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Current Topics in Complex Post-Traumatic Stress Disorder

Rose McMahonill

McMahonill, Rose E., is a student in the Masters of Counseling Psychology program at City University of Seattle, with an anticipated graduation date of June 2013. Rose is currently doing internship counseling work at a private practice in Seattle with a focus on gender issues, depression, anxiety, and relationships.

Abstract

Complex post-traumatic stress disorder (cPTSD), a diagnostic category which addresses the characterological changes that may occur in a survivor of chronic, prolonged abuse, has been proposed for inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000). In this paper, the author examines 1) the research that has been conducted thus far to determine if cPTSD has clinical usefulness and relevance, 2) gaps in the extant research which may impact this usefulness, and 3) how the concept of cPTSD may be applied in a therapeutic setting, taking cultural variables into account.

In 1992, Judith Herman identified the need for diagnostic nomenclature which could address the array of symptoms frequently observed in people who had endured prolonged, chronic trauma in childhood. The symptoms which were identified as being correlated with such trauma, whether physical abuse, sexual abuse, neglect, war trauma, or any other sustained and totalitarian violation of the child's safety, were not found to be sufficiently addressed by the diagnostic criteria for simple post-traumatic stress disorder (PTSD). The main failing of the existing PTSD diagnosis for these cases was that it applied exclusively to events of circumscribed, finite trauma; it did not take prolonged abuse or its potential psychological outcomes into account—and the differences in psychological issues between survivors of these two situations tend to be very different. While survivors of simple trauma experience invasive anxiety, depression, and reliving of the traumatic event (APA, 2000), survivors of prolonged trauma display deeply embedded deformations of character: relational and identity problems, vulnerability to harm (both self-harm and victimization by others), dissociation, extreme anxiety, depression, and somatoform disorders (Herman, 1992). These deformations are thought to be brought on by the child's healthy development being interrupted by sustained safety violations, preventing them to fully integrate their personality as an individual. Herman proposed that complex post-traumatic stress disorder (cPTSD) be developed as a diagnostic category that could aid in conceptualizing and developing an effective treatment paradigm for these psychological maladies.

Complex Post-Traumatic Stress Disorder Rooted in Childhood Abuse

Central to Herman's concept of complex post-traumatic stress disorder is the idea that prolonged sexual and/or physical abuse or neglect has occurred during a critical phase of the survivor's development, disrupting the survivor's ability to effectively integrate the abusive experience into a healthy sense of self. Often, this disintegration mimics other disorders and results in clinicians issuing diagnoses of borderline personality disorder, dissociative identity disorder, or somatization disorder, when a deeper look into the client's history would turn up evidence that his/her symptoms are better accounted for as an adaptive response to sustained abuse. This misdiagnosis is easy to make, as the definitive symptoms of these disorders map uncannily well to the malformations of identity that are indicative of cPTSD; they are long-standing symptoms of a persistent nature which one would expect to see in someone who experienced severe and prolonged abuse in childhood. Herman claimed that the pervasive deficits in identity and the inability to form relationships with reasonable boundaries which are found in borderline personality disorder, the fragmenting of self and need for compartmentalizing or "splitting" which are found in dissociative identity disorder, and the sublimation of psychic pain into physical symptoms found in somatization disorder can often be traced back to sustained abuse in childhood which prevented the victim from forming a well-integrated and well-bounded sense of self. Herman presented this new framework in part to help identify childhood trauma in clients who did not immediately present with classic trauma symptoms. She also aimed to help reduce the stigma often experienced with the diagnosis of these three aforementioned disorders by explaining them through the more sympathetic lens of chronic trauma.

Field studies of this new diagnostic category were used to test its usefulness in clinical populations, and the results were positive. Ford (1999) and Ford and Kidd (1998) were able to establish clinical usefulness for the constellation of symptoms displayed in survivors of prolonged, chronic trauma. Showing further support of the concept overall, the World Health Organization included a similar diagnosis in the ICD-10 addressing enduring personality change following "catastrophic experience" (World Health Organization, 1994). However, the nomenclature of complex post-traumatic stress disorder has yet to enter the *DSM-IV-TR* as a diagnostic category of its own; at present, it exists only as an associated feature of PTSD (APA, 2000).

