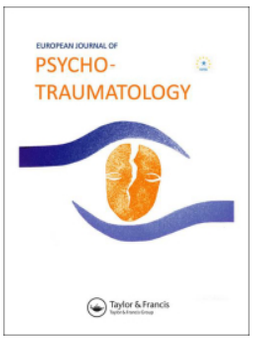

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SHORT COMMUNICATION

A clinician rating to diagnose CPTSD according to ICD-11 and to evaluate CPTSD symptom severity: Complex PTSD Item Set additional to the CAPS (COPISAC)

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ABSTRACT

Background: Researchers who wish to study stress-related disorders need to use valid, reliable, and sensitive instruments and the Clinician-administered PTSD Scale (CAPS) constitutes the gold standard in the assessment of posttraumatic stress disorder (PTSD). While the CAPS corresponds with PTSD criteria according to the DSM-5, researchers face a challenge with the forthcoming ICD-11: ICD-11 introduces the new diagnosis Complex PTSD (CPTSD) that does not exist in DSM-5.

Objective: Researchers as well as clinicians will need to assess the incidence and prevalence of CPTSD and will want to evaluate treatment effects according to both criteria sets. However, using two clinician-rated interviews is often not feasible and a burden to patients, particularly in psychotherapy research.

Method & Results: We have therefore developed the Complex PTSD Item Set additional to the CAPS (COPISAC). This clinician rating is an easy-to-use and economic addition to the CAPS that permits assessing diagnosis and evaluating symptom severity of CPTSD. COPISAC consists of three items that assess disturbances in self-regulation including prompts for symptom description and frequency, and two additional items assessing impairment. Diagnostic status and severity ratings for CPTSD are possible. Items that account for the specific forms of trauma which the ICD-11 describes as precursors of CPTSD (e.g. torture, being enslaved) are further suggested as additions to the Life Events Checklist.

Conclusion: With an introduction of COPISAC at this point, we aim at suggesting an easy transition into diagnosing CPTSD and evaluating its course over treatment.

Una calificación del médico para diagnosticar TEPT-C de acuerdo con CIE-11 y para evaluar la gravedad de los síntomas de TEPT-C: Conjunto de ítems de TEPT complejo adicionales a las CAPS (COPISAC en su sigla en inglés)

Antecedentes: Los investigadores que deseen estudiar los trastornos relacionados con el estrés deben utilizar instrumentos válidos, fiables, y sensibles, y la Escala de TEPT administrada por un médico (CAPS en su sigla en inglés) constituye el estándar por excelencia en la evaluación del trastorno de estrés postraumático (TEPT). Si bien la CAPS se corresponde con los criterios de TEPT según el DSM-5, los investigadores se enfrentan a un desafío con la próxima CIE-11: la CIE-11 presenta el nuevo diagnóstico de TEPT complejo (TEPT-C) que no existe en el DSM-5.

Objetivo: Tanto los investigadores como los médicos deberán evaluar la incidencia y la prevalencia del TEPT-C y querrán evaluar los efectos del tratamiento de acuerdo con ambos conjuntos de criterios. Sin embargo, el uso de dos entrevistas calificadas por médicos a menudo no es factible y constituye una carga para los pacientes, particularmente en la investigación de psicoterapia.

Método y Resultados: Por lo tanto, hemos desarrollado el Conjunto de ítems de TEPT complejo adicional a los CAPS (COPISAC). Esta calificación del médico es una adición económica y fácil de usar a la CAPS que permite evaluar el diagnóstico y evaluar la gravedad de los síntomas de TEPT-C. COPISAC consta de tres ítems que evalúan las alteraciones en la autorregulación, incluidas las indicaciones para la descripción y la frecuencia de los síntomas, y dos ítems adicionales que evalúan el deterioro. Es posible el estado de diagnóstico y las clasificaciones de gravedad para TEPT-C. Los ítems que dan cuenta de las formas específicas de trauma que la CIE-11 describe como precursores de TEPT-C (por ejemplo, tortura, ser esclavizado) se sugieren además como adiciones a la Lista de Verificación de Eventos de la Vida.

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KEYWORDS
Posttraumatic stress disorder; complex PTSD; clinical interview; ICD-11; Clinician-administered PTSD Scale PTSD

PALABRAS CLAVE
trastorno de estrés postraumático; TEPT complejo; entrevista clínica; CIE-11; Escala de TEPT administrada por un médico

关键词
创伤后应激障碍; 复杂性PTSD; 临床访谈; ICD-11; 临床用PTSD量表

HIGHLIGHTS

- The clinician rating COPISAC is an easy-to-use and economic addition to the Clinician-administered PTSD Scale.
- It permits to make a diagnosis of Complex PTSD and evaluate symptom severity.

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Supplemental data for this article can be accessed here.

Conclusión: Con una introducción de COPISAC en este momento, nuestro objetivo es sugerir una transición fácil hacia el diagnóstico de TEPT-C y la evaluación de su curso durante el tratamiento.

