

Review Article

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A Cutting-Edge Trauma Treatment Centre in the United Kingdom: An Integrated, Polyvagal-Informed Model of Residential and Outpatient Trauma Recovery with Practice- Based Outcomes Evidence

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ABSTRACT

Background: PTSD and complex PTSD (CPTSD) are prevalent and burdensome conditions. Recent syntheses of ICD-11 constructs suggest that PTSD and CPTSD occur in the general population and rise substantially in trauma-exposed and clinical groups, underscoring the demand for specialist services capable of addressing both symptom clusters and disturbances in Self-Organization (DSO) [1-4].

Objective: To describe an integrated trauma treatment center delivering residential and outpatient trauma recovery in a stepped pathway, and to report practice-based outcomes using routine outcome monitoring (ROM) from independent analyses.

Method: The clinical model combines “bottom-up” autonomic regulation and relational safety (co-regulation, stabilization) with “top-down” therapies (trauma-focused processing and integration), organized across a staged roadmap (stabilisation → processing → integration) and delivered via residential, step-down, intensive outpatient, and outpatient formats. Outcomes are summarized from independent annual reports using the CORE-Outcome Measure (CORE-OM) for closed cases across multiple cohorts (2012–2019; 2024), including mean pre–post change and recovery/improvement profiles defined via reliable change and clinical cutoffs.

Results: Across cohorts, baseline distress typically fell within moderate-to-severe or severe bands and most clients scored above the clinical cutoff at intake (commonly >90%), consistent with a complex clinical case-mix. Independent reports commonly show clinically meaningful reductions in CORE-OM distress (e.g., ~6–10 point mean reductions in several cohorts), alongside variable recovery/improvement rates (approximately one-third to three-quarters depending on year and context). In years where inpatient and outpatient care were documented within a connected treatment episode, the highest recovery/improvement rates were often observed (while noting small subgroup cell sizes in later cohorts).

Conclusions: A continuity-oriented, staged trauma pathway that integrates residential stabilization with outpatient consolidation can deliver meaningful improvements in routine outcomes for high-severity cohorts under real-world clinical conditions. Future research should incorporate trauma-specific measures for ICD-11 PTSD/CPTSD, follow-up assessments, and comparative designs to clarify mechanisms and durability [5].

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Introduction

Trauma-related disorders are increasingly conceptualized as biopsychosocial conditions involving dysregulation across arousal systems, affect tolerance, cognition, self-concept, and interpersonal functioning. ICD-11’s distinction between PTSD and CPTSD formalizes this broader view: CPTSD includes PTSD symptoms plus DSO features (affect dysregulation, negative self-concept, and relational disturbance) [6]. In recent prevalence syntheses, ICD-11 PTSD and CPTSD estimates vary widely by setting and measurement, but pooled results indicate nontrivial rates even in economically developed general populations, alongside much higher rates in clinical and heavily trauma-exposed samples [4].

Evidence-based trauma-focused psychotherapies remain first-line for PTSD, reflected in the 2023 VA/DoD clinical practice guideline update for PTSD and acute stress disorder, which is anchored in systematic evidence review and graded recommendations [7]. Yet, case complexity, comorbidity, psychosocial instability, and service fragmentation can blunt clinical impact. In particular, discontinuities between acute containment (often inpatient/residential) and outpatient trauma processing may contribute to relapse risk, dropout, and incomplete integration of gains.

Continuity-of-care research in serious mental illness demonstrates that structured transition models can reduce emergency department use and readmission rates, supporting continuity as a plausible service-level mechanism relevant to trauma pathways [8].

At the same time, clinical hesitation about trauma processing persists, often framed as concern about symptom worsening during memory-focused work. A 2024 systematic review/meta-analysis directly examined mid-treatment outcomes and found no evidence that trauma-focused psychotherapy exacerbates PTSD or depression symptoms at mid-treatment compared to controls; in higher-quality studies, mid-treatment effects favored trauma-focused care [9]. This strengthens the rationale for services that can deliver trauma-focused treatment with appropriate pacing, safety planning, and follow-through across levels of care.

