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Reducing Shame, Promoting Dignity: A Model for the Primary Prevention of Complex Post-Traumatic Stress Disorder

Michael Salter[1] and Heather Hall[2]

Abstract

Complex post-traumatic stress disorder (CPTSD) refers to the complex psychological and psychosocial sequelae caused by prolonged interpersonal abuse. Contemporary approaches to CPTSD are dominated by individualized psychological interventions that are long term and costly. However, accumulating evidence indicates that CPTSD is a high prevalence mental illness implicated in significant social problems, with a pattern of lateral and intergenerational transmission that impacts on already disadvantaged communities. Consequently, there have been calls for a public health model for the prevention of CPSTD; however, there has been a lack of clarity as to what this should entail. This article argues that empirical and conceptual shifts framing CPTSD as a shame disorder offers new preventative opportunities. The article presents a series of interconnected literature reviews including a review of available prevalence data on CPTSD, the public health implications of CPTSD, the role of shame and humiliation in CPTSD, and current scholarship on dignity in public policy and professional practice. Drawing on these reviews, this article develops a social ecological model of primary prevention to CPTSD with a focus on the reduction of shame and the promotion of dignity at the relational, community, institutional, and macrolevel. A broad overview of this model is provided with examples of preventative programs and interventions. While the epidemiology of CPTSD is still emerging, this article argues that this model provides the conceptual foundations necessary for the coordination of preventative interventions necessary to reduce to the risk and prevalence of CPSTD.

Keywords

intergenerational transmission of trauma, prevention of child abuse, child abuse, PTSD, attachment, criminology

The recent inclusion of complex post-traumatic stress disorder (CPTSD) into the *International Classification of Diseases* 11th revision (*ICD-11*) is the culmination of over 25 years of research and clinical practice. Since the early 1990s, it has been proposed that a complex variant of PTSD can be differentiated from classical PTSD by alterations in affect and behavioral regulation, interpersonal problems, dissociative symptoms, and somatizations (Herman, 1992). As clinical scholarship and research into CPTSD has developed, it has been linked to concepts of developmental and attachment trauma, recognizing the etiological role of early onset abuse and neglect, and associated disruptions in the child–caregiver bond (Farina et al., 2019). Parallel scholarship into adverse childhood experiences(ACEs) links child-onset trauma to major social and public health challenges, including common mental and physical illnesses, entrenched poverty, and criminality (Lambert et al., 2017). In light of the evidence of the public health burden of CPSTD, Ford (2015) argues for population-level interventions to reduce the prevalence of CPTSD, otherwise "vulnerable individuals and entire populations are at risk for becoming trapped in intergenerational vicious cycles escalating danger, disadvantage, and dysregulation" (p. 3).

To date, the overwhelming majority of CPSTD scholarship has focused on the aetiology of the disorder and the identification of symptoms to inform tertiary responses; that is, individual treatment. In contrast, this article articulates a primary prevention framework that aims to prevent CPTSD before it occurs and reduce the community prevalence of CPTSD. This article begins by summarizing the available evidence of the etiology and prevalence of CPSTD, and its associated human and economic costs. After explaining the concept of primary prevention, the article acknowledges the relevance of overlapping prevention frameworks in mental health, gendered violence, and child abuse. However, drawing on recent scholarship in the fields of complex trauma and attachment

[1] School of Social Sciences, University of New South Wales, Sydney, Australia
[2] International Society for the Study of Trauma and Dissociation, Arlington, VA, USA

Corresponding Author:
Michael Salter, School of Social Sciences, University of New South Wales, Sydney, New South Wales 2052, Australia.
Email: michael.salter@unsw.edu.au

theory, we identify shame as the distinctive driver of CPTSD at the individual and community level, distinguishing it from other traumatic illnesses and experiences, and largely overlooked by existing primary prevention frameworks. Shame is the emotional correlate of attachment failure, child abuse, and neglect; however, it is also as a socially located and politically structured experience that is exacerbated by public policy, professional practice and governmental decision making. The article argues that dignity, as both the emotional experience of feeling valued and the social practice of valuing others, is key to the disruption of those shaming processes that increase the risk of CPTSD. The article closes with some preliminary policy and practice recommendations for the primary prevention of CPSTD.

Method

The article presents a series of interconnected literature reviews, including a review of available prevalence data on CPTSD, the public health implications of CPTSD, the role of shame and humiliation in CPTSD, and current scholarship on dignity in public policy and professional practice. Given the interdisciplinary scope of the article, it was necessary to search databases in psychology, social science, and medicine. The term "complex post-traumatic stress disorder" was combined with the terms "prevalence," "public health," "shame," "humiliation," and "dignity" in order to identify peer-reviewed publications with relevant empirical findings or theoretical contributions. The search terms were also inputted into Google Scholar to identify "gray literature" including reports from government and nongovernment agencies and research centers. The bibliographies of identified sources were examined in order to identify other relevant resources. The literature on CPTSD and shame consistently made reference to a multiplicity of sources of shame from attachment disruption in infancy, to violence and abuse, to experiences of inequality and discrimination, which led to more targeted research on the psychology and sociology of shame and humiliation. This targeted research highlighted dignity as potential ameliorative response to shame and humiliation which provided the basis for conceptual elaboration of the primary prevention framework presented in this article.

