UNDERSTANDING CPTSD

A Psychoeducation Workbook Written for Survivors

The Transcend Stigma Project

Not a diagnosis. Not a verdict. A map.

A Note Before You Begin

This workbook is written to you, not about you.

If you're here, you've probably already spent a lot of time being described. By systems, by clinicians, by people who looked at your behavior and assigned it a story before they knew yours. That experience alone of being named without being known is part of what complex trauma does.

So let's start with what this is not. This is not a checklist to see how broken you are. It is not a manual for fixing yourself. It is not clinical language designed to make you feel like a case.

What it is: a framework for understanding why you are the way you are. A set of words for things you may have been living with for years without any language for them. A map imperfect, incomplete, but orienting.

Complex PTSD is a diagnosis that finally names something many survivors have known in their bodies their whole lives: that prolonged, repeated, inescapable trauma does something different than a single catastrophic event. It gets into the architecture of who you are. It shapes how you see yourself, how you move through relationships, how safe the world feels in your nervous system.

That is not a character flaw. It is not a weakness. It is what happens when human beings survive things that human beings shouldn't have to survive often without the support, safety, or acknowledgment they needed.

> **How to use this workbook**
>
> Read it at your own pace. Skip sections that feel too activating and come back. Use the reflection prompts if they're helpful or ignore them if they're not. Bring it to a therapy session if you have one. Share it with someone who loves you if you want them to understand.
>
> **You are in charge of this.**

> **A word on safety**
>
> Reading about trauma symptoms can sometimes activate them. If you find yourself flooded, dissociating, or in distress, please pause. Put the workbook down. Do something grounding. Reach out to a clinician, a warmline, or a safe person. This material will still be here when you're ready.

Section 1: What Is CPTSD?

And Why Having a Name Matters

Complex Post-Traumatic Stress Disorder,CPTSD is a diagnosis that first appeared in the ICD-11, the World Health Organization's International Classification of Diseases, in 2018. It describes the impact of prolonged, repeated trauma that is difficult or impossible to escape, often beginning in childhood or occurring in contexts of captivity, coercion, or profound powerlessness.

The word 'complex' refers to the complexity of the trauma itself, not the person. It names something specific: trauma that doesn't happen once and then stops. Trauma that keeps going. Trauma that happens in relationships that are also supposed to provide safety. Trauma that happens at the hands of institutions, systems, caregivers, partners, communities.

What kinds of experiences lead to CPTSD?

CPTSD can develop from many kinds of chronic, inescapable trauma, including:

- Childhood abuse (physical, emotional, sexual) or neglect, especially when the perpetrator was a caregiver
- Domestic violence or intimate partner abuse
- Human trafficking, forced labor, or captivity
- Prolonged community violence, gang involvement, or war
- Chronic medical trauma, especially in childhood
- Systemic and racial trauma ongoing exposure to racism, homophobia, transphobia, ableism, and other forms of structural violence
- Religious or cult abuse
- Refugee experiences, displacement, or persecution

This list is not exhaustive. What matters is the pattern: prolonged, repeated, inescapable harm often in the context of relationships or systems that were supposed to keep you safe.

On systemic and identity-based trauma

CPTSD does not only come from individual relationships. Living inside systems that repeatedly dehumanize you because of your race, gender identity, sexuality, disability, immigration status, or class can create the same neurological and psychological impact as interpersonal trauma. The threat doesn't have to come from one person. It can come from the ambient reality of navigating a world that treats your existence as a problem.

Why does having a name matter?

Before CPTSD had a name, many survivors were misdiagnosed with borderline personality disorder, bipolar disorder, treatment-resistant depression, or attachment disorders, diagnoses

that often carried stigma and didn't capture the full picture. Others were told they were 'too sensitive,' 'dramatic,' 'difficult,' or 'resistant to treatment.'

Having the right name does several things:

- It shifts the question from 'what is wrong with you' to 'what happened to you'
- It opens the door to treatments that actually work for complex trauma
- It validates experiences that have been minimized, dismissed, or pathologized
- It connects you to a community of others who understand
- It begins to interrupt the self-blame that is almost always part of the picture

When did you first hear the term CPTSD, or first recognized your own experience in its description? What was that like?

