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A WHITE PAPER · FULL-SPECTRUM TRAUMA RECOVERY

# Beyond Regulation

*Why symptom-focused therapy isn't enough — and how the Becoming Method<sup>®</sup> supports full-spectrum trauma recovery*

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Prepared for clinicians, academic faculty, and researchers

## Abstract

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Standard trauma-focused therapies — prolonged exposure, cognitive processing therapy, EMDR, and trauma-focused CBT — produce reliable symptom reduction for single-incident posttraumatic stress disorder. For the developmental, relational, and complex presentations that dominate real-world clinical caseloads, the evidence is more sobering. A 2024 meta-analysis found that 18–44% of patients receiving first-line psychological treatments for PTSD remain non-responders, with complex trauma history and affect dysregulation as the strongest predictors of poor outcome (Semmlinger et al., 2024). Dropout rates in naturalistic settings approach 60% (Imel et al., 2013; Sripada et al., 2022). Even when patients achieve diagnostic remission, the ICD-11 "disturbances of self-organization" cluster — affect dysregulation, negative self-concept, and relational disturbances — frequently remains unaddressed (Siddaway, 2024). The field's own consensus, formalized in the 2018 International Society for Traumatic Stress Studies guidelines, recommends phase-based, multi-component treatment for complex PTSD rather than single-modality stabilization or exposure (Stein et al., 2019).

This paper presents the *Becoming Method*<sup>®</sup> — a phase-based, consciousness-grounded framework for full-spectrum trauma recovery — as a response to that clinical gap. It maps the Method's five stages against the peer-reviewed evidence base; situates its four foundational questions within the meaning-making literature (Park, 2010; Tedeschi & Calhoun, 2004); locates its lineage across somatic, narrative, parts-based, interpersonal-neurobiological, existential, transpersonal, and intergenerational traditions; and grounds its clinical urgency in Canadian epidemiology of trauma and the nursing workforce crisis (CFNU, 2022; Statistics Canada, 2023). The paper closes with the contested terrain — limits of self-reported posttraumatic growth (Boals, 2023), evidence gaps in body-based modalities, and cultural validity concerns — that any honest scholarly account must name. The aim is not to displace existing trauma treatment but to articulate the territory beyond stabilization that clinicians and clients describe with increasing frequency: regulated, but not whole; functional, but not yet free.

**Keywords:** complex PTSD · posttraumatic growth · meaning-making · phase-based treatment · trauma-informed care · nursing workforce · intergenerational trauma · ICD-11

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*Psychotherapy is a cyclical process from isolation into relationship. It is cyclical because the patient, in terror of existential isolation, relates deeply and meaningfully to the therapist and then, strengthened by this encounter, is led back again to a confrontation with existential isolation.*

— Yalom, 1980, p. 406

## ONE

## Introduction: The Question Beyond Regulation

In every health discipline, there comes a moment when the work asks us to deepen our approach.

Over the past century, psychotherapy, mental health care, and nursing practice have evolved through profound shifts in understanding — from the intrapsychic insights of early psychoanalysis to the neurobiological and relational wisdom of trauma-informed therapy. Today, thousands of skilled practitioners — psychotherapists, nurse psychotherapists, clinical social workers, psychiatrists, and physicians — guide clients through evidence-based approaches that regulate the nervous system, reframe cognition, and restore functioning after adversity.

These frameworks are effective. They help stabilize what has been destabilized. Clients move from dysregulation to regulation, from overwhelm to psychological safety. Cognitive distortions realign. Relationships begin to repair. Functionality is restored.

And for a time, this is enough.

But eventually, something else emerges. Not more pain — something more complex: a search.

Across therapeutic modalities, clinicians witness this moment. Clients no longer present with acute distress, yet they remain in therapy. They feel better, but not whole. Regulated, but not fully alive. A deeper line of inquiry begins to take shape — not from suffering, but from longing:

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*Who am I, really?*

*Why did this happen to me?*

*What does it mean to live a meaningful life now?*

*And what am I now free to do?*

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These are not signs of regression. They are signs of emergence. They are not questions of coping. They are questions of becoming.

The clinical territory these questions name has, until recently, lived at the edges of formal psychotherapy

literature — visible to seasoned clinicians but inconsistently theorized, inconsistently measured, and inconsistently taught. This paper makes the case that the territory is no longer at the edges. It is at the centre of complex trauma recovery, it is supported by a growing peer-reviewed evidence base, and it is the work for which the Becoming Method<sup>®</sup> was developed.

## TWO

## The Limits of Symptom-Focused Therapy

### What the Evidence Shows

Standard trauma-focused cognitive behavioural therapies — including prolonged exposure (PE), cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR) — produce reliable symptom reduction for single-incident PTSD. For complex, developmental, and relational trauma, the picture is meaningfully different.

A 2024 meta-analysis of non-response across first-line PTSD treatments found that **18-44% of patients remain non-responders post-treatment**, with complex trauma history, comorbid dissociation, and affect dysregulation as the strongest predictors of poor outcome (Semmlinger et al., 2024). A 2020 meta-analysis of psychological therapies for PTSD identified a pooled RCT dropout rate of 16% (95% CI: 14-18%), with trauma-focused therapies showing significantly higher dropout than non-trauma-focused approaches (Lewis et al., 2020). Naturalistic data are more sobering still: a 2022 study found that **31.6% of participants dropped out before treatment initiation and only 40.4% completed a full course** of evidence-based trauma treatment (Sripada et al., 2022).

Even patients who achieve "loss of diagnosis" on DSM-5 PTSD criteria — a clinically significant outcome — frequently retain the cluster of symptoms that the ICD-11 (WHO, 2018) calls *disturbances of self-organization* (DSO): affect dysregulation, negative self-concept, and disturbances in relationships. DSM-5 does not formally measure DSO symptoms, which means that diagnostic remission can coexist with substantial unresolved morbidity (Siddaway, 2024). This is not a peripheral

concern. Factor-structure analyses comparing ICD-11 CPTSD with DSM-5 PTSD in clinical samples have repeatedly demonstrated that the DSO cluster is statistically distinct from the PTSD cluster and is not collapsed within it.

**Table 1. Dropout and non-response across evidence-based PTSD treatments**

Source	Finding	Population
Lewis et al. (2020), meta-analysis	Pooled RCT dropout 16% (95% CI: 14–18%); trauma-focused therapies higher than non-trauma-focused	Adults, PTSD
Imel et al. (2013), meta-analysis	RCT dropout ~18%; naturalistic substantially higher	Adults, PTSD
Sripada et al. (2022), naturalistic	31.6% dropped out before treatment initiation; 28.0% after initiation; 40.4% completed	Veterans, complex PTSD
Semmlinger et al. (2024), meta-analysis	18–44% non-response post-treatment	Adults, PTSD, including CPTSD

Note. "Non-response" defined as failure to achieve clinically significant change on the primary outcome measure. Predictors of non-response across studies converge on complex trauma history, comorbid dissociation, affect dysregulation, and limited social support.

