

**The Update on CPTSD: Is it a Distinct Disorder that Requires Different Treatment?**

by

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### Abstract

This capstone explores the experiences of complex trauma and whether CPTSD is a distinct diagnosis that needs attention. The focus will remain on CPTSD as a construct with adults. Although there is growing awareness of complex trauma and literature on being trauma-informed across several fields, many individuals and communities go unsupported in addressing and understanding the symptoms of CPTSD. Very few have access to trauma-specific treatment that considers the unique aspects of CPTSD, including attachment, developmental, and long-term trauma symptoms. The research is complicated and limited in understanding CPTSD since its recent inclusion in the ICD-11 as a new development; testing of assessments and treatment modalities are just beginning to assess for validity and reliability. Previous to the ICD-11, there has been a variety of definitions and explanations of what CPTSD is, which adds to the confusion. Although these are discussion points in the literature, there is limited information on the impact on clients and whether our treatments can be effective. Many argue for and against CPTSD as distinct, and do not see a need for treatment that differs from what is already available. This capstone looks to understand the complications of determining CPTSD as distinct and developing or applying specific treatments through a socio-ecological, developmental, and attachment-based lens. These therapeutic modalities seek to understand individuals within multiple moving contexts and environments that influence their trauma, development, attachment systems, and CPTSD symptoms and treatment. Tailored treatment, community support, psychoeducation, and ethics are pillars to better understanding how to approach CPTSD. This capstone highlights the need to include the voices of those with CPTSD and the therapists who provide treatment for complex and developmental forms of trauma to address the barriers to accessing appropriate care and diagnosis. Social justice and appropriate treatment can help to ensure that individuals feel seen and supported in healing and navigating their journey with trauma.

*Keywords: Complex Post Traumatic Stress Disorder, complex trauma, socio-ecological model, attachment, treatment.*

**Table of Contents**

Acknowledgement .....	ii
Abstract.....	iii
Chapter 1: Introduction.....	1
Introduction.....	1
Research Problem Statement .....	4
Rationale .....	6
Contribution to the Field of Counselling .....	7
Theoretical Framework.....	10
Positioning Statement .....	12
Definition of Key Terms .....	14
Summary Conclusion.....	16
Outline of Chapters.....	16
Chapter 2: Literature Review.....	18
Introduction.....	18
Literature Review Methodology .....	19
Developmental Attachment Theory .....	21
Socioecological Theory .....	22
Difference Between CPTSD and PTSD or BPD .....	23
Causes .....	23
Symptoms .....	28
Physical Differences .....	32
CPTSD Requires Different Treatment.....	34

Conceptualization and Measurement of CPTSD .....	37
Ethical Considerations .....	40
Critical Analysis of the Literature.....	42
Chapter Summary .....	43
Against Distinction .....	44
Supporting Distinction .....	45
Chapter 3: Summary, Discussion, Recommendations and Conclusions.....	49
Summary of Findings.....	49
Discussion.....	49
Recommendations.....	52
DSO Symptom Considerations .....	54
Negative Self-appraisal.....	54
Emotional Regulation .....	56
Relationship Difficulties .....	57
Limitations of the Capstone .....	60
Intersection Consideration .....	62
Conclusion .....	63
References.....	65

## **The Update on CPTSD: Is it a Distinct Disorder that Requires Different Treatment?**

### **Chapter 1: Introduction**

#### **Introduction**

Clients deserve to have an accurate assessment of their symptoms and treatment that meets their needs. Misdiagnosis risks potential trauma and limited healing. Complex PTSD has recently become a diagnosis; however, there is an argument as to whether CPTSD is distinct or a combination/severity of other disorders; this may lead to misdiagnosis. Complex Post-Traumatic Stress Disorder (CPTSD) is a diagnosis included in the eleventh version of the International Classification of Diseases (ICD-11), published in 2019 (World Health Organization, 2019). However, Judith Herman proposed this concept in 1992 (Dyer & Corrigan, 2021; Kwon, 2022). In Herman's pioneering work on the subject, she highlighted the difference between Post Traumatic Stress Disorder (PTSD) and CPTSD by identifying that complex trauma uniquely occurs as a result of prolonged and repeated trauma, during which the individual is in captivity and under the control of the perpetrator (Herman, 1994).

The ICD-11 characterizes CPTSD using three symptom clusters in addition to PTSD criteria: affect dysregulation, negative self-concept, and difficulty maintaining relationships (11th ed, ICD-11; World Health Organization, 2019). An evolving body of research identifies and considers many additional symptoms and proposes unique causes of CPTSD. There are arguments for and against CPTSD being a distinct disorder. The main arguments against official classification are that there has been a historical lack of clarification about several elements of CPTSD and that there is not enough research to support CPTSD as being a disorder separate from a combination of PTSD and Borderline Personality Disorder (BPD) or a grouping of PTSD

(Powers et al., 2022). Research conducted both prior to ICD-11 classification and since has aimed to prove the differences among these disorders and thus support CPTSD as a distinct disorder.

After years of working in the school system and supporting children and their families, I have observed a lack of trauma-informed care and treatment for children and adults experiencing complex trauma. I saw many parents experiencing symptoms of complex trauma and a lack of support from the community and appropriate therapy that addressed the roots of their symptoms. These observations led to curiosity about complex PTSD as a construct and diagnosis. Most parents and individuals I worked with in counselling had few funds and resources, limiting their treatment options to non-profit or sliding scale therapy. Many of these options, including myself as a therapist, involve therapists who are not appropriately trained in trauma-informed or trauma-specific counselling.

CPTSD has been contested in the research, questioning its validity, reliability, and applicability. Some main arguments have examined different causes, symptomology, severity, and physical differences in CPTSD patients. In regard to treatment, there is added complexity with CPTSD being newly existent in the ICD-11 that there is limited data on successful treatment with CPTSD, and many propose that treatment for PTSD that already exists will be enough (Karatzias et al., 2019; Melegkovitis et al., 2022). There remains an argument in the literature about the lack of effective research into CPTSD treatment, which contributes to the confusion about whether CPTSD requires different treatments. In one review of research, they found low study quality with CPTSD clients with missing control groups and a lack of significant differences comparing PTSD and DSO symptoms (Purnell et al., 2021).

There is also the question of treatments that have been proposed, like the phase-based approach to trauma treatment. Judith Herman, who originally came up with CPTSD, recommended phase-based treatment; however, it lacks evidence, and there is disagreement among practitioners about the necessity of certain phases (Herman, 1994). Several studies in the review by Purnell et al. (2021) found significant differences in PTSD and DSO measures, enhancing the argument that the same treatment can improve symptoms for both disorders. Researchers have questioned treatment due to a lack of randomized controlled trials, influenced by CPTSD not being an official diagnosis until recently, lack of control groups and appropriate follow-up to treatment; however, some conclude that phase-based approaches are practical for PTSD and complex trauma and suggest effectiveness for CPTSD (Coventry et al., 2020; De Jongh et al., 2016).

One study found that both PTSD and CPTSD more often had fearful and avoidant attachment styles (Karatzias et al., 2022). However, when re-investigated post-ICD-11, fearful and avoidant attachment styles had a greater association with DSO (Disturbances in the self-organization) symptoms in CPTSD than PTSD and were more severe in PTSD patients with childhood trauma (Karatzias et al., 2022). In understanding from a treatment perspective, the treatment previously proposed of using an attachment framework with PTSD patients demonstrating these results would be the same for those with these attachment styles and CPTSD (Barazzone et al., 2019; Karatzias et al., 2022). Now that there are CPTSD symptom clusters to compare to, there is conflicting evidence around PTSD. Suppose some of the studies did not measure DSO symptoms in their study and found results for PTSD patients. In that case, these patients may have fit the diagnostic criteria for CPTSD, limiting the study results and skewing the results without comparison. The newest study by Karatzias et al. (2022), compared to their

study in 2019, highlights those new measurements, including CPTSD symptoms, found differences in secure and fearful/avoidant attachment styles for PTSD and more insecure and fearful attachment for CPTSD patients (Karatzias et al., 2019; Karatzias et al., 2022). Others argue that there are marked differences in CPTSD and propose a need to develop and test interventions; for example, Greenblatt-Kimrom et al. (2023) found that early maladaptive schemas in CPTSD patients were associated more significantly with symptom clusters of CPTSD than PTSD. Overall, there is still limited data on CPTSD treatment in comparison with treatments for PTSD. Since CPTSD has added components, there may be significant improvement still in the PTSD symptoms of CPTSD with these treatments, adding layers of complexity to understanding if CPTSD requires different treatments.

With the ICD-11's focus on clinical utility, the focus on symptoms can make it challenging to apply the differences that may appear with different types of trauma. Part of the argument for CPTSD is that it stems from a different type(s) of trauma than PTSD. Several argue that the definitions are too broad and are difficult to apply to understanding and treating CPTSD differently (Resick et al., 2012; Wolf et al., 2015). Through one latent class analysis, there is an argument that there is insufficient evidence for the construct validity of CPTSD (Achterhof et al., 2019). The arguments dissipate into understanding the symptoms, causes, and severity of CPTSD, which will be examined to understand whether CPTSD is distinct and requires different treatment.

### **Research Problem Statement**

CPTSD is a diagnostic construct that has been a topic of conflict in the research. Understanding CPTSD and whether it is distinct can help counsellors to understand and gain appropriate training in trauma-specific care. Understanding CPTSD may help inform our

approach to client and community care that considers unique aspects of complex trauma across developmental and ecological domains. The research is divided into themes that examine whether CPTSD is distinct by looking at different causes, symptomology, and physical differences in CPTSD patients. With this information, it is vital to evaluate whether CPTSD would require unique forms of treatment given the present differences. My primary research question examines: Is CPTSD a distinct disorder from PTSD and BPD? My secondary research question inquires: Does CPTSD require different treatment than PTSD?

There may be a lack of accessibility to trauma-specific care and treatment, and several barriers to accessing therapists who have adequate training. The question remains: Can further training and understanding of CPTSD help inform our approach to client care, treatment, and community care that upholds environments that nurture attachment and development? With the knowledge we have on CPTSD, can we work towards prevention and treatment measures that are appropriate for the deep-rooted trauma in CPTSD clients? The clients who experience CPTSD or comorbidity of PTSD and other disorders may not be getting the assessment and treatment required for healing. Without addressing the contention of the CPTSD debate and examining treatment, clients will continue to experience misdiagnosis and a lack of support. They could experience retraumatization or poor treatment outcomes without treatment tailored to their symptoms, presentations and experiences.

Since 2019, there has been further research on CPTSD, and various attitudes and research ideas have come forth regarding better diagnosis of CPTSD and how to provide effective treatment. The research is still lacking in comparison to other disorders, and it still receives limited acknowledgement by the DSM, which is used primarily in Canada and the USA for diagnosis. Since the USA and Canada account for a large percentage of evidence-based research

globally, this influences the spotlight that CPTSD gets. There are also limited tools to compare and contrast disorders across the ICD and DSM (Achterhof et al., 2019). Further analysis of the research done so far and evidence of the distinct nature of CPTSD can shed light on how we can move forward in learning appropriate and effective CPTSD treatment. There is still limited data on CPTSD patients, as many have comorbidities and do not have an official diagnosis, making it difficult to assess the differences. However, with some new diagnostic tools, we can further assess whether CPTSD is a distinct disorder and if it does need a different treatment than treatment for PTSD or BPD, the disorders it is most often compared to. By clarifying whether CPTSD is distinct, we take the first step in identifying the gaps in treatment for this population. Rink & Lipinska (2020) posit that in establishing a distinction between PTSD and CPTSD, there emerges a need to test different treatment options. Some experts have recommended specific approaches or treatments for engaging with CPTSD, such as person-centred care and trauma-informed intake and assessment that is inclusive of complexities like detachment, dissociation, and self-perception (Ford & Courtois, 2021; Rosada et al., 2021). Research suggests that in uniquely classifying CPTSD, there is a strong possibility of a shift in treatment emphasis from reprocessing and rescripting toward reducing symptoms of DSO and ongoing flexibility with various treatment options (Greenberg, 2020; Rink & Lipinska, 2020).

### **Rationale**

The challenge has been that with ongoing definitions that reference childhood trauma, developmental trauma, and complex trauma, it is difficult to ascertain which studies are referring to clients who would fit the current definition of CPTSD. Landy et al. (2015) identified that a significant challenge faced by the movement to classify CPTSD as a distinct disorder has been a lack of clarity regarding its definition, owing to inconsistencies in several areas, including

symptoms, causes, and the meaning of the term 'complex trauma' (Landy et al., 2015). Landy et al. (2015) argued that the addition of specific diagnostic criteria and changes to the DSM-5 in the areas of PTSD and personality disorders was sufficient to capture the symptom domains of CPTSD, negating the need to add the latter to the DSM as a distinct disorder.

