COMPLEX POSTTRAUMATIC STRESS DISORDER

INFORMATION BOOKLET
FOR PRACTITIONERS

CREATED BY EUROPEAN SOCIETY FOR
TRAUMATIC STRESS STUDIES
FUTURE LEADERSHIP GROUP

ESTSS

CONTENTS

DEFINITION OF CPTSD

A new diagnosis of complex posttraumatic stress disorder (CPTSD) was included in the newest 11th revision of the International Classification of Diseases (ICD-11) (World Health Organization, 2018). This new CPTSD diagnosis is based on the construct of CPTSD described by Judith Herman (1992) and the ICD-10 Enduring Personality Change after Catastrophic Experience (EPCACE) diagnosis. It emphasizes long-term changes in personality organization, which usually result from prolonged or repetitive trauma that is difficult or impossible to prevent (Brewin, 2020). Studies show that CPTSD is strongly related to childhood adversity: childhood sexual and physical abuse and emotional neglect during childhood (Leiva-Bianchi et al., 2023). According to ICD-11, a diagnosis of CPTSD can be made if a potentially traumatic event has occurred and specific symptoms related to that event are present. In addition, these symptoms should cause significant impairment in personal, family, social, educational, occupational or other important areas of a person's functioning. The new ICD-11 defined diagnosis of CPTSD incorporates the existing symptoms of posttraumatic stress disorder as well as a cluster of symptoms related to disturbances in self-organization (DSO):

PTSD symptoms

1

Re-experiencing

Can manifest as vivid intrusive memories, flashbacks, or nightmares. The content or affect of the recurring dreams should be related to the traumatic experiences.

2

Avoidance

Involves intense avoidance of thoughts, feelings or memories related to traumatic experiences. It may also involve avoiding people, places, situations or activities that remind one of traumatic experiences.

3

Persistent perceptions of heightened current threat

May manifest by increased alertness or strong startle reactions to various stimuli such as unexpected sounds. It could also manifest by various safety rituals

DSO symptoms

4

Affect dysregulation

Can range from heightened emotional reactions and difficulty calming down to emotional numbness and dissociation in response to minor stressors.

5

Negative beliefs about oneself

Beliefs that the person is diminished, defeated, or unworthy. Clinically significant symptoms of negative self-image should be persistent and occur in most areas of the person's life.

6

Difficulties in relationships

Persistent and consistent difficulties in sustaining relationships and in feeling close to others

DIFFERENCES BETWEEN THE ICD-11 AND THE DSM-5

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders - Text Revision (DSM-5-TR; APA, 2022) and ICD-11 (WHO, 2018) currently are the main classification systems that define diagnostic criteria for trauma- and stress-related disorders. The differences between the two classification systems in relation to the diagnostic criteria for posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD) are presented below:

DSM-5-TR PTSD CRITERIA (APA, 2022):

- **A** Exposure to actual or threatened death, serious injury, or sexual violence.
- **B** Intrusion symptoms associated with the traumatic event(s).
- **C** Persistent avoidance of stimuli associated with the traumatic event(s).
- **D** Negative alterations in cognitions and mood associated with the traumatic event(s).
- **E** Marked alterations in arousal and reactivity associated with the traumatic event(s).
- **F** Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.
- **G** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **H** The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

With dissociative symptoms: Depersonalization and derealization.

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event.

The main difference between the two classifications is that ICD-11 considers CPTSD and PTSD as two different diagnoses and **DSM-5-TR does not define CPTSD.**

Another difference that can be seen between the two classifications concerns the **type of events that can lead to the development of PTSD or CPTSD**. This distinction is very important because the way in which traumatic exposure is defined has implications for determining the epidemiology of PTSD and CPTSD, identifying risk and protective factors, providing access to mental health services and insurance, and planning and evaluating treatment interventions (Hyland et al., 2021).

ICD-11 does not contain a defined criterion like DSM-5 criterion A, but provides a clinical orientation according to which PTSD and CPTSD "may develop following exposure to an extremely threatening and horrific event or series of events". Thus, this perspective operationalizes trauma by highlighting the salience of threat and horror and ensures that the diagnosis depends primarily on the presentation of consequent symptoms or problems (Brewin et al., 2009).

