

**Pseudonym**: Kalpana Chatterjee **Examiner’s Name**: Stephanie B. Ward, MS

**Age**: 22 **Supervisor**: Kate Walsh, PhD

**Sex**: Female

**Intake Assessment**

**REASON FOR REFERRAL**

Kalpana is a 22-year-old Indian-American lesbian woman and undergraduate student studying engineering and computer science at a large research university. Patient was referred to the training clinic by this graduate clinician, who met with Kalpana for individual psychotherapy sessions while working as a practicum trainee at another agency during the previous academic year. The referral was for Kalpana to receive a diagnostic assessment for posttraumatic-stress disorder (PTSD) and subsequent, evidence-based treatment.

**PROCEDURES**

Clinical Interview

Alcohol Use Disorders Identification Test (AUDIT)

Patient Health Questionnaire-9 (PHQ-9)

Generalized Anxiety Disorder-7 (GAD-7)

Personality Assessment Inventory (PAI)

Wechsler Abbreviated Scale of Intelligence—Second Edition (WASI-II)

Life Events Checklist for DSM-5 (LEC-5), Extended Self-Report

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)

**PRESENTING CONCERNS**

Kalpana presented to the clinic in order to receive diagnostic clarity and address issues related to depression, anxiety, and interpersonal trauma. The interpersonal trauma the patient had experienced included experiences of oppression, intervening to prevent a suicide attempt, and sexual assault. Patient described significant irritability, social withdrawal, low appetite, concentration difficulties, and overwhelming apathy towards activities she used to enjoy, such as listening to music and sorority-related leadership duties. She reported mistrust of everyone and gaps in her memory for the traumatic events, as well as feeling “completely numb,” on edge, and exhausted all the time. Kalpana noted that her primary coping strategies were avoidance, staying busy (“overworking”), and self-isolation.

**PERSONAL AND PSYCHIATRIC HISTORY**

Kalpana reported living in the Midwestern United States until roughly age 8, at which point her family moved to a different state in the Northwest, where she lived until moving once more to attend university. Kalpana noted that she is an only child and first-generation American, as her parents emigrated from India before she was born. Kalpana shared that growing up in her family often felt quite terrible because she lived under a microscope, subject to unfair standards and immense pressure to be perfect. She described both her parents, but her mother in particular, as extremely demanding, achievement-oriented, and highly educated. Patient noted that her mother has a PhD and works in biotechnology while her father has an MBA and works in computer science. Kalpana stated that she and her father established a “newfound understanding” and sense of common ground in recent years after she added computer science as a second major. That said, Kalpana noted she speaks with her mother on a weekly basis and that her mother has always been the primary parental figure in their household, with her father generally deferring to her mother’s judgment and decisions.

Patient reported having a “complicated relationship” with money as someone who grew up in an affluent neighborhood but did not have a full appreciation of her family’s financial resources until she left home for university. Relatedly, Kalpana shared that she spent a lot of time alone while growing up because her parents both worked and had rules in place that limited her autonomy. For examine, Kalpana was not allowed to work a part-time job and discipline in their household often involved freezing her access to financial resources and cutting off her social outlets, leaving her totally dependent on her parents. Patient noted it seemed as though her mother did not like when Kalpana spent time with friends outside of school, particularly her white friends. Thus, Kalpana spent the bulk of her time reading, completing schoolwork, and participating in a wide range of extracurricular activities. Despite her academic success, Kalpana recalled feeling as though she was constantly walking on eggshells at home, unsure of what might prompt her mother to criticize her. Patient emphasized how stressful it was, and still is, never knowing what kind of reaction to expect from her mother given her unpredictable behavior, frequent yelling, and tendency toward passive aggressive emotional manipulation (e.g., “well if you don’t need me anymore, I might as well just die”).

