

THE TRAUMA BRIEF

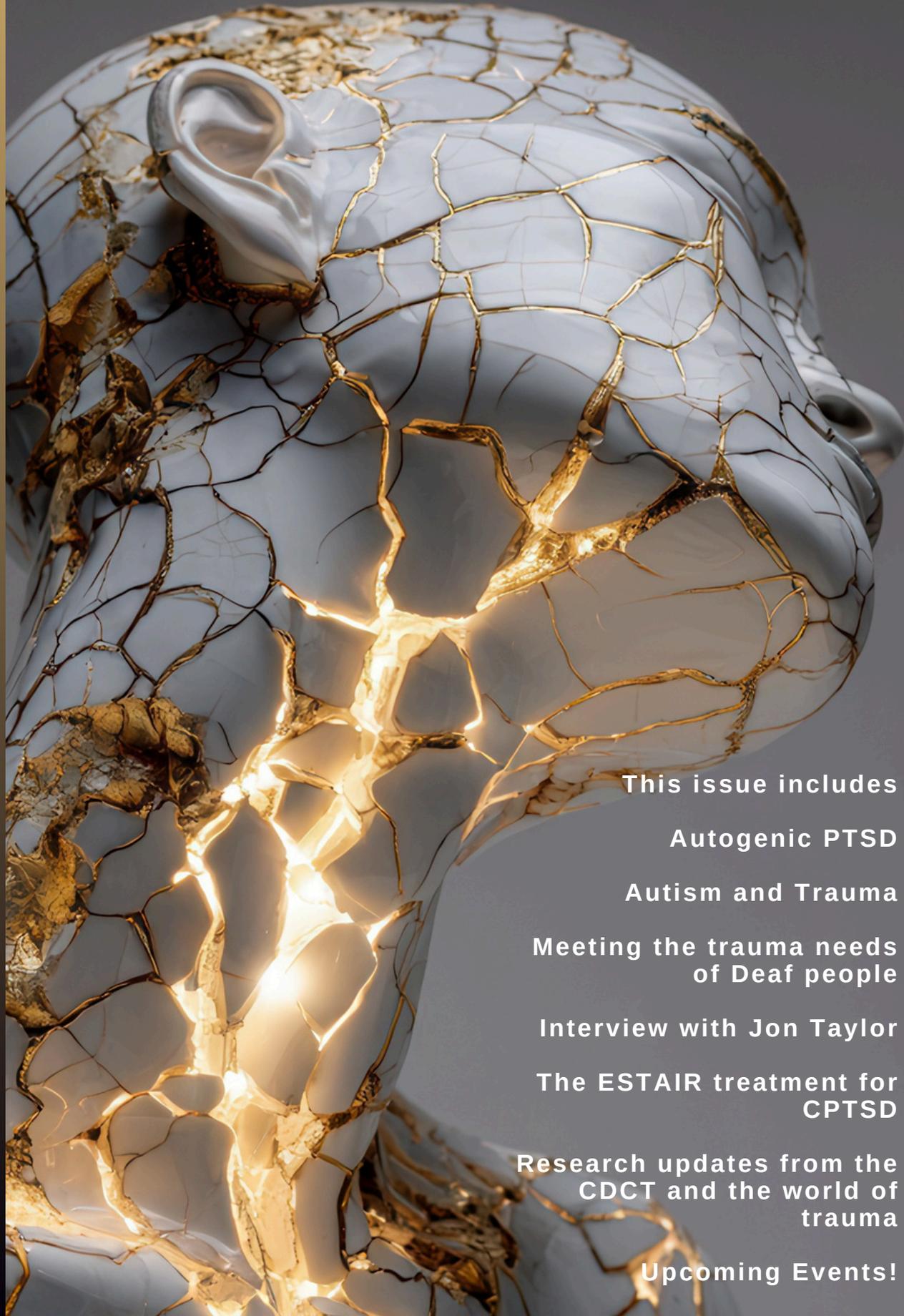
THE OFFICIAL NEWSLETTER FOR THE CENTRE FOR DEVELOPMENTAL AND COMPLEX TRAUMA

VOL 1 ISSUE 1
February 2026



Centre for Developmental
and Complex Trauma

Part of St Andrew's Healthcare



This issue includes

Autogenic PTSD

Autism and Trauma

Meeting the trauma needs
of Deaf people

Interview with Jon Taylor

The ESTAIR treatment for
CPTSD

Research updates from the
CDCT and the world of
trauma

Upcoming Events!

CONTENTS



| | |
|--|------------------------------|
| WELCOME | 2 |
| IN FOCUS: AUTOGENIC PTSD Research updates | 3-4 |
| INTERVIEW WITH PROF JON TAYLOR Turning trauma into danger | 5-6 |
| IN FOCUS: TRAUMA & AUTISM Research updates | 7-8 |
| INNOVATIONS IN MEETING THE TRAUMA NEEDS OF DEAF PEOPLE Research updates | 9-10 |
| INNOVATIONS IN TREATMENT The ESTAIR modular approach for complex PTSD | 11 |
| RESEARCH & CPD UPDATES IN TRAUMATOLOGY Recently published articles of interest from the CDCT and beyond in the field of Trauma | 12-22 12-15 |
| Special Interest Groups (SIGs) | 16 |
| Trauma resources of interest | 17-18 |
| Conferencing and CPD events | 19-22 |
| POSTGRADUATE COURSES IN PSYCHOLOGICAL TRAUMA Information about the courses offered by the CDCT and University of Buckingham, UK | 23-24 |
| ABOUT THE CDCT Our values and activities | 25 |

WELCOME



Dear friends,

A very warm welcome to the first edition of 'The Trauma Brief', the official Newsletter for the Centre for Developmental and Complex Trauma.

With a new year upon us, we have decided to integrate all of our Special Interest Group newsletters into one output. Our goal is to develop a publication that helps reduce the gap between research and practice by sharing the latest evidence and practice guidance, and to raise the profile of underserved populations to ensure that innovations in trauma reflect those most impacted.

In this edition, we talk to Prof Jon Taylor and gain his insights into the complex relationship between trauma and forensic risk, and the ethical challenges of how we currently formulate trauma in secure settings.

We take a closer look at the trauma needs of Autistic people and Deaf people, providing research and practice updates. We also bring a focus to autogenic sources of PTSD, highlighting this often missed, and misunderstood area of trauma need.

In our focus on the new ESTAIR treatment model, we explore the only currently empirically evaluated treatment developed specifically for CPTSD.

2026 is shaping up to be a pivotal year for the CDCT and we look forward to continuing to share with you innovations and opportunities for research collaborations in the field.

With special thanks to Ruby McBain, Senior Administrator, and Dr Elanor Webb, Research Associate, for their key roles in the development of this volume. Enjoy this first edition and we are open to ideas for future volumes!

A handwritten signature in blue ink, which appears to read 'Deborah Morris', enclosed within a hand-drawn oval.

Dr Deborah Morris,
Consultant Clinical Psychologist
Director, Centre for Developmental and Complex Trauma

In focus: Autogenic PTSD

What is Autogenic PTSD?

Autogenic PTSD describes the occurrence of post-traumatic stress symptoms arising from one's own actions. Other potentially pejorative terms used in the wider literature include 'perpetrator trauma', 'offence-related PTSD', and 'self-induced traumatism'. This can arise from one's own offending behaviour, self-harm or a suicide attempt.

What are the impacts of autogenic PTSD?

- Increased risk for harmful behaviours (e.g., attempted suicide, substance use)
- Increased risk for re-offending and violence
- Guilt, shame, isolation and withdrawal from social circles/support
- Impairment in various domains of functioning
- Additional psychological comorbidities



Up to 46.7% meet PTSD symptoms relating to a **suicide attempt** (Bill et al., 2012)



Up to **42.9%** meet PTSD symptoms relating to **self-harm with suicidal intent** (Westermair et al., 2020)



Up to **42.6%** meet full PTSD criteria relating to a **homicide** (Badenes-Ribera et al., 2020)

How can we better respond to the needs of people with autogenic PTSD?



1. Clinician education and awareness

A recent survey indicated that 61.7% of clinicians had no or limited awareness of the concept of PTSD arising from one's own actions (Morris et al., in submission). Integration of autogenic PTSD within pre- and post-qualification training programmes is critical to improve awareness.



2. Provision of supervision

Working with trauma symptoms arising from one's own behaviours can present several ethical challenges. Effective and accessible supervisory spaces that allow clinicians to discuss any conflicts that arise.



3. Increasing empathy and understanding

In consideration of the potential ambivalence towards autogenic PTSD and the moral and ethical dilemmas that may arise for clinicians, embedding training programmes that develop empathy may be beneficial for overcoming negative attitudes as a barrier to treatment and quality care.