## The Field's Own Consensus

The International Society for Traumatic Stress Studies, after reviewing 208 meta-analyses, published updated PTSD prevention and treatment guidelines in 2018 that explicitly recommend phase-based, multi-component treatment for complex PTSD — skills training in affect and interpersonal regulation followed by trauma processing — rather than direct trauma-focused exposure alone (Stein et al., 2019; ISTSS, 2018). The 2012 ISTSS Expert Consensus Treatment Guidelines for Complex PTSD had earlier codified phase-based treatment as the standard framework for complex trauma (Cloitre et al., 2012). The 2018 guidelines reiterated and strengthened that consensus.

The most methodologically rigorous direct test to date is the Sele et al. (2023) RCT, which randomized 92 adults with ICD-11 CPTSD to phase-based STAIR/Narrative Therapy, prolonged exposure alone, or skills-only training. Phase-based treatment produced the broadest improvements across both PTSD and DSO clusters. Stabilization-only and exposure-only conditions produced narrower gains, with weaker change on negative self-concept and relational difficulties. A 2026

follow-up trajectories analysis from the same group confirmed differential symptom-change favouring the phase-based model (Sele et al., 2026). A systematic review of STAIR/NT trials concluded that the approach is clinically indicated for complex posttraumatic stress and consistent with ISTSS guidelines (Lorbeer et al., 2023).

## The Clinical Gap This Paper Names

Three findings together describe the clinical gap that motivates this paper.

First, a substantial minority of patients in evidence-based trauma treatment do not respond, drop out, or respond only partially.

Second, even patients who do respond — measured by symptom-cluster reduction — frequently retain meaningful disturbances in self-organization, identity, meaning, and relationship.

Third, the field's own highest-level guidelines, since at least 2012, have pointed toward integrative, phase-based, multi-component approaches as the appropriate clinical response to complex presentations (Cloitre et al., 2012; Courtois & Ford, 2014; ISTSS, 2018; Stein et al., 2019).

What these findings do not specify is the *content* of the phase that follows stabilization and trauma processing — the work that Herman (1992) named *reconnection*. Herman's three-phase model — safety, mourning, reconnection — explicitly required all three phases for full recovery, with reconnection involving the survivor's reconstruction of a meaningful post-trauma life. In clinical practice and in health system policy, however, the model has frequently been applied as a stabilization-only protocol, with clients held in safety work indefinitely without advancing to mourning or reconnection. Courtois and Ford (2014) name this "chronic stabilization" as a clinical error.

The Becoming Method® is a structured articulation of the reconnection phase: what its core questions are, what process supports its emergence, and what clinical and developmental outcomes it produces.

### THREE

## A New Paradigm for Trauma Recovery and

## Human Development

Most traditional therapy models are not designed to support the phase of healing that follows symptom resolution. They guide individuals through recovery but fall short when clients are ready to rebuild identity, clarify life purpose, or explore posttraumatic growth. Clinicians, too, encounter a quiet impasse: how to accompany someone not just out of pain, but into alignment, meaning, and contribution.

The Becoming Method® emerges in response to this gap. Grounded in over two decades of clinical application, systems-level consulting, and psychospiritual integration, it offers a structured articulation of a natural post-trauma trajectory — one that many clients already move through, whether consciously or unconsciously. It recognizes that healing is not a linear outcome but a dynamic process — one that unfolds across changes in nervous system regulation, identity formation, relational capacity, and spiritual orientation.

## The Five Stages of Full-Spectrum Trauma Recovery

### THE FIVE STAGES

**1 · Traumatic Wounding.** Marked by dysregulation, somatic imprinting, fragmentation of self-concept, and relational disconnection. This is the rupture that initiates the journey.

**2 · Existential Inquiry and Identity Reconstruction.** Clients begin to reassess belief systems, process meaning, and reconstruct identity — not by returning to a pre-trauma self, but by moving toward deeper internal coherence. Maps onto Park's (2010) meaning-making model.

**3 · Self-Discovery and Narrative Integration.** Through trauma-informed storytelling, truth-telling, and shadow work, individuals integrate disowned or suppressed parts of the self, restoring congruence across lived experience. Draws on narrative reconstruction (White & Epston, 1990; Neimeyer, 2016) and parts-based work (Schwartz, 1995).

**4 · Purpose Clarification.** With clarity comes direction. Clients begin to sense their core values, unique gifts, and contribution to the world — often shifting from survival mode to purpose-driven living. Corresponds to the existential and transpersonal stages (Frankl, 1959; Yalom, 1980; Maslow, 1962).

**5 · Functional Integration and Embodied Contribution.** Healing is enacted. Insight becomes action. Purpose is expressed in daily life, leadership, creativity, and relationships — a movement toward self-authorship (Kegan, 1994), generativity, and community impact.

These stages are sequential in theory and non-linear in practice. Clients move back and forth between them, often returning to earlier stages as new material surfaces. The Method does not treat the stages as a stage-gate protocol; it treats them as a map of the territory the clinician and client are traversing together.

### Three Domains of Integrative Care

What distinguishes the Becoming Method® is its ability to hold the full arc of the healing journey — from crisis to coherence, from emotional regulation to spiritual integration, from self-repair to self-actualization. It supports individuals and clinicians alike by integrating three domains:

**Traumatic Wound Healing.** Grounded in somatic therapy, relational attunement, and evidence-informed modalities, this domain supports nervous system regulation, emotional stabilization, and reconnection to the body. It draws on the body-based trauma traditions (Levine, 1997; Ogden et al., 2006; van der Kolk, 1994, 2014; Porges, 2007).

**Self-Discovery and Transformation.** Practitioners guide clients through narrative reframing, forgiveness processes, and identity reconstruction — helping them recover the self beneath the story. This domain integrates narrative therapy, parts-based work, and existential-depth psychology (White & Epston, 1990; Schwartz, 1995; Jung, 1969; Yalom, 1980).

**Purpose Discovery and Integration.** Clients begin to embody their purpose through service, leadership, creative expression, or caregiving — transforming inner work into external contribution. This domain draws on transpersonal psychology and adult-developmental

theory (Maslow, 1962; Wilber, 2000; Kegan, 1994; Loevinger, 1976).

This is not a fragmented or refer-out model. The Becoming Method® is a unified care framework. It combines the depth of psychotherapy, the future-focus of coaching, and the relational wisdom of mentorship — designed for nursing and allied health professionals who want to deliver holistic trauma-informed care with coherence and impact.

