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C-PTSD Assessment in Diagnosing Individuals Affected by Violence: A Preliminary Questionnaire Analysis

ABSTRACT

Post-traumatic disorders are among the most frequently diagnosed mental health conditions. They are typically identified through interviews and self-report tools. Among these disorders, the ICD-11 chapter on stress-related conditions includes Complex Post-Traumatic Stress Disorder (C-PTSD), which often affects people subjected to prolonged domestic violence. It is also prevalent among refugees, torture survivors, victims of persecution, and individuals who have endured lengthy and painful treatments due to chronic illness.

This article introduces a questionnaire developed by the author to assess C-PTSD. It also discusses the analysis of the questionnaire's validity, which takes into account the correlations between its scales and variables describing cognitive, emotional, and social functioning. The research aimed to evaluate the validity and reliability of this C-PTSD questionnaire. The author's intent is to propose this tool for diagnosing C-PTSD disorders, particularly for professionals working with victims of violence. Beyond diagnosis, the questionnaire may also help assess difficulties in forming relationships, including intimate partnerships.

The research employed a diagnostic survey method using questionnaires designed to measure variables that existing studies have identified as correlating with C-PTSD symptoms. Findings indicate that the questionnaire is sufficiently valid and reliable, although further studies with larger sample sizes are recommended.

KEYWORDS
post-traumatic disorders, C-PTSD, domestic violence, C-PTSD questionnaire, diagnosis

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C-PTSD in the diagnosis of individuals affected by violence: Introduction

Post-traumatic disorders are among the most frequently diagnosed mental health conditions, with a prevalence rate of 6.8% in the general population (Dudek 2003). These disorders are so common that the latest edition of the ICD-11 dedicates two separate chapters to them. The first chapter describes disorders specifically related to stress (Sitkowska 2022), including post-traumatic stress disorder (PTSD), complex post-traumatic stress disorder (C-PTSD), prolonged bereavement disorder, adjustment disorder, reactive attachment disorder, inhibited social attachment disorder, and other specified and unspecified stress-related disorders. The second chapter discusses dissociative disorders (Philip 2022), such as dissociative neurological symptom disorder, dissociative amnesia, trance disorder, trance possession disorder, dissociative identity disorder, partial dissociative identity disorder, depersonalization-derealization disorder, and other specified and unspecified dissociative disorders. These disorders are typically diagnosed through interviews and self-report tools. This article introduces the C-PTSD—Complex Post-Traumatic Stress Disorder Survey Questionnaire developed by the author.

Methods for studying post-traumatic disorders

The high prevalence of post-traumatic disorders has led to the development of numerous methods for studying these conditions (Kosydar-Bochenek et al. 2016). Common interview-based methods include the PTSD Scale (CAPS), the Interview for Post-Traumatic Stress Disorder (PTSD-I), the PTSD Symptom Scale Interview (PSS-I), and the Diagnostic Interview Schedule (DIS). Self-report tools include the civil version of the Mississippi Scale (MSC), the Post-Traumatic Diagnostic Scale, the Davidson Trauma Scale (DTS), the Impact of Events Scale (IES), the Revised Impact of Events Scale (IES-R), the K-PTSD Post-Traumatic Stress Disorder Questionnaire, the Post-Traumatic Stress Disorder Questionnaire—Factor Version, the Self-Rating Scale for PTSD, and the PTSD Checklist (PCL). Neuropsychological testing and imaging

techniques have also enriched the study of post-traumatic disorders. Research shows that individuals with a history of trauma exhibit impairments in visual-constructive competence, lower scores on tests assessing immediate and deferred recall of verbal content, and poorer performance on visual-spatial tasks. Brain studies reveal reductions in hippocampal volume, with subcortical activity often dominating over cortical activity.