Frewen et al. (2019) found that adverse childhood experiences such as neglect and emotional abuse, other events such as bullying or harassment, are not conventionally classified as traumatic according to the DSM-5, yet are more predictive of PTSD than other events defined as traumatic, and may be experienced as threatening to survival (Cloitre et al., 2019). These findings, therefore, question the predictive validity of the set of 'traumatic' events in relation to the set of events termed as 'stressful', indicating that there may be significant traumatic events that do not currently meet the definition of Criterion A in the DSM-5. Thus, clinical and research professionals consider that there may be individuals who are not diagnosed with PTSD because the stressful event to which they have been exposed does not meet the current definition of DSM-5 Criterion A (Hyland et al., 2021).

PREVALENCE OF CPTSD

As CPTSD is a new diagnosis, currently, there is no official data on its prevalence. However, there is a growing number of studies that show the probable prevalence of CPTSD assessed by self-report measures. The prevalence of probable CPTSD varies across different countries and different study samples. Studies conducted in the general population show that the prevalence of CPTSD can vary between 0.5% (German general population, one-month prevalence; Maercker et al., 2018) and 14% (Canadian general population, lifetime prevalence; Frewen et al., 2019), with most studies showing the prevalence of about 3% (Ben-Ezra et al., 2018a; Hyland et al., 2020; Karatzias et al., 2017).

Studies show that the prevalence increases significantly when studying samples that have suffered persistent and recurrent trauma (Leiva-Bianchi et al., 2023). Examples of these are war, natural disasters, or political conflicts, or when people are in certain professions or specific situations, such as in prison settings. To illustrate – a study conducted in Lebanon with a clinical sample of Syrian refugees showed a prevalence of probable CPTSD of 36.1% (Vallières et al., 2018). Two studies in the UK with a sample of convicted prisoners (Facer-Irwin et al., 2022) and police officers (Brewin et al., 2022) showed a prevalence of 16.7% and 12.6% for probable CPTSD, respectively. The prevalence of CPTSD risk in a sample of women survivors of intimate partner violence was 39.50% and significantly higher compared to probable PTSD (17.90%) (Fernández-Fillol et al., 2021). In a clinical sample, the results also vary – a Danish study with psychiatric outpatients showed a prevalence of 36% for probable CPTSD (Møller et al., 2020). Studies conducted in the UK with a clinical sample showed a prevalence of CPTSD risk between 12.7% (Lewis et al., 2022) and 69.1% (Hyland et al., 2020).

ASSESSMENT OF CPTSD

SELF-REPORT MEASURES

One of the most well-studied instruments for the assessment of CPTSD is the **International Trauma Questionnaire** (ITQ) (Cloitre et al., 2018), which, due to its short structure (12 symptom items), allows for a very rapid assessment of the risk of ICD-11 PTSD and CPTSD. Validation studies conducted in America, Europe, and Asia show that the instrument has good psychometric properties (Ho et al., 2019; Karatzias et al., 2016; Mordeno et al., 2019; Shevlin et al., 2018). The results also show that posttraumatic reactions can be divided into two groups: PTSD symptoms only and PTSD combined with the symptoms of disturbances in self-organizations. However, a study conducted in Israel (Mordeno et al., 2019) did not find that PTSD and CPTSD are two separate diagnoses. In their sample, they found a single diagnosis of posttraumatic stress disorder, which can manifest itself in 6 distinct symptom clusters and different intensities. This points to the need for further research on applying the ITQ in different cultures.

The **International Trauma Questionnaire Child and Adolescent Version** (ITQ-CA; Cloitre et al., 2018) is one of the best empirically supported instruments that follows the diagnostic criteria for measuring and diagnosing PTSD (Haselgruber et al., 2020) in children and adolescents.

Another way to assess CPTSD is using the **Symptoms of Trauma Scale** (SOTS; Ford et al., 2015). This instrument is based on the DSM-IV and DSM-5 definitions of PTSD and includes additional questions about CPTSD symptoms developed by the authors according to the first ICD-11 proposal of CPTSD. The questionnaire also includes questions on dissociation, sexual behavior, beliefs, and somatic symptoms. The questionnaire consists of two parts: an interview by a trained professional and 12 self-report questions. However, when comparing the two parts of the instrument (the clinical interview and the questionnaire), discrepancies were found between the psychologist's assessment of the symptoms and the patient's self-assessment, particularly the SOTS composite scores and individual items may not validly assess self-reported PTSD hyperarousal (Ford et al., 2017). The results also showed that the instrument differentiated poorly between CPTSD and PTSD.

