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Complex Posttraumatic Stress Disorder

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Abstract

The World Health Organization's proposals in the 11th edition of the International Classification of Diseases, released for comment by member states in 2018, introduce for the first time in a major diagnostic system a distinction between posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD). This article sets the new diagnosis of CPTSD within the context of previous similar formulations, describes its definition and requirements, and reviews the existing evidence concerning its epidemiology, differential diagnosis, assessment, and treatment.

In July 2018 the World Health Organization formally issued ICD-11, the latest revision of the International Classification of Diseases, for consultation with member states. It contains major changes to the diagnosis of posttraumatic stress disorder which is now replaced by two diagnoses, PTSD and Complex PTSD (CPTSD) (Maercker et al. 2013). Consistent with the ICD-11 principle that diagnoses should be simple and have the maximum clinical utility, requirements for PTSD include evidence for the re-experiencing of traumatic events in the present, deliberate avoidance, a current sense of threat, and functional impairment. Complex PTSD requires the same but, in addition, evidence for disturbances in self-organisation (DSO), consisting of affect dysregulation, negative self-concept, and disturbances in relationships. A more detailed rationale for the divergence from PTSD as defined in ICD-10, DSM-IV, and DSM-5 has been presented elsewhere (Brewin 2013, Brewin et al. 2017).

The term “complex PTSD” was first used to describe a syndrome experienced by survivors of repeated, prolonged trauma and involving alterations in affect regulation, consciousness, self-perception, and relationships to the perpetrator and to others (Herman 1992). Other similar diagnoses have previously been put forward. The ICD-10 diagnosis F62.0 “Enduring personality change after catastrophic experience” (EPCACE) described the disturbances in self-organisation that can sometimes result from multiple, chronic or repeated traumas from which escape is difficult or impossible (e.g., childhood abuse, domestic violence, torture, war, imprisonment). Another is “Disorders of Extreme Stress Not Otherwise Specified” (DESNOS) which was included in the Appendix to DSM-IV (American Psychiatric Association 2000). The DESNOS diagnosis has been operationalised using 48 possible symptoms, organised into 6 scales and 27 subscales (Pelcovitz et al. 1997).

A comparable diagnosis for children is developmental trauma disorder (DTD) (Ford et al. 2018).

A number of practical difficulties have been identified with these earlier formulations (Resick et al. 2012). These include the large number of candidate symptoms and the substantial symptom overlap with other diagnoses such as DSM-IV PTSD, major depression, and borderline personality disorder (BPD). Evidence has also been lacking that these formulations are uniquely linked to chronic or repeated trauma. There has been uncertainty over whether these formulations represent a complex and severe form of PTSD or a syndrome distinct from (although often comorbid with) PTSD (Ford 1999). Relatedly, it has been pointed out that complex PTSD might simply represent one end of a spectrum of severity in posttraumatic reactions, rather than being a qualitatively separate disorder.

ICD-11 CPTSD is related to Herman's (1992) concept of Complex PTSD, EPCACE, and DESNOS, and shares with them all an emphasis on enduring changes in self-organisation and the expectation that these changes typically result from exposure to sustained or multiple traumas from which escape is difficult or impossible. In contrast to EPCACE, CPTSD does not describe these symptoms as personality changes and, in contrast to DESNOS, the number of symptoms is relatively small. CPTSD also differs from all these previous formulations in three crucial ways: It requires the three symptom clusters of re-experiencing, avoidance and sense of threat which characterise PTSD; it is based on the symptom profile, not on the type of trauma exposure; and functional impairment is explicitly identified as a requirement for the disorder.

This greater definitional clarity resolves a number of the problems that have hindered Complex PTSD from being recognised as a diagnosis in its own right. First, it is clearly positioned as a separate diagnosis to PTSD (a person can be diagnosed with PTSD or CPTSD

but not both). At the same time, CPTSD must include the same evidence for re-experiencing in the present, avoidance, and sense of threat that is part of PTSD. Thus it shares with PTSD an explicit focus on specific, identifiable traumatic events that are prominent in consciousness rather than being a non-specific response to extreme trauma. Finally, chronic or repeated trauma is a risk factor, not a requirement, for CPTSD. There is an acknowledgment that there is no necessary connection with severe trauma, meaning that it can be diagnosed after a single traumatic event (although this will be less likely).