Summaries of the etiological and epidemiological literature on shame and CPTSD were then organized within a social ecological framework, seeking to clarify the social and structural dimensions of shame and dignity at the relational, community, institutional, and macrosocial level. The potentially relevant literature on shame, abuse, and trauma is broad in scope and includes multiple and intersecting forms of disadvantage and inequality. The review has drawn in particular on scholarship on race, gender, and poverty for the sake of brevity, however, the article raises issues that are relevant for diverse populations. While the evidence for the etiological role of shame in CPSTD is relatively robust, the epidemiology of CPSTD is still emerging since the diagnosis has only recently been integrated into diagnostic systems. As a result, the framework highlights likely causal pathways between shame and CPTSD that needs to be explored through further research. The framework presents a number of interventions which, it is argued, would have a preventative effect on community rates of CPSTD; however, such impacts have yet to be empirically tested. The evidence base to support the primary prevention of CPSTD is still in the process of development, and this review aims to facilitate that process. As a result, the framework developed from the literature review is not definitive but rather lays the groundwork for future empirical research and theoretical elaboration.

The Prevalence of CPTSD

Recognition of the diversity of traumatic presentations and treatment needs of individuals exposed to early onset trauma prompted Herman (1992) to introduce the concept of CPTSD. The CPTSD construct identified the symptom complexity evident in survivors of prolonged interpersonal abuse characterized by experiences of betrayal and helplessness. In her formulation of CPTSD, Herman drew together symptoms associated with Dissociative Identify Disorder (DID; then Multiple Personality Disorder [MPD]), Borderline Personality Disorder and Somatization Disorder, including dissociation, pathological changes to self-identity, emotional and relational alterations, and somatization, and articulated them as responses or adaptations to circumstances of extreme and prolonged stress. While proving to be a highly influential concept, CPTSD has been defined and operationalized in clinical practice and research in a variety of ways that has, until recently, eluded incorporation into international diagnostic systems (Resick et al., 2012).

However, recent trauma studies have consistently delineated a cohort with elevated PTSD symptoms, greater functional impairment, and disturbances in three domains of self-organization (affective dysregulation, negative self-concept, and interpersonal problems) from cohorts with classical PTSD (Brewin et al., 2017; Cloitre et al., 2013; Elklit et al., 2014). This cohort is disproportionately likely to report interpersonal violence and abuse from which escape was impossible, such as childhood abuse (Hyland et al., 2017). Accordingly, CPSTD as a sibling disorder to PTSD, distinguished by the three domains of self-organization outlined above, was incorporated into the *ICD-11* in June 2018. The *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (*DSM-5*) has not articulated a specific CPTSD diagnosis but rather expanded the PTSD diagnostic criteria to include these three domains, as well as identifying a dissociative subtype of PTSD. The inclusion of this dissociative subtype was in response to evidence that a cohort of people with PTSD exhibited a dissociative pattern of neurobiological responses to symptom provocation, requiring alternative treatment approaches to classical PTSD (Lanius et al., 2012). The dissociative PSTD subtype correlates closely with Herman's (1992) formulation of CPSTD characterized by severe dissociative symptoms which she likened to those observed in MPD/DID (p. 381).

Using *ICD* criteria, national prevalence studies have identified a prevalence of CPTSD in the community between 0.5% and 3.8% (Cloitre et al., 2019; Wolf et al., 2015; Maercker et al., 2018) with higher rates in specific populations. In the United States, 13% of veterans who met the criteria for PTSD also met the criteria for CPTSD (Wolf et al., 2015). A survey of 229 survivors of childhood institutional abuse found that the prevalence of CPTSD was 21.4% (Knefel & Lueger-Schuster, 2013). Approximately a quarter of civilians who meet the criteria for PTSD also meet the criteria for CPTSD (Wolf et al., 2015). Latent profile analysis suggests that, after child abuse, the odds of developing CPTSD is double that of developing PTSD (Cloitre et al., 2013). Surveys of clinical samples of trauma survivors in the United Kingdom, the United States, and Europe have consistently found higher rates of CPTSD than PTSD, indicating that CPTSD is a more common clinical presentation than "classic" PTSD (Karatzias et al., 2017a; Vang et al., 2019).

Prevalence studies of PTSD using *DSM-5* criteria include but do not distinguish CPTSD. A large national survey of U.S. adults found a lifetime PTSD prevalence of 8.3% using *DSM-5* criteria (Kilpatrick et al., 2013). Population mental health research indicates that 14.4% of people diagnosed with PTSD fall into a dissociative subtype (Stein et al., 2013), with considerable variation in clinical populations; 12% of veterans and their intimate partners who met the diagnostic criteria for PTSD had high rates of dissociative symptoms (Wolf et al., 2012), whereas 25% of a civilian sample with PSTD fell into the dissociative subtype (Steuwe et al., 2012). Those diagnosed with PTSD and elevated dissociative symptoms have higher incidence of child and adult sexual abuse compared to other groups (Wolf et al., 2012).

There is ongoing empirical and theoretical debate over the role of dissociation in PTSD: namely, whether dissociation features in PTSD as a defence mechanism or whether dissociation is more central to PTSD symptomology as an underlying integrative deficit between psychological subsystems (Dorahy & van der Hart, 2015). These debates are beyond the scope of this article. However, dissociative symptoms and the dissociative disorders have long been linked to CPTSD and associated experiences of prolonged abuse and powerlessness (Herman, 1992) and have a close nosological relationship with PTSD (Dorahy & van der Hart, 2015). Both dissociation and CPSTD have a demonstrated relationship with childhood trauma and frequently co-occur (van Dijke et al., 2015). A recent meta-analysis of surveys of college students found that 11.4% met the criteria for a dissociative disorder, which is consistent with the prevalence of those experiencing multiple forms of trauma in childhood (12%; Kate et al., 2019). The prevalence rate for DID was comparatively high in this population at 3.7%, with previous studies suggesting a community prevalence rate of DID of approximately 1% (Sar, 2011).

