

Slide 1

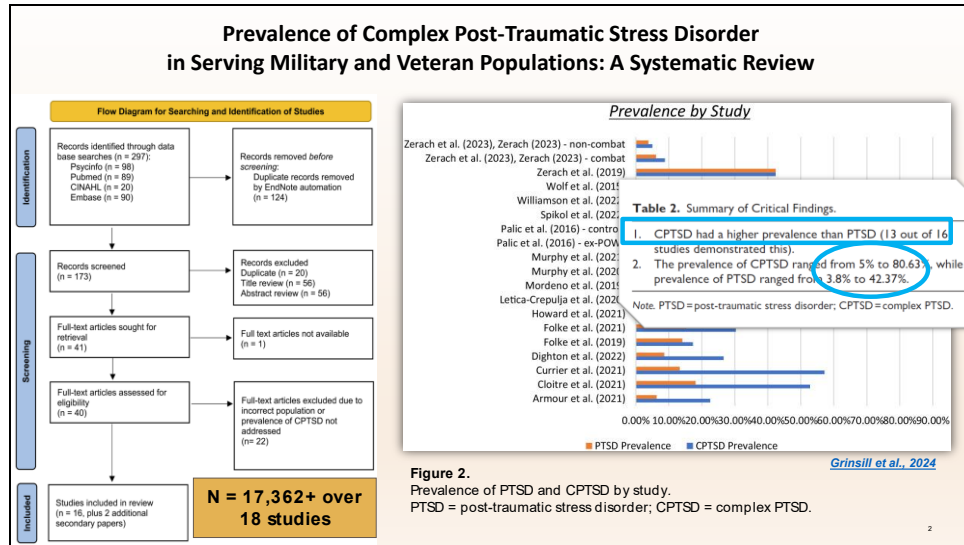


I was looking for a method of understanding which treatments work best for which types of trauma, and low and behold CPTSD was added to the ICD-11 in 2018, and researchers have been mining the coals EBPs ever since.

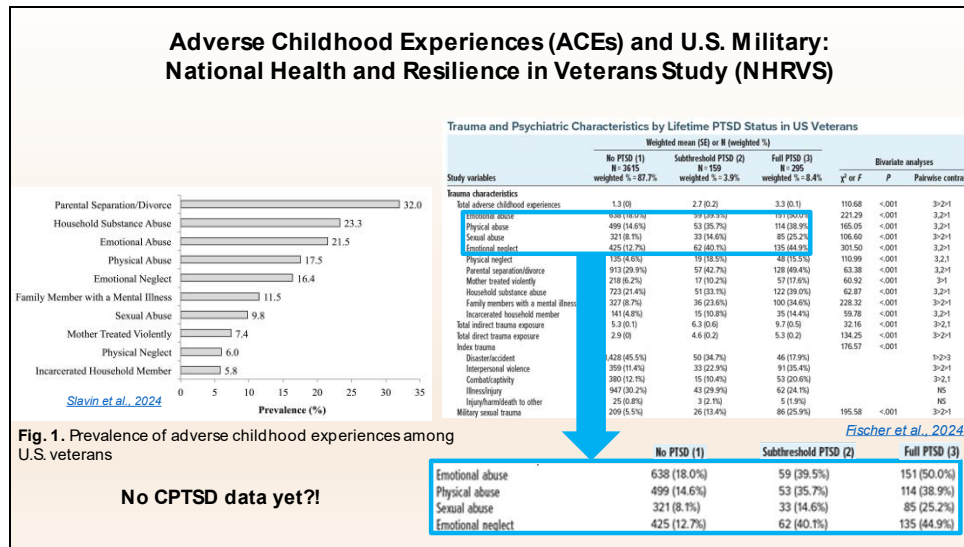
Added to 11th version of the *International Classification of Diseases* in 2018 (*ICD-11: World Health Organization, 2019*)

So before we get into the theory and treatments, let's talk about some stats.

Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377-391. <https://doi.org/10.1002/jts.249005305>
van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, R. S., McFarlane, A., & Herman, J. (1996). Dissociation, affect dysregulation and somatization: The complex nature of adaptation to trauma. *American Journal of Psychiatry, 153*(7), 83-93. <https://doi.org/10.117/ajp.153.7.83>



Focusing on military populations, this 2024 systematic review demonstrated higher rates of CPTSD (with studies ranging from 5 to 80%) compared to PTSD (3% to 48%). Higher rates of childhood adversity and more military-related experiences of emotional/physical bullying (Murphy et al., 2021) and greater MI in the CPTSD group (Currier et al., 2021).