Epidemiology

One of the first studies of a nationally representative sample of trauma-exposed adults was conducted in Israel, finding a one-month prevalence of 9% for ICD-11 PTSD and 2.6% for CPTSD. Women reported higher rates of PTSD than men but did not differ in CPTSD rate (Ben-Ezra et al. 2018). A nationwide sample in Germany, in contrast, found a 1.5% one-month prevalence rate for PTSD and 0.5% for CPTSD, with no significant gender differences (Maercker et al. 2018). A nationally representative survey in the U.S. has reported rates in between these studies, with PTSD at 3.4% and CPTSD at 3.5% (Cloitre et al. in press). Women reported higher rates of both PTSD and CPTSD.

The requirements for PTSD in ICD-10 were less specific than in ICD-11 and did not include evidence of functional impairment. In DSM-5 the PTSD diagnosis is broader in that it includes many of the symptoms that belong both to ICD-11 PTSD and CPTSD. A substantial number of studies have now compared rates within the same community or treatment-seeking sample of ICD-10 PTSD, ICD-11 PTSD/CPTSD combined, and PTSD diagnosed with DSM-IV or DSM-5. In adult samples the ICD-11 rates are reliably lower than both ICD-10 and DSM-IV/5, consistent with the wish to define the disorder more narrowly.

At present there is only very preliminary evidence to support the existence of CPTSD in children and adolescents, according to a position paper published by the International Society for Traumatic Stress Studies (ISTSS) and downloadable from [http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_CPTSD-Position-Paper-\(Adults\)_FNL.pdf.aspx](http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_CPTSD-Position-Paper-(Adults)_FNL.pdf.aspx). In community samples, however, the few studies available do not suggest any difference in prevalence rates among children and young people between ICD-11 PTSD/CPTSD combined and DSM-IV/5 PTSD (Brewin et al. 2017).

Differential Diagnosis

A number of studies have conducted latent profile analysis or latent class analysis to test the assumption that there are different clinical groups corresponding to PTSD and CPTSD. With an occasional exception, these have consistently found one group of patients who report re-experiencing in the present, avoidance, and sense of threat, and another group who report elevated levels of these same symptoms but in addition report problems in affect regulation, social relationships, and a disturbed sense of self (Brewin et al. 2017). Similar findings have been reported for children and adolescents. Factor analytic studies have also consistently found evidence for six clusters of symptoms with three related to a PTSD higher-order factor and three to a DSO higher-order factor in the expected way (Brewin et al. 2017). The cross-cultural validity of the proposals have been tested in a number of countries including Austria, Denmark, Germany, Israel, and Lithuania, and the distinction also appears to be applicable to samples of refugees (Vallieres et al. 2018, Frost et al. 2019).

Consistent with the idea that chronic or multiple trauma is a risk factor for CPTSD, studies have shown that childhood physical or sexual abuse, particularly within the family, is more strongly related to CPTSD than PTSD (Cloitre et al. in press). CPTSD is also associated

with higher levels of psychiatric burden than PTSD, including greater depression and dissociation (Hyland et al. 2018, Cloitre et al. in press).

Questions have been raised about the potential overlap between CPTSD and other disorders for which prolonged or repeated trauma is thought to be a risk factor, such as borderline personality disorder (BPD). Research is in its early stages but two studies employing latent class analysis on samples reporting a history of child abuse (Cloitre et al. 2014, Frost et al. 2018), and one study that used network analysis on an institutionally abused sample (Knefel et al. 2016), have suggested that the two disorders can be meaningfully distinguished. The first point to note is that trauma exposure and PTSD symptoms are required for a CPTSD diagnosis but not a BPD diagnosis. Further, the symptoms that are more characteristic of BPD as compared to CPTSD are being frantic about being abandoned, having an unstable sense of self, having unstable relationships, impulsiveness, and self-harm and suicidal behaviour. The symptoms that are more characteristic of CPTSD as compared to BPD are an extremely negative sense of self, and avoidance of relationships with no significant shifts in identity.

