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A Systematic Review of the Assessment of ICD-11 Complex Post-Traumatic Stress Disorder (CPTSD) in Young People and Adults

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ABSTRACT

Complex post-traumatic stress disorder (CPTSD) was introduced in the International Classification of Diseases (ICD) 11 in 2013 to simplify diagnosis and increase clinical utility. Given the recent ICD-11 conceptualisation, there is no standard approach for its assessment, and a review of research is necessary. This systematic review focuses on ICD-11 CPTSD assessment in young people aged 7 to 17 and adults aged 18 and above, examining measures, differentiating features and clinical considerations. Data from five databases are reviewed using a narrative synthesis approach and the quality of evidence is assessed and discussed. A total of 36 studies involving 5901 participants recruited from clinical settings and 1458 professionals with CPTSD assessment experience were included. Studies predominantly focused on adults, and the most used measure for assessment was the International Trauma Questionnaire. Papers focusing on differentiating features highlighted increased symptom severity, impairment and difficulties in individuals with CPTSD, compared to those with PTSD across various characteristics in both young people and adults. This review also identified the importance of a sensitive clinical approach with adaptations based on culture and age. Although gold-standard recommendations cannot be made, this paper offers tentative clinical practice recommendations and considerations regarding ICD-11 CPTSD assessment.

1 | Introduction

Complex post-traumatic stress disorder (CPTSD) was formally defined by the International Classification of Diseases (ICD) 11 Working Group in 2013 and eventually published in ICD-11 in 2019 (World Health Organization 2019). As outlined by Brewin et al. (2017), the purpose was to differentiate between PTSD and complex forms of the condition, simplify the conceptualisation of the diagnosis and increase the clinical utility.

Although ICD-11 is not prescriptive about the exact nature of trauma exposure, CPTSD is often associated with exposure to threatening or horrific, prolonged and repetitive traumatic events (Brewin 2020; World Health Organization 2019). According to the ICD-11 criteria (World Health Organization 2019), CPTSD includes all the following elements:

- Exposure to an extremely threatening or horrific event or series of events.
- Three core elements of PTSD lasting at least several weeks—re-experiencing the traumatic event in the present, avoidance of trauma reminders and a sense of current threat.
- Three components of long-standing disturbances of self-organisation (DSO)—affect dysregulation, negative self-concept and disturbances in relationships.
- A significant impairment in the person's life in any domain.

Summary

- The International Trauma Questionnaire is the most widely used tool for CPTSD assessment in young people and adults. It has been used in several languages and with individuals with varying trauma histories. Other measures lack thorough validation and require further research.
- There are higher levels of severity for core diagnostic symptoms, functional impairment and other co-occurring areas of difficulty in young people and adults with CPTSD, compared to those with PTSD.
- Assessors should focus on establishing a trusting relationship, and consider the culture, language and developmental needs of the individual being assessed.

The ICD-11 diagnostic criteria of PTSD are simpler than Diagnostic and Statistical Manual of Mental Disorders (DSM) PTSD criteria, which include four symptom clusters, additional subtypes and a prescription on the nature of traumatic event(s). The ICD-11 criteria for CPTSD apply to both young people and adults, but the manifestation may vary. For example, in young people, affect dysregulation may be interpreted as 'tantrums', and relationship difficulties can manifest as resistance towards teachers and dissociation as daydreaming (Maercker et al. 2022).

Several aspects can complicate the diagnosis of CPTSD and require careful consideration. Individuals with CPTSD or PTSD may present similarly due to inherently shared diagnostic criteria. However, the diagnoses are exclusionary to each other (e.g., if an individual meets the criteria for CPTSD, they cannot receive a diagnosis of PTSD). This may result in diagnostic overshadowing, where PTSD is diagnosed and CPTSD is missed. Additionally, the formalisation of CPTSD is relatively recent. The diagnosis is not yet routinely used in clinical settings, resulting in professionals being less aware of CPTSD and misusing terms such as 'complex trauma' and/or 'developmental trauma', which are not currently included in diagnostic classifications (Maercker 2021). The DSO component of CPTSD shares similarities with borderline personality disorder (BPD), which can complicate the process of differential diagnosis (Maercker et al. 2022). However, network analysis has shown that CPTSD and BPD are distinct conditions with specific differences, such as a more pronounced negative self-concept in CPTSD and a more pronounced fear of abandonment in BPD (Owczarek et al. 2023). With young people, differential diagnosis is further complicated by childhood and adolescence being critical periods for the development of self-organisation (Cloitre, Brewin, et al. 2021; Elliott et al. 2021). These shared features and developmental changes highlight the need for careful assessment. An accurate diagnosis can be valuable in conveying information about presenting difficulties and in accessing appropriate services (Jablensky 2016). For instance, individuals with CPTSD may require more or different interventions and/or a longer course of treatment (ISTSS Guidelines Committee 2018). Thus, an accurate assessment of CPTSD is crucial to inform appropriate treatment and to build an evidence base (Brewin 2020).

Given the growing interest in CPTSD since the formalisation in ICD-11, a synthesis of current evidence is required to inform best practices in the assessment of CPTSD. A systematic review conducted by Seiler et al. (2023) was published shortly after this review started and explored assessment measures for CPTSD. The authors found that the International Trauma Questionnaire (ITQ) was the most investigated and validated measure. In situations where the self-report ITQ cannot be used, they suggested the use of interview tools such as the International Trauma Interview, Symptoms of Trauma Scale or Complex PTSD Item Set in addition to the Clinician Administered PTSD Scale. They concluded that these interview tools require further validation. The current review differs in focus by elucidating the assessment of CPTSD as defined specifically by ICD-11 criteria and evaluating the methodological quality of available evidence, to highlight research gaps and provide recommendations for future research. In addition, the current review is novel in exploring key clinical skills in the assessment of CPTSD. To the best of the authors' knowledge, this review paper is the first to provide a comprehensive and systematic review of the literature on the assessment of ICD-11 defined CPTSD; focusing on how ICD-11 CPTSD is assessed in young people (aged 7 to 17 years old) and adults (aged 18 years old and over).

2 | Methods

The systematic review protocol was registered with Prospero (registration number: CRD42022380682). The review was conducted following PRISMA guidelines (Page et al. 2021).

2.1 | Search Strategy

An electronic search was conducted on the following databases: Cochrane Library, Pubmed, PsycInfo, PTSDpubs and Web of Science. The following search terms were used: (complex post-traumatic stress disorder OR complex posttraumatic stress disorder OR complex post traumatic stress disorder OR complex PTSD OR cPTSD OR CPTSD) AND (assess* OR interview OR question* OR measur* OR differen* OR diag* OR overshadow*). These search terms covered assessment methods and tools, differential diagnosis, diagnosis and diagnostic overshadowing. The search was restricted to English language papers published between May 2013 (proposal of CPTSD definition by the ICD-11 working group) and October 2023. The reference lists of included studies and reviews on CPTSD were also screened.

2.2 | Selection Process

To be included in this review, the papers had to meet the following criteria:

- Peer-reviewed empirical studies (quasi-experimental studies, randomised control trials, case studies),
- Use of the ICD-11 definition of CPTSD,
- Sample aged 7 and above recruited from clinical settings with symptoms meeting CPTSD criteria and/or CTPSD being assessed; or sample including professionals reporting on the assessment of CPTSD,

- Reporting on the assessment of ICD-11 CPTSD, in one of the following areas: measures, differentiating features or clinical considerations.

The following were excluded from the review:

- Studies that did not refer to CPTSD using the ICD-11 definition,
- Studies that only involved participants under the age of 7 or were based solely on community samples or nonprofessionals samples,
- Studies that lacked sufficient information on ICD-11 CPTSD assessment, including studies only addressing assessment in the methods sections, studies that did not directly compare clinical features of CPTSD (e.g., studies that solely focused on prevalence of trauma types, biological processes or sociodemographic factors) and studies that focused solely on one aspect of CPTSD criteria (i.e., DSO only or PTSD only),
- Studies published in languages other than English,
- Grey literature.

The initial screening process involved reading titles and abstracts based on the criteria above. A second reviewer (A.Q.) independently screened 20% of the titles and abstracts selected at random. Discrepancies were discussed until a consensus was reached. The same procedure was followed for the full-text screening. Where consensus was not reached, a third reviewer (D.S.) was consulted.

2.3 | Data Extraction

Information about study characteristics, measures, differentiating features and clinical considerations was extracted. A second reviewer (A.Q.) performed independent data extraction on 20% of the papers selected at random. Discrepancies were resolved through discussions until a consensus was reached. When the information was unclear or ambiguous, a third reviewer (D.S.) was consulted. Extracted data were then summarised using narrative synthesis.

2.4 | Quality Assessment

Methodological quality assessment of the cross-sectional quantitative studies was conducted using a modified version of the Joanna Briggs Institute Critical Appraisal Checklist for Analytical Cross Sectional Studies (Joanna Briggs Institute 2020). This checklist was adjusted and modifications included changing Question 3 from 'Was the exposure measured in a valid and reliable way?' to 'Was the CPTSD construct measured in a valid way?' to specify the construct measured. Additionally, Question 7, 'Were the outcomes measured in a valid and reliable way?' was removed to align with the aims of the review, which focused solely on assessment rather than treatment. For qualitative studies, the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (Joanna Briggs Institute 2017) was used without modifications.