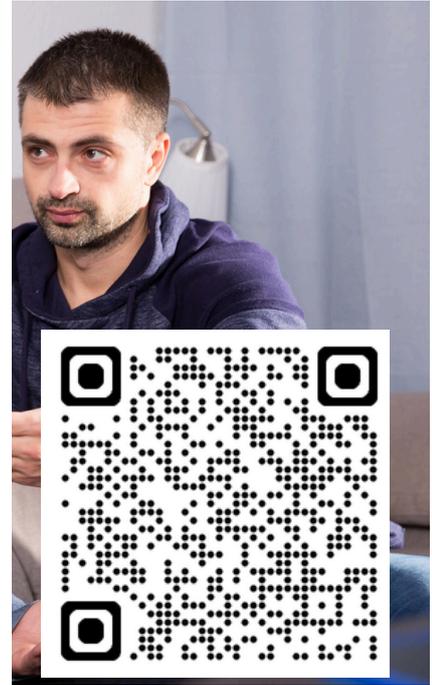


4. Developing professional clinical guidance

Evidence-based guidelines have an important role in driving the success of mental health treatments. In the absence of any current national guidance for working with autogenic PTSD, the development of such for clinicians working with such presentations is of priority.

In healing from Perpetrator trauma: The experiences of Juvenile Offenders incarcerated for Violent Offences in South Africa

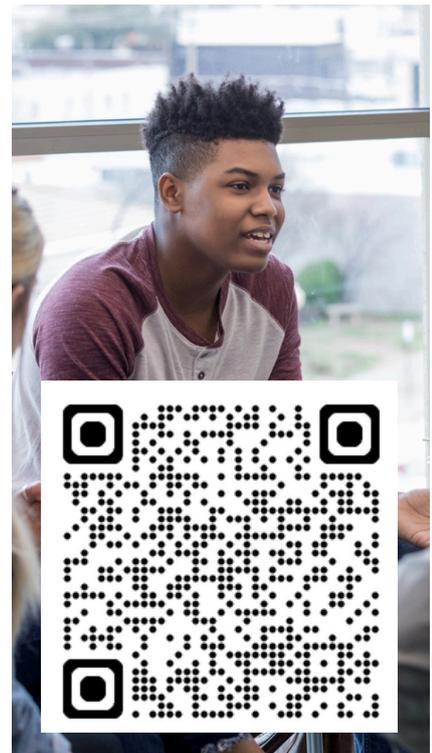
Since the late 1980s, research has highlighted the unique psychological, spiritual, moral, and interpersonal injuries experienced by perpetrators of violence. However, limited attention has been given to managing such trauma, particularly among offenders. This qualitative study explored protective experiences, activities, and behaviours used by juvenile offenders in two South African correctional centres to manage perpetrator trauma. Using semi-structured interviews with 10 participants, data were analysed through reflexive thematic analysis. Four themes emerged: forgiveness and acceptance, rehabilitative programmes and support services, coping mechanisms, and social support. These findings offer insights to inform clinical management and holistic rehabilitation in correctional settings.



Mahlako, G. M., Jordaan, J., & Cronjé, M. (2025). In Healing from Perpetrator Trauma: The Experiences of Juvenile Offenders Incarcerated for Violent Offenses in South Africa. *Journal of Forensic Psychology Research and Practice*, 1–25.

Exploring the Relationship Between Moral Injury and PTSD Symptoms in Suicide Attempt Survivors

Background: Research has suggested that some individuals report posttraumatic stress disorder (PTSD) symptoms following a suicide attempt (SA). However, there is debate as to whether one's own SA should be recognized as a criterion event for PTSD symptoms. Alternatively, trauma research has identified moral injury as a consequence of trauma that is related to PTSD and broader mental health issues. The present study had two primary aims: to broadly explore PTSD and perceptions of one's SA as a PMIE; and to expand our understanding of the relationship between PTSD and PMIEs among SA survivors. Methods: Participants (N = 152) reporting a lifetime SA were recruited from Amazon's Mechanical Turk to complete self-report measures of PTSD symptoms and PMIE specific to their SA, as well as self-report measures of shame, and guilt. Descriptive statistics and regressions were used to examine the study aims. Levels of PTSD symptoms and PMIE secondary to a SA were comparable with previous samples. Results: Perceptions of one's SA as a PMIE were statistically significantly associated with global PTSD symptoms, while PTSD intrusion symptoms were uniquely associated with perceptions of one's SA as a PMIE. Conclusions: The results from this study suggest that a SA is a potentially traumatic event that could lead to symptoms of PTSD and perceptions of one's SA as a PMIE.



Woller, S.J., Boffa, J.W. & Schmidt, N.B. Exploring the Relationship Between Moral Injury and PTSD Symptoms in Suicide Attempt Survivors. *Cogn Ther Res* 49, 1–11 (2025). <https://doi.org/10.1007/s10608-023-10356-x>

Interview with Jon Taylor



“Turning trauma into danger. Weaponizing harms into future risks”

As forensic and prison services focus on becoming more responsive to the trauma needs of those in secure care, the impact of trauma is increasingly being considered in all areas of practice. The role and impact of early adversity has long been considered in Structured Professional Judgement (SPJ) tools and ‘treating harm’ to prevent future harms is becoming increasingly entrenched in risk management.

We spoke to Jon Taylor, Consultant Forensic Psychologist & Psychotherapist, and an established and well respected SPJ trainer. Jon is widely published in forensic mental health, compassion focused approaches and therapeutic communities.

Jon, first of all tell us a bit about how this became an area of interest for you?

I have become increasingly interested in ways that trauma and adversity can influence our developmental trajectory, whether that is through the original ACEs work and more recent neurobiological perspectives. Adversity in its broadest sense can have a profound impact on all aspects of psychosocial development and our contact with services. I wanted to develop a sensitivity to people who have those experiences, I guess to locate trauma and adverse experiences somewhere in the context of their lives and how they came into contact with services.

I also spend a lot of time reviewing SPJs and see how common it is for professionals to talk about traumas that people have experienced. The way it is written down often feels callous, a list of bullet points summarising what has been done to somebody, without any type of narrative. The SPJ item is then ticked as relevant without any real analysis of ‘how did this experience become risky?’. I want to have an understanding of how this influence crept in. I have also spent a lot of time in parole boards and hearing members saying ‘this person needs to do trauma work’ without an understanding, and this is dangerous.

I too have also been culpable of simplifying this relationship. Historically we have come a long way from assuming that disclosures are Machiavellian, but we have a long way to go to develop a more nuanced understanding of the relationship between adversity and risk.

What are your main observations and concerns about the way we are characterising the relationship between trauma and risk?

The big concern is that we are falling into a trap of assuming that traumatic experiences inevitably creates criminogenic capacities in people. This is a shaming and damaging position to hold about people. We are applying population level data to individual people, without the evidence to do so. We are not trying to understand these links and we need to ‘hold people’ affected by them, to understand these experiences, rather than assign a criminogenic pathway.

We also ask people about these experiences, open wounds and then don't create opportunities to help them process these experiences in safe enough environments. I am also concerned that we are increasingly tying making progress in secure services with completing trauma work. We can't force people to do trauma work, yet, this is increasingly the picture. It's an abuse of power.

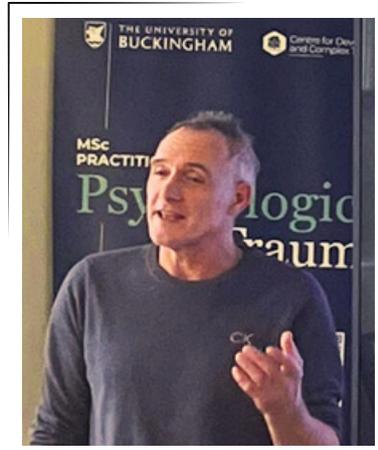
If we don't offer opportunities to undertake take this work safely, we are also negligent. This includes making sure we have the resources, skills, supervision and spaces to do this. We can force this on people. This is especially important if the person experiences guilt and shame about what happened to them. We need to be pragmatic that not everyone can do this and this may not be the right environment in which to undertake this work.

You talk about risk being turned into danger - can you tell us what this means?

In part that is about making people listen!

The risk of the SPJ process is that we assume that if you have experienced trauma or adversity, that we can punish people for having terrible things done to them. We tell them, “You are dangerous because of things done to you that you had no control over.” Lets not tell people you are dangerous because you were abused, this is an oversimplification and may not be related to criminogenic need.

Interview with Jon Taylor



Turning trauma into danger: Continued.....

Just because an experience is present, it doesn't mean that it is relevant. We need a much more holistic approach and understand why for some people they may translate into criminogenic factors.

What are the key ethical issues associated with this the current way we are approaching trauma and risk?

If we allow ourselves to get caught up in the assumption that trauma is always relevant to risk, we are at risk of abusing our power and retraumatizing people. I wonder what it is like to disclose these experiences, to develop the courage to disclose sexual abuse to services, and then to be told that I am now considered at risk of sexually abusing others. That is potentially a traumatising thing to hear.