In data analyzed from a nationally representative survey of 4069 U.S. veterans we see that ...
 The figure on the left shows

In the table on the right..

Table 3 shows results of ANOVA and χ^2 analyses of trauma exposure and psychiatric characteristics by PTSD screening status.

Veterans with full PTSD endorsed the highest number of ACEs and direct trauma exposures. These veterans were also most likely to endorse military sexual trauma and screen positive for most of the psychiatric disorders.

Veterans with subthreshold PTSD endorsed a higher number of ACEs and direct trauma exposures relative to those in the no PTSD group.

These veterans were also more likely to endorse military sexual trauma and screen positive for most psychiatric disorders.

Veterans with full PTSD were most likely to endorse interpersonal violence as their index trauma, followed by veterans in the subthreshold group. Veterans with no PTSD were most likely to endorse disaster/accident as their index trauma, followed by the subthreshold group.

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ICD-11 PTSD, CPTSD and DSM-5 PTSD

Table 1 Description of ICD-11 Posttraumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD)	
Trauma exposure: any extremely threatening or horrific event or series of events	
PTSD	CPTSD
Reexperiencing in the here and now <ul style="list-style-type: none"> Flashbacks Nightmares 	Reexperiencing in the here and now <ul style="list-style-type: none"> Flashbacks Nightmares
Avoidance of traumatic reminders <ul style="list-style-type: none"> Avoidance of internal reminders Avoidance of external reminders 	Avoidance of traumatic reminders <ul style="list-style-type: none"> Avoidance of internal reminders Avoidance of external reminders
Sense of current threat <ul style="list-style-type: none"> Hypervigilance Exaggerated startle response 	Sense of current threat <ul style="list-style-type: none"> Hypervigilance Exaggerated startle response
	Affective dysregulation <ul style="list-style-type: none"> Increased emotional reactivity Decreased emotional reactivity
	Negative self-concept <ul style="list-style-type: none"> Belief that oneself is a failure Belief that oneself is worthless
	Disturbances in relationships <ul style="list-style-type: none"> Disconnection from others Difficulty feeling close to others
Symptoms must persist for several weeks Symptoms must cause significant impairment in functioning.	
Note. ICD-11 = International Classification of Diseases.	

Table 1. Description of ICD-11 Posttraumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD) [Hyland et al., 2023](#)

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Table 1 DSM-5 criteria for PTSD APA, 2022	
Trauma exposure	
A. Exposure	Actual or threatened violent death, serious injury or accident, or sexual violence
Via any of the following:	
1. Directly exposed to trauma	
2. Eyewitness (in person) to others directly exposed to trauma	
3. Learning of direct exposure to trauma of a close family member or close friend	
4. Repeated or extreme exposure to aversive details of traumatic event (eg, trauma workers viewing human remains or repeatedly exposed to details of child abuse, in person or via work-related electronic media)	
Symptom groups B to E (symptoms beginning or worsening after the traumatic event)	
B. Intrusion	≥1 intrusion symptoms:
1. Recurrent, involuntary, distressing trauma memories	
2. Recurrent, distressing trauma-related dreams	
3. Dissociative reactions/flashbacks related to trauma	
4. Intense or prolonged psychological distress to trauma reminders	
5. Marked physiological reactions to trauma reminders	
C. Avoidance	≥1 avoidance symptoms:
1. Avoidance efforts to avoid distressing internal trauma reminders (memories, thoughts, feelings)	
2. Avoidance or efforts to avoid distressing external trauma reminders (people, places, activities)	
D. Negative cognition and mood	≥2 negative cognition/mood symptoms:
1. Amnesia for important parts of trauma exposure	
2. Persistent, exaggerated negative beliefs about self, others, or the world	
3. Persistent, distorted trauma-related cognitions leading to inappropriate blame of self/others	
4. Persistent negative emotional state (eg, fear, horror, anger, guilt, shame)	
5. Loss of interest or participation in significant activities	
6. Detached/estranged feelings from others	
7. Persistent loss of positive emotions (eg, happiness, satisfaction, love)	
E. Hyperarousal	≥2 marked alterations in trauma-related arousal and reactivity:
1. Irritability and angry outbursts with little/no provocation (eg, verbal/physical aggression toward people/objects)	
2. Reckless or self-destructive behavior	
3. Hypervigilance	
4. Exaggerated startle	
5. Concentration problems	
6. Sleep disturbance (eg, difficulty falling or staying asleep, restless sleep)	
Additional criteria	
F. Duration	>1 month
G. Distress/impairment	Clinically significant distress, social/occupational/other important functioning impairment
H. Not attributable to another disorder	Independent of physiological effects of a substance (eg, medication, alcohol) or another medical condition
Source: Reference 3	

