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A Distinct Diagnosis: Complex Posttraumatic Stress Disorder

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By

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Abstract

Posttraumatic Stress Disorder (PTSD) is exhibited in patients who have distressing and/or impairing thoughts and behaviors after a traumatic event. The DSM-IV-TR (Diagnostic and Statistical Manual, 4th edition, text revision) currently lists several associated features of PTSD that researchers have alternatively conceptualized as Complex Posttraumatic Stress Disorder (C-PTSD). PTSD and what would otherwise constitute C-PTSD are different in terms of etiology, symptoms, and response to treatment. They arise in response to different types of trauma, form distinct symptom clusters, and treatments specially suited to each disorder are most effective. Both clients and clinicians would benefit from the disorders being acknowledged separately in a future edition of the DSM, both in terms of accuracy and increased validated research, as well as improved diagnosis and treatment of trauma victims.

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Introduction

The Diagnostic and Statistical Manual (DSM) first included Posttraumatic Stress Disorder (PTSD) in its third edition, the DSM III (American Psychiatric Association, 1980). The current edition of the DSM, the DSM-IV-TR (text revision) includes the most recently updated diagnostic criteria for the disorder and describes the distressing and/or impairing thoughts and behaviors someone might experience after a traumatic event. Though most people are resilient to trauma, some victims exhibit symptoms long after the event (Elwood et al., 2009). PTSD is found in 8% of the American population (American Psychiatric Association, 2000).

Recently, research has been investigating the way victims of interpersonal traumatic events such as child abuse and domestic violence are affected in ways beyond the symptoms accounted for by PTSD. These symptoms, listed in the PTSD diagnosis as features associated with the disorder, affect areas of a person's life such as emotion regulation and inter- and intrapersonal relationships. A growing body of evidence suggests that these symptoms form their own constellation, conceptualized as Complex Posttraumatic Stress Disorder (C-PTSD), and that this syndrome is worthy of a separate and distinct diagnosis (Courtois, 2008).

Based on differences in etiologies, symptoms, and effective treatments of the two posttraumatic stress disorders, it would be beneficial to both clients and clinicians to formalize a C-PTSD diagnosis. Making C-PTSD a distinct diagnosis would provide a clearer and more accurate description of the disorder, aid in the treatment of the specific

C-PTSD symptoms, and garner increased research into the mental illness that would provide helpful information as to its prevalence, development, and prognosis.

Literature Review

A research base is accumulating that describes the differences between PTSD and C-PTSD. These differences may have implications for treatment. Researchers began addressing a possible distinction between PTSD and C-PTSD following the first description of C-PTSD by Herman (1992). Controversy and research has continued after C-PTSD failed to appear as a diagnosis in the DSM-IV or DMS-V.

Roth, Newman, Pelcovitz, Van der Kolk, and Mandel (1997) describe initial research into the PTSD diagnosis. The diagnosis requires that one experience a traumatic event, avoid stimuli that remind them of the event, and re-experience the event in an intrusive way (American Psychiatric Association, 2000). Between 1990 and 1992, several investigators working on the DSM-IV conducted a field trial. The study assessed both 400 traumatized, treatment seeking people and 128 community residents, finding both a treatment seeking group and a control group in the real world. The goal was to research the validity of the PTSD diagnosis to see if any changes needed to be made to the disorder's criteria, such as the minimum symptom requirement or the stressor/traumatic event criterion. In addition, researchers looked at trauma related symptoms not accounted for by the PTSD diagnosis and whether or not they created their own constellation or syndrome. They looked to see if any measures could be taken to assess these symptoms, and what the risk factors are for developing a complicated or complex posttraumatic stress reaction. The information collected is useful in considering future changes to the

DSM. Data from the field trial suggest that more research should be conducted on the symptom cluster of C-PTSD and that a new diagnosis for the symptoms and new nomenclature would better identify specific responses to complex trauma, such as child abuse (Roth et al., 1997). In their own research, Roth et al. found victims of sexual abuse have struggles most consistent with C-PTSD symptoms (1997). They also identified victims of both sexual and physical abuse to be at the highest risk for developing C-PTSD symptoms and suggest the chronicity of this combination contributes to the risk. These findings acknowledge the significant presence of C-PTSD as a response to interpersonal trauma (Roth et al., 1997).

Following the field trial, Van der Kolk, Roth, Pelcovitz, Sunday, and Spinazzola (2005) raised questions about the categorical approach to conceptualizing posttraumatic stress that leaves many PTSD clients diagnosed with comorbid, or co-occurring, conditions. They suggest this does a disservice to those trauma victims experiencing a range of symptoms not accounted for by PTSD. Van der Kolk et al. (2005) reported that those subjects with prolonged trauma or trauma in early life (two factors considered essential to the etiology of C-PTSD) have a significantly higher incidence of problems with affect regulation, memory and attention, identity, interpersonal relationships, somatization, and themes or systems of meaning. The DSM-IV field trial found the symptoms and effects of C-PTSD are beyond a PTSD diagnosis and cluster into distinct patterns and are highly interrelated. The article also reported important treatment implications for clients with C-PTSD symptoms, mentioning that problems related to emotion regulation and interpersonal relationships may take priority in the course of treatment because of the tendency of these symptoms to significantly impair long-term

functioning. Finally, Van der Kolk et al. (2005) reiterates that the field trial found it was incredibly rare for someone to experience C-PTSD symptoms in the absence of PTSD, suggesting that C-PTSD may not be a syndrome that can occur separately from PTSD.