To be clear, I am not saying there isn't a relationship between childhood adversities and mental health, or harms to others, but we need to think about what this specific persons experiences relate to their risk of harm. We need to formulate how it matures into risk, *for that person*. We can't assume an automatic relevant relationship and we need to think about the mediating role. If we don't understand the relevance we can't put in place the right supports.

We need to stop saying that because you have been abused that you will become an abuser. At the same time, we need to acknowledge that SPJ interviews can cause distress, and create and signpost to post-interview support.

What guidance would you suggest for we should approach characterising trauma needs in risk?

Personalise the impact of trauma to the person. In its essence, we think about how children will learn from their environments. How did this particular person respond to what was done, what did they learn, what strategies did they develop to survive and how did they get locked in to these preferred strategies. How did they manifest when no longer children? It is critical to understand how these experiences and defences shape the individual and any relevant criminogenic needs. It must be an individual formulation, no other way around it. HMPPS have also developed decent guidance on how long SPJ's should take

to complete - use that guidance to protect time and develop personalised reports.

What guidance would you give for newly qualified or psychologists in training to develop practice and navigate the challenges in this area?

We need to acknowledge this process is governed by resources, both in terms of people, training and support. So to develop your practice, all three are needed.

Developing skills to interview sensitively, are critical. SPJ's should include at least more than one interview. But we also can't just 'dive in' and ask questions about some of the worst experiences of someone's life and then not follow up. Being aware of how these interviews are experienced is really important to ensure we avoid opening wounds that we then don't provide support for. Narrative Exposure Therapy (NET) approaches for establishing lifelines can be useful to learn, as they avoid opening up hot memories and guide how we can sensitively frame questions.

As forensic psychology moves towards a more relational model, we need to be much more aware of our own relational style, how that is experienced by others. We also need to support forensic practitioners to be sensitive and responsive to their own distress as well as others suffering.

Are there any particular readings or resources you would recommend?

Anything by Lawrence Jones! he has a considerable and respected body of work in this area. Dr Julie Goldenson is done some really important work in Canada too. For a non academic text, consider, "The Compassionate Mind" by Prof Paul Gilbert. It gives a an accessible insight in to the architecture of the human brain, and neurobiological nuances that can lead to distress and make us vulnerable to developing harmful ways of being.

Jon Taylor



Julie Goldenson



Lawrence Jones



In focus: Trauma and Autism

What are the sources of trauma faced by autistic people?

Autistic people are at risk for experiencing a wide range of potentially traumatic events. This includes traumas typically recognised within core frameworks (e.g., childhood abuse and neglect), but also additional adversities pertinent to neurodiverse populations (e.g., sensory trauma, social marginalisation and bullying).

Is trauma symptomology pervasive in autistic populations?

Recent synthesis of data indicates that PTSD lifetime prevalence rates in autistic children and young people (5.74%) and autistic adults (2.72%) are comparable to general population estimates (Mansour et al., 2025).

However, there is much discrepancy in the data. Estimates may be under-inflated due to diagnostic overshadowing, whereby trauma symptoms are incorrectly ascribed as features of autism. Alternatively, higher prevalence rates reported may reflect sampling biases.

A recent meta-analysis (Webb et al., 2025) found that, approximately:



Almost half (49%) of autistic people experience emotional abuse



Over a third (39%) of autistic people experience physical abuse



Over a third (38%) of autistic people experience sexual abuse

*Prevalence rates for other traumas could not be calculated due to insufficient data

What are the key priorities for addressing in future research?

- Insight into the prevalence and impacts of adversities beyond childhood abuse and neglect, including those related to the experience of being autistic.
- Greater inclusion of male and gender diverse/gender minority autistic people in trauma research
- Development and validation of measures that assess exposure to, and symptoms of trauma, for autistic people

How can we better respond to the trauma needs of autistic people?

Drawing on the results of a Delphi study (Rumball et al., 2024) several recommendations are proposed:



Consider potentially traumatic experiences through a more inclusive lens, inclusive of both 'Criterion A' traumas and autistic experiences. Avoid solely relying on frameworks developed in neurotypical populations when carrying out a trauma history assessment.



Equally, avoid sole reliance on self-report tools to assess for PTSD symptoms. In the absence of validated PTSD measures for autistic people, a multi-method approach, including semi-structured interviews are needed.



Professional guidance and training for professionals and others' caring for autistic people is needed to improve recognition of potentially traumatic experiences and associated presentations of trauma-related distress in this population



Research updates: Trauma and Autistic people

Autism, Obesity, and PTSD Among Adolescents and Young Adults: An Analysis of National Medicaid Claims Data

Autistic individuals face higher rates of obesity, cardiovascular disease, diabetes, and PTSD compared to the general population and those with other developmental conditions, particularly during adolescence and young adulthood (ages 15-30). A study analyzed Medicaid claims data from autistic (n = 627,586) and non-autistic (n = 1,223,161) adolescents and young adults from 2008 to 2019. It found that autistic beneficiaries had over twice the odds of obesity and other health comorbidities. PTSD moderated this relationship, with a stronger association seen in those without PTSD. The study highlights the need for further research on stress and trauma's impact on health in autistic individuals.

Hotez, E., Tsevat, R. K., Tao, S., Phan, J. M., Smith, P., Shen, T., ... & Shea, L. (2025). Autism, Obesity, and PTSD Among Adolescents and Young Adults: An Analysis of National Medicaid Claims Data. *Journal of autism and developmental disorders*, 1-12.



Differential diagnosis of autism, attachment disorders, complex post-traumatic stress disorder and emotionally unstable personality disorder: A Delphi study

Individuals with autism, attachment disorders, emotionally unstable personality disorder (EUPD), or complex post-traumatic stress disorder (CPTSD) often exhibit overlapping features, complicating accurate diagnosis. This study examined professionals' views on differentiating these conditions in young people and adults through a Delphi study involving 106 international experts. Consensus was reached on 275 statements regarding assessment methods, diagnostic challenges, and improvements. Findings emphasize current diagnostic practices and highlight areas for future research and clinical implications.

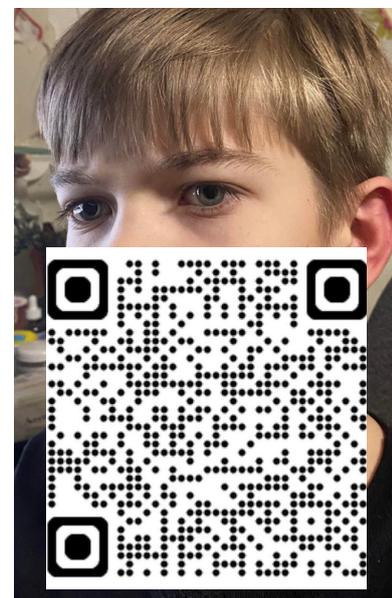
Sarr, R., Spain, D., Quinton, A. M., Happé, F., Brewin, C. R., Radcliffe, J., ... & Rumball, F. (2025). Differential diagnosis of autism, attachment disorders, complex post-traumatic stress disorder and emotionally unstable personality disorder: A Delphi study. *British Journal of Psychology*, 116(1), 1-33.



Autistic traits in childhood and post-traumatic stress disorder as young adults: a cohort study

The study investigates the link between childhood autistic traits and the risk of traumatic experiences, PTSD, and general psychopathology by age 18. Utilizing data from the Environmental Risk Longitudinal Twin Study, it analyzed 1,504 participants whose parents completed the Childhood Autism Spectrum Test. Results indicated that higher autistic traits were significantly associated with increased lifetime trauma exposure, PTSD diagnosis, general psychopathology, and NEET status. The associations with PTSD and general psychopathology remained significant after adjusting for confounding factors. Among trauma-exposed children, autistic traits correlated with PTSD and psychopathology, with the PTSD link persisting post-adjustment. The findings highlight the need for targeted PTSD assessments and treatments for children with high autistic traits, although further research is needed for diagnosed autistic children.

Quinton, A. M., Rumball, F., Ronald, A., Fisher, H. L., Arseneault, L., Happé, F., & Danese, A. (2025). Autistic traits in childhood and post-traumatic stress disorder as young adults: a cohort study. *Journal of Child Psychology and Psychiatry*.



Innovations in meeting the trauma needs of Deaf people

Meeting the trauma needs of Deaf people

Early exposure to trauma is pervasive amongst Deaf people. Data is limited, though the available evidence suggests poly-victimisation (exposure to multiple trauma events) is common, with 57% of a Deaf community sample reporting exposure to 4+ ACEs (Hall et al., 2023).

 Exposure to traumatic childhood event reported by 71% of Deaf outpatients (Øhre et al., 2015), and 92.3% of forensic inpatients (Webb et al., 2023).