Quick review of CPTSD: PTSD and DSO

The *ICD-11* formulation of trauma differs from the *DSM-5* (APA, 2022) where a clear demarcation is made in the *ICD-11* between problems that are directly tied to the traumatic event (i.e., the PTSD symptoms), and problems in self-organization that can emerge or intensify following the traumatic event (i.e., the DSO symptoms).

In contrast, the *DSM-5* takes a “broad tent” approach where problems closely tied to the traumatic event and problems in self-organization (criterion D) are bound together within the same diagnostic entity.

This difference has an important theoretical implication.

By distinguishing PTSD and DSO symptoms so clearly, the *ICD-11* model implies that there must be distinct causal processes that give rise to these problems. From the perspective of the *ICD-11*, it is possible to have severe PTSD symptoms without DSO symptoms. From the perspective of the *DSM-5*, however, the trauma-specific and self-organization problems relate to the same underlying latent construct and therefore must co-occur and must be derived from the same causal process or processes.

APA GUIDELINES for Working with Adults with Complex Trauma Histories

DIVISION 56 (TRAUMA PSYCHOLOGY) OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION
AND THE INTERNATIONAL SOCIETY FOR THE STUDY OF TRAUMA AND DISSOCIATION (ISSTD)

APPROVED BY APA COUNCIL OF REPRESENTATIVES
AUGUST 2024

Why create a PPG for Complex trauma?

1. Heterogeneity within the category of traumatic life events
2. Inattention to contexts surrounding occurrences of traumatic events
3. Exclusion of psychological forms of trauma from the category of traumatic event
4. Overemphasizing specific diagnoses, particularly PTSD.

Does Requiring Trauma Exposure Affect Rates of ICD-11 PTSD and Complex PTSD? Implications for DSM-5 [Hyland et al., 2021](#)

Table 2
Bivariate Associations Between Each Traumatic Life Event in the ITEM and PTSD and CPTSD Diagnostic Status (N = 1,020)

Event	PTSD OR (95% CI)	CPTSD OR (95% CI)
Criterion A traumatic life events		
Diagnosed with a life-threatening illness	3.54 (1.70, 5.83)***	2.11 (1.08, 4.07)**
Someone close to you died or was ever injured	2.94 (1.94, 2.94)**	2.74 (1.72, 2.94)**
Someone close to you had a life-threatening illness or accident	1.21 (0.70, 2.09)	1.78 (1.12, 2.83)*
Life threatened with a weapon	2.97 (1.70, 5.20)***	3.19 (2.01, 5.06)***
Physical assault by a parent/guardian	2.26 (1.31, 3.90)**	2.62 (1.67, 4.10)***
Physical assault by a nonparent/guardian	2.25 (1.30, 3.90)**	2.95 (1.86, 4.66)***
Sexual assault by a parent/guardian	2.76 (1.12, 6.81)*	8.39 (4.43, 15.89)***
Sexual assault by a nonparent/guardian	1.61 (0.81, 3.19)	4.86 (3.00, 7.85)***
Sexual harassment (unwanted comments or behaviors)	2.08 (1.20, 3.59)**	3.05 (1.94, 4.78)***
Criterion A nonpsychological traumatic events		
Kidnapped or tortured	5.58 (2.76, 11.29)***	5.43 (2.94, 10.10)***
Witnessed extreme suffering or death	1.67 (0.94, 2.96)	1.97 (1.24, 3.14)**
Accident where your life was in danger	1.43 (0.78, 2.61)	2.64 (1.67, 4.18)***
Natural disaster where your life was in danger	3.15 (1.56, 6.36)***	5.09 (2.93, 8.84)***
Human-made disaster where your life was in danger	1.94 (0.88, 4.24)	4.05 (2.31, 7.09)***
Criterion A nonpsychological traumatic events		
Stalked by another person	4.13 (2.37, 7.21)***	4.03 (2.54, 6.41)***
Humiliated, put down, or insulted by another	2.20 (1.17, 4.15)**	5.46 (2.79, 10.70)***
Made to feel unloved, unwelcome, or worthless	2.53 (1.41, 4.54)**	8.36 (4.38, 15.95)***
Neglected, ignored, rejected, or isolated	3.10 (1.75, 5.49)***	6.67 (3.90, 11.41)***