Courtois (2008) reviews and discusses the problems in the diagnostic system anticipated by early research. A review of studies shows that many researchers and clinicians did not find the PTSD diagnosis to be a perfect fit for those victims of child abuse and other trauma that occurred repeatedly and over a long duration. Clinicians asserted it was difficult to treat those with complicated or complex conditions, such as PTSD with co-occurring somatoform disorders, depression, self-hatred, dissociation, and revictimization. PTSD and one name for the conceptualization of complex PTSD, Disorders of Extreme Stress Not Otherwise Specified (DESNOS) were found to occur comorbidly but describe different symptoms and impairment, and PTSD and DESNOS were also found to occur separately altogether, suggesting that they are two distinct syndromes.

Methods

The data used in my project came from the review and synthesis of research conducted in the area of trauma and psychology. All sources, except four, are peer-review articles located through the PsycInfo database operated by EBSCOhost. Search terms and phrases included: “Complex Posttraumatic Stress Disorder,” “C-PTSD” and “PTSD,” “complex” and “trauma,” “C-PTSD treatment,” “trauma” and “prevalence,” “PTSD” and “etiology,” “complex” and “trauma” and “attachment,” “interpersonal trauma,” and “C-PTSD” and “PTSD.” Four primary sources of information used in my review are not

peer-review articles. The first is a fact sheet of statistics gathered by the National Highway Traffic Safety Administration accessed through the department's website. Second, diagnostic and descriptive information was found in the DSM-IV-TR. Chapters from the two books, *Practitioner's Guide to Evidence Based Psychotherapy* and *Cognitive-Behavioral Therapies for Trauma* provided specific information about treatment.

In structuring this thesis to support the distinction of C-PTSD as a formalized diagnosis separate from that of PTSD, specific questions needed to be answered regarding the cause, course, and treatment of the two disorders. Research was collected to find unique and significant differences in the etiologies, symptoms, and effective treatments of C-PTSD and PTSD. In addition to supporting the discreteness of the two disorders, research regarding the current rationale for not making C-PTSD its own diagnosis was incorporated into the project.

Articles that were reviewed but not ultimately included in this project consisted almost entirely of those investigating alternative treatment options for both PTSD and C-PTSD. Because of the overwhelming amount of data in this area, only those articles discussing the most common and most recently researched therapies for each syndrome were included. Additionally, articles discussing the psychometric profile of those diagnosed with C-PTSD were excluded for their irrelevancy to the project after considering the clear picture of the disorder that the specific etiology and symptoms provided.

Types of Traumatic Experiences & Responses

Experiencing a traumatic event is not a rare occurrence. A study conducted by Elliot (1997) surveyed 505 people in the United States of various demographics and 72% reported having experienced at least one type of traumatic event in their lifetime. Furthermore, the number of traumatic experiences of each individual reporting a trauma history ranged from one event to thirteen events (Elliot, 1997).

A variety of events are potentially traumatic. Some events are out of a person's control, such as natural disasters. Others are intentionally perpetrated by another individual, such as assault. Not all traumatic events happen with the same frequency, equally across the population, or lead to the same aftermath. The list of events used by Elliot (1997) identified thirteen specific types of trauma and divided them into three categories: "Noninterpersonal Trauma," including motor vehicle accidents and natural disasters, "Witnessed Trauma," including witnessing combat, domestic, and other violence as well as unnatural death of an adult or unexpected death of a child, and "Interpersonal Violence," including child and adult physical assault, adult rape, and child physical and sexual abuse. Elliot found 40% of respondents reported experiencing a noninterpersonal trauma, 43% reported having witnessed trauma, and half of all subjects who responded to the survey indicated having experienced an interpersonal trauma (1997). Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) indicate an adult rape prevalence of 10% in the general population. According to Wang and Daro (1997), there are over 3 million reports of child abuse each year. The National Highway Traffic Safety Administration reported 2,436,000 people injured in car accidents in 2008 (2009).

The prevalence of different traumas by gender is remarkable in terms of noninterpersonal and interpersonal types. Kessler et al. (1995) found that males are most often traumatized by events that are noninterpersonal in nature, such as auto accidents, combat, and natural disasters. Acierno, Resnick, Kilpatrick, Saunders, and Best (1999) go on to specify that of 4 million assaults on men, 63% were perpetrated by strangers. The traumatic experiences for women constitute a very different picture. According to Acierno et al. (1999), women are more likely than men to be traumatized by an interpersonal trauma, especially one perpetrated by someone the victim was close to or intimate with, as discovered using the National Women's Survey, a longitudinal study identifying risk factors for assault and PTSD. Kessler et al. (1995) found through 5,877 responses to the National Comorbidity Survey that in the general population of women, 17-33% report childhood physical or sexual abuse. While the majority of Americans have reported experiencing a trauma in their lifetime and all types of trauma can affect both genders, women encounter a higher incidence of interpersonal trauma.

Following the experience of a traumatic event, the victim can have a number of responses in the aftermath. Psychological distress is expected but overall, humans are resilient to trauma. Elwood, Hahn, Olatunji, and Williams (2009) state that most people continue normal functioning or return to a healthy level of functioning soon after the event. Developing a posttraumatic stress disorder is actually not the most common response to trauma.