The Social and Community Impact of CPTSD

As the section above makes clear, CPTSD and associated clinical diagnoses are high prevalence illnesses (between 0.5% and 11.4% in population studies) compared to better recognized diagnoses such as schizophrenia, which has a prevalence range of 0.4%–0.7% (Saha et al., 2005). Research and clinical literature underscore the significant burden of disability and quality of life deficits associated with CPTSD as well as the impact of CPTSD on community and public health. Self-harm, chronic distress, low self-esteem, and a lack of relationship skills are defining features of CPTSD (Stadtmann et al., 2018a). While some individuals with CPSTD demonstrate high levels of functionality, they recurrently enter into crisis when their coping strategies are exceeded (Stadtmann et al., 2018b). The impairment associated with CPTSD increases the risk of social isolation, unemployment, and financial disadvantage compared to individuals with PSTD (Karatzias et al., 2017b; Perkonigg et al., 2016). Substance abuse and criminality of various forms are also common features of CPTSD, and impacted individuals may be intersecting with the criminal justice system, child protection system, and welfare system in ways that increase the complexity of their needs and clinical presentation (Salter & Breckenridge, 2014).

Trauma exposure and CPSTD are not equally distributed throughout the community and are inextricably linked to social problems including gender inequality, racism, and poverty. At the individual level, the risk of trauma exposure varies by sex, age, race/ethnicity, sexual orientation, and socioeconomic background, while community and sociopolitical factors are also at play since certain types of trauma are more common for certain groups of people and particular geographic areas (Magruder et al., 2017). For example, the forms of violence that differentially impact girls and women, such as child sexual abuse and rape, are linked to the increased prevalence of PTSD among women (Olff et al., 2007) as well as increased likelihood of developing CPSTD (Hyland et al., 2017).

The majority of adults who meet the diagnostic criteria for CPTSD report childhood trauma (Stadtmann et al., 2018) with ACEs acknowledged as a causal contributor to major public health and social policy challenges. ACEs exposure tends to cluster for disadvantages individuals and communities (Braveman & Barclay, 2009) and so do the poor health and social outcomes associated with ACES exposure, including CPTSD (Ford, 2015). A recent systematic review and meta-analysis of ACEs research found that individuals reporting four or more ACEs were seven times more likely to have been violently victimized, eight times more likely to have perpetrated violence, 10 times more likely to have problematic drug use, and 30 times more likely to have attempted suicide (Hughes et al., 2017). Furthermore, the outcomes associated with multiple ACE exposure, such as problematic substance abuse and violence perpetration or victimization, represent ACEs for the next generation (Hughes et al., 2017). The "viral" (i.e., transmissible) and endemic nature of CPSTD is evident in families and communities marked by intergenerational patterns of violence and mental illness (Ford, 2015). Impacted families and communities include refugee, migrant and racialized communities (Magruder et al., 2016), First Nations peoples (Atkinson et al., 2014), and those experiencing the intergenerational

transmission of child sexual abuse and family violence (Salter, 2017; Middleton, 2013).

At present, ameliorative responses to CPSTD are limited to individual treatment approaches, which are intensive and costly. CPTSD is comprised of a greater number and diversity of symptoms relative to PTSD and therefore treatment typically requires more intensive and complex interventions of a longer duration (Courtois & Ford, 2012, pp. 83–84). Best practice treatment involves sequenced psychotherapy with at least weekly or more sessions (Cloitre et al., 2011). Treatment duration for CPTSD is elastic and uncertain, linked to the personal circumstance and resources of the client, and may involve long-term or lifelong treatment in acute cases (Courtois & Ford, 2012, p. 83). Given the prevalence of CPSTD, treatment cannot feasibly be scaled up to provide coverage for all impacted individuals. In the absence of intervention, the human and economic costs of CPSTD will persist and escalate through lateral and intergenerational transmission (Ford, 2015). There is therefore an urgent need for upstream public health approaches that seek not only to reduce the prevalence of factors that contribute to CPTSD, such as ACES, but that specifically target CPTSD as a threat to individual well-being and community health.

The Need for a Primary Prevention Approach to CPTSD

Primary prevention refers to the prevention of a negative outcome before it occurs, in contrast to tertiary interventions (such as clinical treatment) that seek to reduce harm after the fact. Primary prevention interventions are generally broad based and targeted at the population level, compared to secondary and tertiary interventions focused on individuals at risk or directly impacted. To date, there has been limited discussion of primary prevention in the complex trauma field (Ford, 2015), although there are a number of relevant prevention frameworks pertaining to the prevention of child maltreatment and violence against women (e.g., Belsky, 1980; Heise, 1998; Krug et al., 2002). These frameworks adopt a social–ecological model based on Bronfenbrenner's (1979) theory of human ecology. Bronfenbrenner situated child development within its broader context, acknowledging that child outcomes were shaped by factors embedded in the ecological "levels" of society from the interpersonal to organizational contexts and neighborhood settings, as well as larger social and economic forces. This ecological model underpins contemporary primary prevention frameworks for child abuse and violence against women, which have identified a number of shared risk factors, including gender inequality, the cultural normalization of violence and aggression, and other contributors to violence and abuse such as alcohol availability and poverty (Jewkes et al., 2015; Quadara et al., 2015). The promotion of gender equality and nonviolent and respectful relationships within families, institutions, and communities are a mainstay of these prevention approaches.