The Joanna Briggs Institute checklists do not provide an overall methodological quality or risk of bias rating. Categorisation was based on the number of 'yes' ratings to the checklists where an appraisal of at least 70% was considered 'moderate' and 90% 'strong' (Alfeo et al. 2024).

A second reviewer (A.Q.) independently assessed the quality of 20% of the papers selected at random. Any discrepancies were resolved through discussions until a consensus was reached.

3 | Results

3.1 | Study Selection

A total of 36 papers were eligible for inclusion in this review. The study selection process is summarised in Figure 1.

3.2 | Study Characteristics

The 36 studies included in the review are summarised in Table 1. Although studies were conducted in 17 countries and various languages, most of these were Western. Thirty-one of the studies used a cross-sectional design. One of these studies (Cloitre, Hyland, et al. 2021) assessed CPTSD at three time points, but only data from the baseline assessment were included in the review, as the review does not explore the assessment and monitoring of symptoms over time. Additionally, five studies used qualitative or mixed designs: the Delphi method (Grace et al. 2021), a co-design focus group (Chamberlain et al. 2020), case descriptions (Lechner-Meichsner and Steil 2021), interviews (Vallières et al. 2018) and a cross-cultural measure adaptation (Donat et al. 2019). One study (Vallières et al. 2018) incorporated a cross-sectional quantitative and qualitative design. Although the Delphi study (Grace et al. 2021) was a mixed design with a cross-sectional quantitative component, the main research output was qualitative and was included in this review.

Studies included a total of 7359 participants, consisting of 5901 patients recruited from clinical settings who were predominantly treatment-seeking individuals. Just over 34% (2045) of this clinical sample met the criteria for ICD-11 CPTSD. The remaining 1458 participants were professionals with experience in CPTSD assessment, individuals from the general population or community who provided feedback on measures and parents or caregivers of younger participants.

The studies primarily focused on adult populations, with only five studies reporting on young people. In 22 papers, clinical samples were predominantly female. Most clinical sample studies provided information about the types of traumatic events experienced by participants, with physical assault and sexual abuse having the highest reported rates.

3.3 | Measures

Thirty-three of the included studies reported information on CPTSD assessment measures and these are summarised in Table 2. Eleven CPTSD measures were identified, and details of their associated validation studies are available in Table S1.

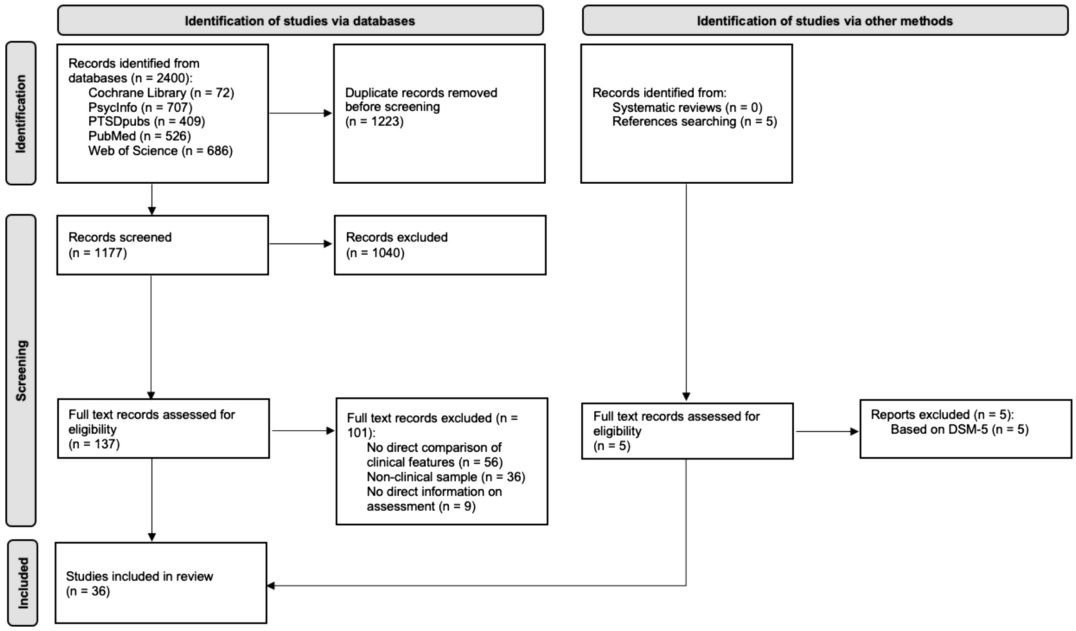

FIGURE 1 | PRISMA flow diagram of the study selection process.

3.3.1 | The International Trauma Questionnaire (ITQ)

The most widely used measure was the ITQ (Cloitre, Shevlin, et al. 2018), used in 21 of the studies. This self-report measure assesses PTSD and DSO symptoms, as well as related functional impairment. It consists of 18 items rated on a 5-point scale or as yes/no. The suggested cut-off for probable CPTSD is a score of 2 or more on at least one item for each symptom (three PTSD symptoms, three DSO symptoms and functional impairment). The reliability of the ITQ was found to be 'moderate' to 'high' across the studies. Eight studies used the ITQ translated into various languages: Brazilian Portuguese (Donat et al. 2019), Lithuanian (Gelezelyte et al. 2022), Danish (Møller, Bach, et al. 2021; Vang et al. 2021), Norwegian (Sele et al. 2020) and Arabic, Bosnian, Danish and other languages (Vang et al. 2021). Results indicated the 'moderate' to 'high' reliability of the translated measures.

A version of the ITQ specifically designed for young people, the International Trauma Questionnaire–Child and Adolescent Version (ITQ-CA; Cloitre et al. 2015), was used in two studies (Haselgruber, Sölva, and Lueger-Schuster 2020a; Ho et al. 2022). The administration and scoring of the ITQ-CA are the same as the adult version. The reliability of the ITQ-CA also ranged between 'moderate' and 'high'. Haselgruber, Sölva, and Lueger-Schuster (2020b) used the adult version of the ITQ with young people and still demonstrated 'high' levels of reliability. Astill Wright et al. (2021) also used the adult ITQ in their study with individuals aged 16 and older. One study adapted the ITQ for use with individuals with intellectual disabilities: the International Trauma Questionnaire–Intellectual Disabilities Version (ITQ-ID; Langdon et al. 2023). The reliability of the ITQ-ID ranged between 'moderate' and 'high'.

3.3.2 | Other Measures

The International Trauma Interview (ITI; Roberts et al. 2018) was used in two studies (Bondjers et al. 2019; Gelezelyte et al. 2022). It was conducted in Swedish in the study by Bondjers et al. (2019) and Lithuanian by Gelezelyte et al. (2022). The ITI is a semi-structured clinical interview that begins with the description of the index traumatic event. Then, it assesses PTSD symptoms, DSO symptoms and related functional impairment. Although there is no number cut-off for probable diagnosis, a diagnosis for CPTSD can be made if categorical criteria are met. Both studies reported 'high' levels of internal reliability.

Another interview, the Complex PTSD Item Set additional to the CAPS (COPISAC), was used in the paper by Lechner-Meichsner and Steil (2021). This is a clinician-rated measure designed to assess DSO symptoms and related impairment. It is intended to be used in conjunction with the CAPS, which assesses PTSD symptoms and related impairment. It includes a diagnostic algorithm to assess probable CPTSD diagnosis and severity. However, the validation study for the COPISAC was still ongoing at the time of publication, and reliability was not reported.

The C-PTSD Interview Scale, originally developed by Ouimette and colleagues in 1996, was used by Shin et al. (2021) with young people and adults. Despite the scale being created before the current ICD-11 definition of CPTSD, the authors used the tool without adaptations to assess ICD-11 CPTSD and demonstrated 'high' reliability. The interview does not have a diagnostic threshold. The Symptoms of Trauma Scale (SOTS), developed by Opler et al. in 2004, was used in Ford et al. (2015). This semi-structured interview assesses the severity of trauma-related symptoms without a diagnostic cut-off. Although it was originally designed to assess symptoms according to the DSM criteria for PTSD, the study aimed to evaluate the applicability to ICD-11 CPTSD, and the reliability was found to be 'moderate'. Similarly, the Lancaster and Northgate Trauma Scales (LANTS), originally developed in 2011, was used by Wigham, Hatton, and Taylor (2021). The LANTS assesses emotional and behavioural symptoms of trauma (without diagnostic cut-off) in individuals with mild to moderate intellectual disability. It consists of a self-report and longer carer-report or

TABLE 1 | Characteristics of the included studies.