The PTSD-I questionnaire, which is the basis for the Polish version of the K-PTSD, is structured into several parts:

A: Traumatic experience
B: Recurrent memories
C: Avoidance
D: Stimulation
E: Duration of disturbance

The Mississippi questionnaire consists of 39 questions. In addition to testing the severity of PTSD, it also measures the intensity of suicidal tendencies, depression, and guilt, using a five-point scale. The questionnaire evaluates six groups of symptoms:

- Unpleasant and distressing memories
- Difficulties in adapting to society
- Affective and memory disorders
- Recurrence of PTSD traits
- Challenges in interacting with the environment
- Insomnia

The civil version of the Mississippi Scale was adapted to Polish conditions by Maria Lis-Turlejska and Aleksandra Łuszczyńska-Cieślak in 2001 (Kosydar-Bochenek et al. 2016). This adaptation categorizes symptoms into three groups:

- recurring traumatic events,
- avoidance and numbing,
- chronic agitation.

Zygfryd Juczyński and Nina Ogińska-Bulik developed the Revised Impact of Events Scale (IES-R) to measure the severity of PTSD symptoms. This tool utilizes a five-point scale and examines three key components of PTSD: intrusion (8 items), arousal (7 items), and avoidance (7 items) (Juczyński, Ogińska-Bulik 2009). The Initial Trauma Review-3 (ITR-3) (Briere, Scott 2010) can also be used for an initial assessment of PTSD symptom severity. This questionnaire

is divided into two parts: the first deals with childhood and the second with adulthood. The childhood section includes six questions about specific traumatic events, while the adulthood section contains nine questions. Each question has additional components that allow the diagnostician to explore the topic in greater depth.

The Brief Interview for Posttraumatic Disorders (BIPD) (Briere, Scott 2010) is another tool for preliminary diagnosis, which helps to determine whether the individual is dealing with acute stress disorder (ASD), PTSD, or a psychotic disorder. Another recommended tool for examining PTSD is the MMPI-2 Minnesota Multiphasic Personality Inventory, standardized and adapted to Polish conditions by Urszula Brzezińska, Marta Koć-Januchta, and Joanna Stańczak (Brzezińska, Koć-Januchta, Stańczak 2012). The Post-Traumatic Stress Syndrome (PK) scale is included among its supplementary scales (Graham 2015). This scale, originally constructed based on studies of Vietnam War veterans, consists of 46 items and reflects significant emotional turmoil associated with PTSD symptoms. Some questions on the PK scale address anxiety and sleep disturbances, while others explore feelings of guilt and depression, distressing thoughts, and emotional dysregulation. Still others assess a sense of being misunderstood or mistreated by others. A high score on this scale during psychological evaluation may indicate the presence of PTSD symptoms in the individual being assessed.

One prominent tool for assessing dissociative disorders is the Taxon Dissociative Experience Scale—Revised Version (DES-R PL) (Pietkiewicz, Życińska, Tomalski 2016). This scale comprises 28 items, each accompanied by the following response options:

a. never
b. this has happened once or twice
c. not more than once a year
d. once every few months
e. at least once a month
f. on average once a week
g. more than once a week
h. once a day or more often

A shortened version of this scale, the DES-T PL, contains eight questions with the same response options (Pietkiewicz, Życińska, Tomalski 2016). Both tools facilitate the diagnosis of core symptoms

associated with dissociative disorders. For the investigation of acute stress disorder (ASD), two tools are commonly used: the Acute Stress Syndrome Interview and the Acute Stress Syndrome Scale (Bryant, Harvey 2011).

Characteristics of C-PTSD

Recent research has revealed that previous attempts to define PTSD are insufficient to capture the full spectrum of symptoms experienced by trauma survivors. Studies indicate that even after the six-month diagnostic period for PTSD has passed, many individuals continue to experience symptoms. In fact, many trauma survivors seek therapy years—or even decades—after the initial traumatic event. This pattern is frequently observed in cases such as childhood sexual abuse. To address these diagnostic problems, the ICD-11 introduced the category of Complex Posttraumatic Stress Disorder (C-PTSD) (Sitkowska 2022). While this condition had already been described in research literature, its formal classification acknowledges the unique symptomatology associated with chronic trauma.

For example, a study examining 96 female partners of perpetrators of violence (Taft et al. 2015) found a significant link between psychological abuse and PTSD symptoms. This indicates that not only violent or catastrophic events, but also chronic exposure to violence can precipitate PTSD. Therefore, researchers have introduced C-PTSD, which abstracts from the time elapsed since the trauma and emphasizes recognizing trauma that persists over time as well as the delayed onset of PTSD symptoms. Complex PTSD, often abbreviated as C-PTSD, or referred to as "disorder of extreme stress, not otherwise classified" (DESNOS), has been increasingly discussed in clinical literature (Briere, Scott 2010). This disorder is typically associated with prolonged and recurrent trauma, almost always of an interpersonal nature. Common underlying causes include torture, prolonged imprisonment, and chronic violence within the family.