Kalpana reported developing an eating disorder in high school as a result of her mother’s criticisms about her body weight and shape. Patient stated this disordered eating was characterized by restricted calorie intake, a pattern that continued through high school into college without any formal resolution. Kalpana reported also developing severe depression and suicidal ideation during high school, resulting in chronic self-harm, specifically cutting, to manage her distress. Kalpana stated that she wanted to see a therapist during this challenging period but it was not an option due to her parents’ beliefs about mental health and illness. Of note, patient sought help from a school guidance counselor who then alerted Kalpana’s parents to her self-injurious behavior, which has been “used against” her ever since.

Before meeting with this graduate clinician, patient reported previously working with two therapists from whom she received diagnoses of Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD). However, both courses of treatment were intermittent and terminated prematurely when her therapists’ training rotations concluded. Kalpana also reported having been prescribed Lexapro (5-10mgs) for depression by a psychiatrist, which she started taking in her sophomore year at the university. Patient noted the physician writing her prescriptions left their job later that spring and wrote Kalpana a prescription for 90 days to last through summer vacation. Patient reported experiencing side effects (e.g., brain fog, fatigue, low libido, weight gain) and quitting “cold-turkey” in the fall because she no longer had a provider.

At present, Kalpana reported no deliberate attempts to restrict her eating but noted she has a very low appetite. Patient also denied any current suicidal ideation or self-injurious behavior. She endorsed drinking one cup of coffee per day on average and drinking socially but denied current drug use. Patient reported using cannabis in the past but shared she has not smoked in years, as it would interfere with her professional aspirations. Kalpana’s sleep schedule during the previous academic year involved staying up very late and consistently waking up early for school and work, though she often struggled to get out of bed. Currently, Kalpana stated she comes home exhausted each day and can barely keep her eyes open, so she goes to sleep much earlier than usual, then wakes up with a jolt to her heart racing. She reported taking no medications at present and her family’s medical history was unremarkable.

**MENTAL STATUS**

Patient was oriented to person, time, and place. Her mood was anhedonic and she demonstrated a limited range of affect appropriate for the situation (e.g., expressing frustration when tasks were difficult). Kalpana remained thoughtfully engaged throughout the intake process, though some distractibility was observed, which aligned with her self-reported concentration difficulties. Kalpana often used humor as a defense mechanism and fidgeted in her seat, both of which were expected during a lengthy and invasive psychological assessment. Her body language fluctuated with session content, as she appeared more guarded (e.g., arms tightly crossed, muscles tense) when discussing sensitive material in her personal history. Kalpana denied current or recent homicidal ideation, suicidal ideation, or non-suicidal self-injury. Across all sessions, her thought content appeared logical and linear and gross memory appeared intact, with the notable exception being inability to recall details of traumatic events. Based on observations of her behavior and the pattern of test scores, the current results appear to be a reliable and valid estimate of Kalpana’s current psychosocial functioning.

**TEST RESULTS AND INTERPRETATION**

**The Alcohol Use Disorders Identification Test (AUDIT)** is a 10-item self-report screening tool designed to assess alcohol consumption, drinking behaviors, and alcohol-related problems in the past year. Scores range from 0 to 40, with a score of 8 or higher suggestive of hazardous alcohol use. Patient’s AUDIT score was an 11, suggesting that she may be at increased risk of experiencing negative consequences from her alcohol use. The Drug Abuse Screening Test (DAST) was not administered to screen for drug problem severity as patient denied drug use in the past year.

**The Patient Health Questionnaire-9 (PHQ-9)** is a 9-item, reliable and valid metric utilized to assess current depressive symptom severity. Kalpana’s responses are summed, which associate with minimal (1-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20+) depressive symptoms. Kalpana was administered the PHQ-9 twice, two weeks apart, with scores (11, 13) falling in the moderate range.

**The Generalized Anxiety Disorder-7 (GAD-7)** is a 7-item, reliable and valid metric utilized to assess current anxiety symptom severity. Kalpana’s responses are summed, which associate with no (0-5), mild (6-10), moderate (11-14), and severe (15+) anxiety symptomatology. Kalpana was administered the GAD-7 twice, two weeks apart, with scores falling in the mild (8) and moderate (13) ranges.

