based on Institute of Medicine standards for independent, reliable, and high-quality CPG (Hollon et al., 2014), and comprised systematic reviews of randomized controlled trials of treatment efficacy regarding the remission or lessening specifically of PTSD symptoms as the primary outcome. The purpose of the CPG is to serve as one of the tools or forms of evidence-based practice (EBP) in psychology. In psychology, EBP refers to "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force Evidence-Based Practice, 2006, p. 273). Psychologists may refer to the CPG for the psychological and pharmacological treatment of PTSD, which guides evidence-based practice specifically with persons who have been exposed to traumatic life events under the current DSM and ICD-11 definition, and therefore who in turn re-experience their traumatic memories in various ways, and experience posttraumatic avoidance, negative cognition and mood, and hyperarousal in response. Several psychological treatments for PTSD have been sufficiently well evaluated to date to be recommended therein. Moreover, additional systematic reviews have investigated outcomes for CPTSD (Karatzias et al., 2019), and additional research is underway. Given that the study of effective treatments for CPTSD is in its early stages, psychologists aspire to keep informed of new developments in the field, incorporating evidence-based, supported, and informed treatment approaches, expert consensus, and their own clinical judgment into treatment planning.

However, as reviewed above, limitations in DSM and ICD-11 definitions of traumatic events include those relating to within-category heterogeneity, inattention to contextual factors, exclusion of psychological forms of trauma from the definition of risks, and underrecognizing the broader role that a person's trauma history may play transdiagnostically; that is, as a risk factor for virtually all mental health problems that may be seen in professional practice. A more general professional practice guideline (PPG) to address these limitations, particularly in addressing persons with complex trauma histories, is therefore needed. This emphasis meets the specific requirement of PPG to benefit both the public and to inform the profession.

While the current PPG may apply to persons with various trauma histories, the guidelines have been articulated explicitly in reference to persons with more "complex" trauma histories (Herman, 1992a, 1992b). Judith Herman (1992b) coined the term in her text *Trauma and Recover.* The complex trauma formulation thus expands the definition of trauma from merely physical forms to include other ongoing, progressive trauma and entrapping/coercive interpersonal violence, usually over the course of childhood but occurring at any age and having age- and stage-related developmental and posttraumatic impact. Regrettably, the term "complex trauma" has often been misunderstood within the literature, perhaps owing to authors conceptualizing it to imply a categorical distinction from "simpler" forms of trauma as conventionally defined in the literature, which may have invalidated the experiences of some victims. In contrast, *the present guidelines employ a dimensional, continuous model* in understanding a person's trauma history as increasingly "complex," as a linguistic device, to the degree that they have experienced traumatic life events: (a) repeatedly, (b) in (often significant) interpersonal relationships and (c) under intentional circumstances, (d) that transgressed deeply held moral/ethical principles, and (e) occurred early and across multiple developmental stages. As such, *trauma complexity may be best understood on a continuum,* from non-interpersonal and accidental (and thereby ethically neutral) circumstances that occurred in a singular instance, to repeated, deliberate, immoral transgressions that occurred within familial, intimate, peer or other close relationships from a young age and across the lifespan.

This is consistent with other definitions, such as those identified by Ford and Courtois (2020) that were denoted by various "I" words to describe complex trauma including as *intentional, interpersonal* acts of victimization and maltreatment that are *inescapable* and *insidious*, and causing of *injury* and developmental harm that is potentially *irreversible* and *irreparable*, or occurred under highly *intimate* circumstances that may be *intrusive* not only to the body but also to the *integrity* of the *identity*-psyche of the victim. Ford and Courtois (2020) further provided the following list of defining characteristics of complex trauma:

"(1) interpersonal experiences and events that often involve relational betrayal; (2) repetitive, prolonged, pervasive, [progressive and escalating in severity] and in some cases, ongoing events; (3) involve direct attack, harm, and/or neglect and abandonment by caregivers or other adults who are responsible for responding to or protecting the victims—this may extend to organizations and cultures that are disbelieving of the victimized individuals and deny the occurrence of the traumatic circumstances and so are unresponsive or that support a safe haven for perpetrators

[referred to as "second injury", above and beyond the original trauma]; (4) occurrence at developmentally vulnerable times in the victim's life, often beginning in early childhood (and sometimes in utero and in infancy); (5) have great potential to compromise severely a child's physical and psychological maturation and development, and to undermine or even reverse important developmental attainments at any point in the lifespan" (Ford & Courtois, 2020, p. 4).

Moreover, although the designation "complex trauma" was originally used to refer to traumatic victimizations over the course of childhood, thereby having an influence on the affected child's development, the term is now understood to refer to events and experiences that may also occur over the course of adulthood, whether *de novo* or layered on top of childhood trauma. As with children, complex trauma in adulthood may interfere with and interrupt developmental accomplishments, in some cases resulting in regression of previously achieved gains. Acknowledgement of the effects of additional types of traumatic stressors, including those that occurred in the recent past, has opened greater understanding of the role of repeated trauma over the entire lifespan. For example, studies of older adults have provided information about how the effects of trauma can be lifelong, and how its silencing or conditions of "forced silence" due to social stigma, shame, and threats have been detrimental to many. Late life and deathbed disclosures indicate some of the ways trauma may be insinuated into life status and quality of life.

Intended Audience and Scope of the Guidelines

APA Division 56 (Trauma Psychology) and the International Society for the Study of Trauma and Dissociation (ISSTD) have jointly developed this PPG to address the need for guidance on general considerations in professional practice with individuals who have experienced traumatic life events, broadly defined. Background regarding the processes and procedures undertaken to develop the guidelines is provided in the appendix. Psychologists may find these guidelines especially helpful in cases when their clients' history of traumatic events is more complex, such as being inclusive of events that occurred repeatedly in the context of interpersonal relationships, involved intentional harm, entailed transgressions of deeply held moral/ethical principles, and began from an early age and continued across multiple developmental and generational/ancestral stages.

Guidelines are written for public and societal benefit and may serve this purpose in various ways. This PPG has a primary aim of informing psychological practice with a particularly vulnerable and often demanding client population as they may be seen in general professional practice; that is, persons seeking relief and recovery following the experience of complex trauma histories. The guidelines apply principles from trauma psychology to improving mental health services, demonstrating the unique contribution and value of trauma psychology to the pursuit of mental health and well-being. It is recognized that a PPG such as this may come to be highly used and cited, serving as a general resource for informing and preparing the discipline and profession with guidance and aims to aspire toward in providing psychological services. Further, while the guidelines are primarily directed to psychologists engaged in providing general clinical services, they may also be relevant to other professionals, including mental health practitioners, researchers, medical providers, educators and trainers, systems leaders and administrators, and decision and policy makers across human service professions.

The guidelines address the application of principles from the discipline of trauma psychology to professional practice in psychology. Considerations regarding medications and other medical interventions are beyond the scope of the guidelines, including not only standard medications that may be used to treat trauma- and stressor-related disorders, such as antidepressant medication, but also the newer medicine-assisted psychotherapies, such as psychedelic psychotherapy that is not yet widely available as of this writing and may require specialized training to prescribe. Where considerations of the relevance of psychopharmacology may be indicated, non-prescribing psychologists refer clients to prescribing psychologists, psychiatrists, or other medical professionals with specialized knowledge about the use of medications for trauma and stressor-related disorders. Close coordination with such providers offers benefits for clients and advances optimal care.

