

## Complex PTSD: what is the clinical utility of the diagnosis?

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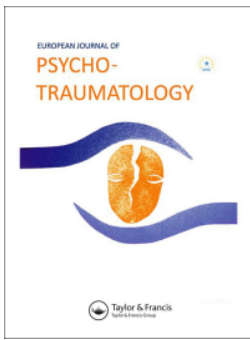
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## Complex PTSD: what is the clinical utility of the diagnosis?

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### ABSTRACT

**Background:** The diagnosis of complex posttraumatic stress disorder (CPTSD) was included in the 11th revised edition of the International Classification of Diseases (ICD-11). CPTSD shares trauma-specific symptoms with its sibling disorder PTSD but is additionally characterized by disturbances of the individual's self-organization (DSO). The clinical utility of the CPTSD diagnosis has yet to be thoroughly investigated.

**Objective:** The current study aimed to examine the clinical utility of the CPTSD diagnosis, considering the upcoming implementation of ICD-11 in clinical practice.

**Method:** International field studies, construct- and validity analyses leading up to the inclusion in ICD-11 are reviewed, and the diagnostic measures; International Trauma Questionnaire (ITQ) and International Trauma Interview (ITI) are presented. Also, the relationship between CPTSD and borderline personality disorder (BPD) is elaborated in an independent analysis, to clarify their differences in clinical relevance to treatment. Treatment implications for CPTSD are discussed with reference to existing guidelines and clinical needs.

**Results:** The validation of ITQ and ITI contributes to the cementation of CPTSD in further clinical practice, providing qualified assessment of the construct, with intended informative value for both clinical communication and facilitation of treatment. CPTSD is found distinguishable from both PTSD and BPD in empirical studies, while the possibility of comorbid BPD/PTSD cases being better described as CPTSD is acknowledged. Practitioners need to employ well-established methods developed for PTSD, while considering additional DSO-symptoms in treatment of CPTSD.

**Conclusions:** The inclusion of CPTSD in ICD-11 may potentially facilitate access to more tailored treatment interventions, as well as contribute to increased research focus on disorders specifically associated with stress. The clinical utility value of this additional diagnosis is expected to reveal itself further after ICD-11 is implemented in clinical practice in 2022 and onwards. Yet, CPTSD's diagnostic inclusion gives future optimism to assessing and treating complex posttraumatic stress symptoms.

### Trastorno de estrés postraumático complejo, TEPT complejo: ¿Cuál es la utilidad clínica del diagnóstico?

**Antecedentes:** El diagnóstico del trastorno de estrés postraumático (TEPT-C) fue incluido en la 11va. edición revisada de la Clasificación Internacional de las Enfermedades (CIE-11). El TEPT-C comparte síntomas específicos del trauma con su trastorno primo el TEPT, pero es adicionalmente caracterizado por trastornos en la autoorganización del individuo (DSO en su sigla en inglés). La utilidad clínica del diagnóstico del TEPT-C no ha sido investigado comprehensivamente todavía.

**Objetivo:** El presente estudio busca examinar la utilidad clínica del diagnóstico del TEPT-C, considerando la pronta implementación del CIE-11 en la práctica clínica.

**Método:** Se revisaron los estudios de campo internacionales y los análisis de validez y constructo que llevaron a la inclusión del CIE-11, y se presentan las medidas diagnósticas, Cuestionario Internacional del Trauma (ITQ en su sigla en inglés) y la Entrevista Internacional del Trauma (ITI en su sigla en inglés). También, la relación entre TEPT-C y el trastorno de personalidad límite (BPD en su sigla en inglés) se elaboró en un análisis independiente, para clarificar las diferencias de la relevancia clínica para el tratamiento. Las implicaciones del tratamiento del TEPT-C se discuten con referencia a las guías existentes y las necesidades clínicas.