 Average of 6 traumatic experiences reported in both outpatient (Øhre et al., 2015) and forensic inpatient deaf samples (Webb et al., 2023)

 Twofold increase in risk for emotional abuse and fourfold increase in risk for physical abuse in deaf and hard-of hearing children (Sullivan & Knutson, 2000)

Increasing recognition of Deaf specific adversities

Being Deaf, in particular, the unique experience of growing up deaf in a hearing-oriented environment, can lead to exposure to Deaf specific ACEs, can lead to a range of negative mental and physical health outcomes. To make sure that assessments of trauma exposure for Deaf people are inclusive of their life experiences, inclusion of the following experiences are recommended.

The CDCT, in collaboration with the Deaf Service at St Andrew's have a programme of studies that aim to improve trauma care with and for Deaf people. To find out more, email cdct@stah.org

 Language Deprivation

 Being punished for using sign language

 Information Deprivation

 Audism

 Attending Deaf Boarding School at an early aged (aged 2-4)

 Forced cochlear implants

 Social exclusion

 Being physically prevented from using sign language

Creating new signs in British Sign Languages

To support Deaf people to access psychological therapies for trauma, new BSL signs are needed.

The CDCT and the St Andrew's Healthcare Deaf services and leading Deaf Mental Health practitioners and linguistic experts in British Sign Language. This event was supported by Dr Alex Hamilton and Dr Sarah Powell, who co-chair our Specialist Interest group, focused on supporting the Trauma needs of Deaf people.



The first seven of a series of newly proposed BSL signs are currently being reviewed. Individuals with clinical or academic expertise in Deaf mental health are being invited to provide feedback on the signs, using the QR code below.



Research updates: Meeting the trauma needs of Deaf People

Meeting the trauma needs of deaf people: Practice guidance and priorities from an international Delphi study

The high incidence of posttraumatic stress disorder in deaf people, combined with insufficient evidence relating to the effectiveness of trauma treatments and the minimal presence of deaf people in policy innovations, highlights the urgency of addressing deaf-specific trauma needs. To meet the challenge of developing evidence-based practice guidance, the current study aimed to establish expert recommendations in key areas of clinical, research, and policy practice. Utilizing a Delphi methodology, experts completed three rounds of an e-survey to establish standards relating to the assessment and treatment of trauma needs, professional practice standards in working with deaf people, and identifying clinical, research, and policy priorities. Forty-one experts, of whom 43.9% were deaf, completed three rounds of the Delphi survey. Consensus was obtained on 98 recommendations relating to assessment and treatment guidance, with 17 recommendations relating to the qualification and support needs of professionals working with deaf people with trauma needs. Experts also identified 23 clinical, research, and policy priorities. Expert guidance endorsed deaf-centric and culturally competent clinical practice and qualification standards for working with trauma-exposed deaf populations. Developing deaf-centric clinical frameworks and including the needs of deaf people in treatment and policy innovations were key priorities to improve outcomes.



Morris, D., Webb, E. L., Baker, K., Wainwright, J., Chatha, K., Farthing, S., & Hamilton, A. (2025). Meeting the trauma needs of deaf people: Practice guidance and priorities from an international Delphi study. *Traumatology*. Advance online publication. <https://doi.org/10.1037/trm0000643>

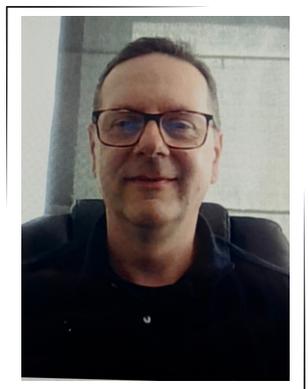
"At home, I never felt included, I always felt on the outside": Deaf peoples' perspectives on how inadequate access to childhood communication influences mental health outcomes

The prevalence of adverse mental health outcomes experienced by deaf adults - members of deaf communities connected through a shared sign language and culture is greater than that faced by their hearing counterparts. In addition to everyday life stressors, deaf people can experience further communication related stressors. For this group, early life communication and language deprivation is a significant contributing factor to subsequent adverse mental health outcomes. This study aimed to understand how deaf people viewed the impact of inadequate access to early life communication on their mental health across their life. One-on-one semi-structured interviews were undertaken with 16 deaf Australian adults who identified as having mental health challenges. Interviews were conducted in Auslan and inductively coded using thematic analysis. Participants attributed various forms of mental ill-health to interactions with people who could not sign, particularly within the family and school environments. Proximal stressors such as language dissonance, identity confusion, cross-cultural code-switching, and distrust were identified by participants. Distal stressors included three themes: bullying, exclusion, and marginalisation and ostracism. These stressors were perceived to be linked to experiences of mental ill health including periods of exhaustion, anger, anxiety, depression and suicidal ideation. The study highlights deaf Australians' perceived negative impacts from proximal and distal communication-related stressors during childhood on mental health outcomes. Addressing communication barriers in childhood through the implementation of interventions and support strategies may help to avoid adverse mental health outcomes for deaf adults.



McRae, R., Backholer, K., Adam, R., David, J., & O'Shea, A. (2025). "At home, I never felt included, I always felt on the outside": Deaf peoples' perspectives on how inadequate access to childhood communication influences mental health outcomes. *BMC Public Health*, 25, 2392.

Innovations in treatment: The ESTAIR modular approach for Complex PTSD



Prof. Thanos Karatzias
Edinburgh Napier University
Lead author for ESTAIR

Complex PTSD and treatment innovations

ICD-11 CPTSD is a relatively new diagnosis and there is a need for developing new interventions and test the effectiveness of existing ones for this debilitating condition.

What is ESTAIR?

ESTAIR is a modular, person-centred intervention for treating complex post-traumatic stress disorder (CPTSD). It focuses on skills building and trauma memory processing across four domains: affect regulation, interpersonal functioning, self-concept, and trauma-related memory processing. The treatment includes up to 25 sessions, starting with an initial formulation session and followed by four structured modules addressing core CPTSD symptoms.

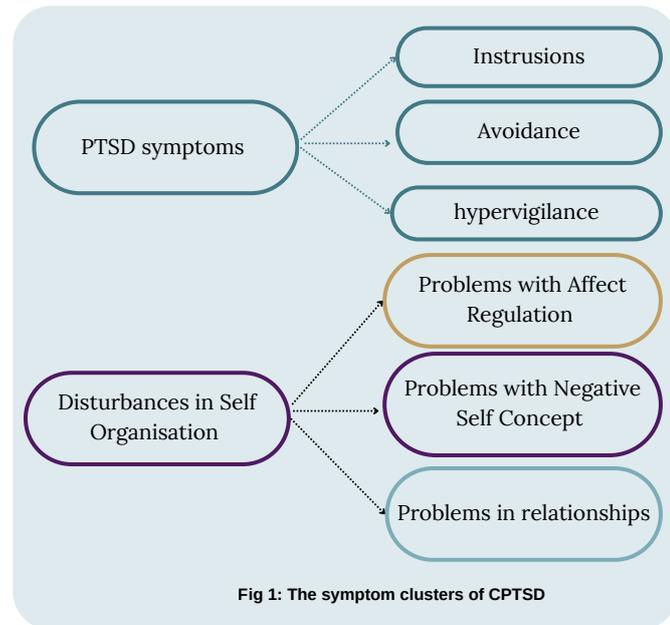


Fig 1: The symptom clusters of CPTSD

Affective dysregulation

- Identifying & labelling feelings,
- emotion management,
- distress tolerance,
- acceptance of feelings,
- and experiencing positive emotions.

Disturbances in relationships

- Exploring schemas;
- effective assertiveness;
- awareness of social context;
- Interpersonal flexibility.

Negative self concept

- Staying in the present moment (working with dissociation)
- Self-compassion & mindfulness skills
- Challenging thinking patterns and developing a balanced view of self.

PTSD Symptoms

- targets re-experiencing, avoidance, and hyperarousal symptoms.
- Emotional processing of trauma memories through verbal narration and cognitive reappraisal

Fig 2: The four modules of ESTAIR

“I feel better about myself...I'm more confident too,”

“I used to hate myself and think I was a bad person who deserved this life, I no longer feel that way”

“My ability to handle emotions is much better now. I trust myself much more.”

Feedback from Veterans who completed the intervention

Key outcomes from the RESTORE trial of ESTAIR

- A pilot randomized controlled study evaluating the feasibility, safety, acceptability, and preliminary efficacy of ESTAIR for ICD-11 complex PTSD (CPTSD).
- Fifty-six veterans with CPTSD were randomized to ESTAIR or treatment as usual (TAU).
- Results showed high retention, low and comparable dropout rates, and no serious adverse events.
- ESTAIR led to **significantly greater reductions in CPTSD severity** than TAU, with large effect sizes for both PTSD and disturbances in self-organization symptoms, and substantially higher remission rates at post-treatment.
- Remission of probable CPTSD diagnosis at post-treatment was substantially greater in ESTAIR compared to TAU with only 13.6% versus 84% ($p < 0.001$) retaining the diagnosis.
- These findings suggest that ESTAIR is a feasible, safe, and potentially effective intervention for CPTSD.