The literature also identifies other groups at risk for C-PTSD, such as victims of human trafficking, refugees, and individuals who have undergone long and painful treatments for chronic illnesses (Courtois 2008). Additionally, C-PTSD has been observed among victims of persecution, particularly those from minority groups facing racial,

religious, or other forms of discrimination (Rittenhouse 2000). Several groups of C-PTSD symptoms have been identified (Johnson 2009). The first group involves affect regulation disorders, which may include suicidal thoughts, self-harm, anxiety attacks, compulsive sexual behavior, or sexual inhibition. Another group pertains to disorders of consciousness, which include trauma-related amnesia, dissociation, derealization, and ruminations. Self-perception disorders are also prominent, featuring symptoms such as initiative paralysis, feelings of guilt, a sense of being different, and the perception of being "marked." Disorders of the perception of the persecutor include preoccupation with the persecutor, unrealistic perceptions of their strengths, idealization of the persecutor, a belief in a special relationship with them, and rationalization of the persecution. This often leads to relationship disorders, characterized by the destruction of intimate relationships, a relentless search for a savior, persistent distrust, and repeated neglect of self-care. Self-soothing disorders are noted, involving the abandonment of faith and feelings of hopelessness and desperation. Lastly, somatizations, involving various physical symptoms without an apparent medical cause, are frequently reported.

C-PTSD questionnaire

To diagnose symptoms of C-PTSD, an experimental version of a questionnaire was developed. This tool consists of 27 items, each accompanied by a five-point scale (1—never, 2—very rarely, 3—sometimes, 4—often, 5—very often). The questions assess the frequency of specific symptoms in individuals, organized into seven scales: affect regulation disorder (5 items), disturbance of consciousness (5 items), paralysis of initiative (4 items), disturbance in perception of the persecutor (5 items), disturbance in relationships with others (4 items), repeated neglect of self-care (3 items), and somatization (1 item). The items for each scale were derived based on theoretical underpinnings (Johnson 2009). Specifically, the descriptions of C-PTSD symptoms outlined in Sharon L. Johnson's textbook on post-traumatic disorders served as the foundation. Confirmatory factor analysis was employed, which assumes a set of factors—often extracted from a specific theory—and tests the validity of these assumptions while estimating the parameters of the model (Hryniewicz 2024).

The affect regulation disorder scale includes questions addressing suicidal thoughts, depressed mood, anxiety attacks, self-harm, and compulsive or inhibited sexual behavior. The disturbance of consciousness scale examines symptoms such as amnesia of difficult experiences, dissociation from one's body, emotions, or history, feelings of derealization, and ruminations about difficult situations. The initiative paralysis scale includes items focused on disturbances in self-perception, feelings of guilt, a sense of being different, and the perception of being "marked." The persecutor perception disorder scale assesses symptoms such as a disturbed relationship with the persecutor, unrealistic perceptions of their strength, idealization of the persecutor, a sense of a special bond, and rationalization of persecution. The relationship disturbance scale contains the following symptoms: isolation, destruction of intimate relationships, a repetitive search for a savior, and persistent distrust. The repeated neglect of self-care scale focuses on symptoms such as impaired self-care, challenges with self-soothing, and feelings of hopelessness and despair. Finally, the somatization scale targets non-medically based somatic symptoms.

Scores for each scale are calculated as an average to account for the differing number of items in each scale). The experimental study for the questionnaire was conducted with a group of 38 pedagogy students. All participants provided written consent for their results to be used anonymously for research purposes. The study took place as part of a course on diagnostic methods. During the course, students were given the opportunity to discuss any issues related to the material, and if problems arose, the instructor facilitated appropriate care for the individual. In addition to the experimental questionnaire, participants were assessed using other tools, allowing for a comparison to determine how well the questionnaire measured the intended constructs. The research group consisted solely of women, purposefully selected from those attending the workshop. The experimental nature of the questionnaire necessitates further studies with groups that are diverse in terms of gender, age, and professional background.