What have you been called or diagnosed with before CPTSD? How did those labels fit, or not fit?

Section 2: CPTSD vs. PTSD

Why the Distinction Matters

PTSD and CPTSD share a foundation both involve the aftermath of traumatic experience. But they are not the same diagnosis, and conflating them has led to inadequate treatment and a lot of unnecessary suffering.

PTSD	CPTSD
Typically follows a discrete traumatic event or events	Follows prolonged, repeated, inescapable trauma
Trauma usually has a clear beginning and end	Trauma is ongoing, cumulative, or begins in childhood
Three core symptom clusters: re-experiencing, avoidance, hyperarousal	Same three clusters PLUS: affect dysregulation, negative self-concept, relationship disturbances
Identity is usually not fundamentally altered	Identity, self-worth, and relational patterns are deeply affected
Person often retains a stable sense of self before and after	Sense of self may feel shattered, fragmented, or never formed solidly
Often responds well to trauma-focused CBT and EMDR	Often requires longer, phased treatment with strong therapeutic relationship

CPTSD is not 'worse' PTSD. It is a different and in many ways more pervasive response to a different kind of threat. The trauma that causes CPTSD tends to be relational at its core, which means it gets into the parts of us that formed in relationship: our sense of self, our trust in others, our ability to regulate our own emotions.

> **The six clusters of CPTSD**
>
> According to the ICD-11, CPTSD includes the three PTSD clusters plus three additional ones that reflect the deeper impact of complex trauma on identity, emotion, and connection:
>
> Cluster 1 — Re-experiencing
> Cluster 2 — Avoidance
> Cluster 3 — Persistent sense of threat / hypervigilance
> **Cluster 4 — Affect dysregulation**
> **Cluster 5 — Negative self-concept**
> **Cluster 6 — Disturbances in relationships**

Clusters 1–3 are shared with PTSD. Clusters 4–6 are what make CPTSD its own diagnosis.

Before reading this workbook, how would you have described what was 'wrong' with you? How does the CPTSD framework change that description, if at all?

CLUSTER
1

Re-Experiencing

The past that won't stay in the past

What is it?

Re-experiencing is the symptom most people associate with trauma: intrusive memories, flashbacks, nightmares. But for those with CPTSD, re-experiencing is often less dramatic than the movies suggest. It doesn't always look like a war veteran ducking at a car backfire. It can be subtle — a feeling that comes out of nowhere, a body state that drops in without warning, a sense of being suddenly somewhere else while you're still in the room.

Re-experiencing happens because trauma memories are stored differently than ordinary memories. Ordinary memories are processed, filed, and can be recalled as past events. Traumatic memories, especially those that were too overwhelming or disorganized to process in the moment can remain unintegrated, stored in fragments: a smell, a physical sensation, a sound, an emotional tone. When something in the present triggers one of those fragments, the nervous system responds as if the threat is happening now.

This is not a thinking problem. It is a nervous system response. Your brain is doing what it learned to do to keep you alive.

HOW THIS MIGHT SHOW UP FOR YOU

- □ Intrusive memories or images that arrive without warning, especially when triggered
- □ Flashbacks, feeling transported back to the traumatic experience, sometimes fully, sometimes partially
- □ Nightmares or disturbing dreams related to the trauma, often repetitive
- □ Emotional flashbacks: sudden overwhelming feelings (shame, fear, rage, grief) without a clear memory attached, common in CPTSD
- □ Physical re-experiencing: body sensations, bracing, nausea, heart racing the body remembering even when the mind doesn't
- □ Being 'triggered' by seemingly small things that are connected to past trauma
- □ Feeling suddenly young, small, or as if you are in a past situation while in a present one

A DIFFERENT WAY TO SEE THIS

Re-experiencing is not your mind torturing you. It is your nervous system trying to complete something that didn't get to complete. It is memory reaching for resolution. The goal of healing is not to make the memories disappear it is to help them become the past.

Do you recognize re-experiencing in your own life? What does it tend to look like for you thoughts, feelings, body sensations, or a combination?

Are there particular triggers you've noticed, sounds, smells, situations, body positions, tones of voice? What do they have in common?