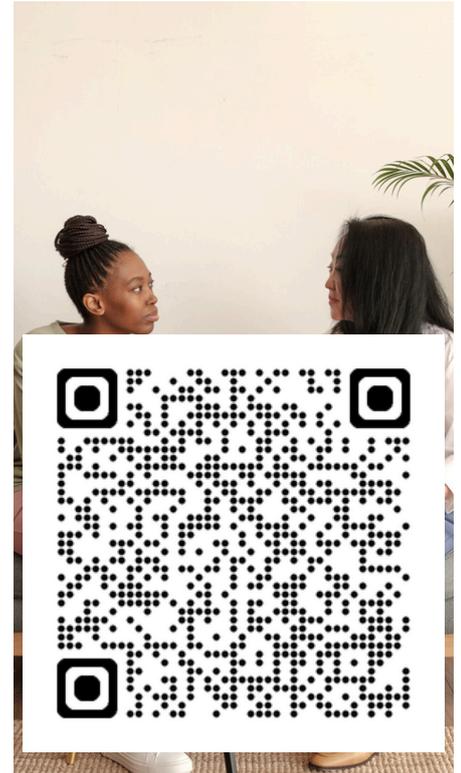
Research & CPD updates in traumatology



Personality disorder and trauma

Associations between Childhood Trauma and Epistemic Trust, Attachment, Mentalizing, and Symptoms of Borderline Personality Disorder

The construct of epistemic trust (ET) has gained wide acceptance and support in the field, although there is little empirical evidence to substantiate the theoretical assumed model. Studies of the assessment of ET were conducted in community samples only and the mediating role of attachment and mentalizing in addition to ET was not investigated. This study examines the theoretical assumed relationships between ET and attachment and mentalizing as well as the mediating role of attachment, mentalizing and ET in the association between childhood adversity and borderline personality disorder (BPD) in a heterogeneous sample containing also patients. Methods: The associations between ET and attachment, mentalizing, childhood mal treatment and BPD were explored in a sample of 245 participants, including subjects from the community as well as patients diagnosed with anxiety and personality disorders from two clinical samples. Multiple mediation analysis was performed to explore the mediating role of attachment (ECR-R), mentalizing (RFQ), and ET within the relationship between childhood trauma (CTQ-SF) and BPD (MSI-BPD). Results: Strong relationships between ET and attachment and mentalizing were found indicating that lower degrees of CET are associated with insecure attachment and lower reflective functioning. Attachment, mentalizing, and ET together accounted for 75% of the mediation between childhood adversity and BPD. Hypomentalizing and anxious attachment accounted for the largest share of the mediation. Conclusion: Our findings provide preliminary evidence for the theoretical supposed model of ET and suggest relevance of ET in the mediation between childhood adversity and PDs, although the role of ET seems smaller than assumed by recent theories.



Knapen SRY, Mensink W, Hoogendoorn AW, Swildens WE, Duits P, Hutsebaut J, Beekman ATF. Associations between Childhood Trauma and Epistemic Trust, Attachment, Mentalizing, and Symptoms of Borderline Personality Disorder. *Psychopathology*. 2025;58(3):187-198

Establishing the relationship between history of childhood trauma and personality disorder using the ICD-11 classification system

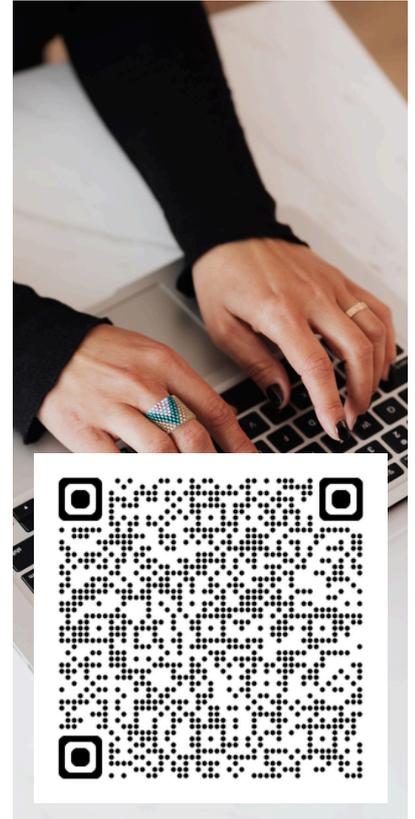
The temporal relationship between childhood trauma and personality status using the ICD-11 classification was examined in 75 adults (65%F) aged between 19 and 72 selected by constrained procedure to ensure the full range of personality disturbance. Trauma history was assessed using the Childhood Traumatic Events Scale, past and recent versions and personality status using scales to assess the severity and domains of the ICD-11 system, PDS-ICD-11 and PAQ-11. The PDS-ICD-11 findings showed 52 (59.3%) had some personality disturbance with 17 (22.7%) having moderate or severe personality disorder. There was a significant association between childhood sexual trauma and ICD-11 personality severity ($p = 0.005$) and a lessened association with recent trauma ($p = 0.02$). Apart from the borderline composite score, the PAQ-11 negative affectivity domain was significantly associated with childhood sexual trauma ($p = 0.003$), but other domains were not linked. The Anankastia domain was significantly associated with early major physical illness ($p = 0.012$), and physical illness both in early life ($p = 0.005$) and recent exposure ($p = 0.024$) were associated with personality disorder. Other forms of childhood abuse and illness or injury in childhood did not differ with regard to later personality disorder. The results confirm a significant but not overwhelming relationship between childhood sexual trauma and severity of ICD-11 personality disturbance in adult life that is greater than for other classes of trauma.



Lock, J., Yang, M., & Tyrer, P. (2025). Establishing the relationship between history of childhood trauma and personality disorder using the ICD-11 classification system. *Personality and Mental Health*, 19(1)

Moral injury and mental health outcomes in nurses: A systematic review

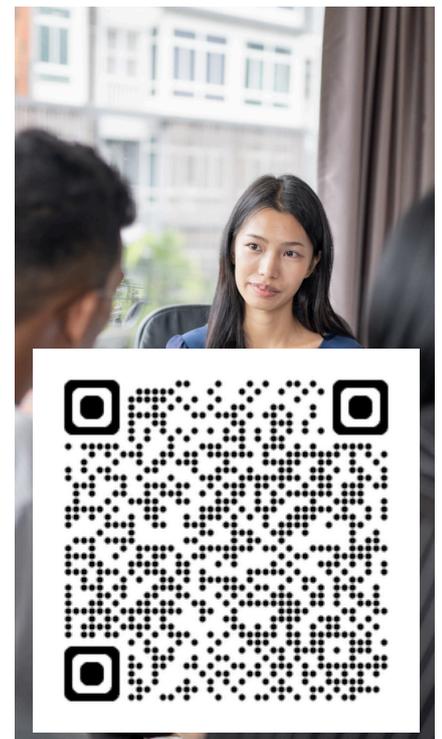
Moral injury involves the adverse psychological, biological, spiritual, behavioural, and social consequences of actions that violate moral values. It can lead to anxiety, depression, burnout, and post-traumatic stress disorder. Nurses, who often face ethical dilemmas, are particularly vulnerable. Despite its significance, the relationship between moral injury and mental health outcomes in nurses remains underexplored. This systematic review aimed to describe the associations among moral injury, anxiety, depression, and quality of life in nurses. The review was registered in PROSPERO (CRD42023438731) and was conducted following the PRISMA guidelines. A literature search was performed in December 2023 across PubMed, CINAHL, Scopus, and Web of Science. Peer-reviewed primary research involving nurses, published in English or Italian, without time restrictions, was considered eligible. The risk of bias and the quality of evidence were assessed using the Joanna Briggs Institute checklist and the GRADE approach. Out of 4730 articles identified, eight met the inclusion criteria. The analysis revealed significant positive associations between moral injury, anxiety, and depression, along with a significant negative association with quality of life. These findings highlight the need for healthcare systems to implement strategies that mitigate moral injury among nurses. Future research should prioritize longitudinal studies to explore causal relationships and develop targeted interventions. Additionally, standardizing the concept and measurements of moral injury is crucial for enhancing the comparability and understanding of this phenomenon.



Anastasi G, Gravante F, Barbato P, Bambi S, Stievano A, Latina R. Moral injury and mental health outcomes in nurses: A systematic review. *Nurs Ethics*. 2025 May;32(3):698-723.