**Resultados:** La validación del ITQ y ITI contribuye a la consolidación del TEPT-C en la subsecuente práctica clínica, proporcionando una evaluación calificada del constructo, con el valor informativo intencionado para tanto la comunicación clínica como para la facilitación del tratamiento. Se encontró que el TEPT-C se distingue de tanto el TEPT como del BPD en los estudios empíricos, mientras que se reconoce la posibilidad de que la comorbilidad en los casos de BPD/TEPT sean mejor explicados como TEPT-C. Los profesionales necesitan emplear métodos bien establecidos desarrollados para el TEPT, mientras consideran los síntomas adicionales de DSO en el tratamiento del TEPT-C.

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Posttraumatic stress disorder; complex PTSD; clinical utility; complex trauma; borderline personality disorder; ICD-11

### PALABRAS CLAVE

Trastorno de estrés postraumático; TEPT-C; utilidad clínica; trauma complejo; trastorno de personalidad límite; CIE-11

### 关键词

创伤后应激障碍; 复杂性 PTSD; 临床效用; 复杂性创伤; 边缘型人格障碍; ICD-11

### HIGHLIGHTS

- The clinical utility of the CPTSD diagnosis has not yet been fully investigated.
- Diagnostic measures provide qualified assessment of the construct, of value to practitioners.
- The inclusion of CPTSD in ICD-11 may in time facilitate access to more tailored treatment interventions.

**Conclusiones:** La inclusión del TEPT-C en el CIE-11 podría facilitar potencialmente el acceso a más intervenciones de tratamiento adaptado, así como también contribuir a aumentar el foco de investigación en los trastornos especialmente asociados con el estrés. Se espera que el valor de la utilidad clínica de este diagnóstico adicional sea revelado por sí mismo luego de que el CIE-11 sea implementado en la práctica clínica desde el 2022 en adelante. Aun así, la inclusión diagnóstica del TEPT-C proporciona un futuro optimista para evaluar y tratar los síntomas de estrés postraumático complejo.

### 复杂性PTSD: 诊断的临床效用是什么?

**背景:** 复杂性创伤后应激障碍 (CPTSD) 的诊断被纳入了第11修订版国际疾病分类 (ICD-11)。CPTSD 与其兄弟疾病 PTSD 具有创伤特异性症状, 但额外特征是个体自组织紊乱(DSO)。CPTSD 诊断的临床效用尚未得到彻底研究。

**目的:** 考虑到即将在临床实践中实施 ICD-11, 本研究旨在考查 CPTSD 诊断的临床效用。

**方法:** 综述了结构和效度分析纳入有关 ICD-11 的国际实地研究, 并介绍了诊断测量工具; 国际创伤问卷 (ITQ) 和国际创伤访谈 (ITI)。此外, 在独立分析中阐述了CPTSD 与边缘型人格障碍 (BPD) 之间的关系, 以明确其与治疗的临床相关性的差异。参考现有指南和临床需求讨论了对CPTSD 的治疗启示。

**结果:** ITQ 和 ITI 的验证有助于在进一步临床实践中巩固 CPTSD, 提供对结构的资质评估, 对临床交流和促进治疗具有预期信息价值。在实证研究中发现 CPTSD 可与 PTSD 和 BPD 区分开来, 同时承认把 BPD/PTSD 并发病例描述为 CPTSD 更好的可能性。从业者需要采用为 PTSD 开发的成熟方法, 同时考虑在 CPTSD 治疗中的其他 DSO 症状。

**结论:** 将 CPTSD 纳入 ICD-11 可能有助于获得更有针对性的治疗干预, 并有助于增加对应激相关疾病的研究关注。在 2022 年及以后的临床实践中实施 ICD-11 后, 预计这种额外诊断的临床效用价值将进一步显现。然而, CPTSD 的诊断包含为评估和治疗复杂性创伤后应激障碍提供了未来的乐观性。