一项根据ICD-11诊断CPTSD和评估CPTSD症状严重程度的临床医生评分：除CAPS（COPISAC）之外的复杂性PTSD条目集

背景: 希望研究应激相关疾病的研究人员需要使用有效，可靠和敏感的工具，临床用PTSD量表 (CAPS) 构成评估创伤后应激障碍 (PTSD) 的金标准。尽管根据DSM-5，CAPS符合PTSD标准，但研究人员面临即将到来的ICD-11的挑战:ICD-11引入了DSM-5中不存在的新诊断——复杂性PTSD (CPTSD) 。
目的: 研究人员和临床医生将需要评估CPTSD的发生率和患病率，并希望根据这两个标准集评估治疗效果。但是，使用两次临床医师评定的访谈通常不可行并且是患者的负担，尤其在心理疗法研究中。
方法与结果: 因此，我们开发了CAPS (COPISAC) 之外的复杂性PTSD条目集。该临床医生评分是一个对CAPS的易于使用且经济的补充，可用于对CPTSD的评估诊断和评估症状严重程度。COPISAC包括三个评估自我调节障碍的条目（包含症状描述和频率的提示），以及另外两个评估损伤的条目。 CPTSD的诊断状态和严重程度评分是可能的。ICD-11描述为CPTSD前兆（例如酷刑，被奴役）的解释特定创伤形式的条目，也被建议作为生活事件清单的补充。
结论: 通过在此介绍COPISAC，我们旨在提议一个轻松过渡到诊断CPTSD及评估其治疗过程的方法。

In the recently released 11th revision of the International Classification of Diseases (ICD-11; World Health Organization, 2019), the diagnosis of posttraumatic stress disorder (PTSD) has seen substantial changes, and the new sibling disorder of Complex PTSD (CPTSD) has been introduced. These changes have direct implications for clinical assessment. The present article seeks to introduce a new clinical interview that allows to follow the ICD-11 guideline while also keeping with established assessment traditions in the field of traumatic stress.

In ICD-11, the diagnosis of PTSD has been moved towards specificity and symptoms that PTSD shares with other disorders (e.g. sleep disturbances) have been eliminated (Maercker et al., 2013). The guideline now focuses on three disorder-specific core elements which constitutes a much narrower approach than taken in the ICD-10 and the DSM-5 where PTSD is now described by 20 symptoms in four clusters (American Psychiatric Association, 2013). The ICD-11 guideline for PTSD requires 1) re-experiencing of the traumatic event in the present in the form of vivid intrusive memories, flashbacks, or nightmares accompanied by strong emotions and physical sensations, 2) avoidance of reminders that trigger thoughts and memories of the event, and 3) a persistent perception of heightened current threat (World Health Organization, 2019). The quality of re-experiencing in the here and now is stressed compared to unwanted memories alone (Maercker et al., 2013).

A detailed comparison between DSM-5 and ICD-11 criteria for PTSD is provided in the Supplement. The different approaches of DSM-5 and ICD-11 to PTSD – one broad, one narrow – resulted in necessary investigations into the concordance between the two guidelines. Higher prevalence rates of DSM-5 PTSD than ICD-11 PTSD have been shown for refugees (Heeke, O'Donald, Stammel, & Böttche, 2020), internally displaced people (Shevlin et al., 2018), US veterans (Wisco et al., 2017), survivors of the Norway terror attack (Hafstad, Thoresen, Wentzel-Larsen, Maercker, & Dyb, 2017), survivors of sexual abuse (Hyland et al., 2016), and in a large web-based survey in Japan (Oe, Ito, Takebayashi, Katayanagi, & Horikoshi, 2020). The level of agreement differed between the studies and ranged from substantial (Heeke et al., 2020; Oe et al., 2020) to low (Shevlin et al., 2018). However, there was a uniform tendency for fewer participants to be diagnosed with PTSD using ICD-11 criteria because they did not meet the re-experiencing criterion (e.g. Heeke et al., 2020; Hyland et al., 2016; Shevlin et al., 2018). Based on these results, it seems impossible to establish a diagnosis according to one system and conclude that the patient also meets the criteria according to the other system.

The new sibling diagnosis of CPTSD is reserved as a reaction to chronic or repeated traumatic events from which escape is difficult or impossible (the ICD-11 names torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). It replaces 'enduring personality change after catastrophic experience' in ICD-10 and does not exist in DSM-5. A diagnosis of CPTSD can be made when all PTSD criteria are fulfilled, and three additional symptoms related to disturbances in self-organization (DSO) are present. DSO criteria are 1) affect dysregulation, 2) negative self-concept that includes beliefs about oneself as diminished, defeated or worthless that is accompanied by feelings of shame, guilt or failure related to the traumatic event, and 3) difficulties in relationships, i.e. sustaining relationships and feeling close to others (World Health Organization, 2019).

Another predecessor of CPTSD is 'Disorders of Extreme Stress Not Otherwise Specified' (DESNOS) which was included in the Appendix to DSM-IV (American Psychiatric Association, 2000). The DSM-IV field trial showed that prolonged interpersonal trauma is associated with problems with affect dysregulation, aggression against self and others, dissociative symptoms, somatization, and character pathology in addition to PTSD (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997) and DESNOS covered these complex problems. However, the overlap with PTSD was substantial (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) and nearly all of those who met criteria for DESNOS also met criteria for PTSD (Roth et al., 1997). For ICD-11, CPTSD was then streamlined according to empirical evidence (see also Ford, 2020; Karatzias & Levendosky, 2019) and a consensus survey of expert clinicians on CPTSD (Cloitre et al., 2011).