'Dampening the flames turmoil' International perspectives on sources of moral harms and their implications for health policy and practice

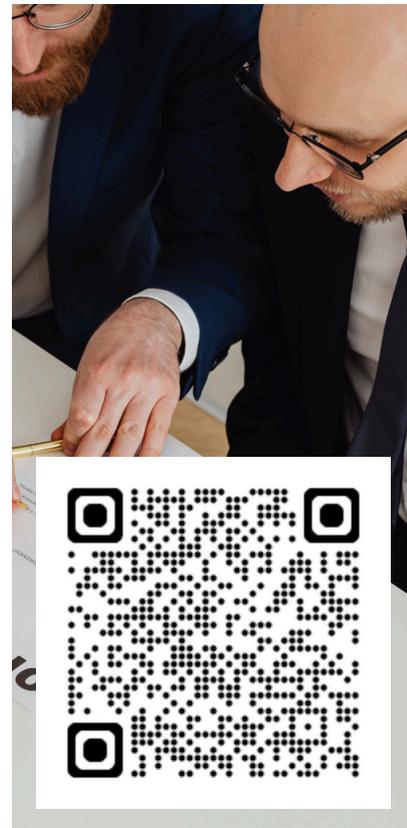
Public health is tasked with preventing harm, promoting health and ensuring equitable access to care. Yet, increasing sociopolitical and economic turmoil is creating barriers to public health delivering its core roles. Whilst moral dilemmas are inherent in public health polycrises and their resultant ongoing impacts has thrust consideration of the moral harms that may be experienced when we are prevented in the delivery of care into discourses about the future priorities of public health. Experiencing moral harms can result in profound impacts for the individual and the delivery and outcomes of care and are emerging as a public health concern. At a time when public health and healthcare are facing interconnected challenges in funding, workforce attrition, erosions in public trust and quality, it is critical we identify the pertinent drivers of moral harms. This commentary explores five different perspectives representing varied geographical locations and health infrastructures. Specifically, we explore the critical roles of economic status, social anthropological considerations, fiscal, organisational and individual factors to outline key drivers to formulate public health policy responses, going forward. Addressing the moral harms is a public health imperative and associated solutions have a critical role to play in dampening the flames of current turmoil.



Morris, D., Molendijk, T., Boyer, L., Bengo, J. M., Mtande, T. S., Bengo, E. M., Bow, S., Bäck, P. S., Murray, E., & Dean, W. (2025). 'Dampening the flames turmoil' international perspectives on sources of moral harms and their implications for health policy and practice. *Journal of Public Health*, 47(Supplement_1), i23-i33

Systematically analyzing behavior change techniques used in 44 interventions to reduce unprofessional behavior between healthcare staff

Behavioral and implementation science frameworks should be employed in the design of interventions to change behavior, to enhance their effectiveness, replicability, and transparency. However, this is often not done well in health services research. This deficiency also impacts interventions to address unprofessional behaviors (UBs) among healthcare staff. UBs include rudeness and bullying, which harm patient safety and staff wellbeing. This study builds on an earlier realist review of UB interventions to identify their active components. A systematic search was updated to July 2024 using MEDLINE, Embase, CINAHL, and Google Scholar. Intervention descriptions were extracted from study reports and independently coded against the May 2024 version of the behavior change technique (BCT) Ontology, which contained 284 BCTs. The search identified 262 titles and abstracts, yielding five new reports. Interventions were categorized as single-session (n = 15), multisession (n = 12), combined session (n = 6), professional accountability (n = 7), and structured culture change (n = 4). Complex interventions used more BCTs: session-based interventions focused on awareness-raising and roleplay, professional accountability on consequences, and structured culture change on goal-oriented techniques. Few interventions reported negative outcomes, limiting understanding of which BCTs drive effectiveness. Complex interventions employ consequence-based and goal-oriented BCTs, but effectiveness of specific BCTs remains unclear due to poor evaluation.



Aunger, J., Ungureanu, B., Maben, J., Abrams, R., Turner, A. M., & Westbrook, J. I. (2025). Systematically analyzing behavior change techniques used in 44 interventions to reduce unprofessional behavior between healthcare staff. *Translational Behavioral Medicine*, 15(1). <https://doi.org/10.1093/tbm/ibaf058>

Requirements for implementing a 'just culture' within healthcare organisations: an integrative review

To identify requirements for implementing a 'just culture' within healthcare organisations. Using Whittemore and Knaf's methodology for integrative reviews, we searched PubMed, PsychInfo, Cumulative Index of Nursing and Allied Health Literature, ScienceDirect, Cochrane Library and ProQuest Dissertations and Theses. Publications were considered eligible when reporting requirements for implementing a 'just culture' within healthcare organisations. After screening for inclusion and exclusion criteria, 16 publications were included in the final review. Four main themes were identified: leadership commitment, education and training, accountability and open communication. The themes identified in this integrative review provide some insight into the requirements for implementing a 'just culture' within healthcare organisations. To date, most of the published literature on 'just culture' is theoretical in nature. Additional efforts are needed to conduct research to explore further what requirements must be addressed in order to successfully implement a 'just culture' which is needed to promote and sustain a culture of safety.



Murray, J. S., Lee, J., Larson, S., Range, A., Scott, D., & Clifford, J. (2023). Requirements for implementing a 'just culture' within healthcare organisations: An integrative review. *BMJ Open Quality*, 12(2). <https://doi.org/10.1136/bmjoq-2022-002237>



Special Interest Groups

The Centre for Developmental and Complex Trauma aims to bring healthcare professionals, academics and those with lived experience who are involved in the development or delivery of care and trauma treatment of people with trauma needs. Our SIG groups are FREE to join and attend,

The objectives of these forums are:

- Learning and sharing: to share best practice, explore the latest research, and discuss challenges to meeting the needs of service users and staff groups.
- Networking and collaborating: using the meeting to build up our networks and work together with clinical and research collaborations.

Respecting each other: As a forum supporting people of different backgrounds, perspectives and experiences, and encourage sharing in a safe environment based on mutual respect and trust.

DEAF TRAUMA NEEDS SIG MEETING...



Tuesday 14th April 2026



**1:15 PM - 3:00 PM (GMT)
Online via Microsoft TEAMS**



TRAUMA AND AUTISM SIG MEETING...



Tuesday 15th September 2026



**1:15 PM - 3:00 PM (GMT)
Online via Microsoft TEAMS**



MORAL INJURY & CLINICAL ETHICS SIG MEETING...



Tuesday 29th September 2026



**1:15 PM - 3:00 PM (GMT)
Online via Microsoft TEAMS**



Access to discounted ticket prices for CDCT conferencing events



Invitations to attend bi-annual SIG meetings.

- Hosted presentations on practice and research advancements and debates within the field
- Discussion of opportunities for research collaborations and partnerships
- Opportunity to network with others in the field

Register here!



To join the SIG, simply scan the QR code or head over to:
<https://forms.office.com/e/sL9u0u5C1v>

Edited by Phil Willmot, Lawrence Jones,
Geraldine Akerman and Adam Mahoney



Trauma-Informed Forensic Interventions

Trauma-Informed Forensic Interventions

Edited By Phil Willmot, Lawrence Jones, Geraldine Akerman, Adam Mahoney

Trauma-Informed Forensic Interventions explores the innovative wave of trauma-informed practices in forensic settings, addressing the unique challenges of implementation in environments that are often ill-suited to such approaches. Written collaboratively by forensic practitioners and service users across prison, forensic mental health, youth justice, and social care settings, this book provides practical guidance for professionals working with justice-involved individuals who commonly have extensive trauma histories.



Feb 2026: 478pp 12 B/W illustrations
Pb: 978-1-032-97884-0 ~~£51.99~~ £41.59
Hb: 978-1-032-94041-0 ~~£155.00~~ £124.00

For more information visit:
www.routledge.com/9781032940410

TABLE OF CONTENTS:

Table of Contents Introduction. 1. The Challenges of Trauma-Informed Forensic Interventions. 2. Trauma-Informed Forensic Mental Health Assessment: Contextual Perspectives. 3. Dying to Survive: Insights from EMDR Trauma Treatment with Men in High Security Hospital. 4. Echoes of the Past - A Trauma Informed Approach to working with Psychosis & Risk in a High Secure Hospital. 5. Trauma-Focused Interventions in a High Secure Offending Personality Disordered Service. 6. Lived Experience Views of "Trauma-Informed Interventions" for People who are on Probation. 7. Trauma-Related Altered States of Consciousness and Offending: Assessment and Intervention. 8. Clinical Approaches to Autogenic PTSD. 9. Reflections on the Implementation of Psychologically and Trauma Informed Practice with People Experiencing Homelessness. 10. A Trauma-Sensitive and Trauma-Informed Treatment Intervention Addressing Problematic Substance Use for Forensic Patients. 11. A Multimodal Approach to Shame-Based Trauma. 12. Trauma-Informed Accredited Programmes in His Majesty's Prison & Probation Service. 13. Can Trauma-Informed Practice be Achieved in Mainstream Male Prison Settings? 14. Trauma Treatment with Young People in Secure Care. 15. Working with Women in Prison who have Histories of Interpersonal Trauma: Lessons from two Compassion-Focused Interventions, Ultimate Self and CRANE. 16. Working with Mothers who Commit Filicide: A Trauma-Informed Neonaticide Case Study. 17. Understanding and managing harmful sexual interests through the lens of traumatic sexuality, loss of intimacy and acceptance of solitude. 18. Holistic Mind-Body Therapies in the Treatment of Trauma in Forensic Settings. 19. Building the Strengths of Justice-Involved People: A Dual-Continua Model of Trauma-Informed Interventions. 20. Nature Based Initiative in Forensic Settings: A Salutogenic and Holistic Approach to Rehabilitation and Wellbeing. 21. Trauma-informed physical healthcare for women in secure inpatient services. 22. Integrating the Art and Science of Trauma-Informed Care: Balancing Processes with Relationships. 23. Working with Traumatized Teams. Conclusions. 24. Future Directions in Trauma-Informed Forensic Interventions.