Against this background, the present paper expands a practice-based description of a UK trauma treatment center designed to deliver an end-to-end pathway across residential and outpatient settings, and summarizes independent routine outcome monitoring evidence from CORE IMS reports across multiple cohorts.

Clinical Model and Care Pathway

The service is organized around the principle that trauma recovery often requires (a) autonomic stabilization and relational safety, (b) trauma memory processing, and (c) integration into functioning and relationships over time. This is operationalized through a staged roadmap—stabilisation → processing → integration—delivered across a stepped continuum of care (residential, step-down, intensive outpatient, and outpatient).

Bottom-Up and Top-Down Integration

The model is framed as “bottom-up meets top-down,” pairing nervous-system regulation and co-regulation strategies with cognitive, meaning-making, and relational approaches. This aligns with a growing evidence base supporting adjunctive body- and movement-oriented interventions (BMOIs) for PTSD symptoms, although heterogeneity and study quality limitations remain. In an updated 2023 meta-analysis of BMOIs for adults with PTSD, pooled effects suggested improvement in PTSD symptoms (with very high heterogeneity), supporting BMOIs as potentially valuable components within multimodal programs [10].

Yoga is often used as a regulation-focused adjunct in trauma services—also has contemporary RCT-based syntheses. A 2024 systematic review/meta-analysis found yoga improved self-reported PTSD and depression symptoms compared with controls, though clinician-rated PTSD outcomes were not consistently improved, highlighting the importance of measurement selection and mechanism alignment [11].

Polyvagal-Informed Care and the “Science of Safety”

The service describes itself as “polyvagal-informed,” emphasizing felt safety, state regulation, and relational co-regulation as prerequisites for trauma processing. In the scientific literature, polyvagal theory is both influential and contested. A 2023 critique in *Biological Psychology* argued that multiple core premises of polyvagal theory are implausible or unsupported as stated, especially regarding neurophysiological claims linking vagal pathways to specific social/emotional functions [12]. A 2024 review further evaluated polyvagal theory in the context of current neuroscience and clinical research, discussing both interpretive value and evidentiary constraints [13]. In parallel, recent clinical scholarship continues to articulate polyvagal theory as a “science of safety,” proposing clinical applications and future research directions, including discussion of methodological critiques and measurement [14]. In this paper, “polyvagal-informed” is treated as a clinical design framework for structuring safety-promoting environments, co-regulation practices, and pacing—not

as definitive proof of unique polyvagal-specific mechanisms. This approach is consistent with current debates and supports empirically grounded evaluation through validated symptom, functioning, and (where feasible) physiological measures [15].

Multimodal Trauma Therapies in Context

The service reports employing multiple modalities, including EMDR, somatically informed psychotherapy, group/relational interventions, and “parts work” approaches (e.g., Internal Family Systems [IFS]-informed therapy). Contemporary evidence supports EMDR as an efficacious trauma-focused therapy. A 2023 systematic review/meta-analysis of randomized clinical trials found EMDR produced small effects across PTSD and related symptoms, with outcomes moderated by factors such as session characteristics and therapist experience [16]. An updated 2025 systematic review/meta-analysis evaluating clinical and cost-effectiveness evidence since the NICE 2018 guideline era found EMDR superior to waitlist/usual care and broadly comparable to trauma-focused CBT for PTSD symptom outcomes, while also summarizing cost-effectiveness modeling results [17].

Evidence for IFS as a trauma intervention is still emerging relative to first-line PTSD psychotherapies. However, recent feasibility and pilot work indicates growing evaluative momentum. A 2024 feasibility/acceptability report described an online group-based IFS intervention for PTSD (Program for Alleviating and Resolving Trauma and Stress), supporting further trials [18]. A 2025 pilot study of an online group-based IFS intervention for comorbid PTSD and substance use disorder (SUD) reported high acceptability and feasibility metrics with exploratory symptom improvements, explicitly calling for larger randomized trials [19].

Method

Design and Data Source

This is a service description with practice-based outcomes summarized from independent annual reports produced by CORE IMS using routine clinical data recorded in CORE Net. The reports typically define inclusion as clients recorded with a “Closed” status (completion or cessation of treatment) and a last session date within the reporting year.