CLUSTER
2

Avoidance

When staying away feels like the only safety

What is it?

Avoidance is the natural companion to re-experiencing. If certain people, places, feelings, thoughts, or situations are reliably associated with overwhelming activation it makes complete sense that you would learn to stay away from them. Avoidance isn't irrational. It was rational, at some point. The problem is that avoidance tends to shrink your world over time.

In CPTSD, avoidance often goes deeper than staying away from specific external triggers. It can include avoiding your own internal experience pushing down emotions, staying numb, dissociating, keeping yourself so busy there's no room to feel. This emotional avoidance can be one of the most invisible and pervasive aspects of complex trauma.

Avoidance can also look like social isolation, not pursuing goals or opportunities because they carry risk of being seen or vulnerable, or choosing relationships and situations that feel predictable and controlled even when predictable means small.

HOW THIS MIGHT SHOW UP FOR YOU

- □ Avoiding people, places, situations, or activities connected to the trauma
- □ Emotional numbness feeling cut off from your own feelings or other people
- □ Staying constantly busy, distracted, or in 'doing mode' to avoid feeling
- □ Using substances, food, screens, work, or other behaviors to manage or suppress distress
- □ Social withdrawal or isolation especially during difficult periods
- □ Avoiding thinking about the future, making plans, or imagining good things happening
- □ Difficulty accessing or describing emotions (alexithymia) a common result of prolonged emotional suppression
- □ Dissociation: feeling detached from yourself, your body, or reality as a way to escape overwhelm

A DIFFERENT WAY TO SEE THIS

Every avoidance behavior made sense at some point. It was a solution to a problem. The work is not to shame yourself for surviving, it is to gently expand what feels survivable, so the solution doesn't become its own cage.

What do you find yourself most consistently avoiding externally (situations, people, places) and internally (feelings, memories, sensations)?

When did avoidance start serving you? What was it protecting you from at the time?

CLUSTER
3

Persistent Sense of Threat

A nervous system that never got the all-clear

What is it?

When you have experienced prolonged trauma, your nervous system learns that danger is ambient. Not occasional. Not something you can see coming. Constant. And so it recalibrates: it stays alert, scanning, reading every situation for signs of threat, never fully powered down. This is hypervigilance and while it is often described as a symptom to be reduced, it is first and foremost an adaptation. It made sense.

The problem is that a nervous system tuned to persistent threat has difficulty distinguishing between real danger in the present and echoes of past danger. A raised voice, a shift in someone's tone, a feeling of being watched, a deadline, a conflict any of these can activate the same alarm system that was once activated by actual danger. The response is real. The threat may not be. But your body doesn't know the difference until you help it learn.

Hypervigilance also takes enormous energy. Living in a state of low-grade or high-grade alertness is exhausting in ways that are hard to explain to people who have not experienced it. The fatigue you feel may not just be about sleep it may be about what it costs to be on guard all the time.

HOW THIS MIGHT SHOW UP FOR YOU

- □ Feeling constantly on edge, jumpy, or unable to fully relax
- □ Scanning rooms, exits, faces assessing threat in every new environment
- □ Strong startle response overreacting to sudden sounds, movement, or touch
- □ Difficulty sleeping too alert to go under, or waking frequently
- □ Feeling unsafe even in objectively safe situations
- □ Reading people's moods, micro-expressions, or tone of voice for signs of danger
- □ Difficulty concentrating because attention is always partially deployed toward threat detection
- □ Chronic tension in the body jaw, shoulders, gut as a held state of readiness

A DIFFERENT WAY TO SEE THIS

Your nervous system is not broken. It became extraordinarily good at something: detecting danger. That skill kept you alive. What healing asks is not that you stop detecting, it's that your system gets enough experiences of actual safety that it can start to calibrate differently.

What does hypervigilance feel like in your body? Where do you carry it? How much energy does it take from you on a daily basis?

Are there places, relationships, or times of day where the sense of threat is lower? What do those contexts have in common?

CLUSTER
4

Affect Dysregulation

Emotions that go from zero to everywhere

What is it?