There has been controversy around CPTSD (see Ford, 2020) but the existence of two distinct symptom profiles of PTSD and CPTSD has been supported in a number of studies for different samples (Brewin et al., 2017), including children and adolescents (Sachser, Keller, & Goldbeck, 2017) and refugees (Hyland et al., 2018). Prevalence rates range from 0.6% to 1% for CPTSD and from 2.3% to 3.0% for PTSD in community samples, and 32.8% to 42.8% for CPTSD and 7.8% to 37% for PTSD in clinical samples (Brewin et al., 2017). Consistent with the ICD-11 conceptualization, CPTSD has been found more likely to result from interpersonal trauma during childhood and chronic trauma in adulthood (e.g. in refugees) (Brewin et al., 2017). In the light of ICD-11, researchers who wish to assess disorders associated with traumatic stress now face a challenge. The standard measure in the field of traumatic stress is the Clinician-administered PTSD Scale (CAPS; Weathers et al., 2018). The CAPS is one of the most widely used structured instruments for diagnosing and evaluating the severity of PTSD, and there are 30 years of research and hundreds of studies on and with the CAPS (Weathers, Keane, & Davidson, 2001). It is sensitive to change in treatment outcome studies (Weathers et al., 2001) and its current version CAPS-5 has proved strong internal consistency, inter-rater reliability, test–retest reliability, and good construct validity (Weathers et al., 2018). It can be expected that the CAPS will continue to be one of the most important instruments for the assessment of traumatic stress symptoms. However, while the CAPS corresponds with DSM-5 where PTSD is described by 20 symptoms in five clusters, a diagnosis of CPTSD according to the ICD-11 is not possible, and CPTSD severity cannot be measured using the CAPS.

Researchers will need to assess the incidence and prevalence of CPTSD and ICD-11 PTSD and the need for instruments that correspond with ICD-11 has been recognized along with the development of the guideline. To date, two instruments based on ICD-11 criteria are available. The International Trauma Questionnaire (ITQ; Cloitre et al., 2018) is a self-report measure and with the International Trauma Interview (ITI) a clinical interview is also available (Bondjers et al., 2019; Roberts, Cloitre, Bisson, & Brewin, 2018). Although the PTSD section of the ITI is based on the CAPS, the ITI is explicitly an ICD-11 instrument. Therefore, one problem remains: Researchers will want (and need) to evaluate treatment effects and prevalence rates according to both ICD-11 and DSM-5. Being forced to choose between criteria sets and measurement traditions is difficult and likely not beneficial for research efforts in the field of traumatic stress. On the other hand, using two clinician-rated instruments will very often not be feasible and too great a burden to patients, especially in psychotherapy research. Because of the above-mentioned discordance between the DSM-5 and ICD-11 guidelines, an economic way to diagnose according to both classification systems is needed. Only this can ensure that research findings stay relevant to populations in both the US, where the DSM is used, and the rest of the world, where the ICD is used. It is especially relevant to investigate if treatments work according to both guidelines instead of one guideline exclusively as this has direct implications for the selection of treatments for patients seen in clinical practice (Hafstad et al., 2017; Heeke et al., 2020).

As a solution to this problem, we have developed the Complex PTSD Item Set additional to the CAPS (COPISAC). This clinical interview is an easy-to-use and economic addition to the CAPS that permits diagnosis and evaluation of symptom severity according to ICD-11.

1. Description of the instrument

1.1. Structure and use

COPISAC was developed with the aim to add items to the CAPS that are needed to make a diagnosis of CPTSD and assess its severity. COPISAC is therefore not an independent instrument but is intended to be used together with the CAPS-5.

As CPTSD is characterized by the presence of DSO symptoms in addition to core PTSD symptoms, COPISAC consists of three items pertaining to DSO. One item each assesses persistent and pervasive difficulties with affect regulation, self-concept, and relationships. Two additional items assess impairment regarding social, occupational or other areas of functioning. The full interview is included in Appendix A.

Items closely follow ICD-11 language on the one hand, and the structure of CAPS items on the other hand. The latter ensures that interviewers who are familiar with the CAPS can administer and score COPISAC without needing much additional training. Every item

includes prompts for symptom description and frequency that can be used to elicit more information from the interviewee if necessary. Upon development, we first created a table comparing the criteria of PTSD according to DSM-5, PTSD according to ICD-11, and CPTSD according to ICD-11. We then identified CAPS items which allowed to determine whether ICD-11 criteria for both PTSD and CPTSD were met. Finally, we developed new items for ICD-11 CPTSD criteria only where the information gathered with the CAPS was insufficient to decide whether criteria are fulfilled or not. These new items were formulated based as much as possible on the description given in the ICD-11. The items were then tested with patients and revised according to feedback from the clinician raters. A revised draft was then circulated among experts in the field. Appendix A contains these newly formulated items and the matching of CAPS items and newly developed items to ICD-11 criteria for PTSD and CPTSD.

Exposure to traumatic events is commonly assessed using the Life Events Checklist (LEC; Weathers et al., 2013). However, some events that are described as precursors of CPTSD in the ICD-11 are not specifically included in the LEC. For those instances where researchers need or want to assess trauma exposure in greater detail, we have developed eight items to account for these specific forms of trauma (i.e. repeated sexual abuse during childhood, repeated physical abuse during childhood, prolonged domestic violence, torture, genocide, being enslaved, repeated medical trauma during childhood, any other prolonged event or series of events of an extremely threatening or horrific nature from which escape was difficult or impossible).

1.2. Scoring

1.2.1. Scoring of items

All items are scored on the familiar 5-point scale from 0 (*absent*) to 4 (*extreme/incapacitating*). Following the basic CAPS-5 symptom scoring rule, a symptom is considered present and counts towards the diagnosis when given a severity rating of 2 (*moderate/threshold*) or higher. A rating of 2 represents a tendency to act, feel or think persistently in a way that is described by the criterion. The higher rating of 3 (*severe/markedly elevated*) is given when the pattern persists most of the time, occurs repeatedly or constitutes marked deviations from what is usually expected.

