

**Title**

Complex Posttraumatic Stress Disorder (CPTSD): The Evolution of a Disorder

**Running Head**

Introduction to the special section

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## Introduction to the Special Section

Complex PTSD (CPTSD) is not an unfamiliar construct within the trauma community but it is certainly one that has caused controversy and disagreement (see for example Resick et al., 2012). Although long-discussed, CPTSD has only recently been officially recognised as a distinct psychiatric disorder. The World Health Organization's 11th version of the International Classification of Diseases (ICD-11) describes two distinct-but-related trauma conditions: Posttraumatic Stress Disorder (PTSD) (6B40) and Complex PTSD (CPTSD) (6B41), both of which exist under a general parent category of 'Disorders specifically associated with stress'.

PTSD is comprised of three symptom clusters including (1) re-experiencing of the trauma in the here and now, (2) avoidance of traumatic reminders, and (3) a persistent sense of current threat. CPTSD includes the three PTSD clusters and three additional clusters that reflect 'disturbances in self-organization' (DSO). These are (1) affective dysregulation, (2) negative self-concept, and (3) disturbances in relationships (ICD-11, 2018). There is substantial evidence that these DSO symptoms are typically associated with sustained, repeated, or multiple forms of traumatic exposure (e.g., genocide campaigns, childhood sexual abuse, child soldiering, severe domestic violence, torture, or slavery), reflecting loss of emotional, psychological, and social resources under conditions of prolonged adversity (Cloitre, 2013; Karatzias et al; 2017).

In 2012, the ICD-11 workgroup reviewed an ICD-10 diagnosis representative of complex PTSD; Enduring Personality Changes after Catastrophic Events (EPCACE). The diagnosis was categorized as a personality disorder and like all personality disorders in ICD, it identified disturbances in three domains: affect, self, and relationships. The diagnosis was removed from personality disorders and placed under the 'Stress and Traumatic Disorder' category by high level leadership in ICD. The benefit of this transfer was that trauma-related problems were no longer viewed as "enduring", as implied by the term personality disorder,

## Introduction to the Special Section

but rather as a set of symptoms that are more likely to change. The ICD-11 workgroup maintained the three categories of problems (affect, self, and relationships), and reviewed findings from the DSM-IV field trials (Roth, Newman, Pelcovitz, van der Kolk & Mandel, 2005) and those from a consensus survey of expert clinicians on Complex PTSD (Cloitre et al., 2011), in order to identify specific problems in each symptom category that are associated with prolonged, enduring, and repeated forms trauma. The symptoms identified in this review were organized into the proposed narrative description of CPTSD for ICD-11 (Maercker et al., 2013).

Defining CPTSD as a distinct stress-related disorder was consistent with an earlier conceptualization of Complex PTSD, as described by Herman (1992), in her seminal text ‘Complex PTSD: A syndrome in survivors of prolonged and repeated trauma’ which was published in the *Journal of Traumatic Stress*. In the foreword to Courtois and Ford (2009), Herman emphasized the interpersonal nature of serious and repeated traumatization that she believed would be more likely to lead to what she called complex PTSD:

*...complex PTSD..... begin[s] with the social ecology of prolonged and repeated interpersonal trauma. There are two main points to grasp here. The first is that such trauma is always embedded in a social structure that permits the abuse and exploitation of a subordinate group... The second point is that such trauma is always relational. It takes place when the victim is in a state of captivity, under the control and domination of the perpetrator (page xiv).*

Courtois and Ford (2009, pg. 13) expanded on the above ideas and proposed a definition of complex traumatization as ‘involving traumatic stressors that are 1) repetitive and prolonged; 2) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; 3) occur at developmentally vulnerable times in the victim’s life; and 4) have the potential to compromise severely a child’s development.’ This definition

Introduction to the Special Section

encapsulates the nature of complex trauma in the context of developmental stressors.

However, evidence indicates that although developmental trauma is a risk factor for CPTSD it is not necessarily a requirement (Hyland et al., 2017). Indeed, data demonstrate that other types of traumatic exposure in adulthood can also lead to CPTSD (for example torture, see Liddel et al, this issue).

CPTSD is a response to a clinical need to describe common difficulties associated with exposure to traumatic stressors that are predominantly of an interpersonal nature. It has also been developed in response to the need to capture non-fear or anxiety responses to traumatic events. Thus, the inclusion of CPTSD in ICD-11 is an important development in the area of psycho-traumatology, and this special issue in JTS aims to contribute to this ongoing work. We briefly review the history of this work on construct validity while describing the articles in this issue.

