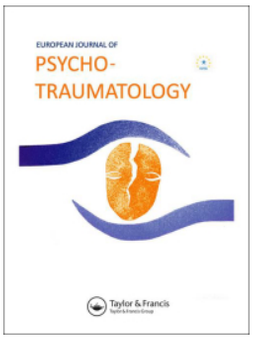

European Journal of Psychotraumatology

ISSN: 2000-8066 (Online) Journal homepage: www.tandfonline.com/journals/zept20

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To cite this article: Odeta Gelezelyte, Greta Guogaite & Evaldas Kazlauskas (2026) Trauma-related shame and depression moderate the relationship between complex posttraumatic stress and suicidal ideation in a treatment-seeking adult sample, European Journal of Psychotraumatology, 17:1, 2604994, DOI: 10.1080/20008066.2025.2604994

To link to this article: https://doi.org/10.1080/20008066.2025.2604994

Published online: 25 Dec 2025.

EUROPEAN JOURNAL OF PSYCHOTRAUMATOLOGY
2026, VOL. 17, NO. 1, 2604994
https://doi.org/10.1080/20008066.2025.2604994

EUROPEAN JOURNAL OF PSYCHO-TRAUMATOLOGY
THE OFFICIAL JOURNAL OF THE EUROPEAN SOCIETY FOR TRAUMATIC STRESS STUDIES

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Trauma-related shame and depression moderate the relationship between complex posttraumatic stress and suicidal ideation in a treatment-seeking adult sample

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ABSTRACT

Background & Objective: There has been a dearth of empirical research examining suicidality in the context of the new diagnosis of the ICD-11 Complex posttraumatic stress disorder (CPTSD). The main aim of the current cross-sectional study was to test the moderating role of trauma-related shame and depression on the relationship between CPTSD symptoms and suicidal ideation.

Method: In total, 300 treatment-seeking trauma-exposed adults were included in the study. The mean age was 39.25 (*SD* = 12.77), ranging from 18 to 72 years. The majority of the sample (90.3%) were female and had a university degree (67%). Self-report measures for assessing complex posttraumatic stress disorder and depression symptoms, suicidal ideation and trauma-related shame were used.

Results: In the study sample, 22.7% of the participants met the criteria for probable PTSD, 45.7% probable CPTSD, and 45% reported suicidal ideation. The levels of trauma-related shame and CPTSD symptoms were the highest in the high suicidal ideation group. Moderation analysis revealed that the association between CPTSD symptom severity and suicidal ideation intensified with increasing levels of trauma-related shame. The findings of the moderated moderation analysis showed that with increasing levels of shame, the effects of interaction between CPTSD and depression symptoms on suicidal ideation were getting stronger.

Conclusions: Results demonstrated that the relationship between CPTSD symptoms and suicidal ideation depends on the levels of trauma-related shame and comorbid depressive symptoms. Such findings provide insights for the assessment and management of suicide risk after trauma exposure and suggest that the relationship between complex posttraumatic stress and suicidal ideation depends on other post-traumatic reactions, comorbid conditions, and on how they interact.

La vergüenza relacionada con el trauma y la depresión moderan la relación entre el estrés postraumático y la ideación suicida en una muestra de adultos que buscan tratamiento

Antecedentes y Objetivo: Ha habido escasez de investigación empírica que examine la suicidalidad en el contexto del nuevo diagnostico de la CIE-11, el trastorno de estrés postraumático complejo (TEPTc). El objetivo principal del presente estudio transversal fue probar el papel moderador de la vergüenza relacionada con el trauma y la depresión sobre la relación entre los síntomas de TEPTc e ideación suicida.

Método: En total, se incluyeron en el estudio 300 adultos expuestos a trauma que buscaban tratamiento. La edad media fue 39,25 (*DE* = 12.77), con un rango de 18 a 72 años. La mayoría de la muestra (90.3%) eran mujeres y con un título universitario (67%). Se utilizaron medidas de auto-reporte para evaluar el trastorno de estrés postraumático complejo y los síntomas depresivos, la ideación suicida y la vergüenza relacionada con el trauma.

Resultados: En la muestra del estudio, 22,7% de los participantes reunía los criterios de probable TEPT, 45,7% probable TEPTc y 45% reportó ideación suicida. Los niveles de vergüenza relacionada con el trauma y los síntomas de TEPTc fueron más altos en el grupo de alta ideación suicida. El análisis de moderación reveló que la asociación entre la gravedad de los síntomas de TEPTc y la ideación suicida se intensificó con el aumento de los niveles de vergüenza relacionados con el trauma. Los hallazgos del análisis de moderación moderada demostraron que, al aumentar los niveles de vergüenza, los efectos de la interacción entre TEPTc y síntomas depresivos sobre la ideación suicida se intensificaron.