## 1. Introduction

The diagnostic manuals are important for how psychologists and psychiatrists assess and treat mental disorders, and the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization's (WHO) International Classification of Diseases (ICD) have since undergone numerous revisions, where diagnoses are updated and re-classified. The clinical applicability of the diagnoses is of great importance for clinical practice, and prior to the latest revision of ICD (ICD-11), experts on behalf of the WHO have sought to uncover how the revision could increase the manual's utility for clinicians through a number of initiatives in a global context (First, Reed, Hyman, & Saxena, 2015; International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011; Maercker et al., 2013; Reed, 2010; Reed et al., 2013). The ICD-11 was launched in 2018, adopted by WHO member countries in 2019 and is set to enter clinical practice on 1 January 2022 (World Health Organization [WHO], 2018a).

Following much scientific and clinical debate during the past decades, complex post-traumatic stress disorder (CPTSD) has been included as an independent diagnosis in ICD-11 (World Health Organization [WHO], 2018b). 'Complex PTSD' was originally conceptualized by Herman (1992), to describe complex behavioural conditions in survivors of prolonged or multiple trauma, where trauma escape is difficult or impossible, and entails changes in affect regulation, consciousness, self-perception, and relationships with others, among other symptoms. Despite supporting empirical evidence, the diagnosis was not included in the DSM-IV but was included in an appendix with research

diagnoses under the name 'disorders of extreme stress not otherwise specified' (DESNOS) (American Psychiatric Association [APA], 2000). In ICD-10, the diagnostic category, F62.0 Enduring personality change after catastrophic experience (EPCACE), was intended to describe personality-related late-onset of complex trauma, but this was used only to a small extent and excluded in favour of the CPTSD diagnosis in the transition to ICD-11 (WHO, 2018b). The introduction of CPTSD is based on DESNOS and EPCACE, as well as a long series of clinical observations and empirical analyses, which indicate that there is a distinct post-traumatic stress disorder which, in addition to core symptoms of PTSD, is characterized by disorders in three domains of self-organization: 1) affective dysregulation, 2) negative self-concept and 3) relational difficulties. The disorder is initially triggered by persistent and invasive stress, without symptoms necessarily arising from trauma-related stimuli at their onset (Maercker et al., 2013). The symptoms appear in different variations, but it is assumed that they cause suffering and disability in personal, family-related, social, educational, work-related, or other important areas of functioning (WHO, 2018b). A significant amount of evidence supports the discriminant validity of CPTSD when compared with PTSD (Brewin et al., 2017), but CPTSD's utility for clinical practice is still unclear (Cloitre, 2020). This article intends to uncover this based on the empirical research literature that has led to CPTSD's inclusion in ICD-11, and an account is given of relevant measuring tools that have been developed in connection with the establishment of CPTSD as a clinical construct. The clinical utility of the diagnosis is evaluated considering past conditions, differential diagnostics, implications for treatment, and future needs in clinical practice.

The International Advisory Group for the Revision of the ICD-10 Mental and Behavioural Disorders set increased clinical utility as a priority for the organization of ICD-11 (First et al., 2015, 2011). According to the WHO's definition, the clinical utility of a classification or category of mental illness depends on: a) its communicative ability (e.g. between clinicians, patients, families, etc.), b) its implementation into clinical practice, including its goodness of fit, ease of use, and time consumption, and c) its usefulness in determining interventions and as support in clinical assessments (Reed, 2010, p. 461). The definition also includes whether the use of the diagnostic category leads to improvements in clinical outcomes, both individually and at population level (Reed, 2010), and the clinical utility of ICD-11 has since its launch been the subject of several internet-based and clinical field studies (Luciano et al., 2020; Peterson et al., 2019; Reed et al., 2018a, 2018b).