The first step in the process of evaluating the construct validity of the ICD-11's proposed model of CPTSD involved the use of archival data to determine whether CPTSD was distinguishable from PTSD. This was assessed using latent class analysis (LCA) to determine if there were distinct groups of trauma-exposed persons with symptom profiles consistent with the distinction between PTSD and CPTSD. Failure to identify such a distinction would falsify the proposal to include CPTSD as a distinct disorder. The initial evaluation proved successful (Cloitre et al., 2013), and several studies have replicated these findings in a range of clinical and community samples including those who had experienced rape and domestic violence, war exposed civilians, and refugees (see Brewin et al., 2017 for review). In addition, studies on the latent symptom structure of CPTSD have shown that CPTSD can be best described in terms of a two-factor higher-order model; a PTSD factor that explains covariation across three first order factors (re-experiencing, avoidance, and threat symptoms) and a DSO factor that explains covariation across another three first order factors

Introduction to the Special Section

(affect dysregulation, negative self-concept and interpersonal problems) (see for an overview Brewin et al., 2017).

Similarly, Liddell and colleagues (this issue) examined the discriminant validity of CPTSD and PTSD using LCA techniques in a sample of 112 refugees residing in Australia. They found evidence of a four class solution that included a PTSD class, CPTSD class, an affective dysregulation class, and a low symptom class. The CPTSD and PTSD classes were predicted by exposure to cumulative traumatic events. In addition, the CPTSD class was predicted by insecure visa status, presumably inducing a sense of ongoing threat to personal safety and stability.

Cloitre and colleagues (this issue) examined prevalence and risk factors associated with PTSD and CPTSD in a nationally representative household sample of adults in the U.S (N = 1893). A total of 7.2% of the sample met criteria for either PTSD or CPTSD (3.4% for PTSD and 3.8% for CPTSD), and women were approximately two-times more likely than men to meet criteria for both PTSD and CPTSD. Similar to Liddell et al. (this issue), cumulative trauma was found a significant predictor of traumatic stress. However, although cumulative adulthood trauma was associated with both PTSD and CPTSD, cumulative childhood trauma was more strongly associated with CPTSD.

Vang and colleagues (this issue) examined profiles of traumatic life events exposure in a general population sample of Israeli adults (N = 834) and their association with PTSD and CPTSD. This study used LCA to identify groups based on profiles of trauma exposure. These classes were then used to predict PTSD and CPTSD, represented as symptom dimensions and probable diagnostic categories. One of the classes was termed “child and adult interpersonal victimization” and it was found to be positively associated with both PTSD and CPTSD.

Numerous studies suggest that stress-related disorders are highly comorbid with other problems including depression, anxiety, and substance misuse (e.g. Shevlin, Hyland, Vallières et al., 2018). Many survivors will present in services with these difficulties as a primary cause for concern rather than traumatic stress symptoms. Consequently, it might not be surprising that in clinical practice there have been as many definitions of CPTSD as there are clinicians or survivors, reflecting the idiosyncrasy of presentations of complex psychological trauma. In clinical practice with complex trauma patients, when inquiring about the most distressing current difficulties, people often state that they had emotional responses such as being angry, or that they had difficulty engaging or maintaining relationships, or were feeling very low about themselves. People would also describe “flashbacks” or “arousal” which are typical symptoms of PTSD. Others would present with symptoms that overlap with Borderline Personality Disorder (BPD). The distinction between CPTSD and Borderline Personality Disorder (BPD) has been highly controversial and questions have been raised whether CPTSD is just co-morbid PTSD with BPD. Indeed, the distinction between the two conditions has ramifications for diagnosis and treatment. In this issue we include a study that explored the discriminant validity of CPTSD and BPD symptoms (see Hyland and colleagues, this issue). This study was conducted using a trauma-exposed community sample (N = 516) from the UK. Exploratory structural equation modelling found a three factor structure of mental health symptoms, which were labelled PTSD, DSO, and BPD. Childhood trauma did not distinguish these factors and was related to all of them indicating that it is a risk factor for symptoms of both CPTSD and BPD. While PTSD produced weak correlations with DSO and BPD, BPD and DSO were strongly correlated. The authors suggest that the findings support the discriminant validity of CPTSD and BPD and further research is required to identify the unique presentations of symptoms of CPTSD and BPD in similar clusters (e.g. sense of self).

## Introduction to the Special Section

Finally, we turn to treatment concerns. Herman (1992) suggested a phased approach to the treatment of CPTSD involving three phases of treatment that may be overlapping and would address both the PTSD and DSO symptoms that are part of the disorder. The first phase of treatment includes establishing safety and symptom management, predominantly by means of psychoeducational interventions to provide the necessary skills for patients to be able to tolerate distress more effectively, and to establish a strong therapeutic alliance with the client. This is essential as interpersonal trauma, especially childhood trauma, can cause disruptions in attachment which can adversely impact on one's sense of self, relational, and emotion regulation capacities (Charuvastra & Cloitre, 2008). The second phase of the treatment focuses on trauma memory processing, and the third phase promotes re-establishment of connections with the wider community.