Conclusiones: Los resultados demostraron que la relación entre los síntomas de TEPTc y la ideación suicida depende de los niveles de vergüenza relacionada con el trauma y de los síntomas depresivos comórbidos. Tales hallazgos proporcionan información para la

ARTICLE HISTORY
Received 30 July 2025
Revised 7 December 2025
Accepted 9 December 2025

KEYWORDS
Complex posttraumatic stress disorder; CPTSD; ICD-11; suicidal ideation; trauma-related shame

PALABRAS CLAVE
Trastorno de estrés postraumático complejo; TEPTc; CIE-11; vergüenza relacionada con el trauma; ideación suicida

HIGHLIGHTS

- The relationship between ICD-11 Complex posttraumatic stress disorder (CPTSD) symptom severity and suicidal ideation depends on the levels of trauma-related shame and depression.
- The association between CPTSD symptoms and suicidal ideation is significantly positive and intensifies with increasing levels of trauma-related shame and moderate to high depression symptom severity.
- With increasing levels of shame, the effects of interaction between CPTSD and depression symptoms on suicidal ideation are getting stronger.

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evaluación y manejo del riesgo suicida tras la exposición a un trauma y sugieren que la relación entre el estrés postraumático complejo y la ideación suicida depende de otras reacciones postraumáticas, condiciones comórbidas y su interacción.

1. Background

In 2018, the World Health Organisation (WHO) included a new disorder of complex posttraumatic stress (CPTSD) into the 11th edition of the International Classification of Diseases (ICD-11; WHO, 2024). In addition to posttraumatic stress disorder (PTSD) symptoms, namely re-experiencing, avoidance and persistent sense of current threat, disturbances of self-organisation should also be present in the case of CPTSD. These symptoms encompass trauma-related affect dysregulation, negative self-concept and disturbed relationships. Complex PTSD, as compared to PTSD, is more commonly associated with prolonged or repetitive traumatic experiences (Maercker et al., 2022). The inclusion of a new diagnosis has stimulated research for risk and protective factors as well as more effective treatments for severely traumatised populations. Nevertheless, there are still significant gaps when it comes to evidence-based knowledge on how to reduce the complex consequences of traumatic experiences.

Suicidality comprises suicidal ideation, suicide plan, suicide attempt, and completed suicide (Cai et al., 2021). Suicidal ideation can be defined as thoughts, ideas, or ruminations about the possibility of ending one's life, which can range from thinking that one would be better off dead to the formulation of elaborate plans (WHO, 2024). Frequency, intent and content of suicidal ideation increase the risk of acting on suicidal thoughts (Turecki et al., 2019). Numerous previous studies have confirmed a strong link between PTSD, suicidal ideation, suicide attempts and deaths by suicide (Akbar et al., 2023), with practical implications that PTSD screening and treatment could enhance suicide prevention efforts. It has also been shown that comorbid PTSD and depression lead to even stronger associations with suicidality (Oquendo et al., 2003; Panagioti et al., 2012; Ramsawh et al., 2014). However, with regard to the new ICD-11 diagnosis of complex PTSD, research is scarce, and the existing results are inconsistent. For example, Karatzias et al. (2019) found that the presence of probable PTSD and CPTSD increased the likelihood of suicidality by more than three times in a trauma-exposed population-based adult sample in the United Kingdom. Whereas in another study across four countries, probable CPTSD was significantly associated with higher suicidality compared to probable PTSD among adults with a history of childhood maltreatment (Chong et al., 2024). In a nationally representative Irish sample of adults, only the symptoms of CPTSD negative self-concept were associated with suicidality (McGinty et al., 2024). Hence, there is a clear need for research on the links between complex posttraumatic stress and suicidality across different samples and cultures.

Early theoretical conceptualisations mainly associated PTSD with the emotion of fear. However, it has since been recognised that other emotions such as anger, guilt, shame or disgust may also play a role in the development of PTSD (McLean & Foa, 2017). In the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders – Text Revision (DSM-5-TR; American Psychiatric Association, 2022), persistent negative emotional state (e.g. fear, horror, anger, guilt, or shame), as well as trauma-related self-blame or angry outbursts, are included among diagnostic criteria for PTSD. In the ICD-11, CPTSD negative self-concept is described as beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic experience. Anger, shame, sadness, humiliation, or guilt are also mentioned as additional common clinical features of individuals with ICD-11 PTSD.

Shame, among other affective PTSD factors, is frequently associated with increased suicidal risk (Bryan, 2016). Shame can be experienced when individuals focus on negative aspects of themselves, whereas guilt is more associated with negative aspects of their behaviour (Tracy & Robins, 2006). Shame has been demonstrated to have a mediating effect on the relationship between PTSD symptomatology and suicidal ideation. In a study of trauma-exposed university students, shame related to self and performance had a significant indirect effect on the association of PTSD symptoms with suicidal ideation (Woller et al., 2025). PTSD also had significant indirect effects on suicidal ideation via shame among male veterans (Cunningham et al., 2019). In another study of military mental health outpatients, shame was found to be linked to increased suicidal ideation (Bryan et al., 2013). Therefore, evidence suggests that shame has potential in explaining some mechanisms underlying the link between posttraumatic stress symptoms and suicide risk.

Depression can also have a significant role in the development and maintenance of suicidality and posttraumatic symptoms. Previous research confirms associations between depression and increased

suicidality (Cai et al., 2021) as well as depression and PTSD (Rytwinski et al., 2013). It is known that comorbid depression increases the risk for suicide in PTSD samples (Panagioti et al., 2012). Furthermore, studies report positive relations between trauma-related shame and depression across various populations (DeCou et al., 2021). Thus, significant interrelations among PTSD, depression, trauma-related shame, and suicidality are evident. However, these findings do not provide much information on how the interaction among different responses to trauma and comorbid conditions may affect suicide risk.