Some argue that this unclear definition of CPTSD in some way proves that it is not a distinct disorder but a comorbidity of other disorders (Giourou et al., 2018). Giourou et al. (2018) also raised the question of whether some psychiatric diagnoses need to be evaluated and possibly regrouped based on new insight, whether or not CPTSD needs its distinct diagnosis, or whether current trauma disorders criteria need to be reassessed and possibly expanded to incorporate features of CPTSD currently missing.

Resick et al. (2012) pointed out that overlap in symptomatology does not disprove CPTSD as a distinct disorder; for example, there are many examples in medicine of "separate classifications of syndromes that symptomatically appear quite similar (e.g., influenza and the common cold)" (p. 246). However, Resick et al. (2012) also argue that there are insufficient numbers of studies showing CPTSD causes and processes to be distinct from traumas linked to PTSD. They highlighted a lack of controlled studies examining the impact of treatment on CPTSD, which made it difficult to form any definite conclusions about effective treatment options for CPTSD (Resick et al., 2012).

### **Contribution to the Field of Counselling**

Diagnosis, specifically CPTSD diagnosis, is relevant to how I and other practitioners may address client assessment, intake, and treatment. Farina et al. (2019) observed that a history of cumulative trauma, CPTSD and comorbidity creates unique treatment difficulties for clinicians. Although counsellors are not responsible for the diagnosis and maintenance of medication,

understanding mental illness, diagnosis, and medication is important to develop appropriate treatments and risk assessments with clients. Psychopathology research is key to developing theories and treatment interventions that effectively reduce symptoms and promote well-being (Maddux & Winstead, 2019).

It is ethical for counsellors to learn about mental illness and research in order to be effective therapists who make their best effort not to harm. A part of understanding and working with CPTSD is understanding the potential causes and risk factors for developing CPTSD. In a qualitative study on therapeutic errors, Yazdian & Khodabakhshi-koolae (2024) found that therapist errors and lack of compliance with ethical standards were factors in negative experiences for clients. The first issue was a failure to establish a treatment relationship. Before attempting treatment, therapists need to be mindful of creating a treatment relationship that is autonomous, transparent, and warm before engaging in specific treatment. Clients with complex trauma may come in with shame and attachment challenges, and if counsellors are not aware of these, they can inadvertently increase shame and further attachment wounding. Although the research disregards the type of trauma, cultural factors, and trauma severity, these factors influence the therapeutic relationship. Therapists need to have sensitivity to the trauma and attachment wounding that a client is bringing.

Riedl et al. (2024) found in their population study of 1918 participants, 1.5% of whom had a diagnosis of CPTSD; most CPTSD patients had accessed mental health treatment and reported less symptom improvement. The study hypothesizes that lower levels of trust were associated with high levels of CPTSD symptoms (Riedl et al., 2024). Trust is essential in the therapeutic alliance, and it is relevant to understand a population of clients who may not have adequate support at this time due to a lack of trust and effective mental health treatment;

therapists need to understand how to approach mistrust and symptoms of CPTSD to work with clients who have experienced trauma effectively. Many clients with CPTSD have experienced relational trauma, which will show up in the therapeutic relationship with potential mistrust, anger, transference, and attachment challenges, which is clinically relevant to utilizing a collaborative approach in therapy (Greenberg, 2020).

CPTSD emotion dysregulation needs a therapeutic understanding of its underlying mechanisms instead of marking dysregulation as resistance (Bryant, 2010). Understanding CPTSD can lead to effective psychoeducation about the impacts of trauma on emotional function and how to become aware of emotions (Sookman & Leahy, 2009). Overall, many clients with CPTSD may have experiences of interpersonal violence and may experience ruptures and derailment in the therapeutic process. Therapists need to understand how to work with numbness and overwhelming emotional effects to process ruptures in a way that does not cause further harm (Sookman & Leahy, 2009). Understanding CPTSD is relevant to upholding ethical and culturally appropriate counselling for clients. Understanding whether CPTSD is distinct, a comorbidity of other disorders, or an extension of PTSD is vital to further developing and testing appropriate treatment methods.

Psychotherapy itself was developed primarily by white, middle-class men and focused mainly on white, middle-class heterosexual individuals (Greenberg, 2020). Funding, the pharmacological industry, and pioneers in theory development who want to prove their therapy is successful heavily influence our research today. Concerning CPTSD, it is vital to keep in mind that cultures may describe emotions, emotional expression and discussion of trauma differently than the Westernized ideas (Greenberg, 2020). In one systematic review of sex and gender in PTSD, only 12 of the studies reviewed utilized a non-binary category, and several studies did not

assess for gender or sex differences (Lonnen & Paskell, 2024). The research defines the categories of identity differences, such as gender, and the resulting exclusion of particular identities reflects potential covert microaggressions of the researchers. Understanding whether CPTSD is distinct or not and the treatment options need consideration of culture, ethics and societal norms in addressing and treating mental illness. Our clients are interwoven in the medical and psychological systems that utilize diagnostics for access to insurance, medication, and counselling treatment options. A client's treatment is dictated by the research and funding currently available. We need to understand the diagnosis and how the systems in place may interact with this diagnosis and oppress or support an individual's treatment. Understanding of trauma and potentially CPTSD, if distinct, is a step towards being able to advocate and best support our clients.

### **Theoretical Framework**

CPTSD tends to be a higher severity and is associated with earlier onset and familiarity with the perpetrator, linking CPTSD development to trauma that occurs during key developmental periods earlier in life (Guzman et al., 2023). Complex trauma can involve multiple traumatic events of an interpersonal nature over time (Chambers et al., 2024). Many individuals with complex forms of PTSD or CPTSD have resulted from childhood trauma, which is why it is important to incorporate the understanding of developmental trauma and theory to understand if CPTSD is a specific disorder requiring unique treatment. Developmental trauma also relates to attachment trauma, which is more commonly associated with CPTSD (Doychak & Raghavan, 2018). Traumatic early-life incidents impact development and the ability to maintain and form secure attachments (Chambers et al., 2024). To understand the best forms of treatment, we can explore developmental and attachment-related challenges. Developmental trauma theory

aims to understand complex trauma by examining sensitive periods of child development, interpersonal attachment, individual safety operations and impacts on cognitive, behavioural and emotional levels for an individual (Cruz et al., 2022).

Attachment theory relates to understanding CPTSD, given that many with CPTSD have experienced childhood and relational trauma (Ford & Courtois, 2020). Attachment is part of an infant's innate biological adaptive systems to a guardian involved in their care (Siegel & Siegel, 2001). The infant uses this attachment to experience closeness and safety; the adult will soothe the child's distress. Consistent soothing helps to develop an internal working model of safety and security, which assists the child to explore the world, self-soothe, and experience a secure base (Bowlby, 1969). In a study on attachment styles and adolescents across different countries, the researchers found that attachment-related adverse childhood experiences were significantly related to CPTSD, and fearful attachment was related to PTSD and CPTSD in the research (Ferrajao et al., 2024). Greenblatt-Kimron et al. (2023) highlight that several literature reviews show a direct association between childhood trauma and PTSD. Childhood trauma is also significantly associated with attachment difficulties (Van der Kolk et al., 2019). Utilizing an attachment framework directly relates to the perception and use of the therapeutic relationship with clients. Understanding how CPTSD, if distinct, influences attachment can help counsellors make informed decisions about treatment and the use of relationships in therapy.

The secondary theory used to approach this paper and understand the research is Bronfenbrenner's socioecological model. Bronfenbrenner's model seeks to understand individuals and their symptoms through the multiple levels of influence in a person's life (Crawford, 2020). Counsellors can utilize the socioecological model to understand risks and positive factors in a person's life concerning complex trauma, specifically the six core systems that Bronfenbrenner's

model utilizes. The microsystem is related to immediate settings and relationships, while the mesosystems are the interactions among those different microsystems (Crawford, 2020). Following outwards towards larger systems, the exosystems are settings without direct influence, and the macrosystem can be cultural patterns or norms (Crawford, 2020). These systems can include understanding developmental processes and many other influences in an individual's life, including trauma-related systems. This interactive model allows for further exploration, especially concerning the complexity of trauma and the diverse range of symptomology and reactions to various kinds of trauma.

### **Positioning Statement**

I have a personal and professional interest in this research topic. My professional work currently is at a non-profit in Victoria; many clients who come in for low-income counselling have experienced severe forms of trauma, specifically in childhood. Before volunteering at a non-profit, I worked with children and families through the school system. I saw many families struggle with domestic violence, generational trauma, trauma through the school system, a lack of trauma-informed care and varying levels of systemic and interpersonal violence. The school system had limited information and resources on how to be trauma-informed, and there was a limitation on who had access to support depending on the diagnosis. Although I have witnessed the stories of trauma from these individuals, I have also found that there was little support in the community to address complex trauma and a lack of appropriate training for understanding PTSD and treatment.

Many families and schools want to support themselves, their children and their community but lack the resources and support to develop a community that is trauma-informed and nurturing to one another. I hope that with this capstone, I can bridge some gaps in my

understanding of trauma treatment and CPTSD and utilize this information to become trauma-informed in my counselling; moving ahead in my career, I want to utilize trauma treatment modalities that have been found helpful for complex forms of trauma. I want to be an empowering support to clients, and this starts with understanding the complexities of trauma and treatment. It can be a place of advocacy for me as a practitioner within Bronfenbrenner's model of systems.

Before I came into counselling, I had struggles with my mental health and managing the symptoms of my trauma. My experiences of complex trauma were normal to me, and I thought that this was what everyone experienced, especially from a do-not-ask, do-not-tell community or other children experiencing poverty and trauma. I did not recognize that what happened was not normal family dynamics until my abuse and neglect class in my first year of university. The trauma influenced my Micro, Meso and Exosystems in my family and community. My worldview is also influenced by being a white, cisgender Canadian who has access to higher education. Privileges I have influenced my worldview daily from these factors. In part due to my privilege, I had access to mental health care when I needed it and found it easy to find a trauma therapist who 'looked' like me. I have the privilege of living on the lands of the Songhees, Esquimalt and W̱SÁNEĆ peoples, and I acknowledge that I live on these lands without the added barriers of racism and colonialism that First Nations individuals have to experience.

My experiences in the medical and medical system were difficult and disempowering, and I want to be a therapist who can be empowering and advocate with my clients for the support they need. I value education as a method of learning knowledge and taking a growth mindset in my personal and counselling work. I hope this paper is another opportunity to understand myself better, my biases, and how I want to approach my work. I must be mindful of my transference,

which can be present when resonating with articles and disagreeing with others. I need to be critical in analyzing the information and taking care of myself as I process the different symptoms and changes that come with CPTSD; I can be aware not to take findings at face value and evaluate who is being researched and their applicability across cultures and systems. I want to remain open-minded to discovering further information and possibilities in this research, and I recognize my hope for CPTSD to be distinct as it matches my experiences with diagnosis and the need for unique treatment.

I will need to be mindful of my personal and professional biases based on the experiences I have had with complex trauma thus far. Developmental, attachment and Bronfenbrenner's social ecological models will be utilized to understand the research and how it can integrate into understanding and treating CPTSD if it is a distinct disorder. As I gain further understanding, my counselling practice and further development will be deepened through this project.

### **Definition of Key Terms**

- **Borderline Personality Disorder:** BPD is a mental health diagnosis in the DSM-5 and ICD-11 that is characterized by mood instability, variations in self-images and unstable relationships. People with BPD tend to struggle with feelings of abandonment, emptiness, intense emotions and impulsivity. The criteria involve unstable interpersonal relationships with extreme ideation and devaluation, unstable self-image, impulsive, self-damaging behaviour, including suicidal behaviour, and mood instability, including frequent anger (Chapman et al., 2024).
- **Childhood Developmental Trauma:** Is referred to as a combination of disruption in attachment with the primary caregiver and traumatic interpersonal victimization (Ford, 2021). This type of traumatization is associated with affective, behavioural, and relational

dysregulation and is linked to both PTSD and CPTSD (Ford, 2021). Childhood developmental trauma is often cumulative and rarely results from a single traumatic experience—child abuse and adversity in childhood result in developmental impairment across several developmental domains (Cloitre et al., 2009).