Because these are observational ROM cohorts, findings describe real-world change associated with service delivery as implemented and should not be interpreted as causal estimates equivalent to randomized controlled trials (RCTs). This approach aligns with the broader ROM literature, which emphasizes that routine measurement and feedback can inform clinical decision-making and quality improvement in real-world settings, while also requiring careful interpretation of confounding, attrition, and case-mix change [20].

Outcome Measure and Operational Definitions

The CORE-Outcome Measure (CORE-OM) is a 34-item standardized measure of psychological distress spanning subjective well-being, symptoms/problems, life functioning, and risk. CORE-OM clinical scores are calculated as the mean of completed items multiplied by 10, yielding a 0–40 scale; a clinical cutoff score of 10 is used to distinguish clinical from non-clinical populations in benchmarking contexts.

Across the service’s independent reports, reliable change is operationalized using a 5-point reliable change index (RCI) for CORE-OM clinical scores. In this framework, “improvement” typically indicates pre-post change ≥ 5 points, and “recovery”

indicates improvement plus a post-treatment score below the clinical cutoff (i.e., reliable and clinically significant change).

Analytic Approach

The independent reports generally provide (a) baseline severity distributions and proportion above cutoff, (b) mean pre–post score changes for clients with valid pre- and post- treatment scores, and (c) recovery/improvement/no change/deterioration profiles, sometimes stratified by gender and by inpatient/outpatient status where sample sizes permit.

Results Baseline Severity and Clinical Threshold Status

Across multiple cohorts, the service’s closed-case samples report high baseline distress; in multiple years, over 90% of clients were above the CORE-OM clinical cutoff at intake, with mean scores commonly within moderate-to-severe or severe severity banding. For example, the 2012 audit reported a mean CORE score of 21 for the broader assessment cohort (moderate-to- severe) with most cases banded moderate or above. The 2015 cohort reported a mean intake score of 25 (severe), with 94% above cutoff. The 2017 cohort reported 96% above cutoff with mean intake 22 (moderate-to-severe). The 2019 report described 95% above cutoff with mean intake around 22 and a cohort “almost exclusively inpatients.” The 2024 cohort reported 93% above cutoff with mean intake 21 (moderate-to-severe) and 88% banded moderate or above.

Taken together, these baseline profiles are consistent with a complex, high-distress case- mix rather than low-severity presentations, matching epidemiologic observations that CPTSD prevalence is substantially higher in clinical samples than in general populations [21].

Pre–post Distress Change and Recovery/Improvement Profiles
Independent outcome reporting indicates clinically meaningful pre–post reductions in CORE-OM distress in several cohorts, with year-to-year variability in recovery/improvement rates.

Early audits and implementation phase (2012–2014): In the 2012 audit, 16 closed cases had valid pre/post CORE data; recovery and improvement totaled 62% (31% recovery; 31% improvement), with an outcomes completion rate of 64% among closed cases. A 2013-era analysis (filtered by post session date 1 October 2012–31

December 2013) reported 63% reliable improvement overall and 32% clinical recovery overall; mean CORE-OM reductions were approximately 6–7 points among those with pre/post CORE-OM data. The 2014 outcome analysis (39 closed cases) reported mean reductions of 10 points for inpatients (24→14) and 6 points for outpatients (22→16), with 72% reliable improvement and 28% “recovered” (reliable and clinically significant change).

Annual cohorts (2015–2017): In 2015, mean CORE-OM decreased by 7 points (25→18) among those with valid pre/post scores, with recovery/improvement totaling 60%. In 2016, the service reported a 6-point mean reduction (23→17) and recovery/improvement totaling 63%. In 2017, mean CORE-OM decreased by 6 points (23→17) and recovery/improvement totaled 50%; subgroup reporting indicated the highest recovery/improvement in those receiving both inpatient and outpatient care within the year (72%), compared with inpatient-only (43%) and outpatient- only (50%), with the report noting small subgroup sizes.