There are also relevant frameworks relating to the primary prevention of mental illness. The World Health Organization recognizes the social, environmental, and economic determinations of mental health, including violence, racism, poverty, and social disadvantage (World Health Organization, 2004). It is well known, for example, that women are at significantly increased risk of depression and anxiety compared to men (Ussher, 2010) and more likely to develop PTSD when exposed to the same stressors as male counterparts (Breslau, 2002; Olff et al., 2007). These differentials are linked to the prevalence of interpersonal violence in the lives of girls and women, as well as pervasive cultures of victim blaming and shaming (Ullman, 2003). Similarly, racism and disadvantage have been linked to significant increases in psychotic diagnoses in immigrant and Black ethnic minority communities (Kirkbride, 2017). Prolonged and more severe exposure to adverse social environments is associated with greater odds of developing psychotic and depressive symptoms in late adolescence (Solmi et al., 2017). Accordingly, empowerment, social participation, social support, and community networks are all identified as protective factors against mental illness at the macrolevel.

As explained, current prevention frameworks describe broad principles for the prevention of violence and mental illness, including structural risk factors such as sexism, racism, and poverty. These prevention approaches acknowledge that endemic forms of discrimination and inequality can be understood as traumatizing and corrosive to mental health. These principles are broadly relevant to the prevention of CPSTD. However, CPSTD is not the inevitable result of violence or inequality but rather it can be understood as a specific adaptation to acute experiences of betrayal and powerlessness; an adaptation arising, centrally, from shame. Shame has been defined as a "painful set of affective and cognitive states typified by self-judgment stemming from a perceived transgression of social/cultural norms or expectations" (Saraiya & Lopez-Castro, 2016, p. 94) and closely linked to the experience of child abuse, gendered violence, and mental illness. However, the centrality of shame in the development and maintenance of CPSTD suggests the need for a specific primary prevention approach that reduces the risk of shame at all levels of the social ecology.

Shame has taken an increasingly central place in trauma literature and scholarship over the last 2 decades, to the point where Herman (2012) has promoted a conceptualization of PTSD as fundamentally a shame-driven disorder. The phenomenology of the abuse and neglect that is casually related to CPSTD is characterized by shame, rather than fear, as the primary affect associated with repeated boundary violations and betrayal (Badour et al., 2017; Herman, 2012) and the multiple casual relationships between shame and CPSTD are explained in more detail below. The following sections organize the literature on shame and CPTSD according to a social ecological model, describing the relationship between shame and CPTSD at the relational, community, institutional, and macrosocial level.

Relational Level

Shame is an emotion that is central to attachment and social processes as the child begins to learn socially appropriate conduct via responses within the primary attachment relationship (Schore, 1998). The capacity to experience shame emerges in the second year of life, as the infant becomes increasingly mobile and vocal, and parenting takes a disciplinary turn for the good of the child and others (Schore, 1998). Shame occurs where the child's expectation of a positive response from the caregiver is contradicted by evident misattunement, communicated in face or tone by the caregiver, resulting in emotional shock and deflation for the child (Schore, 1998, p. 65). Shame is linked with evolutionary prerogatives to maintain individual and group attachments (Herman, 2012), alerting individuals to social rejection and exclusion and promoting the adjustment of their behavior accordingly (Statman, 2000). Caregivers may induce shame in the child, inadvertently or otherwise, through refusing positive feedback where the child engages in inappropriate or harmful behavior. However, Herman (2012) surmises that, where caregivers are incapable of or refuse to engage in reparative action, persistently shaming responses generate pathology in the child's attachment patterns and behaviors.

The empirical literature on disorganized attachment identifies shame as one of the primary affective correlates of parental abuse and neglect (Claesson & Sohlberg, 2002; Mintz et al., 2017; Sedighimornani et al., 2020). Attachment figures who are incapable of repair, or who actively humiliate, ridicule, or reject the child, produce profound and chronic shame states that lead to avoidant and disorganized attachment and enduring psychopathology, including CPTSD (Farina et al., 2019). While attachment research has focused on the emergence of shame through interaction between child and caregiver/s, scholars such as Herman (1992) and Dillon (1997) have emphasized that trauma, abuse, and shame are all socially situated and structured by existing social inequalities. For Herman (1992), the shame of interpersonal violation is shaped by the intersections of gender, race, class, disability, and other factors, and indeed experiences of sexual and domestic violence can be conceptualized as mechanisms of social subordination. Dillon (1997) links shame and related injuries of self-concept to community and social contexts of inequality and discrimination, highlighting how particular groups are frequently targets of social patterns of shaming and devaluation. Hence, shame is intimately connected to the roots of CTPSD in disorganized attachment and the experience of violence, abuse, and neglect, as well as those background and social factors that increase the risk of violence, abuse, and neglect. Community context emerges as an important consideration in the experience and impact of shame, as the next section discusses in more detail.

Community Level

As previously described, shame is implicated in attachment and socialization. Shame is critical to early infant attachment processes, but it is also cued to social reactions and perceptions of status vis-à-vis others. Even the attachment functions of shame are socially contextualized and produced since the responsiveness and attunement of a parent to a child are shaped by family and community context (Osher et al., 2020). The children of parents subject to discrimination and disadvantage are likely to share those experiences and the associated shaming affect (Hartling & Luchetta, 1999), while maternal shame is associated with increased trauma-related distress in the mother and behavioral symptoms in their children (Babcock Fenerci & DePrince, 2018). Psychosocial problems often observed among populations with CPTSD, such as substance abuse and/or intimate partner violence, further impact parenting and child well-being, with heightened challenges for communities impacted by racism and discrimination (Blakey & Hatcher, 2013). The shaming and stigmatization of some groups and communities intersects with experiences of trauma and abuse in complex ways that can disrupt parental attunement and attachment processes, increasing the risk of CPSTD.