*"Understanding why people suffer, how they change, and how to help them live satisfying lives is a fascinating and important undertaking."*

— Sommers-Flanagan, 2018

## FOUR

# A Clinically Grounded Model: Trauma as Disconnection

The Becoming Method® is a holistic psychotherapeutic approach — structured, integrative, and rooted in consciousness. In our practice, we define consciousness as the capacity to observe oneself in the moment, and to think, feel, speak, and act in alignment with who one truly is. From the very first session, clients are invited to bear compassionate witness to their inner world without being overwhelmed by it. They learn to respond with intention rather than react from habit, and to live from essence rather than from the conditioning of trauma, culture, or history.

**At its core, the Method offers a profound reorientation: trauma is not simply an event or diagnosis — it is a state of disconnection from the self.** Healing, then, is the process of reconnection — to the body, to truth, to others, and to the universal whole.

This framing is not metaphorical. It is consistent with the peer-reviewed evidence on what symptom-focused treatment leaves unaddressed. The ICD-11 disturbances

of self-organization cluster — affect dysregulation, negative self-concept, relational disturbances — is precisely a description of disconnection: from one's own internal states, from a coherent sense of self, and from others (Siddaway, 2024). Park's (2010) meaning-making model frames the same phenomenology in terms of discrepancy between global and situational meaning — a disconnection between the orienting beliefs that gave life coherence before the trauma and the appraisal of what happened. The Schore (2001, 2012) right-brain affect regulation framework locates the neurobiological substrate of this disconnection in the right-hemisphere systems that integrate interoceptive, emotional, and relational information.

The clinical question this framing asks is: *what would reconnection require?*

## Reconnection Begins with the Right Questions

The Becoming Method® supports the journey of reconnection by introducing four foundational, trauma-informed questions. Used across all phases of the therapeutic process, these are more than reflective prompts. They are transformative tools that unlock memory, meaning, and emotional healing.

### THE FOUR FOUNDATIONAL QUESTIONS

1. What do I need to forgive?
2. What intergenerational pattern am I here to interrupt?
3. What did I feel that I couldn't express at the time of the trauma?
4. What lie did I come to believe about myself — and what is the truth that will set me free?

These questions emerge from the body's wisdom and the client's own inner healer. They are universal — not bound to any single therapy modality — and when held within a trauma-informed, consciousness-based framework, they offer access to emotional regulation, identity integration, and nervous system healing.

Each question maps onto a known clinical mechanism in the peer-reviewed literature:

**Forgiveness** becomes a reclamation of personal power — not by excusing harm, but by realigning with truth, dignity, and self-respect. The forgiveness-and-trauma

literature (Worthington & Wade, 2019; Griffin et al., 2023) documents forgiveness processes — both self-directed and other-directed — as mechanisms for reducing the moral and existential burden of trauma.

**Intergenerational insight** helps clients see beyond individual trauma, identify inherited emotional patterns, and disrupt cycles of pain. This work is supported by the Yehuda epigenetics research program documenting biological intergenerational transmission of trauma vulnerability through HPA-axis dysregulation (Yehuda et al., 2001, 2007; Bierer et al., 2014), and by the Canadian Bombay-Matheson-Anisman program on intergenerational transmission through Indian Residential Schools (Bombay et al., 2009, 2011; McQuaid et al., 2017, 2022).

**Unexpressed emotion** is brought into conscious awareness, relieving the body of burdens it has carried silently for years. This corresponds to the body-based trauma literature on somatic discharge and interoception (Levine, 1997; Payne et al., 2015; van der Kolk, 1994; Porges, 2007).

**Truth-telling** facilitates cognitive restructuring and inner narrative repair — transforming shame, self-blame, and fear into clarity, peace, and personal agency. The narrative-therapy tradition (White & Epston, 1990; Neimeyer, 2016; Meichenbaum, 2011) provides the theoretical and clinical scaffolding.

Each question is embedded in a structured therapeutic process involving somatic awareness, applied kinesiology, and guided dialogue. Using these tools, clinicians help clients trace the energetic imprint of trauma to its root, identify unresolved relational dynamics, and reprocess core memories through a technique we describe as *conscious forgiveness*.

This is not talk therapy alone — it is embodied psychotherapy, integrating nervous system regulation, conscious forgiveness, and spiritual reconnection. As the client begins to forgive — not only others but themselves — they release distorted beliefs, resolve internal conflict, reframe the narrative, and return to a coherent sense of self. Clients describe this moment as cathartic: clear, grounding, and quietly profound. Peace returns. At first it flickers. With time it settles into something steady, solid, and unshakable.

*"Healing is not about fixing what is broken. It is about reuniting what has been separated. It is about remembering who we were before the wound — and choosing who we now become."*

— Dr. Joan Samuels-Dennis

- Engages intergenerational and systemic dynamics through Bowenian theory and epigenetic trauma research (Bowen, 1978; Yehuda et al., 2001, 2007; Bierer et al., 2014).
- Reorients the therapeutic journey toward self-actualization, in resonance with transpersonal and adult-developmental theory (Maslow, 1962; Wilber, 2000; Kegan, 1994; Loevinger, 1976).

## FIVE

# A Method That Synthesizes the Field

The Becoming Method® emerges not as a departure from the psychotherapeutic tradition, but as an integrative synthesis — one that weaves together decades of theoretical insight and clinical practice into a coherent, evolution-oriented framework. It does not reject established models. It draws from them, honouring their contributions while addressing the existential, intergenerational, and spiritual dimensions that many approaches leave unintegrated.

## Resolving the Fragmentation of the Field

Over the past 50 years, psychotherapy has become increasingly specialized. This has produced significant innovation. It has also produced fragmentation — splitting emotional from somatic work, intrapsychic from relational, and healing from meaning-making. Clinicians often find themselves piecing together disparate models, hoping to meet the complexity of trauma without a unified map.

The Becoming Method® responds by offering a phase-based model that:

- Draws on the somatic precision of trauma physiology (Levine, 1997; Ogden et al., 2006; van der Kolk, 1994, 2014; Porges, 2007).
- Incorporates the narrative reconstruction processes of narrative therapy and parts-based work (White & Epston, 1990; Schwartz, 1995; Neimeyer, 2016; Meichenbaum, 2011).
- Grounds itself in the existential-depth tradition (Yalom, 1980; Jung, 1969; Frankl, 1959; Assagioli, 1965).