**The** **Personality Assessment Inventory (PAI)** is a self-report, objective test of personality and psychopathology designed to provide information on critical aspects of adult patients. Scales yield T-scores with a mean of 50 and a standard deviation of 10. Scale scores greater than 70 are unusual in the general population and likely indicate problems of clinical significance. PAI scales do not, on their own, provide adequate evidence for specific diagnoses. Rather the symptoms and behaviors documented by the PAI can support diagnostic conclusions.

Upon inspection of the validity scales, Kalpana’s profile appears to be valid. Her scores indicate that she attended appropriately to item content and responded in a consistent fashion to similar items. There are some indications that Kalpana may have portrayed herself in a negative light. However, Kalpana’s complex family history and concerns about treatment eligibility may be driving this presentation rather than the likelihood of feigning mental illness; the elevated symptom severity reflected by her responses does not appear exaggerated beyond what the clinical picture would warrant.

Kalpana’s clinical scale profile revealed notable elevations across several scales, including Depression (DEP, T-score = 88) and Anxiety (Name of scale ANX, T-score = 78). The configuration of clinical scales suggests Kalpana is quite distressed and acutely aware of her need for help, which aligns with her presentation during the intake process, as does the combination of hopelessness, irritability, confusion, and agitation apparent in her scores.

Kalpana endorsed a number of difficulties consistent with a significant depressive experience. She is likely plagued by thoughts of worthlessness and personal failure, though elevations in the Depression subscales appear to stem from the affective realm (DEP-A, T-score = 92). She admits openly to feelings of sadness, a loss of interest in normal activities, and a lack of pleasure derived from experiences she previously enjoyed. This combination of features is consistent with concerns Kalpana raised throughout the clinical interviews, including a disturbance in sleep pattern, concentration difficulties, loss of appetite, low energy, and psychomotor slowing.

The elevated Anxiety clinical scale suggests that Kalpana is experiencing a great deal of tension and fatigue associated with the stress of trying to manage and make sense of her emotional experience. Physiological symptoms are also present, such as sweaty palms, trembling hands, complaints of irregular heartbeats, and shortness of breath.

Collectively, this constellation of symptoms impairs Kalpana’s ability to relax or participate fully in life.

Kalpana was administered the ***Wechsler Abbreviated Scale of Intelligence—Second Edition (WASI-II)*** in order to assess her intellectual functioning. Intellectual functioning refers to a person’s ability to problem solve, reason, and learn. The WASI-II provides composite scores that estimate intellectual functioning in two areas: The *Verbal Comprehension Index* (VCI) measures verbal reasoning, verbal conceptualizations, and crystallized knowledge, while the *Perceptual Reasoning Index* (PRI) measures perceptual reasoning, spatial processing, and visual-motor integration. The WASI-II also provides a composite score that estimates general intellectual ability (i.e., *Full-Scale IQ-4 Subtests* [FSIQ-4]). The WASI-II is an abridged version of the *Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV)* and comprises four subtests: Block Design and Matrix Reasoning (comprise the PRI), and Vocabulary and Similarities (comprise the VCI). These subtests are similar in format to their WAIS-IV counterparts and are the subtests most strongly linked to general intellectual functioning. Administration of all four subtests is a means of quickly estimating an individual’s verbal, nonverbal, and general cognitive ability.

The FSIQ-4 and index scores (VCI, PRI) are based on a mean of 100, with a standard deviation of 15. Average scores range from 85 to 115. The confidence interval indicates there is a 95% likelihood that a score representing Kalpana’s true ability lays within that range. FSIQ-4 and index scores are standard scores and can be compared to each other. Individual subtest scores have a mean of 50, with a standard deviation of 10. Average scores range from 40 to 60. Subtest scores are standard scores and can be compared to each other, but not to index scores.