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Astill Wright et al. (2021)	Cross-sectional	Determine the relationship between somatisation and PTSD/CPTSD.	United Kingdom	222 (111 with CPTSD)	Individuals with self-reported current/historical diagnosis of PTSD or reported having experienced a traumatic event.	47 (CPTSD) 51 (PTSD)	49.5% (CPTSD), 42% (PTSD)	Not reported
Bondjers (2019)	Cross-sectional	Evaluate the psychometric properties of the Swedish ITI.	Sweden	184 (11 with CPTSD)	Treatment seeking and nontreatment seeking trauma exposed individuals.	33 (18–76)	79%	Traumatic loss of a loved one, sexual violence and assault, somatic injuries/illnesses, accidents, other (e.g., war, natural disasters, terror, or unspecified).
Chamberlain (2020)	Qualitative	Gather views from predominantly Aboriginal stakeholders on CPTSD assessment and a tool for Aboriginal parents.	Australia	57	Community members with lived experience, people working across community organisations, perinatal and family health experts, mental health professionals, senior managers of community and government service organisations, senior members of professional representative and nongovernmental organisations and researchers.	n/a	n/a	n/a
Cloitre (2018)	Cross-sectional	Finalise the development of the ITQ.	United Kingdom	1051 for the community sample; 247 for the clinical sample	Trauma-exposed community sample and a trauma-exposed clinical sample.	47.1 (community sample) (18–90); 42 (clinical sample) (18–71)	68.4% (community sample); 68% (clinical sample)	Not reported

(Continues)

TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Cloitre, Hyland, et al. (2021)	Cross-sectional (data extracted from first time point only)	Assess the psychometric properties of the ITQ in treatment.	United States of America	254	Trauma-exposed veterans with PTSD and/or depression undergoing a psychosocial transdiagnostic web intervention.	44.2 (22–77)	61.8%	Sudden unexpected death of a loved one, physical assault, transportation accident, combat experience, childhood sexual abuse and childhood physical abuse.
Donat (2019)	Qualitative	Adapt the ITQ for the Brazilian context.	Brazil	5 professionals; academic committee n not reported; 35 adults for comprehension testing; 1 translator	Professionals with trauma expertise (psychologists and psychiatrists), academic committee (composed of undergraduate, master's and doctoral students), translator, individuals from community and clinical samples (trauma victims seeking treatment).	Not reported	62.9% (community and clinical sample)	Not reported
Folke (2023)	Cross-sectional	Compare demographics, comorbidities and impairment in PTSD and CPTSD.	Denmark	599 (188 with CPTSD)	Treatment-seeking soldiers and veterans.	41.7 (CPTSD), 44.9 (PTSD)	6.2% (CPTSD), 7.7% (PTSD)	Warfare or combat trauma, adult life trauma and childhood trauma.
Ford (2015)	Cross-sectional	Evaluate use and psychometric properties of the SOTS.	United States of America	30	Survivors of chronic interpersonal trauma seeking treatment in an outpatient clinic.	41.1 (22–63)	76.7%	Childhood physical abuse, childhood sexual abuse and physical assault as an adult by a known perpetrator.
Frost (2022)	Cross-sectional	Assess the factorial validity and internal reliability of the ITQ.	United Kingdom	114	Adult survivors of sexual violence receiving therapy in a specialist crisis centre.	35.7 (18–74)	88.6%	Sexual violence in childhood, sexual violence in adulthood and sexual violence in both childhood and adulthood.

(Continues)

TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Gelezelyte (2022)	Cross-sectional	Evaluate the psychometric properties of the ITI.	Lithuania	103 (22 with CPTSD)	Adults with a history of traumatic experiences and 50% with ongoing use of mental health services.	32.6 (18–54)	83.5%	Physical abuse in childhood, having experienced sudden violent death of a person close to them, sexual abuse in adulthood, unwanted sexual experiences in childhood, sexual abuse in childhood, accident, assault, physical abuse in adulthood, unwanted sexual experiences in adulthood, other traumatic experience and multiple childhood traumas.
Grace (2021)	Qualitative	Adapt the GPS for young people in the USA.	United States of America	10 professionals; 10 children, 14 adolescents and 24 parents	Professionals affiliated with trauma services with up to 15 years' experience working with young people to revise the adult GPS and nontraumatised young people and their parents to test comprehension and obtain feedback.	6–17	50%	n/a
Gündogmus (2023)	Cross-sectional	Investigate the psychometric properties of the Turkish version of ITQ.	Turkey	283 for the community sample; 112 for the clinical sample	Trauma-exposed community sample and an outpatient and inpatient treatment-seeking clinical sample.	33.2 (community sample); 30.5 (clinical sample)	67.1% (community sample); 45.5% (clinical sample)	Natural disaster, combat, sexual, serious accident or injury, severe physical illness, domestic-relationship violence and death of close person.

(Continues)

TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Guzman Torres (2023)	Cross-sectional	Compare patients with CPTSD to those with PTSD in trauma characteristics, dissociation and psychiatric comorbidities.	Germany	81 (43 with CPTSD)	Treatment-seeking patients from an outpatient trauma department.	39.7	80.2%	Not reported
Haselgruber (2020a)	Cross-sectional	Test the symptom structure of CPTSD and examine the validity of the German ITQ-CA.	Austria	135	Trauma-exposed foster children.	14.3	31.1%	Natural disaster, serious accident or injury, robbery, physical abuse in family, physical abuse in community, witnessing physical abuse in family, witnessing physical abuse in community, sexual abuse, sexual assault, sudden or violent death of close person, physical attack, witnessing physical attack, scary medical procedure and experience of war.
Haselgruber (2020b)	Cross-sectional	Examine the validity of PTSD and CPTSD and the ITQ's applicability in children.	Austria	136	Trauma exposed foster children.	14.3	42.6%	Emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect.
Ho (2022)	Cross-sectional	Provide a Chinese translation and psychometric evaluation of the ITQ-CA.	China	111 (69 with PTSD or CPTSD)	Adolescents from an outpatient psychiatric clinic.	15.2 (12–17)	78.3%	Not reported (exposure to adverse childhood experiences measured using the ACE-IQ).

(Continues)

TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Hyland (2017)	Cross-sectional	Assess the factorial validity of PTSD and CPTSD and compare ICD-11 and DSM-5 diagnostic rates.	United Kingdom	171 (89 with CPTSD)	Trauma-exposed and PTSD diagnosed/ PTSD positive screen mental health service users.	49.9 (18–78)	48.5%	Physical assault, physical and/or sexual abuse during childhood, combat.
Hyland (2018)	Cross-sectional	Compare prevalence rates of PTSD/CPTSD, identify clinical and behavioural variables that distinguish CPTSD and PTSD and examine the diagnostic associations for ICD-11 CPTSD and DSM-5 PTSD.	United Kingdom	106	Patients referred for psychological therapy in a trauma centre.	39.3 (19–62)	93.4%	Most commonly reported traumatic experience was physical assault.
Hyland (2020)	Cross-sectional	Assess the associations between CPTSD and dissociative experiences.	United Kingdom	106 (67 with CPTSD)	Highly traumatised patients from a trauma centre.	39.3 (19–62)	93.4%	Physical assault, sexual assault, other unwanted or uncomfortable sexual experience.
Jannini (2023)	Cross-sectional	Examine post-traumatic symptomatology, depression and hopelessness in PTSD and CPTSD.	Italy	221 (78 with CPTSD)	Psychiatry clinic outpatients.	35.4 (CPTSD), 37.1 (PTSD)	82.1% (CPTSD), 60.1% (PTSD)	Not reported

(Continues)

TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Karatzias (2016)	Cross-sectional	Assess reliability and validity of the ITQ.	United Kingdom	193	Individuals referred for psychological therapy in an NHS trauma centre.	40.7	65.1%	Childhood, adulthood, and both child and adulthood traumatisation, physical assault, sexual assault, assault with a weapon, transportation accident other unwanted or uncomfortable sexual experience.
Langdon (2023)	Cross-sectional	Evaluate the reliability and validity of an adapted ITQ for people with intellectual disabilities.	United Kingdom	40 (15 with CPTSD)	Traumatised treatment-seeking adults with intellectual disability.	30.8	20%	Bereavement, being bullied or beaten up, imprisonment, sexual assault, illness, assault with a weapon and car crash.
Lechner-Meichsner (2021)	Qualitative	Develop the CPTSD Item Set additional to the CAPS.	Germany	3 (1 with CPTSD)	Treatment-seeking patients enrolled in a RCT.	24.3 (20–32)	33%	Repeated physical abuse, repeated sexual abuse and witnessing violence.
Longo (2019)	Cross-sectional	Explore differences in dissociative experiences between PTSD and CPTSD.	Italy	50 (20 with CPTSD)	Patients with PTSD/CPTSD assessed at a psychology clinic.	35.1 (CPTSD), 34.9 (PTSD)	80% (CPTSD), 66.7% (PTSD)	Emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, minimisation.

(Continues)

TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Møller, Bach, et al. (2021)	Cross-sectional	Explore the structural validity of CPTSD, the association between latent CPTSD factors and dissociation and compare CPTSD dissociation to PTSD dissociation.	Denmark	114 (61 with CPTSD)	Traumatised psychiatric outpatients.	41.7	59%	Physical assault, childhood physical assault and transportation accident.
Møller, Søgaard, et al. (2021)	Cross-sectional	Evaluate PTSD and CPTSD on maladaptive personality traits.	Denmark	84 (60 with CPTSD)	Diagnosed trauma patients attending a specialist trauma treatment clinic and psychiatric outpatient clinics.	Not reported	Not reported	Experience of physical assault, childhood physical assault, transportation accident, witnessing or hearing about traumatic experiences happening to someone else.
Murphy (2020)	Cross-sectional	Validate ITQ in treatment-seeking veterans and assess rates of CPTSD in treatment-seeking veterans.	United Kingdom	177	Treatment-seeking veterans.	Not reported	Not reported	Multiple trauma exposure in childhood (physical assaults, sudden unexpected death, unwanted/uncomfortable sexual experience) and adulthood (combat or exposure to a war zone, fire or explosion, sudden unexpected death).
Murphy (2021)	Cross-sectional	Explore risk factors and comorbidity between veterans meeting criteria for PTSD or CPTSD.	United Kingdom	177 (96 with CPTSD)	Help-seeking veterans diagnosed with a mental health difficulty.	Not reported	4.9%	Military trauma (combat, emotional bullying, physical assault, sexual harassment, sexual assault).