Posttraumatic Stress Disorder (PTSD)

PTSD Diagnosis (DSM-IV)

The hallmark of PTSD is its first diagnostic criterion, Criterion A, requiring that the individual have exposure to "an extreme traumatic stressor" such as having personal, direct experience with an event that threatened death, injury, or well-being or witnessing such an event occur with another victim, as well as having felt "intense fear, helplessness, or horror" during the event (American Psychiatric Association, 2000, p. 467).

Table 1 - Diagnostic Criteria for PTSD

Diagnostic criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2. the person's response involved intense fear, helplessness, or horror. **Note:** in children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   1. recurrent and intrusive distressing recollection of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed
   2. recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
   3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
   4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. inability to recall an important aspect of the trauma
   4. markedly diminished interest or participation in significant activities
   5. feeling of detachment or estrangement from others
   6. restricted range of affect (e.g., unable to have loving feelings)
   7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hypervigilance
   5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(American Psychiatric Association, 2000, pp. 467-468)

PTSD Etiology

The etiology of a mental disorder refers to its cause or origin. PTSD is the only mental illness in the DSM-IV other than Acute Stress Disorder (ASD) that requires a specific event to have occurred in a person's life (Herbert & Forman, 2006). Still, it would be an oversimplification to say that having experienced a traumatic event causes PTSD. Most people experience trauma and adapt well and survive without developing any disorders (Connor & Higgins, 2008). One study revealed that 72% of Americans reported experiencing at least one traumatic event in their lifetime, while the DSM-IV-TR reports that only 8% of Americans experience PTSD (American Psychiatric Association, 2000; Elliot, 1997).

As part of the first diagnostic criterion for PTSD, the DSM-IV-TR lists several examples of events that could contribute to the disorder, including but not limited to child abuse, sexual assault, kidnapping, car accidents, natural disasters, witnessing an unnatural death, being robbed, experiencing a terrorist attack, and even being diagnosed with a serious illness (American Psychiatric Association, 2000). However, those events categorized as "interpersonal trauma," including child abuse, sexual assault, rape, and physical assault have been found to affect victims in ways beyond those accounted for by the current PTSD diagnosis, conceptualized as C-PTSD (Herman, 1992).

Research has identified several risk factors or vulnerabilities that contribute to PTSD. For example, Foa and Riggs (1993) discussed three such risk factors in reference to chronic PTSD, related to emotional processing theory (Elwood et al., 2009). First, people with steadfast positive and negative views of themselves, others, and the world,

are considered more vulnerable. Second, having a strong memory of the event, usually affected by the intensity or violence of the trauma, yields an increased number of stimuli in the environment that register to the person as dangerous, thereby reinforcing their anxiety. The third factor increasing an individual's risk involves negative judgments or evaluations of both other people and their personal reactions to the trauma (Elwood et al., 2009).

Research has found other risk factors in addition to those posited by cognitive theories. Brewin, Andrews, and Valentine (2000) discovered the severity of the trauma and post-trauma factors such as continuing stress or lack of support from peers were strong indicators of developing PTSD. Ozer, Best, Lipsey, and Weiss (2003) identified dissociating, or withdrawing, during the event to be the most important factor, with the way the victim understood the threat to his or her life at the time of the trauma and social support afterward as also significant (Elwood et al., 2009).

In recent research, four specific vulnerabilities were assessed and found to be significant in developing the disorder (Elwood et al., 2009). The first, negative attributional style, refers to attributing the traumatic event to causes that are linked to the individual themselves, circumstances that will never change, and the inability to avoid such events in the future. The second vulnerability, rumination, is the inclination to repeatedly think about the events surrounding the trauma and perception of threat. Third, anxiety sensitivity is anxiety about feeling anxious in a way that leads to attempts to avoid or conceal the feelings of fear but that only yields greater anxiety. The fourth vulnerability, looming cognitive style, refers to the way a person assesses their

environment that leads to an increased perception of threat or danger (Elwood et al., 2009).

PTSD Symptoms

These (above mentioned) factors and vulnerabilities contribute to the development of PTSD symptoms. PTSD describes symptoms of re-experiencing the event, hyperarousal, and avoiding reminders of the trauma, but is not diagnosed until the behaviors have been occurring for longer than one month (American Psychiatric Association, 2000). PTSD symptoms can occur immediately, "with a delayed onset" arising 6 months or more after the event, or at some point in between. PTSD symptoms are experienced by the victim for a minimum of one month and may be chronic in some individuals, struggling with PTSD for months or even years (American Psychiatric Association, 2000, p. 468).

PTSD symptoms can take a variety of forms, such as having nightmares and/or flashbacks; avoiding certain people, places, or activities they previously enjoyed; difficulty falling asleep; being overly aware of their surroundings; and being easily startled (American Psychiatric Association, 2000). Ultimately, someone with PTSD struggles with certain overt and covert behavior patterns following a traumatic event, their anxiety level increases, and makes it difficult for them to function in daily life.