Kalpana attained a *Verbal Comprehension Index (VCI)* score of 126, placing her in the ***Superior*** range compared to her same-age peers. The VCI is comprised of the Vocabulary and Similarities subtests. Kalpana attained a *Perceptual Reasoning Index (PRI)* score of 131, placing her in the ***Very Superior*** range compared to others of her same age. The PRI is comprised of the Block Design and Matrix Reasoning subtests. Calculation of the *FSIQ-4* shows that Kalpana attained a *FSIQ-4* score of 132, placing her in the ***Very Superior*** range compared to others of her same age. The FSIQ-4 is comprised of all four WASI-II subtests.

**Index and Subtest Scores from the Wechsler Abbreviated Scale of Intelligence- Second Edition (WASI-II)**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Verbal Comprehension Index = 126*** | | ***Perceptual Reasoning Index = 131*** | |
| Vocabulary | 63 | Block Design | 60 |
| Similarities | 71 | Matrix Reasoning | 75 |

**The Life Events Checklist for DSM-5 (LEC-5)** is an extended self-report measure designed to assesslifetime exposure to Criterion A traumatic events, at least one of which is required for a diagnosis of Posttraumatic Stress Disorder (PTSD). This measure consists of 17 traumatic experiences with response options that include “happened to me,” “witnessed it,” “learned about it,” “part of my job,” “not sure,” and “doesn’t apply.” Kalpana checked 1) “witnessed it” and 2) “happened to me” for “any other very stressful event or experience,” and checked 3) “happened to me” for “other unwanted or uncomfortable sexual experience.”

*Event 1.* The first traumatic event she reported involved immediate danger to a close friend. At the time, Kalpana was in a serious relationship with her girlfriend, Beth, and close friends with her girlfriend's roommate, Carly. Carly was acutely suicidal, such that Beth was trying to monitor her medication adherence and access to any potentially lethal instruments. Carly had seriously considered the means with which she would end her life, had formed a plan, and expressed intent to execute that plan. On the day of the event, Kalpana and Beth interrupted Carly when she was preparing to die by suicide. Kalpana and Beth called for help and were in the process of trying to transport Carly to the hospital when she broke away from them and tried to run into traffic. Kalpana had to tackle her friend to the ground in order to have her involuntarily hospitalized. Kalpana reported gaps in her memory during this event and the week that followed. Of note, she shared that Beth broke up with her a few months later so that she could start a committed, romantic relationship with Carly, the same roommate and mutual friend they had “tried to save.” Carly made another attempt to die by suicide later on, at which point she hung herself from a tree in front of where she lived at the time, which was directly across the street from an elementary school. When asked about current distress related to this experience, Kalpana described avoidance of feelings and memories associated with the event, avoidance of physical reminders (e.g., the entire neighborhood where this event took place, requiring detours), social detachment, and intrusive thoughts, including the image of Carly hanging from the tree despite Kalpana not being physically present for this latter suicide attempt.

*Event 2.* The second traumatic event she reported took place over the course of Thanksgiving when Kalpana was at her parents’ house for the holiday. At the same time, their close family friends were going through an extremely messy, emotionally-volatile divorce that involved “airing each other’s dirty laundry” on social media. On the day that Kalpana was scheduled to fly back to university, she received a call from her aunt with whom she has a close relationship. Her aunt had called to warn her that Kalpana’s lifelong friend, the son of the parents going through the divorce, had started lashing out online. Her aunt relayed that it appeared as though he was trying to harm other community members by exposing their vulnerable secrets, perhaps in an attempt to shift the focus away from his family, causing her aunt to worry that he was going to expose Kalpana’s sexuality to her parents. After receiving this call from her aunt, the childhood friend made a negative comment online about her being a lesbian, then followed up this comment with a direct phone call and explicitly outed her to her parents. Kalpana then pulled her mother aside to explain and remembers most clearly the look on her mother’s face; she described this expression as a look of disgust that confirmed her worst fears regarding what would happen if her parents ever found out she was gay. Kalpana reported gaps in her memory during this event and the week that followed, but stated it felt like the worst parts were especially vivid. When asked about current distress related to this experience, Kalpana described intrusive thoughts, memories, and dreams, most often featuring the look of disgust on her mother’s face. She also described avoidance of thoughts and feelings (e.g., fear, sadness, shame) associated with the event, irritability, social detachment, and concentration difficulties, among others (see PTSD section below for details).