**Figure 1. Lineage Map: The Becoming Method® Across Therapeutic Traditions**

Domain	Established Lineage	Becoming Method® Integration	Key Innovations
Somatic / Body-Based	Levine (Somatic Experiencing); Ogden (Sensorimotor Psychotherapy); van der Kolk (body-based trauma, yoga RCT); Porges (Polyvagal Theory)	Uses body memory as the primary guide; begins each session with somatic anchoring and intention setting	Incorporates applied kinesiology to access energetic imprints of trauma
Narrative / Meaning	White & Epston (Narrative Therapy); Neimeyer (Meaning Reconstruction); Meichenbaum (Constructive Narrative Perspective)	Sessions centre around reframing trauma narratives and restoring coherence	Introduces four foundational questions to guide narrative re-authoring at the level of identity and meaning
Internal Parts Work	Schwartz (Internal Family Systems); Watkins & Watkins (Ego-State Therapy)	Engages fragmented parts through relational inquiry and compassionate witnessing	Adds transgenerational dialogue and forgiveness protocol to support reintegration
Interpersonal Neurobiology	Siegel (IPNB, "mindsight"); Cozolino (neuroscience of psychotherapy); Schore (right-brain affect regulation)	Emphasizes relationship as regulation and reflection; therapist as attuned co-regulator	Frames relational repair as the substrate of identity reconstruction
Existential / Depth	Yalom (existential psychotherapy); Jung (depth psychology, individuation); Frankl (logotherapy); Assagioli (psychosynthesis)	Central focus on meaning, archetypes, and transformation of identity	Frames trauma as disconnection from soul-purpose and healing as reconnection
Transpersonal / Self-Actualization	Maslow (peak experiences, self-actualization); Wilber (Integral Theory); Kegan (constructive-developmental theory); Loevinger (ego development)	Supports client movement into purpose-driven living and integrated identity	Normalizes existential/transcendent experience in the therapy room
Family Systems / Intergenerational	Bowen (Bowenian Family Systems); Yehuda (epigenetics); Bombay-Matheson-Anisman (Canadian Indigenous intergenerational research)	Examines inherited beliefs and unconscious loyalties through systemic mapping	Offers energetic release of intergenerational patterns through conscious forgiveness and narrative completion

Note. This figure presents the canonical primary citation for each lineage. Full references appear in the reference list. The Becoming Method® does not claim originality of these traditions; it claims originality of the integrative phase-based architecture that holds them in coherent clinical sequence.

## Bridging Systems and Soul

The Becoming Method® offers a trauma-informed, consciousness-based care model that speaks directly to the challenges nursing and allied health professionals face in modern clinical settings. Its strength lies in its capacity to hold both the structural realities of health systems and the sacred inner experiences of patients — integrating medical, psychological, and spiritual dimensions of care.

Trauma is not merely an individual or psychological event. It is a systemic disruption shaped by social inequities, cultural silencing, intergenerational legacies, and chronic stress within health environments. The Method honours the biological realities of trauma while making space for identity, meaning, and inner truth to emerge.

Where traditional care models often draw a line between trauma recovery and spiritual awakening, this Method brings them together. It sees trauma not just as a clinical diagnosis but as a rupture in consciousness — a disconnection from purpose, self, and the body's inherent intelligence. In this light, healing becomes a process of reconnection and restoration, not just regulation or symptom management.

### SIX

## Posttraumatic Growth: What the Evidence Supports and What It Does Not

The clinical phenomenon the Becoming Method® describes — clients who move from stabilization through identity reconstruction into purpose and contribution — overlaps substantially with what the empirical literature calls posttraumatic growth (PTG). This section locates the Method within that literature, with attention to both what the evidence supports and what remains contested.

### The Foundational PTG Literature

The construct of posttraumatic growth was formally introduced and operationalized by Tedeschi and Calhoun (1996) through the 21-item Posttraumatic

Growth Inventory (PTGI), measuring five domains: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. Their (2004) theoretical model framed PTG as arising from cognitive processing of "seismic" life events that shatter assumptive worldviews and require reconstruction. A 2017 revision (PTGI-X) added existential and spiritual change as a sixth domain — a development directly relevant to the Becoming Method's psychospiritual framing.

A 2019 meta-analysis synthesizing 73 studies and 22,235 participants found that the prevalence of moderate-to-high PTG ranged from 36% to 83% across trauma types, with female sex, social support, and active coping as consistent positive predictors (Wu et al., 2019). Park's (2010) integrative meaning-making model — published in *Psychological Bulletin* — distinguished global meaning (orienting belief systems, sense of purpose) from situational meaning (event appraisal), and identified discrepancy between the two as the engine of post-trauma meaning-making.

This is the conceptual architecture that maps directly onto the Becoming Method's Four Foundational Questions and onto stages two through five of the recovery arc.

**Table 2. Predictors of posttraumatic growth across trauma types**

Predictor	Direction of Effect	Source
Social support	Positive	Wu et al. (2019) meta-analysis
Active / problem-focused coping	Positive	Wu et al. (2019); Tedeschi & Calhoun (2004)
Time since trauma	Curvilinear; growth often emerges months to years post-event	Tedeschi & Calhoun (2004)
Female sex	Positive (small to moderate)	Wu et al. (2019)
Cognitive engagement (rumination)	Positive when deliberate, negative when intrusive	Tedeschi & Calhoun (2004)
Spiritual / existential orientation	Positive	Tedeschi et al. (2017); PTGI-X validation

## What Is Contested

Intellectual honesty requires that the PTG literature's open debates be named.

A growing critical literature — most prominently Boals (2023) — argues that most self-reported PTG reflects positive cognitive illusion rather than verified behavioural or functional change. The PTGI asks respondents to compare themselves "now" to "before the trauma," a comparison susceptible to recall bias and motivated reasoning. Frazier and colleagues have shown that perceived PTG often exceeds measurable actual growth, although Gangel et al. (2023) found longitudinal evidence that perceived growth can scaffold later observable change. Cognitive-interview validation studies (Grant et al., 2026) have found inconsistent response-process validity in PTGI items.

For clinicians working with full-spectrum recovery, the appropriate stance is one of qualified confidence. PTG is a real phenomenon. It is not, on present evidence, equivalent to verified functional transformation. Self-report measures of growth should be treated as one data source among several — not as outcome certification.

The Becoming Method® treats posttraumatic growth as a clinical orientation rather than a measurable endpoint. The work is not to score higher on the PTGI. The work is to inhabit the four questions, integrate the disowned, and live in alignment with what reconnection reveals.

### SEVEN

## The Canadian Context: Why This Work Matters Now

### Trauma Prevalence in Canada

The case for full-spectrum trauma recovery is strengthened by Canadian epidemiology documenting high and rising mental health burden:

- Pooled cross-sectional data from the Survey on Mental Health and Stressful Events estimated **overall lifetime PTSD prevalence at 6.9% in Canada** (fall 2020 / spring 2021), with the Public Health Agency of Canada reporting 6.1% of Canadian adults meeting PTSD criteria and substantial lost-time workforce

impact (Statistics Canada, 2023b).