Since trauma and PTSD are recognised as contributors, or in some cases even main drivers, to suicidal ideation and behaviour (Holliday et al., 2021), it is essential to understand which specific targets for interventions could affect the management of suicide risk in traumatised populations. While there are studies showing associations between trauma-related emotions, PTSD, depression, and suicidality, there is little research conducted in the context of the new ICD-11 diagnosis of complex PTSD. In addition, in trauma research, assessment tools used for measuring emotions, including shame, greatly vary and are often non-trauma-specific. This complicates the generalisability of the results and limits understanding of the specific impact of trauma on symptoms and suicide risk.

Therefore, the main aim of the current study was to test the moderating role of trauma-related shame and depression on the relationship between complex post-traumatic stress disorder symptoms and suicidal ideation. We intended to explore whether the strength of a relationship between CPTSD and suicidal ideation depend on the levels of trauma-related shame and depression. In the current study, we also evaluate subcategories of shame, namely, external and internal shame, in which two reference norms, personal and social, play different roles in the self-evaluation process (Øktedalen et al., 2014). Internal shame is more related to self-devaluation, and external shame can be perceived as rejection by others. Such analyses could provide important information on how shame and depression, comorbid with CPTSD, can affect trauma-exposed clients' suicidality. Also, this could suggest implications for the potential value of applying specific interventions targeted at reducing suicide risk in clients with CPTSD. We hypothesised that the association between CPTSD symptoms and suicidal ideation would depend on trauma-related shame, as well as depression symptoms (moderation). We also hypothesised that this association would depend on the interaction between trauma-related shame and depression (moderated moderation). Our assumptions were that increased trauma-related shame and depression would strengthen the positive relation between CPTSD and suicidal ideation. In addition, we assessed associations between different levels of suicidal ideation, complex PTSD and trauma-related shame, hypothesising that more intense suicidal ideation would be linked to increased levels of CPTSD symptoms and trauma-related shame.

2. Methods

2.1. Participants

In total, 300 participants were included in the study. Most of the sample (90.3%, $n = 271$) were female, with 9% ($n = 27$) male participants, and 0.7% ($n = 2$) selecting the option 'other'. The mean age of the sample was 39.25 ($SD = 12.77$), ranging from 18 to 72 years. The majority of participants lived in an urban area (89%, $n = 267$) and had a university degree (67%, $n = 201$). All respondents had a history of at least one traumatic experience during their lifetime. The most prevalent traumatic experiences reported were someone close being diagnosed with a life-threatening illness or experiencing a life-threatening accident ($n = 187$; 62.3%), sexual harassment ($n = 180$; 60.0%), physical assault by a parent or guardian ($n = 168$; 56.0%), physical assault by someone other ($n = 136$; 45.3%), witnessing another person experiencing extreme suffering or death ($n = 131$; 43.7%), someone close dying in an awful manner ($n = 100$; 33.3%), being stalked ($n = 99$; 33.0%), being involved in an accident where ones life was in danger ($n = 96$; 32.0%) and experiencing sexual assault by someone other than a parent or guardian ($n = 94$; 31.3%).

2.2. Procedure

The data for the current analyses were collected as part of a larger research project in Lithuania aimed at evaluating the efficacy of an internet-based guided trauma-focused intervention in reducing PTSD symptoms (Gelezelyte et al., 2024). The data were collected during the pre-test assessment. Thus, the sample consisted of adults who were seeking treatment due to mental health issues related to their traumatic experiences. The study was approved by the Vilnius University Committee for Ethics in Psychology Research (No 16 / (1.13 E) 250000-KT-33).

Invitations to participate in the study were disseminated via professional organisations (e.g. Lithuanian Association of Psychologists, Lithuanian Society for Traumatic Stress), mental health centres (e.g. Crisis Intervention Centre), social media (e.g. Facebook), and national media. Adults interested in participation could find all the information about the study and register on the research project webpage. A secure online survey platform was used for the data collection. Informed consent was received from each participant before taking part in the study. The data were collected from April 2024 to June 2025.

2.3. Measures

The International Trauma Questionnaire (Cloitre et al., 2018) is a brief self-report measure based on the ICD-11 diagnostic system (WHO, 2024). It has been widely used in research to identify people at risk for PTSD and CPTSD (Redican et al., 2021). Respondents had to assess symptoms of PTSD (6 items) and Disturbance in Self-Organization (DSO; 6 items) associated with the index traumatic event. Both PTSD and DSO symptoms were followed by an additional 3 items to evaluate functional impairment. For the PTSD items, respondents had to rate how much they had been bothered by the described problem in the past month on a scale from 0 'Not at all' to 4 'Extremely'. To determine the risk of PTSD, at least one of two symptoms from each symptom cluster must be confirmed, i.e. scored ≥2: (1) re-experiencing in the present, (2) avoidance, and (3) sense of current threat. Also, at least one functional impairment item related to PTSD should be scored ≥2. With regard to the DSO items, respondents had to assess them thinking about how they typically feel, think about themselves or relate to others on a scale from 0 'Not at all' to 4 'Extremely'. In addition to meeting all criteria for PTSD, probable CPTSD requires qualifying for at least one of the two symptoms from each of the three DSO clusters: (1) affect dysregulation, (2) negative self-concept, and (3) disturbed relationships. Also, a score of ≥2 on at least one element of functional impairment related to the DSO symptoms should be chosen. An individual can only be given a probable diagnosis of PTSD or CPTSD, not both simultaneously. Also, sum scores can be calculated for each PTSD and DSO symptom cluster, as well as the total CPTSD score, which can range from 0 to 48.

