# Diagnosis and Management of Complex Post Traumatic Stress Disorder (C-PTSD)

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## What You Need to Know

- Complex PTSD is a new diagnosis in ICD 11. It combines the symptoms of PTSD with difficulties in self-organisation. (Full definition in Box 2)
- Complex PTSD arises out of repeated, prolonged or chronic exposure to trauma whilst PTSD is often caused by single episodes of trauma.
- Best practice guidelines advise phase-based and multi-component therapy, personalized to individual needs.

## Introduction

Complex Post traumatic stress disorder (C-PTSD) is a new diagnosis in the International Classification of Diseases (ICD) 11. It is not recognised in the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5. (1) Caused by recurrent, chronic or sustained trauma, C-PTSD has both the clinical features of PTSD and symptoms that reflect the prolonged impact of sustained trauma on self-organization, encompassing affect regulation, negative self-concept, and difficulties sustaining interpersonal relationships. This article explains what C-PTSD is, how to recognise it and the fundamentals of management of this condition, acknowledging that the evidence base continues to grow and evolve.

### Box 1: What is Trauma?

ICD 11 defines trauma as "exposure to an extremely threatening or horrific event or series of events in which escape is difficult or impossible".(1)

## What is Complex PTSD?

Complex PTSD may occur following exposure to events that are traumatic. Typically, this means chronic, repetitive or prolonged trauma but may also arise from a single event or experience. (1)

Complex PTSD comprises two sets of symptoms, with diagnostic criteria requiring the presence of both PTSD symptoms and disturbances of self-organization (Box 2). The essential features of post-traumatic stress disorder (PTSD) include re-experiencing symptoms (nightmares, flashbacks, intrusive images); hyperarousal (anxiety, irritability, exaggerated startle, insomnia) and avoidance. The DSM 5 classification of

PTSD included a fourth category of symptoms of changes in cognition and mood, as well as specifying the presence or absence of dissociation, defined as the involuntary disruption of identity, sensations, perceptions, affects, thoughts, memories, control over bodily movements or behaviour. (2) Whilst ICD 11 does not include dissociation as a core feature of C-PTSD, there is evidence to suggest it is a marker for severity of C-PTSD with poorer health outcomes and highest levels of functional impairment. (3).

## Box 2: ICD 11 description and diagnostic criteria for C-PTSD(1)

**ICD-11 description:** 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)

Diagnostic requirements include at least one symptom from each of the following six categories:
A. PTSD symptoms:

- Intrusions or re-experiencing of the event (such as intrusive memories, repetitive play in which the events or aspects of it are expressed, nightmares, flashbacks, distress triggered by reminders of the event or events).
- Avoidance (such as avoiding thoughts, feelings or memories of the event or events, or avoiding people, places, conversations or situations that are associated with the event or the events).
- Arousal and reactivity or sense of current threat (such as irritability, being overly vigilant, being easily startled, concentration problems, sleep problems).

B. Disturbances in self-organisation

- Problems in affect regulation (such as marked irritability or anger, feeling emotionally numb)
- Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event
- Difficulties in sustaining relationships and in feeling close to others

In 1992 Herman (4) coined the term “Complex Trauma” to describe a constellation of symptoms following chronic, repetitive or prolonged trauma. She highlighted the central feature was a sense of captivity, that escape from the ongoing trauma(s) is not possible. Her description included PTSD symptoms alongside somatisation, dissociation, affect dysregulation, and difficulties in relationships. The next thirty years saw attempts for some version of this original description to be added to psychiatric classifications until ICD 11 introduced C-PTSD in 2021.

The introduction of C-PTSD as a new diagnosis has been controversial, particularly due to the overlap in presentation and risk factors with PTSD. However, the construct validity of C-PTSD versus PTSD has been confirmed by numerous studies, highlighting that the nature of the trauma is more likely to be multiple and prolonged, and the level of functional impairment greater in C-PTSD compared with PTSD (5,6).

Further controversy has arisen from potential diagnostic overlap of C-PTSD with several other conditions. Current C-PTSD criteria demonstrate diagnostic and clinical crossover with neurodiversity, dissociative identity disorder (DID) and emotionally unstable personality disorder (EUPD) which can make accurate diagnosis challenging. Neurodiversity, including ADHD and autism, may impact on the presentation of C-

PTSD as well as being a potential differential diagnosis. Patients with dual diagnoses of neurodiversity and C-PTSD may require specific intervention adaptations. For autism this may include specific communication strategies or recognising the sensory sensitivity. (7,8,9). Dissociation may be a prominent presenting feature of C-PTSD, which creates diagnostic crossover with DID. DID should be considered in cases of severe childhood attachment trauma presenting with amnesic episodes and auditory hallucinations, which can distinguish them from C-PTSD. (10,11).