PTSD Treatment

An empirically validated or evidence-based treatment is one that is supported by randomly controlled trials, as well as by other experiments or studies such as descriptive

studies, cohort studies, and longitudinal design studies (Fisher & O'Donohue, 2006). Empirically supported treatments for PTSD include prolonged exposure, cognitive processing therapy, and acceptance and commitment therapy. Prolonged exposure, cognitive processing therapy, and acceptance and commitment therapy have been validated as effective therapeutic interventions for those who are struggling after experiencing a traumatic event, and they can be used to treat those clients with PTSD. Separate treatment models have been designed specifically for the cluster of C-PTSD symptoms and differ from these aforementioned therapies (Riggs, Cahill, & Foa, 2006; Shipherd, Street, & Resick, 2006; Walser & Hayes, 2006).

Prolonged exposure (PE) aims to decrease the client's anxiety by carefully and systematically confronting feared stimuli such as situations, memories, thoughts, and places that are not intrinsically harmful to the individual (Riggs, Cahill, & Foa, 2006). Though this procedure may seem a harsh practice for a trauma patient, a specific protocol has been made for using PE to treat PTSD. As described in Foa and Rothbaum (1998), PE for trauma has a duration of nine to twelve 90 minute sessions and includes the following elements: psychoeducation, breathing retraining, in vivo (real life) exposure to trauma-related stimuli, and imaginal exposure in which the client repeatedly revisits and recounts memories of the event, and a homework assignment with exercises for the client to do on their own and that will be reviewed in the next therapy session (Riggs et al., 2006). After confronting and processing these situations and stimuli and continually finding that the feared traumatic event does not occur in response to such encounters, anxiety and PTSD symptom severity will decrease over time (Riggs et al., 2006).

Cognitive processing therapy (CPT) addresses feelings in the PTSD client such as

anger, shame, and sadness that may be caused or maintained by cognitive distortions, or faulty or irrational patterns of thinking (Resick & Schnicke, 1992). CPT also finds a balance for the client in regards to adjusting the perceived reality of the traumatic event such that beliefs about themselves, the world, and the event remain or become as accurate, healthy, and undistorted as possible (Shipherd, Street, & Resick, 2006). CPT is outlined as a 12 session therapy that in addition to work with a clinician includes clients responding to specific worksheets involving writing about how the trauma affected them, recording patterns of events, thoughts, and feelings, identifying cognitive distortions, and answering questions to challenge those distortions, as well as writing a detailed narrative of the traumatic event and reading and rereading the narrative (Shipherd et al., 2006).

Acceptance and commitment therapy (ACT) addresses experiential avoidance, or the avoidance of internal stimuli such as feelings and memories, and cognitive fusion, or the experience of viewing distorted thoughts as actual truth and responding behaviorally and emotionally as though those thoughts construct reality (Walser & Hayes, 2006). For example, ACT may focus on a client habitually getting intoxicated to avoid thinking about past trauma as well as behaving as though the thought, "I was raped so I must be worthless and permanently unlovable" is a real fact of life and not a thought produced by the aftermath of the trauma. The ultimate goal of ACT is to challenge these behaviors by utilizing techniques of mindfulness, accepting one's internal experiences without judgment, and making a commitment change behavior in a way that is congruent with one's core, personal values (Walser & Hayes, 2006).

Complex Posttraumatic Stress Disorder (C-PTSD)

C-PTSD

The DSM-IV-TR lists several associated features of PTSD. These associated features have been conceptualized by researchers as forming a disorder separate from PTSD, and they have referred to this syndrome as Disorders of Extreme Stress Not Otherwise Specified (DESNOS) and C-PTSD (American Psychiatric Association, 2000; Van der Kolk et al., 2005). DESNOS and C-PTSD do not yet constitute a formal diagnosis.

C-PTSD Etiology

Evaluating the etiology of C-PTSD is a difficult task. Most people who meet proposed criteria for C-PTSD also meet the criteria for PTSD (Van der Kolk et al., 2005). Since C-PTSD is not yet in the DSM-IV, there are no steadfast diagnostic criteria for the proposed disorder. However, whereas PTSD requires that the person is exposed to a traumatic event, C-PTSD requires that the person experience a complex traumatic event. A complex traumatic event is one that occurs repeatedly, over an extended period of time, and within a relationship or circumstance usually such that escape is not perceived as possible or in which all control is in the hands of a perpetrator (Courtois, 2008). Examples of complex trauma include child physical and sexual abuse, domestic violence, being held a prisoner of war, and being a victim of sex trafficking.

First, complex trauma is generally interpersonal, such that it involves a relationship between the victim and the trauma's cause (the perpetrator). Because of this,

the victim may separate their typical relationship to the perpetrator from the abusive relationship as a means of functioning or maintaining survival (Kohlenberg, Tsai, & Kohlenberg, 2006). However, being successful in this endeavor requires a great amount of separation from both the details of the trauma as well as their internal state during the event. This can have a significant impact on the victim's ability to manage her own emotions and other internal states, trauma related or otherwise. Perceptions of both the perpetrator and other people with whom the victim has a close or intimate relationship are altered, as well as the victim's sense of self (Kohlenberg et al., 2006).