Gaps in the Research

Although cPTSD has gained traction in the last few decades as a useful concept, there is still one striking variable that has yet to be explored: gender. In its current form, the symptoms of cPTSD have little supported applicability for men. Borderline personality Disorder (BPD) is most frequently diagnosed in females, who account for about 75% of the diagnosed population (APA, 2000). Dissociative identity disorder is diagnosed 3 to 9 times more frequently in adult females than in adult males (APA, 2000). Somatization disorder is reported as being "rarely" diagnosed in males in the United States (APA, 2000). Females are estimated to be at twice the risk of males for developing post-traumatic stress disorder (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Yet despite these widely disparate rates of abuse-related symptomatology by gender, the

statistics do not bear out the conclusion that female children are simply abused more: the U.S. Department of Health and Human Services reported in 2009 that the abuse toward the genders was roughly evenly split, with boys accounting for 48.2 percent of the reported victims and girls accounting for 51.1 percent.

A few different theories have been put forth to explain this disparity. Some research points to women being more frequently diagnosed with PTSD as the result of being more frequently victimized sexually (Cortina & Kubiak, 2006), which carries the assumption that the impact of sexual abuse is categorically different than any other violation of one's safety. However, the aforementioned symptoms which can be subsumed under the label of cPTSD are not exclusively the domain of sexual abuse; they are also observed in cases of physical abuse and neglect, which occur at equal rates for boys. Further, if this disparity could be neatly explained as the result of women experiencing a different, more invasive type of trauma than men, we would expect gender rates in PTSD resulting from non-invasive trauma to be similar, and this is not the case: when controlling for type of trauma, the overrepresentation of women in the diagnostic category of PTSD is upheld (Breslau et al., 1998; North et al., 1999; Shore, Tatum, & Vollmer, 1986). Finally, this is not a case of men being better able to heal from their own trauma, leaving women to be overrepresented in the clinical setting: it has been demonstrated that men are not necessarily more adept than women at independently recovering from trauma (Vogt et al., 2011). It follows, then, that one could reasonably expect that men's experiences of childhood trauma would turn up in some form. So how is it being expressed?

Conduct disorder (CD), which is diagnosed more frequently in males than in females (APA, 2000), is firmly established as having a link to simple trauma in childhood (Maschi, 2006). While conduct disorder does not guarantee a later diagnosis of antisocial personality disorder, evidence of CD during adolescence is a diagnostic criterion in antisocial personality disorder. Looking at differential gender rates in the diagnosis of adult personality disorders, antisocial personality disorder stands out as being diagnosed approximately 3 times as frequently in males than in females (APA, 2000). As people diagnosed with antisocial personality disorder tend to violate the rights of others, which may be seen as a corollary of being unable to establish boundaries in BPD, perhaps antisocial personality disorder is the manifestation of prolonged and chronic childhood trauma in males.

The most telling evidence for this case is the number of studies which have concluded that men are more frequently diagnosed with antisocial personality disorder and women more frequently diagnosed with borderline personality disorder *when identical symptoms are present* (Becker & Lamb, 1994). This indicates that perhaps clinician bias, not presentation of actual symptoms, is what results in the conclusion that more women than men are impacted by boundary issues rooted in childhood trauma, and that symptoms of antisocial personality disorder may often be explained through the lens of cPTSD. A literature search to see if this link has been investigated turned up nothing; thus, this is a possible correlation that needs further research.

Relevance to Clinical Practice

Cultural Considerations

The concept of trauma is a universal one, with humans the world over susceptible to violations of their personal safety. What is different across cultures is how the aftereffects of these violations may manifest themselves, and whether the symptomatology linked to the violations is found to be unacceptable within the survivor's culture and thus in need of therapeutic intervention. As one's development of personality invariably occurs within the context of culture, differences in how boundary-violating traumas present are expected to a certain extent.