Many clinicians agree that it is important to first offer a psychoeducational intervention to help patients understand their symptoms by making the connections between current difficulties and the nature of their trauma, as well as to acquire distress tolerance skills before trauma processing can begin. There is now some evidence to suggest that psychoeducational approaches might be useful for stabilisation of difficulties associated with complex traumatisation (e.g., anxiety and depression) but not symptoms of traumatic stress (Mahoney et al., 2019). This evidence highlights the importance of trauma-focused interventions for the treatment of traumatic stress.

Two papers in this issue discuss the important challenges of caring for people with CPTSD from an organisation perspective, and their subsequent treatment. While neither of these papers are empirical, we hope that this work will inspire future studies of CPTSD care and treatment approaches. One paper by Fyvie and colleagues (this issue) describes an attachment-based model of care for people with CPTSD where it is proposed that in order for services to be effective, they should provide people with an alternative model of attachment.

## Introduction to the Special Section

A new model of care was introduced in the Rivers Centre for Traumatic Stress following evidence of dissonance between clinical practice and research findings, where it was not possible to deliver evidence-based interventions without significant modifications or adjustments. Guidelines produced by the National Institute for Clinical Excellence (NICE, 2005) and the Australian Centre for Posttraumatic Mental Health (ACPMH, 2007) recommend the use of exposure based interventions such as Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR). These interventions have been shown to be effective for reducing symptoms of DSM-IV PTSD including re-experience, avoidance, and hyperarousal. Nevertheless, evidence has been accumulating in the last few years suggesting that trauma survivors, especially those who have been exposed to interpersonal trauma have more complex emotional responses to traumatic stressors which also include feelings of shame, disgust, and sadness (Bradley et al., in press).

There is evidence to suggest that exposure interventions might be suitable for people with complex traumatic presentations (Foa et al., 2005) although more recent evidence suggests that this is less the case if the symptoms of CPTSD have resulted from childhood trauma (Karatzias et al., 2019). Outcome research in the area of PTSD exposure trials has also been criticized for enrolling samples which are not representative of the general patient population as the samples represent individuals who self-select to participate in exposure therapy and that many trials exclude individuals with common comorbidities (e.g. Spinazzola et al., 2005). The Rivers team in Scotland found that many CPTSD patients were struggling with exposure interventions, and in order to respond to survivor's needs, they revised their treatment approach to a phase-based modular approach. The rationale for such a flexible multi-modular approach to the treatment of CPTSD is discussed by Karatzias & Cloitre (this issue). The approach highlights flexibility in the selection of empirically supported interventions to target the symptoms of CPTSD sequentially and the order of delivery based



## Introduction to the Special Section

on symptoms that are impairing, severe, and of relevance to the patient. A future research agenda for treatment of CPTSD is laid out in this paper.

The work presented in this special section highlights the need for further research in the field. There is a need to confirm the cultural validity of CPTSD in a number of trauma populations and cultural contexts using the final version of the *International Trauma Questionnaire* (ITQ; Cloitre et al., 2018). The ITQ was developed following evidence from archival data to characterize specific symptoms where distinct groups emerged (Cloitre et al., 2013). Later, the first trial of the scale in a clinical sample was conducted in Scotland (Karatzias et al., 2016) and there are currently numerous studies under way using the ITQ with different trauma exposed samples around the world. The majority of the studies presented in this special section are based on the ITQ, and this scale, including its many translations, is freely available to researchers and clinicians and can be found at the following website: [www.traumameasuresglobal.com](http://www.traumameasuresglobal.com).

With regard to future research priorities, there is a need to finalize and validate the International Trauma Interview (ITI; Roberts, Cloitre, Bisson, & Brewin, 2017), a clinician-administered diagnostic interview for ICD-11 PTSD and CPTSD. Furthermore, the validation of CPTSD as a condition and relevant assessment instruments for children and young people are currently under development. Future work should also address the relationship between ICD-11 PTSD, CPTSD and dissociation. Emerging evidence suggests that dissociation is more strongly associated with CPTSD than PTSD (Elklit, Hyland, & Shevlin, 2014; Hyland, Shevlin, Fyvie, Cloitre, & Karatzias, 2018; Hyland, Shevlin, Fyvie, Cloitre, & Karatzias, 2019). Most importantly, future research should focus on the development of efficacious treatments for CPTSD in adults and children and investigate predictors of treatment outcome. Finally, there is a need to explore factors that buffer the effects of complex traumatic stressors to enable the development of preventative strategies.

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## Introduction to the Special Section

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