Second, complex trauma often presents in the form of child abuse, placing the onset of the trauma at a much younger age than other types of trauma and in a context where the trauma continues for an extended period of time. Researchers hypothesize the long term effects of child abuse to have a deep, negative impact on interpersonal functioning and issues such as intimacy and trust (Kohlenberg et al., 2006). In fact, the DSM-IV field trial supported hypotheses that a young age of onset, early traumatization, and long term exposure to the trauma all made a person more likely to experience symptoms beyond those included in the PTSD diagnosis, including difficulties in emotion regulation, identity, sense of meaning, and the experience of physical pain or ailments in response to psychological distress, a symptom cluster known as somatization (Van der Kolk et al., 2005).

C-PTSD Symptoms

DESNOS and CPTSD do not yet have specified criteria with regard to the onset and duration of symptoms. However, the symptoms of C-PTSD tend to be more

pervasive and long-term in a person's life. Pervasive, chronic symptoms include significant changes in personality, systems of meaning, and world view, and occur almost exclusively in response to long-term, repeated, and interpersonal trauma (Courtois, 2008). The focus of this thesis will be the unique characteristics of C-PTSD and the important ways the syndrome differs from PTSD as it makes a case for formalizing a C-PTSD diagnosis.

Herman (1992) outlined seven specific criteria for C-PTSD that describe these different symptoms, and the field trial workgroup for the DSM-IV also organized those types of symptoms under the heading DESNOS, a category that never made it into the final manual. Signs and symptoms of DESNOS (or C-PTSD) were broken down into several subcategories reflecting struggles in: emotion regulation; attention; the experience of physical pain as a manifestation of psychological distress; self-perception and identity; maintaining an accurate view of the perpetrator of the interpersonal violence; difficulty relating to others; and serious changes in the victim's sense of meaning and purpose (Van der Kolk et al., 2005).

Symptoms in these subcategories are numerous and may present as amnesia, excessive risk taking, chronic shame or guilt, idealizing the perpetrator, the inability to trust others, hopelessness, and a variety of other behavioral and psychological dysfunctions (Van der Kolk et al., 2005). In contrast to PTSD, the symptoms of C-PTSD are more long term, pervasive, and intra- and interpersonal in nature. With respect to avoidance, "the stimuli involved in C-PTSD are rarely specific things or events"

(Kohlenberg et al., 2006, p. 181). The person may not be especially reactive to dark parking lots, for instance, but to intimate moments with other people.

Table 2 – Symptom Subcategories of DESNOS

DESNOS Subcategories
I. Alterations in Regulation of Affect and Impulses
A. Affect Regulation
B. Modulation of Anger
C. Self-Destructive
D. Suicidal Preoccupation
E. Difficulty Modulating Sexual involvement
F. Excessive Risktaking
II. Alterations in Attention of Consciousness
A. Amnesia
B. Transient Dissociative Episodes and Depersonalization
III. Somatization
A. Digestive System
B. Chronic Pain
C. Cardiopulmonary Symptoms
D. Conversion Symptoms
E. Sexual Symptoms
IV. Alterations in Self-Perception
A. Ineffectiveness
B. Permanent Damage
C. Guilt and Responsibility
D. Shame
E. Nobody Can Understand
F. Minimizing
V. Alterations in Perception of the Perpetrator
A. Adopting Distorted Beliefs
B. Idealization of the Perpetrator
C. Preoccupation with Hurting Perpetrator
VI. Alterations in Relations with Others
A. Inability to Trust
B. Revictimization
C. Victimizing Others
VII. Alterations in Systems of Meaning
A. Despair and Hopelessness
B. Loss of Previously Sustaining Beliefs

(Van der Kolk et al., 2005, p. 391)

C-PTSD Treatment

In her review of complex trauma, Courtois (2008) points out that most therapies modeled for C-PTSD are structured into specific stages, influenced by recommendations made by Herman, considered a pioneer in the conceptualization of the syndrome. Such

stage-oriented treatments generally include three stages focusing on first establishing safety and skill building, followed by processing traumatic events and finally focusing on functional, fulfilling ways to live life after the trauma (Courtois, 2008; Van der Hart, Brown, & Van der Kolk, 1989).

One recently researched stage-oriented model is the HEALTH model, designed by Connor and Higgins (2008). The stages in the therapeutic process spell out the acronym HEALTH, and are as follows: "having a supportive therapist, ensuring personal safety, assisting with daily functioning, learning to manage core PTSD symptoms (self regulation), treating complex PTSD symptoms, having patience and persistence to enable "ego strengthening" (Connor & Higgins, 2008, p. 297). This model reflects the three basic, previously researched stages of establishing safety, managing the trauma and symptoms, and laying the groundwork for and working toward a healthy life in the future. Concerning the fifth stage, "treating complex PTSD symptoms," Connor and Higgins highlight the importance of negotiating a the treatment plan with the client and paying special attention to those symptoms related to self-perception, perception of the perpetrator, and sense of meaning (2008). When the HEALTH model was tested in ten patients with C-PTSD, it led to a decrease in both PTSD and C-PTSD symptoms in eight of the participants (Connor & Higgins, 2008).

Connor and Higgins (2008) stated in the end of their analysis that it is important for C-PTSD clients to also partake in group therapy because of the opportunity it provides clients to find acknowledgement, validation, and reframing of their experiences. Payne et al. (2007) conducted a pilot study on the use of client-centered group therapy for six trauma survivors experiencing C-PTSD symptoms following interpersonal violence.

