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Complex Post Traumatic Stress Disorder: A Guide to Diagnosis and Formulation for the Purpose of ACC Cover

For ACC ISSC suppliers, providers and assessors

Complex Post Traumatic Stress Disorder (CPTSD) refers to a specific trauma-related disorder with a spectrum of complexity characterised by typical symptoms of psychological trauma in addition to the distortion of identity of self and significant emotional dysregulation.

There has been a working diagnosis of Complex Post Traumatic Stress Disorder (CPTSD) for 20 years or more and the diagnosis was formally adopted (as part of ICD-11) by the World Health Assembly in May 2019. ICD 11 will replace all earlier versions in January 2022. ACC has been preparing to accept the diagnosis for consideration for cover and has developed guidelines for assessors. These guidelines address the *assessment, diagnosis and causal formulation* of CPTSD.

Assessment considerations

The theoretical construct of CPTSD reflects a diagnostic umbrella which encompasses several traditionally recognised diagnoses. This diagnosis can therefore be considered to include a collection of interrelated/overlapping comorbidities (such as, in addition to PTSD but not limited to, personality dysfunction, depressive and anxiety disorders, and eating disorders to name a few).

Until now, the diagnosis of CPTSD has not been accepted by ACC. Instead, assessors have been asked to reformulate this diagnosis according to available classification systems, which usually entails diagnosing two or more conditions, of which PTSD is one. Causation for each condition diagnosis needed to be considered separately.

Diagnostic Considerations

The ICD-11 describes CPTSD as a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). **All diagnostic requirements for PTSD need to be met in order to make the diagnosis.**

In addition, CPTSD is characterised by **severe and persistent personality issues:**

- problems in affect regulation *(affective domain)*;
- beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event *(self-concept domain)*; and
- difficulties in sustaining relationships and in feeling close to others *(relational domain)*.

These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning and arise from adverse conditions and relationships in childhood.

A commonly found co-morbidity with complex trauma responses is that of PTSD coupled with personality dysfunction, particularly Borderline traits.

Similarities or overlap between BPD and CPTSD occurs in the following areas:

- perceived betrayal and victimisation
- fragmented sense of self and desire to self-harm
- perceived inability to control extreme affects and impulses.

On the other hand, four BPD symptoms have been found to greatly increase the likelihood of a diagnosis of BPD rather than CPTSD:

- frantic efforts to avoid abandonment
- unstable sense of self
- unstable and intense interpersonal relationships
- impulsiveness

In addition, personality disturbance associated with CPTSD may include traits from different personality disorder clusters, not only Borderline Personality.

Causal Formulation

Complex trauma results from exposure to severe stressors that are repetitive and prolonged; involve harm or abandonment by caregivers or those with whom the victim has some form of relational connection; and **most often occur at developmentally vulnerable periods in the victim's life, namely, in childhood or adolescence**, when brain development is occurring or being consolidated. The Causal Formulation needs to draw together psychologically meaningful aspects of the client's history and presentation that support the diagnosis, while at the same time deconstructing the umbrella diagnosis of CPTSD into its constituent parts or symptom clusters along with discussion about the developmental trajectory and causation. The following examples attempt to described some of these situations.

- For clients who have experienced significant adversity in childhood that **included prolonged or repeated sexual abuse**, a diagnosis of CPTSD may be appropriate; and to distinguish the relative contribution of the sexual abuse from other traumatic events (for example, physical abuse, abandonment, neglect) may be impossible. For the purpose of determining cover and assessing impairment, this is relatively simple in that it is clear that the sexual abuse events are likely to have contributed materially to the development of the CPTSD (and all those clinical relevant symptom clusters that fall under it which will need to be described).
- For clients who experience adverse, abusive childhoods **with no sexual abuse**, and who develop significant psychological dysfunction prior to a sexual abuse event occurring in, for example, mid-late adolescence or adulthood, a diagnosis of CPTSD may still be ***clinically*** appropriate. But the contribution of the sexual abuse to the psychological dysfunction or diagnosis is less clear. Those trauma symptoms, or other psychological dysfunction that was not pre-existing, specifically relating to the sexual abuse will need to be highlighted separately. Thus, for example, a diagnosis of CPTSD may be appropriate but the assessor may attribute only the PTSD part of the diagnosis to the sexual

events (while highlighting that, for example, the personality dysfunction and depressive disorder were pre-existing and related to other non-sexual adversity).