Litvin and colleagues developed **The Complex Trauma Inventory** (CTI; Litvin et al., 2017), which consists of 50 questions assessing the symptoms of PTSD and CPTSD. For each question, the participant is asked to rate how much the described symptom has bothered them in the last month and how often it occurs. The initial validation results show good psychometric properties of this instrument, and the CTI also supports the distinction between CPTSD and PTSD (Litvin et al., 2017).

ASSESSMENT OF CPTSD

CLINICAL INTERVIEWS

To this day, two clinical interviews for the assessment of CPTSD have been presented. Currently, the most empirically researched clinical diagnostic tool for CPTSD is the **International Trauma Interview** (ITI; Roberts et al., 2019). This interview is designed to identify symptoms of the ICD-11 PTSD and CPTSD and can only be administered by a trained professional. The interview covers the same symptom clusters of PTSD and CPTSD as the ITQ but collects more detailed information, for example, when the problems started, how long they lasted, how often they occur, and whether they are related to the traumatic event. Several validation studies report good results with high Inter-rater reliability and convergent validity (Bondjers et al., 2019; Gelezelyte et al., 2022; Vindbjerg et al., 2023).

The **CPTSD Item Set addition to the CAPS** (COPISAC; Lechner-Meichsner & Steil, 2021) is a semi-structured interview based on DSM-5. The interview uses questions to assess symptoms of disturbances in self-organization in conjunction with the Clinician-Administered PTSD Scale for DSM-5 (CAPS5). However, this interview has not yet been empirically tested, and its validity and practical usefulness cannot be further explored at present.

The PTSD and CPTSD assessment instrument the ITQ can be found here: www.traumameasuresglobal.com

DIFFERENTIAL DIAGNOSIS WITH BPP

One of the key issues in the diagnosis of CPTSD is the differential diagnosis of the disorder with borderline personality pattern (BPP), as traumatic events (and especially prolonged or repeated trauma) are a major risk factor for borderline personality pattern (Cloitre, 2020). However, while BPP and CPTSD partly overlap in the type of difficulties across affect regulation, self-concept, and interpersonal relationships, there are important distinctions reflected in how symptoms manifest for both diagnoses.

First of all, it should be noted that traumatic experience and PTSD symptoms are a prerequisite for the diagnosis of CPTSD, whereas traumatic experience is only a risk factor for BPP but is not a prerequisite for BPP (World Health Organization, 2018). Also, BPP symptoms are more strongly associated with identity changes - unstable self-image, unstable relationships and fear of abandonment, impulsivity, and high suicide risk (Karatzias, 2023). All of these core symptoms of BPP are not included in the diagnosis of CPTSD, which is more associated with a persistent and stable negative self-image and persistent relationship avoidance (Brewin, 2020).

In CPTSD, intense diffuse emotional distress and self-perceptions of worthlessness, shame, and guilt are related to a sense of betrayal, fear of closeness, and severe emotional detachment in relationships. BPP, by contrast, is characterised by impulsive, intrusive, and angry enmeshment. BPP is also characterized by a terror of abandonment and a fragmented and unstable sense of self, which is acted out as hostile and impulsive demands in relationships (Ford et al., 2021).

In diagnosis, it is crucial to avoid excessive pathologizing of an individual. When assessing symptoms like emotional fluctuations present in both CPTSD and BPP, it's important to consider them for each disorder to evaluate if the criteria for a specific disorder are met. Once a primary diagnosis is established, however, the symptom should not be double-counted to prevent overdiagnosing (Karatzias, 2023).

DIFFERENTIAL DIAGNOSIS WITH BPP

The main differences between affect dysregulation, self-concept and relationship difficulties symptom manifestation in CPTSD and BPP are shown below:

	CPTSD	BPP
Affective Dysregulation	Chronic difficulty calming down when distressed or chronic emotional numbness.	Emotional lability, extreme uncontrolled anger and profound emotional dyscontrol. More extreme strategies to regulate affect. For example, suicidal or self-injurious behaviours often result from attempts to escape or change emotions that seem intolerable.
Negative Self-Concept	Chronic and stable feelings of guilt, shame and worthlessness. Perception of self as damaged.	More unstable and fragmented sense of self that can change from one to another.
Disturbances in relationships	Avoidance and detachment based on a fear of closeness.	Intense volatile relational hostility and alternating enmeshment and disengagement to avoid real or imagined abandonment.