Service variability and development context (2018–2019): In 2018, mean CORE-OM change was minimal (22→21; ~1 point), and recovery/improvement totaled 34%; the report contextualized these findings as occurring during a period where service expansion was not fully matched by clinical staffing capacity and raised the possibility that alternative measures may better capture change in complex trauma populations. In 2019, the report described a cohort that was almost exclusively inpatient and reported a mean reduction of 10 points (23→13), with recovery/improvement reported as 75%, alongside benchmarking statements.

Recent cohort (2024 reporting year; report prepared 2025): For 2024, the report described 42 closed cases and valid pre/post data for 40 clients (95% completion among those with valid pre-therapy scores). Mean CORE-OM decreased by 6 points (21→15). Recovery/improvement totaled 41% (23% recovered; 18% improved), with 7% deterioration. By service status, those recorded as receiving both inpatient and outpatient care had the highest recovery (100% recovered; n=2), followed by outpatient-only and inpatient-only groups; the report cautioned that small subgroup Ns should be interpreted carefully.

Cross-cohort summary table

Table 1: Selected CORE-OM Outcomes from Independent Annual Reports (Closed Cases; Valid Pre/Post where Applicable)

Baseline Cohort							
Cohort report year	size (closed cases)	Valid pre/post (n)	Mean CORE-OM pre	Mean CORE-OM post	Mean change	Recovery + improvement	Notes
2012	25	16	—	—	—	62%	Recovery 31%;
	closed						improvement 31%;
							outcome completion
							rate 64%
2013-	19	17	~21–22	~15	~6–7	63% reliable	Clinical recovery 32%
era		(CORE-				improvement	reported
analysis		OM)					
2014	39	39	23.1	14.9	8.2	72% reliable	Inpatient mean change
			(approx.)	(approx.)	(approx.)	improvement;	10; outpatient 6

						28%	
						recovered	
2015	53	35	25	18	7	60%	Inpatient change -9;
							outpatient -3
2016	39	30	23	17	6	63%	Inpatient change -6;
							outpatient -3
2017	48	36	23	17	6	50%	“Both” subgroup
							recovery/ improvement
							72%
2018	31	23	22	21	1	34%	Report notes service
							expansion/ staffing
							context; measurement
							fit considerations
2019	19	(see	23	13	10	75%	Cohort almost
	unique	report					exclusively inpatient;
	clients	tables)					report notes
	(baseline						benchmarking claims
	profile)						
2024	42	40	21	15	6	41%	“Both” subgroup
							100% recovered; n=2

Discussion Clinical Meaning of Routine Outcomes in Trauma Systems

Across multiple years of independent ROM reporting, cohorts entering the service typically show high baseline distress and high proportions above the clinical cutoff, consistent with complex trauma presentations. This aligns with epidemiologic syntheses indicating markedly elevated CPTSD prevalence in clinical samples, supporting the expectation that specialist trauma services will treat high-severity, heterogeneous populations with variable trajectories and mixed response patterns [22].

Despite heterogeneity, the repeated observation of meaningful pre-post reductions in CORE-OM distress in several cohorts suggests clinically relevant change under real-world conditions. The ROM literature emphasizes that routine outcomes can support both accountability and clinical learning, especially when integrated into practice workflows rather than treated as static audit metrics [20].

Continuity Across levels of Care as a Plausible Mechanism

A clinically coherent pattern in the service’s reporting is that the highest recovery/improvement rates occur when clients receive both inpatient and outpatient treatment within a connected episode (e.g., 2017 “Both” subgroup; 2024 “Both” subgroup). Although the 2024 subgroup is very small (n=2) and must not be overinterpreted,

this signal is consistent with broader health-systems evidence that continuity-of-care models across transitions can reduce adverse system outcomes (e.g., emergency visits, readmissions) in severe mental illness [8].

From a trauma-care perspective, continuity plausibly supports (a) sustained alliance across settings, (b) reduction of abrupt “handoffs” that can activate relational threat sensitivities, and (c) staged consolidation of stabilization skills and meaning-making into daily functioning. These mechanisms are also consistent with the service’s staged roadmap and the broader literature on transition vulnerabilities and discharge-system constraints [23].