Affect dysregulation, difficulty managing emotional states is one of the hallmarks that distinguishes CPTSD from straightforward PTSD, and one of the most exhausting and confusing aspects of living with complex trauma. It can look like emotional explosions that feel out of proportion to the situation. It can look like the opposite: a complete inability to feel anything at all. Often, it looks like both cycling between extremes, with very little solid ground in between.

This isn't about being 'too emotional.' It's about what happens when the systems that regulate emotion, the nervous system, the prefrontal cortex, the attachment relationships that teach us how to self-soothe were overwhelmed, disrupted, or unavailable during the years when those capacities were being developed. You didn't learn emotional regulation in the way people with safer childhoods did, because the environment didn't allow for it.

Affect dysregulation also includes difficulty identifying what you're feeling (alexithymia), difficulty knowing what you need when you're distressed, and a tendency toward shame about having emotions at all because expressing emotions was, at some point, dangerous.

HOW THIS MIGHT SHOW UP FOR YOU

- □ Intense emotional reactions that feel out of proportion to the trigger rage, terror, grief arriving suddenly
- □ Emotional numbness or flatness feeling nothing where feeling is expected
- □ Cycling between intense emotion and shutdown within a short period
- □ Difficulty naming or describing what you're feeling (alexithymia)
- □ Feeling overwhelmed by other people's emotions, especially distress
- □ Shame about having emotions or about how you express them
- □ Difficulty soothing yourself once activated; needing external help to regulate
- □ Using intensity (conflict, crisis, excitement) to feel something when numbness dominates

A DIFFERENT WAY TO SEE THIS

Affect dysregulation is not evidence of instability or immaturity. It is evidence that you were asked to handle overwhelming emotional experiences without the tools, safety, or support to do so. The capacity for regulation can be built. It is never too late, and it was never your fault that it wasn't built earlier.

Which direction does dysregulation tend to go for you more toward intensity and overwhelm, more toward numbness and shutdown, or both? What does it feel like in your body?

When you are most dysregulated, what do you typically do? What has actually helped, even a little?

CLUSTER
5

Negative Self-Concept

The story trauma told you about yourself

What is it?

This is perhaps the most quietly devastating cluster of CPTSD. It describes the profound, chronic shame and self-blame that develops when someone has been harmed repeatedly especially in childhood, and especially by people who were supposed to love them. When the people who were supposed to keep you safe were the source of the harm, the mind does something protective and terrible: it decides that the problem must be you. Because if the problem is you, then maybe you can fix it. Maybe you can earn safety, earn love, earn a way out.

The negative self-concept in CPTSD isn't a distorted thought to simply be corrected. It is often deeply felt experienced as the fundamental truth about who you are. Phrases like 'I am damaged,' 'I am unlovable,' 'I am too much,' 'I am fundamentally broken,' 'I don't deserve good things' aren't just passing thoughts. They are the lens through which everything is filtered.

This cluster is also where internalized oppression lives. For people who have experienced racism, homophobia, transphobia, fatphobia, ableism, or other forms of systemic dehumanization, the negative self-concept can be seeded and reinforced not just by individual harm but by entire systems that communicate that you are lesser, wrong, or expendable.

HOW THIS MIGHT SHOW UP FOR YOU

- □ Chronic, pervasive shame not about something you did, but about who you are
- □ Deep self-blame for what happened to you, even when you know intellectually it wasn't your fault
- □ Feeling fundamentally different from other people, as if you are marked or broken in a way they cannot see
- □ Difficulty accepting care, love, or positive regard it doesn't feel true, or it feels dangerous
- □ Believing you deserve punishment, suffering, or less than others
- □ Difficulty recognizing your own strengths, worth, or accomplishments
- □ Feeling as if you are performing normalcy that if people really knew you, they would leave
- □ Internalized oppression: absorbing messages from systems that devalue your identity

A DIFFERENT WAY TO SEE THIS

The story trauma told you about yourself was a survival strategy. If you believed you were the problem, you maintained some sense of control. That made sense then. The truth is: you were harmed by people and systems that had far more power than you did. Their actions and failures reflect on them, not on your worth.

What is the core belief about yourself that feels most true, most deeply held even when you know intellectually it might not be? Where do you think it came from?