Client-centered therapy (CCT) starkly contrasts most of the previously mentioned treatments in that it does not follow specific steps, session guidelines, or stages. As Rogers (1959) explains, the basis for CCT lies in the notion that clients will be motivated on their own to approach and process the trauma in a way that is comfortable and appropriate for them (Payne et al., 2007). Though the strategy may seem unfocused, the treatment did result in a decrease in C-PTSD symptoms in half of the subjects, contingent on the degree to which the subjects viewed the group as listening with empathy (Payne et al., 2007).

A third intervention investigated for use in treating C-PTSD is functional analytic psychotherapy (FAP), a behavioral therapy utilizing the therapeutic relationship between client and therapist as a training ground for addressing interpersonal struggles and other C-PTSD symptoms. Developing the therapeutic relationship helps both client and therapist identify those situations and stimuli that are troubling for the client, provides a safe place for the client to work through those situations in a way that encourages emotional intimacy, and helps the client re-learn adaptive behaviors in lieu of behaviors that maintain or reinforce avoidance (Kohlenberg et al., 2006).

Differences/Comparison (PTSD vs. C-PTSD)

Etiology

A person can have certain vulnerabilities and experience a traumatic event in his or her lifetime and meet the criteria for PTSD, C-PTSD, both, or neither. However, this does not make the development of the disorders necessarily similar. A different set of factors contribute to the development of C-PTSD. The differences between these

etiologies are important to note as they are significant to the distinction between the conceptualizations of the two disorders.

(PTSD)

As previously reviewed, circumstances that increase the likelihood of developing PTSD include a violent, vivid memory of the trauma, dissociation during the event, lack of social support, and extreme conceptualizations of positive and negative, especially with respect to personal judgment.

(C-PTSD)

C-PTSD is more likely to develop when the specific trauma is interpersonal in nature, is repeated, and occurs over a lengthy time frame. Factors that perpetuate the symptoms are also different in each disorder. For example, threatening, intrusive thoughts of the event and the avoidance of certain stimuli or environments are two symptoms of PTSD that may maintain anxiety and avoidance (American Psychiatric Association, 2000). In PTSD, stimuli that are avoided often include specific people, places, or even films that remind the person of the trauma. In C-PTSD, however, the avoided environments are not so specific, and could include, for example, an avoidance of any emotionally intimate relationship (Kohlenberg et al., 2006).

Table 3 – Key Differences in Etiologies between PTSD and C-PTSD

PTSD	C-PTSD
I. Exposure to any trauma II. Lack of social support III. Strict positive and negative judgment IV. Dissociation V. Perceived Threat	I. Exposure to complex trauma II. Age of trauma III. Relationship to/with perpetrator

Symptoms

The DSM-IV-TR states that mental disorders reflect psychological or behavioral patterns that cause distress or impairment in a person and are signs of dysfunction (American Psychiatric Association, 2000). Currently, the symptoms and signs of the distress conceptualized as C-PTSD are listed as "associated descriptive features" of PTSD and not as a separately categorized diagnosis. According to the DSM-IV-TR, the "associated descriptive features" section "includes clinical features that are frequently associated with the disorder but that are not considered essential to making the diagnosis" (American Psychiatric Association, 2000, p. 8). In order to assess to what point it would be beneficial to make a distinction between the two, a close look should be taken at the differences between the symptoms of the two disorders and what someone diagnosed with each syndrome struggles with.

Symptoms - Pathology/Thematic resolution

In addition to the differences between symptoms of PTSD and C-PTSD, research has been conducted in regards to the mechanisms underlying these two clusters of symptoms, particularly concerning the restructuring of a person's beliefs following trauma. This concept is referred to as thematic resolution. Newman, Riggs, and Roth (1997) posited that experiencing a traumatic event disrupts the victim's world view and belief system in a way that contributes negatively to their functioning, and hypothesized they would find differences between thematic resolution in those with PTSD versus those with C-PTSD. The 15 themes investigated in the study included such feelings and beliefs as those related to helplessness, self-worth, validity of one's feelings, and the

trustworthiness of others (Newman et al., 1997). The results of the study revealed that those subjects who met criteria for C-PTSD had more themes deeply affected by the trauma and fewer themes that managed to not be affected at all in comparison to those with PTSD and without either syndrome (Newman et al., 1997). This finding suggests not only a difference between PTSD and C-PTSD in terms of how each group of subjects were affected by the trauma experienced, but also illustrates differences in how each group struggles with "resolving trauma-related issues and creating adaptive meaning" (Newman et al., 1997, p. 209).

Table 4 – Key Differences in Symptoms between PTSD and C-PTSD

PTSD	C-PTSD
I. Systems of meaning less affected	I. Systems of meaning profoundly affected
II. Avoidance of specific, external stimuli	II. Avoidance of internal states (emotions, trust)
III. Increased anxiety (hyperarousal, reexperiencing)	III. Changes in emotions, worldview, personality, sense of self

Treatment

In contrast to PTSD, therapies designed for C-PTSD tend to be longer in term and more open-ended and subject to the client's individual needs. Courtois (2008) comments on this point, recognizing that C-PTSD treatment is longer in duration "because of the self-identity, self-regulatory, and relational deficits" that contribute in large part to the disorder (p. 92). Therapies for C-PTSD focus considerably more attention on the relationship the client has to the therapist and group members. C-PTSD therapies emphasize the importance of factors such as an agreement to the treatment plan, empathic listening, and the function of emotional intimacy in the therapeutic relationship not as a

positive part of therapy, but as an active, dynamic aspect of therapeutic work. As Kohlenberg et al. (2006) explain, the feared or avoided stimuli in C-PTSD are often much less the concrete, literal stimuli that are the subject of clinical focus in PTSD. C-PTSD treatments engage the client in deep, dynamic interpersonal relationships that help them approach symptoms related to self-perception, the perception of others, and the other long-term, pervasive struggles that significantly affect their world view and systems of meaning and purpose.

