Beyond the Gold Standard: Evolving CAPS-5 to Address Polyvictimization, Diagnostic Overshadowing, and Complex PTSD

Cristina Pearse
Wake Forest University
CNS 736: Appraisal Procedures for Counselors
Dr. George Stoupas, Lead Instructor
Ana Clara Blesso, Practitioner Instructor
February 19, 2026

Abstract

The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) remains the established benchmark for posttraumatic stress assessment. However, the ongoing nosological divergence between the DSM-5 and ICD-11 regarding complex posttraumatic stress—specifically, whether Disturbances in Self-Organization (DSO) constitute a distinct disorder (ICD-11 CPTSD) or a subordinate specifier (DSM-5)—exposes critical structural flaws in prevailing diagnostic frameworks. This paper argues that the DSM-5's adherence to a fear-based, single-event model represents a fundamental cartographic error, failing to accommodate a distinct class of traumatic injury: that which arises not from discrete "impact" but from the sustained "atmospheric pressure" of chronic, developmental environments. The discovery of DSO reveals a form of trauma oriented not toward past fear memory but toward a present-oriented failure of self-concept–an injury to personality structure itself. This paper evaluates the psychometric validity of the CAPS-5, identifying its inherent limitations in capturing the DSO symptoms characteristic of such atmospheric, developmental trauma. Furthermore, it contends that the CAPS-5's reliance on a single disclosed "index event" fundamentally conflicts with the epidemiological realities of sexual violence and Adverse Childhood Experiences (ACEs), which are frequently shrouded in toxic shame or normalized as ambient conditions of captivity. Relying on this fear-based, event-driven model risks diagnostic overshadowing, misdiagnosis, and iatrogenic harm by compressing a pervasive, complex sequelae of injury into a framework designed for a bounded one. In response, this conceptual paper synthesizes extant research to critically evaluate the CAPS-5 and proposes an Integrated Assessment Model as a clinically and ethically necessary alternative. The proposed model features two core components: (1) the Integrated Trauma Spectrum Assessment (ITSA), a novel framework designed to capture both DSM-5 PTSD and ICD-11 CPTSD symptomatology, and (2) the ethical integration of multimodal Artificial Intelligence (AI) to enhance objective physiological assessment while preserving human clinical judgment. This model seeks to transform trauma assessment from a reductive forensic classification task into a compassionate, agency-restoring process capable of charting the true depths and dimensions of lived experience.

Keywords: antifragility, artificial intelligence (AI), Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), Complex PTSD (CPTSD), diagnostic overshadowing, Disturbances in Self-Organization (DSO), Integrated Trauma Spectrum Assessment (ITSA), polyvictimization, toxic shame, trauma nosology.

Part I: Architecture of the CAPS-5

Introduction to the "Gold Standard"

The assessment of psychological trauma is a high-stakes clinical endeavor requiring a delicate balance between rigorous standardization and empathetic attunement (Sweeney et al., 2022; Herman, 1992; van der Kolk, 2014). For decades, the Clinician-Administered PTSD Scale (CAPS) has served as the clinicians' blueprint for this process (Weathers et al., 2018; Jackson et al., 2015). Its current iteration, the CAPS-5, is a 30-item structured interview meticulously aligned with the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013).

The status of CAPS-5 as the "gold standard" is based on its robust psychometric properties. A recent meta-analysis of 15 studies confirmed the instrument's high reliability, reporting a global reliability coefficient of .92 (Wojujutari et al., 2024). Specifically, the CAPS-5 demonstrates strong interrater reliability (κ = .78 to 1.00) and test-retest stability (κ = .83), ensuring that diagnostic conclusions are consistent across different clinicians and time points (Wojujutari et al., 2024; Weathers et al., 2018).

Multicultural Validity

Standard E.8 of the *ACA Code of Ethics* mandates recognizing the effects of culture on assessment administration and interpretation (American Counseling Association [ACA], 2014). While the CAPS-5 has shown adaptability across languages, the construct of PTSD is Western-centric, prioritizing individual cognitive appraisal (Wojujutari et al., 2024). Clients from collectivist cultural backgrounds may express distress somatically or through cultural idioms that the structured, behaviorally anchored prompts of the CAPS-5 may miss entirely (Hays, 2023). This includes Asian, African, and Latin American populations that prioritize group goals, social harmony, and interdependence over individual aspirations. These worldviews often necessitate more collectivistic approaches to assessment rather than relying solely on individualistic paradigms (Flores et al., 2003; Hays, 2023; Paniagua, 2014, as cited in Hays, 2023).

Establishing Functional Etiology and Trauma-Relatedness

A defining strength of the CAPS-5 is its rigorous assessment of trauma-relatedness. Unlike self-report measures such as the PTSD Checklist for DSM-5 (PCL-5), which are prone to over-endorsement due to general distress, negative affectivity, or misunderstanding of item wording, the CAPS-5 requires the clinician to establish a strict functional etiology for every endorsed symptom (Weathers et al., 2018). The protocol operationalizes trauma-relatedness by requiring that each symptom be specifically and directly attributable to a single, identified "index event." This means the clinician must determine not merely that a symptom is present, but that it originated from, or significantly worsened following, the focal traumatic experience. This methodological rigor minimizes false positives and enhances diagnostic precision, but only when trauma presents as a discrete, identifiable incident.

This distinction is critical for "non-specific" symptoms such as sleep disturbance or irritability, which frequently overlap with other psychiatric conditions. To ensure diagnostic specificity, the CAPS-5 guides the clinician in ruling out confounding factors (such as substance use or independent stressors) that might otherwise yield false positives (Hays, 2023; Weathers et al., 2001). Furthermore, the recently developed CAPS-5-R (Revised) has expanded the symptom severity scoring scale from 0–4 to 0–10 to increase granularity and address range restriction issues, further cementing the tool's precision in tracking symptom change over time (Jackson et al., 2025). Yet this increased precision in measurement does not resolve a more fundamental problem: for the *polyvictimized* survivor, the instrument may still be measuring the wrong construct entirely.

Part II: Structural Limitations, Secrecy, and the Ecology of Shame

The "Index Event" Dilemma

Despite these psychometric strengths, a critical structural limitation of the CAPS-5 is its methodological anchor to a specific, disclosed "index event" (Criterion A). This approach presumes that the client is willing and able to identify the primary driver of their pathology during the intake. However, relying on a generic index event without accounting for the highly specific nature of that event is

insufficient. Recent network analyses demonstrate that the type of trauma fundamentally changes the symptom architecture; for example, flashbacks and amnesia are central drivers for survivors of sexual abuse, whereas hypervigilance and blame drive the pathology of refugees (Ferreira et al., 2022).

The Secrecy Gap and Toxic Shame

The presumption of a disclosed index event also clashes directly with the epidemiological reality of sexual violence. Globally, over 25% of women experience sexual violence (with figures remaining unchanged over two decades), yet the majority of these assaults go unreported, leaving millions suffering in silence (World Health Organization [WHO], 2021). This silence is largely driven by toxic shame.