Good psychometric properties and sufficient factorial validity of the ITQ have been confirmed in multiple countries worldwide (Cloitre et al., 2018; Redican et al., 2021). The Lithuanian version of the ITQ used in previous studies also demonstrated good psychometric properties in the general population (Kvedaraite et al., 2022) and clinical (Kvedaraite et al., 2021) samples. Cronbach's α coefficients in the current sample were .76 (PTSD), .80 (DSO), and .82 (CPTSD).

The International Depression Questionnaire (IDQ) is a novel self-report measure of ICD-11 Single Episode Depressive Disorder (Shevlin et al., 2023). The scale is used for measuring depression symptom severity over the last two weeks. The IDQ consists of 9 items with an additional question for evaluating functional impairment caused by the measured symptoms. Participants were asked to rate the IDQ 9 items on a scale from 0 'Never' to 4 'Every day'. The functional impairment item response is binary 'Yes' or 'No'. The depression severity score is obtained by summing the scores of the nine IDQ items, with the final score ranging from 0 to 36, with a higher score indicating higher levels of depression. The IDQ can also be used to identify probable diagnostic cases of depression by applying the ICD-11 diagnostic algorithm. If at least one of the first two items is scored >2, and a total of 5 or more items are endorsed (scored >2), and the functional impairment question is answered 'Yes', a case is considered as meeting criteria for probable Depressive Disorder.

Previous studies demonstrated the reliability and validity of the IDQ (Hyland et al., 2024; Shevlin et al., 2023). The Lithuanian version of the IDQ also showed good psychometric properties (Geležėlytė et al., 2025). In the current sample, Cronbach's α coefficient was .92.

The Suicidal Ideation Attributes Scale (SIDAS) was used to measure the severity of suicidal ideation (Van Spijker et al., 2014). The SIDAS is a brief 5-item self-report scale used to assess frequency and controllability of suicidal thoughts (item 1: 'In the past month, how often have you had thoughts about suicide?' and item 2: 'In the past month, how much control have you had over these thoughts?'), closeness to suicide attempt (item 3: 'In the past month, how close have you come to making a suicide attempt?'), as well as distress and interference with daily activities caused by suicidal thoughts (item 4: 'In the past month, to what extent have you felt tormented by thoughts about suicide?' and item 5: 'In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as work, household tasks or social activities?') over the past month. Items are measured on a 10-point scale, with a sum score ranging from 0 to 50, where higher scores indicate more intense suicidal ideation. The second item is reverse-coded. If the frequency of zero ('Never') on the first SIDAS item is selected, the remaining items are skipped. Van Spijker et al. (2014) suggested the following cut-off scores to identify risk for suicidal behaviour: no ideation (score 0), low ideation (score 1–20), and high ideation (score >20). Any ideation could indicate risk for suicidal behaviour, and a cutoff of 21 on the scale shows a high risk of suicidal behaviour (Van Spijker et al., 2014).

The SIDAS has shown good psychometric properties in previous studies (Batterham et al., 2015). The Lithuanian version of the SIDAS scale also demonstrated good internal consistency, construct, convergent, and criterion validity (Gužas et al., 2024). Cronbach's α in the current sample was .79.

Trauma-Related Shame Inventory – Short Form (TRSI-SF) is a short version of the Trauma-Related Shame Inventory (TRSI; Øktedalen et al., 2014) which is a self-report instrument to measure trauma-related shame (Grau et al., 2022). The TRSI-SF

consists of 10 items scored on a 4-point scale (0 'Not true of me' to 3 'Completely true of me'), with summed higher scores indicating elevated levels of trauma-related shame. A two-factor solution measuring internal (related to self-devaluation) and external (perceived rejection by others) shame, each consisting of 5 items, demonstrated a good fit in previous studies (Grau et al., 2022).

As the Lithuanian version of TRSI-SF has not been previously used in research, we conducted CFA to test the factor structure of the scale. An adequate fit of the two-factor model with two correlated factors of internal and external shame, and additional correlations between item 2 and item 9, as well as item 9 and item 10 residuals, was confirmed [χ^2 (32) = 82.34, $p < .001$, CFI/TLI = 0.970/0.958, RMSEA (90% CI) = 0.072 (0.053, 0.092), SRMR = 0.038]. Standardised factor loadings varied from .70 to .91. Cronbach's α coefficients in the current sample were .89 (Internal Shame, IS), .94 (External Shame, ES), and .93 (total).