1.2.2. Diagnostic status and symptom severity

COPISAC allows assessing both diagnostic status and severity of CPTSD symptoms. To determine diagnostic status, it first needs to be determined if ICD-11 PTSD criteria are fulfilled. Diagnostic algorithms that allow ICD-11 PTSD diagnosis based on CAPS items have already been proposed and used (Barbano et al., 2019). Accordingly, for the CAPS-5 the following rule can be applied: One item out of CAPS-5 items 2 and 3 (DSM-5 criteria B2 and B3), one out of items 6 and 7 (C1 and C2), and one out of items 17 and 18 (E3 and E4). In addition, the presence of the DSO criteria is required. The three COPISAC items (CO1 to CO3) and CAPS item 13 (D6) are used to make this decision, together with impairment criteria. For severity, a sum score is computed with a range from 0 to 16 for DSO and 0 to 40 for CPTSD (i.e. PTSD + DSO).

So far, scoring rules are rationally derived and purposefully modelled after the CAPS. An ongoing validation study is aimed at gathering empirical evidence for the proposed rules.

1.3. Case study

COPISAC was used with treatment-seeking patients who were enrolled in a randomized-controlled trial (Steil et al., 2021). The study was approved by the ethics committee of the German Psychological Association and informed consent was obtained before the assessment. Table 1 presents three cases to illustrate the clinical utility of the instrument. All patients had experienced multiple single or repeated traumatic events and were diagnosed with PTSD according to DSM-5, but differences emerged concerning diagnosis according to ICD-11 when COPISAC was administered: Patient 1 fulfilled criteria for ICD-11 CPTSD. Patient 2 met criteria for ICD-11 PTSD, but not CPTSD. He reported no relevant difficulties in relationships and thus only fulfilled two of the three DSO criteria. Patient 3 did not meet criteria for ICD-11 PTSD because he did not meet the criterion of re-experiencing in the here and now. He was also the only patient who did not experience any of the chronic trauma types added to the LEC. The assessment results from these case descriptions demonstrate that COPISAC can exhibit both sensitivity and specificity and illustrate the need for in-depth evaluation of both ICD-11 and DSM-5 criteria.

1.4. Validation study

Our ongoing validation study will determine interrater reliability, test–retest reliability, internal consistency, convergent and discriminant validity, and factor structure for COPISAC in conjoint use with the CAPS. Trained interviewers administer the CAPS and COPISAC along with other measures of traumatic stress and mental health to treatment-seeking patients at the outpatient clinic of the Department of Clinical Psychology and Psychotherapy of the Goethe University Frankfurt.

Feedback from interviewers will be used to revise prompts, if necessary. Scoring rules will be empirically validated by holding calibration meetings and performing receiver operating characteristics (ROC) analysis.

Table 1. Case descriptions.

	Patient 1	Patient 2	Patient 3
Patient history and symptoms	The 20-year old woman had come to Germany one year ago. She had left her home country with her brother because of severe violent family conflicts. As a child and young woman, she had experienced repeated physical abuse by a family member and was repeatedly sexually abused by another man. She now suffered from intrusive memories, nightmares, memory problems, panic attacks, physical pain in her whole body, and lived in a permanent state of fear. She reported to harm herself by cutting and felt as though her body did not belong to her during these moments.	The 32-year old man had come to Germany as a refugee six years ago. Beginning in childhood, he had experienced and witnessed severe physical and sexual violence by members of a terrorist organization. He fled his home country when he was forced to commit acts of violence himself. During his flight he was again raped and witnessed how another refugee was tortured. The patient now suffered from frequent nightmares, was constantly agitated, felt worthless, and avoided interacting with other people. He often brooded on the past and felt ashamed. He had recently started a job as a shop assistant.	The 21-year old man had come to Germany four years ago. He had been threatened by a terrorist organization that had also killed his uncle. The patient had witnessed the murder and felt haunted by that memory. He also feared for the well-being of his family who had remained in his home country. Thinking about the past made him feel helpless. He constantly felt tense, had panic attacks, and sometimes hurt himself on purpose. Since a car accident during his flight, he suffered from headaches and had trouble sleeping. He had withdrawn socially and was very isolated.
COPISAC symptom profile	The patient clearly fulfilled all six symptoms suggested in the algorithm for diagnosis of ICD-11 PTSD (B3 & B2: moderate, C1 & C2: severe, E3 & E4: severe). The PTSD severity score was 16. DSO criteria were also fulfilled. Both persistent and pervasive problems in affect regulation (CO1) and negative beliefs about oneself (CO2) were rated as severe. The patient also showed difficulties in sustaining relationships and in feeling close to others. Both items (D6 and CO3) were rated as extreme. The resulting DSO severity score was 14. The total severity score was 30.	The patient fulfilled both re-experiencing symptoms (B3: moderate, B2: severe), both avoidance symptoms (C1 & C2: moderate), and one arousal symptom (exaggerated startle response, E4: moderate; E3: absent). The PTSD severity score was 11. Two DSO symptoms were fulfilled. Persistent and pervasive problems in affect regulation (CO1) were rated as severe and negative beliefs about oneself (CO2) were rated as moderate. However, difficulties in sustaining relationships (CO3) were rated as mild and difficulties feeling close to others (D6) were rated as absent. This criterion was thus not fulfilled. DSO severity score was 6. The total severity score was 17.	The patient fulfilled none of the two re-experiencing symptoms (B3: absent, B2: mild), but fulfilled one avoidance symptom (avoidance of thoughts and feelings, C1: moderate; C2: absent), and one arousal symptom (exaggerated startle response, E4: moderate; E3: absent). The PTSD severity score was 5 and caseness was not met. One DSO symptom was present. Persistent and pervasive problems in affect regulation (CO1) were rated as moderate, but negative beliefs about oneself (CO2) were rated as mild and difficulties in sustaining relationships (CO3) were rated as mild and difficulties in feeling close to others (D6) were rated as absent. DSO severity score was 4. The total severity score was 9.
Diagnosis according to ICD-11	Complex PTSD	PTSD	No diagnosis of a stress-related disorder
Diagnosis according to DSM-5	PTSD (severity score: 59; 26 symptoms)	PTSD (severity score: 39; 15 symptoms)	PTSD (Severity score: 29; 11 symptoms)

2. Discussion

Researchers who wish to study stress-related disorders need to use valid, reliable, and sensitive instruments. With an introduction of COPISAC at this early point in its development, we aim at providing an easy transition into making diagnoses according to ICD-11.