In the context of complex trauma, shame is defined not merely as a fleeting emotion, but as a global, debilitating devaluation of the self (e.g., "I *am* bad" rather than "I did something bad") (Zhu et al., 2020). The defining behavioral characteristic of shame is the overwhelming urge to withdraw and hide (Zhu et al., 2020). Because the survivor is motivated to avoid the shame of a sexual assault, they may direct the CAPS-5 interviewer to a less stigmatizing "decoy event" (e.g., a car accident, natural disaster, war). Consequently, the CAPS-5 may accurately diagnose PTSD related to the decoy event, while the profound, shame-driven complex trauma remains entirely unassessed.

This diagnostic gap points to a fundamental limitation in the PTSD construct itself. *Complex PTSD (CPTSD)* is distinguished from PTSD by the addition of three symptom clusters collectively termed *Disturbances in Self-Organization (DSO)*: affective dysregulation, negative self-concept, and disturbances in relationships (Karatzias et al., 2017). While PTSD captures the fear-based responses to discrete threats (hyperarousal, re-experiencing, and avoidance), CPTSD encompasses the pervasive disruptions to identity and relational capacity that arise from chronic, inescapable, and developmentally adverse traumatic exposure (Cloitre et al., 2013; Herman, 1992). Unlike the event-anchored fear of PTSD, the DSO symptoms of CPTSD are present-oriented, reflecting the internalization of the traumatic environment into the very structure of the personality (Hyland et al., 2018). This distinction is not merely academic; it carries profound implications for assessment, treatment planning, and the prevention of iatrogenic harm.

The Normalization Gap: Trauma as an Ecosystem

The methodological requirement of the CAPS-5 to anchor symptoms to a single index event stands in stark contrast to the epidemiological reality of trauma exposure, which is heavily characterized by polyvictimization. Polyvictimization–the experience of multiple, distinct types of traumatic events–is the rule rather than the exception for individuals who develop complex trauma (Finkelhor et al., 2007; Burke Harris, 2018; Zilberstein, 2022). In a national sample of youth, 64% of children exposed to one type of trauma experienced at least one additional type, and 26% endured four or more distinct victimizations (Finkelhor et al., 2007).

This cumulative burden persists into adulthood. In clinical samples of adults seeking treatment for trauma related to childhood abuse, individuals report exposure to an average of over six different types of trauma throughout their lives (Priebe et al., 2018). When asked to identify the source of their current posttraumatic distress, an overwhelming 95% of these individuals attribute their symptoms to multiple traumatic events rather than a single incident (Priebe et al., 2018). Furthermore, the broader prevalence of Adverse Childhood Experiences (ACEs) reinforces this reality: an estimated 63% of adults in the United States report at least one ACE, with a significant portion reporting compounding adversities such as concurrent physical abuse, sexual violence, and household dysfunction (Felitti et al., 1998; Peterson et al., 2023).

Consequently, forcing a poly-victimized client to isolate a single index event for diagnostic scoring creates a cognitive paradox. It fragments their lived reality and risks missing the cumulative, developmental impact of the trauma, as the severity of their symptoms is driven by the ecosystem of abuse rather than a single, isolated incident (Karam et al., 2014; Priebe et al., 2018; Zilberstein, 2022).

For these survivors, they may not remember a time “prior” to the trauma to establish a baseline; it is difficult to prove the functional link required by the CAPS-5. The survivor cannot say the shame “started” after the event because the shame is their developmental baseline (Zhu et al., 2020). As a result, the client is unable to establish a functional etiology linking their distress to a single index event,

rendering the instrument's method of determining trauma-relatedness inadequate for their lived experience (Weathers et al., 2018; National Center for PTSD, n.d.).

The global context further magnifies this concern. Research indicates that pandemic-related stressors during COVID-19 effectively functioned as an ACE for children worldwide, introducing widespread experiences of household adversity, caregiver distress, and disrupted safety that compound existing developmental vulnerabilities (Verlenden et al., 2022). This global public health crisis has thus elevated the baseline of childhood trauma exposure, underscoring the urgent need for assessment frameworks capable of capturing cumulative, multifaceted traumatic burden rather than isolated events.

Part III: Diagnostic Overshadowing

The Gap Between DSM-5 and ICD-11

This limitation is exacerbated by the DSM-5's failure to recognize CPTSD. While the DSM-5 views PTSD as a singular disorder, the ICD-11 defines CPTSD as meeting the criteria for PTSD plus three clusters of Disturbances in Self-Organization (DSO): severe affect dysregulation, negative self-concept (shame), and relational disturbances (Cloitre et al., 2013; WHO, 2019). Because the CAPS-5 does not explicitly score these DSO symptoms as a distinct cluster, clinicians risk adopting a "one-size-fits-all" approach that fails to address the complex needs of the complexly traumatized client (Cloitre et al., 2014; Nestgaard Rød & Schmidt, 2021; Barnett et al., 2020).

Diagnostic Overshadowing and the "Forensic Frenzy"

When tools like the CAPS-5 rely on observable behaviors without capturing the functional intent behind them, clinicians risk *diagnostic overshadowing.* For instance, the hyperarousal of CPTSD, which manifests as fear-based, "vibrating" energy and severe insomnia, is frequently misidentified as Bipolar mania (Chopra et al., 2024). Similarly, the relational avoidance of CPTSD is often mislabeled as Borderline Personality Disorder (BPD), although comorbidity is possible (Powers et al., 2022).

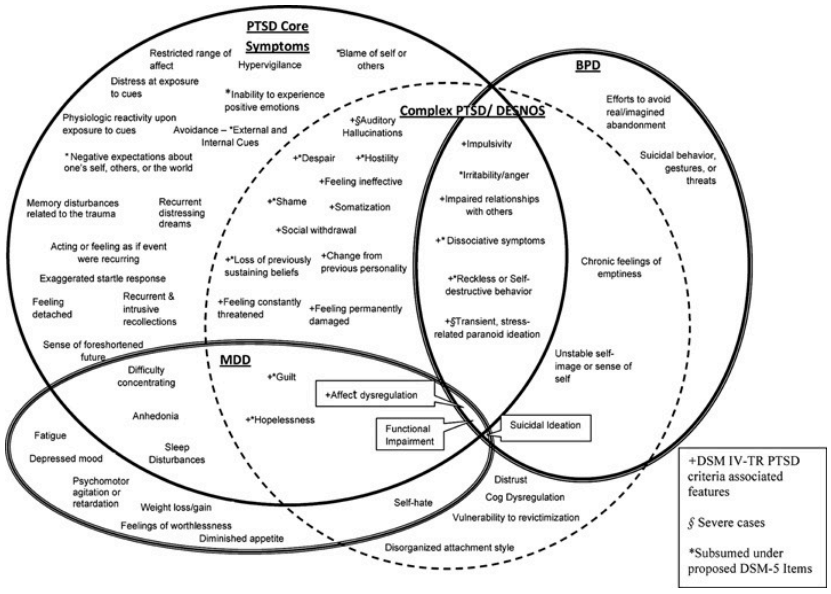
This diagnostic ambiguity is exacerbated by a profound semantic gap between the clinician's checklist and the survivor's internal reality. Survivors often lack the mental health literacy to articulate their own neurobiological states, leaving critical data regarding dissociation and dysregulation unspoken. To bridge this gap, emerging frameworks such as the Sovereign Soul model (Pearse, 2026) propose utilizing a "translation layer" that reframes abstract clinical jargon (e.g., hyperarousal) into accessible ecological metaphors (e.g., "The Rapids"). Without this shared lexicon, clinicians risk engaging in a "forensic frenzy" (Pearse, 2026) of pathologizing symptoms that are actually logical survival adaptations, leading to iatrogenic harm through the prescription of incorrect pharmacological treatments. These include mood stabilizers, which entirely fail to address the underlying autonomic dysregulation (Chopra et al., 2024; Sørensen et al, 2022; Pearse 2026).