2.4. Data analyses

Pearson correlation coefficients were calculated to assess associations between study variables. The relationship between categorical variables was explored with a Chi-square test. A one-way ANOVA was conducted to explore the differences in continuous variables between groups. To test whether the effect of complex posttraumatic stress symptoms on suicidal ideation is dependent on trauma-related shame and depression symptoms, we ran a series of moderation models (Hayes, 2022). Moderated moderation analyses were further conducted to test a three-way interaction where the effects of CPTSD on suicidal ideation by the level of depression symptoms also depend on shame intensity. Johnson–Neyman (JN) technique was used for probing interactions (Hayes, 2022). In moderation analysis, JN values of the moderator show the scores along the continuum of the moderator, where the conditional effect of CPTSD on suicidal ideation transitions between statistically not significant and significant. Thus, it identifies the 'region of significance' of the effect. No estimated transition points mean that the region of significance of the effect is the entire range of the moderator. In moderated moderation analysis, the JN value demarcates where the conditional interaction between CPTSD and the first moderator transitions between statistically significant and not along the distribution of the second moderator. In addition, the pick-a-point approach at moderator values in the 16th, 50th, and 84th percentiles was used. There was no missing data in the dataset as the measures were mandatory in the online survey (i.e. participants had to complete them). The data analyses were conducted using IBM SPSS version 29. Moderation analyses were conducted with the PROCESS macro v4.2 in SPSS v29.

To evaluate the structure of the Lithuanian version of the TRSI-SF scale that has not been used in research before, we conducted confirmatory factor analysis (CFA). The CFA model was estimated using the Robust Maximum Likelihood (MLR) estimator. To test the goodness of fit of the model, we evaluated the Comparative Fit Index (CFI), the Tucker–Lewis Index (TLI), and the Root Mean Square Error of Approximation (RMSEA), following the goodness of fit recommendation provided by Kline (2011); namely, CFI/TLI values higher than 0.90 indicated an acceptable fit and values higher than 0.95 represented a very good fit; RMSEA values below 0.08 indicate of an acceptable fit and values less than 0.05 suggested a good fit. In addition, the value of Standardized Root Mean Square Residual (SRMR) ≤ .08 is considered a good fit (Hu & Bentler, 1999). CFA analysis was conducted using the Mplus version 8.8.

3. Results

3.1. Descriptive analyses

In the study sample, 22.7% ($n = 68$) of the participants met the criteria for probable PTSD, and 45.7% ($n = 137$) for probable CPTSD. Almost half of the sample met the criteria for probable depressive disorder (43%, $n = 129$). In total, 45% ($n = 135$) of the sample was identified as being at risk for suicidal behaviour, with 12% ($n = 36$) of the sample belonging to the high-risk group. Descriptive statistics and correlations between the main study variables are presented in Table 1. CPTSD symptoms were significantly correlated with suicidal ideation, depression, and trauma-related shame ($r = .41–.67$, $p < .001$).

3.2. Group comparisons

We also compared the levels of trauma-related shame and CPTSD symptoms among three suicidal ideation groups (Table 2). Participants with high suicidal ideation had the highest levels of CPTSD symptoms and trauma-related shame. General trauma-related shame, internal shame and CPTSD symptom averages were significantly different among all groups, with large effect sizes. External shame was only significantly increased in the high suicidal ideation group, with a medium effect size.

Chi-squared test indicated a significant association between different groups of posttraumatic stress disorders (PTSD, CPTSD, no PTSD/CPTSD) and suicidal ideation ($\chi^2(4, N = 300) = 38.91$, $p < .001$, Cramer's V = 0.26). The majority of participants with high suicidal ideation (88.9%, $n = 32$) were also at risk for CPTSD.

Table 1. Descriptive statistics and correlations between main study variables.

	M (*SD*)	Min	Max	2	3	4	5	6
1 CPTSD	27.66 (8.76)	3	48	.67	.50	.53	.56	.41
2 Depression	19.29 (8.58)	0	36		.55	.42	.43	.34
3 Suicidal ideation	6.26 (10.02)	0	42			.38	.41	.29
4 Shame	10.61 (8.59)	0	30				.92	.92
5 Internal shame	6.38 (4.62)	0	15					.69
6 External shame	4.23 (4.74)	0	15					

Note: CPTSD = Complex Posttraumatic Stress Disorder symptoms.
All correlations are significant at $p < .001$.

3.3. Moderation analyses

We further explored the moderating role of trauma-related shame on the association between complex PTSD symptoms and suicidal ideation (Table 3). Age was included as a covariate in the models. The relationship between CPTSD symptoms and suicidal ideation got stronger as the levels of trauma-related shame increased (Table 4). In addition, we tested the moderating role of depression symptoms on the association between CPTSD and suicidal ideation. Depression severity was a significant moderator. In the current moderation analysis, Johnson-Neyman technique values of the moderator show the scores along the continuum of depression symptoms, where the conditional effect of CPTSD on suicidal ideation transitions between statistically not significant and significant (identifies 'region of significance' of the effect). JN technique revealed that the effect of CPTSD on suicidal ideation was significantly negative up until the IDQ value of 8.044, decreasing at increasing levels of depression. The effect was significantly positive, starting with the IDQ value of 16.265, increasing with higher severity of depression.

Next, moderated moderation analysis was conducted. The model included CPTSD symptoms as an antecedent variable, suicidal ideation as a consequent variable, depression symptom sum was the primary moderator, trauma-related shame (TRSI sum score) was the secondary moderator, and age was included in the model as a covariate. The results revealed a significant three-way interaction between CPTSD, depression and trauma-related shame (Table 3). Conditional effects of CPTSD on suicidal ideation at values of the moderators (depression and shame) are presented in Table 5. Visual representation can be seen in Figure 1. With increasing levels of shame, the effects of interaction between CPTSD and depression symptoms on suicidal ideation were significantly positive and intensified. However, it is important to note that although this three-way interaction is significant, it accounts for only 0.8% of the variance in suicidal ideation.