- The **Canadian Community Health Survey – Mental Health 2022** found that the prevalence of mood and anxiety disorders increased substantially from 2012 to 2022 (Statistics Canada, 2023a).
- Adverse Childhood Experiences (ACEs) are widespread: a representative Canadian sample found **approximately 60% reporting at least one ACE and 23% reporting four or more** (Joshi et al., 2021). The dose-response relationship between ACE score and lifetime mental and physical health outcomes is well established (Felitti et al., 1998).

These prevalence figures almost certainly undercount complex and developmental PTSD, which DSM-5-based screeners do not fully capture. Canadian surveillance does not separately measure ICD-11 CPTSD. This is a methodological gap with clinical consequences: a system that does not measure DSO will not treat it.

## Indigenous Trauma and Intergenerational Transmission

Canada's Indigenous populations represent the clearest case of systemic complex developmental trauma — trauma inflicted by state policy, transmitted across generations, and systematically undertreated by a mental health system oriented around symptom management. The Bombay-Matheson-Anisman research program at Carleton University provides the most rigorous Canadian peer-reviewed evidence:

- The foundational Bombay et al. (2009) model documented biological, psychological, and social transmission pathways from Indian Residential Schools.
- Bombay et al. (2011) showed elevated stress reactivity and mental health vulnerability in children of Residential School survivors.
- McQuaid et al. (2017) linked Residential School intergenerational transmission to current suicide ideation and attempts among First Nations peoples living on-reserve.
- McQuaid et al. (2022) demonstrated direct links between ongoing child welfare removals and intergenerational trauma transmission.

A full-spectrum recovery framework — one that addresses identity reconstruction, meaning-making, and the interruption of intergenerational patterns alongside

nervous system regulation — has direct clinical relevance for these populations. Implementation must be guided by Indigenous-led leadership, cultural humility, and recognition that "intergenerational resilience" is as empirically grounded as "intergenerational trauma" and is the framing many Indigenous communities themselves prefer.

## The Healthcare Workforce: Burnout, Moral Injury, Secondary Traumatic Stress

The case for full-spectrum care is sharpened by the state of the Canadian healthcare workforce. The 2022 Canadian Federation of Nurses Unions report *Sustaining Nursing in Canada* found that **94% of actively working nurses show signs of burnout, 83% report their units are so understaffed they worry about quality of care, and 50% wish to change jobs** (CFNU, 2022). A peer-reviewed Canadian health workforce study found nursing burnout reached **89.5% during the COVID-19 pandemic** (Khan et al., 2025).

The literature increasingly distinguishes three related but distinct phenomena affecting clinicians:

- **Burnout** — occupational exhaustion arising from chronic workplace stress (Maslach et al., 2001).
- **Moral injury** — damage to the moral self from perpetrating, failing to prevent, or witnessing events that violate moral beliefs (Litz et al., 2009). Dean & Talbot (2019) argue that framing clinician suffering as burnout rather than moral injury mislocates the problem in individual pathology rather than systemic failure.
- **Secondary traumatic stress and vicarious traumatization** — schema disruption and trauma response arising from sustained empathic engagement with traumatized patients (Figley, 1995; McCann & Pearlman, 1990). A 2024 systematic review of emergency nurses found pooled STS prevalence in the 35–45% range (Liu et al., 2024).

Importantly, vicarious posttraumatic growth and secondary traumatic stress are not mutually exclusive. A 2024 meta-analysis of nurses found pooled moderate-to-high PTG prevalence of 51.7%, reframing the nursing workforce as also a potential growth population, not only a burnout population (Zeng et al., 2024).

A network meta-analysis evaluating interventions for compassion fatigue, burnout, and STS in nurses concluded that **comprehensive organizational interventions — combining individual psychological skill-building with systemic supports — outperformed psychological or behavioural interventions alone** (Onishi et al., 2024). This is consistent with the Becoming Method's position that workforce sustainability is a system-design problem requiring both individual-clinician capacity and organizational architecture.

The Becoming Method® equips clinicians with the inner architecture that sustained engagement with complex trauma requires, and provides a framework that organizations can adopt to address moral injury and vicarious trauma at the structural level rather than as individual deficits.

### EIGHT

## For Clinicians and Faculty: An Invitation Into the Work

*"It seems to me that the good life is not any fixed state. The good life is a process, not a state of being. It is a direction, not a destination."*

— Rogers, 1961/1995

Whether you are an experienced psychotherapist refining your approach, a nurse exploring psychotherapy as a next step, a faculty member designing curriculum for the next generation of trauma-informed clinicians, or a researcher locating clinical phenomena that current treatment models do not adequately address — this work is for you.

You may sense what your clients often express: that while symptom relief is important, something deeper is asking to be addressed — a desire for coherence, purpose, and long-term transformation.

The Becoming Method® is not here to replace what you already do well, but to expand it. Designed for those who want to integrate somatic therapy, narrative processing, parts-based work, and trauma-informed

care into a coherent phase-based architecture, this method supports healing beyond crisis stabilization. It is for clinicians who recognize that full-spectrum trauma recovery involves not just managing distress, but restoring identity, meaning, and connection.

*"Nothing ever goes away until it has taught us what we need to know."*

— Chödrön, 1997

NINE

## What Remains Contested

This paper would be incomplete without naming the questions on which the evidence is still unsettled. Five domains deserve explicit acknowledgment.

**On PTG measurement.** Self-reported posttraumatic growth, as measured by the PTGI, reflects a mix of genuine psychological change and positive cognitive reappraisal. The latter is not clinically worthless — positive reappraisal is itself therapeutic — but clinicians should not claim PTG as equivalent to verified behavioural or functional improvement without longitudinal evidence (Boals, 2023; Frazier et al., 2009; Grant et al., 2026).

**On somatic modalities.** Somatic Experiencing, Sensorimotor Psychotherapy, and most body-based trauma modalities have a strong theoretical foundation but a limited large-RCT evidence base. The strongest evidence remains the van der Kolk yoga RCT (van der Kolk et al., 2014) and theoretical-mechanism papers (Payne et al., 2015). This is a genuine evidence gap to be transparent about, not a fatal limitation — it is the same evidence gap that characterized cognitive therapy in the 1970s and EMDR in the 1990s. Continued rigorous outcome research is needed.

**On Internal Family Systems for PTSD.** The Hodgdon et al. (2021) pilot effectiveness study is the strongest published trial of IFS for complex trauma, but with a small sample and no randomization. IFS evidence for PTSD specifically is pre-RCT in quality. Readers should not cite it as equivalent to the evidence base for prolonged exposure or cognitive processing therapy.