The average age of the respondents was 26 years. Among them, 12 individuals reported experiencing violence, while 26 stated that they had not.

The research utilized a diagnostic survey method with a survey technique. The tools employed in the study included Anna Matczak

and Aleksandra Jaworowska's Emotional Intelligence Questionnaire, Anna Matczak's Social Competence Questionnaire, Stanisław Popek's KANH Creative Behavior Questionnaire, the STAI Questionnaire in the Polish adaptation by Tytus Sosnowski, Kazimierz Wrześniewski, Aleksandra Jaworowska, and Diana Fecenec, and the Revised Version of the Attention and Concentration Test d2-R by Rolf Brickenkamp, Lothar Schmidt-Atzert, and Detlev Liepmann. These tools facilitated an assessment of the participants' emotional, cognitive, and social functioning. The results of the analyses in these areas were expected to correlate with the results of the C-PTSD symptom questionnaire. This comparative analysis provides a preliminary examination of the questionnaire's validity and relevance for assessing C-PTSD symptoms.

The Emotional Intelligence Questionnaire is a psychological test consisting of 33 items. Respondents rate their agreement with each statement on a scale from 1 to 5. The Social Competence Questionnaire includes 90 items rated on a scale of 1 to 4. The KANH Creative Behavior Questionnaire comprises 60 items, rated on a scale from 0 to 2. The STAI Questionnaire contains two scales: X-1, which measures state anxiety, and X-2, which measures trait anxiety. Respondents rate the items on a scale from 1 to 4. The Revised Version of the d2-R Test for Attention and Concentration is a timed psychological test in which participants identify the correct letter "d" among other characters.

The variables analyzed were as follows: for the emotional sphere, emotional intelligence, the ability to use emotions to support thinking and action, the ability to recognize emotions, anxiety-state, and anxiety-trait; for the social sphere, intimate behavior, social exposure, and assertiveness; and for the cognitive sphere, attention focus, algorithmic thinking, heuristic thinking, non-conformist thinking, and conformist thinking. According to the existing literature, these variables correlate with PTSD symptoms (Ghazali 2014; Saar-Ashkenazy et al. 2023; Allen et al. 2021; Jaconis, Boyd, Gray 2020; Harms et al. 2018; Camacho-Conde 2020).

Relevance testing of the C-PTSD questionnaire

To evaluate whether the C-PTSD questionnaire accurately measures the intended variables, its results were analyzed in relation

to data obtained from the other tools. The correlations were calculated using the Spearman's rho test, as not all variables were normally distributed, necessitating a non-parametric approach. The tools previously described, which assess cognitive, emotional, and social competencies, were used for this purpose.

Table 1 presents the correlation results calculated using Spearman's rho. In the table, concentration is broken down into four consecutive sequences of sign counts as measured by the questionnaire.

The level of anxiety defined as anxiety-trait as well as anxiety-state—i.e., the level of anxiety at the time of the survey—correlates positively with disorders in perceiving the persecutor as measured by the questionnaire. Higher levels of these disorders are associated with higher levels of anxiety-trait (rho = 0.41) and anxiety-state (rho = 0.47). Additionally, the level of state anxiety correlates to a statistically significant degree with the level of somatization (rho = 0.40). Somatization also correlates positively and significantly with creativity (rho = 0.37). Both heuristic and nonconformist creative behaviors show positive correlations with somatization. Higher levels of somatization are associated with higher levels of heuristic behavior (rho = 0.40) and nonconformist behavior (rho = 0.41). Nonconformist behavior further demonstrates a statistically significant positive correlation with distorted perceptions of the persecutor (rho = 0.40).

Several statistically significant correlations were observed involving social exposure (a scale in the Social Competence Questionnaire that measures the ability to endure social exposure). The level of social exposure correlates negatively and significantly with affect regulation disorder (rho = −0.40), impaired consciousness (rho = −0.42), initiative paralysis (rho = −0.55), and repeated neglect of self-care (rho = −0.46). This suggests that individuals with higher levels of these C-PTSD symptom components tend to struggle with social exposure. Similarly, intimate behavior (a scale in the Social Competence Questionnaire assessing the ability to engage in intimate relationships) correlates negatively and significantly with initiative paralysis (rho = −0.36) and impaired perception of the persecutor (rho = −0.40). These findings indicate that individuals with high scores in these C-PTSD symptom components face challenges in forming intimate relationships.