C-PTSD and EUPD show considerable overlap in risk factors, clinical presentation and diagnostic criteria. Research suggests differences include C-PTSD having a more stable but negative self-concept, less severe shifts in affect, and less likelihood of engaging in self-injurious or suicidal behaviour (12,13). However, there is a growing survivor movement and increasing numbers of clinicians rejecting the EUPD label due to the stigma, shame and potential re-traumatisation linked to it, and many survivors are seeking re-diagnosis to C-PTSD. (14,15).

**How might Complex PTSD present?**

C-PTSD can present in different ways, without patients initially making mention of or necessarily understanding the relevance of their underlying trauma. This means C-PTSD may be easily missed and people may present to medical services with symptoms of anxiety or depression, persistent unexplained physical symptoms or difficulties with relationships.

People with C-PTSD may not disclose their trauma because of associated fear, shame, guilt or stigma, such as with child sexual abuse, adult sexual assaults and interpersonal or domestic violence and abuse. (12,16) They may also try to avoid re-experiencing the impact of their symptoms due to their intrusive and unpleasant nature, which can lead to a "shutting down" of their emotions or an attempt to manage them through substance misuse, eating disorders, self-harming behaviours or somatisation.
Risk factors for C-PTSD are wide ranging. In a meta-analysis of predictive variables (17), the main risk factor identified was the experience of sexual abuse in childhood (k=12; OR= 2.880). In the UK, the Independent Inquiry into Childhood Sexual Abuse estimates that 1 in 6 girls and 1 in 20 boys experience sexual abuse. (18) Emotional neglect in childhood, physical abuse throughout life, and being female were further significant risk factors. While emotional neglect and abuse, bullying and stalking don't necessarily fulfil the ICD-11 definitional requirement for trauma to be "extremely threatening" or "horrific" in nature, they have also been found to be significantly associated with the diagnosis (19).

Population prevalence rates for C-PTSD have been estimated at 1-8% with lifetime prevalence in the UK reported at 13%. (20) . Studies in different populations indicate a prevalence of 16-38% in refugees and asylum seekers (21), 15% in former political prisoners, (22) and 64% in Croatian veterans. (23). C-PTSD is 2-3 times more common in women than men, thought to be due to sexual assaults and sexual abuse being a common underlying trauma that more frequently affects women. (24)

**How do you make the diagnosis?**

Clinicians should actively consider the potential for underlying trauma to ensure that it is approached and recognized; issues may otherwise remain hidden and patients may continue to present with a variety of difficulties that arise out of their response to trauma. The role of primary care doctors and clinicians in non-mental health roles is to take a history which allows the patient to feel their trauma has been recognized and demonstrate that the clinician is keen to understand and help them, without premature or insensitive probing into traumatic experiences before the patient is ready to disclose.

Primary care doctors may not consider they are in a position to make a formal diagnosis but should be able to identify the possibility of significant underlying trauma and potential C-PTSD issues and to provide ongoing support whilst patients await secondary care assessment. Use of the 18 item self-report International Trauma Questionnaire (ITQ) for PTSD and C-PTSD may be helpful to guide referral, assess severity of symptoms and provide a baseline pre-treatment if administered at an appropriate time. (25)

Discussing trauma is likely to raise anxieties in both the patient and the clinician. Patients may be concerned about re-experiencing unpleasant symptoms and the underlying trauma, as well as any associated feelings of fear and shame. Clinicians may be concerned about opening a 'Pandora's box' of difficulties with associated distress and feel uncertain about their ability to deal with this. There may also be concerns about potential safeguarding issues, and uncertainty about appropriate and available pathways of care once someone has disclosed a history of past trauma and its consequences. Continuity of care and meeting with the patient on several occasions is likely to aid the formation of a trusting therapeutic relationship and enable disclosure in a "safe space". Patients value care from known clinicians who understand their story and can contextualise their ongoing health needs in light of their trauma history.

It is important to consider whether the trauma or contact with persons involved is ongoing, especially if there could be some risk to the patient or vulnerable others. The person best placed to assess this is usually the patient themselves, and it is important to maintain their trust and ensure they have agency in any disclosures. Confidentiality must be respected but it is also important to clarify who any information may be shared with going forward. Courses on facilitating and responding to disclosures for frontline and specialist staff are now available. (see box 3)

Trauma informed practice seeks to recognise and respond to the potential impact of trauma on individuals' health and wellbeing, thereby reducing the risk of re-traumatisation. Courses are available on the principles of trauma-informed practice as well as training in relevant interview techniques aiming to facilitate disclosure where appropriate, whilst maintaining patients' trust and confidence. The guidance listed below in Box 3 describes the principles which all clinicians should follow with all patients, recognizing that a trauma history may not initially be known. Trauma-informed care should be followed by clinicians at all levels of care. Trauma informed care is considered best practice based on expert consensus.

