

Original Article
Psychiatry & Psychology



Psychological Interventions for Complex Post-traumatic Stress Disorder Symptoms: A Systematic Review

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OPEN ACCESS

Received: Jan 9, 2025

Accepted: Mar 28, 2025

Published online: Sep 12, 2025

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Disclosure

The authors have no potential conflicts of interest to disclose.

ABSTRACT

Background: Complex post-traumatic stress disorder (CPTSD) is characterized by the presence of post-traumatic stress disorder symptoms combined with disturbances in self-organization. However, treatment strategies for this newly defined condition remain lacking.

Methods: In this systematic review of international studies exploring psychological interventions for CPTSD in children, adolescents, and adults, we screened PubMed and Google Scholar for relevant literature while adhering to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.

Results: In total, 6 studies met our inclusion criteria. The psychological interventions explored in these studies encompassed a range of therapeutic modalities, including trauma-focused cognitive behavioral therapy, prolonged exposure therapy, skill training in affect and interpersonal regulation narrative therapy, mindfulness-based practices, and group therapies with a focus on somatic or body-oriented techniques. For children and adolescents with CPTSD, interventions were typically concise and followed a structured, phase-based approach, whereas adults often benefited from longer intervention durations that facilitated a more gradual and profound therapeutic process.

Conclusion: This review highlights the effectiveness of psychological interventions in addressing CPTSD symptoms. However, treatments specifically targeting CPTSD's unique symptom clusters, especially disturbances in self-organization, remain limited. Future research should prioritize the development of interventions tailored to address these distinct features.

Keywords: Complex Post-Traumatic Stress Disorder; Psychological Intervention; Developmental Stage; Systematic Review

INTRODUCTION

In 2018, the World Health Organization (WHO) published the International Classification of Diseases 11th Revision, which introduced complex post-traumatic stress disorders (CPTSDs) as a distinct diagnostic category.¹ CPTSD is a debilitating condition that arises from prolonged and repeated trauma, particularly of an interpersonal nature.²

Author Contributions

Conceptualization: Ahn H, Han DH. Data curation: Ahn H. Formal analysis: Ahn H. Methodology: Hong JS, Han DH. Writing - original draft: Ahn H, Hong JS, Han DH. Writing - review & editing: Hong JS, Han DH.

While CPTSD shares common symptoms with post-traumatic stress disorder (PTSD), namely re-experiencing, avoidance, and hyperarousal, it is also characterized by disturbances in self-organization, including affective dysregulation, negative self-concept, and interpersonal difficulties, which significantly impair daily functioning.^{3,4}

Cumulative trauma associated with interpersonal relationships, such as childhood abuse, domestic violence, physical assault, torture, and war imprisonment, have been identified as risk factors for CPTSD.⁵ Such experiences lead to more profound and lasting internal changes than single-event traumas, disrupting attachment security, physiological regulation, emotional regulation, behavioral control, and self-concept formation.⁶ The impact of CPTSD varies among individuals depending on the type of trauma experienced, developmental stage, and life circumstances, with persistent and severe negative outcomes often observed in children and young people in particular.⁷ Intrafamilial abuse, whether direct or indirect, can serve as an indicator of repeated traumatic events in children and adolescents.⁸ Research from the Diagnostic and Statistical Manual of Mental Disorders (DSM) 4th Edition field trial indicates that trauma experienced in early childhood, particularly within the first 10 years of life, profoundly affects an individual's development,⁹ and adverse childhood experiences (ACEs) are significant contributors to CPTSD in adulthood.¹⁰ The ACE study revealed an association between repeated childhood abuse and family dysfunction with increased risks of physical and mental health issues, social and legal challenges, and mortality in adulthood.^{11,12}

Although traumatic experiences are irreversible and cannot be erased, appropriate interventions based on addressing CPTSD symptoms can provide an opportunity to mitigate chronic effects or further deterioration.¹³ To date, many effective treatments for PTSD have been used to treat CPTSD. Specifically, trauma-focused therapies, such as cognitive behavioral therapy, prolonged exposure therapy, and eye movement desensitization and reprocessing (EMDR), could effectively reduce CPTSD symptoms.¹⁴ Additionally, other therapeutic approaches, including skill training in affect and interpersonal regulation (STAIR), narrative exposure therapy, skill training in affect and interpersonal regulation combined with narrative therapy (SNT), and dialectical behavior therapy, have shown potential for treating CPTSD.¹ However, CPTSD-specific interventions,¹⁴ particularly those addressing disturbances in self-organization, remain lacking. Hence, interventions that are both quantitatively and qualitatively distinct from those currently available for PTSD are warranted.

