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Introduction to the Special Issue on Complex Posttraumatic Stress Disorder: The Evolution of a Disorder

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The inclusion of complex posttraumatic stress disorder (CPTSD) in the 11th revision of the *International Classification of Diseases* is an important development in the field of psychotraumatology. Complex PTSD was developed as a response to a clinical need to describe difficulties commonly associated with exposure to traumatic stressors that are predominantly of an interpersonal nature. With this special section, we bring attention to this common condition following exposure to traumatic stressors that only recently has been designated an official diagnosis. In this introduction, we review the history of CPTSD as a new condition and we briefly introduce the papers for the special section in the present issue of the *Journal of Traumatic Stress.* It is our hope that the work presented in the special section will add to an ever-expanding evidence base. We also hope that this work inspires further research on the cultural validity of CPTSD, its assessment, and treatment.

Complex PTSD (CPTSD) is not an unfamiliar construct within the trauma scholarly 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 recognized as a distinct psychiatric disorder. The World Health Organization's (WHO) 11th revision of the *International Classification of Diseases* (*ICD-11*) describes two distinct but related trauma-related 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."

In the *ICD-11,* PTSD comprises three symptom clusters including (a) reexperiencing of the trauma in the here and now, (b) avoidance of traumatic reminders, and (c) a persistent sense of current threat. CPTSD includes the three PTSD clusters as well as three additional clusters that reflect disturbances in self-organization (DSO), comprising (a) affective dysregulation, (b) negative self-concept, and (c) disturbances in relationships (WHO, 2018). There is substantial evidence that these DSO symptoms are specifically 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, Garvert, Brewin, Bryant, & Maercker, 2013; Karatzias et al; 2017).

In 2012, the *ICD-11* workgroup reviewed an *ICD-10* diagnosis representative of complex PTSD, termed enduring personality changes after catastrophic events (EPCACE). The diagnosis was categorized as a personality disorder and, like all personality disorders in the *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 *ICD* leadership. The benefit of this transfer was that trauma-related problems were no longer viewed as "enduring," as was implied by the term "personality disorder," but rather as a set of symptoms that have more potential to change. The *ICD-11* workgroup maintained the three categories of problems (affect, self, and relationships) and reviewed findings from the field trials for the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; Roth, Newman, Pelcovitz, van der Kolk & Mandel, 2005) as well as those from a consensus survey of expert clinicians on CPTSD (Cloitre et al., 2011) in an effort to identify specific problems in each symptom category that were associated with prolonged, enduring, and repeated forms of trauma. The symptoms identified in that 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 CPTSD, as described by Herman (1992) in her seminal text "Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma,"

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which was published in the *Journal of Traumatic Stress*. In her foreword to Courtois and Ford's (2009) book, *Treating Complex Traumatic Stress Disorders*, 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 (p. xiv).

Courtois and Ford (2009) expanded on these 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 (p. 13).

This definition 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, empirical data demonstrate that other types of traumatic exposure in adulthood (e.g., torture; see Liddell et al., 2019, current issue) can also lead to CPTSD.

The diagnosis of Complex PTSD 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 nonfear or anxiety responses to traumatic events. Thus, the inclusion of CPTSD in *ICD-11* is an important development in the field of psychotraumatology, and this special section in the present issue of the *Journal of Traumatic Stress* aims to contribute to this ongoing work. Here, we briefly review the history of the work on construct validity of CPTSD while also describing the articles in this issue.

The first step in the process of evaluating the construct validity of the proposed *ICD-11* 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 individuals who had symptom profiles consistent with the distinction between PTSD and CPTSD. Failure to identify such a distinction would undermine 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 individuals who had experienced rape and domestic violence, war-exposed civilians, and refugees (see Brewin et al., 2017 for a 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 (reexperiencing, avoidance, and threat symptoms) and a DSO factor that explains covariation across another three first-order factors (affect dysregulation, negative self-concept, and interpersonal problems; see Brewin et al., 2017, for an overview).

Similarly, Liddell and colleagues (2019; current 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 PTSD, CPTSD, affective dysregulation, and low-symptom classes. 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 (2019; current issue) examined prevalence and risk factors associated with PTSD and CPTSD in a nationally representative household sample of adults in the United States ($N = 1{,}893$). 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. (2019; this issue), cumulative trauma was found to be a significant predictor of posttraumatic stress symptoms. However, although cumulative adulthood trauma was associated with both PTSD and CPTSD, cumulative childhood trauma was more strongly associated with CPTSD.