The stakes of this diagnostic failure extend far beyond a semantic disagreement over labels. Individuals with significant DSO symptoms require treatment approaches that differ markedly from standard PTSD protocols. For these survivors, psychotherapy, and particularly phase-based, relationally-focused interventions, is the recommended first-line treatment, with pharmacotherapy playing a secondary, adjunctive role (Lang et al., 2024; Schnurr et al., 2024). While SSRIs and SNRIs remain viable options for some, clinicians must exercise particular caution with medications that may exacerbate dysphoria or suicidality, and should avoid classes known to be harmful in trauma populations, such as benzodiazepines (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2023; Bernardy & Montaño, 2024; Schnurr et al., 2024). The presence of DSO fundamentally shifts the treatment calculus: the goal is no longer simply the suppression of fear-based symptoms, but the long work of stabilization, self-regulation, and the gradual restoration of relational capacity. When the CAPS-5 fails to identify DSO, it does not merely mislabel the patient—it steers them toward a treatment pathway that cannot address their core pathology.

Accurately diagnosing complex trauma is exceptionally difficult. Even assuming a clinician is fundamentally trauma-informed and actively looking for trauma history, navigating the dense intersection

of overlapping symptoms presents a profound clinical challenge. As illustrated in Figure 1, there is significant phenomenological overlap between the core symptoms of PTSD, Complex PTSD (historically conceptualized as DESNOS), Borderline Personality Disorder (BPD), and Major Depressive Disorder (MDD)(Resick et al., 2012). This visual representation highlights how shared features—such as affect dysregulation, suicidality, and functional impairment—create a diagnostic maze that can easily obscure a survivor's underlying complex trauma pathology, even for well-intentioned providers (Powers et al., 2022; Resick et al., 2012].

Figure 1: Diagnostic Challenge of Trauma-Related Symptomology



Note. Venn diagram illustrating the phenomenological overlap between posttraumatic stress disorder (PTSD) core symptoms, PTSD-associated symptoms, disorders of extreme stress not otherwise specified (DESNOS)/complex PTSD, borderline personality disorder (BPD), and major depressive disorder (MDD). From Resick et al., 2012.

Part IV: Toward a New Paradigm: The Integrated Assessment Model

To ethically serve survivors, the field must move toward an *Integrated Assessment Model* that bridges the gap between DSM-5 requirements and ICD-11 clinical reality (Zilberstein, 2022). The transition from relying solely on the CAPS-5 to adopting a more comprehensive framework is not merely a matter of clinical utility; it is a fundamental ethical imperative. The *ACA Code of Ethics* is anchored by the moral principles of nonmaleficence and beneficence, working for the good of the individual by promoting their overall well-being (ACA, 2014). When clinicians rely on an assessment instrument that structurally obscures the DSO inherent to complex trauma, they risk misidentifying a survivor's logical adaptations as innate personality defects. This diagnostic overshadowing directly violates nonmaleficence by exposing the client to iatrogenic harm.

Furthermore, Standard E.5.c explicitly mandates that counselors "recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups" (ACA, 2014). Standard E.6.a reinforces this by requiring counselors to critically evaluate the "psychometric limitations and appropriateness of instruments when selecting assessments" (ACA, 2014). Because the CAPS-5 requires the identification of a single index event, it is structurally inappropriate for poly-victimized populations whose trauma is atmospheric rather than episodic (Zhu et al., 2020). Consequently, ethical practice demands the adoption of an Integrated Assessment Model.

This model must also reflect a shift in clinical goals: moving beyond symptom reduction toward the cultivation of strengths that emerge through adversity. The concept of *antifragility*—drawn from systems theory and increasingly applied to human development—describes systems that do not merely withstand stress but grow stronger and more complex because of it (Aven, 2015; Taleb, 2012). While distinct from resilience (which implies return to baseline), antifragility aligns with established clinical constructs, including posttraumatic growth, adaptive coping, and the deep structural wisdom that survivors of chronic trauma often develop (Tedeschi & Calhoun, 2004; Zilberstein, 2022). This conceptualization is supported by posttraumatic growth research documenting positive psychological

change following adversity and by emerging neurobiological evidence that adaptive stress responses can enhance neural integration (Hermans et al., 2025). An integrated assessment must therefore be capable of measuring not just the damage of trauma, but the profound, complex adaptations the survivor has built to withstand it.

This reframing aligns directly with the ACA's foundational principle of beneficence because it works for the good of the individual by actively promoting their empowerment and overall well-being (ACA, 2014). When assessment captures both pathology and strength, it transforms from a sterile audit of damage into an initial therapeutic intervention. It shifts the clinical narrative from a deficit-based inquiry into a collaborative exploration, empowering the survivor to recognize and mobilize the antifragile intelligence they have already begun to develop through survival itself (Zilberstein, 2022). In this light, incorporating antifragility into assessment is not a conceptual stretch but an ethical deepening—a commitment to seeing the whole person, not merely their wounds.