## 2. Preliminary field studies

Unlike previous revisions as well as the DSM, several field studies of ICD-11's section on mental and behavioural disorders were conducted prior to the publication of the final edition (Evans et al., 2013; Reed, Correia, Esparza, Saxena, & Maj, 2011; Reed et al., 2018a, 2018b; Reed et al., 2013, 2015; Roberts et al., 2012; Robles et al., 2014). The purpose was to facilitate WHO's goals of clinical utility and global applicability (Reed, 2010), and to address potential shortcomings in advance. In two large international studies with 4,887 psychiatrists and 2,155 psychologists, from 44 to 23 countries, respectively, a diagnostic system was generally preferred which facilitated communication and informed treatment (Evans et al., 2013; Reed et al., 2011), and in an associated qualitative study, CPTSD was found to be the most frequently suggested diagnosis (12.2%) for future inclusion, in the absence of categorizations that covered complex trauma to a satisfactory degree (Robles et al., 2014). In other field studies, ICD-11 was overall evaluated with higher diagnostic precision than ICD-10, and CPTSD with significantly better results than its predecessor EPCACE (Gaebel et al., 2020; Keeley et al., 2016). Although ICD-11 could demonstrate higher clinical utility than ICD-10, this was not found for CPTSD specifically (Gaebel et al., 2020), and both PTSD and CPTSD have been measured with moderate interrater reliability in ecological field studies (Reed et al., 2018b). These findings thus warrant replication, but if nothing else, the implementation of the ICD-11 should be supplemented with diagnostic training, to comply with WHO's goals of minimized time consumption, global applicability, and diagnostic precision.

In an earlier phase, CPTSD as a clinical construct was characterized as being insufficient in the absence of a clear definition, validated measurement tools and discriminative

validity (Resick et al., 2012). This criticism has been replaced by extensive research over the past decade, in line with the inclusion of CPTSD into ICD-11. With the revision of ICD-11, the disorder was given a uniform definition, based on a limited number of symptoms, and standardized measuring tools have since been developed, such as the International Trauma Questionnaire (ITQ) (Cloitre et al., 2018), including ITQ-CA for adolescents between 7 and 17 years (Haselgruber, Sölvä, & Lueger-Schuster, 2020a, 2020b), and the International Trauma Interview (ITI) (Bondjers et al., 2019; Roberts, Cloitre, Bisson, & Brewin, 2018), which seeks to identify and differentiate PTSD and CPTSD in clinical practice. The development of ITQ is in line with WHO's principle of maximum clinical utility, as it is defined by few symptoms, is not time-consuming, and has simple guidelines for diagnostic identification (Cloitre et al., 2018). Both ITQ and ITI assess core symptoms and measure trauma exposure in a time-span perspective, as well as the prevalence of functional difficulties. Structured measurement tools such as these promote compliance between clinicians (Bondjers et al., 2019), and as they are directly derived from ICD-11, they contribute to qualified measurements of CPTSD, which can further support clinical assessments and inform treatment. The newly established instruments have demonstrated promising psychometric properties in terms of diagnostic precision (goodness of fit), are not prohibitively time consuming, are relatively easy to use (Bondjers et al., 2019; Cloitre et al., 2018; Shevlin et al., 2018), and provide good prospects for the assessment of PTSD and CPTSD in ICD-11. Comparatively, other more well-established instruments for trauma assessment, such as the Clinician Administered PTSD-scale (CAPS), are based on the PTSD definition from the DSM-5 (Weathers et al., 2018), and as such may provide an inadequate reflection of the CPTSD symptomatology in the ICD-11.

As summarized by Brewin et al. (2017), several studies support the discriminative validity of the disorder and a symptom-based factor structure where symptoms of PTSD and disturbances in self-organization (DSO) together constitute a construct of CPTSD. Compared to PTSD, patients with CPTSD have more often experienced multiple and persistent trauma and experience more invasive functional difficulties as a result of the disorder (Brewin et al., 2017). In a recent systematic review, it was concluded that ITQ was able to distinguish CPTSD from PTSD, but that the constructs appear more uniform when the study population is characterized by more extensive trauma history and distress, and the reviewers therefore question whether a hierarchical structuring of the two diagnoses is meaningful (Redican et al., 2021). Some researchers have also criticized the use of latent class analysis (LCA) and latent profile analysis (LPA) to demonstrate the construct validity of CPTSD and find different clinical groups depending on the statistical methods used (Achterhof, Huntjens, Meewisse, & Kiers, 2019; Ford, 2020). They assume that there is a much greater variation among PTSD patients, which

