

THE BEHAVIOUR INSTITUTE
Diploma in Trauma-Informed Psychotherapy

UNIT 3 • CORE READING 2 OF 6

02

Complex PTSD

Beyond the single-incident model

What This Document Covers

The previous document covered PTSD as it is classically understood — arising from a specific, identifiable event. This document covers Complex PTSD, a related but distinct presentation arising from prolonged or repeated trauma, typically within relationships the person could not easily escape.

Where Complex PTSD Comes From

Complex PTSD, often abbreviated CPTSD, was developed to describe a pattern seen repeatedly in survivors of prolonged, repeated trauma — childhood abuse or neglect, domestic captivity, human trafficking, prolonged combat exposure, and similarly sustained circumstances — that the standard PTSD framework did not fully capture. The concept was formally recognised in the ICD-11 diagnostic system as its own distinct diagnosis, sitting alongside PTSD rather than replacing it. This is a genuinely important point for practitioners: PTSD and Complex PTSD are related but separate diagnoses, not simply a milder and more severe version of the same thing.

The Additional Features

Complex PTSD includes the same core PTSD symptom clusters covered in Document 1, alongside three additional clusters, sometimes referred to together as “disturbances in self-organisation.”

Emotional Dysregulation

Difficulty managing emotional responses — this can present as heightened emotional reactivity, or, in the opposite direction, emotional numbing and a diminished capacity to feel much of anything. Some people move between both, sometimes within a single day.

Negative Self-Concept

Persistent, deeply held beliefs of being worthless, defeated, or diminished, often accompanied by pervasive feelings of shame or guilt connected to the trauma — even where, from an outside perspective, the person clearly bears no responsibility for what happened to them.

Relational Disturbances

Persistent difficulty sustaining relationships and feeling close to others — this can show up as chronic avoidance of relationships altogether, or a pattern of relationships marked by real difficulty trusting, or both at different points.

Pause and Consider

Think about the difference between a single frightening event and a sustained period of danger you could not escape — even a non-traumatic example, like a genuinely difficult period at work you felt unable to leave. Does that distinction help you understand intuitively why prolonged, inescapable trauma might produce a different, broader pattern than a single incident?

Why Escapability Matters So Much Here

Document 3 in Unit 2 identified escapability and control as one of the strongest predictors of lasting impact. Complex PTSD sits directly on that logic: it develops overwhelmingly in contexts where a person could not leave, could not fight back effectively, and had no reliable path to safety — a child dependent on an abusive caregiver, a partner in a coercively controlling relationship, a person held captive. The prolonged, inescapable nature of the trauma, not simply its repetition, appears central to why the additional three clusters develop.

A Story to Make This Real

Consider a composite scenario drawn from patterns seen repeatedly in practice. A client, “Naomi,” 31, sought therapy for what she described as “always feeling on edge and never really trusting anyone, even people who've never given me a reason not to.” Naomi had grown up with a parent whose behaviour was volatile and unpredictable across her entire childhood — sometimes warm, sometimes frighteningly volatile, with no reliable way to predict which she would encounter on a given day.

Naomi met the core PTSD criteria covered in Document 1, including intrusive memories and hypervigilance. But her presentation extended further: profound, longstanding shame she could not fully articulate the origin of, a persistent inner conviction that she was fundamentally unlovable despite considerable external evidence to the contrary, and a pattern of either avoiding closeness entirely or forming relationships marked by significant difficulty trusting her partner's stated intentions, even when those intentions were consistently demonstrated over time.

Naomi's presentation reflects the additional three clusters of Complex PTSD directly: emotional dysregulation (the persistent sense of being on edge), negative self-concept (the deep, hard-to-articulate shame and sense of being unlovable), and relational disturbance (the pattern of avoidance or difficulty trusting). Treating Naomi's presentation as standard PTSD alone, addressing only the intrusive memories and hypervigilance, would have left a substantial part of her actual experience unaddressed.

Why the Distinction Matters Clinically

Recognising Complex PTSD as distinct from PTSD has real, practical treatment implications, which Unit 4 will cover in depth. Approaches developed primarily for single-incident PTSD do not always translate directly to Complex PTSD without meaningful adaptation, particularly given the added emphasis Complex PTSD requires on self-concept, emotional regulation skills, and relational safety — work that often needs to happen before, or alongside, more direct trauma processing, rather than only after it.

What's Next

The next document turns to a phenomenon closely connected to both PTSD and Complex PTSD, and touched on already in Unit 2's coverage of freeze: dissociation, and the different forms it can take.

A Few Things to Take With You

- Complex PTSD is a distinct diagnosis, recognised in ICD-11, arising typically from prolonged or repeated, inescapable trauma
- It includes the core PTSD clusters plus three additional clusters: emotional dysregulation, negative self-concept, and relational disturbances
- Escapability, as covered in Unit 2, is central to why prolonged trauma produces this broader pattern
- Complex PTSD is not simply a more severe version of PTSD — it is a related but separate presentation, requiring adapted treatment approaches

Before You Move On

- In Naomi's story, which of the three additional clusters do you think would be hardest for a client to name or articulate directly in an early session?
- Why do you think Complex PTSD was formally recognised as its own diagnosis, rather than simply being folded into existing PTSD criteria?
- How might treating Complex PTSD as identical to standard PTSD lead to a client's full experience going unaddressed?