Table 5 – Key Differences in Treatment Approaches for PTSD and C-PTSD

PTSD	C-PTSD
I. Structured into number of sessions II. Focus on feared stimuli III. Address anxiety	I. Long term, open ended II. Focus on relationships, especially the therapeutic relationship III. Address long term issues of identity and worldview

Discussion

Considering the contrast between the experiences and vulnerabilities of clients with these different syndromes and the separate packages they bring to the table, it would be helpful to both client and clinician to categorize and research PTSD and C-PTSD as distinct disorders that may occur independently or together.

Based on Etiology

The DSM-IV field trial conducted between 1990 and 1992 found C-PTSD occurring without a person also suffering from PTSD to be very rare, constituting only 4% of a community sample (Van der Kolk et al., 2005). This suggests that the symptoms

conceptualized as C-PTSD are not their own syndrome but features occurring in addition to PTSD. This is likely why the DSM-IV does not include any distinction between such features and PTSD despite the Subcommittee on PTSD, a group of professionals specializing in the area, encouraging otherwise (Van der Kolk et al., 2005). However, later studies conducted between 1996 and 1999 found a much higher number of trauma patients suffering from Disorders of Extreme Stress Not Otherwise Specified/C-PTSD symptoms without meeting criteria for PTSD, varying between 25–45% (Van der Kolk et al., 2005).

It is appropriate to distinguish C-PTSD symptoms from the diagnostic criteria for PTSD. PTSD's criteria and description are focused on the anxiety pervasive in the person's life in the aftermath of the trauma, whereas C-PTSD symptoms surround emotions and struggles in the client's life that are more grounded in guilt, shame, and hopelessness than in anxiety causing significant impairment (Herman, 1992). Moreover, the current PTSD conceptualization not requiring these additional associated features (C-PTSD symptoms) accurately describes 8% of the American population with posttraumatic stress symptoms (American Psychiatric Association, 2000). The PTSD criteria address behaviors potentially encountered after experiencing a range of traumatic events, whereas C-PTSD symptoms more accurately address those struggles encountered only after experiencing a prolonged or interpersonal trauma. Research has found C-PTSD to occur in a smaller population of those with trauma histories, with one study finding only 53% of those meeting criteria for PTSD also meeting the criteria for C-PTSD (Newman et al., 1997). Incorporating the current "associated descriptive features" into

the required diagnostic criteria for PTSD would drastically and unnecessarily redefine the validated PTSD disorder.

Symptom Clusters

The DSM-IV field trial found that C-PTSD symptoms "tend to cluster into distinct patterns and to be highly interrelated," (Van der Kolk et al., 2005, p. 395). This would indicate the "associated descriptive features" of PTSD are more than a list of extraneous struggles a client may have in addition to PTSD. Furthermore, what is to be made of those clients who experience many of the "associated features" of PTSD without actually meeting criteria for PTSD? Though such a population does not compose a majority of trauma patients, they do experience a group of symptoms that are very distinct from the PTSD criteria and are so interrelated and specific that delegating the conceptualization to a fringe category of anxiety disorders such as "Anxiety Disorder Not Otherwise Specified" would not be suitably descriptive or accurate for the client in diagnosis or clinician in treatment. C-PTSD symptoms form their own group that a client may struggle with in addition to or instead of PTSD in a way that demands clinical focus treating these symptoms more specifically. Assuming these symptoms are features of PTSD may also lead one to believe the client would similarly respond to treatments designed for PTSD, which may or may not be the case. Recognizing C-PTSD as its own, distinct diagnosis better describes the pathological and functional differences of the two posttraumatic reactions.

Needs for Treatment

As illustrated in the processes and focuses of the treatments for PTSD and C-PTSD, it is clear that the target issues in therapy for each syndrome may be similar, but benefit from a specialized format and difference in treating avoidance of certain stimuli. Considering that the "associated features" of PTSD assemble into their own cluster of symptoms and respond well to a distinct type of treatment, it would be beneficial for the treating clinician to recognize the gravity of these symptoms and appropriately treat them as more than side-effect struggles of PTSD that may resolve as the specific PTSD symptoms improve.

The DSM-IV-TR acknowledges that symptoms conceptualized as C-PTSD occur especially in those individuals with PTSD who experienced interpersonal trauma (American Psychiatric Association, 2000). It does not acknowledge that these symptoms associated with PTSD cause additional and distinct functional impairment and benefit from treatment different than that being used to treat the PTSD symptoms described in the PTSD diagnostic criteria. Separate treatments have been designed to target the specific deficits related to interpersonal dysfunction, marked dissociation, changes in meaning and schemas, impulsivity, etc. not inherent in a PTSD diagnosis alone. The development and successful utilization of separate treatment modalities to address these C-PTSD symptoms certainly suggest such resolution, and improvement without direct intervention is not the case.