*Event 3.* The third event, and second of which she endorsed on the LEC-5 for “happened to me,” was in regard to an unwanted or uncomfortable sexual experience. When queried, Kalpana stated this was in reference to an experience with her first boyfriend that was “debatably sexual assault.” She attributed the ambiguity around whether this was a consensual sexual experience to the fact that her discomfort and lack of interest were due to her sexual orientation, which she herself was not entirely conscious of at the time. When asked if she experiences any distress about this event, she said not about the event itself but rather the implications (i.e., her not being attracted to men).

**The Clinician Administered PTSD Scale for DSM-5 (CAPS-5)** is the “gold standard” for the assessment of PTSD. To meet criteria for past-month PTSD, an examinee must have at least 1 B (Reexperiencing) symptom (out of 5), 1 C (Avoidance) symptom (out of 2), 2 D (Cognitive and Mood) symptoms (out of 7), and 2 E (Arousal and Reactivity) symptoms (out of 6). A symptom is considered present if it is experienced with moderate frequency [at least twice per month or some of the time (20-30%)] and clinically significant intensity or distress. The CAPS-5 was administered to Kalpana twice, first in reference to Event 1 (which she refers to as the “Carly event”) and second in reference to Event 2 (which she refers to only as “Thanksgiving”). Event 2 was ultimately identified as the “worst event” by the patient, who found discussing Thanksgiving to be most difficult.

In both administrations, Kalpana met past-month criteria for the following 12 symptoms (those with asterisks\* also were significant problems in the months following the event):

B4. Emotional distress about trauma cues\*

B5. Marked physiological reactions when cued\*

C1. Avoidance of memories, thoughts, or feelings about the event\*

D1. Inability to remember important aspects of traumatic event

D3. Persistent, distorted cognitions about the cause of the trauma\*

D5. Markedly diminished interest in activities she used to enjoy \*

D6. Feelings of detachment or estrangement from others\*

D7. Persistent inability to experience positive emotions\*

E1. Irritable behavior and angry outbursts\*

E4. Exaggerated startle response

E5. Problems with concentration

E6. Sleep disturbance

In the second administration in reference to “Thanksgiving,” Kalpana also met past-month criteria for symptom:

D2. Persistent, exaggerated negative beliefs or expectations\*

She was subthreshold (i.e., did not meet the frequency or intensity criteria to be considered present) for the following past-month symptoms:

C2. Avoidance of external reminders of the event (people, places, conversations)\*

D4. Persistent negative emotional state\*

The following symptoms were absent in the past month:

B1. Intrusive, distressing recollections of the trauma\*

B2. Recurrent distressing dreams with content related to the trauma\*

B3. Flashbacks or dissociative reactions

E2. Reckless or self-destructive behavior\*

**SUMMARY & DIAGNOSIS**

As noted above, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* Criterion A for PTSD specifies the type of event that constitutes a trauma. It requires that the individual endure “exposure to actual or threatened death, serious injury, or sexual violence” through one of several possible means (e.g., direct exposure, witnessing, learning that the event happened to a loved one).1 In its current form, Criterion A encompasses a variety of traumatic events, including some—but not all—forms of childhood abuse, as well as physical or sexual assault and kidnapping, among others. Thus, Criterion A as its currently written fails to capture experiences of oppression, despite scientific literature providing empirical evidence of the relationship between various oppressive forces (e.g., heterosexism, racism) and trauma-related symptoms.2,3,4

In light of empirically-supported arguments for expanding Criterion A to include experiences of oppression,5 considered in tandem with information gathered through the intake assessment process, it is determined that Kalpana meets diagnostic criteria for ***Posttraumatic Stress Disorder 309.81 (F43.10)***. Kalpana met past-month full criteria for 2 B symptoms, 1 C symptom, 6 D symptoms, and 4 E symptoms associated with the event that she identified as most traumatic, which involved being outed as a lesbian to her homophobic mother and father. In addition to meeting the specific symptom cluster criteria, symptoms need to have lasted for longer than one month (Criterion F) and need to cause significant distress or functional impairment (Criterion G), which are both true for Kalpana. Her current impairments are largely centered around social functioning, but by her self-report, she is also experiencing academic difficulties that represent a notable deviation from her baseline inclination toward academic achievement. Her total past-month PTSD severity score was 38, which falls within the moderate range of severity on the CAPS.