Proposal: The Integrated Trauma Spectrum Assessment (ITSA)

To operationalize this paradigm shift, this paper proposes an Integrated Assessment Model—a comprehensive clinical approach that bridges DSM-5 and ICD-11 frameworks. Within this model, a hybrid diagnostic tool is introduced: the **Integrated Trauma Spectrum Assessment (ITSA)**, a structured clinical interview outlined in Figure 2 and presented in full as a draft instrument in Appendix A. The ITSA is designed to act as a bilingual diagnostic bridge; it satisfies the DSM-5 criteria necessary for institutional reimbursement while explicitly capturing the DSO required to identify ICD-11 CPTSD (Cloitre et al., 2018; Maercker et al., 2013). Crucially, the ITSA diverges from the traditional reliance on a singular "index event" mandated by the CAPS-5 (Weathers et al., 2018). Instead, it utilizes an "Atmosphere" anchor to evaluate cumulative trauma load, thereby validating the survivor's lived experience of chronic captivity without forcing them into a reductive and potentially retraumatizing hierarchy of their own suffering during intake (Hays, 2023; Herman, 1992; Pearse, 2026). To demonstrate the clinical utility of this integrated approach, a comprehensive administrative draft of the ITSA—detailing the shift to a cumulative "Atmosphere" anchor, explicit DSO clinical prompts, and the differential diagnostic scoring algorithm—is provided for clinician review in

Appendix A. The ITSA is offered as a conceptual foundation for future instrument development and requires rigorous psychometric validation before clinical implementation. However, as a proposed framework grounded in the reviewed literature, it already fulfills the counselor's ethical obligation to mitigate the risk of misdiagnosis by explicitly assessing DSO symptoms and employing functional prompts, ensuring the survivor's true lived experience is accurately and safely witnessed.

Figure 2: Comparison of CAPS-5 and the Proposed ITSA

Feature	CAPS-5 (Current Standard)	ITSA (Proposed)
Primary Purpose	**Diagnose DSM-5 PTSD with high psychometric precision:**	**Diagnose both DSM-5 PTSD and ICD-11 Complex PTSD (CPTSD):**
Trauma Anchor	The Index Event: Requires the patient to identify and describe one specific "worst" traumatic event to anchor all subsequent questions (Weathers et al., 2018).	The "Atmosphere" / Cumulative Load: Anchors to Life Eras or developmental periods. Asks: "Think about the period of your life where you felt least safe…" (Hays, 2023; Herman, 2015).
Assessment of DSO	Absent/Implicit: Mood and cognition symptoms (Criterion D) are mixed with fear-based symptoms. No distinct score for Affect Dysregulation or Negative Self-Concept (Wojujutari et al., 2024).	Explicit DSO Cluster: Three distinct sub-scales derived from the ITQ/COPISAC: (1) Affect Dysregulation, (2) Negative Self-Concept (Toxic Shame), (3) Relational Disturbances (Cloitre et al., 2018; Lechner-Meichsner & Steil, 2021).

Multicultural Validity	Mixed/Limited Evidence: Demonstrates strong global reliability* across translated versions (Brazilian-Portuguese, Dutch, German, Korean, etc.). However, this reflects translation, not cultural adaptation. It cannot capture culturally-specific idioms of distress (e.g., somatic presentations common in Asian and Middle Eastern populations) or trauma expressions that differ from Western, individualistic paradigms (Hays, 2023). The CAPS-5's structure presumes PTSD is expressed uniformly across cultures. This assumption is contradicted by evidence that trauma symptoms manifest differently based on cultural context.	Built-In Cultural Responsiveness: Designed with ecological validity as a core feature. By anchoring to atmospheres rather than discrete events, the ITSA aligns with collectivist worldviews where trauma is often embedded in family/community systems rather than isolated incidents. Its flexible, narrative-based approach allows clinicians to explore culturally-specific trauma manifestations (e.g., *ataques de nervios*, somatic distress, *khyâl* attacks) without forcing them into DSM-5 categories. The ITSA explicitly fulfills ACA Standard E.5.c by structurally protecting against the misdiagnosis that occurs when Western instruments are applied to non-Western populations without adaptation.
Differential Diagnosis	Risk of Error: High scores in irritability (E1) or reckless behavior (E2) can easily lead to misdiagnosis of Bipolar Disorder or Borderline Personality Disorder (Powers et al., 2022).	"Function" Prompts: Includes forced-choice qualifiers to distinguish the *intent* behind behavior (e.g., "*Do you avoid people because you fear they will leave you [BPD]?*" versus "*Do you avoid people because you fear they will hurt you [CPTSD]*?").
Utility in Primary Care	Low: Takes 45–60 minutes; requires specialized training and is often impractical for non-specialty settings (Hamblen et al., 2025).	High: Uses a "Gateway" system. A brief positive DSO screener triggers the full CPTSD protocol, making it adaptable for busy clinical environments.
Outcome Focus	Symptom Reduction: Tracks the severity of fear-based symptoms over time.	Antifragility & Function: Measures the damage of trauma and the profound adaptations the survivor has built, aiming for growth beyond baseline function (Aven, 2015; Pearse, 2026).

Ethical Alignment	Partial: Meets psychometric standards but may violate ACA standards E.5.c and E.6.a for polyvictimized and culturally diverse populations by structurally obscuring their lived experience (ACA, 2014).	Comprehensive: Explicitly designed to fulfill the ethical mandate of nonmaleficence by reducing misdiagnosis and honoring the survivor's full cultural and developmental context (Zilberstein, 2022).

Note: The CAPS-5 is translated; the ITSA is culturally adapted. The distinction is critical. CAPS-5 assumes that if the words are accurately translated, the instrument works. Research shows this is insufficient because 23% of items on translated trauma measures show significant bias due to cultural differences in symptom conceptualization. Western patients may report psychological distress directly, while patients from Asian, Middle Eastern, or Latin American backgrounds may express the same distress through somatic complaints or spiritual idioms that CAPS-5's behaviorally-anchored prompts miss entirely. ITSA is designed from the ground up to be culturally responsive. Its "Atmosphere" anchor validates the experience of survivors from collectivist cultures where trauma is understood as a family or community phenomenon, not an individual "event." Its flexible structure allows clinicians to explore culturally-specific trauma responses without forcing them into inappropriate diagnostic boxes, directly addressing the measurement invariance problems documented in cross-cultural trauma research.

*Demonstrates strong global reliability across translated versions (α range: 0.83–0.92; Wojujutari et al., 2024) . However, this reflects translation, not cultural adaptation. Instruments that are merely translated show item functioning imbalance in 23% of items due to cultural differences in symptom conceptualization (Rahmadi et al., 2025). Western patients may report psychological distress directly, while patients from non-Western backgrounds often express distress through somatic complaints or spiritual idioms that behaviorally-anchored prompts miss entirely (Hinton & Lewis-Fernández, 2021; Mohamed et al., 2023). Cross-cultural measurement invariance

research confirms that comparisons of symptom severity across culturally distal groups using standard instruments are often not valid (Rasmussen et al., 2023).

The ITSA integrates explicit DSO screening derived from tools like the International Trauma Questionnaire (ITQ) or the Complex PTSD Item Set Additional to the CAPS (COPISAC) (Cloitre et al., 2018; Lechner-Meichsner & Steil, 2021). It utilizes a "Gateway" system: if a brief DSO screener is positive, it triggers a full CPTSD protocol that includes forced-choice qualifiers to distinguish the function of behaviors (e.g., pulling away due to fear of abandonment [BPD] vs. need for safety [CPTSD]).