Along with the ICD-11 proposal for PTSD and CPTSD, there has been an increasing number of studies on factor structure, symptom profiles, and prevalence rates for these disorders (Brewin et al., 2017). It is a limitation that up until this point most studies on CPTSD have only used approximations of ICD-11 symptoms. For example, studies have used items from the Brief Symptom Inventory (Derogatis & Melisaratos, 1983) to determine the presence of CPTSD symptoms (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014). Approaches like this have led to invaluable insights into the disorder but going forward a more precise clinician-rated assessment of the construct is needed (Ford, 2020). COPISAC allows to assess problems with affect regulation, self-concept, and relationships as outlined in the ICD-11 guideline. We hope that in the future this will allow precise estimates and insights into prevalence, specific risk factors, and comorbidity. The case descriptions illustrate how the presence of the DSO criteria can be evaluated using COPISAC and how the instrument allows to differentiate between ICD-11 PTSD and CPTSD. It is now important to validate the proposed procedure of diagnosing ICD-11 CPTSD with use of the modified LEC, CAPS-5, and COPISAC before it can be confidently used in treatment outcome studies and routine clinical practice. A validation study is currently ongoing at our department.

Assessment of symptom change during treatment is also of importance. COPISAC allows to evaluate treatment effects regarding DSM-5 and ICD-11 guidelines without much additional effort. This will hopefully lead to further insights into differences and similarities of the two criteria sets regarding treatment response. It has already been shown that the change in the PTSD guideline from ICD-10 to ICD-11 has led to the identification of fewer and more severe cases (Barbano et al., 2019). Treatment response and its differences regarding whether patients meet ICD-11, ICD-10, or DSM-5 criteria are now of interest and COPISAC will allow researchers to gather the data needed for these comparisons. Adding types of trauma to the LEC can also improve understanding of precursors of PTSD and CPTSD.

Attempting to establish an ICD-11 diagnosis when the CAPS closely follows DSM-5 criteria comes with some challenges and limitations. Challenges for the proposed procedure result mostly from the differences in the trauma and reliving criteria (see Supplement for a comparison of the criteria sets). While the DSM-5 describes a strict trauma criterion, ICD-11 provides only some guidance and leaves it to clinical judgement whether this criterion is met. The proposed use of an extended LEC for DSM-5 might therefore lead to missing some potentially traumatizing events. However, in a recent study (Hyland et al., 2020) the difference between the DSM-5 trauma criterion and no trauma criterion at all led only to a minimal difference (1%) in PTSD prevalence. Second, ICD-11 requires re-experiencing of the traumatic event in the present. There is still uncertainty about how re-experiencing in the here and now as required by ICD-11 should be assessed (Brewin et al., 2017). However, in a study by Hafstad et al. (2017) the PTSD prevalence did not differ significantly between models with or without a third item measuring intrusive memories. Thus, our use of CAPS items B2 (nightmares) and B3 (dissociative reactions such as flashbacks) seems suitable to capture ICD-11 re-experiencing and the difference in re-experiencing between ICD-11 and DSM-5 most likely does not disturb our suggested procedure.

With this early introduction of COPISAC, we aim to bring attention to patients with CPTSD and their specific needs in routine clinical care and suggest an economic way of assessment. Our ongoing validation study will provide psychometric characteristics of COPISAC. Nonetheless, by providing access to COPISAC at this point we want to open a dialogue that can lead to further revisions of the instrument according to researchers' and clinicians' needs.

Data availability statement

There is no data set associated with this manuscript.

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References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text revision).
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). doi:10.1176/appi.books.9780890425596.
Barbano, A. C., van der Mei, W. F., Bryant, R. A., Delahanty, D. L., deRoon-Cassini, T. A., Matsuoka, Y. J., … Shalev, A. Y. (2019). Clinical implications of the proposed ICD-11 PTSD diagnostic criteria. *Psychological Medicine*, *49*(3), 483–490. doi:10.1017/S0033291718001101.
Bondjers, K., Hyland, P., Roberts, N. P., Bisson, J. I., Willebrand, M., & Arnberg, F. K. (2019). Validation of a

clinician-administered diagnostic measure of ICD-11 PTSD and Complex PTSD: The International Trauma Interview in a Swedish sample. *European Journal of Psychotraumatology*, *10*(1), 1665617. doi:10.1080/20008198.2019.1665617.

Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., … Reed, G. M. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review*, *58*, 1–15. doi:10.1016/j.cpr.2017.09.001.

Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices: Treatment of Complex PTSD. *Journal of Traumatic Stress*, *24*(6), 615–627. doi:10.1002/jts.20697.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology*, *4*(1), 20706. doi:10.3402/ejpt.v4i0.20706.

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. doi:10.3402/ejpt.v5.25097.

Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., … Hyland, P. (2018). The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatrica Scandinavica*, *138*(6), 536–546. doi:10.1111/acps.12956.

Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine*, *13*(3), 595–605.

Ford, J. D. (2020). New findings questioning the construct validity of complex posttraumatic stress disorder (cPTSD): Let's take a closer look. *European Journal of Psychotraumatology*, *11*(1), 1708145. doi:10.1080/20008198.2019.1708145.