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TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Oe (2020)	Cross-sectional	Examine the internal consistency and concurrent validity of the Japanese GPS.	Japan	58	Help-seeking traumatised population.	47.6	93.1%	Domestic violence, natural disasters, accidents, physical assault, sexual traumatic experiences, unwanted or uncomfortable sexual experiences and childhood physical assaults.
Sachser (2022)	Cross-sectional	Examine psychometric properties of the CATS-2 and PTSD/CPTSD discrimination.	Germany, Norway and United States of America	283 (with additional 255 caregivers)	Traumatised young people and their caregivers, patients at participating sites.	12.2	59%	Not reported
Sele (2020)	Cross-sectional	Examine the psychometric properties of the preliminary 22-item ITQ and the current shortened ITQ.	Norway	202 (122 with CPTSD)	Patients participating in trauma treatment studies.	41.5 (24–69)	84.7%	Emotional abuse, sexual abuse and physical abuse.
Shin (2021)	Cross-sectional	Examine deficits in emotional and cognitive functions in adolescents with CPTSD.	South Korea	69 (39 with CPTSD)	Treatment-seeking adolescents with a history of parental abuse, living in shelters with PTSD/CPTSD diagnosis.	16.3 (CPTSD), 14.9 (PTSD) (13–24)	76.9% (CPTSD), 56.7% (PTSD)	History of childhood parental abuse (physical assault, neglect, sexual assault).

(Continues)

TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Valdovinos (2023)	Cross-sectional	Evaluate the validity of a Spanish translated version of the ITQ.	Mexico	112	Women attending a psychiatric outpatient service specialised in domestic and sexual violence.	46.1	100%	Natural catastrophe, unexpected death of a family member or friend, witnessing family violence, threatened with a weapon, sexual abuse, been beaten by family members, followed and harassed and perpetrated serious physical harm on another person.
Vallières (2018)	Cross-sectional	Evaluate the factor structure of PTSD/CPTSD among refugees in the Middle East.	Lebanon	112 (39 with CPTSD)	Treatment-seeking Syrian refugees.	33 (18–60)	80.2%	Forced displacement, exposure to bombing, unexpected death of a loved one and forced separation from family members.
	Qualitative	Evaluate the clinical utility of the ITQ in a humanitarian context.	Lebanon	6	Lebanese psychotherapists treating Syrian refugees.	n/a	n/a	n/a

(Continues)

TABLE 1 | (Continued)

First author (year)	Study design	Study aims	Country	Participants *n*	Sample	Mean age in years (range)	Female %	Trauma types
Vang (2021)	Cross-sectional	Test the validity of PTSD and DSO using the ITQ.	Denmark	1197 (632 with CPTSD)	Adult survivors of sexual abuse, women in shelters due to violence exposure, psychiatric outpatients with PTSD diagnosis, heterogenous sample of psychiatric outpatients, refugees and torture survivors.	36.6 (adult survivors of sexual abuse) (18–71), 34.6 (women in shelters) (18–79), 41.7 (psychiatric outpatients with PTSD diagnosis) (18–65), 34.1 (heterogenous sample of psychiatric outpatients) (18–65), 43.5 (refugees and torture survivors) (14–71)	85.6% (adult survivors of sexual abuse), 100% (women in shelters), 41.4% (psychiatric outpatients with PTSD diagnosis), 73.6% (heterogenous sample of psychiatric outpatients),48.1% (refugees and torture survivors)	Sexual abuse, partner violence, childhood abuse (direct and witnessed), exposure to torture, traumatic flight, war and captivity prior to the patients' arrival in Denmark.
Wigham (2021)	Cross-sectional	Evaluate the factor structure of the LANTS and assess compatibility CPTSD.	United Kingdom	98	Treatment-seeking adults with mild to moderate intellectual disabilities.	41	14%	Not reported

TABLE 2 | Studies reporting on CPTSD assessment measures.

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Astill Wright et al. (2021)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adolescents and adults (16+)	Rating scale	Self-report; 12 symptoms items; items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*)	CR full scale = 0.86–0.96
Bondjers (2019)	International Trauma Interview translated to Swedish (Bondjers et al. 2019) based on International Trauma Interview (Roberts et al. 2018)	PTSD and DSO symptoms–diagnostic threshold	Adults (18+)	Interview and rating scale	Clinician-rated; description of index traumatic event; 6 items assessing PTSD symptom; items assessing PTSD functional impairment; 6 items assessing DSO; items assessing DSO functional impairment; PTSD symptoms items are rated on a 5-point scale from 0 (*not present*) to 4 (*extreme*); DSO symptoms intensity and frequency items are rated on a 5-point scale from 0 (*not present*) to 4 (*extreme*); items for impairment rated from 0 (*no adverse impact*) to 4 (*extreme impact, little or no functioning*) for impairment; symptoms relatedness question scored from unlikely to definite	CR PTSD scale = 0.86 CR DSO scale = 0.89
Cloitre (2018)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 12 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 16 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR clinical sample full scale ≥ 0.79

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Cloitre, Hyland, et al. (2021)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR full scale = 0.89
Donat (2019)	International Trauma Questionnaire translated to Brazilian Portuguese (Donat et al. 2019) based on International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms; 6 items assessing DSO symptoms; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*)	Not reported
Folke (2023)	International Trauma Questionnaire translated to Danish (Hansen et al. 2021) based on International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR full scale = 0.92 IR PTSD scale = 0.89 IR DSO scale = 0.89
Ford (2015)	Symptoms of Trauma Scale (Opler et al. 2004)	Trauma-related symptoms according to DSM and ICD–nondiagnostic threshold	Adults (18+)	Interview and rating scale	Clinician-rated; semi structured interview and 12 symptom items scored on a 7-point scale from *absent* to *extreme*	IR ICD-11 CPTSD scale = 0.71 IR full scale = 0.73

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Frost (2022)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	CR PTSD scale = 0.81 CR DSO scale = 0.84
Gelezelyte (2022)	International Trauma Interview translated to Lithuanian (Gelezelyte et al. 2022) based on International Trauma Interview (Roberts et al. 2018)	PTSD and DSO symptoms–diagnostic threshold	Adults (18+)	Interview and rating scale	Clinician-rated; description of index traumatic event; 6 items assessing PTSD symptom; items assessing PTSD functional impairment; 6 items assessing DSO; items assessing DSO functional impairment; PTSD symptoms items are rated on a 5-point scale from 0 (*absent*) to 4 (*extreme/incapacitating*); DSO symptoms intensity and frequency items are rated on a 5-point scale from 0 (*not at all*) to 4 (*extremely*); items for impairment rated from 0 (*no adverse impact*) to 4 (*extreme impact, little or no functioning*) for impairment; validity question from 0 (*excellent*) to 4 (*invalid responses*)	CR PTSD scale = 0.88 CR DSO scale = 0.92
	International Trauma Questionnaire translated to Lithuanian (Gelezelyte et al. 2022) based on International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Young people (7–17)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR full scale = 0.93 IR PTSD scale = 0.86 IR DSO scale = 0.89

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Grace (2021)	Global Psychotrauma Screen adapted for children and adolescents (Grace et al. 2021) based on Global Psychotrauma Screen (Schnyder et al. 2017)	Trauma-related symptoms (PTSD, DSO, depression, anxiety, dissociation, sleep, self-harm and other difficulties), risk factors and protective factors–nondiagnostic threshold	Young people (7–17)	Rating scale	Self-report; final adapted measure not reported (validation study planned)	Not reported
Gündogmus (2023)	International Trauma Questionnaire translated to Turkish (Gündogmus et al. 2023) based on International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR clinical sample PTSD scale = 0.89 IR clinical sample DSO scale = 0.81
Guzman Torres (2023)	Screening for Complex PTSD (Dorr, Sack, and Bengel 2018)	Trauma characteristics, CPTSD symptoms–nondiagnostic	Adults (18+)	Rating scale	Informant not reported; 21 items are scored on a 7-point scale ranging from 0 (*not at all*) to 6 (*entirely*)	IR full scale = 0.82
Haselgruber (2020a)	International Trauma Questionnaire–Child and Adolescent Version translated to German (Haselgruber, Sölva, and Lueger-Schuster 2020a) based on International Trauma Questionnaire–Child and Adolescent Version (Cloitre, Bisson, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Young people (7–17)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 5 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 5 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	CR PTSD scale = 0.85 CR DSO scale = 0.95

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Haselgruber (2020b)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Young people (7–17)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	CR PTSD scale = 0.86 CR DSO scale = 0.91
Ho (2022)	International Trauma Questionnaire–Child and Adolescent Version translated to Chinese (Ho et al. 2022) based on International Trauma Questionnaire–Child and Adolescent Version (Cloitre, Bisson, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Young people (7–17)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 5 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 5 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR full scale = 0.87
Hyland (2017)	International Trauma Questionnaire without impairment items based on ICD-11 Trauma Questionnaire (ICD-TQ version 1.2; Cloitre et al. 2015)	PTSD and DSO symptoms–nondiagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms; 16 items assessing DSO symptoms; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*)	IR PTSD scale = 0.96 IR DSO scale = 0.97