**On phase-based treatment.** The phase-based framework is well-supported as a clinical heuristic, but

"phase" is a descriptive construct rather than an empirically isolated treatment component. Some RCTs of prolonged exposure show good outcomes without formal phase structure for non-complex presentations. The Sele et al. (2023, 2026) trials are the strongest direct evidence that phase-based treatment outperforms single-component approaches for complex PTSD specifically.

**On cultural validity.** The PTGI and most outcome measures cited in this paper were developed primarily in Western, individualistic samples. Cross-cultural validity — including with Canadian Indigenous, Black, and other racialized populations — is variable and incompletely studied. Implementation of the Becoming Method® in these populations should be guided by cultural humility, community leadership, and willingness to revise measures and processes as required.

Naming these limitations does not weaken the case. It locates the Becoming Method® where it belongs: in active, ongoing relationship with the empirical literature, holding both clinical conviction and intellectual honesty in the same hand.

TEN

## A Note on Terminology

This paper uses several diagnostic and conceptual terms that have specific technical meanings.

**Complex PTSD (ICD-11)** is a formally recognized distinct diagnosis (WHO, 2018) requiring PTSD criteria plus the disturbances of self-organization cluster: affect dysregulation, negative self-concept, and disturbances in relationships. It is endorsed by the 2018 ISTSS guidelines and represents the most operationally precise term for the phenomenology the Becoming Method® addresses.

**DSM-5 PTSD** (APA, 2013) does not formally recognize CPTSD as a distinct category. Its dissociative subtype partially captures some CPTSD phenomenology, but DSM-5 criteria omit the DSO cluster. This divergence means that diagnostic remission measured on DSM-5 criteria may leave the majority of complex trauma sequelae unmeasured.

**Complex trauma** (Courtois & Ford, 2009, 2014) is a clinical and theoretical term — not a DSM/ICD

diagnosis. It refers to traumatic exposure that is prolonged, repetitive, interpersonal, and often developmental. It is distinct from "Complex PTSD" (the response) and "complex trauma" (the exposure).

**Developmental Trauma Disorder** (van der Kolk, 2005) was proposed for DSM-5 and not adopted. It remains a clinically useful descriptor of the developmental sequelae of early relational trauma and is cited here as a proposed but officially unrecognized construct.

This paper uses "Complex PTSD (ICD-11)" when citing the diagnostic literature, "complex trauma" when referring to the exposure type, and "full-spectrum trauma recovery" to describe the clinical aim that integrates symptom resolution with identity reconstruction, meaning-making, and embodied contribution.

## ELEVEN

# Conclusion: From Recovery to Becoming

*"God grant us the serenity to accept the things we cannot change; the courage to change the things we can; and the wisdom to know the difference."*

— Niebuhr, as cited in Schaffner, 2021, p. 38

The clinical literature has moved. The 2018 ISTSS guidelines, the Sele et al. (2023) trial, the Semmlinger et al. (2024) meta-analysis on non-response, the Bombay-Matheson-Anisman intergenerational research, the CFNU workforce data, and the Park (2010) meaning-making model converge on a single argument: stabilization is necessary and not sufficient; symptom resolution is necessary and not sufficient; what comes next is reconnection, identity reconstruction, and the embodied expression of meaning in daily life.

This is the territory the Becoming Method® was developed to traverse. It does not displace evidence-based trauma treatment. It extends it.

For clinicians who have noticed the moment when a client moves from suffering to longing — from *help me feel better* to *help me become* — the Method offers a phase-based map, a set of foundational questions, and an integrative architecture grounded in the

peer-reviewed traditions of somatic, narrative, parts-based, interpersonal-neurobiological, existential, transpersonal, and intergenerational work.

For faculty designing the next generation of trauma-informed curriculum, the Method offers a framework that can be taught, sequenced, and evaluated — and that aligns with the field's own consensus that complex trauma requires multi-component phase-based care.

For researchers, the Method offers a set of testable clinical claims: that phase-based, consciousness-grounded, meaning-making-oriented intervention produces gains on identity, purpose, and relational dimensions that single-modality stabilization or exposure does not.

The work is not finished. The evidence base for somatic, parts-based, and integrative methods continues to mature. The cultural validity of growth measures continues to be tested. The architecture of organizational interventions continues to be refined. What we know now — and what this paper has tried to set out — is that the gap between regulated and whole is real, the literature names it, clients feel it, and a clinical response is both possible and overdue.

The Becoming Method® is one such response. It is offered in conversation with the field, not in opposition to it. **Trauma is a state of disconnection from the self. Healing is the process of reconnection. Becoming is what reconnection makes possible.**

## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Assagioli, R. (1965). *Psychosynthesis: A manual of principles and techniques*. Hobbs, Dorman & Company.
- Bierer, L. M., Bader, H. N., Daskalakis, N. P., Lehrner, A., Makotkine, I., Seckl, J. R., & Yehuda, R. (2014). Elevation of 11-beta-hydroxysteroid dehydrogenase type 2 activity in Holocaust survivor offspring. *Psychoneuroendocrinology*, *48*, 105–113. <https://doi.org/10.1016/j.psyneuen.2014.06.001>
- Boals, A. (2023). Illusory posttraumatic growth is common, but genuine posttraumatic growth is rare. *Clinical Psychology Review*, *102*, 102301. <https://doi.org/10.1016/j.cpr.2023.102301>
- Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *International Journal of Indigenous Health*, *5*(3), 6–47.
- Bombay, A., Matheson, K., & Anisman, H. (2011). The impact of stressors on second-generation Indian Residential School survivors. *Transcultural Psychiatry*, *48*(4), 367–391. <https://doi.org/10.1177/1363461511410240>
- Bowen, M. (1978). *Family therapy in clinical practice*. Jason Aronson.
- Canadian Federation of Nurses Unions. (2020). *Occupational stress injuries in nursing*. [https://nursesunions.ca/wp-content/uploads/2020/06/OSI\\_report\\_final.pdf](https://nursesunions.ca/wp-content/uploads/2020/06/OSI_report_final.pdf)
- Canadian Federation of Nurses Unions. (2022). *Sustaining nursing in Canada*. [https://nursesunions.ca/wp-content/uploads/2022/11/CHWN-CFNU-Report\\_-Sustaining-Nursing-in-Canada2022\\_web.pdf](https://nursesunions.ca/wp-content/uploads/2022/11/CHWN-CFNU-Report_-Sustaining-Nursing-in-Canada2022_web.pdf)
- Chödrön, P. (1997). *When things fall apart: Heart advice for difficult times*. Shambhala.
- Cloitre, M., Courtois, C. A., Ford, J. D., Green, B. L., Alexander, P., Briere, J., Herman, J. L., Lanius, R., Stolbach, B. C., Spinazzola, J., van der Kolk, B. A., & van der Hart, O. (2012). *The ISTSS expert consensus treatment guidelines for complex PTSD in adults*. International Society for Traumatic Stress Studies.
- Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. Guilford Press.
- Cozolino, L. (2002). *The neuroscience of psychotherapy*. W. W. Norton.
- Dean, W., & Talbot, S. G. (2019). Reframing clinician distress: Moral injury not burnout. *Federal Practitioner*, *36*(9), 400–402.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, *14*(4), 245–258. [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)
- Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner/Mazel.
- Ford, J. D., & Courtois, C. A. (Eds.). (2014). *Treating complex traumatic stress disorders in adults* (2nd ed.). Guilford Press.
- Frankl, V. E. (1959). *Man's search for meaning*. Beacon Press.
- Frazier, P., Tennen, H., Gavian, M., Park, C., Tomich, P., & Tashiro, T. (2009). Does self-reported posttraumatic growth reflect genuine positive change? *Psychological Science*, *20*(7), 912–919. <https://doi.org/10.1111/j.1467-9280.2009.02381.x>
- Gangel, M. J., Kemmerly, R., Wilson, L., Glickson, S., Frazier, P., Tennen, H., & Jayawickreme, E. (2023). Does perceived posttraumatic growth predict observed changes? *Clinical Psychological Science*, *11*(4), 764–775. <https://doi.org/10.1177/21677026231182329>
- Grant, A. I., Furr, R., & Jayawickreme, E. (2026). Assessing the response process validity of the Posttraumatic Growth Inventory using cognitive interviews. *Journal of Personality Assessment*. <https://doi.org/10.1080/00223891.2025.2609697>
- Griffin, B. J., Weber, M. C., Hinkson, K. D., Jendro, A. M., Pyne, J., & Worthington, E. L. (2023). Toward a dimensional contextual model of moral injury. *Current Psychiatry Reports*, *25*, 553–565. <https://doi.org/10.1007/s40501-023-00296-4>
- Herman, J. L. (1992). *Trauma and recovery*. Basic Books.
- Hodgdon, H., Anderson, F., Southwell, E., Hrubec, W., & Schwartz, R. (2021). Internal Family Systems (IFS) therapy for PTSD among survivors of multiple childhood trauma. *Journal of Aggression, Maltreatment & Trauma*, *30*(8), 1–22. <https://doi.org/10.1080/10926771.2021.2013375>
- Imel, Z. E., Laska, K., Jakupcak, M., & Simpson, T. L. (2013). Meta-analysis of dropout in treatments for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *81*(3), 394–404. <https://doi.org/10.1037/a0031474>
- International Society for Traumatic Stress Studies. (2018). *Posttraumatic stress disorder prevention and treatment guidelines: Methodology and recommendations*. <https://istss.org/wp-content/uploads/2024/08/Posttraumatic-Stress-Disorder-Prevention-and-Treatment-Guidelines-Methodology-and-Recommendations.pdf>
- Joshi, D., Raina, P., Tonmyr, L., MacMillan, H. L., & Gonzalez, A. (2021). Prevalence of adverse childhood experiences among Canadian adults. *Health Promotion and Chronic Disease Prevention in Canada*, *41*(11), 367–376.
- Joseph, S., & Linley, P. A. (Eds.). (2008). *Trauma, recovery, and growth: Positive psychological perspectives on posttraumatic stress*. Wiley.
- Jung, C. G. (1969). *The archetypes and the collective unconscious* (Vol. 9, Part 1, Collected Works, 2nd ed.). Princeton University Press.
- Kegan, R. (1994). *In over our heads: The mental demands of modern life*. Harvard University Press.
- Khan, N., Palepu, A., Dodek, P., Salmon, A., Leitch, H., Ruzycki, S., Townson, A., Lacaille, D., & Soklaridis, S. (2025). Burnout among Canadian healthcare workers during the COVID-19 pandemic. [PMCID: PMC12344211](https://doi.org/10.1101/2025.03.11.25111111)