 **Routledge**
Taylor & Francis Group

Scan the QR code to order your book
or visit: www.routledge.com/9781032940410



* Please note that this discount code cannot be used in conjunction with any other offer or discount and only applies to books purchased directly via www.routledge.com. This code expires on 30th June 2026.



3rd International meeting trauma needs in secure settings

Online Conference, 24th March 2026, 09:15 - 17:00 GMT

Symposia 1

Staff and organisational trauma needs

PTSD and CPTSD in prison staff
Organisational contexts of Trauma informed Care in secure services
Moral Injury: Prevention and management responses

Symposia 2

Risk assessment and management

Trauma responsive approaches to risk formulation
Using Compassion Focused reflective
Practice groups to reduce restrictive practices
Optimising TIC in secure settings

Symposia 3

Meeting the trauma needs of women in secure care

Gender responsive assessment approaches
Gender responsive treatment approaches



Dr Elanor Henry-Webb
CDCT, University of Buckingham, England



Dr Katie Dhingra
Leeds Beckett University, England



Dr Clare Crole-Rees
University College of London, England



Dr Abdullah Mia
The Pebble Practice, Birmingham and Solihull Mental Health NHS Foundation Trust, England



Dr Daniel Lawrence
Cardiff Metropolitan University, Wales



Keynote
Professor Vivienne de Vogel
Hogeschool Utrecht, Netherlands



Dr Adam Mahoney
Edinburgh Napier University, Scotland



Prof Jon Taylor
CDCT, University of Buckingham, England

Ticket & Booking information

| | |
|--|--------|
| Standard Delegate | £45.00 |
| St Andrew's Employees, BPS, CDCT members | £30.00 |
| Student and Poster Presenter Rate | £25.00 |

Scan to book your place!



Discounted group booking rates available on request cdct@stah.org

FREE TRAUMA RESOURCES

International Trauma Consortium Home Page (ITC)



The International Trauma Consortium (ITC) is a collaboration of researchers and clinicians working in the field of traumatic stress studies. Our goal is to advance the science and practice of psychotraumatology to improve the lives of people affected by trauma.

International Trauma Exposure Measure (ITEM)



Scan the QR to go the webpage, alternative versions of the ITEM are available in:

- Arabic
- Estonian
- French
- Danish
- German
- Greek
- Italian
- Polish
- Portuguese
- Romanian
- Spanish
- Turkish
- Ukrainian

International Trauma Questionnaire (ITQ)



Scan the QR to go the webpage, alternative versions of the ITQ are available in:

- English - IDs
- Albanian
- Albanian - IDs
- Arabic
- Arabic - IDs
- Albanian
- Bosnian
- Chinese (Traditional)
- Chinese (Simplified)
- Czech
- Danish
- Dari
- Dutch
- Estonian
- Farsi
- Finnish
- French
- French (Quebecois)
- German
- German
- Georgian
- Greek
- Hebrew
- Italian
- Japanese
- Korean
- Lithuanian
- Norwegian
- Polish
- Portuguese
- Romanian
- Russian
- Serbian
- Spanish
- Swedish
- Thailand
- Turkish
- Ukrainian
- Welsh

International Prolonged Grief Disorder Scale (IPGDS)



Scan the QR to go the webpage, alternative versions of the ITEM are available in:

- Arabic
- French
- Danish
- German
- Greek
- Japanese
- Mandarin
- Portuguese
- Polish
- Spanish
- Turkish
- Ukrainian

DEVELOPING EXPERTISE IN CARRYING OUT DELPHI STUDIES THAT BRING ABOUT CHANGE

TUESDAY 10TH
MARCH 2026

9:30 AM - 4:30 PM

ONLINE

Delphi studies are a valuable group decision-making research method. They are especially useful for exploring topics and developing expert guidance for working with marginalised or underserved populations, for whom there is often little evidence to draw on from the literature.

Delphi studies can be used to develop policy and practice guidance through integrating existing evidence with expert opinion. This workshop is designed for beginners, and those with some working knowledge. The course will cover:

- Introduction to the purpose and processes of the Delphi method
- Designing and conducting impactful Delphi studies
- Structuring and writing up a Delphi study for publication and wider disseminations

To learn more about workshops scan the QR code



Delegate feedback from previous Delphi workshops

"Really enjoyed the workshop, I feel much more skilled. I also feel motivated to start a Delphi!"

"The workshops are always great fun. Well planned and presented, and great atmosphere!"

"Clear delivery, and well-structured course. I found it really helpful to complete our own planning sheet during the workshop, as it helped to put the information we were learning into practice"

The trainers



Dr Deborah Morris

Deborah is a consultant clinical psychologist who has published over 100 journal papers, book chapters and conference presentations.

She has published several Delphi studies focused on

- Developing clinical and practice guidance
- Establishing research, clinical and policy priorities

Deborah is also the course director for the MSc Practitioner in Psychological trauma and leads the research programme for the CDCT



Dr Elanor Henry-Webb

Elanor is a research associate and lecturer at CDCT. Her publications to date have spanned a range of topics relating to trauma, including the prevalence and impacts of early adversity in marginalised secure mental healthcare populations, and comorbidity in trauma and personality disorder presentations.

She has developed, led and published a number of Delphi studies, with different populations. Elanor is also the co module lead for the MSc research module.



Dr Grace Trundle

Grace is a Principal Psychologist and Lecturer at the CDCT and in the NHS.

Grace teaches on the research and clinical modules of the MSc Practitioner in psychological trauma and is also involved in a number of projects exploring autism diagnosis, trauma, and the evaluation of forensic services. Grace is the lead author on a recently published Delphi study exploring Autism and Women and clinical guidance.

Day 1 Conference Programme



Complex PTSD Overview
Prof. Marylene Cloitre
New York University, USA



How CPTSD develops
(theory)
Prof. Phil Hyland
Maynooth University,
Ireland



Assessing CPTSD using
the International Trauma
Questionnaire
Prof. Mark Shevlin
Ulster University, UK



Assessing CPTSD using
the International Trauma
Interview
Prof. Neil Roberts
Cardiff University, UK



Treating CPTSD using
ESTAIR
Prof. Thanos Karatzias
Edinburgh Napier
University, UK



Treating people with
Psychosis and CPTSD
Prof. Filippo Varese
Manchester University,
UK



Emerging ethical issues
in CPTSD
Dr Deborah Morris,
Centre for Developmental
and Complex Trauma

2nd International Complex PTSD (CPTSD) Conference: Advances in Understanding, Assessment and Treatment

2-Day Conference and Workshops 19th & 20th March 2026

We invite you to join an exciting two-day conference and masterclass skills workshop event, led by international expert in Complex PTSD (CPTSD), Professor Thanos Karatzias of Edinburgh Napier University.

- **Day 1:** Court House Hotel, Shoreditch: Deepening our understanding of CPTSD with a focus on practical applications for clinicians working with adults with repeated traumatic experiences (such as childhood abuse and neglect, domestic violence, sex trafficking, slavery, torture or war).
- **Day 2:** BPS Offices, Tabernacle Street: Skills masterclass workshops for clinicians with experience of treating CPTSD to deepen clinical judgement in the assessment of CPTSD and the management of affective and interpersonal instability in complex presentations. Choose between workshop I) How to use the ICD-11 International Trauma Interview (ITI) when assessing CPTSD or workshop II) treating CPTSD using the Enhanced Skills Training in Affect and Interpersonal Regulation (ESTAIR) programme; a trauma-focused intervention combining skills and memory processing.

Delegates can attend one or both days, with limited places in masterclass workshops to ensure quality teaching. Certificates of attendance for the conference and workshops are provided.