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Hyland (2018)	ICD-11 Trauma Questionnaire (ICD-TQ version 1.2; Cloitre et al. 2015)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 16 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR PTSD scale = 0.74 IR DSO scale = 0.89
Hyland (2020)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR PTSD scale = 0.74 IR DSO scale = 0.81
Karatzias (2016)	ICD-11 Trauma Questionnaire (ICD-TQ version 1.2; Cloitre et al. 2015)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 23 items; items are scored on a scale ranging from 0 (*not at all*) to 4 (*extremely*)	CR subscales = 0.71–0.95
Langdon (2023)	International Trauma Questionnaire–Intellectual disabilities (Langdon et al. 2023)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Interview and rating scale	Clinician-rated; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items and functional impairments items are scored on a 3-point scale (*no*, *sometimes*, *yes*)	IR full scale = 0.90 IR PTSD scale = 0.83 IR DSO scale = 0.81

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Lechner-Meichsner and Steil (2021)	Complex PTSD Item Set additional to the CAPS (Lechner-Meichsner and Steil 2021) based on CAPS-5 (Weathers et al. 2013)	DSO symptoms and functional impairment (to be used with CAPS which assesses PTSD)–diagnostic threshold	Adults (18+)	Interview	Clinician-rated; 5 items; items are scored on a 5-point scale from 0 (*absent*) to 4 (*extreme/incapacitating*)	Not reported
Møller, Bach, et al. (2021)	International Trauma Questionnaire translated to Danish (Møller, Bach, et al. 2021) based on International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	Not reported
Møller, Søgaard, et al. (2021)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR full scale = 0.85 IR PTSD scale = 0.71 IR DSO scale = 0.81

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Murphy (2020)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR full scale = 0.91 IR PTSD scale = 0.88 IR DSO scale = 0.90
Murphy (2021)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR PTSD scale = 0.90 IR DSO scale = 0.93
Oe (2020)	Short version Global Psychotrauma Screen translated to Japanese (Oe et al. 2020) based on Global Psychotrauma Screen (Schnyder et al. 2017)	Trauma-related symptoms (PTSD, DSO, depression, anxiety, dissociation), risk factors and protective factors–nondiagnostic threshold	Adults (18+)	Rating scale	Self-report; 22 items; items are scored in a yes/no format	IR full scale = 0.90 IR PTSD scale = 0.84 IR DSO scale = 0.66 IR depression scale = 0.64 IR anxiety scale = 0.57 IR dissociation scale = 0.64 IR risk factor scale = 0.58

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Sachser (2022)	Child and Adolescent Trauma Screen 2 (modified) translated to German and Norwegian (Sachser et al. 2022) based on Child and Adolescent Trauma Screen (Sachser et al. 2017)	Traumatic events, trauma symptoms and impairment according to DSM-5 and ICD-11–diagnostic threshold	Young people (7–17)	Rating scale	Self-report and parallel carer report;15 potentially traumatic events checklist in a yes/no format; 25 symptoms items rated on a 4-point scale from 0 (*never*) to 3 (*almost always*); 5 impairment items in a yes/no format	IR self-report CPTSD scale = 0.83 IR caregiver CPTSD scale = 0.87
Sele (2020)	International Trauma Questionnaire translated to Norwegian (Bækkelund, Sele, and Berg 2019) based on International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms only–nondiagnostic threshold	Adults (18+)	Rating scale	Self-report; 22 symptoms items and 12 symptoms items version; items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*)	Not reported
Shin (2021)	C-PTSD Interview Scale (Ouimette, Saxe, and Van der Kolk 1996)	CPTSD symptoms–nondiagnostic threshold measure	Adolescents and adults (13+)	Interview	Clinician-rated; 37 items; frequency and intensity of each symptom are scored on a 5-point scale ranging from 0 to 4	IR full scale = 0.97
Valdovinos (2023)	International Trauma Questionnaire translated to Spanish (Valdovinos et al. 2023) based on International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	IR full scale = 0.92 IR PTSD scale = 0.84 IR DSO scale = 0.87

(Continues)

TABLE 2 | (Continued)

First author (year)	Measure	Construct assessed	Study age group	Format	Administration	Internal reliability (IR) or composite reliability (CR) in the study sample
Vallières (2018)	International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms and 3 items assessing PTSD functional impairment; 6 items assessing DSO symptoms and 3 items assessing DSO functional impairment; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) and functional impairments items are yes/no	CR PTSD scale = 0.80 CR DSO scale = 0.94
Vang (2021)	International Trauma Questionnaire translated to Danish, Arabic, Bosnian and other (Vang et al. 2021) based on International Trauma Questionnaire (Cloitre, Shevlin, et al. 2018)	PTSD and DSO symptoms, functional impairment–diagnostic threshold	Adults (18+)	Rating scale	Self-report; 6 items assessing PTSD symptoms; 6 items assessing DSO symptoms; symptom items are scored on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*)	IR full scale = 0.81–0.85 IR PTSD scale = 0.73–0.92 IR DSO scale = 0.77–0.86
Wigham (2021)	Lancaster and Northgate Trauma Scales (Wigham, Hatton, and Taylor 2011)	Emotional and behavioural symptoms of trauma–nondiagnostic threshold	Adults (18+)	Rating scale	Self-report and carer-report or clinician-rated; 29 items for self-report and 43 items for informant; items are rated on a 4-point visual scale (ranging from *no* to *a lot*)	Not reported

clinician-rated versions with visual scales. Although the study aimed to evaluate ICD-11 CPTSD compatibility, reliability was not reported.

The Global Psychotrauma Screen (GPS; Schnyder et al. 2017) was used in the studies conducted by Grace et al. (2021) and Oe et al. (2020). The GPS is a self-report tool, without a diagnostic threshold, that assesses trauma-related symptoms, risk factors and protective factors. The first study used GPS adapted for children (GPS-C) and adolescents (GPS-T). Reliability for the sample was not included, but a validation study is reportedly planned. In the second study, a shortened version of the GPS translated into Japanese was used. 'High' reliability for the full scale was reported but the individual subscales showed lower reliability.

Screening for Complex PTSD (Dorr, Sack, and Bengel 2018) was used by Guzman Torres, Krause-Utz, and Sack (2023) and demonstrated 'high' reliability. It is designed to inform diagnosis by assessing trauma characteristics and the severity of CPTSD symptoms. However, administration details were not specified.

Finally, the Child and Adolescent Trauma Screen 2 (CATS-2; Sachser et al. 2017) was used with young people in Sachser et al. (2022). This measure assesses potentially traumatic events, post-traumatic stress symptoms and impairment based on DSM and ICD criteria. The CATS-2 is a self-report questionnaire, with a parallel carer report. It incorporates a checklist for potentially traumatic events and items assessing symptoms and impairment. A score of 13 or higher on specific items indicates positive screening, while 16 or higher suggests probable CPTSD. However, these cut-offs are pending validation and only apply to the carer measure. ICD-11 CPTSD categorical scoring is also provided. This rating scale demonstrated 'moderate' reliability.

3.4 | Clinical Skills

3.4.1 | Differentiating Features

Twelve studies examined the differentiating features of CPTSD, and the information is summarised in Table 3. The data extracted from these studies specifically focused on the differentiating features between CPTSD and PTSD. This included core diagnostic symptoms and other co-occurring features that are not intrinsic to diagnosis.

In the two studies focusing on young people (Haselgruber, Sölva, and Lueger-Schuster 2020b; Shin et al. 2021), those in the CPTSD group had significantly higher levels of functional impact, internalising behavioural difficulties, externalising behavioural difficulties and maladaptive emotion regulation strategies compared to those in the PTSD group (Haselgruber, Sölva, and Lueger-Schuster 2020b). Adolescents with CPTSD had significantly higher levels of depression, stress, dissociation and self-harm compared to those in the PTSD group (Shin et al. 2021). Adolescents with CPTSD also displayed more alterations in affect and impulse, attention or consciousness, self-perception, relationships with others and the meaning system compared to those in the PTSD group (Shin et al. 2021). No significant difference was found between adolescents with CPTSD and those with PTSD in terms of mood disorder, conduct disorder, anxiety, psychotic symptoms, eating disorder, somatisation and anxiety (Shin et al. 2021).

Adults with CPTSD showed higher levels of overall symptoms compared to adults with PTSD (Longo et al. 2019). Functional impairment was also found to be higher in adults with CPTSD (Murphy et al. 2021). Anxiety (Folke et al. 2023; Murphy et al. 2021), stress (Folke et al. 2023), depression (Folke et al. 2023; Hyland et al. 2018; Jannini et al. 2023; Longo et al. 2019; Murphy et al. 2021), anger (Murphy et al. 2021), negative affectivity (Møller, Søgaard, et al. 2021), suicidal ideation (Møller, Søgaard, et al. 2021), suicidality (Folke et al. 2023), suicide risk (Jannini et al. 2023) and hopelessness (Jannini et al. 2023; Longo et al. 2019) were all significantly higher in adults with CPTSD, compared to those with PTSD. Somatic symptoms (Astill Wright et al. 2021), loneliness and social isolation (Murphy et al. 2021) were also higher in adults with CPTSD. Dissociation was explored in several studies. Increased dissociation (Hyland et al. 2018, 2020; Longo et al. 2019; Murphy et al. 2021) and psychoform dissociation (cognitive and psychological symptoms) and somatoform dissociation (physical and bodily symptoms) (Møller, Bach, et al. 2021) were found in CPTSD. However, one study found no difference in dissociation (Guzman Torres, Krause-Utz, and Sack 2023). Finally, psychoticism (Møller, Søgaard, et al. 2021) and borderline personality traits (Hyland et al. 2018) were found to be higher in adults with CPTSD, compared to those with PTSD. Studies did not find a significant difference between adults with CPTSD and adults with PTSD regarding destructive behaviours (Hyland et al. 2018), dangerous drinking and sleep difficulties (Murphy et al. 2021), detachment, antagonism and disinhibition (Møller, Søgaard, et al. 2021).