Vang and colleagues (2019; this issue) examined profiles of traumatic life event exposure and their associations with PTSD and CPTSD in a general population sample of Israeli adults ($N = 834$). The authors 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, termed "child and adult interpersonal victimization," 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 et al., 2018). Many trauma survivors present in clinical practice with these difficulties, rather than traumatic stress symptoms, as a primary cause for concern. 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 idiosyncratic presentations of complex psychological trauma. When clinicians inquire about the most distressing current difficulties experienced by complex trauma patients, people often state that they had emotional responses, such as being angry; that they had difficulty engaging in or maintaining relationships; or that they were feeling very bad about themselves. People also describe "flashbacks" or "arousal," which are typical symptoms of PTSD. Others present with symptoms that overlap with borderline personality disorder (BPD). The distinction between

CPTSD and BPD has been highly controversial, and questions as to whether CPTSD is just comorbid PTSD with BPD have been raised. Indeed, the distinction between the two conditions has ramifications for diagnosis and treatment. In the current special section, we include a study that investigated the discriminant validity of CPTSD and BPD symptoms (see Hyland, Karatzias, Shevlin, & Cloitre, 2019; this issue). This study was conducted using a trauma-exposed community sample ($N = 516$) from the United Kingdom. Exploratory structural equation modeling found a three-factor structure of mental health symptoms, which were labeled as 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. Although PTSD demonstrated 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).

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 one's sense of self as well as relational and emotion regulation capacities (Charuvastra & Cloitre, 2008). The second phase of the treatment focuses on trauma memory processing, and the third phase promotes reestablishment 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 stabilization of difficulties associated with complex traumatization (e.g., anxiety and depression) but not symptoms of posttraumatic stress (Mahoney, Karatzias, & Hutton, 2019). This evidence highlights the importance of trauma-focused interventions for the treatment of traumatic stress.

Two papers in this special section discuss the important challenges of caring for people with CPTSD from an organizational perspective as well as their subsequent treatment. Although neither paper is empirical, we hope that this work will inspire future studies of CPTSD care and treatment approaches. The paper by Fyvie and colleagues (2019; this issue) describes an attachment-based model of care for people with CPTSD in which it is proposed that for services to be effective, they should provide people with an alternative model of attachment. A new model of care was introduced in the Rivers Centre for Traumatic Stress in Scotland (United Kingdom) 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 (National Institute of Clinical Excellence, 2018) and the Australian Centre for Posttraumatic Mental Health (Forbes et al., 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 fear-based symptoms of *DSM-IV* PTSD, including reexperiencing, 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, Karatzias, & Coyle, 2018).

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 likely to be 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 that are not representative of the general patient population, given that the samples represent individuals who self-select to participate in exposure therapy, and that many trials exclude individuals with common comorbidities (e.g., Spinazzola, Blaustein, & van der Kolk, 2005). The Rivers team in Scotland found that many CPTSD patients were struggling with exposure interventions and, in order to respond to survivors' needs, the team revised their treatment approach to a phase-based modular approach. The rationale for such a flexible multimodular approach to the treatment of CPTSD is discussed by Karatzias and Cloitre (2019; current issue). The approach highlights flexibility in the selection of empirically supported interventions to target the symptoms of CPTSD sequentially and with the order of delivery based on symptoms that are impairing, severe, and of relevance to the patient. A future research agenda for treatment of CPTSD is presented 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 various trauma populations and cultural contexts using the final version of the International Trauma Questionnaire (ITQ; Cloitre et al., 2018). The ITQ was developed from evidence in archival data in which distinct groups of symptoms 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 that are 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; it can be found at the following website: www.traumameasuresglobal.com

Regarding 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 is under way, and relevant assessment instruments for children and young people are currently under development. Future work also should also address the relations among *ICD-11* PTSD, CPTSD, and dissociation. Emerging evidence suggests that dissociation is more strongly associated with CPTSD than with PTSD (Elklit, Hyland, & Shevlin, 2014; Hyland, Shevlin, Fyvie, Cloitre, & Karatzias, 2019; Hyland, Shevlin, Fyvie, & Karatzias, 2018). Most importantly, future research should focus on the development of efficacious treatments for CPTSD in adults and children and should 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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