TREATMENT FOR CPTSD

Due to the identification of CPTSD in the eleventh revision of the ICD-11 as a new condition, a need arises to identify effective interventions for CPTSD (Karatzias et al., 2019). The following is the current scenario in terms of pharmacological and psychological treatments in relation to the CPTSD.

Psychological treatment

The study of effective psychological treatments for CPTSD is also in its early stages but a path is emerging that indicates where the development of specific therapies for CPTSD may be heading.

The recent meta-analysis conducted by Karatzias et al. (2019) evaluating 51 treatment trials found beneficial effects of standard trauma-focused treatments such as CBT, exposure therapy and EMDR in reducing PTSD symptoms in patients with CPTSD. They also indicated that CBT and exposure therapy reduced symptoms such as negative self-concept and relationship disturbances, although there was insufficient evidence on their effects on emotional dysregulation. Still, it is noted that current trauma-focused therapies for PTSD are probably not optimal for CPTSD patient populations.

In relation to the need to find specific therapies for CPTSD, several alternatives have emerged. For example, Integrative Adaptation and Developmental Therapy after Persecution and Trauma (ADAPT) may be effective in the treatment of CPTSD (and other comorbid disorders) in refugees (Tay et al., 2019). Other studies suggest EMDR therapy as a possible effective treatment for people with CPTSD, either as the main treatment or in combination with other treatments in an intensive way (De Jongh et al., 2023; Voorendonk et al., 2020). Another alternative to established treatments for CPTSD is a phase-based intervention called STAIR (Skills Training in Affective and Interpersonal Regulation plus Modified Prolonged Exposure) which first addresses the symptoms of DSO and related problems in daily functioning by generating stabilisation and then introduces trauma memory processing. This treatment is currently being tested in different groups of survivors in different countries in Europe and results are expected soon. So far, early results indicate that it is a good alternative treatment to traditional treatments for PTSD (Oprel et al., 2021). However, given that CPTSD is a relatively new diagnosis, we need to continue to work on building an empirical basis for how best to treat it in diverse populations.

TREATMENT FOR CPTSD

Pharmacological treatment

As far as we know, there are no evidence-based treatments for the pharmacotherapy of CPTSD. So far, in terms of pharmacological information, the closest is information on pharmacological treatments for PTSD and the development of effective interventions for CPTSD can build on the success of interventions for CPTSD (Karatzias et al., 2019). Most guidelines or recommendations that appear in research recommend cognitive behavioural therapy (CBT) as the first-line psychological PTSD treatment and selective serotonin reuptake inhibitors (SSRIs) as the first-line pharmacological PTSD treatment. Concretely, recent extensive review and meta-analysis (Martin et al., 2021; Williams et al., 2022) concluded that SSRIs improve PTSD symptoms; they are first-line agents for PTSD pharmacotherapy, based on evidence of moderate certainty. The evidence is strongest for paroxetine and fluoxetine, as well as for the SNRI venlafaxine, which is also commonly recommended as a first-line pharmacological treatment for post-traumatic stress disorder. The NaSSA mirtazapine and the TCA amitriptyline may also improve PTSD symptoms, but there is not as much consensus as with SSRIs. Given that in the case of tricyclic antidepressant (TCA), pharmacological options were not recommended as first line unless CBT and EMDR are not available, have failed or there is severe comorbid depression. In addition, they found no evidence of benefit for the number of participants who improved after treatment with the antipsychotic group compared to placebo, based on very low certainty evidence. Thus, there remains a continuing need for effective agents in the treatment of PTSD. In terms of CPTSD and pharmacological treatment, Karatzias et al. (2019) indicated that studies comparing the efficacy of pharmacotherapies alone or in combination with psychotherapy would be necessary.