Table 1: Correlations of the C-PTSD Questionnaire Scales with Variables Describing Cognitive, Social and Emotional Development

Variable	Spearman rank order correlation (red: p < 0.05)						
	Affect regulation disorders	Disorders of consciousness	Paralysis of initiative	Disturbance in the perception of the persecutor	Relationship disorders	Repeated neglect of self-care	Somatizations
Anxiety-trait	0,29	0,00	0,10	0,41	0,20	0,10	0,24
Anxiety-state	0,26	0,04	0,00	0,47	0,24	0,15	0,40
Creativity	–0,16	0,03	–0,16	0,25	0,02	0,03	0,37
Conformism	0,21	0,00	0,32	0,26	0,19	0,08	–0,26
Algorithmic behavior	–0,18	–0,26	–0,04	–0,10	–0,28	–0,34	–0,48
Non-conformism	–0,05	0,13	–0,10	0,40	0,04	0,03	0,41
Heuristic behavior	–0,15	0,10	–0,14	0,24	0,03	0,09	0,40
Assertiveness	0,11	–0,13	–0,05	–0,32	0,17	0,01	0,15
Social exposure	–0,40	–0,42	–0,55	–0,18	–0,30	–0,46	0,20
Intimate behavior	–0,21	–0,27	–0,36	–0,40	–0,09	–0,29	0,17
Ability to use emotions to support thinking and acting	–0,25	–0,14	–0,46	0,02	–0,35	–0,44	0,20
Ability to recognize emotions	–0,22	0,00	–0,40	0,13	–0,32	–0,47	0,35
INTE: emotional intelligence	–0,27	–0,05	–0,39	0,02	–0,42	–0,54	0,14
K1: concentration	–0,06	0,07	–0,19	–0,06	0,06	0,00	0,37
K2: concentration	–0,12	–0,05	–0,26	–0,17	0,06	0,00	0,35
K3: concentration	–0,10	–0,10	–0,25	–0,15	0,14	0,10	0,42
K4: concentration	–0,03	–0,07	–0,18	–0,07	0,13	0,09	0,30

Source: author's own research (p = 0.95).

The level of emotional intelligence correlates negatively and significantly with initiative paralysis (rho = –0.39), impaired relationships with others (rho = –0.42), and repeated neglect of self-care (rho = –0.54). This suggests that individuals with high levels of these C-PTSD symptom components tend to have lower levels of emotional intelligence. When analyzing individual components of emotional intelligence, the ability to use emotions to support thought and action shows statistically significant negative correlations with initiative paralysis (rho = –0.46), impaired relationships with others (rho = –0.35), and repeated neglect of self-care (rho = –0.44). Similarly, the ability to recognize emotions correlates negatively and significantly with initiative paralysis (rho = –0.40) and repeated neglect of self-care (rho = –0.47). A single statistically significant positive correlation was observed between the ability to recognize others' emotions and somatization (rho = 0.35).

The level of concentration, particularly the ability to recognize distractors, correlates positively and significantly with somatization across all sequences of the study. As part of the questionnaire's relevance analysis, differences in the levels of individual components of C-PTSD symptoms were examined between groups of individuals who had experienced violence and those who had not. The non-parametric Mann–Whitney U test was used for this analysis. For the affect regulation disorder scale, the difference between individuals who had experienced violence and those who had not was statistically significant ($Z = 4.32$; $p = 0.001$). On the disturbance of consciousness scale, no statistically significant differences were observed between the two groups. However, on the initiative paralysis scale, a statistically significant difference was identified ($Z = 3.31$; $p = 0.001$). Similarly, the difference was statistically significant on the disturbance in perception of the persecutor scale ($Z = 2.43$; $p = 0.01$), the relationship disorder scale ($Z = 3.32$; $p = 0.001$), and the repeated neglect of self-care scale ($Z = 3.25$; $p = 0.001$). On the somatization scale, no statistically significant difference was found between those who had experienced violence and those who had not. In all cases where the difference was statistically significant, individuals who had experienced violence scored higher on the component symptoms of C-PTSD. At the end of the analysis, the reliability of the questionnaire, or how accurately it measures what it is intended to assess,

can be evaluated. The Cronbach's alpha reliability coefficient for the entire questionnaire is 0.81. The somatization scale was identified as the weakest scale, as its removal increases the overall reliability score.