Has anyone ever tried to show you that this belief wasn't true? What happened? What made it hard to take in?

CLUSTER
6

Disturbances in Relationships

Connection that was supposed to be safe and wasn't

What is it?

Because so much complex trauma happens in relationships with caregivers, partners, institutions, communities it fundamentally shapes how we experience and navigate connection. This cluster describes the lasting impact of relational trauma on our capacity for intimacy, trust, and belonging.

This is not about being 'bad at relationships.' It is about what happens when the people who were supposed to teach you that relationships are safe were themselves the source of harm, unpredictability, or abandonment. You learned what you learned because that is what the environment taught. And those lessons about whether people can be trusted, whether closeness is dangerous, whether you have to earn love or hide yourself to keep it don't simply disappear when the harmful relationship ends.

Disturbances in relationships can look like patterns of hyperattachment and anxious clinging, or like detachment and avoidance of closeness sometimes cycling between both. They can include difficulty setting or maintaining boundaries, chronic caretaking at the expense of self, and what is now sometimes called fawning: the survival strategy of placating, accommodating, and making yourself useful or invisible to avoid conflict and danger.

HOW THIS MIGHT SHOW UP FOR YOU

- □ Difficulty trusting people, especially those who are close or caring
- □ Fear of abandonment intense distress at the thought of being left or rejected
- □ Alternating between intense closeness and sudden distance (push-pull patterns)
- □ Fawning: automatically accommodating, placating, or shrinking to keep others comfortable
- □ Difficulty identifying and expressing your own needs in relationships
- □ Choosing relationships that replicate familiar dynamics even painful ones
- □ Feeling responsible for other people's emotions, reactions, and wellbeing
- □ Feeling fundamentally alone, even in the presence of people who care about you
- □ Difficulty being truly seen either hiding yourself or testing whether others will stay

A DIFFERENT WAY TO SEE THIS

The relational patterns that cause you the most pain are the ones that are most essential to your survival. Fawning, hyperattachment, avoidance these were not mistakes. They were intelligent adaptations to environments that were genuinely unsafe. The work of healing is not to condemn the pattern but to learn, slowly, that something else is possible.

Which relational patterns do you recognize in yourself most strongly hyperattachment, avoidance, fawning, or something else? What does the pattern cost you?

Is there a relationship in your life now or in the past where you felt or feel genuinely safe? What made or makes it different?

CPTSD and the Body

Why Trauma Lives in the Tissue

Trauma is not only a psychological event. It is a physiological one. From the moment a threat is perceived, the body mobilizes: stress hormones flood the system, the heart accelerates, muscles brace for action, digestion slows, and the prefrontal cortex, the part of the brain responsible for reasoning and language, partially goes offline. The body is preparing to fight, flee, or freeze.

In the presence of a single traumatic event, this response eventually completes and the system returns to baseline. In the presence of prolonged, repeated, inescapable threat, it doesn't. The activation becomes chronic. The nervous system gets locked into a posture of readiness that never fully releases and over time, that posture becomes structural.

This is why 'just think positive' and 'have you tried reframing it?' are often insufficient responses to CPTSD. The trauma is not stored only in thought. It is stored in the body in tension patterns, in gut reactivity, in the startle response, in the way the throat closes before a difficult conversation, in the dissociation that drops in before pain gets too large.

Common somatic (body-level) experiences in CPTSD

- Chronic pain especially in the neck, back, jaw, or gut that doesn't have a clear structural cause
- Gastrointestinal symptoms: IBS, nausea, digestive disruption the gut has its own nervous system and is deeply responsive to threat
- Fatigue that isn't explained by activity level the energy cost of chronic vigilance and emotional suppression
- Somatic flashbacks: physical sensations from past trauma that arise without a clear memory attached
- Difficulty sensing the body from the inside (reduced interoception) often developed as protection
- Chronic bracing: muscles held in tension without awareness jaw, shoulders, pelvis, hands
- Sleep disruption: difficulty falling asleep, staying asleep, or feeling rested after sleep
- Sensitivity to sensory input sounds, light, touch, smell can feel like too much

Healing CPTSD often requires working at the body level not just the cognitive level. This is why modalities like somatic experiencing, EMDR, sensorimotor psychotherapy, yoga, and movement practices are often central to complex trauma recovery. The body needs to complete what it was never allowed to complete. It needs to learn, through actual physical experience, that the threat is over.