- In addition, there may be clients who have experienced sexual abuse as one small component of an adverse history, such as in the case of a single incident or several relatively minor instances of childhood sexual abuse in the context of severe, repeated and prolonged developmental adversities of a non-sexual nature. In this case it becomes more difficult to formulate how the development of the CPTSD was materially linked to the sexual abuse. Although the client may present with some trauma symptoms related to sexual abuse, they would likely have developed many of the relevant symptoms (such as relational and affective difficulties) even without the sexual abuse. Providing substantial evidence for the links to sexual abuse may be impossible in such a presentation and due consideration needs to be given to what, if any, symptoms are related to the sexual abuse, and how can they be diagnosed for cover.

Accepting cover for CPTSD

It is important that CPTSD is described in as clear, deconstructed a manner as possible in order that the client's eligibility for treatment and/or compensation is not compromised.

With regard to **cover** for **treatment** and **impairment of functioning**, it is essential that a clear understanding of the client's presentation, diagnosed disorders/symptom clusters, and links to sexual abuse are provided.

Treatment recommendations for the mental injuries that are linked to the sexual abuse events and are part of a CPTSD will follow from a clear description. Where there are mental injures that are not linked, it will require the provider to approach treatment with sensitivity to those injuries (for example, BPD), while attending to injuries that are under a covered condition (for example, PTSD).

Impairment assessors must apportion for impairment that is due to factors ***other than the sexual abuse*** and requires that the diagnosis is accompanied by a clear explanation of which aspects of the presentation are ***not due to the sexual abuse***.

In order to ensure clients are not disadvantaged and can still be awarded cover and entitlements, these guidelines propose a way forward when assessing, reporting and treating CPTSD.

Recommendations for causal formulation of CPTSD

It is recommended that Assessors should familiarise themselves with the ICD-11 diagnostic criteria, and also the relevant academic literature on this disorder. As a newly included disorder in the diagnostic manuals, it is important that careful consideration is given to diagnosis and causation.

ACC proposes the following guidelines:

- When considering a diagnosis of CPTSD the report needs to describe the symptomatic clusters, for example: *trauma-related symptoms, mood-related symptoms, personality traits or behavioural patterns*, and support these with a clear **description of the symptoms** and using **diagnostic psychometric measures** where appropriate.
- The report needs to include a discussion regarding differential diagnoses, given the likely overlap of symptoms, in setting out the diagnoses or clinically relevant symptom clusters included under the CPTSD umbrella.
- A clear developmental pathway will be required for all diagnoses and the assessor will need to provide a robust clinical opinion as to which aspects of the CPTSD are materially linked/caused by the Schedule 3 events and which are not.
- For ACC to accept a diagnosis of CPTSD a minimum expectation would be that the

identified PTSD has to be linked to the Schedule 3 event.

We recommend that assessors consider the following options where **factors unrelated to sexual abuse** are identified as contributing significantly to the development of the CPTSD:

(1) Where various causal factors can be disentangled from each other, assessors may prefer to use ICD-10, DSM-IV or DSM5 classification systems as a guideline for differentiating symptom clusters in which more than one diagnosis is offered, namely PTSD and another diagnosis (or diagnoses) which best encapsulates the symptoms considered largely **unrelated** to the sexual abuse.

(2) Where assessors choose to diagnose CPTSD they are advised to distinguish between symptoms/ aspects of the presentation that are considered to be causally linked to the sexual abuse and those that are more likely to be causally linked to other factors.

Examples to assist understanding of CPTSD presentations and causality are provided below.