A CPTSD treatment proposal following ICD-11 criteria

Skills Training in Affective and Interpersonal Regulation plus Modified Prolonged Exposure (STAIR-MPE) treatment described by Cloitre et al. (2020) is a modular treatment that includes skills training in identifying feelings, managing and expressing emotions, enhancing assertiveness, managing power dynamics, optimising levels of intimacy, and increasing flexibility in relationships, which all build on each other to create emotional and social resources. This treatment includes a module of narrative therapy to provide clients with a method for remembering and managing past pains during the process of recovery and change. Also, STAIR-MPE highlights the importance of cultivating self-compassion through the learning process.

Therefore, STAIR provides skills that fill the gaps left by the turmoil of trauma. The aim of STAIR is to make the world a little less mysterious and a lot more manageable for these clients. The skills are intended to provide support for clients to achieve important life goals and have a greater number of life choices.

CPTSD IN CHILDREN/ ADOLESCENTS

Complex PTSD can occur at all ages, but the responses to a traumatic event, i.e. the core elements of the characteristic syndrome, may manifest differently depending on age and developmental stage. Children and adolescents are more vulnerable than adults to developing complex post-traumatic stress disorder when exposed to prolonged and severe trauma (ICD-11; WHO, 2018).

Children and adolescents with complex post-traumatic stress disorder are more likely than their peers to demonstrate such difficulties (ICD-11; WHO, 2018):

1. Cognitive (e.g., problems with attention, planning, organisation)
2. Interferences with academic and occupational functioning
3. Affective regulation problems (positive and negative emotions)
4. Persistent difficulties in maintaining relationships
5. Reckless or aggressive behaviour towards self or others
6. Dissociation
7. Substance use, risk-taking behaviours (e.g. unprotected sex, unprotected driving, non-suicidal self-injury)

CPTSD IN CHILDREN/ ADOLESCENTS

In the case of events such as sexual abuse, children and adolescents often develop a disorganised attachment style that may manifest as unpredictable behaviours towards these individuals (e.g., alternating between neediness, rejection and aggression). In children under 5 years of age, maltreatment-related attachment disorders may also include reactive attachment disorder or disinhibited social engagement disorder, which may coexist with complex post-traumatic stress disorder.

Children and adolescents with complex PTSD often report symptoms compatible with depressive disorders, eating and feeding disorders, sleep-wake disorders, attention deficit hyperactivity disorder, oppositional defiant disorder, behavioural-dissocial disorder and separation anxiety disorder. At the same time, other mental disorders may also develop after extremely stressful or traumatic experiences. Additional concurrent diagnoses should only be made if all diagnostic criteria for CPTSD.

KEY POINTS FOR PRACTITIONERS

1. CPTSD is strongly related to childhood adversity, and it is important to recognize CPTSD symptoms as early as possible, as they are linked with stronger pathology and disturbances in everyday functioning.

2. The prevalence of probable CPTSD can vary between 0.5% and 14%, with most studies showing a prevalence of about 3%.

3. The most well-studied instruments for the assessment of CPTSD are the self-report International Trauma Questionnaire (ITQ) (Cloitre et al., 2018) and the clinically administered International Trauma Interview (ITI; Roberts et al., 2019).

4. BPP and CPTSD partly overlap in difficulties across affect regulation, self-concept, and interpersonal relationships. However, important distinctions can be reflected in how symptoms manifest for both diagnoses and differential diagnoses.

5. A common perspective suggests that, in order to intervene in the totality of the diagnosis, each of its component symptoms should be addressed (Kneffel et al., 2019; Karatzias et al., 2018). Recent research raises possible recommendations that could be incorporated into interventions for CPTSD: treatments should focus on patient-centred care (Karatzias & Cloitre, 2019), self-compassion could be a useful treatment target for DSO symptoms (Karatzias et al., 2019) and interventions designed to enhance adult attachment security and reduce adult fear in their working models of attachment would be suggested (Courtois & Ford, 2012; Karatzias et al., 2022).

6. There are some differences in the effects or impact of trauma on children and adolescents due to the stage of life at which the trauma occurs. The effects of trauma can affect attachment and relationships, neurodevelopmental and bodily impairment, difficulties in emotional responses and verbalization, dissociation as a habitual resource, difficulties in behavioural self-regulation, cognitive difficulties and consequent learning problems, shame, guilt, low self-esteem, poor self-image and image of the world as a dangerous place, and increased likelihood of exposure to risky behaviours in adulthood and development of chronic diseases (NCTSN, n. d.)

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AND MONIKA KVEDARAITE