- **Complex PTSD:** According to the ICD-11, three symptom clusters characterize CPTSD in addition to PTSD symptoms: affect dysregulation, negative self-concept, and difficulties in maintaining relationships (11th ed, ICD-11; World Health Organization, 2019). CPTSD can refer to trauma(s) that are more prolonged, complex, and repeated with an inability to escape, which can involve sexual abuse, child abuse, neglect, and interpersonal victimization (Cloitre et al., 2012; Dyer & Corrigan, 2021; Ford & Courtois, 2020). CPTSD meets all criteria for PTSD and, in addition, includes symptoms of affect regulation difficulty, negative beliefs about oneself and relationship challenges (World Health Organization, 2019). CPTSD requires the presence of at least one symptom from each of the original PTSD clusters of reexperiencing, avoidance, and hyperarousal, along with the presence of DSO symptoms (Ford & Courtois, 2020).
- **Disorders of Extreme Stress Not Otherwise Specified:** DESNOS is a historical understanding of CPTSD. Before CPTSD was proposed for the DSM-5, DESNOS was suggested for the DSM-IV; however, it was denied by the World Health Organization due to the high comorbidity with PTSD. DESNOS has the same symptoms of CPTSD, including relational impairment, affect dysregulation and identity alterations and is associated with childhood trauma (van Dijke et al., 2018).
- **Disturbances in Self Organization:** DSO refers to the additional symptom categories to PTSD that make up CPTSD. These symptom groups are difficulties with emotion

regulation, relationships and a negative self-concept. These symptoms are characterized by dysregulation, avoidance in relationships and negative beliefs about oneself as bad, broken, or a failure (Maercker, 2021).

- **PTSD: Post-Traumatic Stress Disorder (PTSD):** can develop from being exposed to threatening or horrific events, otherwise known as trauma. These events typically involve exposure to serious injury or violence (5th ed.; DSM-5; American Psychiatric Association, 2013). According to the ICD-11, PTSD is characterized by reexperiencing of the trauma, overwhelming emotions, somatic symptoms and avoidance of reminders of the trauma (World Health Organization, 2019).

### **Summary Conclusion**

Through preliminary research, there is apparent disagreement about whether CPTSD is a distinct disorder, a comorbidity of other disorders or a severe form of PTSD. There are gaps in the research on CPTSD treatment, given the new diagnosis in the ICD-11, although CPTSD has been discussed since 1994. There is an emphasis on exploring treatment for CPTSD and proving its validity and reliability in the research. The current literature will be explored to evaluate whether CPTSD is a distinct disorder that may require different treatment. Having this information clarified can help counsellors better understand CPTSD and the unique implications for client assessment and treatment planning. This paper aims to explore the literature further in a way that provides a further understanding of CPTSD as a construct and diagnosis, as well as apply this understanding under a developmental and socioecological lens to counselling practice.

### **Outline of Chapters**

Chapter two will first explore complex CPTSD as a construct and the efforts made to validate CPTSD thus far. Then, a comprehensive review of the current research on CPTSD and the arguments for and against CPTSD regarding causes, symptom severity and physical differences will be explored. This chapter will critically examine the ethical and cultural considerations in understanding and validating CPTSD and identify any limitations and gaps. Chapter two also evaluates the current research methods on CPTSD and validation measures being tested. In chapter three, key findings around treatment for CPTSD and the research thus far on whether different treatment is needed will be explored and transferred to practical recommendations for treatment through attachment-based, developmental, and social-ecological lenses. This capstone lays the foundation for understanding if CPTSD is distinct and what treatment it will require, and examines the current gaps in support and understanding that need to be addressed. Given the current research on CPTSD, treatment considerations, including Accelerated Experiential Dynamic Psychotherapy, will be explored. Considerations are made about the benefits and limitations of diagnosis, clinical utility and treatment implications. Overall, CPTSD needs to be understood in the context of counselling as a disorder or not, to be able to adequately conceptualize clients and plan for treatment, including exploring symptoms, causes, and psychological changes in CPTSD.

## Chapter 2: Literature Review

### Introduction

This capstone aims to provide an overview of Complex PTSD and to evaluate whether or not Complex PTSD is a distinct disorder. The capstone will look at differences in causes, symptoms, risk factors, neurological and physical implications, and treatment of CPTSD. I will then highlight arguments for and against classifying CPTSD as a separate diagnosis. The International Trauma Questionnaire (ITQ) will be explored as it is the primary assessment tool for CPTSD. The gaps, limitations and treatment methods used currently in the literature will be evaluated, and recommendations for future research will be put forth.

There is limited data on CPTSD patients, as it has only recently become an official diagnosis and patients with comorbidity can be excluded from studies. For this reason, data on complex trauma and child abuse victims are sometimes included in the absence of CPTSD data, as these patients align most closely with people with CPTSD. By exploring the literature, we can identify if prevention and treatment measures are appropriate for CPTSD clients. The clients who experience CPTSD or comorbidity of PTSD and other disorders may not be getting the assessment and treatment required for healing. Without addressing the contention of the CPTSD debate and examining treatment, clients will continue to experience misdiagnosis and a lack of support. They could experience retraumatization or poor treatment outcomes without treatment tailored to their symptoms, presentations and experiences.

While there is research on CPTSD and the diagnosis process, there is still a lack of information about how our understanding of this diagnosis can influence therapeutic support for its unique aspects; the supports needed at an individual and community level need to be understood. There is still an immense focus on whether CPTSD is a distinct disorder, and limited

data on its clinical utility in practice. Many therapists offer trauma-informed counselling. However, people with CPTSD need support that is specific to the developmental and attachment-related trauma that is related to CPTSD. Trauma-specific treatment may be able to target the individual at a microsystem level, the family and mesosystem and the further community-level systems beyond.

To understand CPTSD, we must first understand its many definitions over the years of its development (Dyer & Corrigan, 2021; Kwon, 2022; World Health Organization, 2019). Often, before the ICD-11 diagnosis, there were unclear distinctions between CPTSD and other disorders. Judith Herman, who originally coined the term CPTSD, believed it was not a separate disorder but an additional symptom cluster to already established disorders like Disorders of Extreme Stress Not Otherwise Specified (DESNOS) and simple PTSD (Herman, 1994). DESNOS is a proposal of CPTSD criteria in chapter two that matches similarly with the current definition of CPTSD, including disturbed relationships, negative sense of self, and emotion regulation difficulties (Ford, 2021). Rink and Lipinska (2020) examined the prevalence of PTSD and CPTSD in low- and middle-income countries among 576 university students in South Africa. They found a clear distinction between a PTSD class and a CPTSD class of participants. Others, like Achterhof et al. (2019), have argued that CPTSD has not been validated enough by the research. Overall, there is contention around whether CPTSD is distinct and valid as a disorder; many articles questioned the usefulness of adding another disorder into the DSM or keeping it in the ICD if the treatment is already effectively utilizing treatment methods for PTSD. Different methodological tools were utilized to gather a thorough understanding of the research.

### **Literature Review Methodology**

A narrative review helped to gather the current research and materials on treatment for Complex PTSD. Firstly, a thorough general search of Complex PTSD in different abbreviations and keywords, like complex trauma, was used to gather a baseline of the language used in resources. To keep the topic specific enough, the age group of focus will be adults. Next, Search databases related to counselling and trauma were utilized to get a baseline of the main arguments and understandings of CPTSD. These databases include PsycINFO, JSTOR, Cochrane Library, PubMed, ERIC, and StatCan. These are recommended and highly rated through Google Scholar. Additionally, the City University of Seattle Library and the University of Victoria Library were combined with Google Scholar and books on complex trauma to gather a holistic perspective of CPTSD.

Research article references also expanded the search by cross-referencing through the City University of Seattle library and Google Scholar to ensure peer review and legitimacy. RefWorks stored relevant articles to organize the references. After most articles were organized into an Excel document, missing gaps and counterarguments were examined through a secondary search of articles through reputable databases. This method was meant to diminish bias from personal choices in choosing articles and gathering information. Information from articles was sorted into themes around whether CPTSD was distinct or not, requiring different treatment with different subsections according to the main topics in the research.

The focus of this research is to look more closely at the current status of the research question of whether CPTSD is a distinct disorder requiring unique treatment, which means that the period for most articles and resources searched is in the last ten years. Since the intention is to apply the research to understand CPTSD treatment, most research has focused on Western journal articles and counselling settings. Research includes articles and resources utilizing

qualitative, quantitative, mixed methods, literature reviews, and treatment manuals. Most research was gathered through peer-reviewed resources so that reputable journals can accurately document the information. In the remainder of the literature review, the topics of understanding CPTSD are distinct and divided into different causes, different symptoms, and physical differences. Next is a brief overview of whether there is a need for different treatment compared to PTSD and other trauma-related disorders.

### **Developmental Attachment Theory**

Attachment theory believes that attachment to our primary caregiver in infancy acts as a signifier of nervous system and emotional regulation (Bowlby, 1985). A caregiver's ability to co-regulate with an infant who is entirely dependent on them to meet biological needs influences attachment. Inconsistency in meeting these needs can lead to attachment disruption and may result in insecure attachment (Bowlby, 1969). Attachment theory includes the categories of insecure-ambivalent, insecure-avoidant, and secure; however, several argue for a more dimensional model to understand these categories (Forslund & Duschinsky, 2021).

With secure attachment, an infant usually will seek proximity to the caregiver and will maintain contact after a separation occurs with little resistance. Infants became distressed during separation, but parents easily soothed them post-separation (Forslund & Duschinsky, 2021). Ambivalent infants may show more intense distress during separation, and after separation, may show a desire for contact but struggle to be soothed and may appear more passive or angry in seeking contact (Forslund & Duschinsky, 2021). Anxious-avoidant attached infants would often avoid the mother after separations. Developmental attachment theory includes perspectives of development across the lifespan while considering attachment theory.

Attachment may change and influence an individual across the developmental stages (Rees, 2007). Over time, children not only use automatic behaviours of avoidance, ambivalence, and seeking soothing, but also integrate the reactions of those around them to those behaviours. These attachment experiences develop into beliefs, memories and internal working models of attachment figures, which can change over time and across environments through the developmental continuum (Obegi, 2008). There becomes an interaction between working models and contextual factors that interact with cognitions, emotions, and behaviours related to attachment (Obegi, 2008). Repeated attachment disruptions and unmet biological needs can be damaging, mainly because of the dependency and basic assumptions of the infant to be taken care of. Early interpersonal trauma has long-lasting impacts on relational functioning and increases risk for further attachment trauma throughout development (Briere & Scott, 2015). These complexities tie directly into the therapeutic relationship where mistrust, guilt and fear may be present (Fluckiger et al., 2018).

### **Socioecological Theory**

Socioecological theory was created by Urie Bronfenbrenner, originally named ecological systems theory (Harkonen, 2001). Bioecological systems theory adds layers of the child's biology in the microsystem, such as when interacting with stress and environmental surroundings (Harkonen, 2001). These form different cognitive beliefs and worldviews as the child matures in their development (Harkonen, 2001). The socioecological theory understands developmental processes as bidirectional, where a child interacts within their immediate environment and interacts with the child (Antony, 2022). The micro system is those in an immediate setting, and the meso systems are the interactions of the individual and the smaller communities. The exo

system extends beyond family and immediate supports, and the macro system extends beyond politics, culture, and media (Antony, 2022).

Each system involved in the counsellor's and client's lives may impact the therapeutic relationship, especially with trauma and adversity. Each individual may respond differently to these challenges, given the bidirectional interaction of environments and individual factors (Antony, 2022). Mental health and counselling include individual, societal and social factors that interact (Eriksson et al., 2018). To prevent and work with traumatized individuals, it is also vital to include system layers of mental health promotion and support. Socioecological theory has the added advantage of several contexts that influence the individual and can give further understanding to their challenges (Eriksson et al., 2018).

### **Difference Between CPTSD and PTSD or BPD**

#### ***Causes***

Post-Traumatic Stress Disorder (PTSD) can develop from being exposed to threatening or horrific events, otherwise known as trauma. The DSM-5 defines trauma as "events in which a person directly experiences or witnesses exposure to actual or threatened death, serious injury, or sexual violence" (5th ed.; DSM-5; American Psychiatric Association, p. 271). The history of PTSD diagnoses stems from the observation of people who experienced rape, combat, and natural disaster as singular events and how they responded to treatment (Herman, 1994). CPTSD can refer to trauma(s) that are more prolonged, complex, and repeated with an inability to escape, which can involve sexual abuse, child abuse, neglect, and interpersonal victimization (Cloitre et al., 2012; Dyer & Corrigan, 2021; Ford & Courtois, 2020). These traumas pose an imminent threat, real or perceived, of death, which can cause deep psychological damage (Ford & Courtois, 2020). Complex trauma can also develop from domestic violence, refugee experience,

cyberbullying, human trafficking and slavery (Cloitre et al., 2012; Ford & Courtois, 2020). The ICD-11 references torture, genocide, domestic violence and repeated childhood abuse as some causes of CPTSD (World Health Organization, 2019).