Part V: The Future Landscape: AI and Multimodal Models

The future of trauma assessment extends beyond paper-and-pencil interviews. The integration of Artificial Intelligence (AI) and multimodal neurobiological models offers a revolutionary opportunity to overcome the limitations of subjective self-reporting, the "secrecy gap," and hidden shame.

Recent systematic reviews indicate that AI-enabled diagnostic models–ones that utilize multimodal data such as functional MRI (fMRI), heart rate variability (HRV), and electrodermal activity–can detect PTSD phenotypes with classification accuracies exceeding 90% (Hossain & Ara, 2025; Bourla et al., 2018; Rollwage et al., 2023). Furthermore, conversational AI tools have been shown to significantly improve clinical efficiency in real-world psychotherapy settings by gathering granular clinical information before assessment. This reduces wait times, improving overall recovery rates (Rollwage et al., 2023). AI should be used to validate the invisible physiological load of trauma (reducing the need for patients to verbalize deep shame), rather than acting as a replacement for human empathy.

However, the integration of AI introduces profound ethical risks. Deep-learning models that lack explainability (the "Black Box" problem) mirror the dysfunction of a trauma system: opaque and

unaccountable (Anghelescu et al., 2025; Pearse, 2026). Future assessment architectures must adopt a "Human-in-the-Loop" stewardship framework, where AI serves as an objective decision-support tool to validate the survivor's physiological dysregulation without replacing the empathetic attunement of the clinician (Johnsson et al., 2023). This aligns with the World Health Organization's (2021) guidance on AI in health, which emphasizes that AI systems should be 'human-centered' and that final diagnostic decisions must remain with qualified clinicians (World Health Organization, 2021).

Limitations and Future Directions

This conceptual paper has several limitations. First, while the ITSA is grounded in existing research, it has not undergone empirical validation; its clinical utility, reliability, and diagnostic accuracy remain to be tested. Second, the proposal for AI integration assumes technological capabilities that may not be universally accessible, raising concerns about equity in implementation. Third, the paper focuses primarily on individual assessment and does not fully address systemic and structural factors that perpetuate trauma. Future research should prioritize psychometric validation of the ITSA, investigate the feasibility of AI-assisted assessment in diverse clinical settings, and examine how integrated assessment models can be adapted for low-resource environments.

Conclusion

The CAPS-5 remains an essential instrument for diagnosing PTSD, providing the structural validity necessary for clinical practice (Weathers et al., 2018). However, regarding Complex PTSD, it serves as an incomplete blueprint. The epidemiological reality of polyvictimization, the danger of diagnostic overshadowing, and the debilitating nature of toxic shame demand a more nuanced approach that honors the distinct architecture of CPTSD (Zhu et al., 2020). By adopting an Integrated Assessment Model–one that supplements the CAPS-5 with explicit measures of self-organization like the ITSA and leverages the objective, multimodal precision of ethical AI–counselors can fundamentally transform the assessment process (Hossain & Ara, 2025). It becomes far more than a method of labeling pathology; it becomes a collaborative process of

witnessing the survivor's full reality, distinguishing their systemic injuries from innate personality defects, and laying the foundation for a sovereign recovery.

This paradigm shift represents the necessary evolution of trauma-informed care, as detailed in **Appendix B**. As Zilberstein (2022) observes, the field has successfully transitioned from asking the pathologizing question, "What is wrong with you?" to the validating inquiry, "What happened to you?" Yet, to capture the true complexity of human adaptation, assessment must extend even further. To form a comprehensive clinical picture, we must also ask, "How did the trauma affect you, your family, and your community?" (Zilberstein, 2022). By integrating these contextual factors, the assessment process moves past mere symptom reduction and historical auditing, ultimately culminating in the most empowering question of all: "*How did you brilliantly adapt, AND how will you move beyond resilience to achieve antifragility?*" (Pearse, 2026). Originally coined in systems engineering, antifragility rejects the 'myth of recovery' that expects a traumatized individual to simply 'bounce back' to their pre-trauma state, like a rubber ball returning to its original shape. Instead, it recognizes that an architecture under extreme load must evolve; the survivor does not regress to who they were, but rather reshapes their internal landscape to grow stronger, more integrated, and more complex precisely because of the stress they endured.

References

American Counseling Association. (2014). *2014 ACA code of ethics*. https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Anghelescu, A., Munteanu, C., Spinu, A., Ciobanu, V., Popescu, C., Cioca, I. E. & Onose, G. (2025). Standardized clinical assessments and advanced AI-driven instruments used to evaluate neurofunctional deficits, including within biomarker based framework, in Parkinson's disease - human intelligence made vs. AI models - systematic review. *Frontiers in Medicine, 12*, 1565275.

Aven T. (2015). The concept of antifragility and its implications for the practice of risk analysis. *Risk analysis:an official publication of the Society for Risk Analysis, 35*(3), 476–483. https://doi.org/10.1111/risa.12279

Barnett, M. L., Kia-Keating, M., Ruth, A., & Garcia, M. (2020). Promoting equity and resilience: Wellness navigators' role in addressing adverse childhood experiences. Clinical Practice in Pediatric Psychology, 8(2), 176–188. https://doi.org/10.1037/cpp0000320

Basile, K. C., Smith, S. G., Kresnow, M., Khatiwada, S., & Leemis, R. W. (2022). *The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Sexual Violence*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Bernardy, N., & Montaño, M. (2024). *Use of benzodiazepines for PTSD in Veterans Affairs*. U.S. Department of Veterans Affairs, National Center for PTSD. https://www.ptsd.va.gov/professional/treat/txessentials/benzos_va.asp

Bourla, A., Mouchabac, S., El Hage, W., & Ferreri, F. (2018). e-PTSD: An overview on how new technologies can improve prediction and assessment of Posttraumatic Stress Disorder (PTSD). European Journal of Psychotraumatology, 9(sup1), 1424448.

Burke Harris, N. (2018). *The deepest well: Healing the long-term effects of childhood adversity*. Houghton Mifflin Harcourt.

Chopra, A., Matta, S. E., Vyas, C. M., Cohen, J. N., Temes, C. M., Ghaznavi, S., & Stern, T. A. (2024). Comorbid bipolar disorder and posttraumatic stress disorder: Clinical implications and management. *Primary Care Companion for CNS Disorders, 26*(6), 24f03768.

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.

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.

Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., Karatzias, T., & 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.

Dorrepaal, E., Thomaes, K., Hoogendoorn, A. W., Veltman, D. J., Draijer, N., & van Balkom, A. J. L. M. (2014). Evidence-based treatment for adult women with child abuse-related Complex PTSD: a quantitative review. *European Journal of Psychotraumatology, 5*(1). https://doi-org.wake.idm.oclc.org/10.3402/ejpt.v5.23613

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Ferreira, F., Gysi, D., Castro, D., & Ferreira, T. B. (2022). The nosographic structure of posttraumatic stress symptoms across trauma types: An exploratory network analysis approach. *Journal of Traumatic Stress*.