To address this gap, we conducted a systematic review of intervention outcomes in studies involving individuals with complex trauma, categorizing interventions according to participant age to account for developmental distinctions. This approach aimed to identify effective age-specific interventions for CPTSD symptoms and guide the development of improved intervention strategies tailored to the distinct needs of patients with CPTSD, with a focus on addressing symptom-specific and developmental differences.

METHODS

This systematic review examined international studies on CPTSD treatment interventions for children, adolescents, and adults published between 2014 and 2024. The review involved a comprehensive database search of PubMed and Google Scholar using medical subject headings (MeSH) keywords including “child,” “adolescent,” “adult,” “complex post-traumatic,” “CPTSD,” “complex PTSD,” “symptoms,” “psychosocial,” “therapy,”

“treatment,” and “intervention.” The study adhered to the guidelines outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), comprising the search, screening, and selection stages. After removing duplicates from the final databases and web searches, titles and abstracts were screened to assess study relevance. The selected articles were then analyzed in full and categorized according to the following inclusion and exclusion criteria.

The inclusion criteria were: i) relevance to the research topic, ii) clarity of study findings, iii) presence of psychosocial intervention, iv) publication in English, v) studies involving participants aged between 6 and 65 years to align with the target populations of children (6–12 years), adolescents (13–18 years), or adults (> 18 years), and vi) studies with a sample size ($N > 1$) and quantitative statistical analyses to evaluate the intervention outcomes. Randomized controlled trials were considered primarily due to their ability to minimize bias and provide high-confidence evaluations of intervention effectiveness. Non-randomized designs, including naturalistic observational studies and single-trial designs, were also included to capture intervention outcomes in more ecologically valid and diverse contexts. Studies were eligible for inclusion if participants met the diagnostic criteria for CPTSD according to the International Classification of Diseases (ICD)-11 or if they were diagnosed with PTSD (ICD-10 and/or DSM-5 criteria) with at least one of the additional CPTSD criteria at baseline (affective dysregulation, negative self-concept, and relational disturbances). Both self-reported and clinician-administered trauma symptom assessments were considered. Participants were also required to have experienced ≥ 1 traumatic event, such as childhood abuse, or multiple interpersonal traumas. We focused on studies evaluating psychosocial interventions aimed at reducing PTSD or CPTSD symptoms, or related disturbances in self-organization. Interventions could be delivered individually or in group formats. Studies with trauma-focused approaches or other evidence-based treatments were included if the effect of the psychosocial intervention was clearly evaluated.

Exclusion criteria were: i) unclear results, ii) publication in a language other than English, iii) low relevance to the topic, iv) reviews and reports, v) studies involving participants with psychosis, severe mental disabilities, complex dissociative disorders, or severe somatic illnesses, and vi) recent substance abuse (< 3 months), acute suicidality, current life crises, severely impaired group functioning, or recent suicide attempts.

The final study selection was decided based on a consensus between two primary researchers, with input from a co-researcher for opinion consolidation.