Assessment of Complex PTSD

PTSD and CPTSD are more tightly defined diagnoses than DSM-5 PTSD, requiring a smaller number of more specific symptoms to be diagnosed. For example, DSM-5 includes five re-experiencing symptoms, involving any kind of intrusive memory as well as any kind of emotional or physiological reaction on encountering reminders of the event. Because several of these symptoms, including intrusive memories, are found in many other psychiatric disorders, ICD-11 requires that there should be an element of re-experiencing *in the present*. This involves one of two symptoms: Either a nightmare that recapitulates some aspect of the event (but does not have to be an exact replay), or a daytime flashback in which the event is

vividly replayed. DSM-5 and ICD-11 now both define flashbacks as existing on a continuum: at one end is total absorption in the traumatic memory, with a complete loss of awareness of the current environment, while at the other is a vivid intrusive memory of the traumatic event in which the person does not lose contact with their current surroundings but has a sense, however fleeting, that the event is happening again in the here and now. This requirement is important to differentiate PTSD from other conditions such as major depression in which people have intrusive memories of distressing events but experience them as belonging to the past. If the person has no conscious memory of the event (perhaps because of a head injury or intoxication) ICD-11 allows this criterion to be met by an emotional response to reminders of it.

ICD-11 also requires evidence (again, at least one symptom) of both avoidance and a sense of threat. Although the deliberate avoidance symptoms are the same as in DSM-5, the hyper-arousal symptom cluster is replaced in ICD-11 by the more specific construct of a continuing sense of threat despite the event being in the past. This can be manifested either by hypervigilance or an exaggerated startle reaction. The requirement for functional impairment in some important aspect of the person's life also differentiates PTSD in ICD-11 from the equivalent diagnosis in ICD-10.

For CPTSD to be diagnosed the person must also demonstrate pervasive, long-standing disturbances in self-organisation (DSO). DSO consists of three components, and again there must be evidence, in the form of at least one symptom, that all three are simultaneously present. Affective dysregulation may take the form either of hyper-activation, the tendency to experience intense emotions that cannot readily be moderated, or of hypo-activation, in which there is an absence of normal feeling states, or of both. Negative self-concept refers to feelings of worthlessness or being a failure, while disturbances in

relationships component focusses on detachment and withdrawal from others. These symptoms too must be accompanied by evidence of impairment in important life roles.

Different aspects of CPTSD may be more salient than others depending on the type of stressor. For example, uncontrollable anger tends to have relatively low endorsement as part of the affect dysregulation cluster among adults with childhood sexual and/or physical abuse (Cloitre et al., 2014), but much higher endorsement among those who were exposed to armed conflict and abducted into child soldiering (Murphy et al., 2016). ICD-11 further recognises that many other symptoms commonly accompany a PTSD presentation, even though they do not discriminate it from other disorders. These symptoms include anxiety symptoms such as panic, obsessions, and compulsions, ruminative thoughts indicating preoccupation with the traumatic event(s), general dysphoria in the form of emotional blunting, anhedonia, lack of a perceived future, insomnia, irritability, and concentration problems, dissociative symptoms such as memory disturbances (e.g. dissociative amnesia) and pseudo-hallucinations (e.g. hearing own thoughts as voices), somatic complaints without organic basis including headache and dyspnea, suicidal ideation and behaviour, changes in interpersonal attitudes and behaviour including social withdrawal, suspicion, and distrust, excessive use of alcohol or drugs to avoid re-experiencing, excessive risk-taking (e.g. dangerous driving), and psychotic reactions with hallucinations and delusions related to the trauma.