## Box 3: Principles of trauma informed practice (26)

Guidance: Vulnerabilities: applying all our health. Office for Health Improvements and Disparities.
Published 29 March 2022

Consider applying the 6 principles of trauma informed practice.

**Safety**

- put measures in place so that individuals feel emotionally and physically safe
- consider the wider impact of your actions
- ask what they need to feel safe and how you can create a safe environment for them
- keep the person informed
- do what you say you will do when you say you will do it

**Trustworthiness**

- be transparent and do what you say you will do
- explain what will happen next
- give relaxed, unhurried attention – listen effectively
- not over-promise – always manage expectations

**Choice**

- listen to what the person wants
- if there is a choice – give it
- always explain clearly and transparently what will happen next
- validate any concerns as understandable and normal

**Collaboration**

- ask what they need
- be clear about what will happen and what they have control over and choice in – empower them where possible
- understand local services and support agencies so that you can suggest places to go to access help

**Empowerment**

- validate people's feelings and engage with them in a non-judgemental manner
- listen to what they need and ensure they are signposted or referred to appropriate support
- don't take over – encourage and empower people to take positive action themselves (with your support if they want it)

**Cultural consideration**

- adopt an open non-judgemental attitude
- have an awareness of your own cultural values and an awareness and acceptance of cultural differences
- consider how you can expand your own cultural awareness – familiarise with the worldviews of cultural groups other than your own
- ask people about their culture to understand their preferred language, how healthcare decisions are made in their family and whether their culture prohibits any healthcare procedure or tests

**Trauma- informed care training**

Trauma-informed care: Using trauma awareness to enhance everyday practice
Online two day training for health and social care .
https://tavistockandportman.ac.uk/courses/trauma-informed-care-using-trauma-awareness-to-enhance-everyday-practice-cpd31/

Trauma-informed care: from theory to practice
Online 12 week course aimed at wide range of professionals in health and social care.
https://tavistockandportman.ac.uk/courses/trauma-informed-care-from-theory-to-practice-dab004/

Trauma-informed approaches
"Bite-sized" learning packages
https://mycareacademy.org/packages/Trauma-Informed%20Approaches/story.html

**Disclosure training co-produced with survivors**
Online training for all health and social care professionals – 8 hours total available across one year
https://tavistockandportman.ac.uk/courses/child-sexual-abuse-disclosure-how-to-support-adult-survivors-daa019/

## Box 4: Specialist agencies with public resources that may be helpful

**Trauma and Dissociation** http://traumadissociation.com/complexptsd

**The CPTSD Foundation** https://cptsdfoundation.org/

**The Survivors Trust** https://www.tstresources.org/

**International Society for the Study of Trauma and Dissociation**
https:/www.isst-d.org/public-resources-home/

**Independent Inquiry into Childhood Sexual Abuse - support services**
https://www.iicsa.org.uk/reports-recommendations/publications/inquiry/final-report/ii-inquirys-conclusions-and-recommendations-change/part-h-supporting-victims-and-survivors/h2-current-support-services.html

**PTSD UK** https://www.ptsduk.org/what-is-ptsd/complex-ptsd/

**What is the treatment?**

C-PTSD still has a developing evidence base and National Institute for Clinical Excellence (NICE) guidelines are not yet available. Clinicians can use guidelines produced by the International Society for Traumatic Stress Studies (ISTSS) (27). This standard recommends a flexible phase-based approach of:

1. Stabilisation and safety
2. Trauma processing
3. Reintegration

The principles of trauma informed care are important in the treatment of C-PTSD across all phases (Box 3). Working collaboratively with patients to develop a personalised package of care which addresses the most appropriate treatment for each person is part of best practice guidance. (20) Most trauma services work with a range of psychological modalities. Not all patients will require a stabilisation phase (28) and the phases do not always unfold in a linear fashion.

***Phase 1: Stabilisation and Safety***

Stabilisation work focuses on trauma psychoeducation which aims to help patients understand their trauma and its potential impact. The emphasis is on the management of hyperarousal and dissociative symptoms, learning to regulate emotions, strengthening of support networks, attendance to physical health and general self-care.

Stabilisation work can be commenced in primary care before specialist intervention. This may include education, work on self-care and social networks through introducing some of the self-help resources suggested in this article or by referral to community supports such as social prescribing. Timing is important and consideration needs to be given to when someone feels ready to begin this work. Trauma impacts on trust which means time and careful relationship building is part of any therapeutic engagement for C-PTSD.