RESULTS

Study characteristics

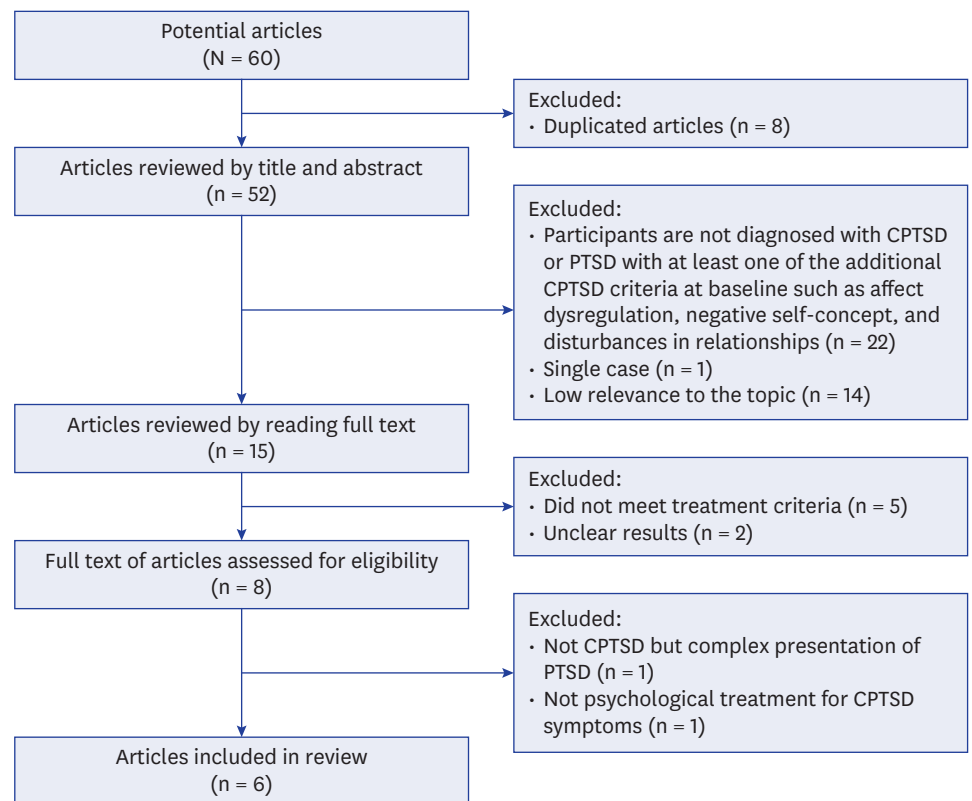
Six articles that met the inclusion criteria were reviewed. The study selection process is outlined in Fig. 1, Tables 1 and 2 summarize the main characteristics of the six studies in terms of authorship, sample sizes, age ranges, sex distribution, intervention methods, and key outcomes.

Sample sizes ranged from 10 to 155 participants, primarily recruited from mental health care facilities. Participant ages ranged from 7 to 65 years, with a higher percentage of female participants in most studies. The traumatic experiences reported were predominantly

Table 1. Results of studies conducted on child/adolescent populations

First author (year)	Sample characteristics (n, age, sex, complex traumatic events)	Study design	Intervention	Intervention details	Main outcomes
Sachser et al. ¹⁵ (2017)	n = 155 Age range: 7–17 yr M: 27.7%, F: 72.3% Interpersonal traumas	RCT CPTSD subgroup (n = 62) vs. PTSD subgroup (n = 93)	TF-CBT	3 phases, 12 sessions	TF-CBT significantly reduced DSO symptoms, with medium effects on affective dysregulation ($d = 0.40$ – 0.60) and large effects on negative self-concept ($d = 0.87$ – 1.16) and relationship disturbances ($d = 0.88$ – 1.03).
Hendriks et al. ¹⁶ (2017)	n = 10 Age range: 12–18 yr M: 20%, F: 80% Multiple interpersonal traumas, multiple sexual abuse, multiple violent assaults, emotional abuse, neglect	Time series design (baseline phase, intervention phase, follow-up phase)	Intensive PE	5 consecutive weekdays, 15 sessions	Intensive PE led to a significant reduction in self-reported PTSD severity ($P = 0.002$), with 80% no longer meeting PTSD criteria ($P < 0.05$). No detailed information on CPTSD-specific symptoms was provided.
Jensen et al. ¹⁷ (2022)	n = 73 Mean age: 15.4 yr M: 11%, F: 89% Sexual abuse, community violence, bullying, domestic violence, accidents/illness	Naturalistic observational study	TF-CBT	3 phases, 12–16 sessions	TF-CBT significantly reduced PTSS (1.42 reduction for PTSD; 2.09 for CPTSD; $P < 0.001$) and showed greater reductions in CPSS and DSO scores among youth with CPTSD ($P < 0.001$), highlighting its effectiveness for CPTSD symptoms.

RCT = randomized controlled trial, CPTSD = complex post-traumatic stress disorder, PTSD = post-traumatic stress disorder, TF-CBT = trauma-focused cognitive behavioral therapy, DSO = disturbances in self-organization, PE = prolonged exposure, PTSS = post-traumatic stress symptom, CPSS = complex post-traumatic stress symptom.


Fig. 1. Flow diagram for study selection.