APA Guidelines and Standards

For the purposes of this document, *guidelines* refer to statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists and other providers (APA, 2015b). *Guidelines* differ from standards. *Standards* are mandatory and, thus, may be accompanied by an enforcement mechanism; *guidelines* are not mandatory, definitive, or exhaustive. *Guidelines* are aspirational in intent. They aim to facilitate the continued systematic development of the profession and to promote a high level of professional practice by psychologists (and other mental and behavioral health professionals). *Guidelines* may not apply to every professional and clinical situation within the scope of that document. As a result, *guidelines* are not intended to take precedence over the professional judgment of psychologists (or other licensed psychotherapists) that are based on the scientific and professional knowledge of their field or profession (see APA Ethics Code, Std. 2.04). Moreover, these guidelines are to be understood and practiced consistent with the APA Ethics Code (APA, 2017a, under revision). Finally, it is acknowledged that federal and state law may supersede these guidelines.

The definition and purpose of CPG and PPG per the APA (2015b) are notably different. Here, "both types of guidelines

rely on the scientific and professional literature to inform recommendations. However, CPGs are founded on systematic reviews of evidence focused on key clinical questions, while PPGs may rely on consensus and familiarity with the body of literature but are not necessarily developed on the basis of systematic reviews" (APA, 2023). Further, while CPGs "provide specific recommendations about treatments for particular health conditions or diagnoses," PPGs instead "address psychological practice with particular populations… or in particular areas… without focusing on specific disorders or treatments," thus allowing for transdiagnostic approaches to be considered (APA, 2024). Thus, as stated above, this PPG is directed, rather than only to a specific disorder such as PTSD or CPTSD, toward persons with complex trauma histories as generally seen in professional practice. This benefits both the public and informs professionals.

Guidelines Status Expiration

This document is expected to require periodic revision and is scheduled to expire on September 1, 2034; a planned update to account for advances in the scientific and clinical-professional literature will occur on September 1, 2029. After the expiration date, individuals are encouraged to contact the APA Practice Directorate, Practice Committee, and Executive Council of Division 56, and the Board of Directors of the ISSTD to confirm that this document remains in effect.

Guidelines for Interventions in Professional Practice with Adults with Complex Trauma Histories

The following seven guidelines were extrapolated from the trauma psychology literature, both scientific and professional. Recognizing the ubiquity of trauma histories in the human experience and hence the broad, transdiagnostic relevance of trauma psychology to professional practice, these guidelines are not limited to the scope and aims of CPG to "provide specific recommendations about treatments for particular health conditions or diagnoses" (APA, 2023), such as for PTSD or CPTSD, but rather are more far reaching. These guidelines address the potential etiological role of the complexity of a client's trauma history "without focusing on specific disorders or treatments" (APA, 2023); that is, *transdiagnostically*, for *all* mental health problems with which they may present.

In this regard, these guidelines are in alignment with and grounded in concepts relevant to Trauma Informed Care (TIC) (Baker et al., 2020; Clark et al., 2015; Classen & Clark, 2017; Harris & Fallot, 2001; SAMHSA Trauma and Justice Strategic Initiative, 2014), a grass roots movement and philosophy of treatment that encourages the broad relevance of using a "trauma lens" when assessing and intervening with clients in mental and physical health settings by including questions about past and more recent experiences of traumatic life events and stressors. This orientation may lead to the recognition that an individual's trauma history has played an etiological factor in their clinical presentation across myriad and heterogenous presenting problems seen in professional practice. This may lead effectively to prioritizing the question "*What happened to you?*" in comparison with focusing exclusively on diagnosis and symptomology (e.g., "*What is wrong with you?*"). The following guidelines are in alignment with and incorporate this philosophy and orientation to professional services.

The Guidelines

The seven guidelines themselves are arranged on the acronym ***HISTORY*** that is utilized as a mnemonic for the considerations and approaches articulated below[1]. Thus, the seven guidelines refer to: (a) *Humanistic*, (b) *Integrative*, (c) *Sequential*, (d) *Temporal*, (e) *Outcomes-focused*, and (f) *Relational* principles that assist clients' in understanding (g) *Why* the traumatic events occurred, in turn supporting resilience, recovery, and growth. Additional considerations are taken up after the 7 guidelines pertaining to education, training, and professional development; equity, diversity, and inclusion; and self-care.

GUIDELINE 1:

Psychologists are guided by HUMANISTIC principles and values in their way of relating to persons with complex trauma histories.

Rationale

Certain clients seen in professional practice may be found, upon assessment, to have suffered repeated and extensive harm and betrayal or other types of inhumane treatment including coercive control at the hands of other people, including family members and peers, intimate partners, authority figures, designated helpers, and organizations and their agents. This may also take the form of human rights violations that dehumanize victims through means of emotional (e.g., antipathy and hatred, shaming, bullying, humiliation, harassment, discrimination, oppression, re-culturation), physical (e.g., assault, interpersonal violence, entrapment, imprisonment, pain, torture), and sexual violence (e.g., rape, child sexual abuse, incest, prostitution, human trafficking, the production of child sexual abuse materials). Elements of coercive control may be involved in many of these types of traumas (Herman, 2023). Many survivors also lack basic and essential life resources.

Intentional (or pre-meditated) forms of violence and exploitation may serve to objectify victims. In the process, these circumstances, especially when repeated over a prolonged period, may perpetuate lower self-worth, and undermine a victim's sense of identity and their personal control and agency. Individuals may also internalize blame or be blamed for their own victimization (often by the perpetrator, as well as others) and be stigmatized for its effects on them, leading to guilt or shame, including in relationships with mental healthcare providers. Accordingly, clients may benefit from interventions that provide a compassionate "safe haven" for the restoration of feelings of integrity, dignity, and self-worth.

Application

Psychologists and other mental health professionals have an ethical obligation to "Do no harm" in providing care to clients (APA, 2017a, under revision) that may, particularly in the case of persons with a complex trauma history, extend to **"Do no *more* harm"** in recognition of the past harms they have already suffered at the hands of others (Courtois, 2015). Psychologists may apply this principle by providing interventions aimed at undoing harms of *past* inhumane treatment or addressing personal safety against *present and future* harms, including current abusive relationships and self-harming and suicidal behavior. It is also important to recognize that the inherent power differential between a psychologist and client can itself hinder the aspiration to facilitate a safe haven.

Psychologists seek to **support dignity, self-compassion, and self-worth** as means of combating trauma-related experiences of misunderstanding, dehumanization, and victimization that may have resulted in guilt, shame, and self-loathing/self-attack. Dignity and self-worth may be reinforced by applying interventions from positive psychology that support individual strengths, resiliency, and the potential to heal, recover, and even experience posttraumatic growth.

Psychologists seek to **foster personal agency** in the context of the therapy and in everyday living. Psychologists may apply this by explicitly involving individuals in treatment decisions and seeking to enhance motivation and engagement in the process. This may include collaborative decision making and a strong focus on client preferences for various intervention options available. These steps may facilitate modeled healthy forms of assertiveness outside the context of therapy, including in interpersonal relationships with family members, partners, and peers, and in other settings.