Although there are a few instruments that assess different forms of complex PTSD (Pelcovitz et al. 1997, Litvin et al. 2017), at present only one instrument is available that specifically assesses ICD-11 CPTSD, the International Trauma Questionnaire (Cloitre et al. 2018). The questionnaire is in use in at least 29 countries on six continents. A companion structured interview measure is under development.

Treatment of Complex PTSD

An important debate has been taking place over whether complex PTSD requires a different kind of psychological treatment to PTSD. The International Society for Traumatic Stress Studies produced a position paper (downloadable from

[http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_CPTSD-Position-Paper-\(Adults\)_FNL.pdf.aspx](http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_CPTSD-Position-Paper-(Adults)_FNL.pdf.aspx))

recommending three stages or phases of treatment, each with a distinct function. Phase 1 focusses on ensuring the individual's safety, reducing symptoms, and increasing important emotional, social and psychological competencies. Phase 2 focusses on processing the unresolved aspects of the individual's memories of traumatic experiences so that they are integrated into an adaptive representation of self, relationships and the world, using standard or somewhat adapted methods taken from conventional trauma-focussed cognitive-behaviour therapy. Phase 3 involves consolidation of treatment gains to facilitate the transition from treatment into a greater engagement with the outside world.

Currently validated treatments include STAIR/MPE (Cloitre et al. 2010), which includes a first phase emphasising the acquisition of affective and interpersonal regulation skills followed by a modified version of prolonged exposure to address the traumatic memories. Another alternative that could be considered for Phase 1 is compassion-focussed therapy (Karatzias et al. 2019). This addresses the frequent tendency for those with complex PTSD to feel intense shame and to be highly self-blaming and self-denigratory, reactions that are risk factors for PTSD and would be expected to make exposure to the traumatic memories too painful to tolerate. Treatment of children and adolescents with a phase-based approach

has been found to achieve similar gains in those diagnosed with CPTSD as those with PTSD, although those with CPTSD started and finished therapy with higher symptom levels (Sachser et al. 2017).

The need for a phased approach to treatment has been challenged by other experts (de Jongh et al. 2016), however. They pointed to the lack of direct evidence for the superiority of a phase-based approach as well numerous indications that immediate trauma-focussed treatment (i.e., bypassing Phase 1) could be effective for many patients with histories of multiple traumatisation, including child abuse. For example, an intensive form of trauma-focussed treatment that involved 12 × 90-minute sessions of prolonged exposure over four days followed by four weekly 90-minute booster sessions achieved large treatment effects that persisted over six months (Hendriks et al. 2018). A recent meta-analysis (Karatzias et al. 2019) has confirmed that standard treatments for PTSD do reduce CPTSD symptoms in the form of negative self-concept and disturbances in relationships, although little evidence is available for affective dysregulation. The analysis also found that treatment gains were reduced when trauma exposure dated from childhood.

This debate largely preceded the current conceptualisation of CPTSD in ICD-11 which has refocused attention on the presenting symptoms rather than the nature of the trauma. Rigorous comparisons of alternative treatment approaches are lacking but it is unlikely that diagnostic concerns alone will prove to be decisive. Theoretically, the factors that are thought to undermine direct work with trauma memories generally involve cognitive and emotional reactions that prevent the person from holding the most traumatic material in consciousness and keeping a degree of detachment and reflection as they do so (Brewin et al. 2010). For example, loss of trust very frequently accompanies CPTSD (Ebert & Dyck 2004) and may impede the formation of a therapeutic relationship strong enough to allow the patient to share

critical experiences or even revisit them privately. This is to be expected given that trauma survivors not infrequently have the experience of being disbelieved or denigrated, or are betrayed by individuals or organisations who have a duty of care towards them. Some other factors impacting on CPTSD treatment are discussed further below.