Hafstad, G. S., Thoresen, S., Wentzel-Larsen, T., Maercker, A., & Dyb, G. (2017). PTSD or not PTSD? Comparing the proposed ICD-11 and the DSM-5 PTSD criteria among young survivors of the 2011 Norway attacks and their parents. *Psychological Medicine*, *47*(7), 1283–1291. doi:10.1017/S0033291716002968.

Heeke, C., O'Donald, A., Stammel, N., & Böttche, M. (2020). Same same but different? DSM-5 versus ICD-11 PTSD among traumatized refugees in Germany. *Journal of Psychosomatic Research*, *134*, 110129. doi:10.1016/j.jpsychores.2020.110129.

Hyland, P., Ceannt, R., Daccache, F., Abou Daher, R., Sleiman, J., Gilmore, B., … Vallières, F. (2018). Are posttraumatic stress disorder (PTSD) and complex-PTSD distinguishable within a treatment-seeking sample of Syrian refugees living in Lebanon? *Global Mental Health*, *5*, e14. doi:10.1017/gmh.2018.2.

Hyland, P., Karatzias, T., Shevlin, M., McElroy, E., Ben-Ezra, M., Cloitre, M., & Brewin, C. R. (2020). Does requiring trauma exposure affect rates of ICD-11 PTSD and complex PTSD? Implications for DSM–5. *Psychological Trauma: Theory, Research, Practice, and Policy*. doi:10.1037/tra0000908.

Hyland, P., Shevlin, M., McNally, S., Murphy, J., Hansen, M., & Elklit, A. (2016). Exploring differences between the ICD-11 and DSM-5 models of PTSD: Does it matter which model is used? *Journal of Anxiety Disorders*, *37*, 48–53. doi:10.1016/j.janxdis.2015.11.002.

Karatzias, T., & Levendosky, A. A. (2019). Introduction to the special issue on complex posttraumatic stress disorder: The evolution of a disorder. *Journal of Traumatic Stress*, jts.22476. doi:10.1002/jts.22476.

Maercker, A., Brewin, C. R., Bryant, R. A., Cloitre, M., Reed, G. M., van Ommeren, M., … Saxena, S. (2013). Proposals for mental disorders specifically associated with stress in the International Classification of Diseases-11. *Lancet*, *381*(9878), 1683–1685. doi:10.1016/s0140-6736(12)62191-6.

Oe, M., Ito, M., Takebayashi, Y., Katayanagi, A., & Horikoshi, M. (2020). Prevalence and comorbidity of the ICD-11 and DSM-5 for PTSD caseness with previous diagnostic manuals among the Japanese population. *European Journal of Psychotraumatology*, *11*(1), 1753938. doi:10.1080/20008198.2020.1753938.

Roberts, N., Cloitre, M., Bisson, J., & Brewin, C. (2018). *International Trauma Interview (ITI) for ICD-11 PTSD and complex PTSD* (Test Version 3.1).

Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trial for posttraumatic stress disorder. *Journal of Traumatic Stress*, *10*(4), 539–555. doi:10.1002/jts.2490100403.

Sachser, C., Keller, F., & Goldbeck, L. (2017). Complex PTSD as proposed for ICD-11: Validation of a new disorder in children and adolescents and their response to Trauma-Focused Cognitive Behavioral Therapy. *Journal of Child Psychology and Psychiatry*, *58*(2), 160–168. doi:10.1111/jcpp.12640.

Shevlin, M., Hyland, P., Vallières, F., Bisson, J., Makhashvili, N., Javakhishvili, J., … Roberts, B. (2018). A comparison of DSM-5 and ICD-11 PTSD prevalence, comorbidity and disability: An analysis of the Ukrainian Internally Displaced Person's Mental Health Survey. *Acta Psychiatrica Scandinavica*, *137*(2), 138–147. doi:10.1111/acps.12840.

Steil, R., Lechner-Meichsner, F., Johow, J., Krüger-Gottschalk, A., Mewes, R., Reese, J.-P., Schumm, H., Weise, C., Morina, N.*, & Ehring, T.*… (2021). Brief imagery rescripting vs. usual care and treatment advice in refugees with posttraumatic stress disorder: Study protocol for a multi-center randomized-controlled trial. *European Journal of Psychotraumatology*. doi:10.1080/20008198.2021.1872967.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*(5), 389–399. doi:10.1002/jts.20047.

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Checklist for DSM-5 (LEC-5)*. Instrument available from the National Center for PTSD. Retrieved from www.ptsd.va.gov.

Weathers, F. W., Bovin, M. J., Lee, D. J., Sloan, D. M., Schnurr, P. P., Kaloupek, D. G., … Marx, B. P. (2018). The Clinician-Administered PTSD Scale for DSM–5 (CAPS-5): Development and initial psychometric evaluation in military veterans. *Psychological Assessment*, *30*(3), 383–395. doi:10.1037/pas0000486.

Weathers, F. W., Keane, T. M., & Davidson, J. R. T. (2001). Clinician-administered PTSD scale: A review of the first ten years of research. *Depression and Anxiety*, *13*(3), 132–156. doi:10.1002/da.1029.

Wisco, B. E., Marx, B. P., Miller, M. W., Wolf, E. J., Krystal, J. H., Southwick, S. M., & Pietrzak, R. H. (2017). A comparison of ICD-11 and DSM criteria for posttraumatic stress disorder in two national samples of U.S. military veterans. *Journal of Affective Disorders*, *223*, 17–19. doi:10.1016/j.jad.2017.07.006.

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en.