Finally, psychologists seek to **reinforce personal self-efficacy, resourcefulness, and functioning**. Psychologists may apply a strength-based approach designed to recognize the individual's resilience in surviving past trauma (e.g., recognizing certain currently unhealthy behaviors as previously necessary as survival skills). They may also seek to support clients' capacity to self-regulate, recover, and experience posttraumatic growth (McCormack et al., 2021; Tedeschi & Moore, 2021). This may improve clients' perceived self-efficacy and confidence, thereby reducing trauma-related feelings of helplessness, hopelessness, and extreme self-criticism.

Psychologists are also mindful of some complexly traumatized persons' need for **practical and pragmatic resources.** For example, survivor support groups and other community resources may be important to consider given that many persons with complex trauma histories lack family support, live alone, are socially isolated, belong to marginalized groups, are destitute or even homeless, and may not have health insurance or other means to obtain or continue psychotherapy.

1 Here we wish to acknowledge that our choice of this acronym is not intended as a gender-specific word, and we note the relevance of the word "HERSTORY" in understanding posttraumatic responses in women.

GUIDELINE 2:

Psychologists seek INTEGRATIVE solutions to the complex psychological and psychosocial problems often experienced by persons with complex trauma histories.

Rationale

While evidence-based treatments, largely of the cognitive-behavioral modality, exist for PTSD as detailed in APA's CPG (APA, 2017b, revision forthcoming) and elsewhere, unfortunately not all persons who participate in such treatment benefit to the same degree. It is possible thus that "one size does not fit all" (Cloitre, 2015; Courtois, 1999; Greenberg, 2020), and that arguably psychology often neglects a personalized approach to professional practice that includes individualized and contextually focused interventions for specific persons (Courtois & Marotta-Walters, 2021). Accordingly, it may be that a personalized, client-centered approach that is flexible, eclectic, and tailored to individual clients' presenting issues and concerns, goals and preferences, and identity intersections and group contexts, could benefit professional practice with individuals with complex trauma histories. Such an "integrative" approach (Zarbo et al., 2016) has been advocated by certain scholars in trauma psychology (Ford & Courtois, 2020; Karatzias & Cloitre, 2017; McFetridge et al., 2017; Kezelman & Stavropoulos, 2019; Wampold, 2019) as a means to compile evidence-based and evidence-informed interventions into a multi-dimensional and multi-component treatment plan to address specific client's needs, desires, preferences, resources, and capacities.

Application

One way that psychologists may aspire toward integration involves striking a balance between sessions focussed on the processing of past-traumatic memories, as is the mainstay of evidence-based traumatic memory focused treatments such as exposure therapy, with various present-centered interventions addressing current day-to-day problems (Frost et al., 2014). This could also include addressing therapeutic goals the client may have other than the working through of traumatic memories, such as psychotherapies that take as a primary focus the client's function in current social relationships (Althobaiti et al., 2020; Gold, 2020). It may also involve balancing a focus on reducing negative emotions with increasing positive emotions (Contractor et al., 2022a, 2022b; Ferrandez et al., 2022) or complementing a primary focus on verbal dialogue with non-verbal (e.g., expressive) interventions (Schouten et al., 2015).

Another application of an integrative approach to therapy may involve augmenting and synthesizing traditional evidence-based psychotherapy by other non-traditional, innovative, evidence-informed interventions. However, psychologists recognize that not all novel therapies can be expected to be shown to be equally efficacious (Metcalf et al., 2016). Augmentation strategies that may be increasingly regarded as evidence-informed include certain so-called "mind-body" approaches (Kim et al., 2013), such as mindfulness meditation or mindfulness-based therapies (Hilton et al., 2017; Hopwood & Schutte, 2017; Liu et al., 2022) and possibly related exercises like yoga (Cramer et al., 2018; Gallegos et al., 2017). Alternately, certain neuroscientifically-informed treatments (Lanius et al., 2015) have shown promise (Askovic et al., 2023; Kearney et al., 2023). Further, use of computerized techniques available through web-based, telehealth, and other computer science technologies may also hold promise, such as the application of virtual reality beyond exposure therapy as an integrative modality (Frewen et al., 2020). Use of augmentation strategies may require additional training, supervision, or collaboration among providers.

GUIDELINE 3:

Psychologists aim to SEQUENCE therapy and support for persons with complex trauma histories based on individual readiness and client preference.

Rationale

The relative need for professional attention to acute crisis management vs. processing of past traumatic events may vary among clients with complex trauma histories. Some clients may enter treatment in states of crisis with or without ongoing risk to their personal or others' safety, therefore requiring immediate attention to stabilization, risk management, and safety planning. Comparably, others may be in a greater position of present life stability to allow attention to the reprocessing of past traumatic memories. Thus, the **principal consideration in sequencing, flexibly applied, may relate to the relative prioritization of management of present distress and acute stressors vs. past trauma history in clinical sessions.** Such prioritization may change over the course of treatment as new life stressors are encountered (e.g., revictimization). Treatment sequencing may therefore be best understood as a non-linear and reiterative process that aligns with the literature on change processes in psychotherapy more generally (e.g., Krebs et al., 2018; Procheska & Norcross, 2001; Norcross et al., 2011), than as a linear, static, and fixed schedule. Sequencing interventions into components to align flexibly with client readiness, preference, and relative impact on client's day to day functioning may therefore be an important aspect of ongoing treatment planning.

Outside of acute periods of crisis and stabilization, a matter of historical and ongoing debate is whether initiation of evidence-based trauma-focused therapies may be best prefaced by an initial period of developing coping skills (e.g., emotional regulation and social skills) (Cloitre et al., 2011). Arguments for including this step are predicated on the fact that engaging in trauma focused therapy is likely to be distressing to some clients and therefore that teaching and practicing coping skills to regulate such distress may be of direct benefit. Some authors have thus advocated that **professional services may be optimized when sequenced into phases or components**, a flexible framework that allows alignment with the presenting problems, needs, and preferences of individual clients (Cloitre, 2015). This framework is often originally attributed to Janet (1889; Van der Kolk & Van der Hart, 1989) and endorsed by Herman (1992a, 1992b), and is a model that has been revised and updated in various ways (Brand et al., 2022; Ford & Courtois, 2020; Kezelman & Stavropolous, 2019). While the rationale and merit of first teaching coping skills has at times been passionately debated (De Jongh et al., 2016), resolution has been increasingly forthcoming (Dyer & Corrigan, 2021). It is acknowledged that trauma-focused therapy, independent of sequencing, has received the greatest endorsement as to efficacy and relative safety for the psychological treatment of symptoms of PTSD, and may therefore be given initial consideration in treatment planning. Further, where readiness for trauma-focused treatment is initially determined to be lacking, the psychologist may revisit these approaches throughout the course of therapy, where they may be integrated with other approaches into a comprehensive treatment plan.

Application

The relative need for prioritizing present distress and acute stressors vs. past trauma history in clinical sessions may be determined through a *broad-based psychosocial assessment*. The aim of preliminary assessment is to gain not only background information about the individual but also the individual's present status, including mental health problems, present ability to function in everyday life, life stability, and any health or safety matters of urgency.

Following an introductory assessment, the initial phase of treatment may begin with a relative prioritization toward **present-centered concerns and stabilization,** including managing current crises and promoting personal safety behaviors. As clients experience greater emotional and interpersonal stability, additional therapeutic targets may include psychoeducation on key principles from trauma psychology that may be applied in professional practice and instruction in certain coping skills (emotional and interpersonal regulation).