What is important is to be aware that in order to strengthen the therapeutic relationship and prevent drop-out some patients with CPTSD are likely to benefit from a stabilisation phase prior to trauma-focussed treatment that directly addresses their traumatic memories. Consistent with this, the recently updated NICE guideline on PTSD notes that trauma-focussed cognitive-behavioural interventions should normally be provided over 8-12 sessions but may need to be extended for those with more complex presentations (National Institute of Health and Care Excellence 2018). The recommendations include: building in extra time to develop trust with the person, by increasing the duration or the number of therapy sessions according to the person's needs; take into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might affect engagement with and success of treatment; help the person manage any issues that might be a barrier to engaging with trauma-focused therapies, such as substance misuse, dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception; and work with the person to plan any ongoing support they will need after the end of treatment, for example to manage any residual PTSD symptoms or comorbidities. NICE did not give any indication of how much additional time might be needed, but therapeutic experience indicates that while 20-30 sessions will be sufficient for many, 1-2 years of weekly therapy may be needed for the more complex cases.

Factors Impacting on Treatment of Complex PTSD

There are numerous clinical challenges that are regularly encountered in the management of CPTSD and that interfere with psychological treatment even in patients who are well-motivated and engaged. Of these chronic dissociation and/or voice-hearing are among the most common.

Dissociation. The tendency for patients to dissociate within therapy sessions when confronted by traumatic reminders is well recognised. Dissociation can involve either too much absorption in or too much disengagement from the traumatic material. In either case the ability to reflect deliberately on the material, essential for positive therapeutic change, may be compromised. However, the literature shows that dissociative symptoms tend to improve with PTSD treatment and need not be a barrier to a good outcome. The outcome is likely to depend on how successfully dissociation can be managed in the individual case.

CPTSD, however, may be accompanied by much more pervasive dissociation, including complete loss of awareness of the current environment that occurs both in the therapy session and in everyday situations such as crossing roads (sometimes in the form of fugue states). Such episodes are usually frightening and potentially put the patient at increased risk – it is likely that they will need to be addressed before the commencement of direct trauma work that may exacerbate them. The presence of these episodes can be assessed with the Dissociative Experiences Questionnaire (Carlson & Putnam 1993) or a briefer 10-item version that focusses on the most pathological dissociation symptoms (Waller et al. 1996). An adolescent version is also available (Armstrong et al. 1997).

Stabilisation work may therefore be required to assess which external situations provoke such reactions and to teach the patient to monitor and control them, for example

using grounding techniques (Kennedy et al. 2013). In vivo practice accompanied by a therapist may be required occasionally in order to guarantee the patient's safety in real-world roles such as driver or pedestrian. Severe dissociative reactions occurring in the therapeutic session are also likely to be frightening and may require the traumatic memories to be approached very slowly and gradually, greatly extending the therapeutic process.

Voice-hearing. Although now recognised as an associated feature of PTSD in both DSM-5 and ICD-11, the symptom whereby patients report hearing their thoughts in the form of a voice speaking to them is rarely acknowledged in textbooks or treatment manuals. Following a number of observational studies in the U.S. military, voice-hearing has been identified as prevalent in U.K. military and civilian samples, particularly in those with more complex forms of the disorder (Anketell et al. 2010, Brewin & Patel 2010). These studies reported voice-hearing to be correlated with increased dissociative symptoms, consistent with some theoretical views of voice-hearing in people with psychosis (McCarthy-Jones & Longden 2015). Although the average number of different voices is generally between one and three, the presence of large numbers of voices indicates that the person may attract a comorbid diagnosis of a dissociative disorder.

Clinical experience confirms that voice-hearing often has a very substantial impact on CPTSD patients' lives, with the potential to greatly worsen mood and alter their sense of identity. Further, voices may be active in the therapeutic environment, commenting on mental health professionals and their interventions and sometimes counselling non-cooperation. Voices appear to have greater impact than negative thoughts because, similar to the experience of psychosis, patients describe relationships with them in which the patient often inadequate or intimidated (Brewin & Patel 2010).

Techniques proposed for working psychologically with voices in patients with psychosis (Corstens et al. 2012) are relevant to patients with CPTSD (Brewin in press). It appears to be helpful to explore patients' attitudes to and assumptions about their voices, as well as their content, with the aim of destigmatising the experience of voice-hearing and reassuring patients about their sanity. It is likely that the presence of voices will not previously have been disclosed to anyone. At the same time patients can be taught to question and evaluate the content of what the voices say, using standard techniques of Socratic questioning that are part of cognitive therapy. These methods often enable the patient to distance themselves from their voices for the first time, stop treating them as infallible, and accept them as a part of their mental life that needs to be acknowledged rather than believed or obeyed.