Note. ITEM = International Trauma Exposure Measure; PTSD = posttraumatic stress disorder; CPTSD = Complex PTSD; OR = odds ratio; CI = confidence interval. The PTSD and CPTSD diagnostic status are based on symptom and impairment criteria only. Bivariate associations are statistically significant at: *p < .05. **p < .01. ***p < .001.

*Certain non-Criterion A events involving extreme fear and horror should be considered traumatic

[Veterans' risk factors for PTSD and CPTSD \[Murphy et al., 2021\]](#)

2025

Treating CPTSD: M & I

5

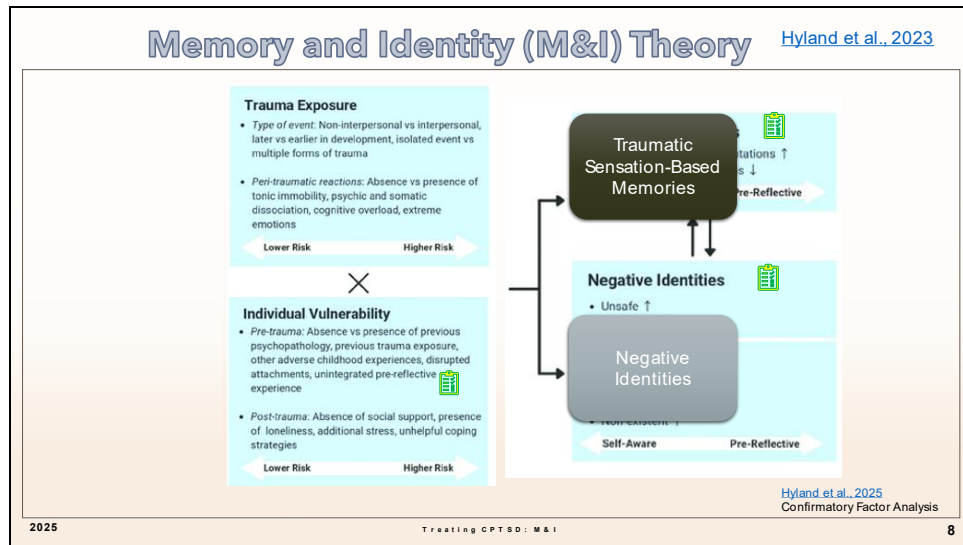
- This study was based on a nationally representative sample of noninstitutionalized Irish adults
- The ICD-11 approach of providing clinical guidance rather than a formal definition offers a viable solution to some of the problems associated with the current and previous attempts to define traumatic exposure.

Slide 7

Treating
CPTSD with
Empirically
Supported
Theory

To understand how our clinical interventions can directly address CPTSD, a theory needs to explain how exposure from multiple traumatic events increases risk of CPTSD and outline mechanisms of trauma symptoms and model causal pathways in relation to each individual symptom.

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The M&I theory posits that there is a higher risk for meeting criteria for PTSD or both PTSD and DSO (i.e., CPTSD) if there are multiple forms of trauma, occurs earlier and interpersonally in development, and if during the trauma, the individual freezes, psychically and somatically dissociates, occurring with extreme emotions and cognitive overload and THAT RISK can MULTIPLY with pre-trauma psychopathology, trauma exposure, other ACEs, attachment wounding, and unintegrated pre-reflective experiences (or multisensory bodily and affective signals that they are unable to put into words; Vandekerckhove & Panksepp, 2009).