Subsequent phases of treatment may include greater **attention to facing and addressing (vs. avoiding) the emotional content of past trauma history.** Application of evidence-based trauma-focused therapy is likely to be effective foci in such sessions. Emotional processing of traumatic memories may be directed toward the most difficult responses experienced at the time (sometimes called "hot spots") as well as resolving of outstanding issues and concerns (sometimes called "stuck points"). Care is taken to ensure this process is not unduly distressing or retraumatizing by titrating to the emotional, cognitive, and behavioral regulation capacity of the client. New issues may also emerge as the client recognizes losses associated with their traumatic history such as lost self, lost childhood, lost parenting, and additional impacts across the lifespan. Dialogue may also bring into stronger focus the role of various potential perpetrators and bystanders, and psychologists may play a role in helping clients assess the costs/benefits and relative risks associated with any number of interpersonal actions to be considered (e.g., disclosures, reports, discussions/confrontations, legal actions, and termination or reconstitution of relationships including separations/divorce, etc.). Additional losses may be involved when a family is unable to reconstitute or other significant relationships end.

A present- and future-oriented phase may have as its focus the client's re-connection to life apart from (and less encumbered by) past trauma history and symptoms. Further dialogue may allow an integration of the traumatic events into broader meaning systems and an analysis of the impact of trauma on the client's relationships and life history. This phase of therapy may also accentuate possible forms of posttraumatic growth, such as addressing matters of the clients' broader meanings of life, including existential and spiritual meanings and struggles (Sherman et al., 2015). Here, considering whether and how to forgive, or to seek personal reparative actions or amends, may also take place; support groups and couple or family therapy may be particularly useful and relevant in this regard. Psychologists are also mindful that new life concerns (e.g., relationship, sexual, vocational, economic) may emerge at any point due to the resolution of past trauma and require additional therapeutic attention. This may extend the length of treatment or may require collaboration with other professionals with specific areas of expertise (e.g., couple or family therapist, sex therapist, vocational counselor, social service providers).

Lastly, psychologists aspire toward careful planning and preparation for the end of treatment to avoid reactivating previous losses, ensuring against an abrupt departure that may feel to the client like rejection or abandonment. This stage also allows the opportunity for review of the work and for engaging in closure and farewells, a process that can itself be therapeutic. This may counter the effects of relationship ruptures, cut-offs, and losses experienced by the client before therapy.

Such planning may also make it possible for the client to seek further contact with the psychologist in the future, as needed, whether for a check-in, check-up, or resumption of therapy.

GUIDELINE 4:

Psychologists endeavor to understand the psychological effects that complex trauma histories may have across the TIMELINE of an individual's lifespan.

Rationale

An adage is "trauma begets trauma," which is to say that the experience of one traumatic event may increase vulnerability to experiencing another (Breslau et al., 2008; Cougle et al., 2009). A comprehensive lifespan perspective may aid treatment planning by enabling a better understanding of complex interactions and layering within an individual's trauma history.

Traumatic life events may occur at any age, and the overall impact of traumatic stressors may accumulate across repeated events. Trauma histories may begin in infancy/early childhood in the form of disruptions in attachment and early child rearing as well as explicit abuse, and progress through development in various forms of familial, household, and community disorganization and dysfunction commonly referred to as adverse childhood experiences (Hughes et al., 2017; Petruccelli et al., 2019). Such early life relational and attachment trauma may set the victimized child lifelong revictimization and have a cumulative adverse effect over the lifespan (Copeland et al., 2018), delaying or altering neurodevelopment of cognitive, affective, relational/social, and self-regulation skills (Teicher & Samson, 2016) that continue over the life course.

Moreover, intergenerational, and historical/ancestral trauma comprise additional transgenerational risk for certain racial, ethnic, and cultural groups, such as experienced by indigenous populations. Finally, more recent traumatic events and experiences and their aftermath may drive acute treatment seeking.

Application

Psychologists endeavor to adopt a ***developmental, lifespan*** **conceptualization that describes a person's trauma history** by attending not only to *what* happened to their client but also *when* and with *whom,* as occurrences that took place in a chronological order. Developing a comprehensive lifeline (or chronology) of traumatic events, from early infancy and onward, may offer important insights on the client's presenting issues and concerns. Use of a standard paper-and-pencil genogram or a computerized means of collecting similar information (Frewen et al., 2024) may assist in developing a relationally and developmentally contextualized assessment of a client's trauma history within the familial and broader socioecological circle, while cultural formation interviews may be one means of providing information on broader cultural and racial ancestry and intergenerational trauma.

Psychologists aim to understand the relative impact of recent vs. early life stressors on current functioning and **prioritize present- vs. past-centered therapies** according to the acute vs. longer term needs and preferences of the client. Acute trauma exposure generally indicates the need for immediate attention and intervention, and psychologists strive to adopt the principle of **current safety first**. As such, psychologists aim to conduct ongoing risk and violence assessments to ascertain an individual's health and safety status, including potential danger to self and others (Mersky et al., 2021). This helps ensure the immediate safety of the client and others takes precedence over other long-term issues in treatment planning, such as through introduction of a **collaboratively derived safety plan that the client agrees to follow.**

GUIDELINE 5:

Psychologists strive for positive OUTCOMES for all psychological problems presented by persons with complex trauma histories.

Rationale

Applying a transdiagnostic framework is useful in working with individuals with complex trauma histories as no single diagnosis could possibly fully explain the range of psychological, behavioral, social, emotional, and physiological outcomes of repeated exposure to traumatic stressors (Ford & Courtois, 2020). Instead, non-specific trauma histories (and particularly childhood trauma history) have been revealed to confer increased vulnerability for transdiagnostic outcomes of virtually *all* mental health problems (Hogg et al., 2023). As a result, psychologists strive to be comprehensive in their assessment of the presenting problems of persons who have endorsed a complex trauma history, considering if and how such history may relate to the client's current presenting problems and, in turn, treatment planning for said concerns.

Here, certain of the more often-noted signs and symptoms of posttraumatic outcomes will be considered, acknowledging that it is beyond the scope of the current guidelines to consider all possible heterogeneity of outcomes. Among the more frequent posttraumatic problems with which clients may present include: (a) emotional and psychophysiological arousal dysregulation; (b) negative sense of self; (c) dissociative

experiences; (d) psychosomatic symptoms; (e) addictive behavior; and (f) self-harm and suicidality. Psychologists aspire to develop a comprehensive and flexible treatment plan to address each problem directly, either sequentially or in various combinations. Further, beyond a focus on symptoms and mechanisms, it is important to consider an individual's overall level of psychosocial functioning, and whether professional practice is working toward an individual's value-driven goals.

Application

Given the heterogenous, transdiagnostic outcomes of complex trauma histories, efforts to simplify diagnosis (Cloitre, 2020) may inadvertently result in oversimplifications and failure to assess for all relevant posttraumatic outcomes (Frewen et al., 2023). While comprehensively assessing for posttraumatic sequelae can be time-consuming, **treatment may be best guided by a thorough assessment of all presenting problems**, and transdiagnostic screening measures are being validated for this purpose (Frewen et al., 2021).