Finkelhor, D., Ormrod, R., & Turner, H. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect, 31*(1), 7–26. https://doi.org/10.1016/j.chiabu.2006.06.008

Flores, L. Y., Spanierman, L. B., & Obasi, E. M. (2003). Ethical and professional issues in career assessment with diverse racial and ethnic groups. Journal of Career Assessment, 11(1), 76–95. https://doi.org/10.1177/106907202237461

Ford, J. D., & Courtois, C. A. (2021). Complex PTSD and borderline personality disorder. Borderline Personality Disorder and Emotion Dysregulation, 8(1).

Hamblen, J. L., Merrick, C., Marx, B. P., & Bovin, M. J. (2025). Acceptability and feasibility of the Clinician-Administered PTSD Scale for DSM-5 Training Simulator. *Psychological Trauma: Theory, Research, Practice, and Policy*.

Hays, D. G. (2023). *Assessment in counseling: Procedures and practices* (7th ed.). American Counseling Association.

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

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence--from domestic abuse to political terror*. Basic Books.

Hermans, E. J., Hendler, T., & Kalisch, R. (2025). Building resilience: The stress response as a driving force for neuroplasticity and adaptation. Biological Psychiatry, 97(4), 330–338. https://doi.org/10.1016/j.biopsych.2024.10.016

Herzog, J. I., & Schmahl, C. (2018). Adverse childhood experiences and the consequences on neurobiological, psychosocial, and somatic conditions across the lifespan. *Frontiers in Psychiatry, 9.*

Hinton, D. E., & Lewis-Fernández, R. (2021). Beyond the DSM-5 diagnoses: A cross-cultural approach to assessing trauma reactions. Focus, 19(2), 197–206. https://doi.org/10.1176/appi.focus.20200049

Hossain, M. A., & Ara, S. (2025). AI-enabled neurobiological diagnostic models for early detection of PTSD and trauma disorders. *American Journal of Interdisciplinary Studies, 6*(2), 1–39.

Hyland, P., Shevlin, M., Fyvie, C., & Karatzias, T. (2018). Posttraumatic stress disorder and complex posttraumatic stress disorder in DSM-5 and ICD-11: Clinical and behavioral correlates. *Journal of Traumatic Stress, 31*(2), 174–180. https://doi.org/10.1002/jts.22272

Jackson, B. N., Weathers, F. W., Jeffirs, S. M., Preston, T. J., & Brydon, C. M. (2025). The revised Clinician-Administered PTSD Scale for DSM-5 (CAPS-5-R): Initial psychometric evaluation in a trauma-exposed community sample. *Journal of Traumatic Stress, 38*, 40–52.

Johnsson, V., Søndergaard, M. B., Kulasegaram, K., Sundberg, K., Tiblad, E., Herling, L., Petersen, O. B., & Tolsgaard, M. G. (2023). Validity evidence supporting clinical skills assessment by artificial intelligence compared with trained clinician raters. *Medical Education, 58*(1), 105–117.

Karam, E. G., Friedman, M. J., Hill, E. D., Kessler, R. C., McLaughlin, K. A., Petukhova, M., ... & Kovess-Masfety, V. (2014). Cumulative traumas and risk thresholds: 12-month PTSD in the World Mental Health (WMH) surveys. *Depression and Anxiety, 31*(2), 130–142. https://doi.org/10.1002/da.22169

Karatzias, T., Shevlin, M., Fyvie, C., Hyland, P., Efthymiadou, E., Wilson, D., Roberts, N., Bisson, J. I., Brewin, C. R., & Cloitre, M. (2017). Evidence of distinct profiles of posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD) based on the new ICD-11 trauma questionnaire (ICD-TQ). *Journal of Affective Disorders, 207*, 181–187. https://doi.org/10.1016/j.jad.2016.09.032

Lang, A. J., Hamblen, J. L., Holtzheimer, P., Kelly, U., Norman, S. B., Riggs, D., Schnurr, P. P., & Wiechers, I. (2024). A clinician's guide to the 2023 VA/DoD Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder. *Journal of traumatic stress, 37*(1), 19–34. https://doi.org/10.1002/jts.23013

Lechner-Meichsner, F., & Steil, R. (2021). 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). *European Journal of Psychotraumatology, 12*(1).

Leemis, R. W., Friar, N., Khatiwada, S., Chen, M. S., Kresnow, M., Smith, S. G., Caslin, S., & Basile, K. C. (2022). *The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Lekkas, D., & Jacobson, N. C. (2021). Using artificial intelligence and longitudinal location data to differentiate persons who develop posttraumatic stress disorder following childhood trauma. *Scientific Reports, 11*, 10303.

National Center for PTSD. (n.d.). *Challenges to establishing trauma-relatedness*. U.S. Department of Veterans Affairs.

Nestgaard Rød, Å., & Schmidt, C. (2021). Complex PTSD: what is the clinical utility of the diagnosis?. *European Journal of Psychotraumatology, 12*(1), 2002028. https://doi-org/10.1080/20008198.2021.2002028

Pearse, C. (2026). *Sovereign Soul: A Field Guide to Blooming on Broken Ground* (Manuscript in preparation).

Peterson, C., Aslam, M. V., Niolon, P. H., Bacon, S., Bellis, M. A., Mercy, J. A., & Florence, C. (2023). Economic burden of health conditions associated with adverse childhood experiences among US adults. *JAMA Network Open, 6*(12), e2346323. https://doi.org/10.1001/jamanetworkopen.2023.46323

Pitman, R. K. (2013). A Brief Nosological History of PTSD. *J Trauma Stress Disor Treat* 2:1.

Powers, A., Petri, J. M., Sleep, C., Mekawi, Y., Lathan, E. C., Shebuski, K., Bradley, B., & Fani, N. (2022). Distinguishing PTSD, complex PTSD, and borderline personality disorder using exploratory structural equation modeling in a trauma-exposed urban sample. *Journal of Anxiety Disorders, 88*, 102558.

Priebe, K., Kleindienst, N., Schropp, A., Dyer, A., Krüger-Gottschalk, A., Schmahl, C., Steil, R., & Bohus, M. (2018). Defining the index trauma in post-traumatic stress disorder patients with multiple trauma exposure: Impact on severity scores and treatment effects of using worst single incident versus

multiple traumatic events. *European Journal of Psychotraumatology, 9*(1), 1486124. https://doi.org/10.1080/20008198.2018.1486124

Rollwage, M., Habicht, J., Juechems, K., Carrington, B., Viswanathan, S., Stylianou, M., Hauser, T. U., & Harper, R. (2023). Using Conversational AI to Facilitate Mental Health Assessments and Improve Clinical Efficiency Within Psychotherapy Services: Real-World Observational Study. *JMIR AI, 2*, e44358.