In the empirical literature, traumatic symptomology emerges as another negative effect of concentrated neigborhood disadvantage, albeit mediated by social ties and community cohesion. Social disorganization theory proposes that the structural characteristics of a geographical community, including poverty and rates of crime, can disrupt community cohesion and social ties, producing a range of negative effects (Sampson & Groves, 1989). The literature on social disorganization and PTSD finds a consistent relationship between neighborhood disorder, community cohesion, and PTSD symptoms, in which the experience of living in a disadvantaged or marginalized community increases the risk of PTSD (Gapen et al., 2011; Johns et al., 2012; Monson et al., 2016). This association persists even where exposure to traumatic events is controlled for. Research in disadvantaged communities has consistently emphasized the psychosocial impacts of social disorganization, specifically the ubiquity of shame and humiliation (Estanislau & Ximenes, 2019), which suggests that the emotional milieu of disadvantaged communities may increase the risk of CPSTD.

Community and neighborhood social disorganization are not natural artifacts but rather products of both politics and history. A significant body of research and clinical literature has highlighted how the historical legacies of genocide, slavery and dispossession, and the contemporary realities of racism, poverty, and other forms of disadvantage, have resulted in the concentration of complex trauma in particular communities including Australian Aboriginal peoples (Atkinson et al., 2014), African Americans (Vaughans, 2016), and other communities with histories of mass violence (Bezo & Maggi, 2015). The ubiquity of collective rather than individual trauma is such that Zarowsky and Pederson (2000, p. 292) suggest that "collective trauma, where the experience of an individual is explicitly connected to that of a group, has been and continues to be the norm rather than the exception." At the community level, the interactions between intergenerational trauma and contemporary disadvantage have pervasively shaming effects (Atkinson, 2002).

Institutional Level

Shame is evident at the institutional level in two ways relevant this this review: through processes and practices that are inadvertently humiliating and through the intentional deployment of humiliation as a tool of social control. Humiliation describes the social practice of shaming, defined as any form of behavior or social situation in which a person experiences an injury to their self-respect (Margalit, 1998, p. 9). It is characterized by social practices including social exclusion, discrimination, and criticism and attended by feelings of powerlessness and a diminished sense of self (Elshout et al., 2017).

A key example of systemic but inadvertent humiliation is provided by research into institutional betrayal, which examines the psychological impact of reporting sexual assault and receiving an inadequate or trivializing institutional response. This research underscores the traumagenic nature of shaming institutional responses to abuse and the frequency of such responses (Birrell et al., 2017; Smith & Freyd, 2013). Research has demonstrated that institutional betrayal is a significant predictor of psychological outcomes for traumatized people, increasing the severity and complexity of trauma (Andresen et al., 2019; Lee et al., 2019). Responses to trauma characterized by disbelief, betrayal, and shame are particularly pronounced for women (Freyd & Birrell, 2013) and have complex implications for racialized communities (Gómez, 2019) as violence and abuse intersect with sexism and racism in dynamic ways that can compound traumatization. While institutional betrayal is a common characteristic of formal responses to sexual assault, and shaped by social inequalities, it is often a form of unintended humiliation; shame is the by-product rather than goal.

However, humiliation is an intentional tool of government in many areas of public policy (Klein, 1991). In his recent book, Rothbart (2019) identifies humiliation as a governance strategy that is deployed most often against otherwise subordinate or oppressed populations as a form of social control, and to further legitimize and entrench inequality. Rothbart identifies a number of means by which states can institutionalize humiliation: via discriminatory legislation and practices, by erasing the history and experiences of marginalized groups from public recognition, and through government policies that position some citizens over others. Similarly, in his overview of collective humiliation, Neuhäuser (2011) identifies the mechanisms of discrimination and stigma, the defilement of cultural practices, and debasing media representations. Recognizing its severe implications for mental health, Hartling and Lindner (2018, p. 25) describe systematic humiliation as a form of mental cruelty, just as torture is a form of physical cruelty.

In contemporary governance, humiliation most frequently targets the already traumatized. This pattern is particularly evident in refugee and migration policy. In the United States, refugees and migrants have been subject to punitive detention measures and separation from their children for prolonged periods of time, intentionally disrupting child–caregiver attachment and creating the conditions for CPTSD and dissociative disorders (Smidt & Freyd, 2018). In Australia, the mandatory prolonged detention of refugees has been implemented in order to deter asylum seeking in conditions that are profoundly traumatizing to adults and children fleeing violence and civil unrest (Newman, 2013). In both cases, the intentional degradation of refugees and migrants, and the deliberate disruption of attachment processes, are central to the supposed deterrent effect of such policies.

Macrosocial Level

Social inequality is intrinsically humiliating. In relation to socioeconomic inequality, Sen (1983, p. 159) argues that shame is part of the "irreducible absolutist core" of poverty. This assertion is supported by international research with people living in poverty, which finds that the shame of poverty is universal, linked to social withdrawal, mental illness, and suicidality (Walker et al., 2013, p. 230). Similarly, Dillon (1997) focuses on the pervasive undermining of the self-esteem of girls and women in a sexist society, and the ways in which broader structures of humiliation inevitably pervade socialisation and intimate life, while Rothbart (2019) interrogates the "symbolic violence" of racism in the humiliation of racialized and ethnic minority communities. If social structures and political practices of humiliation are major drivers of shame, then they can be understood as significant contributors to CPTSD, particularly once the effects of inequality on parenting and family relations are acknowledged. Hartling and Luchetta (1999) observe the intergenerational transmission of shame from parent to child, often reinforced by broader community contexts of discrimination and disempowerment (p. 274). Walker et al.'s (2013) research with people living in poverty across seven countries (p. 224) described how the shame of poverty impacted family relations, in which the emotional milieu of families can become characterized by pejorative and diminished views of each other, linked to family conflict and domestic violence. The next section examines potential preventative responses focused on dignity as the countermanding force to shame.