Emotional dysregulation in persons with complex trauma histories may alternate between hyper- and hypo-arousal. *Hyper*-arousal states may be expressed in various forms, including panic attacks and anxiety, impulsive behavior (e.g., risk-taking), dyscontrol over anger, frustration, irritability, or aggression—or complex social emotions such as guilt and shame. Comparably, *hypo*-arousal states may present as emotional numbing, detachment, anhedonia, and hopelessness/despair. Interventions to **regulate emotional and psychophysiological arousal** may emphasize both top-down (mind-to-body) approaches; for example, teaching and practicing emotion regulation skills such as through top-down and primarily verbal strategies such as identifying, describing, accepting/tolerating, and re-appraising negative emotions, as well as primarily through non-verbal strategies (e.g., Schore, 2019) such as bottom-up (body-to-mind) approaches (e.g., somatosensory-based interventions) (e.g., Fisher, 2019; Ogden & Fisher, 2016; Ogden et al., 2006a, b; Porges, 2021; Schore, 2019). Beyond a focus on emotion dysregulation, psychologists may also seek out deeper levels of emotional transformation and change (Chirico et al., 2022), for example, resolution of deep-seated experiences of guilt, shame, and moral injury.

Negative sense of self is also a common outcome of complex trauma history (Cox et al., 2014). Negative self-referential processing may relate to self-conscious emotions such as shame (Taylor, 2015). While a cognitive symptom of depression is worthlessness, depending on trauma-type, self-referential themes in trauma may be considerably darker and include feeling unlovable, dirty or defiled, and less than human (Frewen et al., 2011, 2017). These deeply negative thoughts and feelings about oneself and others may be partly addressed through cognitive re-structuring (Banz et al., 2022; cf., Wiseman et al., 2021), ego-state work (Schwartz & Sweezy, 2019), and related emotion-focused interventions (Fisher, 2017), as well as reparative attunement in the therapeutic relationship. Therapists understand that such deeply embedded and conditioned negative views of self may require a great deal of time and attention to reverse.

Psychologists strive to address and **reduce dissociative reactions and processes** that are functionally impairing (Jowett et al., 2022). Dissociative experiences may range from relatively mild instances of inattention or brief "spacing out," to more obvious trauma-related alterations in consciousness such as flashbacks, time-distortion, voice hearing, depersonalization, and marked emotional numbing (Frewen & Lanius, 2015; Frewen et al., 2023b) that may demarcate a subtype of PTSD (Lanius et al., 2012; White et al., 2022), to more fundamental alterations in self-state that may include identity confusion and alteration with associated periods of amnesia. Specialized interventions for dissociative experiences may be helpful in these areas (Bromberg, 2006; Kluft, 1999; Putnam, 1989; Ross & Halpern, 2009) and include grounding and other stabilization techniques, such as sensory awareness and mindfulness practices (Myrick et al., 2015), and psychoeducation and skill-building exercises (Brand et al., 2022; Schielke et al., 2022; Steele et al., 2017) to help individuals reorient to time, place, and present reality. Guidelines for dissociative disorders in clinical practice, such as dissociative identity disorder, are also available (International Society for the Study of Trauma and Dissociation, 2011; Kezelman & Stavaropolous, 2019).

Psychosomatic manifestations are often prominent posttraumatic sequelae. Diffuse pain syndromes and other medically unexplained symptoms may be addressed through education, collaboration with other providers, and a trauma-informed approach to physical symptom management that recognizes the involvement of psychological factors in symptom expression (Abdallah and Geha, 2017) while avoiding client-blaming and shaming (Clark et al., 2015). People who experience repeated dismissal of genuine medical concerns over time and by multiple healthcare professionals may face barriers to forging trusting, compassionate, and secure therapeutic relationships. Trauma-informed approaches to medical management may be especially important as complexly traumatized individuals often first present their concerns and symptoms to primary healthcare rather than mental and behavioral health providers.

Addictive behaviors can often be understood as a secondary coping mechanism for avoiding or suppressing trauma-related distress (e.g., self-medication)(Moustafa et al., 2021). Such may present in the conventional forms of alcoholism or traditional illicit substance use disorders (Najavits et al., 2017, 2020), various sexual

behaviors (deceptive sexual practices, infidelity, promiscuity, pornography use), or other behavioral addictions (e.g., video games, social media, gambling). Other forms of risk-taking behavior (e.g., unsafe driving or sex, self-harm) may create vulnerabilities for further traumatization; assisting clients to gain insight into the possible role such behaviors exhibit as traumatic re-enactments may help facilitate more healthy behavior (Briere, 2019). If abstinence is not possible initially, ongoing and progressive harm reduction may be an option (Hein et al., 2021), as is concurrent treatment of trauma symptoms and the addictive behavior.

Self-Harm and suicidality may be ongoing problems or may emerge periodically, sometimes due to issues within the treatment, while at other times due to present-day issues and subsequent victimizations. Many clients with a complex trauma history experience global hopelessness about their capacity to feel better or to have a better life. Ongoing suicidality may paradoxically be what keeps them alive since they may view it as a last resort if nothing improves. Psychologists may seek out training in dealing with such acuity to manage their own responses. Ongoing assessment and risk management efforts, including an ongoing safety plan, are also recommended.

GUIDELINE 6:

Psychologists appreciate the therapeutic RELATIONSHIP as the foundation for working with persons with complex trauma histories.

Rationale

Trauma history may be complexly embedded within unhealthy relationships from a young age, such as familial, intimate, or otherwise, that have involved rejection, non-response, non-protection, deception, control, abuse, violence, loss, betrayal, and abandonment. Such relationship experiences and resultant attachment styles and behaviors manifest in the client's difficulty relating to others, including the therapist. Avoidance, hypervigilance, and testing regarding trustworthiness may be brought to the therapeutic relationship as these individuals may not expect or know how to receive and accept healthy and non-exploitive interactions with others. What's more, they may hold the belief that they are to blame for their own mistreatment and fear that clinicians will join them in this perspective, bringing further shame and fear of abandonment once the psychologist gets to know them better. Psychologists thus strive to remain cognizant about such dynamics and may utilize psychoeducation and other techniques to ameliorate such concerns. Additionally, because these challenges can be very trying, the psychologist seeks to exercise the ability to self-monitor and manage their own emotional arousal and countertransference responses through self-monitoring and self-care strategies.

The establishment of a safer attachment experience within the therapeutic relationship is an important goal to foster, that may take the form of developing a new attachment template for security and the possibility of meaningful and safer relationships with trustworthy others outside of psychotherapy (Norcross & Lambert, 2018; Wu & Levitt, 2020; Cloitre et al, 2004). Research shows that the quality of the therapeutic alliance is associated with a reduction in various trauma-related symptoms (Ellis et al., 2018), considered to be both directly therapeutic and a catalyst for the development and upgrading of relationship skills (Kinsler, 2017; Kinsler et al., 2009; Paivio & Pascual-Leone, 2023; Pearlman & Courtois, 2005; Porges, 2021). Importantly, when ruptures occur in the therapeutic relationship, they can be treated as opportunities for repair, which can be regarded as an antidote to mistrust, acknowledging that a degree of mistrust may remain. Notably, clients who have experienced ongoing mistreatment without opportunity for either discussion or acknowledgement may marvel at the repair process as the contradiction of their past experiences and expectations; furthermore, it provides them with an alternative model for developing and maintaining meaningful and safe relationships.