Recruitment into armed conflict, slave trade, labour camps, genocide and organized violence can also lead to these symptoms (Cloitre et al., 2012; Kwon, 2022). Many complex trauma survivors have experienced betrayal trauma and interpersonal trauma. These are traumas caused by someone with whom they have a relationship. In childhood, the perpetrator may be a parent or older sibling in a position of power (Ford & Courtois, 2021).

Some patients with BPD also have a history of trauma, most commonly sexual abuse, but it is not necessarily the cause of BPD. This trauma can enhance a biological predisposition for BPD (Mendez-Miller et al., 2022). BPD is said to be caused by trauma, genetic transmission and inheritance, neurological factors and psychosocial factors. A challenge with identifying CPTSD as a distinct disorder is that trauma impacts many, if not all, disorders, and tends to have a high degree of overlapping symptoms and comorbidity with other disorders (Cloitre et al., 2014; Farina et al., 2019).

However, CPTSD distinguishes itself by additional symptoms, tacked onto the symptoms of BPD and PTSD, which may derive from the trauma being complex. Survivors of childhood trauma may develop more complex reactions that extend beyond PTSD categories, and are typically categorized as CPTSD (Karimov-Zwienenberg et al., 2024). Although the research ascribes trauma as a cause in these disorders, it is a broad term that covers a range of varying extremes from a single incident to prolonged and/or developmental trauma. CPTSD differs from PTSD and BPD in the severity of pathology or cause. The cause of CPTSD is argued in assessments of clients to be much more extreme, interpersonal and prolonged. Escape is usually

impossible because of environmental, social, and psychological barriers (Resick et al., 2012). Although there is contention about whether CPTSD has different causes and the ICD-11 is not prescriptive about the type or nature of trauma exposure, there seems to be a different set of causes that lead to higher severity or symptoms across a group exposed to childhood developmental trauma (Sarr et al., 2024). The main argument in the research is that different causes are not enough to differentiate a disorder, particularly the exact cause of trauma. However, different types of traumas, as several disorders, are associated with trauma experiences.

While Complex PTSD has many risk factors associated with its development, there is a significant amount of similarity to the risk factors for other disorders, including PTSD and BPD. Various environmental and genetic factors play significant roles in the evolution of mental disorders (Malla et al., 2015). While an examination of the risk factors of CPTSD seemingly does little to distinguish it from other disorders, it is worth noting that many disorders, such as PTSD and BPD, share several risk factors, and the DSM still recognizes them as distinct disorders. Having other disorders be distinguished implies that a lack of unique risk factors for CPTSD does not disprove any potential validity as a distinct disorder.

One significant risk factor for developing CPTSD is related to age at the onset of the trauma; trauma in childhood is more likely to develop into complex PTSD (Cloitre et al., 2011). Stress level, or allostatic load, can also impact whether an event leads to trauma or regular processing. When an individual is under constant stress, they are less likely to be able to cope (Ford & Courtois, 2020; Gandubert et al., 2016). Complex trauma can occur and stem from intergenerational trauma and be passed down through groups and individuals (Ford & Courtois, 2020, p. 5). Some risk factors for collective trauma or allostatic load could include race,

economic status, faith, skin colour, gender identity and orientation, ability, age and location (Belamy, 2015; Gandubert et al., 2016; Langlous et al., 2012; Van Ameringen et al., 2008). Indigenous people in Canada experience higher rates of poverty and lower rates of education, along with the trauma of colonization and the residential school system. These factors increase their risk for developing CPTSD (Belamy, 2015). This complex trauma can take shape as group or societal trauma and historical cumulative trauma (Ford & Courtois, 2020).

Trauma that involves personal relationships and relations with an unbalanced power dynamic can lead to complex trauma (Van Der Kolk, 2015). Traumas that are repetitive and prolonged, and that involve direct harm or neglect from caregivers, resulting in a sense of betrayal, can lead to more complex forms of PTSD, including CPTSD. These types of trauma include cults and organizations that abandon individuals for not obeying the rules or for reporting abuse by a member. Escape can become difficult when trauma happens within a family, religion or group, which further compounds the trauma for the individual (Ford & Courtois, 2020). Van Ameringen (2008) found that women are at an increased risk of developing CPTSD (Van Ameringen, 2008).

Psychiatric history, education level, substance abuse, being divorced or widowed, post-migration challenges, are all also considered factors (Schiess-Janconovik et al., 2021; Van Ameringen, 2008; Worthington et al., 2020). Epigenetic factors reflect the effect of environmental influences on disorder occurrence and progression. Recent studies have investigated the role of epigenetic modifications, including DNA methylation, in PTSD (Sheerin et al., 2017). Altered DNA methylation patterns of genes that are linked with immune system functioning have been identified in PTSD. These changes can include the FKBP5 genetic variant caused by childhood abuse that is present in people with PTSD; this variant has implications in

stress response (Marinova & Maercker, 2015; Sheerin et al., 2017). Marinova & Maercker (2015) explain that epigenetic factors may be relevant in understanding CPTSD alongside utilized models of gene-environment interactions. There is a lack of research on the impact of epigenetic factors on Complex PTSD. In a sample of firefighters, experiencing higher levels of trauma increased the risk of both PTSD and CPTSD; however, they found that traumas unrelated to work more consistently predicted symptoms of CPTSD (Langtry et al., 2021). Non-work-related traumas may add allostatic load to traumas from work and may be more relational.

Worthington et al. (2020) conducted a survey study of 34,653 individuals. They found that being a minority, having a mood or personality disorder, interpersonal violence, experiencing natural disaster, a history of incarceration, domestic violence and suicide in the family all increased the risk of developing PTSD and CPTSD (Worthington et al., 2020). With regards to BPD, it is interesting to note that having BPD puts individuals at significant risk of developing PTSD and possibly CPTSD. Jowett et al (2019) found that traumatic exposure was a strong factor in the development of BPD, CPTSD, and PTSD, and the comorbidity of those disorders. However, he also found that PTSD shows up more in the population than BPD, which acts to counter the argument that CPTSD is BPD and PTSD combined; if this were the case, the disorders would have a higher level of comorbidity (Jowett et al., 2019). There are a large number of risk factors for developing CPTSD. The risk factors for CPTSD, PTSD, and BPD are similar, and the risk for developing additional disorders increases once a person develops one of these disorders. Having one will influence the development and presentation of the other(s), leading to comorbidity that is difficult to dissect. Just as many survivors who have CPTSD fit criteria for PTSD (92%); however, there has not been a study conducted to show how many with PTSD fit criteria for CPTSD (Resick et al., 2012).

### *Symptoms*

Before the ICD recognized CPTSD as an official diagnosis, the ICD-10 applied similar diagnostic criteria to "Enduring personality change after catastrophic experience" (World Health Organization, 1993). Meanwhile, the Diagnostic Statistical Manual, specifically the DSM-IV, identified Disorders of Extreme Stress Not Otherwise Specified (DESNOS) but does not yet recognize CPTSD as an approved diagnosis (Cloitre et al., 2012; Maercker, 2021). In addition to DESNOS, the DSM-5 also contains a dissociative subtype of PTSD with the added components of depersonalization or derealization and emotional detachment. This subtype also involves dissociative amnesia and flashbacks, but only looks at hypoarousal and not the combination of hypoarousal and hyperarousal that is often present in people with CPTSD (Ford & Courtois, 2020; Schiavone et al., 2018).

Complex PTSD includes the core symptoms of PTSD, with some additions (Cloitre et al., 2011). According to the ICD-11, PTSD is characterized by flashbacks, nightmares, and intrusive memories that cause overwhelming emotions, causing a feeling of reexperiencing the trauma in the present time (World Health Organization, 2019). Many with PTSD will avoid anything that triggers the flashbacks, including avoidance of certain memories, places, activities, or people; several will experience a higher danger response to potential threats, leading to functional impairment (World Health Organization, 2019). Three symptom clusters compose PTSD: reexperiencing, avoidance, and hyperarousal. Subsequently, the ICD-11 defines CPTSD with the following criteria:

- Exposure to event(s) that are very threatening, usually repetitive and prolonged, where the individual cannot escape
- The individual meets the criteria for PTSD

- The individual has difficulties with Disturbances in Self-Organization, including challenges with emotion regulation, relationships with others, specifically sustaining close relationships, and negative self-perception.
- The symptoms cause significant impairment across several domains of health and functioning (World Health Organization, 2019).

As Schiess-Jokanovic et al. (2021) state that both PTSD and CPTSD need to have functional impairment, CPTSD includes the three DSO symptoms as well as avoidance, sense of current threat, and reexperiencing. CPTSD requires the presence of at least one symptom from each of the original PTSD clusters of reexperiencing, avoidance, and hyperarousal, along with the presence of DSO symptoms (Ford & Courtois, 2020).

The arguments across the research are that these additional symptoms are unique to CPTSD (Howard et al., 2021; Li et al., 2025; Nickerson et al., 2016; Schwartz, 2016; Zerach et al., 2019). Some argue that the symptoms overlap too much with other disorders (Cloitre et al., 2014; Ford, 2020; Putica & Agathos, 2024). Nestgaard Rod & Schmidt (2021) argue that the diagnosis has limited clinical utility. Some patients experience comorbidity of Borderline Personality Disorder (BPD) and CPTSD, making it challenging to identify the relationships between symptoms and disorders due to how they influence each other and interact (Giourou et al., 2018). Others have identified overlap in PTSD, BPD and CPTSD symptoms, as well as in substance abuse disorder (Ford & Courtois, 2014, 2021; Frost et al., 2020).

Conversely, Frost et al. (2020) found that CPTSD can be distinguished from BPD by relational avoidance and emotional numbing (Frost et al., 2020). In a study of 246 trauma-exposed individuals, perceived social support was lower for those with CPTSD than PTSD (Simon et al., 2019). In a small study of ten women, Faveretto et al. (2022) found that the

patients with CPTSD had further struggles with individuation, anguish, and functional impairment in comparison to the individuals with PTSD. A cross-sectional study of 109 patients showed higher scores on internalized personality traits, negative affectivity and psychoticism, specifically at higher levels than those with PTSD (Moller et al., 2021).

Within the affect dysregulation symptom cluster, some dissociative symptoms can manifest themselves in a lack of ability for survivors to view themselves as human and can cause them to lose their sense of identity and self (Giourou et al., 2018; Herman, 1994). Symptoms within the negative self-concept symptom cluster may include self-mutilation and an increased risk of repeated harm as adults (Ford & Courtois, 2020, 2021; Herman, 1994). CPTSD can also cause individuals to develop an avoidant-attachment type after the complex trauma, further impacting their relationships (Giourou et al., 2018). The additive effects or allostatic load of multiple traumas can produce more severe symptoms, such as extreme dissociation, hearing voices, lower cognitive capacity and expression, and suicidality (Kira et al., 2011). Schwartz (2016) identified additional symptoms of CPTSD, including emotional distress, somatic sensations, disorientation, irritability, eating disorders, social anxiety, and excessive risk-taking (Schwartz, 2016).

Some patients experience comorbidity of Borderline Personality Disorder (BPD) and CPTSD, making it difficult to identify the relationships between symptoms and disorders due to how they influence each other and interact. Giourou et al. (2018) state that BPD is similar in the core symptoms of CPTSD, including impaired relationships, dissociations, and reckless self-destructive behaviours (Giourou et al., 2018). Others have identified overlap in PTSD, BPD and CPTSD symptoms, as well as in substance abuse disorder (Ford & Courtois, 2014, 2021; Frost et al., 2020). In comparison to personality disorders, symptoms tend to overlap in self-perception

and relational challenges. However, CPTSD requires a history of trauma, and the self-perception tends to be stable with avoidance in relationships, whereas with personality disorders, relationships and self-perception can fluctuate greatly (Felding et al., 2021).

CPTSD does differ from BPD in a few ways. Although the research found that CPTSD did eventually lead to personality change, even in adulthood, in some studies, it is not a diagnostic requirement of CPTSD and, in that sense, differs from BPD (Ford & Courtois, 2020; Giourou et al., 2018; Herman, 1994). This personality change allows individuals to adopt traits that can help them cope with the trauma. These adaptations can affect emotional processing and self-organization (Giourou et al., 2018). With CPTSD, self-concept is negative, whereas in BPD, the self-concept is characterized as unstable, shifting between grandiose and negative (Giourou et al., 2018). Aggressive behaviours are seen more in BPD patients with interpersonal challenges. BPD has additional symptoms including feelings of emptiness, paranoid dissociation, and fear of rejection or abandonment (Frost et al., 2020). Although some people with CPTSD do self-harm, this is more closely aligned with BPD (Frost et al., 2020). Knefel et al. (2016) studied 1984 individuals who experienced abuse in foster care and found that the interaction between solely CPTSD symptoms was stronger than both BPD symptoms and CPTSD-BPD combined symptoms (Knefel et al., 2016).