Schnurr, P. P., Hamblen, J. L., Wolf, J., Coller, R., Collie, C., Fuller, M. A., Holtzheimer, P. E., Kelly, U., Lang, A. J., McGraw, K., Morganstein, J. C., Norman, S. B., Papke, K., Petrakis, I., Riggs, D., Sall, J. A., Shiner, B., Wiechers, I., & Kelber, M. S. (2024). The Management of Posttraumatic Stress Disorder and Acute Stress Disorder: Synopsis of the 2023 U.S. Department of Veterans Affairs and U.S. Department of Defense Clinical Practice Guideline. *Annals of internal medicine, 177*(3), 363–374. https://doi.org/10.7326/M23-2757

Sørensen, J. Ø., Rasmussen, A., Roesbjerg, T., Verhulst, F. C., & Pagsberg, A. K. (2022). Suicidality and self-injury with selective serotonin reuptake inhibitors in youth: Occurrence, predictors and timing. *Acta Psychiatrica Scandinavica, 145*(2), 209–222. https://doi.org/10.1111/acps.13360

Sweeney, A., Cunningham, S., Slinger, E., Clement, C., & Dodd, S. (2022). Survivor‐led guidelines for conducting trauma‐informed psychological therapy assessments: Development and modified Delphi study. *Health Expectations, 25*(6), 2818–2827. https://doi.org/10.1111/hex.13585

Taleb, N. N. (2012). *Antifragile: Things that gain from disorder*. Random House.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01

Thieme, A., Belgrave, D., & Doherty, G. (2020). Machine learning in mental health: A systematic review of the HCI literature to support the development of effective and implementable ML systems. *ACM Transactions on Computer-Human Interaction, 27*(5), Article 34. https://doi.org/10.1145/3398069

U.S. Department of Veterans Affairs & U.S. Department of Defense. (2023). *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*. https://www.healthquality.va.gov/guidelines/MH/ptsd/

Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Viking.

Verlenden, J., Kaczkowski, W., Li, J., Hertz, M., Anderson, K. N., Bacon, S., & Dittus, P. (2022). Associations between Adverse Childhood Experiences and Pandemic-Related Stress and the Impact on Adolescent Mental Health during the COVID-19 Pandemic. *Journal of Child & Adolescent Trauma, 17*(1), 1–15. Advance online publication. https://doi.org/10.1007/s40653-022-00502-0

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

Weathers, F. W., Bovin, M. J., Lee, D. J., Sloan, D. M., Schnurr, P. P., Kaloupek, D. G., Keane, T. M., & 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.

Wojujutari, A. K., Idemudia, E. S., & Ugwu, L. E. (2024). The assessment of reliability generalisation of clinician-administered PTSD scale for DSM-5 (CAPS-5): A meta-analysis. *Frontiers in Psychology, 15*, 1354229.

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

World Health Organization. (2021). *Devastatingly pervasive: 1 in 3 Women Globally Experience Violence*. https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence

World Health Organization. (2021). *Ethics and governance of artificial intelligence for health: WHO guidance.* https://www.who.int/publications/i/item/9789240029200

Zhu, P., Lau, J., & Navalta, C. P. (2020). An ecological approach to understanding pervasive and hidden shame in complex trauma. *Journal of Mental Health Counseling, 42*(2), 155–169. https://doi.org/10.17744/mehc.42.2.05

Zilberstein, K. (2022). Trauma in Context: an Integrative Treatment Model. *Journ Child Adol Trauma 15*, 487–500. https://doi-org/10.1007/s40653-021-00416-3

Appendix A. Proposed Integrated Trauma Spectrum Assessment (ITSA)

The Integrated Trauma Spectrum Assessment (ITSA)

A Bilingual Diagnostic Tool for DSM-5 PTSD and ICD-11 Complex PTSD

Purpose: To provide a reliable, structured clinical interview that bridges the DSM-5 framework for PTSD and the ICD-11 framework for Complex PTSD (CPTSD). The ITSA replaces the rigid "Index Event" anchor with a "Cumulative Load" assessment and explicitly screens for Disturbances in Self-Organization (DSO).

Target Population: Adults and adolescents with suspected single-incident trauma, poly-victimization, or developmental trauma (ACEs). **Administration Time:** 15–25 minutes (via Clinical Interview).

Part I: The "Atmosphere" (Cumulative Load)

Rationale: Standard assessments anchor to a single "index event," which can force survivors of chronic abuse to fragment their narrative. This section establishes the trauma baseline as an "atmosphere" or "era".

Clinician Script: *"Instead of trying to pick one specific worst day, I want us to focus on the period of your life when you felt least safe, or the environment where you lived on high alert. We will treat that whole era as the 'event' for this assessment."*

1. Cumulative Exposure Context:

- Was the trauma repeated or prolonged? (Yes/No)
- Was escape from the situation difficult or impossible at the time? (e.g., childhood dependence, incarceration, domestic entrapment) (Yes/No)

(Proceed to standard CAPS-5 Criteria B, C, and E for core PTSD fear-based symptoms (Intrusion, Avoidance, and Hyperarousal), anchoring the questions to the established "era" of trauma).

Part II: Disturbances in Self-Organization (DSO) Clinical Interview

Rationale: To meet the ICD-11 criteria for CPTSD, the patient must demonstrate persistent and pervasive impairments in three domains.

General Scoring Scale (Adapted from CAPS-5/COPISAC) Rate each item based on combined **Frequency** and **Intensity** over the past month.

- **0 = Absent:** Problem denied or does not fit criteria.
- **1 = Mild / Subthreshold:** Problem is present but not clinically significant.
- **2 = Moderate / Threshold:** Clinically significant. Occurs at least 2x/month or 20-30% of the time. Tendency to overreact or deactivate, with some difficulty recovering.
- **3 = Severe / Markedly Elevated:** Well above threshold. Occurs at least 2x/week or 50-60% of the time. Pronounced pattern, considerable difficulty managing or recovering.

- **4 = Extreme / Incapacitating:** Pervasive, unmanageable, and overwhelming. Little to no functioning intact.

Cluster A: Affect Dysregulation (AD)

Assesses severe difficulties in emotion regulation, including both hyper-activation and hypo-activation.

AD-1: Emotional Cascades (Hyper-activation)

- **Prompt:** *"When you get upset about a minor stressor, how long does it take you to calm down? Do you feel like your emotions spiral out of control easily?"*
- **Severity Score (0–4): _____**

AD-2: Emotional Numbing (Hypo-activation)

- **Prompt:** *"Do you experience times where you feel completely physically numb or emotionally shut down, unable to feel positive emotions like love or joy?"*
- **Severity Score (0–4): _____**

Cluster B: Negative Self-Concept (NSC)

Assesses persistent beliefs of worthlessness and toxic shame related to the trauma.