Application

Psychologists seek to develop a "safer haven" for their clients within the context of the therapeutic relationship, which provides relative security of attachment and a "learning laboratory" for exploration of self in relationship to others. Psychologists are mindful of the central role that violations of trust may have played for persons with complex trauma histories. Clients may express their mistrust through avoidance and watchfulness on one hand, and to over-engagement, fearful compliance, preoccupation, and over-dependency on the other. These discrepant dynamics create what is often a confusing combination of approach-avoid behaviors. Clients with a complex trauma history often present therapeutic challenges involving personal, relational, and life instability; psychologists offer compassion, patience, and constancy in response to these issues. Mentalizing strategies may draw out the teaching and modeling of healthy alternatives for understanding and interacting with others. An increased quality of interactions with the therapist and others is in the interest of developing "earned security" of attachment, based on the relational and identity changes experienced through the therapeutic bond (Brown & Elliott, 2016; Muller, 2010, 2017; Wallin, 2007).

Boundary maintenance is an especially important consideration. Psychologists have the ethical and professional obligation to manage

such behavior by educating clients on the value of healthy and appropriate interpersonal boundaries and teaching skills for the development and maintenance of these in interactions with others. There is the potential that clients will romanticize or sexualize the therapist, or orient toward the clinician as if an abuser, as a transference reaction, acknowledged as "treatment traps" in the literature (Chu, 1988, 1992, 2011). Sexual involvement with clients is highly damaging and against professional codes of conduct and professional standards (Steinberg et al., 2021). It is the sole responsibility of the psychologist to scrupulously maintain personal and sexual boundaries, manage their own counter-transference reactions (especially romantic or sexual attraction to the client), and to seek outside assistance in managing, as necessary. This is especially true if the therapist is in the throes of personal crises, which may increase vulnerability to boundary crossings and violations.

GUIDELINE 7:

Psychologists aspire to help persons with complex trauma histories answer the question WHY the trauma occurred.

Rationale

It has long been known that survivors' subjective appraisals and attributions are more predictive of longer-term outcomes than are objective event characteristics (Brewin et al., 2000). Survivors' perceptions concerning their own or others' roles are highly influential in determining risk for chronic posttraumatic stress in both trauma-exposed children and adolescents (Mitchell et al., 2017) and adults (Gómez de La Cuesta et al., 2019). Unfortunately, survivors' appraisals of reasons for the occurrence of traumatic events may be erroneous and over emphasize self-blame and shame (Hoppen et al., 2020). Such viewpoints may have been espoused by perpetrators, many of whom systematically groom and coerce victims through misrepresentation and victim-blaming (Freyd, 1996), a process now identified as "gaslighting." Deception and misrepresentation of this sort can have profound and deleterious effects on identity and self-worth (Steinberg et al., 2021). Specific types of posttraumatic events and posttraumatic appraisals have been found to provoke alienation (McIlveen et al., 2020), impact personal and narrative coherence (Schäfer et al., 2019), and inspire feelings of betrayal (DePrince et al., 2011; Freyd, 1996). Accordingly, the question of "why?" and "why me?" may be especially vexing and urgent for survivors.

Application

Psychologists strive to promote the exploration of "why" and other existential questions to help clients **adaptively re-appraise** the possibly unhealthy and maladaptive meanings they have ascribed to what happened to them. This may include addressing biases or inaccuracies in cognitive appraisals and learning realistic, adaptive, and balanced viewpoints, including regarding the relationship with the perpetrator and their and others' (e.g., bystanders') roles and behaviors. A more accurate and adaptive differentiation of self from experience (e.g., "*It's not you, it's what happened to you*") may be a critical step to resolution and recovery as integration of new information and perspectives begins to challenge previous beliefs. Importantly, gender, gender identity, and sexual orientation may be directly relevant to re-appraisals, as are family history and ethno-cultural, religious/spiritual, and political beliefs and influences. As such, psychologists **seek to identify how to assist the client in meaning-making and resolution.** This process aims to support self-determination, locus of control, and mentalizing, with a number of different therapeutic approaches from the cognitive-behavioral and "third-wave" modalities developed to assist clients in re-appraising their experiences.

Clients may present ambivalent attachment to and traumatic bonding with perpetrators, making it imperative that psychologists appreciate these dynamics and not scapegoat perpetrators, separating their identity and relationship with the victim from their actions. Clients may be helped to explore such roles from an outside, third-person perspective. Gaining an understanding of these contextual factors and dynamics may **assist with reappraisal and reattribution of blame and responsibility** that had previously led to feelings of guilt, shame, failure, hopelessness, and moral injury. Group therapy and peer support may also provide important grounding and perspectives in re-interpretation of the events.

Finally, psychologists may seek to **engage in existentially and spiritually focused discussions** (e.g., "Why me?") with the aim of determining their potential role in helping to client find solace and healing from traumatic events and relationships (Sherman et al., 2015). Nevertheless, psychologists acknowledge the challenges of adaptive reappraisal for certain types of trauma, including but not limited to systematized forms of discrimination, oppression, abuse, and torture, understanding that in such cases an adaptive reappraisal of why a trauma occurred may not always be achievable or appropriate. On the other hand, engaging in conversations about these issues and discharging related emotions may be restorative.

Additional Considerations

In addition to the seven guidelines noted above, additional considerations pertaining to trauma psychology in professional practice for complex trauma history include: (a) Education, Training and Professional Development; (b)

Equity, Diversity, and Inclusion (EDI); and (c) Therapist Self-monitoring and Self-Care.

Education, Training, and Professional Development

Psychologists strive to be informed and stay current of core competencies and guidelines. Among these include the APA CPG for PTSD (2017b, revision forthcoming), and core competencies for psychologists relevant to treatment of PTSD in adults (APA, 2015a; Cook et al., 2014). Other disciplines may consult their own competency documents and curricula (Council on Social Work Education, 2015). **Specialized training and resources, however, may be needed to advance understanding and professional services with persons with particular sub-types of trauma history** (e.g., survivors of repeated child abuse, human trafficking, torture survivors, and so on) **as well as those with particular comorbid psychiatric diagnoses** (e.g., certain serious mental illnesses such as bipolar, psychotic, some dissociative disorders). These populations may present additional complications, challenges, and risks for which generic clinical training may not be adequate. Here, psychologists may particularly benefit from advanced training in the identification, assessment, and treatment of dissociation as a common consequence of complex trauma histories that is most often not taught in standard psychology training (Kumar et al., 2022). Resources that may be helpful along these lines include several texts (Brand et al., 2022; Dorahy et al., 2023).

Psychologists strive to be informed and stay current with the scientific and clinical literature. Relevant clinical resources may be obtained through membership in professional societies (e.g., APA, APA Division 56, the ISSTD, the ISTSS) and attendance at conferences and continuing education workshops established by these and other professional organizations. While certain dedicated volumes provide a helpful introduction (e.g., *The APA handbook of trauma psychology* (Gold & Cook, 2017]); *The handbook of PTSD: Science and practice* (Friedman et al., 2021)), psychologists aspire to consult the primary literature often, such as peer-reviewed journal articles published in the flagship journal of APA Division 56, *Psychological Trauma: Research, Treatment, Practice and Policy*; that of the ISSTD, *The Journal of Trauma and Dissociation;* and that of the ISTSS, *The Journal of Traumatic Stress,* among many other journals.