- Levine, P. A. (1997). *Waking the tiger: Healing trauma*. North Atlantic Books.
- Lewis, C., Roberts, N. P., Gibson, S., & Bisson, J. I. (2020). Dropout from psychological therapies for PTSD in adults. *European Journal of Psychotraumatology*, 11(1), 1709709.
- Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans. *Clinical Psychology Review*, 29(8), 695–706. <https://doi.org/10.1016/j.cpr.2009.07.003>
- Liu, W., Zhang, Q., Zhang, J., Pan, W., Gu, C., & Xu, Y. (2024). Prevalence and associated factors of secondary traumatic stress in emergency nurses. *European Journal of Psychotraumatology*, 15(1), 2321761. <https://doi.org/10.1080/20008066.2024.2321761>
- Loevinger, J. (1976). *Ego development: Conceptions and theories*. Jossey-Bass.
- Lorbeer, N., Knaevelsrud, C., & Niemyer, H. (2023). STAIR and STAIR/NT as a treatment for posttraumatic stress: A systematic review. *Psychotherapy and Psychosomatics*, 92(3), 142–154. <https://doi.org/10.1159/000526592>
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397–422. <https://doi.org/10.1146/annurev.psych.52.1.397>
- Maslow, A. H. (1962). *Toward a psychology of being*. Van Nostrand.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization. *Journal of Traumatic Stress*, 3(1), 131–149. <https://doi.org/10.1007/BF00975140>
- McQuaid, R. J., Bombay, A., McInnis, O. A., Humeny, C., Matheson, K., & Anisman, H. (2017). Suicide ideation and attempts among First Nations peoples living on-reserve in Canada. *Canadian Journal of Psychiatry*, 62(6), 422–430. <https://doi.org/10.1177/0706743717702075>
- McQuaid, R. J., Schwartz, F., Blackstock, C., Matheson, K., Anisman, H., & Bombay, A. (2022). Parent-child separations and mental health among First Nations and Métis peoples in Canada. *International Journal of Environmental Research and Public Health*, 19(11), 6877. <https://doi.org/10.3390/ijerph19116877>
- Meichenbaum, D. (2011). A constructive narrative perspective on trauma and resilience. In S. M. Southwick et al. (Eds.), *Resilience and mental health*. Cambridge University Press.
- Neimeyer, R. A. (2016). The narrative arc of tragic loss. *Rivista di Psicologia Clinica*, 11, 10–23.
- Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body*. W. W. Norton.
- Onishi, M., Wakabayashi, H., Makihara, M., Kaneko, M., & Takahashi, M. (2024). Interventions for compassion fatigue, burnout, and secondary traumatic stress in nurses. *Nursing & Health Sciences*, 26, e70042. <https://doi.org/10.1111/nhs.70042>
- Park, C. L. (2010). Making sense of the meaning literature. *Psychological Bulletin*, 136(2), 257–301. <https://doi.org/10.1037/a0018301>
- Payne, P., Levine, P. A., & Crane-Godreau, M. A. (2015). Somatic experiencing: Using interoception and proprioception as core elements of trauma therapy. *Frontiers in Psychology*, 6, 93. <https://doi.org/10.3389/fpsyg.2015.00093>
- Porges, S. W. (2007). The polyvagal perspective. *Biological Psychology*, 74(2), 116–143. <https://doi.org/10.1016/j.biopsycho.2006.06.009>
- Porges, S. W. (2011). *The polyvagal theory*. W. W. Norton.
- Public Health Agency of Canada. (2025). *PTSD impact on Canada's workforce: Lost-time claims*. <https://health-infobase.canada.ca/ptsd/lost-time-claims/>
- Public Health Ontario. (2020). *Adverse childhood experiences (ACEs)*.
- Rogers, C. R. (1995). *On becoming a person*. Houghton Mifflin. (Original work published 1961)
- Schaffner, A. K. (2021). *The art of self-improvement: Ten timeless truths*. Yale University Press.
- Schore, A. N. (2001). The effects of early relational trauma on right brain development. *Infant Mental Health Journal*, 22(1–2), 201–269.
- Schwartz, R. C. (1995). *Internal Family Systems therapy*. Guilford Press.
- Sele, P., Hoffart, A., Cloitre, M., Hembree, E., & Øktedalen, T. (2023). Comparing phase-based treatment, prolonged exposure, and skills-training for complex posttraumatic stress disorder. *Journal of Anxiety Disorders*, 97, 102786. <https://doi.org/10.1016/j.janxdis.2023.102786>
- Sele, P., Hoffart, A., Hembree, E., & Øktedalen, T. (2026). Trajectories of complex posttraumatic stress disorder symptoms change. *Behaviour Research and Therapy*. <https://doi.org/10.1016/j.brat.2026.105044>
- Semmlinger, V., Leithner, C., Klöck, L. M., Ranftl, L., Ehring, T., & Schreckenbach, M. (2024). Prevalence and predictors of nonresponse to psychological treatment for PTSD: A meta-analysis. *PTSD Research Quarterly*, 2024, 9899034. <https://doi.org/10.1155/2024/9899034>
- Siddaway, A. P. (2024). Assessment and diagnosis of post-traumatic stress disorders for medico-legal and other clinical purposes. *BJPsych Advances*, 30(5), 315–330. <https://doi.org/10.1192/bja.2024.27>
- Siegel, D. J. (1999). *The developing mind*. Guilford Press.
- Sommers-Flanagan, J. (2018). *Counseling and psychotherapy theories in context and practice* (3rd ed.). Wiley.
- Sripada, R. K., Blow, F. C., Rauch, S. A. M., Ganoczy, D., Hoff, R., Harpaz-Rotem, I., & Bohnert, K. M. (2022). Examining the nonresponse phenomenon. *Journal of Anxiety Disorders*, 86, 102532.
- Statistics Canada. (2023a). *Mental disorders and access to mental health care* [Health Reports, Catalogue No. 75-006-X].
- Statistics Canada. (2023b). *Mental disorders in Canada, 2022* [The Daily, Catalogue No. 11-627-M2023053].
- Stein, D. J., Koenen, K. C., Friedman, M. J., Hill, E. D., McLaughlin, K. A., Petukhova, M., Ruscio, A. M., Shahly, V., Spiegel, D., et al. (2019). Posttraumatic stress disorder prevention and treatment guidelines: Methodology and recommendations. *Journal of Traumatic Stress*, 32(4), 567–568. <https://doi.org/10.1002/jts.22421>

- Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455–471. <https://doi.org/10.1007/BF02103658>
- Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1–18. [https://doi.org/10.1207/s15327965pli1501\\_01](https://doi.org/10.1207/s15327965pli1501_01)
- Tedeschi, R. G., Cann, A., Taku, K., Senol-Durak, E., & Calhoun, L. G. (2017). The Posttraumatic Growth Inventory: A revision integrating existential and spiritual change. *Journal of Traumatic Stress, 30*(1), 11–18. <https://doi.org/10.1002/jts.22155>
- van der Kolk, B. A. (1994). The body keeps the score. *Harvard Review of Psychiatry, 1*(5), 253–265. <https://doi.org/10.3109/10673229409017088>
- van der Kolk, B. A. (2005). Developmental trauma disorder. *Psychiatric Annals, 35*(5), 401–408.
- van der Kolk, B. A. (2014). *The body keeps the score*. Viking.
- van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. *Journal of Clinical Psychiatry, 75*(6), e559–e565. <https://doi.org/10.4088/JCP.13m08561>
- Watkins, J. G., & Watkins, H. H. (1997). *Ego states: Theory and therapy*. W. W. Norton.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W. W. Norton.
- Wilber, K. (2000). *Integral psychology*. Shambhala.
- World Health Organization. (2018). *International classification of diseases for mortality and morbidity statistics* (11th rev.). <https://icd.who.int/>
- Worthington, E. L., & Wade, N. G. (Eds.). (2019). *Handbook of forgiveness* (2nd ed.). Routledge.
- Wu, X., Kaminga, A. C., Dai, W., Deng, J., Wang, Z., Pan, X., & Liu, A. (2019). The prevalence of moderate-to-high posttraumatic growth: A systematic review and meta-analysis. *Journal of Affective Disorders, 243*, 408–415. <https://doi.org/10.1016/j.jad.2018.09.023>
- Yalom, I. D. (1980). *Existential psychotherapy*. Basic Books.
- Yehuda, R., Halligan, S. L., & Grossman, R. A. (2001). Childhood trauma and risk for PTSD. *Development and Psychopathology, 13*(3), 733–753. <https://doi.org/10.1017/S0954579401003170>
- Yehuda, R., Teicher, M. H., Seckl, J. R., Grossman, R. A., Morris, A., & Bierer, L. M. (2007). Parental posttraumatic stress disorder as a vulnerability factor for low cortisol trait in offspring of Holocaust survivors. *Archives of General Psychiatry, 64*(9), 1040–1048. <https://doi.org/10.1001/archpsyc.64.9.1040>
- Zeng, L., Wang, J., Liu, G., Yuan, Z., Yang, F., Liu, D., Li, L., & Peng, Y. (2024). The prevalence and factors of posttraumatic growth among nurses based on the PTGI. *International Nursing Review, 71*(2), 345–356. <https://doi.org/10.1111/inr.12967>

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