However, the diagnostic category most consistent with Kalpana’s presentation and developmental history is **Complex Posttraumatic Stress Disorder (cPTSD)**, as specified in the 11th version of the World Health Organization’s *International Classification of Diseases* (ICD).6 The diagnosis of cPTSD is comprised of six symptom clusters, including three PTSD symptom clusters that relate specifically to the traumatic event (re-experiencing, avoidance of reminders, and a sense of current threat), and three symptom clusters representing pervasive disturbances in self-organization: affect dysregulation, an impaired sense of self-worth, and interpersonal problems.7

Kalpana also has a history of symptoms consistent with Generalized Anxiety Disorder (GAD) and Major Depressive Disorder (MDD), some of which persist at present, as indicated by her scores on the GAD-7, PHQ-9, and PAI. It is currently unclear whether Kalpana would meet full diagnostic criteria for either disorder in the absence of cPTSD. As such, her treatment plan is structured with the intention of first addressing posttraumatic stress, emotion dysregulation, and interpersonal difficulties; if generalized anxiety and major depression remain salient concerns following improvements in these domains, adjunctive interventions will be offered until Kalpana graduates.

**INITIAL TREATMENT PLAN**

This graduate clinician recommends that Kalpana begin treatment by receiving Cognitive Processing Therapy (CPT) for PTSD. CPT is a manualized, evidence-based gold-standard treatment for PTSD that typically involves 12 weekly therapy sessions, 60-90 minutes each, with patient homework activities between sessions to reinforce change. Kalpana’s tendency to engage in self-blame (e.g., she reported that she should have known her childhood friend would out her) suggests that she may be an excellent candidate for CPT because it uses a variety of techniques to address cognitive distortions of this nature. As treatment progresses, elements of DBT-PTSD should be incorporated so as to address the symptom clusters associated with cPTSD.

Kalpana has a number of complicating factors that could suggest she will require a longer course of treatment than the standard 12 weeks. First, cPTSD is recognized as needing a longer treatment duration due to the self-identity, self-regulatory, and relational challenges inherent to the broader symptom profile.8 For example, Kalpana has little social support, which is one of the strongest predictors of positive treatment response and PTSD recovery. Her cPTSD symptoms are interfering with her ability to meaningfully engage with and maintain strong relationships, which further impacts her negative self-concept. Second, Kalpana has a premorbid recurrent history of MDD. MDD often co-occurs with PTSD and can increase the treatment duration necessary to address both sets of symptoms simultaneously. On its own, MDD is a cyclical and recurring condition, but when co-morbid with PTSD, the presence of MDD is associated with more severe symptomatology, worse functioning, and a more complicated treatment trajectory. As such, Kalpana will likely benefit from more time in therapy than the standard, 12-week CPT protocol. Weekly sessions are indicated for up to 45 individual sessions within 1 year, consistent with the successful approach utilized in treatment protocols targeting cPTSD.9,10

Finally, although she did not report early physical or sexual abuse, there are certain indications that Kalpana may have experienced emotional abuse by her biological mother (e.g., controlling behavior, critiquing her appearance). As previously described, these experiences do not meet Criterion A for PTSD because they are not life-threatening, but they can nonetheless contribute to difficulties in recovery by impacting one’s sense of agency and self-efficacy. This early adversity may lay the foundation for interpreting traumatic events through a distorted lens, especially given her mother’s role as the common denominator across the recent and developmental experiences.

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Graduate Clinician: Date

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Supervisor: Date:

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