Finally, **psychologists endeavor to obtain ongoing professional support, mentoring, and supervision when treating persons with complex trauma histories.** Psychologists seek expert consultation as needed in addressing particularly complex presenting problems, while regular peer consultation and supervision is also advised even for the expert clinician providing the services. Supervisors and consultants may find that they are vicariously impacted by the clinician's stories and needs. It is important for psychologists to self-evaluate their effectiveness, including their individual strengths and weaknesses in treating complexly traumatized persons with different presenting problems and, distinctly, with different presenting identities. It is important to acknowledge that therapists can be imperfect evaluators of their own problem- and identity-specific strengths, and that being humble (i.e., underestimating effectiveness) can lead to better overall outcomes. Therapists may aspire to specialize to their personal strengths and/or engage in training and supervision to amplify their personal strengths.

Equity, Diversity, and Inclusion (EDI)

Research shows that members of minority communities experience elevated exposure to traumatic life events, partly the result of diachronic systemic oppression. It is thus important to recognize that a sense of safety may not be a default experience that all complexly traumatized persons have access to without barriers, and to which persons must somehow return to as corrective. For groups who are systemically oppressed, this may not even be a realistic pursuit, and the seeking out of relatively safer environments may be the best that can be realistically hoped for. Accordingly, **psychologists aim to recognize the relevance of equity, diversity, inclusion, and intersectionality when working with persons with complex trauma history.** Such considerations may include but are not limited to ethnicity, culture, race, caste, tribe, nationality, community, family, gender, sexual orientation, age, ability, spirituality/religiosity, and political beliefs, factors that may be causative, heavily embedded in, or interact with trauma history and posttraumatic responses (Brown, 2008, 2021; Hays, 2016; Krieger, 2019). As clinical practice can fail to attend sufficiently to cultural context and intersectionality (Bryant-Davis, 2019), psychologists serving persons with complex trauma histories seek to attend to the APA's EDI framework (APA, 2021a), for example, by using inclusive language and policies to promote cultural and emotional intelligence, access and equity, education, and advocacy. Psychologists serving persons with complex trauma histories are also mindful of their responsibility in advancing population health broadly (APA, 2022), and advocating for human rights for all persons (APA, 2021b).

Psychologists are also mindful that beliefs and traditions associated with different groups and communities may support or counter rationalization of discrimination, violence, and abuse and to sensitively explore such connections with their clients. Psychologists strive to recognize the intergenerational transmission of trauma in racial, ethnic, gender, caste, and nationality discrimination and oppression, colonial/genocidal/collective and systemic forms of trauma history, refugee trauma and forced migration experiences, and in experiences of personal and sexual harassment and humiliation by others (unfortunately, now both virtually and in person), and seek to understand the progression of

structural injustice to embodied harm (Krieger, 2019).

Psychologists strive to be knowledgeable of EDI and intersectionality issues not only from a theoretical perspective but also from the personal lived experience of individual clients. This may require psychologists to seek to attune to their own responses, conscious and unconscious biases, and lack of information (known as "cultural humility"). Psychologists are also **aware of the power differential in the therapeutic relationship** and how it may intersect with identities of privilege, or surface in the therapeutic context (Hook et al., 2013). Awareness of such factors may promote the use of appropriate and productive verbal and non-verbal indicators (e.g., language, tone, facial expressions, body language, physical space, eye contact, and so on).

Psychologists recognize the role of the socioecological context to understand the frequently embedded nature of complex trauma—not only within relationships and families—but broader institutions, communities, nations, and cultures. This framework recognizes that interventions applied in a social or community context that incorporates knowledge, traditions, and ritual healing practices and healers may be particularly helpful for some clients (Alpert & Goren, 2017; Staub et al., 2005; Saul, 2014). Culturally competent practice may indeed be a wellspring for posttraumatic growth for client and therapist alike (Weiss & Berger, 2010).

Psychologists aspire to an understanding of intersectional systemic issues that contribute (directly or indirectly) to the context in which traumatic events, retraumatization, and historical and intergenerational trauma may occur. For example, **Black, Indigenous, and People of Color (BIPOC) and other ethnic and cultural groups** may experience increased trauma exposure through re-culturation efforts (e.g., residential schools, re-education camps), disparate treatment, and other racial and ethnic discrimination and oppression. From an early age, BIPOC youth frequently experience race-based stressors (e.g., slurs, microaggressions, discrimination, rejection, and violence due to their skin color and race) or vicarious trauma from witnessing violence against a member of the community (e.g., harassment, shootings, hate crimes, police brutality). Psychologists are mindful of their responsibility to help in the dismantling of systemic racism (APA, 2021c) and advancing health equity in psychology as it relates to race and ethnicity (APA, 2021d).

Psychologists understand that being **transgendered or gender non-conforming (TGNC)** increases risk of hostility and violence (up to and including homicide) being directed at TGNC people that is frequently a source of mental health issues and health care disparities. TGNC people are more likely to experience familial and social rejection, stigma, intimate partner and other forms of community-based violence (McCrone, 2018; Scheer & Poteat, 2021). Studies suggest that TGNC people have higher rates of depression, anxiety, substance use, homelessness, and suicidality compared to national averages (Russell & Fish, 2016; Valentine & Shipherd, 2018).

Aging may also be an important EDI consideration in providing trauma-informed and responsive philosophy to professional services. For example, psychologists understand that **older adults** are at increased risk of trauma-related mental health issues and that PTSD has been found to be associated with aging-related cognitive concerns such as reduction in attention, working memory, and executive functioning (Schuitevoerder et al., 2013), in addition to physical concerns like illness and physical weakness, factors that may lead to the delayed onset of posttraumatic responses or disclosure of previous trauma.

Psychologists are also mindful that disability may cause vulnerability to traumatic events that can begin early in life and continue over the lifespan. **Persons with disabilities and differences** may face personal and institutionalized ableism, especially prevalent in youth- or able bodied-centric culture. Persons (including veterans) with intellectual and other forms of disability/differences may face ongoing stress and trauma in the form of deep poverty, insufficient housing or homelessness, drug and alcohol addiction, increased risk of domestic and community violence, and social isolation. Further, neurodiverse populations are at increased risk for adversity, including during childhood (Lambdin-Pattavina, & Dart, 2022; Webb et al., 2024). As a result, people with cognitive and physical disabilities and differences may experience less or problematic support, such as false information, lack of understanding, and deprivation of agency (Coty & Wallston, 2010; Tough et al., 2017). They may experience poorer access to quality health care, often caused by misunderstanding, mistreatment, infrastructure, and transportation difficulties, that may be exacerbated by their physical and mental health conditions and limitations (Wagner et al., 2013).

Finally, psychologists seek to recognize the intersectionality and impact of **socioeconomic status and marginalization** on individuals, including deep poverty (Loberg et al., 2018). Such disparities may present not only associated life challenges and deficits but may also constitute barriers to receiving psychological care.

In fact, all contextual factors may intersect and operate in synergistic ways with experiences of trauma, as described by Kira (2010). For example, a BIPOC individual who is gay or transgender may be especially vulnerable to complex trauma exposures, as may be a disabled woman in poverty; psychologists therefore aspire to understand their clients' overlapping vulnerabilities and consequences due to characteristics and group membership that may be related to and causative of traumatic events and experiences and their consequences. Psychologists strive to be responsive to contextual issues and to incorporate them into treatment as appropriate or feasible. Maintaining professional relationships with social workers and caseworkers, medical

providers, clergy, and other professionals in the community care space can be invaluable to informed and optimal practice and support.