Courtois (2008) points out that the application of some PTSD treatments may actually be harmful to the client with C-PTSD symptoms. In this way, the characteristics

of C-PTSD are more than associated features of PTSD; they demand their own level of recognition, psychoeducation, clinician sensitivity, and treatment plan. Symptoms conceptualized as C-PTSD are often diagnosed or included as symptoms of a mental disorder other than PTSD. Both Courtois (2008) and van der Kolk et al. (2005) speak to this, and note that potential risks of relegating symptoms such as affect regulation, dissociation, and alterations in personality to disorders such as Major Depressive Disorder and Borderline Personality Disorder include employing inappropriate approaches to treatment and failure to recognize those symptoms as specific to the aftermath of the trauma. This scenario is especially troublesome to those who have C-PTSD symptoms and not PTSD, such that none of their symptoms are attributed to posttraumatic stress.

The benefit of collective research under a separate DSM diagnosis

Both clients and clinicians would benefit from finding C-PTSD as a distinct diagnosis in the DSM. The outline of specific criteria and symptoms describes the syndrome with better accuracy than listing them as features, and would further categorize these symptoms by type of dysfunction. In addition to providing a clear picture of what C-PTSD looks like in terms of dysfunctional or maladaptive behaviors, the DSM would also provide important information about C-PTSD just as it does for all disorders in the manual. This information falls into subheadings including "Specific Culture, Age, and Gender Features," "Prevalence," "Course," "Familial Pattern," and "Differential Diagnosis" (American Psychiatric Association, 2000, p. 8-9). Extensive research on the part of clinical researchers could yield similar information, but it is more helpful to have

the data collected and interpreted by the American Psychiatric Association and legitimate work groups focusing on the diagnosis. Making C-PTSD a distinct diagnosis would make the condition more accurately diagnosed and treated, launch increased research into the subject, and lend validation and support to the disorder.

Future Research: C-PTSD and Borderline Personality Disorder

One area of future research related to the formalization of C-PTSD as a diagnosis in a future edition of the DSM is how its inclusion as a separate diagnosis may affect the diagnosis of and stigma related to Borderline Personality Disorder. Borderline Personality Disorder is a chronic disorder often found in victims of abuse and includes symptoms such as dissociation in times of stress, self-harming behaviors, unstable sense of self, and unstable relationships with others (American Psychiatric Association, 2000). If C-PTSD becomes its own diagnosis, Borderline Personality Disorder may not be diagnosed as frequently because the C-PTSD diagnosis may be given instead. Additionally, it would be important to investigate over time whether or not C-PTSD is diagnosed in excess and whether or not the possible diagnosis is due to clinicians attempting to avoid giving clients the Borderline Personality Disorder label that currently carries with it a negative stereotype.

Conclusion

To say PTSD and C-PTSD are or should be distinct disorders simply because they have different etiologies is an exaggeration. For example, one could posit that some people develop depression due to a negative attributional style and others develop the disorder based on brain chemistry. What is important about these differences in

posttraumatic stress reactions is the implication the differences have for the trauma victim and the management of their symptoms. Someone presenting with C-PTSD symptoms most likely has a different trauma history with different vulnerabilities than someone without C-PTSD features. These causes and histories present different symptoms and groups of symptoms. Further, the backgrounds and experiences of clients with C-PTSD and those with PTSD will no doubt, or should, affect the course of treatment.

PTSD and C-PTSD clearly have differences in terms of the types of symptoms and impairments attributed to each disorder and what types of treatment options are best suited to treat those symptoms. While victims of interpersonal, prolonged, and repeated trauma are often diagnosed with PTSD, this population also exhibits C-PTSD features that should be specifically addressed and not left to be treated as characteristics of PTSD that will diminish as PTSD symptoms improve. These symptoms should also not be treated as though they are related to a different mental illness not related to the trauma. These C-PTSD symptoms are interrelated; a client diagnosed with PTSD who experiences C-PTSD symptoms does not only experience one or two of these "associated descriptive features," but typically as entire constellation that affects their life in ways beyond the PTSD symptoms and demand separate, focused clinical attention. Making C-PTSD a distinct diagnosis is in the best interest of the client in terms of increased accuracy in diagnosis and treatment, and is in the best interest of the clinician by the DSM providing increased information regarding C-PTSD. Though the DSM's formalization and validation of the disorder may be of little consequence to the client's immediate treatment, such recognition would greatly impact the future understanding of posttraumatic stress reactions and treatment approaches, as well as upcoming research of

the C-PTSD population. A side-effect of this acknowledgement may also include important changes in the way certain clients are viewed or diagnosed, specifically those women who may be considered to have a personality disorder such as Borderline Personality Disorder, an illness with a focus on interpersonal turbulence and associated with a trauma history. Another possible area of investigation considering a future formalization of C-PTSD would be rates of treatment seeking specifically for the disorder, in light of it including symptoms such as depressed mood and self-harm, behaviors that typically increase treatment seeking. The legitimization of C-PTSD as a distinct diagnosis separate from that of PTSD holds positive and significant implications for the future of trauma victims, clinicians, and the academic and clinical field of psychology.

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