Dignity in the Primary Prevention of CPTSD

As research into the role of shame in CPSTD has burgeoned, clinicians and scholars have pointed to "dignity" as its affective opposite (Chefetz, 2017). Dignity is a touchstone concept in human rights, ethics, politics, and philosophy, albeit often an ill-defined one. The Kantian notion that human dignity is inalienable and grounded in inherent human worth and that people should never be treated as a means to the ends of others, has proven highly influential in Western thought. In the post-war period, the instantiation of dignity in international human rights instruments and conventions reflects a set of overlapping concerns rather than an agreed upon definition. Dignity is a foundational value in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and

Political Rights, the Convention on the Rights of the Child and the Declaration on the Elimination of Discrimination against Women. It is also a guiding value in medical ethics and features prominently in the Declaration of Helsinki, the World Medical Association International Code of Medical Ethics, and the Universal Declaration on Bioethics and Human Rights.

There is broad agreement of what dignity stands against; that is, dignity is the opposite of humiliation and shame (Statman, 2000, p. 523). At least in the Western canon, references to both dignity and humiliation tend to be moral or metaphysical in tone (Statman, 2000). However, the work of Hicks (2011, 2015) has been integral to the development of a concrete definition of dignity that can be integrated into policy and practice. She defines dignity as "an internal state of peace that comes with the recognition and acceptance of the value and vulnerability of all living things" (Hicks, 2011, p. 1). This dual focus on human value and human vulnerability is key to Hick's conceptualization of dignity, in which recognition of human value is grounded in the acknowledgement of human vulnerability to injury and humiliation.

The concept of dignity has been applied in traumatology primarily at the level of individual traumatization and treatment. In relation to trauma therapy, Chefetz (2017) argues that the pathogenic shame of profoundly traumatized clients can be acknowledged and addressed in treatment by promoting a dignifying milieu that seeks to ameliorate the shaming impacts of abuse and neglect. However, Herman's (2005) work on justice from the perspective of sexual and domestic violence survivors has emphasized the sociopolitical dimensions of dignity. She describes the crimes of sexual and domestic violence as offenses of degradation that are intended to "dishonor" and shame the victim to herself and others (Herman, 2005, p. 573). In interviews with 22 survivors of sexual abuse, domestic violence and rape, Herman (2005) emphasized the desire of survivors for the restoration and recognition of their dignity, and the ways in which criminal justice responses to the offenses against them were often shaming in ways "only too reminiscent of the original crime" (p. 583).

Much like shame, dignity is an emotion but also a mode of social and political practice. A feeling of dignity is not a personal or private experience but rather a characteristic of social and historical location and context (Dillon, 1997, p. 243). If shame and shaming processes are central to the current epidemic rates of CPTSD, including intergenerational transmission and community-level concentration, then scholarship on the role of dignity in the amelioration of shame, trauma, and abuse suggests new opportunities for primary prevention. In this approach, dignity is not a merely an abstract moral principle, but rather dignity describes the felt experience of being valued while the innate human vulnerability to shame and injury is acknowledged and addressed (see Hicks, 2011). Dignified environments and processes are those in which both human value and human vulnerability are acknowledged and accommodated simultaneously, producing the experience of being recognized, understood, and treated with safety, fairness, and accountability (Hicks, 2011, 2015). Given the role of shame in the etiology and epidemiology of CPSTD, it would seem that dignified contexts and processes would significantly reduce the risk and prevalence of CPSTD. The following section will examine in more detail how the amelioration of shame and the promotion of dignity through public services, professional practice, and public policy could be integrated into a public health approach to CPSTD.

A Framework for the Primary Prevention of CTPSD

This section presents a social ecological approach to the primary prevention of CPSTD, which addresses shame and dignity at the relational, community, institutional, and macrosocial levels. Consistent with primary prevention approaches, the framework identifies key policies and programs that aim to reduce shame as a risk factor for CPTSD and promote dignity as a resiliency factor. The framework seeks to achieve these goals by identifying potential interventions that could achieve these interlocking goals at each level of the social ecology, recognizing that the preventative effect of these recommendations have not been empirically tested.

Relational Level

At the relational level, the framework seeks to promote secure attachment and prevent child abuse and domestic violence as major threats to secure attachment. At this level, dignity is understood as the felt experience of the infant who is valued and whose vulnerability is acknowledged and addressed by their caregivers, and also as a key characteristic of the caregiving environment in which parent/s are resourced and supported in order to provide optimal care for their children. This goal can be achieved through multiple initiatives:

Pre- and postnatal home visitation programs. Since the late 1970s, a number of programs have attempted to improve child–mother attachment and the overall health of mother and child through structured programs of prenatal and postpartum home visitation. Some home visitation programs have demonstrated reductions in child maltreatment through rigorous evaluation, particularly among families at greater risk of abuse and neglect (Donelan-McCall et al., 2009). There is evidence that home visitation interventions targeted specifically at improving attachment security and emotional coregulation between child and parent are effective (Moss et al., 2011).