Appendix A. COPISAC (Complex PTSD Item Set additional to the CAPS)

Introduction

COPISAC is a set of items that can be added to the CAPS-5 (Weathers et al., 2013b) in order to make a diagnosis of Complex PTSD according to ICD-11 and assess its severity. Structure, use, scoring and anchor points were modelled after the CAPS.

Complex PTSD may develop as a reaction to chronic or repeated traumatic events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). A diagnosis of Complex PTSD is made when all PTSD criteria are fulfilled (see below), and three additional symptoms related to disturbances in self-organization (DSO) are present. DSO criteria are:

(1) affect dysregulation
(2) negative self-concept that includes beliefs about oneself as diminished, defeated or worthless that is accompanied by feelings of shame, guilt or failure related to the traumatic event
(3) difficulties in relationships, i.e. sustaining relationships and feeling close to others

COPISAC allows to assess the DSO criteria and related impairment. The described reactions need to constitute persistent and pervasive problems that occur in a variety of situations and circumstances. A symptom is considered present when given a rating of ≥2.

A diagnosis of PTSD according to ICD-11 is made when the following core criteria are present:

(1) re-experiencing of the traumatic event in the present in the form of vivid intrusive memories, flashbacks, or nightmares accompanied by strong emotions and physical sensations
(2) avoidance of reminders that trigger thoughts and memories of the event
(3) a persistent perception of heightened current threat

Table 1 provides an overview of CAPS-5 items that can be used to determine if these symptoms are present. A symptom is considered present when given a rating of ≥2.

As an addition to the Life Events Checklist (Weathers et al., 2013a), items that account for the specific forms of trauma which the ICD-11 describes as precursors of CPTSD (e.g. torture, being enslaved) are suggested. Response categories are the same as in the original LEC.

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013a). *The Life Events Checklist for DSM-5 (LEC-5)*. Instrument available from the National Centre for PTSD at www.ptsd.va.gov.

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, D. G., & Keane, T. M. (2013b). *Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)*. https://www.ptsd.va.gov

To be added to the Life Events Checklist for DSM-5 Interview version (Weathers et al., 2013)

Did you experience _____ ?

a: repeated childhood sexual abuse **If yes: What happened?** (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)	**__NO __YES**: □ Experienced □ Witnessed □ Learned about □ Exposed to aversive details **Life threat**: __NO __YES (__self __other) **Serious injury?** __NO __YES (__self __other) **Criterion A met?** __NO __probable __YES
b: repeated childhood physical abuse **If yes: What happened?** (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)	**__NO __YES**: □ Experienced □ Witnessed □ Learned about □ Exposed to aversive details **Life threat**: __NO __YES (__self __other) **Serious injury?** __NO __YES (__self __other) **Criterion A met?** __NO __probable __YES

(*Continued*)

(Continued).

c: prolonged domestic violence **If yes: What happened?** (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)	**__NO __YES**: □ Experienced □ Witnessed □ Learned about □ Exposed to aversive details **Life threat**: __NO __YES (__self __other) **Serious injury?** __NO __YES (__self __other) **Criterion A met?** __NO __probable __YES
d: torture **If yes: What happened?** (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)	**__NO __YES**: □ Experienced □ Witnessed □ Learned about □ Exposed to aversive details **Life threat**: __NO __YES (__self __other) **Serious injury?** __NO __YES (__self __other) **Criterion A met?** __NO __probable __YES
e: genocide campaigns **If yes: What happened?** (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)	**__NO __YES**: □ Experienced □ Witnessed □ Learned about □ Exposed to aversive details **Life threat**: __NO __YES (__self __other) **Serious injury?** __NO __YES (__self __other) **Criterion A met?** __NO __probable __YES
f: being enslaved **If yes: What happened?** (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)	**__NO __YES**: □ Experienced □ Witnessed □ Learned about □ Exposed to aversive details **Life threat**: __NO __YES (__self __other) **Serious injury?** __NO __YES (__self __other) **Criterion A met?** __NO __probable __YES
g: repeated medical trauma during childhood **If yes: What happened?** (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)	**__NO __YES**: □ Experienced □ Witnessed □ Learned about □ Exposed to aversive details **Life threat**: __NO __YES (__self __other) **Serious injury?** __NO __YES (__self __other) **Criterion A met?** __NO __probable __YES
h: any other prolonged event or series of events of an extremely threatening or horrific nature from which escape was difficult or impossible **If yes: What happened?** (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)	**__NO __YES**: □ Experienced □ Witnessed □ Learned about □ Exposed to aversive details **Life threat**: __NO __YES (__self __other) **Serious injury?** __NO __YES (__self __other) **Criterion A met?** __NO __probable __YES

To be added after administering the CAPS-5 (Weathers et al., 2013)

(CO1) Persistent and pervasive problems in affect regulation.

Do you have problems regulating your emotions? Dou you sometimes experience more or less intense emotions than others? [*If not clear*: Are you easily upset or angry and have difficulties calming down? Or do you often feel numb or emotionally distant?] Can you give me some examples when you feel that way? [*If not clear*: Do you only feel like that in specific situations or do you think that you generally react differently than others?] How often has this happened in the past month? _____ *# of times in the past month* Are you able to calm down or shake off the feeling of numbness? How long does this take?	Persistent and pervasive problems 0 Absent 1 Mild/subthreshold 2 Moderate/threshold 3 Severe/markedly elevated 4 Extreme/incapacitating
Key rating dimensions Moderate = at least 2x month, tendency to overreact or deactivate. Some problems to calm down or reactivate. Severe = at least 2x per week, pronounced pattern to overreact or deactivate even regarding small stressors. Pronounced problems calming down or recovering from deactivation.	

(CO2) Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event.