CPTSD = complex post-traumatic stress disorders, PTSD = post-traumatic stress disorders.

interpersonal, including various types of abuse (physical, sexual, and emotional) during childhood, adulthood, or both. Each study assessed trauma-related symptoms, focusing on PTSD or CPTSD, using various diagnostic tools to confirm the eligibility of participants. Additionally, comorbid diagnoses alongside CPTSD were identified among the participants.

Table 2. Results of studies conducted on adult populations

First author (year)	Sample characteristics (N, age, sex, complex traumatic events)	Study design	Intervention	Intervention details	Main outcomes
Classen et al. ¹⁸ (2021)	n = 37 Age range: 24–64 yr F: 100% Childhood trauma	RCT Immediate treatment group (n = 18) vs. Waitlist control condition group (n = 19)	TBG	20-session group psychotherapy based on sensorimotor psychotherapy principles	Significant improvements in body awareness ($F = 8.15$, $P = 0.007$, $d = 0.91$), anxiety ($F = 6.30$, $P = 0.02$, $d = 0.81$), and soothing receptivity ($F = 12.62$, $P = 0.001$, $d = 1.12$). TBG may enhance body awareness, receptivity to self and relational relaxation, and reduce anxiety.
Dumarkaite et al. ¹⁹ (2022)	n = 53 Mean age: 23.21 yr M: 11.6%, F: 84.9% Childhood abuse	RCT Intervention group (n = 17) vs. Waiting list control group (n = 36)	Online mindfulness-based intervention	8 structured modules, with pre-, post-, and 3-mon follow-up	Multivariate analysis showed significant changes in PTSD and DSO symptoms ($F = 3.11$, $P = 0.016$). Univariate analysis showed reduced DSO symptoms, particularly in negative self-concept ($F = 4.20$, $P = 0.019$) and disturbances in relationships ($F = 3.39$, $P = 0.038$), with no significant effect on affective dysregulation ($F = 1.08$, $P = 0.362$).
Sele et al. ²⁰ (2023)	n = 92 Age range: 18–65 yr M: 19.6%, F: 80.4% Childhood abuse	RCT SNT (n = 30) PE (n = 32) STAIR (n = 30)	SNT, STAIR, PE	Comparisons across different therapy approaches	No significant difference in CPTSD symptom reduction across conditions. PE was most effective for PTSD symptoms, while both PE and STAIR were more effective than SNT for CPTSD symptoms.

RCT = randomized controlled trial, TBG = trauma and body group, PTSD = post-traumatic stress disorder, DSO = disturbances in self-organization, SNT = skills training in affect and interpersonal regulation narrative therapy, PE = prolonged exposure, STAIR = skills training in affect and interpersonal regulation, CPTSD = complex post-traumatic stress disorder.

The studies employed various psychological interventions, comprising four randomized controlled trials with control groups and two studies with non-randomized designs. Outcomes were categorized to distinguish between adult and child/adolescent populations, providing insights into the effectiveness of different therapeutic interventions for each group.

Studies on child/adolescent populations

Sachser et al.¹⁵ assessed the efficacy of trauma-focused cognitive behavioral therapy (TF-CBT) in treating CPTSD in children and adolescents following interpersonal traumas. A latent class analysis identified two distinct groups: a PTSD group (n = 62) and a complex PTSD group (n = 93). These groups differed significantly in terms of sex distribution, the index trauma type, and the presence of co-occurring depressive disorders. Both groups demonstrated significant reductions in post-traumatic stress symptoms over time following TF-CBT, with substantial pre-to-post treatment effect sizes (PTSD: $d = 2.81$; CPTSD: $d = 1.37$). The 12-session intervention, delivered in 3 stages, was evaluated by comparing pre- and post-treatment disturbances in self-organization scores. TF-CBT effectively reduced complex symptoms in children and adolescents, with significant improvements in disturbances in self-organization scores. Specifically, the intervention resulted in a medium effect on affective dysregulation ($d = 0.40$ – 0.60), while showing a large effect on both negative self-concept ($d = 0.87$ – 1.16) and relationship disturbances ($d = 0.88$ – 1.03).