Promotion of equal and healthy parenting. Programs for first-time parents that aim to promote parenting and relationship skills have been shown to build parenting capacity and reduce conflict and abuse within the home (Bouma, 2012; Flynn, 2011). While these programs have focused on the reduction of domestic and family violence, they may also have utility for the prevention of child sexual abuse. The study by Williams and Finkelhor (1995) comparing incestuous to nonincestuous fathers suggested that active involvement in caregiving in

infancy confers some protection against later child sexual abuse. Thus, supporting infant and parenting programs may prevent both the onset of domestic violence and child sexual abuse.

Community Level

At the community level, the framework seeks to promote social bonds between community members and the strengthening of community networks and capacities. Community-level intervention is critical to the disruption of the "viral" nature of CPSTD, including its contribution to intergenerational trauma. At the community level, dignity is understood as the valuing of community bonds as well as the acknowledgment of community-level trauma and the need for collective restoration and healing. These goals could be accomplished through:

Investment in community mobilization and development. Communities with high rates of CPTSD and co-occurring social disadvantage are likely to be experiencing high rates of social disorganization; that is, a lack of social bonds indicated by factors such as family isolation, high crime rates and substance abuse, often exacerbated by the absence of robust health and welfare policies and social assistance (Garbarino & Kostelny, 1992). Community mobilization and development programs aim to support and resource communities to strengthen social bonds and capacity in order to solve collective problems (Michau, 2007). Through this approach, communities are resourced to identify their own problems, build community networks, develop a community-based action plan, invest in skilled workers and services, and deliver community activities designed to address community problems (Mehta & Gopalakrishnan, 2007; Michau, 2007).

Community-level healing programs. A range of scholars and practitioners have advocated for the provision of community-level healing programs where there has been mass traumatization of community groups through processes such as genocide, colonization, war and/or forced migration (Atkinson, 2002; Chen, 2017). In such circumstances, Atkinson et al. (2014, p. 298) argue that the provision of individual trauma care to individuals is likely to be undermined in a community context of widespread traumatization, and hence community-level interventions may be crucial in creating a conducive environment for clinical care. Similar to community mobilization approaches, community-level healing programs are grounded in community cultures, traditions, and perspectives, often involving a group of respected community members who are resourced to guide individuals away from harmful or criminal behavior (Atkinson et al., 2014, p. 298).

Institutional Level

At the institutional policy level, the framework has two aims. The first is the reduction of systematic humiliation. While the origins of CPTSD may lie in the shame of early relational trauma, subsequently exacerbated by violence and abuse, it is clear that traumatizing shame is also a product of institutional practices and government policy. The framework calls for the identification and removal of humiliation as an unintentional side effect or intentional goal of institutional practice and public policy. The second aim of the framework at the institutional policy is the promotion of systematic dignity as a key goal of government policy that is protective against shame and associated negative psychological and social outcomes. The interlinked goals of reducing shame and promoting dignity for institutional action and policy can be pursued through:

Implementation and coordination of trauma-informed care (TIC). TIC refers to frameworks of professional practice and service response that acknowledge the impacts of trauma on clients and staff (Wilson et al., 2013). There are a wide range of TIC frameworks across sectors including mental health (Cleary & Hungerford, 2015), human services (Wall et al., 2016), education (Howard, 2019), alcohol and drug (Mills, 2015), and disability care (Jackson & Waters, 2015), which aim to accommodate traumatized clients and promote their health and well-being. Across these multiple frameworks, the principles of TIC include an understanding of trauma and its impacts, the promotion of rapport and trust between consumers and providers, a focus on client autonomy and empowerment, the provision of holistic care and a focus on recovery (Cleary & Hungerford, 2015). In the absence of TIC, the experience of traumatized clients in service settings is frequently humiliating and retraumatizing, characterized by routine misdiagnosis (Salter et al., 2020). Despite proliferation of TIC frameworks, the efficacy of TIC depends not on only on implementation within services but also high-level coordination across services to avoid a discontinuity of care models and practices (Wall et al., 2016, p. 2).

Trauma-informed legal and policing processes. Trauma-informed legal and policing processes recognize the role of trauma in criminal perpetration and victimization, the prevalence of trauma in the lives of people in contact with legal systems and the police, and the potentially traumatic nature of legal and policing interventions. Available TIC models for lawyers include the integration of information about trauma into law curricula, as well as a focus on professional reflexivity and cultural safety (Carnes, 2017). Models of trauma-informed policing include collaboration between trauma-specialist mental health works and community-based policing, including shared training, case consultation, joint attendance at critical incidents, and the provision of therapeutic programs for trauma-exposed juveniles and families (Berkowitz & Marans, 2000).

Dignified financial support for parents. Financial insecurity and stress have a significant impact on the quality of the relationship between children and parents (Morrison Gutman et al., 2005). Family poverty produces pervasive shame and humiliation that impacts on all family relations (Walker et al., 2013) to

which some men respond with violence and abuse (Jeremiah et al., 2013). Furthermore, poverty can entrap mothers in violent and abusive relationships where they are financially unable to leave (Tolman & Rosen, 2001). In contrast, public policies that bolster financial security for expecting and new parents are likely to increase the safety of women and children (Gartland et al., 2011, p. 577).

Social marketing and community education campaigns. Processes that increase the risk of CPSTD, including child maltreatment and institutional betrayal, are underpinned by problematic social norms and attitudes including victim-blaming attitudes and myths about child abuse (Clayton et al., 2018; Smith et al., 2014). Social marketing and community campaigns therefore have an important role to play in promoting victim supportive attitudes, providing accurate information about child abuse, and encouraging supportive responses and bystander intervention in situations of child abuse and neglect, domestic violence, and sexual assault.