Several symptoms specific to borderline personality disorder exist which are considered in Western culture to be indicative of a history of identity-disrupting trauma, but may be easily confused with culturally sanctioned expressions of emotion in other parts of the world. Alarcon and Leetz (1998), in discussing potential misdiagnosis of BPD across cultures, also touched on symptoms of dissociative identity disorder which overlap with cPTSD:

In this context, the external circumstances of current life in urban areas generate a set of behaviors that often mimic the features of BPD... in these cases, issues of unresolved intrapsychic conflicts give rise to mood swings, impulsiveness, instability, ambiguity, unpredictability, intense anger and displays of temper that can be confused with BPD. Suicide-like behavior, such as wrist slashing, may be part of culturally determined rituals of bonding among Native American, Asian Americans, and Middle East persons. The passivity of some individuals in some of these groups can be misperceived as a pessimistic outlook. Depersonalization, trancelike, and psychosis-like episodes are also well-known culturally determined events in the lives of people from many non-Western societies. Often fueled by deeply rooted religious traditions, these traits are exacerbated under the impact of acculturation. (p.179)

Clearly the ability to distinguish between a culturally-endorsed means of expressing oneself and a true psychological problem is a critical skill to have in the clinical setting, particularly when working with difficult-to-validate symptoms such as dissociation. Therapists are advised to do their research when working with someone of a cultural background with which they are unfamiliar, such that their ability to make this distinction is well-informed. Additionally, it is important to note that the cultural association of victimization with femininity may result in males underreporting or minimizing their experience of sexual abuse in particular (Sorsoli, Kia-Keating, & Grossman, 2008). Acknowledging these barriers and providing a safe space for males to discuss abusive experiences without shame will allow the therapist to perform a better informed, more accurate assessment of the presenting symptoms and their possible causes.

Applications in the Therapeutic Setting

As previously stated, the emotionally labile and relationally troubled symptom cluster which commonly maps to the diagnosis of BPD is often treated with a great deal of stigma. Clinicians are frequently dismissive of BPD cases and consider them difficult

to work with and even more difficult to effectively treat (Herman, 1992). Understanding these symptoms through the lens of cPTSD has the potential to help the clinician approach the case with increased understanding and empathy, leading to higher quality of care for the client.

In terms of direct application, Courtois (2004) has proposed a strategy for treatment and assessment of cPTSD based on the extant literature and the established connection between trauma and dissociative or emotionally labile symptoms. For assessment, it is recommended that the therapist begin with an inquiry about childhood trauma from the first intake meeting, with the understanding that the client may be unwilling to disclose this immediately and may wait until a more stable rapport has been built between client and therapist. The idea is to get the subject of trauma out in the open and establish a precedent of speaking frankly about it, such that even if the client does not respond positively to the first inquiry, they will feel welcome to speak about it when they become comfortable enough to do so.

Once a history of trauma has been established, several guiding principles are set forth for the therapist in discussions of trauma. First, Courtois (2004) advised that the therapist explicitly recognize that discussion of trauma can be extremely painful, and to maintain an open, neutral, and respectful position from which to ask questions of the client in order to empower them. Second, the therapist must monitor for signs of decompensation following discussion of trauma, as spontaneous emergence of symptoms may occur as a result of the discussion. If the client does not appear able to process the subject without experiencing harm to him or herself, the therapist should be prepared to reduce the discussion of trauma and respond to the client in a preventative manner. The therapist must put the client's welfare and protection from harm above the story of the trauma. Finally, it is important that if the therapist is not trained in detecting subtle and gradual emergence of dissociative symptoms, then they seek assistance in periodic reassessment of the client to help them identify the emergence of these symptoms as the client progresses.

In terms of treatment, a three-stage, long-term model has been widely adopted based on recommendations from Herman (1992). This model mirrors what Pierre Janet found to be an effective method for treating chronic trauma as far back as 1919. The first and longest stage focuses on relationship building between the therapist and client, educating the client, and helping the client establish appropriate affect regulation and safety in their life. Once the client has shown the ability to regulate their emotions effectively and has established some stability in their life, the second stage can begin. In this stage, the client's history of trauma is addressed explicitly and uncovered in order to allow them to function daily with fewer invasive post-traumatic symptoms. The final stage focuses on consolidation and restructuring, which allows the client to move forward with a life less impacted by the original trauma. Throughout these three stages, the therapist should maintain a strong emphasis on creating a sense of safety and security for the client as well as helping them establish coping skills for affect regulation.

Conclusion

The concept of complex post-traumatic stress disorder is a useful one, both for clinicians trying to understand their clients' needs, and for clients who historically have

not been helped by the current structure of disorders in the *DSM-IV-TR*. While more field work is needed to establish how male populations exhibit symptoms of prolonged abuse experienced in childhood, the proposed structure of cPTSD as it currently stands is a boon for women who have been marginalized or stigmatized due to ill-fitting diagnoses.

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