3.4.2 | Clinical Considerations

Three studies reported information on clinical considerations during CPTSD assessment. These are summarised in Table 3.

Chamberlain et al. (2020) emphasised creating safety, building trust and empowerment while acknowledging that building a trusting relationship takes time. They recommended conducting the assessment in a private space; however, this can take place in a clinical setting or other locations such as someone's home or within the community. The authors suggested that the assessment should ideally be conducted by someone of the same gender as the individual being assessed. However, they were unable to conclude whether the assessor should share the same cultural background and if the family and community should be involved in the assessment. The authors highlighted that communication involves various culturally appropriate methods such as genograms, practicing 'dadirri' (deep listening), storytelling or art. A traditional questioning style may be perceived as interrogative and overly direct, so alternative approaches were recommended by the authors. They also stated that remaining silent can be a coping mechanism, so they recommended avoiding forcing individuals to speak. They found that effective communication also requires assessors to have

TABLE 3 | Studies reporting on CPTSD assessment clinical skills.

First author (year)	Differentiating features		Clinical considerations
	Characteristics	Outcomes	
Astill Wright et al. (2021)	Somatic symptoms	Significantly higher rates of somatic symptoms ($p < 0.001$) in the adults CPTSD group, compared to the PTSD group.	n/a
Chamberlain (2020)	n/a	n/a	Emotional, physical and cultural safety are important to consider. Assessment can be conducted in a clinical setting or not (i.e., someone's home, in the community). Assessor should be with someone of the same gender. Results are mixed regarding the usefulness of the assessment conducted by an Aboriginal worker. It takes time to build a trusting relationship. Traditional questioning style can be interrogative. Cultural methods of communication can be incorporated. Crucial to have the right skills to respond to what is being said. Assessment should employ a strength-based approach to empower the individual and normalise difficulties.
Folke (2023)	Depression symptoms Anxiety symptoms Stress symptoms Suicidality (suicide attempts in the past and within the last year)	Significantly higher levels of depression symptoms ($p < 0.0001$), anxiety symptoms ($p < 0.0001$), and stress symptoms ($p < 0.0001$) in the adults CPTSD group, compared to the PTSD group. Significantly higher levels of suicidality ($p < 0.0001$) in the adults CPTSD group, compared to the PTSD group.	n/a
Grace (2021)	n/a	n/a	With children, the GPS requires considerations of: adaptations to language and definition of traumatic as certain items and types of trauma types are not understood; difficulties remembering the time frame of event; brief items are not helpful. With adolescents, the GPS requires considerations of: certain trauma types can be retraumatising; difficulties remembering the time frame of event; certain items are not understood.
Guzman Torres (2023)	Dissociation	No difference in dissociation levels in the adults CPTSD group, compared to the PTSD group.	n/a

(Continues)

TABLE 3 | (Continued)

First author (year)	Differentiating features		Clinical considerations
	Characteristics	Outcomes	
Haselgruber (2020b)	Internalising behavioural difficulties Externalising behavioural difficulties Maladaptive emotion regulation Functional impairment (social, occupational and other)	Significantly higher rates of internalising behavioural difficulties ($p < 0.01$), externalising behavioural difficulties ($p < 0.01$), maladaptive emotion regulation ($p < 0.01$) and functional impairment ($p < 0.01$) in the young people CPTSD group, compared to the PTSD group.	n/a
Hyland (2018)	Dissociation Depression symptoms Borderline personality disorder symptoms	Significantly higher levels of dissociation ($p < 0.01$), depression symptoms ($p < 0.05$), and borderline personality disorder symptoms ($p < 0.05$) in the adults CPTSD group, compared to the PTSD group. No difference for destructive behaviours.	n/a
Hyland (2020)	Dissociative experiences	Significantly higher dissociative experiences ($p < 0.001$) in the adults CPTSD group, compared to the PTSD group.	n/a
Jannini (2023)	Depressive symptoms Hopelessness Suicide risk	Significantly higher levels of depressive symptoms ($p < 0.001$) in the adults CPTSD group, compared to the PTSD group. Significantly higher levels of hopelessness ($p < 0.001$) and suicide risk ($p < 0.001$) in the adults CPTSD group, compared to the PTSD group.	n/a
Longo (2019)	Traumatic symptoms Depressive symptoms Dissociative symptoms Hopelessness symptoms	Significantly higher levels of traumatic symptoms ($p = 0.001$), including re-experiencing symptoms, avoidance-numbing symptoms and hyper-arousal symptoms in the adults CPTSD group, compared to the PTSD group. Significantly higher levels of depressive symptoms ($p = 0.006$), including depressive cognitive symptoms in the adults CPTSD group, compared to the PTSD group. Significantly higher levels of dissociative symptoms ($p = 0.001$), including amnesia, absorption and derealisation-depersonalisation in the adults CPTSD group, compared to the PTSD group. Significantly higher levels of hopelessness ($p = 0.000$) including feelings and loss of motivation in the adults CPTSD group, compared to the PTSD group.	n/a

(Continues)

TABLE 3 | (Continued)

First author (year)	Differentiating features: Characteristics	Differentiating features: Outcomes	Clinical considerations
Møller, Bach, et al. (2021)	Psychoform dissociation Somatoform dissociation	Significantly higher psychoform ($p = 0.00$) and somatoform dissociation ($p < 0.001$) in the adults CPTSD group, compared to the PTSD group.	n/a
Møller, Søgaard, et al. (2021)	Suicidal ideation Negative affectivity Psychoticism	Significantly higher levels of suicidal ideation ($p = 0.002$) in the adults CPTSD group, compared to the PTSD group. Significantly higher levels of negative affectivity traits ($p = 0.004$) and psychoticism traits ($p = 0.001$) in the adults CPTSD group, compared to the PTSD group. No difference for detachment, antagonism and disinhibition.	n/a
Murphy (2021)	Loneliness Social isolation Sleep difficulties Dissociation Functioning impairment Anger Anxiety and depression symptoms	Significantly higher levels of loneliness ($p < 0.001$), social isolation ($p < 0.001$), dissociation ($p < 0.001$), functioning impairment ($p < 0.001$), anger ($p < 0.001$), anxiety and depression symptoms ($p < 0.001$) in the adults CPTSD group, compared to the PTSD group, and no difference for dangerous drinking and sleep difficulties.	n/a
Shin (2021)	Dissociation Self-harm Alterations in regulation of affect and impulse Alterations in attention or consciousness Alterations in self-perception Alterations in relations with others Alterations in meaning system Depression symptoms Stress	Significantly higher levels of dissociation ($p = 0.03$) and self-harm ($p < 0.01$) in the adolescents CPTSD group, compared to adolescents in the PTSD group. No difference for mood disorder, conduct disorder, anxiety, psychotic disease and eating disorder. Significantly higher levels of affect and impulse alterations ($p = 0.003$), attention or consciousness alterations ($p < 0.001$), self-perception alterations ($p = 0.001$), relationships with others alterations ($p = 0.006$), and meaning system alterations ($p = 0.003$) in the adolescents CPTSD group, compared to adolescents in the PTSD group. No difference for somatisation. Significantly higher levels of depression symptoms ($p = 0.014$) and stress ($p = 0.015$) in the adolescents CPTSD group, compared to adolescents in the PTSD group. No difference for anxiety.	n/a

(Continues)

TABLE 3 | (Continued)

First author (year)	Differentiating features: Characteristics	Differentiating features: Outcomes	Clinical considerations
Vallières (2018)	n/a	n/a	With Syrian refugees, ITQ items are helpful to initiate discussions and to facilitate emotional expression. Clinical difficulties with the use of ITQ with the refugee population: some symptoms identified in refugees are not included in the ITQ; some symptoms included in the ITQ are not relevant to the refugee population; the use of the ITQ requires an established therapeutic relationship. Additional practical difficulties: Many refugees are not familiar with the use of measures and specifically the Likert scale format; administration can take 25 to 45 min; variations between formal written Arabic and vernacular form leads to comprehension complications.

the appropriate skills to respond to what is being said. This means providing a containing space and appropriate support. Chamberlain et al. (2020) suggested that the assessor should offer choices, instil hope, normalise and educate with a gentle, respectful, caring and compassionate approach.