Dignified services and systems. The literature on institutional betrayal highlights how large bureaucracies in health, welfare, law, child protection, and other sectors may be mandated to deliver individualized care and support but frequently violate the dignity of those in contact with them through depersonalizing and objectifying practices and attitudes (Lee et al., 2019; Smidt & Freyd, 2018; Smith et al., 2014). However, emerging paradigms of personalized and TIC within bureaucracies point to the potential for the promotion of dignity using existing large-scale services and systems (Salter et al., 2020).

Dignified immigration processes. Border control policies and state responses to refugee and migration flows are sources of significant global trauma as well as violence and death. It is undeniable that the policy stance of many states in relation to refugee response and processing has become a direct driver of CPTSD among a range of negative mental and physical health outcomes (Newman, 2013). The development of dignified immigration and refugee policies is therefore integral to the reduction of CPSTD for asylum seekers, migrants, and their communities.

Macrosocial Level

The literature on shame, stigma, and trauma makes it clear that social and economic inequalities are traumagenic through the cascading effects of inequality on the risks of neglect, abuse, violence, discrimination, and humiliation, mapping onto the well-documented social gradient in child development and subsequent physical and mental health (Marmot, 2015). The primary prevention of CPSTD therefore shares with other primary prevention agendas a focus on the reduction of social and economic inequalities as major drivers of shame and humiliation that increase the risk of CPSTD at all levels of the social ecology. At the macrolevel, the framework calls for government leadership and recognition that shame and stigma are inextricable components of all forms of inequality and thus inequality is inherently traumagenic. Social and economic inequalities generate the conditions in which the shame of attachment disruption, neglect, violence, and social subordination are inevitable, and therefore, the primary prevention of CPTSD shares with other prevention frameworks a focus on the reduction of inequality and the promotion of social justice.

Conclusion

CPTSD is a relatively common mental illness that is caused by, and contributes to, significant social problems including child maltreatment, substance abuse, and violence. The social costs of CPTSD are considerable due to associated disability and quality of life deficits and its impacts on the risks of violence and substance abuse. Unusually for a psychiatric disorder, CPSTD is transmissible through its impact on parenting and social disorganization, as well as via the criminality and vulnerability to victimization that characterizes the life trajectories of some people with CPTSD. These impacts are evident at all levels of the social ecology and can produce entrenched and accelerating cycles of disadvantage. Recognizing that individual treatment for CPTSD is costly and cannot feasibly be delivered at scale, this article has presented a conceptual framework for the primary prevention of CPSTD that specifically targets shame at the relational, community, institutional and macrosocial levels as the key driver of CPTSD. Shame is identified as the outcome of attachment disruption and social disorganization linked to inequality and discrimination, and compounded by institutional betrayals and failures. Accordingly, the framework advocates for the instantiation of dignity within the design and deployment of services, systems, and programs, with the aim of promoting secure attachment, community coherence and recovery, and the reduction of inequality and discrimination. A focus on the prevention of CPSTD brings to the fore unexpected commonalities between apparently diverse social problems and public policies, from child maltreatment and family violence to institutional response to sexual assault, the culture of welfare service provision and the practice of border control, and responses to refugees. While these practices and systems are diverse and take place in different locations within the social ecology, they are characterized by compounding experiences of shame which increase the risk and prevalence of CPTSD. They are also, this article argues, opportunities for safeguarding and the promotion of human dignity. As the evidence grows that CPTSD is widespread and implicated in a range of major social problems and that effective treatment is costly and intensive, then the prerogative for a primary prevention approach is only strengthening over time. This article highlights that the prevention of CPTSD before it occurs is an achievable public policy goal, albeit one that would require significant political will and systemic reform. This is a particularly timely contribution, given recent social mobilization in the United States and internationally regarding state violence against Black, ethnic minority, and Indigenous groups, linked to long-standing inequalities. A whole-of-

government shift to trauma-informed and dignified policies and practices, as outlined in this framework, provides a wholistic response to the multiple and compounding injuries of intergenerational trauma and contemporary racism and discrimination.

Implications of the Review for Practice, Policy, and Research

- CPTSD is amenable to primary prevention efforts and the reduction of CPSTD would have significant benefits for public health and safety.
- Professional practice and public policy are vectors of shame, humiliation, and inequality and thus contribute to the burden of CPSTD.
- Practitioners and policy makers should seek to reform service provision and intervention in ways that reduce shame and promote dignity and equality.
- There is a need for further research into the epidemiology of CPTSD and the evaluation of preventative interventions.

Critical Findings of the Review

- CPTSD is a high prevalence psychiatric condition that is both the cause and effect of significant social problems and inequalities.
- Shame plays an important etiological role in the development of CPSTD.
- The shame of interpersonal abuse and neglect, which causes CPSTD, is socially and structurally situated and therefore amenable to primary prevention efforts.
- Dignity has been identified in clinical practice and social scientific research as an ameliorative response to shame and humiliation.
- The risk and prevalence of CPSTD can be reduced through the reduction of shame at multiple levels of the social ecology and the simultaneous promotion of dignity.

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ORCID iD

Michael Salter https://orcid.org/0000-0001-6446-9498

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Author Biographies

Michael Salter, PhD, is a Scientia Fellow and associate professor of criminology at the school of social sciences at the University of New South Wales. His research focuses on child abuse, gendered violence, and complex trauma. He is interested in multisystemic responses to complex trauma and the primary prevention of abuse and violence.

Heather Hall, MD LLC, is a psychiatrist who specializes in working with adults from diverse backgrounds. She is a member of the Board of Directors of the International Society for the Study of Trauma and Dissociation and has expertise in working with patients who have a history of early childhood trauma.