In a study by Hendriks et al.,¹⁶ intensive prolonged exposure therapy based on Foa's protocol was delivered to adolescents with CPTSD and comorbid conditions over 5 consecutive weekdays, comprising 15 sessions. None of the participants dropped out of the treatment. Time-series analyses showed a significant decrease in PTSD symptoms ($P = 0.002$), with 80% of the participants no longer meeting the diagnostic criteria for PTSD ($P < 0.05$). Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version, PTSD section total scores also significant decreased from baseline to post-treatment ($z = -2.81$, $P = 0.005$) with a large effect size ($r = 0.63$). Depressive symptoms, assessed using Beck Depression Inventory-II total scores, also showed a significant reduction ($z = -2.24$, $P = 0.025$) with a large effect size ($r = 0.50$). Although this study supported

the safety and effectiveness of intensive prolonged exposure for adolescents with CPTSD, specific symptom changes related to CPTSD were not detailed.

A naturalistic observational study examined the effectiveness of TF-CBT in reducing PTSD and CPTSD symptoms among young populations.¹⁷ Post-intervention results indicated a mean reduction in post-traumatic stress symptom scores of 1.42 for youth with PTSD ($P < 0.001$) and 2.09 for those with CPTSD ($P < 0.001$), revealing a significantly larger treatment-related effect in individuals with CPTSD than those with PTSD. Reductions in complex post-traumatic stress symptom and disturbances in self-organization scores following TF-CBT among youths with CPTSD were also observed ($P < 0.001$). Additionally, dropout rates were not significantly different between the groups (CPTSD: 20.0%, $n = 9$; PTSD: 32.1%, $n = 9$).

Studies on adult populations

Classen et al.¹⁸ evaluated the effectiveness of a 20-session trauma and body group body-oriented therapy based on the principles and techniques of sensorimotor psychotherapy in addressing the effects of psychological trauma on the body. Participants were evaluated 1 month before treatment, immediately after treatment, and 6 months post-treatment. Among the 32 female participants who enrolled in the study, 5 discontinued participation following the baseline assessment. Upon comparing dropouts and completers, the only significant demographic difference was found to be in racial/ethnic background. However, baseline outcome measures did not significantly differ between participants who remained in the study and those who withdrew. The results showed significant improvements in body awareness ($F = 8.15$, $P = 0.007$, $d = 0.91$), anxiety ($F = 6.30$, $P = 0.02$, $d = 0.81$), and soothing receptivity ($F = 12.62$, $P = 0.001$, $d = 1.12$) in the treatment group compared to the control group. These findings suggest that trauma and body group therapy may help complex trauma survivors by improving body awareness, increasing self-receptivity and relational relaxation, and alleviating anxiety. However, no significant effects on PTSD symptoms were observed, as measured using the PTSD Checklist ($F = 3.42$, $P = 0.070$, $d = 0.59$).

Dumarkaite et al.¹⁹ conducted an 8-module online mindfulness-based intervention to examine its effect on PTSD and CPTSD-related disturbances in self-organization symptoms, with pre-intervention, post-intervention, and 3-month follow-up evaluations. Multivariate analysis revealed significant differences in the changes in PTSD and disturbances in self-organization symptoms over time between the intervention and control groups ($F = 3.11$, $P = 0.016$). At the univariate level, the intervention group demonstrated a notable decrease in disturbances in self-organization symptoms compared to the control group ($F = 4.90$, $P = 0.009$), specifically in negative self-concept ($F = 4.20$, $P = 0.019$) and disturbances in relationships ($F = 3.39$, $P = 0.038$). However, no significant changes were observed in affective dysregulation ($F = 1.08$, $P = 0.362$).

Upon evaluating treatment outcomes following STAIR, SNT, and prolonged exposure for CPTSD symptoms, Sele et al.²⁰ reported no significant differences in socio-demographic factors, comorbidities, or CPTSD symptom reduction across the treatment conditions. At the one-year follow-up, prolonged exposure (33.0%) resulted in the greatest improvement in PTSD symptoms compared with SNT (19.0%) and STAIR (18.0%). Both prolonged exposure (41.0%) and STAIR (25.0%) led to significant reductions in CPTSD symptoms compared with SNT (22.0%). This indicates that prolonged exposure was the most effective in alleviating PTSD symptoms, whereas both prolonged exposure and STAIR showed more significant improvements than SNT in addressing CPTSD symptoms.