can neither be described by PTSD nor CPTSD, and it is speculated whether CPTSD thus represents a subtype of PTSD associated with higher levels of cumulative trauma exposure. As an alternative to two separate post-traumatic stress disorders, a dimensional approach has been proposed in which post-traumatic stress is defined on a spectrum (Ford, 2020; Wolf et al., 2015). Consensus exists in the research field that LCA and LPA alone cannot confirm the validity of a diagnostic construct, although other researchers insist that CPTSD should be recognized as a unique concept, as it is based on a strong theoretical and empirical foundation and can be identified in the real world (Cloitre et al., 2020).

### 3. Differential diagnostics

In other words, there is compelling evidence that CPTSD reflects a real and recognizable cluster of symptoms, which can be distinguished from PTSD by disturbances in self-organization. However, CPTSD places itself with symptomatologic proximity to other disorders marked by emotional dysregulation, loss of consciousness, identity, or self-control, such as dissociation disorders, depression, addiction, and BPD (Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Ford, 2020). It is noteworthy that borderline personality disorder (BPD) has been closely related to CPTSD, since the latter's recent classification, both in terms of aetiological risk factors and symptoms, particularly those pertaining to affective dysregulation and relational difficulties (Herman, 1992; Resick et al., 2012). By synthesizing results from a targeted literature search for studies comparing BPD and CPTSD, the distinction between the two is unfolded in a differential diagnostic analysis. The search was limited to the last five years (2016–2021), with the aim of presenting an up-to-date presentation, taking into account revised diagnostic terminology. In both PubMed and PsychNet, 'borderline', 'BPD', 'borderline personality disorder', 'complex ptsd' and 'cptsd' were included in a search string.

Here, most studies find clear commonalities between CPTSD and BPD (Ford, 2019; Frost, Hyland, Shevlin, & Murphy, 2020; Frost et al., 2020; Giourou et al., 2018; Hyland, Karatzias, Shevlin, & Cloitre, 2019; Jowett, Karatzias, & Albert, 2020; Jowett, Karatzias, Shevlin, & Albert, 2020; Saraiya et al., 2021; van Dijke, Hopman, & Ford, 2018), specifically regarding affective dysregulation, which is attributed to transdiagnostic risk factors. Several of these studies have used latent class analyses (Frost et al., 2020; Jowett et al., 2020; Saraiya et al., 2021), but also extended analyses such as structure equation modelling have been used (Frost et al., 2020; Hyland et al., 2019; van Dijke et al., 2018) to address limitations in factor analytical methods for discriminative purposes, as BPD and CPTSD have conceptual similarities (Achterhof et al., 2019; Ford, 2020; Hyland et al., 2019). Despite these identified similarities, CPTSD is distinguishable from BPD in these studies, except for one (Saraiya et al.,

2021), thus also confirming findings from previous studies (Cloitre et al., 2014; Ford & Courtois, 2014). The differences are seen primarily in the phenomenological expression of the disorders; BPD marked by an unstable self-concept, and CPTSD by a more persistent negative self-concept (Frost et al., 2020; Jowett et al., 2020). Mood fluctuations are generally more prominent in BPD and are expressed, among other things, through unstable social connections, separation anxiety, and emotional reactivity such as self-harming behaviour (Hyland et al., 2019). Contrary to this, CPTSD is characterized by emotional numbing and withdrawal from social relationships (Frost et al., 2020; Hyland et al., 2019). The latter can be considered as a post-traumatic symptom of avoidance, as social interactions can trigger trauma responses. Similarly, as certain DSO- and BPD symptoms co-occur in some, but not all sub-groups in the referred studies, recent findings indicate that there are more multifaceted symptom combinations to complex trauma than simply PTSD and DSO (Ford & Courtois, 2021).