Although there are symptom differences between CPTSD, BPD and PTSD, it can be challenging to distinguish given so much overlap and interaction between the disorders. In one study comparing PTSD and CPTSD patients, the CPTSD group showed lower hedonic and eudemonic well-being than the PTSD group, which may indicate further challenges in living meaningful, fulfilling lives than PTSD patients (Li et al., 2023). Dissociation, although not included in the ICD-11 CPTSD criteria, has been assessed for a multitude of disorders, including

DSO symptoms. Byun et al. (2016) found that childhood abuse is connected to dissociation and disorganized attachment; this may contribute to the evidence that childhood trauma is associated with CPTSD. Hyland et al. (2020) add to this evidence of DSO symptoms and dissociation levels being higher than those with PTSD. Dissociation is linked with childhood and adolescent trauma exposure during the developmental stages.

Regardless of the requirement for exposure to trauma, dissociation is related to PTSD, BPD and DID (Jowett et al., 2020). There remains a limited amount of research comparing Complex PTSD patients to BPD and/or PTSD patients, and there is an argument that there is too much overlap for CPTSD to be distinct. Several clusters of CPTSD and PTSD symptom classes have come forth and increased the challenges of defining CPTSD; Ford (2020) states that this dispersion of symptom levels does not necessarily invalidate CPTSD as a construct.

### ***Physical Differences***

There is limited data on CPTSD, given that it only became a diagnosable disorder in 2019 (World Health Organization, 2019). Most studies involve assessing child abuse patients using neuroimaging. These studies showed hippocampal dysfunction, decreased grey matter density, and disturbances in the prefrontal cortex in these patients. In CPTSD patients, the dysfunction showed up more severely than in those with PTSD (Giourou et al., 2018; Marinova & Maercker, 2015). The terms used to define patients in several studies make it difficult to ascribe these differences among most people with CPTSD. Many studies refer to childhood trauma survivors or those with developmental trauma as their criteria, which have limited applicability to defining CPTSD as having different symptoms.

Thomaes et al. (2009) found changes to the activation level of left ventrolateral prefrontal and dorsomedial prefrontal cortex (Thomaes et al., 2009). In sexual abuse victims, there can be

damage in the right and left primary visual cortices, occipital gyrus, left fusiform gyrus, and parts of the somatosensory cortex (Kwon, 2022). The damage to the hippocampus and prefrontal cortex can lead to challenges in emotional regulation, memory, somatic regulation (hypo or hyperarousal), and decision making (Uniformed Services University of the Health Sciences, 2019).

CPTSD can also affect hormone levels, and patients with PTSD had elevated blood pressure and heart rate (Marinova & Maercker, 2015). Patients showed an extreme physical response to triggers, which increased blood pressure, heart rate, and norepinephrine levels. Changes in these levels can cause hyperactivity, commonly seen in PTSD. Changes have also been found in amino acid and thyroid levels in patients with PTSD (Marinova & Maercker, 2015). Thomas et al. (2009) found brain volume reductions in PTSD patients. Through neuroimaging, Marinova & Maercker (2015) found that abused children had decreased cerebral and intracranial volumes that correlate with the onset of the trauma (Marinova & Maercker, 2015). Van der Kolk (2015) observed that, during flashbacks, the amygdala lit up on each scan of complex trauma patients. The limbic brain, visual cortex, and right limbic area had activation. The brain only lit up on the right side during the flashback (Van Der Kolk, 2015). Childhood trauma impacts the hypothalamic pituitary adrenal axis, which can alter brain structure. Chronic stress impacts the hippocampus and plasticity of the amygdala, reducing its volume (Rosada et al., 2021).

A study conducted by Rosada et al. (2021) found no differences in brain changes between patients with BPD or PTSD; however, they commented that it appears that the damage to the brain has more to do with the severity of the trauma than being related to the disorder. In studies on BPD and the brain, a reduction in hippocampal volume is evident in patients with BPD.

Rosada et al.'s (2021) study has found that there was a negative correlation between brain volume and emotional and physical neglect, sexual abuse, and physical abuse (Rosada et al., 2021). Bryant et al. (2020) conducted a study of PTSD, CPTSD and trauma-exposed individuals using fMRIs. They found that CPTSD patients had greater amygdala activation in the bilateral insula than PTSD patients (Bryant et al., 2020). Using a modified Stroop experiment, Herzog et al. (2017) found that CPTSD patients had increased activation with trauma-related words in the insula and regions contributing to cognitive control. Both the reaction time and mistakes made were greater for the CPTSD patients than for PTSD patients in other Stroop studies (Herzog et al., 2017).

Although there is limited information as to how CPTSD has impacted the brain and if the severity of this impact differs from BPD and PTSD, this could be a starting point to study the differences in brain functioning among these patients and better define if there are distinctions among those with CPTSD and other disorders or comorbidity of other disorders. There is much contention in approaches to understanding and questioning CPTSD from limited research thus far; attempts to validate CPTSD, differing symptoms, causes, and physical changes in patients across disorders and varying definitions of CPTSD have contributed to the questioning and understanding of CPTSD.

### **CPTSD Requires Different Treatment**

Researchers have increasingly addressed the treatment of CPTSD in recent years. ITSCS Guidelines propose a phase-based approach to treating patients who are diagnosed with CPTSD, with a focus on "strength-based interventions...intended to improve functioning, contribute to symptom management and facilitate the integration of the survivor into family and community life" (Cloitre et al., 2012, p.5). Cloitre et al. (2011) believe phase-based approaches reflect expert

opinions on trauma work (Cloitre et al., 2011). Karatzias et al. (2019) identified that people with CPTSD need better treatment options. Individuals with childhood trauma may have less improvement in trauma-focused treatment with the current modalities (Karatzias et al., 2019). The International Society for Traumatic Stress (ITSCS) (2012) used an expert survey to look at recommendations for treatment options based on their experience treating patients with PTSD and CPTSD (Cloitre et al., 2011).

A significant barrier to CPTSD is a lack of self-regulation, and many professionals have expressed the need to build capacity for self-regulation and a safe relationship with the client before entering further phases of treatment (Cloitre et al., 2014). Furthermore, CPTSD can lead to disorganized attachment, meaning part of the therapeutic work needs to be attachment-focused and relationship-based (Ford & Courtois, 2021). The importance of the therapeutic relationship, especially to emotional development, is also highlighted in ITSCS guidelines (Cloitre et al., 2012). When compared to individuals with PTSD, people with CPTSD may not respond to treatments as optimally due to the severity and complexity of the trauma. Patients may have different expressions of emotional dysregulation, switching from hypoarousal to hyperarousal or being predominantly in one or the other state. The treatment duration for CPTSD is likely required to be longer than that for PTSD, owing to the larger number and variety of symptoms (Cloitre et al., 2012). However, treatment length can depend on the comorbidities present, presence of betrayal trauma, patient sense of identity, social supports and the ability to self-regulate.

People with CPTSD can have a more diverse range of symptoms present than those with PTSD (Cloitre et al. 2012, 2014). However, it is important to recognize that BPD and CPTSD can sometimes be comorbid along with other disorders; this increases the complexity, and some

patients may demonstrate an unstable sense of self and self-injurious behaviour characteristic of BPD. Experts emphasize that, given the spectrum of CPTSD, person-centred care is vital in order to treat these patients appropriately. To this point, Ford & Courtois (2021) argue that clinicians need to look at dissociation, detachment, and other complexities during trauma-informed intake for CPTSD (Ford & Courtois, 2021). It is the hope that interventions can meet the needs of patients whose profiles differ and blur together with PTSD, CPTSD and BPD and that new models for working with this mixture can be determined (Cloitre et al, 2014).

Many specific therapies are effective with Complex Trauma and PTSD. Eye Movement Desensitization and Reprocessing (EMDR), developed by Francine Shapiro in 2001, uses a phase-based approach for somatic processing of trauma (Arthur et al., 2013; Brown, 2020; Gerge, 2020; Poole & Greaves, 2012; Schwartz, 2016). Brown (2020) combined EMDR with the Internal Family Systems Model (IFS) for CPTSD treatment and found that the IFS provides language for the client to describe their internal experience, allowing the self to become more present and able to cope during EMDR (Brown, 2020). Somatic experiencing and sensorimotor psychotherapy focus on the body and the release of psychological and physiological impact of trauma through awareness, sequencing, and grounding (Arthur et al., 2013; Poole & Greaves, 2012; Schwartz, 2016; Van Der Kolk, 2015). A 20-session sensorimotor group of 32 women found that there were improvements in anxiety levels and self-awareness/mindfulness when compared to no treatment (Classen et al., 2020). Limbic system therapy and the body-centred approach could be effective with CPTSD patients as they address affect regulation, self-regulation, executive functioning, and window of tolerance (Van Der Kolk, 2015).

Dialectical Behaviour Therapy (DBT), developed in the 1980s, was originally used for borderline personality disorder but is also used for CPTSD. It uses dialect, mindfulness, emotion

regulation, distress tolerance and interpersonal effectiveness skill-building (Schwartz, 2016). DBT is effective with several mental illnesses and addresses some of the symptoms of CPTSD (Schwartz, 2016). Trauma-focused Cognitive Behavioural Therapy (CBT) is considered an effective treatment for PTSD. Trauma-focused CBT treatment involves exposure therapy and cognitive processing therapy. Trauma-focused CBT reduced symptoms in a sample of sexual abuse victims who endured abuse as youth (Eilers et al., 2021). In a study of 20 patients receiving ACT treatment, a form of CBT, participants had a difference in negative perceptions of self and the world and greater mental flexibility (Pourabdol et al., 2020).

In 200 clinical trials, motivational interviewing boosted engagement and positively reduced substance use. Patients had better mental health outcomes. This treatment has proven to be effective with minorities, who it is known to have a higher likelihood of PTSD (Poole & Greaves, 2012). Narrative exposure therapy (NET) helps one identify specific events in their life story that are both positive and traumatic, and develops a narrative of one's identity (Schwartz, 2016).

There is limited research on CPTSD using specific treatment modalities. Many of these apply to patients who have experienced child abuse, complex trauma or PTSD. Perhaps with CPTSD becoming a diagnosable condition, more research can be conducted with individuals who fit that diagnosis. To date, therapists have used somatic experiencing, DBT, CBT, mindfulness-based stress reduction, mentalization, EMDR, IFS, and neurofeedback to varying degrees of success in treating complex trauma (Poole & Grieves, 2012). Further research into these methods may result in benefits for CPTSD patients.

### **Conceptualization and Measurement of CPTSD**

In order to validate CPTSD, it is vital to have reliable and valid sources of measurement for CPTSD as a construct and a diagnostic criterion. Creating tools that can accurately assess CPTSD can confirm the distinct classes between CPTSD, PTSD, and BPD through the actual assessment of clients. The WHO's goal in creating diagnostic criteria is that it is clinically easy to use and has good psychodiagnostic properties across several studies. Specific to CPTSD, it was important to demonstrate discriminatory validity from BPD (Maereker, 2021). The WHO conducted clinical field studies, including comparing CPTSD criteria and diagnosis to other diagnoses in controlled field studies. These field studies aimed to investigate the reliability and validity of the diagnostic guidelines for CPTSD (Keely et al., 2016; Maereker, 2021). The WHO found validity through an 83% interrater agreement by clinicians. Three hundred forty clinicians conducted these studies across 1806 patients and 13 countries (Maereker, 2021). One phase of the study was to utilize a case vignette to members of the Global Clinical Practice Network to investigate the diagnostic decision making and if practitioners would diagnose CPTSD or PTSD separately and recognize when there was an absence of the three additional symptom clusters in PTSD (Keely et al., 2016). Secondly, the WHO used ecological implementation with patients to see if the diagnostic criteria were generalizable. Several studies then occurred through latent profile and factor analysis to further evaluate the symptom structure of CPTSD (Keely et al., 2016; Hansen et al., 2025). The extensive work of the WHO to evaluate the clinical utility and construct of CPTSD proved the validity of CPTSD as a construct across several countries, separate from BPD and PTSD.