NSC-1: Pervasive Worthlessness

- **Prompt:** *"Do you feel that you are a failure as a person, or that you are somehow permanently damaged or 'ruined' by what happened to you?"*
- **Severity Score (0–4): _____**

NSC-2: Toxic Shame/Guilt

- **Prompt:** *"Do you feel deep, persistent shame or guilt? Do you feel that the abuse or the trauma was ultimately your fault, or that you somehow 'deserved' it?"*
- **Severity Score (0–4): _____**

Cluster C: Disturbances in Relationships (DR)

Assesses difficulties in sustaining relationships and feeling close to others.

DR-1: Relational Avoidance & Detachment

- **Prompt:** *"Do you find it hard to feel close to people? Do you tend to intentionally keep everyone at a distance to protect yourself from getting hurt?"*
- **Severity Score (0–4): _____**

Part III: The "Function" Prompts (Differential Diagnosis)

Rationale: To prevent the "forensic frenzy" of misdiagnosis, these forced-choice qualifiers distinguish the functional intent behind overlapping symptoms (e.g., CPTSD vs. Borderline or Bipolar Disorder).

1. The Relational Check (CPTSD vs. BPD)

- **Prompt:** *"You mentioned pulling away from people. Do you do this because you fear they are going to abandon you, or because you feel safer alone and don't trust them not to hurt you?"*
    - [ ] Fear of Abandonment / Frantic efforts to keep them *(Suggests BPD)*
    - [ ] Relational Avoidance / Need for safety *(Suggests CPTSD)*

2. The Identity Check (CPTSD vs. BPD)

- **Prompt:** *"Does your view of yourself change rapidly from day to day, or do you consistently feel 'worthless' or 'damaged'?"*
    - [ ] Rapid Shifting / Unstable Identity *(Suggests BPD)*
    - [ ] Stable, pervasive negative self-concept *(Suggests CPTSD)*

3. The Energy Check (CPTSD vs. Bipolar Mania)

- **Prompt:** *"When you experience racing thoughts and sleeplessness, do you feel powerful, gifted, and euphoric, or do you feel a vibrating sense of terror and a desperate need to stay on guard?"*
    - [ ] Euphoric / Grandiose *(Suggests Bipolar/Mania)*
        - [ ] Fear-based / Hypervigilant *(Suggests CPTSD / Trauma Hyperarousal)*

Part IV: Diagnostic Scoring Algorithm

To yield a formal diagnosis, calculate the symptom clusters based on the **Severity Rule of 2 (SEV2)**. A symptom is considered "Present" if it receives a score of **2 or higher**.

Step 1: Core PTSD Requirements (DSM-5 & ICD-11)

- [ ] At least ONE Intrusion/Re-experiencing symptom ≥ 2
- [ ] At least ONE Avoidance symptom ≥ 2
- [ ] At least TWO Hyperarousal/Threat symptoms ≥ 2
- **Result:** If YES to all, patient meets base criteria for **PTSD**.

Step 2: DSO Requirements (ICD-11 CPTSD)

- [ ] **Affect Dysregulation:** AD-1 OR AD-2 is ≥ 2
- [ ] **Negative Self-Concept:** NSC-1 OR NSC-2 is ≥ 2
- [ ] **Disturbed Relationships:** DR-1 is ≥ 2
- **Result:** If YES to **all three** clusters, patient meets DSO criteria.

Step 3: Functional Impairment

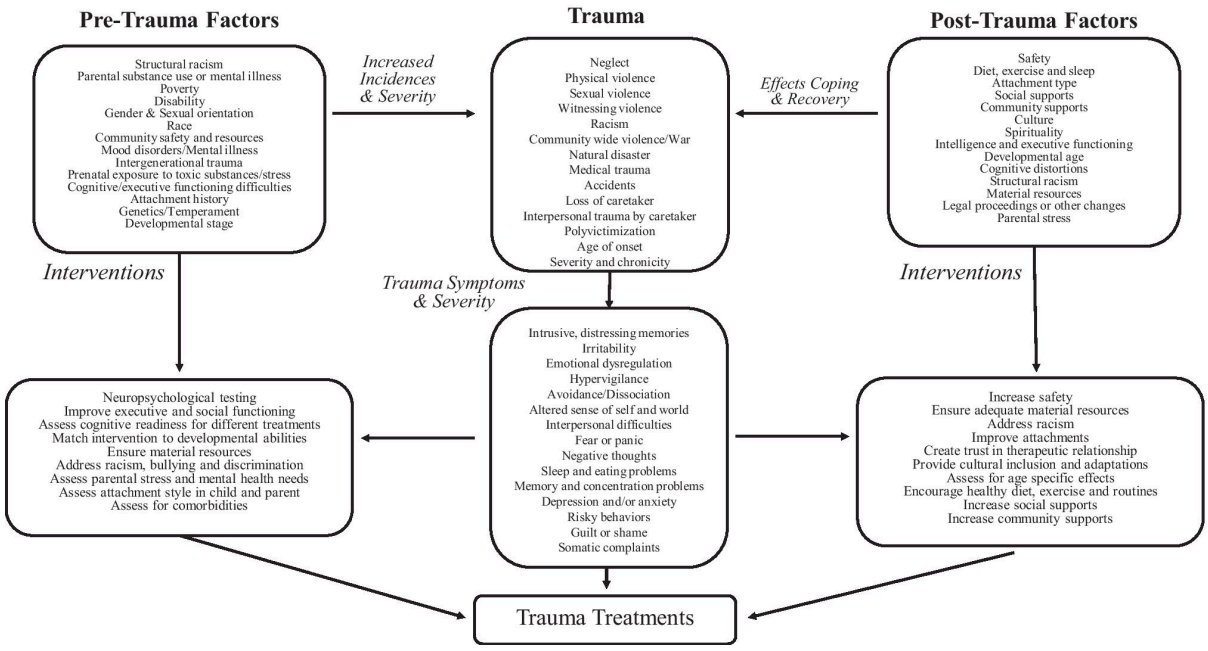
- [ ] Symptoms cause significant impairment in social, occupational, or other important areas of functioning (Score ≥ 2).

Final Diagnostic Determination:

- **Complex PTSD (CPTSD):** Meets criteria for Step 1 (PTSD) **PLUS** Step 2 (DSO) **PLUS** Step 3 (Impairment).
- **PTSD (Standard):** Meets criteria for Step 1 and Step 3, but fails to meet the full DSO cluster in Step 2.
- **Subthreshold / Clinical Attention Needed:** Fails Step 1, but scores highly on specific DSO clusters. Evaluate for developmental trauma impacts or appropriate Z-codes.

Note: This is a proposed framework grounded in the reviewed literature. It is offered as a conceptual foundation for future instrument development and requires rigorous psychometric validation—including interrater reliability, test-retest stability, and discriminant validity—before clinical implementation.

Appendix B: An Integrative Treatment Model Fits Within an Integrated Assessment Model



Note: Evolving the CAPS-5 within an Integrated Assessment Model ensures that the entire process, from assessment to treatment, is beneficial for the individual, thereby establishing an Integrative Treatment Model grounded in multicultural and ethical standards (Zilberstein, 2022).