DISCUSSION

This systematic review, conducted in adherence to the PRISMA guidelines, evaluated the effectiveness of psychological treatments for CPTSD. Our findings show that trauma-focused and skill-based approaches, such as cognitive behavioral therapy, dialectical behavior therapy, prolonged exposure, and STAIR, can effectively address CPTSD symptoms, including affective dysregulation, negative self-concept, and relational disturbances. While these interventions demonstrated positive outcomes in participants with CPTSD, differences in treatment protocols and inconsistent symptom reporting across the studies make it difficult to determine the most effective intervention.

Trauma-focused treatments, such as cognitive behavioral therapy, EMDR, and prolonged exposure, have demonstrated efficacy across various PTSD populations²¹ by targeting traumatic memories and identifying the personal meaning of the trauma, typically through techniques involving repeated exposure (in vivo or imaginal) and/or cognitive reappraisal of the significance and consequences of the trauma.²² However, these approaches have predominantly focused on single-event adult trauma,²² and their utility for treating more complex traumas, such as CPTSD, remains controversial. For complex trauma, clinicians widely employ the phase-based model proposed by Herman (1992), which comprises the following phases: i) stabilization, which focuses on enhancing symptom management, promoting self-soothing skills, and addressing current stressors to establish safety and stability; ii) memory processing, which involves engaging in trauma-focused work such as prolonged exposure, EMDR, or TF-CBT to process traumatic memories; and iii) reconnection (integration), which addresses broader life issues beyond trauma, including relationships, work, spirituality, and leisure. As such, this phase-based approach first addresses disturbances in daily functioning, such as safety, emotional regulation, and social skills, prior to introducing trauma processing through exposure-based therapies.²³ However, research comparing phase- and non-phase-based approaches for CPTSD is limited; hence, this systematic review excluded phase-based interventions to focus on individual therapies.

Compared to intervention approaches for children and adolescents, adults with CPTSD often required more intensive or long-term interventions. For children and adolescents, interventions were structured and more concise, such as those implemented by Sachser et al.¹⁵ and Jensen et al.¹⁷ in children (12 and 16 sessions, respectively) and by Hendriks et al.¹⁶ in adolescents (15 intensive sessions over 5 days). In contrast, interventions for adults with CPTSD frequently required longer durations and integrated multimodal techniques, such as the 20-session trauma and body group and the 8-module online mindfulness-based intervention implemented by Classen et al.¹⁸ and Dumarkaite et al.,¹⁹ respectively. These differences underscore the importance of gradual and deeper engagement in adults with CPTSD. Furthermore, Sele et al.²⁰ emphasized that it is essential to investigate the benefits of combining skill training with CPTSD interventions to address accumulated trauma over time and establish maladaptive coping mechanisms. Hence, while adolescents and children may respond more rapidly to treatment, immediate intervention is beneficial to prevent severe trauma symptoms. Overall, developmental stage and accumulative trauma-related symptoms significantly influence treatment outcomes and must be carefully considered when designing interventions.

Studies that provide detailed analyses of disturbances in self-organization domains offer valuable insights into addressing CPTSD symptom patterns, underscoring the importance of developing symptom-specific interventions.^{15,19} Yet, comprehensive research on

intervention methods distinct from those available for PTSD is lacking, as most studies have not sufficiently explored interventions that are specifically designed to target the unique symptom clusters of CPTSD, particularly disturbances in self-organization.¹⁴

Unlike PTSD treatments, which mainly target trauma-related symptoms such as re-experiencing, avoidance, and hyperarousal, CPTSD requires a more profound approach that simultaneously addresses both trauma symptoms and complicated disruptions in self-regulation, identity, and relational functioning.²⁴ For example, interventions targeting affective dysregulation should focus on mindful awareness and acceptance of emotions and labeling and expressing feelings to enhance emotion regulation²⁵; interventions for negative self-concept should focus on rebuilding self-worth and identity²⁶; and interventions for interpersonal difficulties should involve training in social skills, setting boundaries, and developing healthy attachment styles.²⁵ Considering the distinct characteristics of CPTSD, which are characterized by prolonged exposure to traumatic events and complex interpersonal and self-regulatory disruptions, interventions should integrate trauma processing for emotional regulation, relational capacities, and self-concept reconstruction.²⁷ Developing specialized therapeutic interventions that target both trauma-specific symptoms and each specific disturbances in self-organization domain may enhance treatment efficacy, potentially leading to better long-term outcomes and functional recovery for patients with CPTSD.^{27,28} Future research should rigorously evaluate symptom-specific interventions targeting disturbances in self-organization domains and optimizing CPTSD treatment. Given the potential benefits of an integrative approach combining multiple psychotherapy modalities,²⁹ studies should explore how such methods address both trauma symptoms and disturbances in self-organization. Qualitative research, including interviews or focus groups with individuals who have undergone various therapeutic interventions, can provide deeper insights into their experiences and recovery. Prioritizing patient perspectives will enrich our understanding of how disturbances in self-organization affect daily functioning and which interventions are most effective.