4. Discussion

The current cross-sectional study contributes to the ICD-11 complex PTSD research by providing new evidence on the importance of the role of shame and depression on the links between CPTSD symptoms and suicidal ideation. In particular, our study unfolds potential underlying mechanisms linking CPTSD to suicidal ideation by highlighting the moderating role of trauma-related shame and comorbid depression. We found a significant moderating role of trauma-related shame, both internal and external. As the levels of shame increased, the association between CPTSD and suicidal ideation became stronger. Depression severity also seems to be important for the relation between complex CPTSD and suicidal ideation: the association between CPTSD and suicidal ideation was significantly positive and increased from moderate levels of depression. We further continued with the analysis, which included both depression and trauma-related shame as moderators. This moderated moderation model revealed a significant three-way interaction: with rising levels of shame, the effects of the interaction between CPTSD and depression symptoms on suicidal ideation increased. This means that the levels of trauma-related shame changed how depression moderated the CPTSD and suicidal ideation relationship. We as well found that the severity of CPTSD and trauma-related shame were the highest among participants with high suicidal ideation (i.e. at high risk for suicidal behaviours [Van Spijker et al., 2014]).

Table 2. Comparison of trauma-related shame and CPTSD symptoms among suicidal ideation groups.

	No suicidal ideation ($n = 165$)		Low suicidal ideation ($n = 99$)		High suicidal ideation ($n = 36$)				
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F* (2, 297)	*p*	η^2
Shame	8.43[a]	7.97	11.36[b]	7.87	18.53[c]	8.46	24.22	<.001	0.14
Internal shame	5.02[a]	4.26	6.97[b]	4.17	11.00[c]	4.06	31.29	<.001	0.17
External shame	3.41[a]	4.46	4.39[a]	4.50	7.53[b]	5.26	12.05	<.001	0.08
CPTSD	24.68[a]	7.90	29.15[b]	7.87	37.22[c]	6.85	41.18	<.001	0.22

Note: CPTSD = Complex Posttraumatic Stress Disorder symptoms. Means with different superscripts differ at the $p < .05$ level by post-hoc comparisons using the Bonferroni test.

Table 3. Testing the moderating role of trauma-related shame and depression on the relationship between complex PTSD and suicidal ideation

	b	*SE b*	*LLCI*	*ULCI*	*p*	*F* (4, 295), *p*	R^2
Two-way interactions							
CPTSD	0.18	0.09	−0.01	0.36	.054	36.29, <.001	0.33
Shame	−0.60	0.20	−0.99	−0.21	.003		
CPTSD × Shame	0.03	0.01	0.01	0.04	<.001		
Age	−0.11	0.04	−0.19	−0.04	.003		
CPTSD	0.08	0.10	−0.11	0.28	.404	38.21, <.001	0.34
Internal Shame (IS)	−1.18	0.36	−1.89	−0.48	.001		
CPTSD × IS	0.05	0.01	0.03	0.08	<.001		
Age	−0.11	0.04	−0.18	−0.04	.004		
CPTSD	0.34	0.08	0.19	0.50	<.001	32.58, <.001	0.31
External Shame (ES)	−0.97	0.40	−1.75	−0.19	.015		
CPTSD × ES	0.04	0.01	0.02	0.06	.002		
Age	−0.12	0.04	−0.19	−0.04	.003		
CPTSD	−0.49	0.12	−0.73	−0.24	<.001		
Depression	−0.62	0.17	−0.95	−0.29	<.001	60.09, <.001	0.45
CPTSD × Depression	0.04	0.01	0.03	0.05	<.001		
Age	−0.10	0.03	−0.17	−0.04	.003		
Three-way interactions							
CPTSD	−0.04	0.20	−0.44	0.36	.850	33.16, <.001	0.48
Depression	−0.23	0.25	−0.72	0.27	.371		
Shame	0.49	0.40	−0.29	1.27	.214		
CPTSD × Depression	0.02	0.01	−0.01	0.03	.112		
CPTSD × Shame	−0.03	0.02	−0.06	−0.01	.044		
Depression × Shame	−0.02	0.02	−0.06	0.02	.401		
CPTSD × Depression × Shame	0.01	0.01	0.00	0.01	.034		
Age	−0.09	0.03	−0.16	−0.03	.006		

Note: CPTSD = Complex Posttraumatic Stress Disorder. IS = Internal shame. ES = External shame.

Our findings are in line with previous studies that demonstrated associations between posttraumatic stress symptoms and suicidality (Akbar et al., 2023). However, our study adds new insights to the understanding of suicidal ideation in the context of complex posttraumatic reactions. We found that CPTSD symptoms were the most severe among adults with highly elevated risk for suicidal behaviours, a tendency that has also been described in some previous studies (Chong et al., 2024). Complex PTSD is associated with multiple traumas, more comorbidities and greater psychiatric burden (Lewis et al., 2022; Maercker et al., 2022). Thus, its stronger links to increased risk for suicidal behaviours are not unexpected.