Vallières et al. (2018) used the ITQ with Syrian refugees and highlighted that the ITQ helped initiate discussions and facilitate emotional expression. They emphasised the importance of establishing a therapeutic relationship before conducting the assessment, particularly with individuals who may have inherent distrust due to past experiences. However, the authors highlighted that some of the ITQ items may not be suitable for assessing CPTSD in refugees as they may not be relevant to their experiences. For instance, 'reckless driving' as an example of risk behaviour does not apply to Syrian refugees living in Lebanon, while 'going out at night' would be more suitable to their context. Features like amnesia or concentration difficulties, commonly observed among refugees, are not included in the ITQ. The study also highlighted that refugees may not be familiar with using a Likert scale and that the Arabic language used in the questionnaire may not be appropriate or easily understood. For example, the authors highlighted the differences between the formal written Arabic and the vernacular form. Finally, they reported that the administration may take longer than expected (up to 45 mins), depending on the literacy levels of the individuals and the level of support they require.

Finally, in Grace et al. (2021), the GPS was used with children and adolescents. The authors reported that young people may have difficulty remembering the specific time frame of the traumatic event. Additionally, they found that some GPS items can be difficult for young people to understand, indicating a need for clearer and age-appropriate wording. The authors found that certain traumatic events (e.g., labelled as physical, sexual or emotional abuse) were not well understood by children. It was more effective to use terms such as 'frightening or horrible' rather than 'traumatic'. Brief items were deemed unhelpful by the authors, as children require more details to aid comprehension. With adolescents, the authors stated that being asked about and recalling the type of trauma could retraumatise. They highlighted that this is unnecessary as it is uncertain whether adolescents would access or accept treatment at the assessment stage.

3.5 | Quality Assessment

A modified version of the Joanna Briggs Institute Critical Appraisal Checklist for Analytical Cross Sectional Studies (Joanna Briggs Institute 2020) was used to assess the cross-sectional quantitative studies (see Table 4). Eleven studies were deemed of 'weak' methodological quality, 10 were of 'moderate' quality and 11 were of 'strong' quality. The quality of qualitative studies was assessed using the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (Joanna Briggs Institute 2017) (see Table 5). One study was deemed of 'weak' quality, three were of 'moderate' quality and one was of 'strong' methodological quality.

4 | Discussion

The current systematic review sought to explore the assessment of ICD-11 CPTSD in young people and adults. It reports the measures commonly used to assess and inform diagnosis of CPTSD, the differentiating features between CPTSD and PTSD, and

TABLE 4 | Quality assessment of quantitative studies using the modified Joanna Briggs Institute Critical Appraisal Checklist for Analytical Cross Sectional Studies (Joanna Briggs Institute 2020).

First author (year)	Criteria for inclusion in the sample clearly defined	Study subjects and the setting described in detail	CPTSD construct measured in a valid way	Objective, standard criteria used for the condition	Confounding factors identified	Strategies to deal with confounding factors stated	Appropriate statistical analysis used
Astill Wright et al. (2021)	Yes	Yes	Yes	Unclear	Yes	Yes	Yes
Bondjers (2019)	Yes	Yes	Unclear	Yes	Yes	Yes	Yes
Cloitre (2018)	Unclear	Yes	Yes	Yes	Yes	Yes	Yes
Cloitre, Hyland, et al. (2021)	Yes	Yes	Yes	Yes	No	No	Yes
Folke (2023)	Yes	Yes	Yes	Yes	No	No	Yes
Ford (2015)	No	Yes	Unclear	Yes	Yes	Yes	Yes
Frost (2022)	Yes	Yes	Yes	Yes	No	No	Yes
Gelezelyte (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gündogmus (2023)	Yes	Yes	Yes	Unclear	Yes	No	Yes
Guzman Torres (2023)	Yes	Yes	No	Yes	Yes	Yes	Yes
Haselgruber (2020a)	Yes	Yes	Unclear	Unclear	Yes	Yes	Yes
Haselgruber (2020b)	Yes	Yes	No	Yes	Yes	Yes	Yes
Ho (2022)	Yes	Yes	Unclear	Yes	No	No	Yes
Hyland (2017)	Yes	Yes	Unclear	Yes	Yes	Yes	Yes
Hyland (2018)	No	Yes	Unclear	Unclear	No	No	Yes
Hyland (2020)	No	No	Yes	Yes	No	No	Yes
Jannini (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Karatzias (2016)	Unclear	Yes	Unclear	Unclear	No	No	Yes
Langdon (2023)	No	Yes	Yes	Yes	No	No	Yes
Longo (2019)	Yes	Yes	Unclear	Yes	No	No	Yes
Møller, Bach, et al. (2021)	Yes	Yes	Yes	Yes	No	No	Yes
Møller, Søgaard, et al. (2021)	Yes	Yes	Yes	Yes	No	No	Yes
Murphy (2020)	Yes	No	Yes	No	Yes	No	Yes
Murphy (2021)	No	Yes	Yes	Yes	Yes	Yes	Yes
Oe (2020)	No	Yes	Yes	Yes	Yes	No	Yes
Sachser (2022)	Yes	Yes	Yes	No	No	No	Yes

(Continues)

TABLE 4 | (Continued)

First author (year)	Criteria for inclusion in the sample clearly defined	Study subjects and the setting described in detail	CPTSD construct measured in a valid way	Objective, standard criteria used for the condition	Confounding factors identified	Strategies to deal with confounding factors stated	Appropriate statistical analysis used
Sele (2020)	No	Yes	Unclear	Yes	No	No	Yes
Shin (2021)	Yes	Yes	No	Yes	Yes	Yes	Yes
Valdovinos (2023)	Yes	Yes	Yes	Unclear	No	No	Yes
Vallières (2018)	Yes	Yes	Unclear	Yes	Yes	No	Yes
Vang (2021)	Yes	Yes	Yes	No	Yes	Yes	Yes
Wigham (2021)	Yes	Yes	Yes	Unclear	No	No	Yes

highlights clinical considerations for assessment. The quality assessment found the majority of the reviewed studies of 'moderate' or 'strong' methodological quality.

4.1 | Measures

The International Trauma Questionnaire (ITQ) was the most used measure to assess CPTSD and demonstrated 'moderate' to 'high' reliability. It was used in 10 languages with individuals with various trauma histories. This aligns with previous reviews which found that ITQ was widely used to assess CPTSD (Maercker et al. 2022; Seiler et al. 2023). Given the limited number of items and ease of scoring, the ITQ can inform the assessment of CPTSD. Furthermore, as it can measure change over time (Cloitre, Hyland, et al. 2021), it has merit as an outcome measure in therapeutic settings.

Some studies reviewed used interview tools to assess ICD-11 CPTSD, with the most common being the International Trauma Questionnaire (ITI). Although more comprehensive and personalised, the administration of these interview measures can be difficult in clinical settings. For example, the ITI should only be administered and scored by clinicians who have received ITI training, and the administration may take up to 1.5 h (Gelezelyte et al. 2022). Interviews can be helpful where self-report measures are not appropriate, questionnaires score in the borderline range and more detailed symptom information is needed to inform formulation or treatment (Maercker et al. 2022; Seiler et al. 2023). However, additional research is required for their validation in diverse samples.

The review found that there are fewer measures available to assess CPTSD in young people. The International Trauma Questionnaire–Child and Adolescent Version (ITQ-CA) was validated for self-report in children aged 10 and older. An informant (caregiver) version of the ITQ-CA is reportedly under development (B. Schuster, personal communication, 15 June 2023). A multi-informant approach through parents or caregivers, teachers and self-report is recommended when assessing young people (De Los Reyes et al. 2015). The Child and Adolescent Trauma Screen 2 (CATS-2) is currently the only measure that incorporates both self and informant reports, which can be used from 7 years old. Although it has been validated in the United States and European countries with mixed genders, varied trauma history and symptoms, it has not been validated in non-Western and non-English speaking samples (Sachser et al. 2022). In addition, while the CATS-2 offers options for use with young people through self-report and informant versions, the informant cut-off is described as an 'approximation' pending validation, and there is currently no cut-off established for the self-report version.

It is important to note that studies on the assessment of CPTSD are still in the early stages. While many of the studies in this review used tools that were specifically designed to measure ICD-11 CPTSD criteria (i.e., ITQ, ITQ-CA, CATS-2 and ITI), a proportion of studies used measures that were developed before the ICD-11 CPTSD conceptualisation, such as the C-PTSD Interview Scale and LANTS. Furthermore, although the C-PTSD Interview Scale was developed to assess 'complex trauma', as defined by Herman (1992), the measure is inaccessible for

review, so it is not possible to determine whether it aligns with ICD-11 CPTSD. Measures created to assess DSM-5 PTSD were also used (e.g., SOTS), although the classifications differ somewhat in their conceptualisations of trauma-related diagnoses. Other measures were transdiagnostic and not specific to a diagnostic classification (e.g., GPS, LANTS). While these measures can map onto certain ICD-11 CPTSD criteria, they do not adequately assess the full symptom profile. For instance, while the GPS evaluates feelings of worthlessness and blame, and feelings of anxiety, depression and anger, which may map onto ICD-11 CPTSD criteria of negative self-concept and affect dysregulation, it does not assess disturbances in relationships. Similarly, the LANTS assesses features which may map onto DSO symptoms, but it does not assess re-experiencing and avoidance. Additionally, measures that are not specifically designed to assess ICD-11 criteria can result in assessing factors that are not required for CPTSD diagnosis (e.g., Screening for Complex PTSD, which assesses risk factors). Thus, while measures that are not specific to ICD-11 may be appropriate to assess certain aspects of CPTSD and provide contextual information, there is a risk of symptoms of PTSD or DSO being overlooked and CPTSD not being appropriately assessed if the measures are not adapted to formally capture ICD-11 criteria. The CATS-2 is an example of appropriate adaptation. The CATS was originally designed to assess DSM-5 PTSD, but now integrates ICD-11 criteria through additional questions explicitly assessing DSO symptoms.