Understanding the timing of complex trauma exposure is critical for tailoring interventions for patients. Trauma experienced at different developmental stages, such as early childhood, adolescence, and adulthood, can influence individuals differently and affect the severity and presentation of CPTSD symptoms.²⁹ For example, complex interpersonal trauma during formative years can disrupt crucial developmental processes, such as attachment and identity formation,³⁰ potentially leading to extensive impairment in self-organization and interpersonal abilities. Early interventions targeting these developmental disruptions may alleviate the long-term impact of such trauma.³¹ Future studies should focus on the age or developmental stage at which trauma occurs to elucidate how early traumatic experiences shape CPTSD symptomatology and to inform age-specific intervention development. Longitudinal studies are needed to examine the long-term effects of various CPTSD interventions across developmental stages. This can help identify which treatments provide lasting symptom relief and prevent relapse. Additionally, research should explore interventions tailored to attachment orientations, as childhood traumatic experiences can disrupt secure attachment formation, contributing to the development of disturbances in self-organization symptom clusters.³⁴ Developing empirical evidence on the relationships among various trauma types, attachment orientations, and CPTSD symptomatology is needed.

Socioeconomic factors also influence CPTSD experiences. For example, poverty, limited access to healthcare or medical services, and unstable housing can exacerbate the impact

of CPTSD by hindering access to supportive resources and increasing vulnerability to re-experiencing trauma.^{32,33} Individuals from lower socioeconomic backgrounds may also be thwarted by additional barriers to seeking treatment, which could prolong symptom duration and reduce treatment efficacy. Given the cumulative impact of environmental stressors, future research should investigate how socioeconomic factors interact with CPTSD symptom development and treatment responses to develop accessible, culturally responsive interventions that address the contextual difficulties faced by diverse CPTSD populations.

This study had several limitations. First, CPTSD is variably defined across different diagnostic manuals. The ICD-11 recognizes it as a distinct category, whereas the DSM-5 does not, leading to inconsistencies in diagnosis and potential ambiguity in research findings. Second, the cultural context significantly influences the manifestation of CPTSD symptoms and treatment responses. Few systematic reviews have included studies from diverse cultural backgrounds, which could limit the generalizability of their conclusions.

Nonetheless, this review has clinical implications. Enhancing the accuracy of CPTSD symptom identification, particularly regarding disturbances in self-organization, can help differentiate CPTSD from PTSD. This distinction is essential for refining diagnostic criteria, facilitating precise interventions, and preventing the chronic progression of symptoms through timely and appropriate treatment. Since individuals respond differently to interventions based on their age, clinicians should consider the developmental stage of patients with CPTSD when designing treatment plans. Additionally, understanding the relationship between CPTSD symptom severity and the timing of cumulative trauma exposure can yield critical insights into patients' conditions and guide more effective intervention strategies. This study highlights the importance of customizing interventions based on specific disturbances in self-organization symptom clusters. This approach can broaden treatment options and improve effectiveness in alleviating symptom severity. Furthermore, recognizing the impact of interpersonal trauma and cumulative traumatic experiences reflects the complexities of modern society, where individuals face multifaceted and recurrent traumatic events.

In conclusion, this review supports the effectiveness of trauma-focused and skill-based approaches in treating CPTSD symptoms and elucidates an important distinction between children/adolescent and adult populations with CPTSD. Moreover, our findings underscore the critical need for symptom-specific interventions that address the unique symptom clusters of CPTSD, that are distinct from PTSD, particularly disturbances in self-organization domains. Future research should focus on advancing CPTSD-specific treatment models to foster the specialized development of effective interventions to improve therapeutic outcomes that address the complex and diverse needs of CPTSD populations.

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