To book a place scan
here:



19 March: Courthouse
Hotel Shoreditch, 335-
337 Old Street, London,
EC1V 9LL

bps.enquiries@planit-live.com



TRAUMA SENSITIVE RISK ASSESSMENT AND FORMULATION WORKSHOP

5TH 6TH OCT | 9:30 AM | Foster Postragrudate | £300
19TH-20TH OCT | 4:30 PM | Centre, Northampton | (all 4 days)

Trauma exposure and responses are key considerations impacting individuals in the Criminal Justice System, especially in the management of risk. Trauma related factors can inform contextualising an responding to psychological sequelae, as well as internalising and externalising (risk) behaviours. Trauma sensitive approaches can help ensure an accurate formulation of psychological, social and criminogenic needs to optimise treatment pathways.

This in person course blends the latest evidence with extensive clinical experience to provide attendees with critical skills needed in this area of practice.

By completing this training, you will gain knowledge and skills to:

- Integrate the latest evidence into clinical practice
- Deliver safer, more effective, and compassionate risk assessment clinical practice and service pathways
- Improve engagement and reduce the risk of re-traumatizing service users during assessment and formulation activities
- Evaluate the impact of trauma-responsive risk assessments in your organization

For enquires and to book your place at this event, please contact cdct@stah.org

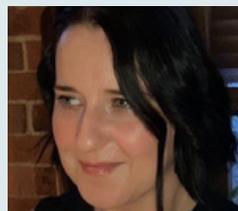
The trainers



Professor Jon Taylor

Jon is a forensic psychologist and psychotherapist with nearly 30 years of experience in prisons and secure hospitals. He emphasizes the impact of trauma on offending behaviour and promotes a compassionate approach to forensic services.

As a leading Compassion Focused Therapist and cofounder of the CFT forensic group, he has published extensively on risk assessment and trauma while also providing international training on this topic



Dr Deborah Morris

Deborah is a Clinical Psychologist with over 15 years of experience in secure services, including women's, intellectual disability, autism, and male prison settings. She works clinically in a prison, providing trauma therapy.

As an experienced SPJ tools trainer and practitioner, Deborah has published on risk assessments, focusing on co-production, the effects of trauma on validity, and SPJ assessments across different populations.

Course outline

Day 1

Trauma and adversity: Their impact on global development

- Psychopathology
- Moral development
- levels of consciousness
- Trauma defence responses
- Betrayal trauma

Day 2: Assessment and Formulation (part I)

- Assessment processes
- Therapeutic relationships
- Developing trauma sensitive life story narratives
- Harming others as an autogenic source of trauma
- Self and social identity

Day 3

Reconceptualization of criminogenic need

- Functional and analytic aspects of risk
- Trauma responses and criminogenic need
- Applied meanings (self & Others)
- -Formulation (part II)
- Protective factors

Day 4: Integrating trauma factors into SPJs

- Trauma and (mis) inflated risk
- Co-producing risk assessments
- Scenario planning
- Offense paralleling behaviour
- Integrating treatment planning
- Evaluating the impact of this approach in your organisation



MSc Practitioner in Psychological Trauma

-Faculty of Medicine and Health Sciences-

Now open for applications for September 2026

The MSc is now open to accepting applications into its 4th Cohort. An innovative course designed to equip clinicians with the clinical, leadership and research skills to deliver high quality care to those impacted by psychological trauma

The structure and content of the MSc follows the level three 'trauma expert' competencies outlined by the BPS. Face to face teaching is delivered at the dedicated Foster Postgraduate Centre at the Centre of Developmental and Complex Trauma, St Andrew's Healthcare, Northampton.

- ✓ In person teaching
- ✓ Part-time (taught 1 day a week), 2 years
- ✓ Elevate your knowledge of the specialist care required around trauma, with access to quality teaching and state-of-the-art facilities.
- ✉ Course Director: deborah.morris@buckingham.ac.uk

Course Structure

The course, taught over six modules covers:

- M1:** Theoretical models informing practice
- M2:** Idiosyncratic assessment and formulation of the whole person impact of trauma and associated needs
- M3:** Idiosyncratic treatment approaches for trauma needs
- M4:** Working with underserved populations
- M5:** Developing trauma informed organisational frameworks, including the assessment of and development of leadership skills.
- M6:** Research and service development skills including the completion of a dissertation.

Transferable skills

- **Clinical Skills:** Advanced skills in designing, implementing and evaluating trauma focused psychological interventions, including training to practitioner level for one psychological therapy
- **Research and Design:** The ability to design, develop, implement and evaluate trauma focused interventions, service frameworks, and complete applied research, to ensure an ongoing culture of service improvement
- **Leadership:** Developing leadership skills through a trauma-informed lens, guiding trauma-informed service development.

Anonymous student feedback

"I have found the course as very though provoking. There have been many aspects I have been using in my clinical practice, and I have noticed a clearer understanding of why certain tasks need to be carried out."

"I appreciate the additional mechanisms for support, which have been invaluable. Lunchtime sessions, tutor meetings, the approachability of the team has been greatly appreciated."

"The support and guidance is amazing"... "Lectures are well prepared and the slide are fab"

"I have really enjoyed all of the lectures"

"I found critiquing/analysing diagnoses very useful, which provokes thinking with an open mind in regards to labelling.

What students have told us about their experiences of the course....

EXCELLENT

- I can access support from the course team when needed
- Materials influence and improve clinical practice
- Interesting content
- Interactive sessions
- safe to ask questions
- Increased understanding of subject matter and practice
- The materials covered a wide range of clinical groups & populations
- I feel able to ask questions I want

Our **External Examiner** assessment of the course reported a rating of Strongly Agree in all areas:

- The teaching of the programme had a positive effect on the standard achieved by students.
- There are strengths, distinctive and/or innovative features in relation to the standards and assessments.
- The processes of assessment and the determination of awards were sound and fairly conducted.

To learn more
about the MSc
scan the QR code



“Elevate your practice and become equipped to provide psychological services to those who require specialised trauma care.”

Applications open for September 2026 intake

This part time (1-year), distance learning course equips students with the theoretical frameworks and clinical skills to develop, deliver and evaluate interventions, services and organisational frameworks that mitigate the impact of complex psychological trauma and reduce the likelihood of re-traumatisation.

Course modules

Module 1: Key concepts and theories in complex psychological trauma

Module 2: Idiosyncratic assessment and formulation of complex trauma needs

Module 3: Idiosyncratic holistic treatment approaches

Module 4: Working with ‘hard-to-reach’ and specialist populations: Practice guidance and professional practice issues

Career skills developed upon completion of the PgDip:

- A strong theory-driven knowledge base to support clinical, research and service development activities.
- Theoretical and applied skills equivalent to Level 3 ‘trauma expert’ competences outlined by the British Psychological Society.
- Knowledge of how to implement, evaluate, and reflect on specialist trauma assessments and interventions in different settings.
- Skills to work within an ethical framework to promote the wellbeing of service users and practitioners.

✓ Distance learning online course

✓ Part-time (taught 1 day a week), 1 year

Developed to support professionals working clinically with adults impacted by prolonged or

✓ significant exposure to trauma & adversity

POSTGRADUATE
DIPLOMA

Practitioner in Complex Trauma

NEW

Learn more and
apply here



For further information head over to the course website via the QR code or the link below, or contact Dr Deborah Morris (deborah.morris@buckingham.ac.uk), course director, for an informal discussion:

<https://www.buckingham.ac.uk/courses/postgraduate/postgraduate-diploma-practitioner-in-complex-trauma/>



About us

The Centre for Developmental and Complex Trauma (CDCT) was established in 2020 and is based in Northampton, apart of St Andrew's Healthcare. The core aim of the CDCT is to drive better outcomes for people who have experienced repeated incidents of trauma across the lifespan.

Our values

Our values integrate contemporary frameworks of working with trauma; combined with a high level of academic rigour to deliver research, further education and CPD activities that are theoretically underpinned and focused on developing data-driven approaches to understanding trauma and delivering personalised care.

Central to our values are the role of co-production and empowerment. The CDCT operates a highly collaborative working model, prioritizing developing relationships with stakeholder groups to ensure that our work is co-produced, relevant, impactful and translatable to clinical services.

Our CPD events, research and service development activities are conducted through an intersectional lens, with the differential impact of gender, neurodiversity and ethnicity playing a central role in the design and reporting of our activities.

The CDCT's portfolio of current activities

To achieve our goals, the CDCT delivers a growing portfolio of activities and services that seek to advance knowledge, skills and clinical practice.



For further information about the CDCT, Please head over to our website at www.stah.org/cdct/ or via the QR code here:



You can also get in touch at CDCT@stah.org



Centre for Developmental and Complex Trauma

Part of St Andrew's Healthcare

The Foster Postgraduate Centre, Main Building
St Andrew's Healthcare
Billing Road
Northampton
NN1 5DG



CDCT@stah.org



[@CDCT_Updates](#)



www.stah.org/cdct/