Summary

CPTSD has been discussed in one form or another for many years but now in ICD-11 has been defined in a way that is consistent with empirical evidence that it is not inevitably linked to certain types of traumatic exposure. The presence of re-experiencing, avoidance and sense of threat symptoms also helps to demarcate it from other disorders that may be the result of prolonged or repeated trauma. In its new form CPTSD is readily distinguished by clinicians (Keeley et al. 2016) and meets a long-expressed need. It also, as discussed by NICE, has resource implications as brief treatments are unlikely to be adequate. Although conventional trauma-focussed treatment may be effective for some there are numerous complicating factors that will require practitioners specialising in CPTSD to develop additional skill sets.

Declaration of Interests

CB was an unpaid member of the Working Group on Classification of Stress-Related Disorders for the World Health Organization's International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. The views expressed in this article are those of the authors and do not represent the official policies or positions of the International Advisory Group or the WHO.

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Box: ICD-11 Complex PTSD Definition and Diagnostic Guidelines**Definition:**

Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Diagnostic Guidelines:

- Exposure to a stressor typically of an extreme or prolonged nature and from which escape is difficult or impossible such as torture, concentration camps, slavery, genocide campaigns and other forms of organized violence, domestic violence, and childhood sexual or physical abuse.
- Presence of the core symptoms of PTSD (re-experiencing the trauma in the present, avoidance of reminders of the trauma, and persistent perceptions of current threat).
- Following onset of the stressor event and co-occurring with PTSD symptoms, there is the development of persistent and pervasive impairments in affective, self and relational functioning including problems in affect regulation, persistent beliefs about oneself as diminished, defeated or worthless, persistent difficulties in sustaining relationships

The stressors associated with Complex PTSD are typically of an interpersonal nature, that is are the result of human mistreatment rather than acts of nature (e.g., earthquakes, tornadoes, tsunamis) or accidents (train wrecks, motor vehicle accidents). In addition to the typical symptoms of PTSD, Complex PTSD is characterized by more persistent long-term problems in affective, self and relational functioning. Problems in all three areas are often co-occurring.

Objectives

Understand the relationship between Complex PTSD and precipitating events

Distinguish Complex PTSD from PTSD and borderline personality disorder

Be aware of current issues and practices in psychological treatment

MCQs

1. ICD-11 Complex PTSD can be diagnosed following exposure to:
 - a) Repeated trauma
 - b) Child abuse
 - c) Any traumatic event*
 - d) Any upsetting event
 - e) Chronic trauma

2. Which of the following are not recognised accompaniments of ICD-11 Complex PTSD?
 - (a) Suicidal ideation
 - (b) Hearing thoughts as voices
 - (c) Mistrustfulness
 - (d) Delusions*
 - (e) Dissociative states

3. A diagnosis of ICD-11 Complex PTSD requires:
 - (a) Disturbances in relationships
 - (b) Re-experiencing the traumatic event in the present
 - (c) Problems in regulating emotions
 - (d) A continuing sense of threat
 - (e) All of the above*

4. ICD-11 Complex PTSD:
 - (a) Requires more qualifying symptoms than DSM-5 PTSD
 - (b) Can be diagnosed after childhood or adult trauma*

- (c) Does not require functional impairment
 - (d) Is a subtype of ICD-11 PTSD
 - (e) Is indistinguishable from borderline personality disorder
5. Psychological treatment for ICD-11 Complex PTSD:
- (a) Always involves a period of stabilisation
 - (b) Is unlikely to bring about lasting improvement
 - (c) Requires additional sessions compared to treatment for PTSD*
 - (d) Is unaffected by the presence of housing or asylum problems
 - (e) Is not possible with children and adolescents