Where does your body tend to carry your trauma? Are there physical symptoms, chronic pain, or somatic experiences you've had that might be connected to your history?

CPTSD in Context

Systems, Identity, and the Trauma We Don't Always Name

Individual healing work has limits if we treat CPTSD as purely a personal, internal problem. The same systems that created or compounded the trauma are often still present. The racism that contributes to complex trauma doesn't stop when therapy starts. The medical system that harmed you doesn't become trustworthy because you've learned a new coping skill. The economic conditions that kept you in an abusive situation don't shift because you completed a workbook.

This is not hopeless, it is honest. And honest is where real healing begins.

Race and Racism

Research increasingly documents racial trauma, the psychological and physiological impact of experiencing racism, both in acute incidents and as chronic ambient exposure. For Black, Indigenous, and other People of Color, the hypervigilance that characterizes CPTSD is often a rational response to real ongoing danger. This distinction matters enormously: healing is not about convincing yourself the threat isn't real. It's about finding safety where safety actually exists, and expanding capacity in the presence of a world that hasn't fully changed.

Gender-Based Violence and LGBTQ+ Experience

Intimate partner violence, sexual violence, and family rejection carry high rates of complex trauma. For LGBTQ+ people particularly transgender and nonbinary people the experience of living in a body and identity that may be rejected, policed, misgendered, or targeted adds layers of relational and systemic trauma that are often underrecognized in clinical settings. The body dysphoria, the erasure, the violence: these are not just emotional experiences. They are traumatic ones.

Disability and Medical Trauma

People with chronic illness, physical disability, or histories of hospitalization and invasive medical intervention often carry significant trauma from those experiences including from healthcare providers who caused harm, dismissed pain, or failed to obtain genuine consent. Medical trauma is real, it is underdiagnosed, and it often overlaps with CPTSD in ways the field is only beginning to understand.

> **Your trauma exists in relation to the systems you move through.**
>
> Healing that ignores those systems will always be incomplete. You are allowed to hold both things: the work you do inside yourself and the understanding that some of what you carry was placed there by forces far larger than one relationship.

Are there systemic or identity-based experiences that have contributed to your trauma? How often has that been acknowledged in treatment, in relationships, in your own self-understanding?

What Healing Actually Looks Like

Not a straight line. Not a destination. A process.

Healing from CPTSD is not linear. It does not look like moving steadily forward from point A to point B until you arrive somewhere called 'healed.' It looks more like a spiral: you revisit the same themes, the same clusters, the same patterns but ideally from a slightly different position each time. With a little more ground under your feet. A little more capacity. A little more of yourself intact.

It also doesn't always look like feeling better. Sometimes it looks like finally feeling things you couldn't feel before. Sometimes it looks like getting angry when you used to only feel fear. Sometimes it looks like your nervous system getting louder for a while before it gets quieter, because safety is new and safety is triggering when you've spent years expecting the other shoe to drop.

What healing often looks like in practice

- □ Increasing capacity to tolerate emotions without being overwhelmed or shutting down
- □ More access to the window of tolerance more time feeling regulated
- □ Reduced intensity of re-experiencing symptoms over time
- □ Greater ability to recognize triggers and choose a response rather than react automatically
- □ More self-compassion and less chronic shame not all the time, but more often
- □ Expanding tolerance for connection being able to let people in without it feeling like danger
- □ A firmer sense of self knowing who you are, what you value, what you need
- □ The trauma becoming history something that happened to you, not something that is still happening

A Note on Treatment

CPTSD typically responds best to phased treatment beginning with stabilization and skill-building, moving into trauma processing when the window of tolerance is wide enough, and eventually integrating the work into a forward-facing life. Approaches with strong evidence for complex trauma include:

Approach	What it is
Phase-Based Trauma Therapy	A structured framework recommended by the International Society for the Study of Trauma and Dissociation that moves through three phases: (1) safety, stabilization, and skill-building; (2) processing traumatic memories; and (3) integration and reconnecting with life. The key principle is that trauma processing should not begin until the

	person has enough internal and external resources to handle it. For CPTSD, this phase structure is especially important.
EMDR	Eye Movement Desensitization and Reprocessing uses bilateral sensory stimulation (typically side-to-side eye movements, tapping, or sounds) while the person holds a traumatic memory in mind. The process helps the brain reprocess stuck memories so they can be stored as past events rather than present threats. EMDR has strong research support for PTSD and is widely used for CPTSD, typically within a phased approach.
Somatic Experiencing	Developed by Peter Levine, somatic experiencing works with the body's stored trauma responses rather than the cognitive or narrative content of trauma. The focus is on tracking physical sensations, completing interrupted survival responses (fight, flight, freeze), and gradually discharging the nervous system's held activation. It is particularly useful for people whose trauma is stored more in the body than in accessible memory.
Internal Family Systems (IFS)	Developed by Richard Schwartz, IFS understands the mind as made up of distinct 'parts' including protective parts that manage pain and exiled parts that carry it. Rather than trying to eliminate difficult thoughts or behaviors, IFS works to build a relationship between those parts and the person's core Self, which is naturally curious, compassionate, and clear. It is especially well-suited to the fragmented self-experience common in CPTSD.
DBT	Dialectical Behavior Therapy was originally developed for people with intense emotion dysregulation and chronic suicidality. It teaches concrete skills across four areas: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. For people with CPTSD, DBT skills are often used in the stabilization phase building the internal resources needed before trauma processing begins.
Narrative Exposure Therapy	A structured approach, developed partly for use with refugees and survivors of organized violence, that helps people create a coherent chronological narrative of their life including traumatic events. By repeatedly telling and contextualizing the story with a trained therapist, the traumatic memories gradually lose their fragmented, present-tense quality and become part of a larger life history. Particularly useful when trauma is connected to persecution, displacement, or systemic violence.
ACT	Acceptance and Commitment Therapy helps people develop psychological flexibility the ability to hold difficult thoughts and feelings without being ruled by them, and to move toward what matters even in the presence of pain. Rather than trying to eliminate distress, ACT teaches defusion from unhelpful stories, acceptance of what can't be controlled, and values-based action. It is especially useful for the avoidance patterns and negative self-concept clusters of CPTSD.

Liberation Psychology	A framework rooted in the work of Ignacio Martín-Baró and others, liberation psychology insists that individual suffering cannot be understood outside of the social and political conditions that created it. For survivors whose trauma is rooted in racism, colonization, homophobia, poverty, or other systemic forces, a liberation psychology lens shifts the question from 'what is wrong with you' to 'what has been done to you and by what systems.' It is not a standalone treatment but a frame that should inform all trauma work with marginalized people.

Medication does not treat CPTSD directly but it can reduce symptom intensity enough to make therapy more possible, especially for sleep disruption, hyperarousal, and depression. Talk to a prescriber you trust.

What to look for in a therapist

- □ Explicit training in trauma not just general mental health
- □ Familiarity with CPTSD as distinct from PTSD
- □ A phased approach not jumping straight into exposure or trauma processing
- □ Cultural humility and responsiveness to your specific identities and contexts
- □ Attention to the therapeutic relationship itself trauma heals in relationship
- □ Willingness to go at your pace

What has healing already looked like for you even in small ways? What shifts, however brief, have you noticed?

What feels most essential for your healing right now? What do you need that you don't yet have?

A Closing Word

You made it through this workbook. That is not nothing.

You came to it carrying something real, something that has likely been shaping your life for a long time, often without the right words or the right witness. Hopefully some of what you found here gave you language. Hopefully some of it gave you relief, the particular relief of being seen, even just on a page.

CPTSD is not who you are. It is what happened to you, and what your mind, body, and relational self learned in response. Those responses were intelligent. They were loyal to your survival. And they can change not because you are broken and need fixing, but because you are alive and capable of learning new things, including that safety is possible, that you are worth caring for, and that the past, however enormous, is not the whole story of what comes next.

> ***You are not the worst thing that happened to you.***
> *You are the one who survived it and who is still here, still reaching toward something more.*