Traumatic Memories

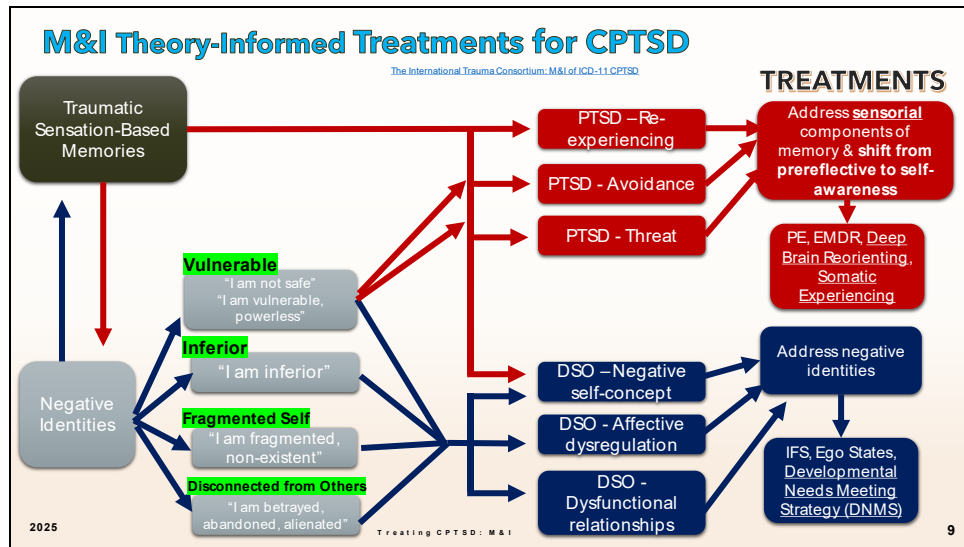
In comparison to pre-reflective experiences, **Self-awareness experiences** 😊 develops later in childhood; part of health identity development- involving meta-awareness of our conscious state and permitting **a sense of coherence among various parts of the self**

Per the prereflective and self-awareness experience continuum, intrusive memories in PTSD reflect the dissociation between perceptual memory (involving high absorption of vivid, detailed traumatic imagery, sensation-based) and episodic memory that would dictate context and integrate with adaptive knowledge; resulting in our classic ICD-11 PTSD symptoms of re-experiencing, avoidance, and sense of current threat.

With little contextual and adaptive information – heightened engagement of the body via absorption of sensation-based memories results in pervasive affective dysregulation

This dysregulation can account for either :

- The inability to control an already activated state (mobilization; fight/flight) via the under regulation of the prefrontal cortex to modulate amygdala reactivity or
 - the inability to experience normal emotions (immobilization; freeze) via the overregulation of the prefrontal cortex onto amygdala activation. This excessive shutdown can increase the likelihood of dissociative responses affecting both the mind and body (e.g., similar to those with PTSD, dissociative subtype in *DSM-5-TR*).
-
- **Before we jump into the theorized negative identities...we'll see on the next slide...**



As discussed, the sensation based-memories load onto the PTSD criteria, in addition to the DSO negative self-concept criterion, since non-criterion A traumatic events, e.g., rejection, humiliation can cause beliefs such as I am worthless. [CLICK]

Here, the MI theory is structured into 4 latent Negative Identity factors: Vulnerable, Inferior, Fragmented Self, and Disconnected from Others. [CLICK]. Vulnerable loads onto PTSD avoidance and threat, and [CLICK] the rest load onto the DSO symptom cluster, accordingly.

When considering these identities, perhaps we are reminded of our stuck points in CPT or our negative cognitions in EMDR therapy. [CLICK]