Self-monitoring and Self-Care

Psychologists have an **ethical imperative to maintain their own emotional, mental, and physical health in order** to be relationally available and optimally attentive in all their psychotherapeutic interventions but especially when treating clients with complex trauma histories. Psychologists strive to understand that relational styles and interactions are core components of treatment, along with specific therapeutic strategies. Transference and counter-transference matters also require ongoing monitoring and addressing as it has been noted in the literature that treatment of complexly traumatized persons may involve intense, confounding, and confusing transference and counter-transference responses. Identified treatment traps include the tendency on the part of the therapist to become over-involved, or "rescuing" of the client (a.k.a. "savior role"), or the opposite of overly distancing, and even aggressing toward the client. In consequence, psychologists strive to maintain emotional equilibrium and model effective emotional regulation and communication skills for clients to emulate.

Vicarious trauma and secondary traumatic stress are important considerations in maintaining high quality professional practices, including the ability to empathize with and attune to clients on an ongoing and possibly long-term basis (McCann and Pearlman, 1990; Sprang et al., 2019). Since some of these clients exhibit challenging behaviors and modes of interaction with others, including therapists, and they may also have a variety of posttraumatic and dissociative symptoms as well as co-occurring conditions and life crises, the presenting problems of persons with complex trauma histories risk wearing down and exhausting the therapist. For this reason, psychologists are encouraged to monitor their own mental and physical health and well-being, engage in ongoing self-care and stress management, and seek professional education, supervision and consultation, and personal treatment as needed (Saakvitne, 2017). Concerns around EDI also pertain here, including when the psychologist may be the one in groups who are systemically oppressed, and may also be retraumatized by the client not through means of vicarious trauma but via interpersonally mediated oppressive acts.

In addition to the possible negative impact and transformation in the helper indicated by the vicarious trauma/secondary stress literature, **treatment is now understood to have transformational potential for both the individual and therapist** (Gartner, 2017; Hopper et al., 2020). Beneficial aspects of vicarious experiences with clients may include the therapist being better able to face and overcome their own personal and professional problems as they bear witness to their clients' perseverance and courage (Cohen & Collens, 2013). These responses may be considered as *posttraumatic resilience, vicarious posttraumatic growth* (Calhoun & Tedeschi, 2013), or *vicarious resilience* (Gartner, 2017; Hernandez-Wolfe, 2018). Experienced trauma therapists have been known to express a deep sense of purpose and satisfaction in both the challenge and value of helping clients with complex trauma histories recover (Cohen & Collens, 2013; Tedeschi and Moore, 2021).

Summary and Conclusion

Limitations exist to narrowly defining trauma as a physical event in terms of death,serious injury, or sexual violence, and in situations of an extremely threatening or horrific nature. These limitations relate to: (1) category heterogeneity (i.e., *not all types of traumatic events are the same*); (2) inattention to contextual factors (i.e., *not all traumatic events occur under the same circumstances*); (3) exclusion of psychological trauma from the definition (i.e., *not all traumatic events are physical in nature*); and (4) overemphasizing specific diagnoses that inadvertently lead to a failure to recognize trauma as a possible *transdiagnostic risk factor for virtually all presenting problems seen in general professional practice*. Further, whereas complex trauma may have been previously understood as a categorical distinction from other kinds of trauma, *the complexity of trauma histories may be better understood along a continuum,* from non-interpersonal, accidental (and thus ethically neutral) circumstances that occurred only once in life, to repeated, intentional, immoral transgressions that occurred within close relationships from an early age and throughout life, as well as across generations and whole cultures.

Psychologists may utilize the acronym *HISTORY* as a memory prompt for the current seven guidelines when providing interventions, care, and support to persons who have experienced transdiagnostic mental health problems in response to complex trauma histories. The guidelines regard: (1) *Humanistic*, (2) *Integrative*, (3) *Sequential*, (4) *Temporal*, (5) *Outcomes-focused*, and (6) *Relational* principles, while assisting clients' in understanding (7) *Why* the traumatic events occurred. Through application of these guidelines, psychologists aspire to support their clients in seeking resilience, recovery and growth following their experience of complex trauma.

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APPENDIX

Guidelines Development Processes and Procedures

The original impetus for the development of this PPG was to inform professional practice concerning the unique needs and characteristics of persons with complex trauma histories beyond posttraumatic symptoms and to include attention to both developmental impact and dissociative responses. Due to her experience in developing best practice standards and other guidelines for the treatment of complex trauma (Cloitre et al., 2011, 2012; Courtois & Ford, 2009), Dr. Courtois was approached independently by both Division 56 (Trauma Psychology) of the American Psychological Association and the International Society for the Study of Trauma and Dissociation (ISSTD) to develop a PPG to supplement available Clinical Practice Guidelines (CPGs) that address such concerns. The definition and purpose of these two different types of treatment guidelines are per the American Psychological Association (2015b). Here, "both types of guidelines rely on the scientific and professional literature to inform recommendations. However, CPGs are founded on systematic reviews of evidence focused on key clinical questions, while PPGs may rely on consensus and familiarity with the body of literature but are not necessarily developed on the basis of systematic reviews" (American Psychological Association, 2023). Further, while CPGs "provide specific recommendations about treatments for particular health conditions or diagnoses," PPGs "address psychological practice with particular populations… or in particular areas… without focusing on specific disorders or treatments," thus allowing for transdiagnostic approaches to be considered (American Psychological Association, 2024). Since both organizations have an interest in improving treatment for persons with complex trauma histories, the decision was made by the Executive Boards of each to join forces and to cooperatively develop this joint document.

To produce a set of recommended practices that represent the current state of the science and clinical practice, potential members of this guideline panel from both organizations were approached to participate based on their research, clinical expertise, authoritative writings on the topic. Experts were identified by the Chair (Courtois) and the former Chair of the Practice Committee of Division 56 (Dr. Bethany Brand), along with the President of the ISSTD at the time (Kathy Steele, MS). The resultant working group members conducted narrative reviews of the literature, with a preference for citations to systematic reviews and meta-analyses. Expert clinicians were also surveyed concerning professional practice with individuals who have endured the myriad clinical manifestations of complex trauma as they present in general practice Cloitre et al., 2011; ISTSS, 2012). Clinical consensus was derived from discussions among the panel of identified experts.

Over more than a decade of work, working group members volunteered their time and expertise and contributed to the drafting and several revisions of this document. By virtue of being identified experts in researching and treating persons with complex trauma histories, all working groups have an identified intellectual interest in the subject matter described in this PPG, and some have received research grant funding for studies including participants with complex trauma histories. Particularly over the last 5 years, Drs. Courtois and Frewen have been the primary authors of this finalized PPG. While 35 recommendations were initially produced by the larger working group, as incoming Chair of the Practice Committee of Division 56, Dr. Frewen took the lead on conducting thematic analyses of guideline comments and committee meeting minutes to collapse the number to reduce repetition and redundancy. Certain recommendations (e.g., those pertaining to psychopharmacology) were also ultimately considered beyond the scope of the final set of guidelines retained herein. Dr. Frewen also authored the acronym "HISTORY" as a mnemonic aid to facilitate guideline application in professional practice.

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

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