As CPTSD is characterized by a combination of symptoms from PTSD and DSO, and has significant similarities to BPD, several studies have questioned whether CPTSD is in fact a fusion of PTSD and BPD (Frías & Palma, 2015; Resick et al., 2012), and could therefore be represented in two separate comorbid diagnoses. This can be extended to a question of comorbidity; whether symptoms should be described in aggregate diagnoses or as multiple coexisting disorders. If a complex disorder is to be defined in one unifying diagnosis, it presupposes that it is both precise and applicable. In ICD-11, specifying diagnostic guidelines for the core symptoms of the disorder, including CPTSD, has been a means of precisely minimizing overlap with other diagnoses and increasing the applicability of the diagnoses in clinical practice (Møller, Augsburger, Elklit, Søgaaard, & Simonsen, 2020; Reed, 2010), with the intention to facilitate transparency for treatment planning (Cloitre, 2020). For such a diagnostic fusion to be clinically useful, it is contingent that clusters of symptoms do not have divergent implications for treatment, which is the case for PTSD and BPD, and CPTSD and BPD (Karatzias et al., 2019). Evidence that DSO symptoms are phenomenologically different from BPD symptoms indicates that CPTSD should not be equated with comorbid PTSD and BPD (Borroni, Masci, Franzoni, Somma, & Fossati, 2021; Frost et al., 2020), and in differential diagnostic studies, BPD is also characterized as an individual construct, which does not only occur comorbidly with trauma disorders (Ford & Courtois, 2014; Knefel, Tran, & Lueger-Schuster, 2016). However, it cannot be excluded that there are cases of BPD or comorbid BPD/PTSD, which could have been better described as CPTSD, given that the cluster of symptoms are representative hereof. As a result of many people with BPD having experienced traumatic life events, some argue that the diagnosis could have been co-organized with PTSD and CPTSD on a trauma

spectrum (Ford, 2020; Ford & Courtois, 2014; Giourou et al., 2018). In this way, transdiagnostic dispositions such as overlapping aetiology may be better addressed when prioritizing interventions, which could generally optimize the usefulness of the diagnoses regarding clinical outcomes.

#### 4. Treatment

Differential diagnostics are undoubtedly important for informing treatment of complex clusters of symptoms, and divergent symptom expressions show how ICD-11 can facilitate targeted and symptom-specific treatment in practice. In contrast to the previous diagnostic classification DESNOS, CPTSD is defined from few specific symptoms, which can be advantageous both within differential diagnostic assessments and in prioritizing treatment, as it brings greater definitional clarity to what symptoms to address. In the DSM-5, complex trauma responses are not separated into a separate diagnostic category such as CPTSD, but incorporated into an extended PTSD category, which is presently defined by up to 636,120 symptom combinations (Galatzer-Levy & Bryant, (2013)). With regards to clinical utility, clinicians using the DSM-5 may risk neglecting complex symptoms in self-organization in the treatment of the disorder, if these additional symptoms are not given the necessary attention. While pending increased consensus and publication of adequate intervention studies for CPTSD, practitioners must adhere to the best available evidence and apply well-established methods developed for PTSD, preferably trauma-focused CBT and EMDR, and adapt where necessary (Karatzias et al., 2019; National Institute for Health and Care Excellence [NICE], 2018). It can be seen as beneficial if CPTSD treatment is developed further from methods that clinicians are already engaged with, as necessary adjustments can then be made with support from clinical experience within trauma treatment. In the latest treatment guidelines, sequenced treatment is not considered necessary to ensure sound and effective trauma treatment, but there is consensus that stabilizing elements can be advantageously integrated into therapy (International Society for Traumatic Stress Studies [ISTSS], 2018; NICE, 2018). Existing guidelines recommend an extended treatment process, which considers any progression-inhibiting barriers, such as substance misuse, dissociation, or dysregulation, and prioritizes the development of a trusting treatment relationship (NICE, 2018). The treatment process can be extended with more sessions, can be extended over a longer period, or both. It seems plausible that complex additional symptoms reflect the individual's adaptation to persistent trauma exposure, and consequently it is presumed to require interventions of longer duration for sufficient processing and symptom-relieving effects to take place. CPTSD also often follows interpersonal trauma, which is expressed symptomatically by the patient's relational difficulties, and can have an impact on the motivation to enter a therapeutic relationship