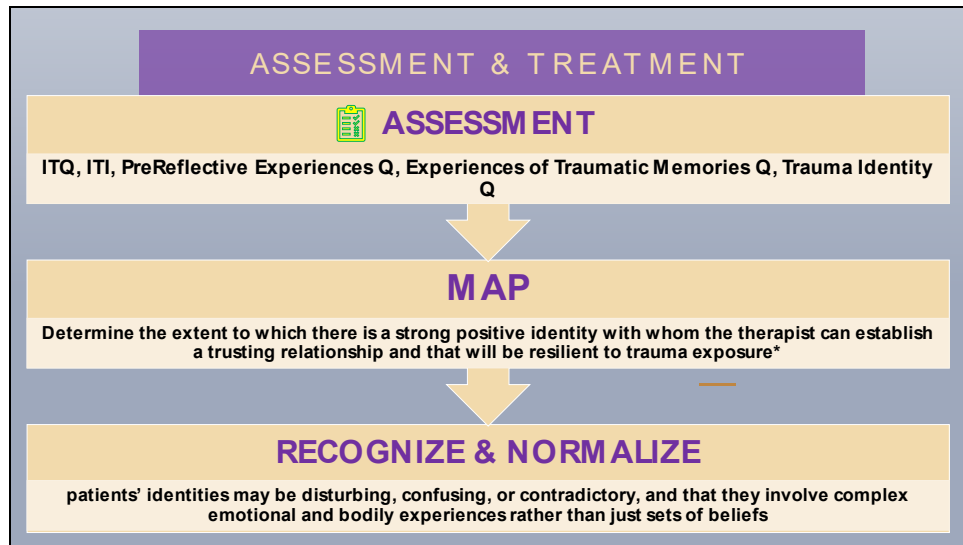
There is a considerable bidirectional relationship between trauma memories and negative identities, such that the two PTSD and DSO symptom clusters are reflexive.

The MI theory models which negative identities map onto which criterion; notable for understanding how our treatment interventions will address the individual symptoms of both PTSD and DSO criterion of CPTSD.

Notably, our frontline EBPs for PTSD contain elements of exposure; however, mere exposure may not be enough. The MI theory posits that treatments must address how trauma is stored in the body, e.g., EMDR is known for its focus on somatic responses during and in between therapy sessions, DBR focuses on pre-affective shock (the "alarm metaphor we talk about") from activity in the periaqueductal gray, especially if our veterans score high on the Experiences of Traumatic

Memories and Prereflective Experiences measures. By having a better idea of which veterans may need more attention to how features of their index trauma is stored in their body, our treatments will then be geared to somatic interventions, e.g., body awareness/ scanning, pendulating from tension to ease- in Somatic Experiencing.

Similarly, depending on our veterans' scores on the Trauma Identity Questionnaire, we will have a better idea of the likelihood of the # of, and type of negative identities to direct our interventions, which can be beneficial as these treatments listed can be integrated with many treatments, in addition to those listed above, or used as a standalone.



, as well as inquire about the presence of other, more vulnerable identities.

*Recognition and normalization of the fact that

; this can play a valuable role in strengthening the therapeutic relationship.

TREATMENT PHASES I - III

Phased based if there is presence of a strong prereflective element*

- I. **Goal with PHASE I**
 - I. Increase positive identities; link negative identities to relevant experiences; thereby, increasing predictability
- II. **Goal with PHASE II**
 - I. Exposure to traumatic memory with key sensory information (e.g., sights, sounds, smells, bodily sensations) for *sufficient time to create new representations that are linked to an alternative context.*

bringing the memory to mind is only of value if the patient remains in a state of self-awareness and is not overwhelmed by pre-reflective self-experience
- III. **Goal with PHASE III**
 - I. Increase the *retrieval* strength of positive identities relative to negative identities

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Goal with PHASE I : is to help patients develop a model to increase positive identities; make intrusion of aspects of their negative identities more predictable and linked to relevant experiences → thus, providing a context that gives events meaning. The extent to which positive identities can be quickly restored to high levels of accessibility or must be nurtured over a relatively long period is likely to depend on the patient’s attachment history.

Goal with PHASE II:

Goal with Phase III...

So starting with Phase I

PHASE I: Fragmentation of Self

STRUCTURAL DISSOCIATION MODEL

Defense System
When a child is abused, their defense system will naturally work to shield them from harm, BUT ...

Attachment System
... their attachment system will still want to be loved and cared for by the parent.

✖

This creates an internal tug-of-war where different motivational systems are working against each other simultaneously.

This can cause a patient's conflicting parts to separate. That can lead to a split in their sense of self and a dysregulated nervous system.

Which identity am I working with (which age from trauma)?

Figure 20.1. Resistances to the Integration of Traumatic Memories

- Traumatic memory
- Conflicts and threats
- Phobia of traumatic memory
- Phobia of dissociative parts
- Phobia of inner experience
- Phobia of therapeutic relationship

Increasing 'amount' of dissociation →

Absorbed States	Hypnotic phenomena	Dissociative Amnesia	Dissociative Identity Disorder
Daydreaming	Depersonalisation disorder	Somatization disorder	
Transient depersonalisation	PTSD	Complex PTSD	Borderline Personality Disorder