Do you think about yourself as diminished, defeated or worthless? Can you give me some examples? [*If not clear*: Do you have these negative beliefs only in some situations? Do you think you feel differently about yourself than others?] How strong are these beliefs? [*If not clear*: Can you see other ways of thinking about yourself?] Do you have feelings of shame, guilt or failure related to the [event]? [*If not clear*: Did these feelings start after the [event] or get worse?] How much of the time in the past month have you felt that way?_____*% of time*	Persistent and pervasive problems 0 Absent 1 Mild/subthreshold 2 Moderate/threshold 3 Severe/markedly elevated 4 Extreme/incapacitating
Key rating dimensions Moderate = some of the time (ca. 20-30%), negative beliefs are clearly present, some difficulty considering more realistic beliefs. Severe = much of the time (ca. 60%), pronounced negative beliefs, considerable difficulty considering more realistic beliefs.	

(CO3) Difficulties in sustaining relationships and in feeling close to others.

Do you have any close relationships? Can you tell me more about these relationships? [*If not clear*: Do you feel close to others?] How long do your relationships normally last? Do you have any relationships (like friendships and intimate relationships) that last for a long time or are your relationships fairly short? [*If not clear*: Do you feel that relationships are more difficult for you than for others?]	Persistent and pervasive problems 0 Absent 1 Mild/subthreshold 2 Moderate/threshold 3 Severe/markedly elevated 4 Extreme/incapacitating
Key rating dimensions Moderate = difficulties to begin and sustain relationships some of the time, tendency to avoid or withdraw from relationships. Some emotionally close and trusting relationships exist. Severe = pronounced difficulties beginning and maintaining relationships most of the time. Relationships are generally avoided or broken off when intensive negative emotions arise.	

(CO4) Impairment in social functioning

In the past month, have these [problems with emotions, beliefs about yourself, and with relationships] affected your relationships with other people? How so? [Consider impairment in social functioning reported on earlier items] [Impairment must be clearly related to DSO-Symptoms (not only PTSD-symptoms).]	0 No adverse impact 1 Mild impact, minimal impairment in social functioning 2 Moderate impact, definite impairment but many aspects of social functioning still intact 3 Severe impact, marked impairment, few aspects of social functioning still intact 4 Extreme impact, little or no social functioning

(CO5) Impairment in occupational or other important areas of functioning

[If working:] **In the past month, have these [problems with emotions, beliefs about yourself and in relationships] affected your work or your ability to work? How so?** [Consider reported work history, including number and duration of jobs, as well as the quality of work relationships. If premorbid functioning is unclear, inquire about work experiences before the trauma. For child/adolescent trauma, assess pre-trauma school performance and possible presence of behaviour problems]	0 No adverse impact
[If not working:] **Have these [problems with emotions, beliefs about yourself, and with relationships] affected any other important part of your life?** [As appropriate, suggest examples such as parenting, housework, schoolwork, volunteer work, etc.] **How so?**	1 Mild impact, minimal impairment in social functioning 2 Moderate impact, definite impairment but many aspects of social functioning still intact 3 Severe impact, marked impairment, few aspects of social functioning still intact
[Impairment must be clearly related to DSO-Symptoms (not only PTSD-symptoms).]	4 Extreme impact, little or no social functioning

Diagnosis of PTSD and Complex PTSD according to ICD-11

A diagnosis of **PTSD** requires symptoms from all three core criteria and significant impairment caused by these symptoms. A criterion is met when severity is given a rating of 2 or higher.

	Item	Severity rating	Criteria met?	
(A) Exposure to traumatic event	LEC		0 = No	1 = Yes
(B) Re-experiencing (at least one item ≥ 2 needed)				
(1) Re-experiencing in the here and now (flashbacks)	B3			
(2) Nightmares	B2			
		=	0 = No	1 = Yes
(C) Avoidance (at least one item ≥ 2 needed)				
(1) Avoidance of thoughts and feelings	C1			
(2) Avoidance of reminders	C2			
		=	0 = No	1 = Yes
(D) Persistent perception of heightened current threat (at least one item ≥ 2 needed)				
(3) Hypervigilance	E3			
(4) Exaggerated startle response	E4			
		=	0 = No	1 = Yes
Total Severity PTSD (Severity B, C, D) =				
(E) Impairment (at least one item ≥ 2 needed)				
Impairment in social functioning	24			
Impairment in occupational and other areas of functioning	25			
		=	0 = No	1 = Yes
(F) Duration of disturbance > a few weeks	21 & 22		0 = No	1 = Yes
PTSD present: Criteria A, B, C, D, E & F			0 = No	1 = Yes

A diagnosis of **Complex PTSD** is given when all criteria for PTSD are met and all DSO symptoms are present. Symptoms must cause significant impairment. A criterion is met when severity is given a rating of 2 or higher.

	Item	Severity rating	Criteria met?	
(A) Affect dysregulation (at least rating ≥ 2 needed)	CO1		0 = No	1 = Yes
(B) Negative self-concept (at least rating ≥ 2 needed)	CO2		0 = No	1 = Yes
(C) Difficulties in relationships (two items with rating ≥ 2 needed)				
Difficulties sustaining relationships	CO3			
Difficulties feeling close to others	D6			
		=	0 = No	1 = Yes
Total Severity DSO =				
(D) Impairment (at least one item ≥ 2 needed)				
Impairment in social functioning	CO4			
Impairment in occupational and other areas of functioning	CO5			
		=	0 = No	1 = Yes
DSO-criteria met: Criteria A, B, C, D			0 = No	1 = Yes

PTSD present	0 = No	1 = Yes
CPTSD present: all PTSD and DSO criteria met	0 = No	1 = Yes
Total severity PTSD + DSO	=	