(Brewin, 2020). Prioritization of a trusting treatment alliance is therefore not only expected to promote progression in the trauma-focused treatment but can also positively influence the patient's other relationships and social life. More research targeting CPTSD symptoms is under development, and there is initial supportive evidence for complementary interventions that address disturbances in self-organization more directly, including DBT-PTSD (Bohus et al., 2019, 2020) and self-compassion-oriented therapy (Karatzias et al., 2019). For a more elaborate description of the relevant adaptations in treating complex post-traumatic stress symptoms and disturbances in self-organization, we refer the readers to Ford and Courtois (2020).

As ICD-11 has an overarching goal of improving clinical outcomes (Reed, 2010), it is relevant to evaluate the political, economic, and practical circumstances that characterize the individual assessment and treatment in a long-term context. Optimal specialized treatment may be unavailable to the traumatized person, and the awareness of differences in global treatment options is therefore important and may need modifications across national treatment guidelines. In short, CPTSD, no matter how apt the diagnostic description may be for the patient in question, will not be beneficial if it does not positively affect the treatment outcome. Thus, facilitating symptom relief for less resourceful traumatized clinical groups is therefore an important task for WHO and their member countries.

#### 5. Research implications

With a diagnosis that can convey the complexity of the post-traumatic response that characterizes CPTSD, interventions can more easily target the specific symptoms of the disorder and improve treatment outcomes. Several studies on the nature of symptoms and global prevalence of CPTSD are expected to contribute to the further development of effective interventions across patient sub-groups. ICD-11 is created with an expectation that diagnoses can create treatment protocols, which target the cluster of symptoms and the level of functioning associated with each disorder, and development and validation of this type of protocols should be prioritized in future research (Cloitre, 2020). Another important priority for the understanding of CPTSD will be ongoing evaluation of the diagnosis, in line with its implementation in clinical practice across diverse groups, and in different countries and cultures. As some context-dependent variation in symptom profiles is to be expected, ecological field studies could help inform future revisions of the diagnosis. Additionally, the inclusion of CPTSD in ICD-11 has given rise to more consensus-based studies, and future research can consequently be based on a uniform description of the concept. This is demonstrated in the operationalization of ITQ and ITI; both instruments which identify the core symptoms of the disorder from ICD-11. These can help enable new

prevalence studies and can be used as outcome measures when developing novel treatments for CPTSD. Finally, symptom-specific results from these measures can help inform appropriate optimization of individual patient treatment, and further research on the construct can thus help facilitate an increasingly evidence-based clinical practice.

## 6. Conclusion

Preliminary evidence indicates that the inclusion of CPTSD in ICD-11 meets a demand among practicing clinicians and the diagnosis has shown promising results for assessment in international field studies. Here, CPTSD arguably represents a clinically valuable diagnostic category if the diagnosis increases access to more tailored treatment and stimulates further research on post-traumatic stress in diverse samples. A reciprocal and informative relationship between research and clinical practice can create fruitful conditions for the clinical basis of the diagnosis. After ICD-11 is fully realized into clinical practice, a more concise clarification of the clinical utility value of the diagnosis is expected, and it can be concluded that the addition of CPTSD into the ICD-11 gives way for future optimism for a severely traumatized and vulnerable patient group.

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Data sharing is not applicable to this article as no new data were created or analyzed in this study.

## Ethics statement

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