***Phase 2: Trauma Processing***

Trauma processing with a specialist therapist can be achieved using a variety of modalities include eye movement desensitisation and reprocessing (EMDR), trauma-focused cognitive behavioural therapy (tf-CBT), adapted psychodynamic therapy, trauma-focused mentalisation therapy and art therapy. Stand-alone

treatments such as sensori-motor psychotherapy (29) or somatic experiencing (30) show preliminary results and there is also emerging evidence for the use of body-based therapies including trauma-sensitive yoga (31) as adjuncts to talking therapies. Few direct comparisons of these modalities currently exist.

Meta-analyses of treatment trials suggest that, although trauma-focused treatments such as EMDR and tf-CBT are likely to reduce PTSD symptoms, disturbances of self-organisation (DSO) symptoms may not reduce and attrition rates were high (32,33). Veterans and war-affected populations showed significantly reduced effects from trauma-focused treatments (EMDR and tf-CBT). Results of meta-analyses also suggest that multi-component interventions including distress tolerance and emotional self-regulatory strategies can make trauma-focused interventions in C-PTSD more effective. (32,33)

Two multicomponent sequential approaches have shown positive results – Skills Training in Affect and Interpersonal Regulation (STAIR) combined with narrative therapy (Phase two) (34) and Dialectical behavioural therapy for PTSD. (34,35)

Further randomised controlled trials of these interventions are needed. Research into strategies for increasing patient engagement is warranted due to the high attrition rates of patients during phase 2 interventions. (20,1)

***Phase 3: Reintegration***

Reintegration focuses on connection with others and with life in the present. This can be done through group work, both therapeutically and in the community. The interpersonal difficulties often encountered due to C-PTSD, alongside avoidance, can lead to chronic and significant social isolation or loneliness. The reintegration phase highlights the long-term nature of recovery, challenging the idea that trauma can be fixed. Instead, it focuses on the ongoing nature of the work and addresses the integration of the knowledge, skills and processing work completed in the first two phases. Social prescribing can be a helpful tool to facilitate reintegration.

> *"It can be really hard to connect with people after trauma, and we can even lose the connection to ourselves - forgetting who we are and how to be. The important thing is to start to practise the art of connecting. This can be with anything - nature, animals, spirituality, anything with purpose; learning, meaningful activities or hobbies."* Beverley Chipp, Trauma Survivor.

## Self-help - free resource list for patients

**PTSD & CPTSD Self help guide** https://www.nhsinform.scot/illnesses-and-conditions/mental-health/mental-health-self-help-guides/ptsd-and-cptsd-self-help-guide

**PTSD - Get Self Help** https://www.getselfhelp.co.uk/ptsd-self-help/

**Mind - What is complex PTSD?** https://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd-and-complex-ptsd/complex-ptsd

**What is cptsd?** https://www.beautyafterbruises.org/what-is-cptsd

**8 tips for living with CPTSD** https://themighty.com/topic/suicide/complex-trauma-how-to-live-with-chronic-suicidality-ptsd/

**How trauma lodges in the body- Bessel van der Kolk** https://youtu.be/tnKxZqObIWk

**Movement and trauma** https://youtu.be/0ZxPMlljyFQ

**Free courses for holistic wellbeing and recovery** https://www.dailyom.com/courses/all/

**Tai Chi for trauma** https://youtu.be/yTlbqgtcDVk

**Life Experiences Reflection Tool** - https://victimfocus.outgrow.us/LERT

## Podcasts

- How Trauma Can Affect Everyday Life with consultant psychiatrist in psychotherapy Jo Stubley
- The Wellbeing Lab – Trauma and EMDR with Jo Stubley and Catriona Morten
- Thanos Karatzias - Complex PTSD and Borderline Personality Disorder
- The Social Matters Podcast: Episode 5 (S5). The Impact of Childhood sexual violence (featuring Patrick Sandford)

## Education into practice

1. What distinguishing features would you consider when making a diagnosis of C-PTSD over PTSD?
2. Can you think of patients you have seen who may meet the diagnostic criteria for C-PTSD?
3. What aspects of trauma-informed practice could you integrate into your care now?

### How patients were involved in the creation of this article

This article was written by a medical psychotherapist, an expert by experience and a GP. The planning, writing and editing were done collaboratively using a shared document. The Tavistock Trauma Service Panel ( service user reference group) was also consulted on the project and they contributed to the resource section. The article includes personal artwork from the expert by experience.

## How this article was created

The article was created through the use of personal archives of references alongside consulting the PsycInfo database using search terms of complex PTSD and Complex trauma.

**Contributorship Statement**

This article was co-designed and written by all three authors.

**Copyright Statement**



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**Further Reading**

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