In our study, the relationship between complex posttraumatic stress symptoms and suicidal ideation depended on trauma-related shame. When shame was more pronounced, the association got stronger. Such results support the role of trauma-related shame in the development of suicidal ideation and behaviour after complex traumatisation. In our study, both internal and external shame were significant moderators, which is not surprising, as even though they are viewed as separate subcategories of shame, external and internal shame are usually highly correlated (Øktedalen et al., 2014). The findings build on the results of previous research demonstrating the mediating effects of shame on the relationship between PTSD and suicidal ideation (Chou et al., 2023; Cunningham et al., 2019; Woller et al., 2025). According to Wilson et al. (2006), shame and suicidal ideation share the same emotional centre with a wish for escape from pain and self-obliteration related to self-destructive coping patterns. Furthermore, our results revealed the potential role of depression in the association between complex PTSD and suicidal ideation. Previous studies have demonstrated links between depression and increased suicidality (Cai et al., 2021). Besides, comorbid PTSD and depression were found to lead to stronger associations with suicidality (Oquendo et al., 2003; Panagioti et al., 2012; Ramsawh et al., 2014). In our study, the positive association between CPTSD symptoms and suicidal ideation increased from moderate to high levels of depression. As complex PTSD can often co-occur with depression (Karatzias et al., 2019; Lewis et al., 2022), it is highly relevant to take the levels of depressive symptoms into account in clinical practice.

The analyses described above were performed separately. However, we also wanted to test the potential role of the interaction of these responses to trauma in predicting suicidal ideation. Our further analysis of moderated moderation revealed a significant interaction among CPTSD symptoms, depression, and shame. With increasing levels of shame, the effects of interaction between CPTSD and depression symptoms on suicidal ideation intensified. Therefore, in the presence of higher trauma-related shame, the role of depression on the association between CPTSD and suicidal ideation increases. These results show that the relationship between complex posttraumatic stress and suicidal ideation is not straightforward and depends on other post-traumatic reactions, comorbid conditions, and on how they interact.

Table 4. Conditional effects of CPTSD on suicidal ideation at values of the moderator.

Moderator	Effect	*SE*	*p*	LLCI	ULCI	J-N_w
Shame						≥0.087
2.00	0.23	0.08	.006	0.07	0.40	
9.00	0.42	0.07	<.001	0.29	0.54	
19.84	0.70	0.09	<.001	0.53	0.87	
Internal shame						≥1.617
1.00	0.14	0.09	.135	−0.04	0.32	
6.00	0.41	0.07	<.001	0.28	0.54	
12.00	0.73	0.09	<.001	0.56	0.91	
External shame						Entire range
0.00	0.34	0.08	<.001	0.19	0.50	
2.00	0.42	0.07	<.001	0.29	0.55	
10.00	0.73	0.10	<.001	0.54	0.93	
Depression						≤8.044;
9.16	−0.14	0.09	.119	−0.31	0.04	≥16.265
19.00	0.24	0.07	<.001	0.11	0.37	
29.00	0.62	0.09	<.001	0.45	0.79	

Note: Moderator values are presented in the 16th, 50th, and 84th percentiles. J-N_w = values of the moderator generated using the Johnson–Neyman (JN) technique, defining the region of significance of CPTSD effect on suicidal ideation. CPTSD = Complex Posttraumatic Stress Disorder.

Our findings have important practical implications, demonstrating that the association between complex posttraumatic stress symptoms and suicidal ideation depend on trauma-related shame and severity of depression. Namely, in the presence of trauma-related shame, a clinician should bear in mind that complex PTSD symptoms may be more strongly associated with suicidal ideation. Also, with intense trauma-related shame, depression severity comorbid with CPTSD can be a significant indicator of increased suicidal ideation. Such results also suggest that targeting shame and depression in trauma-care interventions could have an impact on reducing suicide risk. Continuing such research, including more different trauma-related reactions in analyses, could provide significant guidance for tailoring treatments for suicidal trauma-exposed clients, depending on their unique patterns of trauma-related symptoms, comorbid conditions and affective reactions to traumatic experiences.

Despite these important implications, study results have to be seen in the light of its limitations. First of all, the sample was predominantly female and self-selected, consisting of participants registering for an internet-based trauma-focused intervention; thus, it has limited generalizability. However, it is important to note that the participants were treatment-seeking adults with a high prevalence of the risk for complex posttraumatic stress and depressive disorders, meaning it can highly resemble patients that clinicians meet in their daily practice. Also, self-report scales were used in the study. As clinician-administered instruments, such as the ICD-11 International Trauma Interview (ITI; Roberts et al., 2025), are seen as the reference standard for assessing posttraumatic disorders, the use of diagnostic interviews in future studies would ensure a more accurate and thorough assessment. There have also been recent developments in updating the ITQ with additional 'clinical checks' to ensure that responses better reflect the intended clinical meaning of the scale item (Shevlin et al., 2025). Moreover, although we aimed at testing more complex three-way interactions in predicting suicidal ideation, with depressive symptoms taken into account, it is important to evaluate interactions between different trauma-related emotions in future studies. Kealy et al. (2021) found that the association between guilt and suicidal ideation intensified with higher shame. Brake et al. (2017) concluded that, after controlling for depressive symptoms, PTSD symptoms were associated with suicide risk via increased disgust with oneself. The impact of the interaction among various affective responses to trauma can reveal a different picture as compared to evaluating only individual effects of separate trauma-related emotions. It has been proposed that these relationships can be rather complex (Taylor, 2015; Wilson

Table 5. Conditional effects of CPTSD on suicidal ideation at values of the moderators.