Client A has a history of a poor relationship with her mother with significant attachment issues. Her father was an alcoholic and violent, and she was placed in care from 4-9, due to neglect and maternal drug use. Here she was sexually abused by two perpetrators over the five-year period. She is now aged 42, has an ongoing history of alcohol and drug abuse beginning at 16, several instances of self-harm (cutting), two suicide attempts, and presents with chronic trauma symptoms, anxiety, and depression.

The client presents a picture which would be considered for a diagnosis of CPTSD. The personality development was compromised from an early age and the client was removed from her family due to neglect. She entered care at 4 and experienced 5 years of sexual abuse. The impact of these factors cannot easily be separated out and while it is likely that the client would have had personality dysfunction resulting from her early relationships, the sexual abuse is of significance to her personality development between 4 and 9 years.

This client would fulfil criteria for CPTSD, and it could be opined that client's experience of sexual abuse was a material contributor to the development of the CPTSD.

However, for the purposes of ACC the assessor will need to deconstruct this into its constituent parts. For example, under the umbrella of CPTSD it could be formulated that the client suffers from PTSD and Borderline Personality traits/Disorder, Alcohol Abuse Disorder, and Cannabis Abuse Disorder. The developmental trajectory of each symptom cluster will also be required. In the above case it appears likely that all the symptom clusters could be considered materially linked to the S.3 events (given the near impossibility in separating out the various abuses experienced).

It may be more difficult to differentiate whether personality issues are materially linked to the S.3 events when the events occur later in childhood or adolescence.

Client B is 45 years old. She was one of seven children in a dysfunctional family in which alcohol and drug use by both parents was prevalent, along with harsh emotional abuse, throughout her childhood. Her mother was largely absent, and her father abandoned the family at age 6. There is a documented medical history of depression with adolescent onset, along with the client exhibiting angry and reckless behaviours, misusing substances, and some significant eating dysfunction. In her early twenties she engaged in a 10-year abusive relationship, in which she was physically, emotionally, and sexually abused. Currently the client presents a complex picture of trauma symptoms, relationship and personality dysfunction, depression, eating disorder and substance abuse (all of which have a long history).

The client would likely meet the criteria for CPTSD. However, the personality dysfunction, mood disorder, eating difficulties and substance misuse all appear to

be pre-existing and linked to childhood adversity and other factors that occurred prior to the sexual abuse. There are, however, clear thematic links between the intrusive trauma symptoms and the sexual assaults in her adult relationships, which have persisted for over twenty years. It is likely to be opined that the PTSD is materially linked to the S.3 events. Thus, the clinician could diagnose the umbrella diagnosis of CPTSD, but deconstruct this as comprising PTSD, Borderline Personality Disorder, Dysthymic Disorder, Binge Eating Disorder and Polysubstance Use Disorder – opining that only the PTSD would be considered a MICSA.

References

American Psychiatric Association (APA). (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*. (DSM-IV). APA: Arlington, VA.

American Psychiatric Association (APA). (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. (DSM-5). APA: Arlington, VA.

Cloitre, M., Garvert, D.W., Weiss, B., Carlson, E.B., & Bryant, R.A. (2014) Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis. *European Journal of Psychotraumatology*, 5(1), 25097. **https://doi.org/10.3402/ejpt.v5.25097**

Ford, J. & Courtois, C. (2014). *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models, 2nd Edition*. New York: The Guilford Press.

Herman, J. (1992). Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377-391.

Herman, J. (2014). Foreword. In J. Ford, & C. Courtois. (2014). *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models, 2nd Edition*. New York: The Guilford Press.

World Health Organisation (WHO). (2016). ICD-10: *The International Classification of Diseases and Related Health Problems: Tenth Revision*. World Health Organisation. **https://icd.who.int/browse10/2016/en**

World Health Organisation (WHO). (2019). ICD-11: *The International Classification of Diseases and Related Health Problems: Eleventh Revision*. World Health Organisation. **https://icd.who.int/en**