Summary and possibilities for implementing the questionnaire in educational work

In conclusion, the analyzed questionnaire demonstrates sufficient reliability. However, the somatization scale warrants further consideration. Its reliability is low (Cronbach's alpha = 0.34), and results from the relevance studies also indicate its weakness. This may be attributed to the fact that somatization is a feature of numerous disorders and may not be specifically tied to trauma. Studies examining the questionnaire's relevance did not show the correlation reported in the literature between post-traumatic disorder symptoms and cognitive problems (Camacho-Conde 2020). Existing research tends to draw more on memory impairments in individuals affected by trauma. It places less emphasis on attention deficits and does not suggest a lack of creativity as a characteristic feature. Both anxiety-state and anxiety-trait levels correlate with C-PTSD symptoms, particularly with the perception of the persecutor. This confirms the results from previous research (Camacho-Conde 2020; Saar-Ashkenazy et al. 2023). C-PTSD symptoms also show correlations with levels of emotional intelligence. Individuals with higher levels of initiative paralysis, neglect of self-care, and relationship disorders demonstrate lower levels of emotional intelligence. This applies to both the ability to use emotions to support thought and action and the ability to recognize emotions. These findings are also consistent with existing research (Ghazali 2014).

Correlations were also observed between C-PTSD components and variables related to social relationships. Affect regulation disorder, impaired awareness, initiative paralysis, and repeated neglect of self-care correlate negatively with the ability to endure social exposure. This suggests that individuals with high C-PTSD scores have reduced capacity for social exposure. To some extent, this is supported by existing research (Allen et al. 2021; Jaconis, Boyd, Gray 2020). However, prior studies also point to the phenomenon

of post-traumatic growth, which involves the strengthening or validation of certain relationships (Harms et al. 2018). This aspect was not confirmed in the present research. The only positive correlation observed was between the somatization scale and the ability to recognize other people's emotions, which may indicate an increased sensitivity in traumatized individuals.

The results of the study also reveal a strong negative correlation between the ability to form intimate relationships and both initiative paralysis and distorted perceptions of the persecutor. This also confirms that individuals affected by trauma often experience precisely these types of problems in their social relationships. These findings are also in line with existing research (Allen et al. 2021; Jaconis, Boyd, Gray 2020). Post-traumatic disorders are among the most prevalent conditions among individuals undergoing rehabilitation. These cases often involve children, adolescents, and adults who have been victims of family violence. Educators in various institutional settings frequently face the challenge of making an initial assessment of their pupils' difficulties to appropriately refer them to appropriate specialists. Since C-PTSD symptoms frequently emerge in individuals who have experienced family violence during childhood, there is a particular need to employ the presented questionnaire in diagnosing such cases. The questionnaire offers a valuable tool for analyzing the problems faced by these individuals, potentially enabling better preparation for their engagement in family life and partnerships. Most importantly, it serves as a means of facilitating diagnoses for post-traumatic support and therapy.

The questionnaire can also facilitate collaboration among professionals working to support individuals experiencing violence. While the diagnostic process itself should be carried out by a psychologist, this is only the initial step in implementing further measures of assistance. To provide comprehensive support for someone experiencing violence, it is necessary to combine the diagnosis of their condition with an assessment of their educational environment and the outcomes of the educator's interventions (Wysocka 2006). For this to be effective, the diagnosing psychologist must cooperate with the educator or counsellor. By understanding the diagnostic results, the educator can address the individual's specific problems through workshops, sociotherapeutic sessions, or pedagogical therapy. Simultaneously,

the involvement of a psychotherapist or psychotraumatologist is vital. The tool developed—though currently in an experimental phase—can be the basis for this kind of interdisciplinary collaboration. The questionnaire also holds value for those designing preventive training programs. Presenting this type of tool can be particularly beneficial in specific institutions. For instance, it could support the training initiatives provided by the Child Protection Centre in Cracow.

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