Moderator 1 Depression	Moderator 2 Shame	Effect	*SE*	*p*	LLCI	ULCI	J-N_{Shame}
9.16	2.00	0.06	0.13	.649	−0.19	0.30	≥1.558
9.16	9.00	−0.08	0.09	.384	−0.26	0.10	
9.16	19.84	−0.30	0.15	.052	−0.59	0.01	
19.00	2.00	0.23	0.10	.024	0.03	0.43	
19.00	9.00	0.18	0.07	.012	0.04	0.32	
19.00	19.84	0.11	0.11	.302	−0.10	0.32	
29.00	2.00	0.40	0.14	.003	0.14	0.67	
29.00	9.00	0.45	0.10	<.001	0.26	0.65	
29.00	19.84	0.52	0.12	<.001	0.29	0.76	

Note: Moderator values are presented in the 16th, 50th, and 84th percentiles. J-N_{Shame} = value of the moderator 'Shame' generated using the Johnson–Neyman (JN) technique. CPTSD = Complex Posttraumatic Stress Disorder.

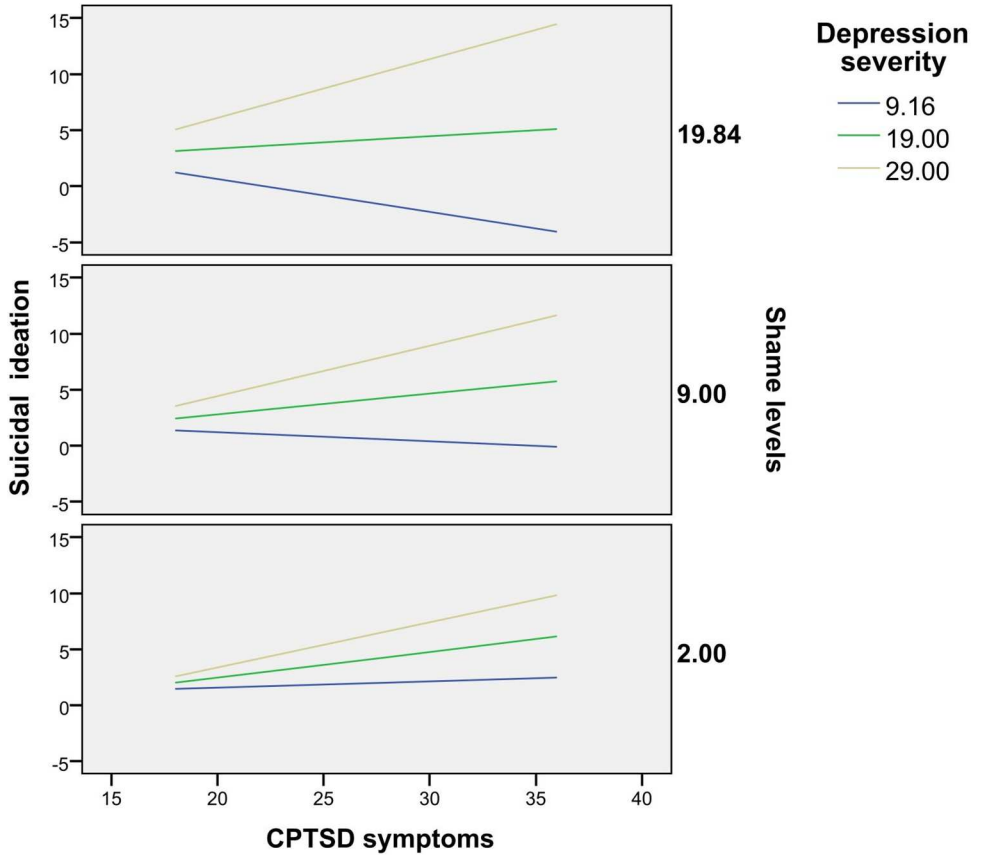

Figure 1. The conditional effect of CPTSD on suicidal ideation as a function of depression symptoms and trauma-related shame from a moderated moderation model.

Note: CPTSD = Complex Posttraumatic Stress Disorder.

et al., 2006). For example, depression can be seen as one of the social consequences of the patterns of avoiding shame, and disgust can act as a way of representing these avoidance patterns (Webb, 2010).

Despite limitations, to our knowledge, this is one of the first studies examining the associations and interactions between the ICD-11 complex PTSD, trauma-related shame, depressive symptoms and suicidal ideation. As suicidality is associated with a serious threat to the patient, timely assessment and effective interventions aimed at the management of suicide risk in trauma treatments are crucial. Suicide-focused interventions should be considered immediate clinical targets in case of heightened suicide risk after trauma (Bryan, 2016), so understanding how to best navigate clinical care in the combined presence of different manifestations of posttraumatic reactions and suicide risk is essential. It is critical to continue research on the mechanisms underlying the relationship between complex posttraumatic stress and suicide risk to gain more insights into how treatments should be tailored in relation to the comorbid conditions and profile of different affective reactions to traumatic experiences.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Research Council of Lithuania under grant number S-MIP-23-14.

Data availability statement

The dataset used in this study is available from the first author upon a reasonable request.

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