Although measures can be helpful in screening and/or informing diagnosis of CPTSD, they must be used in conjunction with a comprehensive assessment of the individual's history and current context (Seiler et al. 2023). The UKPTS guidelines (2017) provide recommendations regarding the domains that should be considered during the assessment of CPTSD, including: presenting problems, history of difficulties, history of achievements, trauma history and index trauma history, current symptoms of PTSD and CPTSD, positive psychotic symptoms, background history, current sexual functioning, current social challenges, risk and substance use, previous mental health difficulties, psychological support, hopes and goals. This information, in combination with that obtained from standardised measures, is helpful in developing a comprehensive formulation and appropriate intervention plan (UKPTS 2017).

The review findings provide professionals with insight into suitable measures for use in assessments. The ITQ demonstrates particular promise, with good psychometric properties across various adult samples, showing generalisability to a wide population. However, professionals must consider cultural adaptations when using it in different contexts, such as changing idiomatic expressions (Donat et al. 2019; Vallières et al. 2018). It is also important to note that apart from the ITQ, other adult CPTSD measures lack thorough validation studies. The ITQ-CA shows potential for use with young people aged 10 and above, featuring a validated cut-off and an informant version currently under development. Future research should prioritise developing tools for young people (e.g., interviews incorporating self and informant perspectives), and ensuring existing tools are validated across diverse populations (e.g., validated CATS-2 cut-offs for self and informant versions, ITQ-CA informant version), including different cultures, genders and clinical and nonclinical samples.

TABLE 5 | Quality assessment of qualitative studies using the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (Joanna Briggs Institute 2017).

First author (year)	Congruity between philosophical perspective and research methodology	Congruity between research methodology and research question	Congruity between research methodology and methods to collect data	Congruity between research methodology and representation and analysis of data	Congruity between research methodology and interpretation of results	Statement locating researcher culturally or theoretically	Influence of researcher on research, and vice-versa, addressed	Participants, and their voices, adequately represented	Research ethical and evidence of ethical approval by an appropriate body	Conclusions drawn in the research report flow from analysis, or interpretation, of the data
Chamberlain (2020)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Donat (2019)	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes
Grace (2021)	Yes	Yes	Yes	No	Not applicable	Yes	No	Yes	Yes	Yes
Lechner-Meichsner (2021)	Unclear	Yes	Yes	No	No	No	No	No	Yes	Unclear
Vallières (2018)	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes

TABLE 6 | Comparison of features in CPTSD and PTSD across age groups.

	Young people	Adults
Increased difficulties in CPTSD	Internalising and externalising behavioural difficulties	Anxiety
	Emotional regulation Depression	Depression
	Stress	Stress
	Dissociation	Anger
	Self-harm	Negative affect
	Impulse control	Traumatic symptoms Dissociation
	Attention	Psychoticism
	Self-perception	Borderline personality traits
	Meaning system	Suicidal ideation
	Relationships with others	Suicidality
	Functional impairment	Suicide risk
		Hopelessness
		Somatic symptoms
		Loneliness
		Social isolation
		Functional impairment
No differences in difficulties	Anxiety	Destructive behaviours
	Mood disorder	Dangerous drinking
	Conduct disorder	Sleep difficulties
	Psychotic symptoms	Detachment
	Eating disorder	Antagonism
	Somatisation	Disinhibition

4.2 | Differentiating Features

Papers focusing on the differentiation of CPTSD from PTSD were identified and a summary of these findings can be found in Table 6. These included a comparison of core diagnostic symptoms, as well as other co-occurring areas of difficulty that are not intrinsic to diagnosis. A few studies reported no differences between individuals with CPTSD and PTSD on certain features (e.g., anxiety and mood difficulties in young people, dangerous drinking and sleep difficulties in adults). However overall, young people and adults with CPTSD exhibited increased emotional, behavioural and social difficulties compared to those with PTSD. This aligns with previous research showing a greater psychopathological burden in CPTSD, compared to PTSD (Brenner, Köllner, and Bachem 2019).

Dissociation was explored in many of the included studies and overall, levels were found to be significantly higher in CPTSD, compared to PTSD. This suggests that dissociation can be a useful indicator for differential diagnosis (Hyland et al. 2020), and when present it is an important feature to address in treatment as dissociation is strongly associated with re-experiencing, affect dysregulation, and relationship disturbances (Hyland et al. 2020). Interestingly, a recent latent class analysis conducted by Hyland et al. (2024) found that CPTSD can occur without dissociative experiences. Derived from a general population study, their findings showed that only a minority of individuals with CPTSD symptoms had elevated dissociative experiences, which were strongly associated with a history of parental verbal abuse. This group of individuals had poorer mental health and higher levels of impaired functioning, once more highlighting the importance of addressing dissociation in treatment.

The reviews findings highlighted features that have higher levels of severity in CPTSD, compared to PTSD. Several studies found significantly higher symptom severity, higher level of difficulty in other areas and higher impact on the functioning in CPTSD. This illustrates the importance of timely and comprehensive assessments, exploring both symptomatology, co-occurring difficulties and impact/impairment. Further research is necessary to support clinicians in differentiating CPTSD from other trauma-related disorders, especially where co-morbidities may be present. Qualitative research with professionals who are familiar with assessing CPTSD and/or individuals with confirmed diagnoses of CPTSD may help in identifying clinical nuances and further assessment considerations. Finally, the scarcity of studies in young people highlights the need for more research to understand differences in presentation based on age or developmental level and aid accurate assessment of young people and those with developmental differences.

4.3 | Clinical Considerations

The review showed that an empowering approach, with an assessor who is gentle, caring and compassionate, is crucial to establishing a strong and trusting relationship during the assessment

(Chamberlain et al. 2020; Vallières et al. 2018). It also highlighted the need to educate and normalise the emotional, behavioural and social difficulties associated with trauma, while providing appropriate signposting and support (Chamberlain et al. 2020). Considerations of cultural and language factors were also emphasised, due to differences in presentations and understanding among groups (Vallières et al. 2018). Findings related to the developmental needs of young people included using appropriate language, providing detailed descriptions and being sensitive to potential triggers of retraumatisation (Grace et al. 2021).

Experiencing traumatic events that are threatening, horrifying, prolonged and repetitive can cause individuals with CPTSD to feel like their sense of safety and security has been shattered (Lee 2022). This can make it harder to form connections with others, to feel cared for and safe (Lee 2022). Given histories of betrayal or not being believed by others, trauma survivors may be hesitant to disclose information during an assessment (Brewin 2020), may display detachment or have difficulties trusting professionals, as found in the current review. Research has found that clinicians' gender or ethnicity could also act as potential trauma triggers (Williamson et al. 2021), which could detrimentally impact the trust, detachment and disclosure of information. Previous papers have highlighted the importance of creating a calm and safe environment during the assessment process (Maercker et al. 2022) and taking a compassionate approach (Lee 2022) to improve trust and rapport. The focus of assessment should be on understanding the impact on the individual, as opposed to obtaining a detailed account of the trauma (Maercker et al. 2022).

Although there are many pressures on clinical services, findings emphasise the careful consideration and care that should be given to individuals with DSO symptoms. Taking time to build the relationship over several appointments, instead of a one-off appointment, should be considered by services supporting individuals with suspected CPTSD. Given that only three papers outlining clinical considerations were identified, further research into the nuances of conducting assessments with individuals who may have CPTSD is warranted, such as exploring barriers to effective and accurate assessment from the perspectives of both professionals and individuals with CPTSD.

4.4 | Limitations

The exclusion of grey literature and non-English papers means that valuable information may have been missed. Another important limitation is the heterogeneity among the included studies. As much information as possible tried to be captured but the variation in methodological quality, study designs, samples and assessment methods make it challenging to draw definitive conclusions. There were a limited number of papers that specifically focused on assessment so studies with different aims were included, which may have affected the findings due to the heterogeneity of methods and participants. Additionally, most of the research was conducted in Western countries with female samples and predominantly focused on samples accessing clinical services, limiting the generalisability of the findings to other populations. The scarcity of research on CPTSD assessment in young people and clinical considerations intrinsically impacted the depth of this review. Due to the infancy of the field, gold-standard recommendations cannot be made currently, and this paper offers tentative clinical recommendations.

5 | Conclusion

The current review provides valuable insights into the assessment of ICD-11 CPTSD in young people and adults. The ITQ was the most used measure to evaluate CPTSD symptoms in both young people and adults, and it has shown promise as a valid and reliable tool available in multiple languages. Individuals with CPTSD were found to have higher levels of emotional, behavioural and social difficulties, compared to those with PTSD. This was true for intrinsic diagnostic symptoms and co-occurring nondiagnostic features. Although using appropriate assessment tools and gathering relevant history are important, this review highlighted that trust, cultural sensitivity and tailored communication should be prioritised when assessing individuals with suspected CPTSD. Given the infancy of ICD-11 research, this review contributes to the evidence base of CPTSD and offers tentative clinical recommendations to help improve assessment and diagnostic accuracy, to inform subsequent treatment decisions.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

N/A.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.