The International Trauma Questionnaire is a tool that has been validated to evaluate for PTSD and has since undergone further testing to apply for the diagnosis of CPTSD (Redican et al., 2021). The ITQ has 18 items rated yes or no or on a 5-point scale (Cloitre et al., 2021). For

CPTSD, patients need a score of two on one item of each PTSD and DSO symptom cluster. Twenty-one studies found moderate reliability (Sarr et al., 2024). Haselgruber et al. (2025) agreed that the ITQ has exhibited discriminant and convergent validity across several studies that they reviewed. Seiler et al. (2023) also conducted a systematic review and found the ITQ was a highly validated measure and recommended the international trauma interview when the questionnaire cannot be self-reported; however, there is little validation so far on this interview's reliability and validity with CPTSD (Seiler et al., 2023). Several studies assessed factorial and discriminant validity of the ITQ using both six and two-factor models in the general population and clinical settings (Cloitre et al., 2021; Redican et al., 2021). The studies using ITQ found distinct classes, which included PTSD and CPTSD or a separate DSO class with low PTSD symptoms (Haselgruber et al., 2025; Hyland et al., 2020; Karatzias et al., 2016; Redican et al., 2021).

Atchterhof et al. (2019) have argued that latent class analysis is not enough to test the construct validity of CPTSD; however, several studies have found discriminant validity across several classes, including CPTSD (Folke et al., 2023; Haselgruber et al., 2025). Frewen et al. (2023) also argued that the constructs for CPTSD and the use of the ITQ are too simplified and inaccurate. Clinical checks have been created in two languages thus far to help further clarify with patients who may not understand the questions (Shevlin et al., 2025). Vallieres et al. (2018) consider that some items in the ITQ may not apply to refugees as their lifestyle and reckless behaviours may be very different than those in Western society. They also add that the ITQ can be helpful with the consideration of building a therapeutic relationship prior to assessment, which is especially important considering attachment and developmental disruptions present in CPTSD (Sarr et al., 2024; Vallieres et al., 2018). The ITQ is now commonly used to assess both

CPTSD and PTSD as separate constructs, given its internal validity and reliability across the research.

Other measurements for ICD-11 CPTSD included the CPTSD interview scale, LANTS, and CATS-2; however, they currently lack validity for CPTSD diagnostic criteria. Overall, the ITQ appears valid and reliable across several field studies, narrative reviews, latent class analysis, confirmatory factor analysis and interviews. Although, as demonstrated thus far, CPTSD can have different and overlapping causes, risk factors and symptomology, there appears still to be distinct classes separate from PTSD and BPD.

### **Ethical Considerations**

CPTSD is a disorder that many experience due to relational harm. Ethical and cultural competence assist in reducing the likelihood of harm in therapeutic relationships. Clients are in social contexts that involve discrimination, racism, and class influences (Greenberg, 2020). Greenberg (2020) highlights that by avoiding discussions of race, culture, and class, we are mirroring the current negation of the existence of these experiences. Therapists can create a space of openness and understanding by utilizing trust and good timing to discuss socio-contextual issues and microaggressions. These microaggressions are associated with negative worldviews, self-esteem, depression, and anxiety (Wong-Padoongpatt et al., 2017).

Counselling people with CPTSD requires creativity and reliability in utilizing various techniques in working on the coping mechanisms clients utilize. Through a trauma-informed lens, the therapist needs to examine their motivations, levels of acceptance, and ability to access empathy with clients. Providing space for clients to label and define their experiences, regardless of whether they see something as traumatic, is imperative; this risks damage by defining a client's experience before understanding their history (Greenberg, 2020). Labelling a client's

experience may create relational harm by choosing to know more than the client and defining their identity as a traumatized person may reenact a relationship of power and control (Greenberg, 2020). Autonomy and choice are vital in ethical counselling, especially when contending with symptoms of DSO. Sookman & Leahy (2009) highlight that sessions are opportunities to enhance alliance through modelling healthy interpersonal functioning, acknowledging one's competence and limitations, being genuine and validating clients' emotional experiences. Apologizing for mistakes and taking responsibility for microaggression can help predict ruptures and build exposure to corrective emotional experiences and conflict resolutions (Greenberg, 2020; Sookman & Leahy, 2009).

In trauma therapy, it is essential to be aware of the power differential and the intensity of therapy, leaving room to mismanage the power and pace of the therapeutic process; counsellors can be mindful of self-disclosure while also having an honest and open dialogue about the therapeutic relationship (Sookman & Leahy, 2009). Therapists can provide the best support possible when assessing the balance of their caseload and the intensity of the therapeutic modalities offered; through this observation, the therapist can assess their limits and access appropriate consultation, balance, and support (Sookman & Leahy, 2009). Across the research, therapists need to understand that CPTSD research is still limited and that clients often are in inpatient or outpatient settings, which may not directly apply to the clients they see. Several studies of non-military populations have more female clients, meaning that gender aspects may influence our understanding.

Diagnoses can have various effects on an individual, including meso, exo, and macro-level interactions. In one sample of 18- 65-year-old relatives of those with CPTSD, it was found that there were several challenges with the unpredictable nature of CPTSD and the relationships

required support, education, and involvement in the treatment. Support from family appeared to help manage symptoms (Stadtman et al., 2018). However, as a counsellor, assessing the safety and potential positive and negative impacts of familial participation in counselling is vital.

Many clients with CPTSD have experienced trauma throughout childhood and attachment challenges, most likely with family members; it may be complex to involve family members in counselling without careful consideration and a well-established relationship with the client and continued continuity of care (Stubley et al., 2025). Therapists can consider whether contact with the individuals involved in the trauma continues and provide choice in who is involved in their treatment and what gets disclosed to others, including when there is a safety risk (Stubley et al., 2025). In one study, they found that stigma was greatly associated with mental health diagnosis; however, there is limited information on stigma associated with CPTSD (Hazell et al., 2022). There may be unique stigma, especially in families and communities, when the trauma in some way has been caused by those individuals or environments, requiring great sensitivity and attunement on behalf of the counsellor (Greenberg, 2020).

As highlighted through chapter two, there are several components to consider in ethics when working with CPTSD. Therapists must consider the unique and complex circumstances of each client, including the common DSO and PTSD symptoms that lead to a heightened sense of threat, avoidance or reexperiencing and uncertainty with coping, including a lack of belief in oneself (Stubley et al., 2025).

### **Critical Analysis of the Literature**

A limitation is that most studies and literature reviews require English proficiency, limiting the populations studied. Some studies were done with refugees and translated questionnaires or interviews; however, they often had small sample sizes. Several studies were

cross-sectional, had small sample sizes, and used clinical populations, limiting our understanding of CPTSD in the general public. However, since this capstone focuses on counselling, clinical samples may align more with the clients that counsellors would work with. Most research occurred in the USA, New Zealand, and the United Kingdom, limiting the understanding of CPTSD across cultures. Some research on refugees helped to lower the bias in the research, but did not eliminate the bias. Most of the studies and literature reviews did not disclose cultural and racial differences among participants, and very few utilized population stratification to ensure that the population studied closely followed the current population. These challenges greatly limit the applicability and understanding of CPTSD across cultures.

Throughout the research assessed in chapters one and two, several formats, research methods, and measurements were used across the literature. Literature reviews, cross-sectional, longitudinal, randomized control trials, case studies, and qualitative and quantitative studies were included in the review of the research. Books, treatment manuals, and opinion pieces from clients' perspectives were also included. Most of the research utilized validated and reliable measures, including the ITQ, DSM, ICD, CAPS, PHQ and others. Some studies took bits and pieces from reliable measures to assess specific constructs like dissociation or symptoms in relationship with others. Most research had a slight offset regarding gender- military studies were predominantly male, and clinical studies were primarily female. Most studies included adults aged 18-45. The client base and lack of disclosure of cultural factors provide a gap in the literature of applicability across cultures. Due to the limited research on CPTSD treatment, there remains a significant gap in understanding what treatment modalities are effective with CPTSD clients.

## **Chapter Summary**

### *Against Distinction*

Several professionals have contributed to the debate evaluating whether the research, DSM, and ICD should classify CPTSD as a distinct disorder. While the following discussion section does not exhaust the body of research available for examination and analysis, it aims to identify a balance of key scholarly contributions along the debate spectrum. In a comparison of CPTSD and BPD, Giourou et al. (2018) suggested that, in light of the difficulty of accurate clinical diagnoses and high rates of comorbidity with trauma-related disorders, treatment professionals may better diagnose some patients as having a trauma disorder rather than BPD. The authors proposed that CPTSD may be diverse in its severity of symptoms in comparison with other trauma disorders (Giourou et al., 2018). The authors also suggested that to be a new and distinct diagnosis, CPTSD must have essential additions such as biological reasons, course, and treatment options (Giourou et al., 2018, p. 13).

Giourou et al. (2018) also raised the question of whether some psychiatric diagnoses need to be evaluated and possibly regrouped upon new insight and whether or not CPTSD needs its distinct diagnosis, or if current criteria of trauma disorders need to be reassessed and possibly expanded to incorporate features of CPTSD currently missing (Giourou et al., 2018). Resick et al. (2012) pointed out that an overlap in symptomatology does not disprove CPTSD as a distinct disorder; for example, there are many examples in medicine of "separate classifications of syndromes that symptomatically appear quite similar (e.g., influenza and the common cold)" (p. 246). However, Resick et al. (2012) argue that, while medical diseases can be categorized as separate based on differences in causes and processes, it has not yet been empirically shown that the proposed cause of CPTSD, complex trauma, is distinct from traumas linked to PTSD. Resick et al. (2012) argued against the distinct CPTSD classification. They highlighted a lack of

controlled studies examining the impact of treatment on CPTSD, which made it difficult to form any definite conclusions about effective treatment options for CPTSD (Resick et al., 2012). According to the authors, the variance of symptom presentations does not qualify a disorder for separate classification. Resick et al. (2012) arrived at a similar conclusion as Giourou et al. (2018), agreeing that PTSD symptomology may be on a continuum of severity and that qualitatively different causes need to be established to prove CPTSD (Resick et al., 2012, p. 248).

Landy et al. (2015) explored whether or not CPTSD should be classified as a distinct disorder, based on the necessity for treatments different than those for PTSD (Landy et al., 2015). They identified that a significant challenge faced by the movement to classify CPTSD as a distinct disorder had been a lack of clarity regarding its definition, owing to inconsistencies in several areas, including symptoms, causes, and the meaning of the term complex trauma (Landy et al., 2015). Landy et al. (2015) also contended that conflicting theories about whether CPTSD requires repeated trauma or if it can result from a single traumatic event inhibit efforts to understand CPTSD (Landy et al., 2015). Landy et al. (2015) also argued that the addition of specific diagnostic criteria and changes to the DSM-5 in the areas of PTSD and personality disorders was sufficient to capture the symptom domains of CPTSD, negating the need to add the latter to the DSM as a distinct disorder (Landy et al., 2015). The authors do recognize, however, the absence of disorganization in the DSM-5 PTSD criteria.

### ***Supporting Distinction***

Moving towards the pro-distinct side of the debate, Elklit et al. (2014) considered what determines whether a disorder is distinct or separate. Ben-Ezra et al. (2017) conducted a study on 1003 members of the Israeli population using a measure specific to trauma disorders, the

International Trauma Questionnaire. The results indicated distinctive classes in accordance with CPTSD and PTSD. They concluded that their results strongly supported the ICD-11 proposals for separate classification of PTSD and CPTSD (Ben-Ezra et al., 2018). Frost et al. (2020) found that self-concept symptoms in CPTSD and BPD manifest differently in either disorder, with BPD having an oscillating sense of self for BPD and a very negative self-perception in CPTSD. Frost et al. (2020), in their study of 617 Israeli adults, concluded that BPD and CPTSD are distinguishable.

Rink and Lipinska (2020) examined the prevalence of PTSD and CPTSD in low- and middle-income countries among 576 university students in South Africa. They found a clear distinction between the PTSD class and the CPTSD class of participants. In their study, Rink and Lipinska (2020) hypothesized that childhood trauma differences would discern PTSD and CPTSD and found emotional abuse and neglect related differently to CPTSD symptomology (Rink & Lipinska, 2020). Further, Rink & Lipinska (2020) found that the number of different types of childhood trauma did not correspond to a distinction between PTSD and CPTSD. However, they did see that the CPTSD class had a much lower number of individuals who reported no exposure to childhood trauma, in comparison to the PTSD class. Rink & Lipinska (2020) suggest from their findings that CPTSD may be more specific to the severity of childhood trauma than the types of trauma experienced. Intriguingly, the authors found that in addition to a distinct CPTSD class (in which individuals presented with both PTSD and CPTSD symptom profiles), there also emerged a distinct DSO (disturbances in self-organization) class (Rink & Lipinska, 2020).