Integrating Trauma-Focused Psychotherapy with Regulation-Based Components

The service’s “bottom-up meets top-down” model is aligned with contemporary evidence that trauma-focused psychotherapies are effective and, on average, do not cause mid-treatment symptom exacerbation relative to controls [9]. This supports the clinical strategy of enabling trauma processing within a regulated therapeutic environment rather than indefinitely deferring trauma work due to fear of destabilization.

At the same time, the evidence base supports the plausibility of including regulation- focused adjuncts. Body- and movement-

oriented interventions have a 2023 updated meta-analytic support signal for PTSD symptom reduction, though with substantial heterogeneity and notable quality limitations, encouraging careful implementation and measurement [10]. Yoga has contemporary RCT-based meta-analytic evidence for self-reported PTSD symptom improvement, reinforcing its potential as an adjunctive stabilization and integration tool in multi-modal programs [11].

Emerging intervention research also shows that autonomic-focused approaches can produce clinically meaningful PTSD symptom change. A 2026 randomized waitlist-controlled trial found heart rate variability biofeedback reduced PTSD symptoms and pain interference in participants with comorbid PTSD and chronic pain, supporting the broader autonomic-regulation premise even though translation to residential trauma care requires additional study [24]. Related neuromodulation work in treatment-resistant PTSD (e.g., vagus nerve stimulation paired with prolonged exposure) is also in early-phase evaluation and supports ongoing interest in enhancing plasticity and regulation as adjuncts to trauma-focused therapy [25].

Polyvagal-Informed Practice and Scientific Responsibility

The polyvagal framing resonates clinically because it prioritizes safety, co-regulation, and state flexibility. However, because of substantial scientific debate—ranging from fundamental critiques to nuanced reviews and updated clinical articulations—publication-quality reporting should explicitly distinguish between (a) polyvagal theory as a contested explanatory model and (b) safety-oriented clinical design principles that may still be beneficial and testable [15].

A pragmatic research agenda consistent with this stance is to evaluate whether measurable indices (symptom change, functioning, relational outcomes, and feasible physiological measures) mediate or predict outcomes within a staged, continuity-oriented pathway, rather than attributing change to polyvagal mechanisms as established facts [26].

Limitations and Future Directions Limitations of the Current Evidence Base

The practice-based outcomes summarized here are derived from observational routine data and are not controlled comparisons. As a result, causal attribution to the integrated model, to specific modalities (e.g., EMDR), or to the environmental “polyvagal-informed” framework is not warranted. ROM cohorts can also be influenced by case-mix shifts, variable treatment dose, staff turnover, and differential missingness (although several cohorts report high completion among eligible closed cases).

Additionally, CORE-OM is a broad distress measure; for trauma services treating CPTSD, clinician and research communities increasingly recommend trauma-specific measurement to capture PTSD/CPTSD symptom clusters and DSO domains more directly. The ITQ is widely used for ICD-11 PTSD/CPTSD assessment and is explicitly recommended in recent clinical guidance resources [27].

Research and Service-Evaluation Recommendations

Future evaluations would be strengthened by integrating:

- (a) Trauma-specific measurement (e.g., ITQ for ICD-11 PTSD/CPTSD) and, where feasible, structured clinical interviews such as the International Trauma Interview (ITI) [28].
- (b) Pathway-position tracking, to estimate differential effects of stabilization vs processing vs integration, and to test whether

continuity across steps predicts outcomes after adjusting for baseline severity and treatment intensity [29].

- (c) Follow-up measurement (e.g., 3-, 6-, 12-month), given that integration aims (relationships, functioning, relapse prevention) may not be fully captured at discharge [30].
- (d) Comparative designs, including pragmatic or quasi-experimental comparisons (e.g., matched cohorts receiving residential-only vs residential + structured step-down), consistent with contemporary PTSD treatment research emphasizing real-world engagement and effectiveness constraints [31].
- (e) Mechanism-informed adjunct evaluation, including autonomic regulation components (e.g., HRV biofeedback) where emerging controlled evidence supports symptom improvement [24].

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