Rink and Lipinska (2020) posit that in establishing a distinction between PTSD and CPTSD, there emerges a need for unique treatment modalities. They also suggest that in

uniquely classifying CPTSD, there is the strong possibility of a shift in treatment emphasis on targeting DSO symptoms and not just reprocessing of trauma (Rink & Lipinska, 2020).

Farina et al. (2019) observed that:

an increasing number of studies and clinical observations show that an [sic] history of cumulative childhood trauma and comorbidity with dissociative symptoms, complex PTSD, or any other traumatic spectrum disorders...worsens the prognosis of DSM disorders and generates treatment difficulties that require specific knowledge and training for clinicians (para. 6).

They found that in nearly 80% of cases, a PTSD diagnosis does not sufficiently represent the complexity of the trauma suffered by the patient including developmental trauma which often led patients to getting diagnosed with multiple disorders. Farina et al. (2019) further express that counsellors need to understand how to address the challenges of trauma-related dissociation in counselling.

It is important to note that the two studies above that argued against the classification of CPTSD as a distinct disorder were written prior to the publication of the ICD-11, in which CPTSD was classified along with specific diagnostic criteria. Subsequently, the argument put forth by Landy et al. (2015), regarding the lack of a defined set of CPTSD symptoms, has begun to be addressed in recent years following the publication of the ICD-11 in 2019, which identified the distinct CPTSD symptoms as comprised of disturbances in self-organization (DSO): i) affect dysregulation, ii) negative self-concept, and iii) disturbed relationships. This definition has guided research on the subject in recent years (Ben-Ezra et al, 2018; Cloitre et al., 2020; Frost et al., 2020; Rink & Lipinska, 2020). The fact that the DSM-5 fails to mention the DSO set of criteria in its PTSD entry, as pointed out by Landy et al., takes on some degree of significance in

light of research and studies conducted on CPTSD in recent years, as much of this focuses on disturbances in self-organization (DSO) as the leading diagnostic criteria of CPTSD (Frost et al., 2020; Rink & Lipinska, 2020).

As demonstrated, although there are arguments for and against CPTSD, there is now enough evidence to conclude that CPTSD is a distinct disorder. There are beginning conversations and research around treatments for CPTSD, separate from PTSD, or whether PTSD treatments are enough. Moving into the next chapter, the information regarding symptoms, physical differences, and the need for different treatment is integrated to consider treatment options specific to CPTSD. Accelerated experiential dynamic psychotherapy is considered a potential treatment method for CPTSD. Limitations and intersectional factors are considered leading into the conclusion of this capstone.

### **Chapter 3: Summary, Discussion, Recommendations and Conclusions**

#### **Summary of Findings**

CPTSD has faced decades of challenges in terms of its legitimacy as a clinical diagnosis. Integrating CPTSD into the ICD-11 was a massive step towards validating this diagnosis across populations. Previously, there had been mixed revisions and definitions of CPTSD across the research. However, because the ICD focuses on clinical utility, some have argued that it is inaccurate at assessing and diagnosing CPTSD because it is vague. Some have also expressed concerns about high overlap and comorbidity of PTSD and BPD with CPTSD. By understanding CPTSD as a disorder, further research can be done on appropriate treatment and assessment in counselling for this population.

Through the literature in chapter two, it was discovered that CPTSD does present differences in risk factors, symptoms, and causes. Further research must be conducted to understand the physical differences in CPTSD. Overall, it is determined that CPTSD is a distinct disorder with challenges that need treatment considerations beyond PTSD and BPD. However, since there is a high level of comorbidity of PTSD, CPTSD and personality disorders, it is vital to consider the complexity of each unique composition of the impacts of trauma on the individuals and their community.

#### **Discussion**

There are arguments for and against CPTSD being a distinct disorder. The main arguments against official classification are that there has been a historical lack of clarification about several elements of CPTSD and that there is not enough research to support CPTSD as a disorder separate from a combination of PTSD and BPD. Research conducted both prior to ICD-11 classification and since has aimed to prove the differences among these disorders and thus

support CPTSD as a distinct disorder. CPTSD may require additional layers of treatment that attend to DSO symptoms as well as dissociation and shame. Therapists must be aware of their limitations in experience and training when working with CPTSD and understand the commitment and balance necessary to work long-term with CPTSD clients.

CPTSD has limitations in understanding, even when it comes to its prevalence. A challenge with understanding prevalence rates in CPTSD is a lack of valid tools in assessing CPTSD as distinct from PTSD assessment tools, and the conflict about whether or not CPTSD is a disorder. Nestgaard Rod & Schmidt (2021) validated the International Trauma Questionnaire and Interview in providing an assessment construct for CPTSD. As this is a newly validated diagnostic tool, there is confirmation of its validity and reliability, but it is not used to understand treatment effectiveness.

In order to understand CPTSD and its presence across various populations, it is useful to have data on its prevalence. Overall, there is limited data on CPTSD, especially within Canada. Studies across other countries found around 2% prevalence rates of CPTSD in national samples and approximately 20% across a sample of foster children (Ben-Ezra et al., 2018; Haselgruber et al., 2019). Maddux & Winstead (2019) state that the understanding of different types of trauma exposure and their link to CPTSD and PTSD differences has not been substantiated concerning different functional deficits. A lack of clarity on trauma exposure, types of trauma, and the impact makes it difficult to assess CPTSD prevalence. An area of future research could be assessing the prevalence of CPTSD across cultures and clinical and non-clinical populations.

An additional challenge is the comorbidity of other disorders and trauma being risk factors for several disorders. Worthington et al. (2020) conducted a survey study of 34,653 individuals. They found that being a minority, having a mood or personality disorder,

experiencing interpersonal violence, experiencing a natural disaster, having a history of incarceration, domestic violence, and suicide in the family all increased the risk of developing PTSD and CPTSD (Worthington et al., 2020).

Concerning BPD, it is interesting to note that having BPD puts individuals at significant risk of developing PTSD (El-Gabalawy et al., 2010; US Department of Health and Human Services, 2022). Jowett et al. (2019) found that traumatic exposure was a substantial factor in the development of BPD, CPTSD, and PTSD, and the comorbidity of those disorders. However, he also found that PTSD shows up more in the population than BPD, which acts to counter the argument that CPTSD is BPD and PTSD combined; if this were the case, the disorders would have a higher level of comorbidity (Jowett et al., 2019). Having one will influence the development and presentation of the others, leading to comorbidity that is difficult to dissect, just as many survivors who have CPTSD fit the criteria for PTSD (92%) in one study (Resick et al., 2012). Resick et al. (2012) found this through searching a wide array of studies on posttraumatic personality disorder and complex trauma. Given that there is so much overlap between BPD and PTSD, this finding further contributes to the doubt about CPTSD.

In comparison to autism and adhd assessment, which several professionals listed as specialties on their websites, CPTSD still appears to be a more hidden diagnosis. Overall, it is vital to consider attachment, developmental, and sociocultural influences in planning for treatment. Based on the findings that CPTSD relates to developmental, relational, attachment-based trauma, the focus of therapy may include those aspects.

As demonstrated in the previous chapter, CPTSD can place individuals at a higher risk for suicide ideation, affect dysregulation, negative self-perception, personality change, and overall poorer outcomes in overall functioning and treatment success. These are vital to consider

when engaging with treating clients who have CPTSD and potential comorbidity of other disorders. Attachment trauma is related to CPTSD, which can influence the ability to form trusting relationships and, therefore, potentially a therapeutic relationship with the counsellor. Counsellors need to be sensitized to how a negative self-appraisal and insecure attachment may influence treatment and stabilization with clients. In a general search of psychiatrists and psychologists in Victoria, none directly mentioned the assessment of CPTSD.

CPTSD has several complications currently in the research, including unknown prevalence, comorbidity with other disorders, a lack of research on treatment, missing information on culture in assessing CPTSD and limited understanding of the different effects of various traumas and compounded traumas. CPTSD needs to be understood so we can effectively provide treatment that reduces the risk of harm and further traumatization. Accelerated Experiential Dynamic Psychotherapy (AEDP) is an approach that focuses on attachment; in addition, sociocultural considerations are added to recommendations in treating clients.

### **Recommendations**

The theories utilized in this capstone are developmental attachment theory and socioecological theory. AEDP offers interactive therapy experiences that are attuned to the specific client and their attachment needs. AEDP explicitly utilizes the therapeutic relationship as the vehicle for treatment, which aligns well with developmental attachment theory. A challenge with some theories is the lack of consideration for development. AEDP meets clients where they are developmentally and builds growth through developmental stages in the therapeutic process. AEDP is an experiential model of psychotherapy built by Diana Fosha that focuses on utilizing corrective emotional and relational experiences to process emotions. AEDP stems from developmental, relational, experiential and emotion-focused theories (AEDP Institute, 2025).

The belief with AEDP is that transformation in therapy occurs through an attuned, affirming therapeutic relationship that utilizes affect (Fosha, 2000). The therapeutic relationship focuses on strengths, the client's positive aspects, and corrective relational experiences that foster healing (Fosha, 2000). The therapeutic relationship and focus on emotions can create an environment for the self to come through and flourish, creating a drive to heal through strengthened secure attachment (AEDP, 2025). By providing a secure base, the client can move from what is titled self at worst functioning to self at best functioning (AEDP, 2025). Defences are welcomed and discussed through the therapeutic dynamics in the relationship, which can increase a sense of mastery in processing the emotional experience. A client can experience being witnessed in the emotional experience, which can help deplete the profound sense of aloneness accompanying attachment disruption (Iwakabe et al., 2020)

AEDP utilizes the triangle of experience model to understand a client's behaviour and guide primary interventions. The triangle focuses on an interaction between affective experiences and responses to those experiences through affects and defences. The process is interactional between affect, response and experience, and the attuned therapist utilizes this to track the experience in the moment. A second triangle, which depicts the self, other, and emotions, adds the attachment layer to affect and the therapeutic relationship with an individual's internal working model. The triangle of self-other-emotion is utilized to bring the experience into the therapeutic relationship and relate these experiences to past experiences and current affect or defences (Fosha, 2009). These two triangles consider each client's attachment style (Fosha & Thoma, 2020). Based on the defences and clinical impressions, the therapist may attune differently to each client to repair the attachment disruptions and navigate the defences that present themselves in affect processing and therapeutic relationship (Iwakabe et al., 2020).

AEDP has been proven effective across people with attachment difficulties and negative self-perception, both challenges for those with CPTSD (Iwakabe et al., 2020; Spinazzola & Wilson, 2019). AEDP can target DSO symptoms in the first phase of its treatment, and comes with the assumption that these symptoms may be present. A focus on co-creating safety and therapeutic alliance takes precedence over a focus on solutions. (Podolan & Gelo, 2024). The secure relationship helps to prepare the client to respond adaptively to their emotions (Fosha, 2000). Attention is given to the core effective experiences as well as processing grief, helplessness and aloneness, often experienced by people with CPTSD (Podolan & Gelo, 2024). AEDP also provides attention to sitting in positive affect and dyadic regulation with the client and therapist, which can create a body felt sense of safety and togetherness (Podolan & Gelo, 2024). AEDP has the potential to target DSO symptoms, attachment, and developmentally related challenges with CPTSD; however, more research needs to be conducted to confirm.

### **DSO Symptom Considerations**

Clients with CPTSD struggle with mistrust, insecure attachment, dissociation and dysregulation, which need to be attended to in the therapy room. From a socioecological perspective, it may be useful to utilize a biopsychosocial assessment to understand CPTSD symptoms. Clients are influenced and interacting within several contexts and environments which impact DSO symptoms and their sense of self, including their engagement within the mental health system. In attending to DSO, it may be helpful to consider the interactions among the aspects of negative self-appraisal, self-regulation, and relationship difficulties to tailor treatment that targets all three in an interactive process.

#### ***Negative Self-appraisal***

A therapist must remember how vital it is that positive regard and a strengths focus are unconditional towards a client. Many clients have dealt with inconsistency in their attachment relationships, and it may take time to believe any positive regard provided by the therapist. Clients may experience dysregulation as a response to positive regard, and it may be helpful for the therapist to check in around how positive regard lands for the client and welcome any concerns or worries. As mentioned across most theories, the therapeutic alliance is vital. Negative self-appraisals on the end of the client may lead to distancing, avoidance, anger, and other defences when experiencing conflicting ideas from the self and the therapist. Negative self-appraisal may be connected with shame or a sense of being humble in some cultures; it may be viewed positively to have a negative perception of oneself.

In order to fully understand a client's experience with negative self-appraisal, a socioecological approach is needed to understand the influence of culture, race, gender roles, socioeconomic status, education level, community involvement, work environment, and perspectives on age and development among other contexts. When therapists only look at the diagnosis, they may miss aspects, like shame, family roles, and current cultural perspectives on self-identity and therapy that interact with an individual's sense of self. Through reviewing the literature, IFS has tools and resources to help clients externalize their beliefs about themselves and formulate a relationship with that critical part of themselves or consider the self worthless. The part is honoured as protective and functional to the person at one point. Labelling these aspects' parts' can diffuse some of the power of a negative self-view and encourage compassion and curiosity, rather than a pathological approach (Schwartz, 2021). Overall, therapists need to attune to a client's stage of readiness in addressing their negative self-perception, which will depend on the level of trust in the therapeutic relationship and their self-regulation.

### ***Emotional Regulation***

As stated in the previous chapter, clients with CPTSD can experience severe emotional regulation difficulties. Therapies like DBT offer tools that may be useful in times of dysregulation. Additionally, the therapeutic relationship can be utilized for co-regulation and soothing, such as in infancy. Breathing together or practicing meditations and other relaxation tools with the therapist may be useful in addressing aloneness, building confidence, and a sense of safety with the therapist. Clients who have experienced relational wounding may also be more attuned to the therapist's reactions and behaviours. Therapists need to be aware of their self-regulation during therapy, as clients may disclose traumatizing materials or have unpredictable reactions to triggers that are not known to the therapist and/ or the client. The therapist can utilize appropriate self-disclosure around different regulation strategies that have worked for them and others and utilize a strengths focus in the client, even risking trying different regulation tools. DBT-PTSD specifically has been made to target the symptoms present in CPTSD with additional components of CBT, ACT and compassion-focused therapy (Bohus et al., 2019). Through a residential program, clients found a significant reduction in their symptoms compared to treatment as usual (Bohus et al., 2019).

A socioecological perspective is necessary in understanding emotional regulation because the micro, meso, exo and macro systems influence an individual's emotional expression and coping ability. In one review, socioeconomic status, parents, and environment were associated with emotional dysregulation (Razman & Hoesni, 2023). Brown (2020) states that "Complex trauma occurs within the psychosocial framework or external cultural realities, and the internal, intrapsychic representations of those realities" (p.166). Emotional regulation and the expression of emotion are cultural. Therapists need to be mindful of pathologizing different ways of coping

with and expressing emotion, and whether Westernized cultural ideas of emotional regulation influence the therapist's assessment of problematic dysregulation. Person-centred focus is vital in understanding if the emotional experience is distressing for the client and how dysregulation impacts them across contexts.

### ***Relationship Difficulties***

Clients may come in with several perceptions about relationships and what they look like, and experience an array of emotions when the therapeutic relationship is different. The therapeutic relationship is consistent, with positive regard and empathy, which may be shocking to a nervous system that has never experienced this, and may even be perceived as threatening to certain aspects of a client's identity and sense of worthlessness. Complex trauma is interpersonal and is connected with culture, identity, politics, and context; the cultural background, political stance, and identity of the therapist may have an influence and an interactive nature with the client's interpersonal experiences with these aspects of themselves and others (Courtois & Ford, 2009).

Due to attachment difficulties related to CPTSD and the developmental implications, therapists need to consider developmentally informed treatments that foster self-development and secure attachment (Courtois & Ford, 2009). Utilizing therapeutic relationship-oriented interventions can help navigate the therapeutic relationship and relationships outside the counselling room while attending to other CPTSD symptoms (Bruch, 2015). Considerations regarding attachment may include making additional comfort measures, making contact between sessions, and advocating within the mental health systems. Each therapist may have their own unique associations with trauma that are vital to understand, as countertransference may arise, especially with such an intense focus on attachment (Courtois & Ford, 2009). Focus on the

therapeutic relationship, and interventions that utilize the relationship as a primary tool may help repair the damages and challenges associated with attachment-related trauma present in CPTSD clients.

Therapists should consider if they have adequate training in safety and stabilization, as well as trauma processing techniques, before considering taking on clients. Many clients with CPTSD utilize long-term therapy and have a multidisciplinary team, which can be utilized in planning for treatment; therapists can also advocate for increased levels of care with clients to access the team they need. Therapists should also consider their attachment style and ability to be attuned and present for various defences and attachment challenges. A counsellor in these circumstances must be able to provide as much autonomy and choice as possible while informing the clients of the risks in going too quickly. Clients should be informed about safety and stabilization, and how, with CPTSD, slower can be faster. Therapists need to focus on attachment and regulation as the main tenets of the therapeutic session, as well as the tools, techniques, and interventions. Therapists can do this by checking in about how each session was with the clients and utilizing immediacy around body language, dissociation, and attachment defences.

Clients may come in with several perceptions about relationships and what they look like, and experience an array of emotions when the therapeutic relationship is different. The therapeutic relationship is consistent, with positive regard and empathy, which may be shocking to a nervous system that has never experienced this, and may even be perceived as threatening to certain aspects of a client's identity and sense of worthlessness. Complex trauma is interpersonal and is connected with culture, identity, politics, and context; the cultural background, political stance, and identity of the therapist may have an influence and an interactive nature with the

client's interpersonal experiences with these aspects of themselves and others (Courtois & Ford, 2009).

Due to attachment difficulties related to CPTSD and the developmental implications, therapists need to consider developmentally informed treatments that foster self-development and secure attachment (Courtois & Ford, 2009). Utilizing therapeutic relationship oriented interventions can be helpful in navigating the therapeutic relationship and relationships outside the counselling room while attending to other CPTSD symptoms (Bruch, 2015). Considerations regarding attachment may include making additional comfort measures, making contact between sessions, and advocating within the mental health systems. Each therapist may have their own unique associations with trauma that are vital to understand, as countertransference may arise, especially with such an intense focus on attachment (Courtois & Ford 2009). Focus on the therapeutic relationship, and interventions that utilize the relationship as a primary tool may help repair the damages and challenges associated with attachment-related trauma present in CPTSD clients.

Therapists should consider if they have adequate training in safety and stabilization as well as trauma processing techniques before considering taking on clients. Many clients with CPTSD utilize long term therapy and have a multidisciplinary team which can be utilized in planning for treatment; therapists can also advocate for increases the level of care with clients to access the team they need. Therapists should also consider their attachment style and ability to be attuned and present for various defences and attachment challenges. A counsellor in these circumstances must be able to provide as much autonomy and choice as possible while informing the clients of the risks in going too quickly, clients should be informed about safety and stabilization and how with CPTSD, slower can be faster. In session, therapists need to focus on

attachment and regulation as main tenants to the therapeutic session above tools, techniques and interventions. Therapists can do this by checking in about how each session was with the clients and utilizing immediacy around body language, dissociation, and attachment defences.

### **Limitations of the Capstone**

There are several limitations to the research in this capstone and in understanding CPTSD and whether it requires different treatment. The past several years, post-ICD-11 inclusion, have focused on finding an appropriate tool to assess CPTSD. Now that the ITQ has been validated for CPTSD, the research is taking its first steps to validate treatments for CPTSD. However, the current climate of research focuses mainly on treatments that are manualized and have a short-term focus, which limits our understanding of effective treatments. Long-term and more nuanced therapeutic approaches are more difficult to study and find enough evidence base. We still have limited information on the impact and comparison of various treatments, and there are few current guidelines on treating CPTSD.

I have a personal bias towards CPTSD being distinct, given my diagnosis of CPTSD and the theories I draw from. By coming from a developmental and attachment-based lens, I may look towards research that is more validating of the impacts of trauma in these areas, including CPTSD. I wonder if I would find different research if I were coming from a cognitive behavioural lens instead. My firm belief in coming from an attachment-based approach also influenced my desire to look into AEDP therapy for CPTSD, and it reflects the types of therapy I have found helpful. The limitations of three chapters also condensed the ability to fully explore a range of theories and ideas relating to CPTSD.

Most of the studies accessed were conducted in Western, individualistic countries, influencing the methods used to understand CPTSD. Many used similar measures of

questionnaires, which have been validated, but also create little room for clients to express their experiences in their voice. These methods also restrict the voices of professionals who work with people who have CPTSD and have found practical treatment approaches. Several therapists utilize an eclectic approach to therapy, which may be unique to each relational dynamic in therapy, especially when working with CPTSD. Our understanding is limited by what and how we can study the phenomena of the therapeutic process. There are several limitations in my ability to conduct vigorous research as someone who is just learning appropriate research methods, which limits some of my ability to gather unbiased research and the amount of research I can access for free. The capstone was a learning opportunity that allowed me to begin a basic understanding of CPTSD and explore the current research and suggestions for treatment in this exciting time.

CPTSD needs to be studied further using various qualitative, quantitative, and mixed methods. Additionally, indigenous research may be incredibly useful in understanding CPTSD across indigenous cultures in Canada. I wonder about how epigenetics and understanding of intergenerational trauma can influence our conceptualization of CPTSD. We need to consider the potential risks of stigma, family acceptance and systemic oppression in clients who have a CPTSD diagnosis. Many are diagnosed additionally with a personality disorder, which influences how their care team interacts with them. As therapists, we can be the ones who provide unconditional positive regard among the complex systems they navigate to access care. Further research could address the gaps in the influence of the medical system and diagnosis on clients with CPTSD. Research must include clients' voices about their treatment, diagnosis, and experiences.

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### **Intersection Consideration**

Currently, at agencies, the most common therapy offered for low-income families and individuals is CBT, trauma-informed CBT or solution-focused therapy. Many of these agencies offer low-cost counselling through interns or volunteer counsellors. In the agencies where I worked, there was no training on cultural competence, adaptations for language or information on how to include culture in supporting an individual or family. Very few treatments and research methods spoke about assessing and involving culture in their considerations with CPTSD. However, cultural factors like level of support, nurturance, and emotional expression can influence the therapeutic process with individuals who have CPTSD. The lack of seeking to understand cultural influences and factors limits the applicability of understanding CPTSD and

how it presents across cultures. Minimal mention is made about the cultural differences between researchers and patients.

AEDP lacks a thorough evidence base thus far, which limits its application depending on the agency that provides treatment. Due to space limitations in this capstone, very few approaches could be explored, and no evidence-based treatments for CPTSD could be found. As the research progresses, the counsellor will better understand the research on CPTSD and the effective treatments; however, several theories express that their therapy works for CPTSD.

The reason I chose socioecological theory was to acknowledge that although therapy is very individualized, society and the several systems that interact with an individual all influence mental wellness and the environments that create disorders like CPTSD. However, the research focuses on individual symptomology and mental disorders that already exist; therefore, there is limited focus on prevention and understanding systemic influence in CPTSD aside from examining the causes of CPTSD. Exploring the systemic and societal factors that increase risk for CPTSD may help to broaden the research around effective treatment, not just at an individual level but at a systemic level; however, there may be restrictions in funding for this preventive and systemic research.

## **Conclusion**

In summary, this capstone set out to better understand and address the unique needs of CPTSD, including understanding its distinction from PTSD. Focus was explicitly given to research on adults with complex trauma. Although CPTSD is not a new concept, the research highlighted the challenges of creating a new diagnosis and the process of legitimizing a mental illness as distinct, as well as the challenges of identifying effective treatments.

Theory developers and researchers have biases in finding or proposing effective treatments influenced by financial, systemic and political factors. These influence the challenge of choosing treatments that may be less evidence-based but are well-advertised and less manualized versus treatments that have been well-researched and manualized but have limitations on utilizing multiple approaches across various contexts. Defining and understanding CPTSD symptomology also remains limited by the tools that can be validated to assess CPTSD adequately, which currently is the ITQ. The ITQ is valid and reliable; however, it limits how we gather information about our clients and understand their progress.

Contributing to the literature on diagnosis may increase the continuing pathologizing of functional responses to trauma and place the 'problem' within the individual. Additionally, focusing on causes and researching why this disorder exists may help deepen the understanding that mental disorders may stem from trauma and systemic or environmental factors that impact the individual. The main takeaway from the research is that CPTSD is a distinct disorder, and it is practical for therapists to understand the impacts of CPTSD on the therapeutic process as well as consider culturally sensitive factors in treatment planning. Very little training is currently provided across agencies that typically see clients with CPTSD, which limits the support individuals can receive. Being trauma-informed is not enough; we must deepen our understanding and learn how to approach clients with an understanding of developmental, attachment-based, and socioecological factors. There is still much more to do to advocate for accurate diagnosis if the client desires and post-diagnosis support; however, the literature is hopeful in paying more attention to CPTSD.

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