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Complex Posttraumatic Stress Disorder: Issues in Diagnosis and Treatment

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Course outcomes:

When you have completed this course you will have an understanding of:

- Complex posttraumatic stress disorder
- The existing definitions and features of Complex posttraumatic stress disorder
- Treatment options for the disorder
- Differential diagnoses of Complex posttraumatic disorder
- Proposals for the inclusion of Complex posttraumatic stress disorder in the DSM V

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A note on the learning and teaching approach

This course is built on the principles of supported open learning pioneered by the UK Open University and developed by South African Institute for Distance Education (SAIDE) and The SACHED Trust. Course participants (Students) are asked to do all the tasks as they appear in the text in order to take full value from the course. There are three kinds of task:

1. ***Fact check*** – to memorise key knowledge items.
2. ***Reflection and analysis*** – to take time to actively engage with the ideas in the course.
3. ***Assignments*** – a chance for an extended written task to consolidate your knowledge and express your views.

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1. Overview

Complex Posttraumatic Stress Disorder (PTSD) is a relatively new concept in the field of psychology, and as such is accompanied by contention as well as its own set of issues when it comes to both the diagnosis and treatment of this disorder. Complex PTSD is precipitated by repeated and chronic traumatic events, more commonly in childhood, and often in a circumstance of captivity such as child abuse, domestic abuse, prisoner of war camps and so forth. Being precipitated by trauma, differentiating between the symptoms of Complex PTSD and other disorders becomes difficult as many of the symptom sets are similar, especially those symptoms of Complex PTSD, Posttraumatic Stress Disorder and Borderline Personality Disorder. This article provides an overview of varied opinions on Complex PTSD, the definitions of the disorder, the features of Complex PTSD, the treatment options available, and the differential diagnoses. The overview will illustrate the difficulties in diagnosis, as well as highlighting salient differences, and proposals of Complex PSTD for inclusion in the DSM-V.

2. Definitions of complex trauma

Complex trauma - also known as the disorder of extreme stress not otherwise specified (DESNOS) in the DSM-IV-TR - describes the problem of children's exposure to multiple or prolonged traumatic events and the impact of this exposure on their development according to Friedman, Keane & Resick (2007). Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence that is chronic, and begins in early childhood and occurs within the primary care giving system (Friedman, Keane & Resick, 2007).

Complex Posttraumatic Stress Disorder differs from Posttraumatic Stress Disorder, essentially in the nature of the trauma. A diagnosis of PTSD normally involves a list of symptoms that result from exposure to a single traumatic event or experience. Examples of these events or experiences can include, but are not limited to car accidents, natural disasters, rape, muggings and the like. These are considered traumatic events of short duration (Slone & Whealin. 2007).

Chronic trauma happens over an extended period of time. According to Slone and Whealin (2007) the current PTSD diagnosis does not capture the extent of the psychological harm caused by what they call chronic trauma. Judith Herman (1992) suggested that a new diagnosis, Complex PTSD, is needed to describe the symptoms of long-term trauma. The current diagnosis, closest to the symptoms of complex PTSD, is Disorders of Extreme Stress not otherwise specified (DESNOS) (American Psychiatric Association, 2000). It is a term used to describe a syndrome involving a disturbance in the following areas namely (Busuttil, 2006):

Affect and impulse;

Attention and concentration;

Self-perception;

Perception of perpetrator;

Relationships with others;

Somatic complaints; and

Systems of meaning

There are a number of different types of trauma, over and above child abuse that are also associated with Complex PTSD. It usually involves long-term trauma, and the victim is in a state of captivity. The perpetrator is in control of the victim who is, for a variety of possible reasons, unable to escape their situation.

Examples of such traumatic situations include (Slone & Whealin, 2007):

Concentration camps,

Prisoner of War camps,

Prostitution,

Long-term domestic violence,

Long-term child physical abuse,

Long-term child sexual abuse, and

Organized child exploitation rings

The term Complex Posttraumatic Stress Disorder (CP) is used to refer to a symptom constellation often seen in individuals who have experienced chronic and multiple traumas either in childhood or in adulthood (Herman, 1992). A study conducted by Cloitre et. al. (2009) on childhood and adult cumulative trauma as predictors of symptom complexity, indicates that “childhood cumulative trauma is associated in a rule-governed way to a complex symptom set, and that childhood cumulative trauma significantly influences the presence of these symptoms in adulthood” (Cloitre, Stolbach, Herman, Van Der Kolk, Pynoos, Wang & Petkova, 2009, p. 7). What this means is that, adults are more likely to suffer from symptoms of complex trauma in adulthood when they have been exposed to both cumulative and chronic trauma in both childhood and adulthood.

Individuals with Complex Posttraumatic Stress Disorder often display a variety of symptomatic and pathological behaviours, rather than one dominant set of symptoms. They typically report alterations in attention, consciousness, self-perception, perception of the perpetrator, dysregulation in relations with others, somatisation and dysregulation of systems of meaning (Van Der Kolk, et.al, 2005).

“The DSM-IV field trial for PTSD supported the notion that trauma, particularly trauma that is prolonged, that first occurs at an early age and that is often of an interpersonal nature, can have significant effects on psychological functioning above and beyond PTSD symptomology” (Van Der Kolk, et.al 2005, p. 394).

A field trial set out by Van Der Kolk et.al (2005) demonstrated that

α. Early personal traumatisation gives rise to more complex post-traumatic psychopathology than later interpersonal victimisation.
β. These symptoms occur in addition to PTSD symptoms and do not necessarily constitute a separate cluster of symptoms.
χ. The younger the age of onset of the trauma, the more likely one is to suffer from the cluster of DESNOS symptoms in addition to PTSD.
δ. The longer individuals were exposed to traumatic events, the more likely they were to develop both PTSD and DESNOS.
ε. Although the community sample and the treatment seeking sample had approximately the same prevalence of PTSD symptoms, almost half of the treatment seeking sample also met criteria for DESNOS, suggesting that DESNOS symptoms rather than PTSD may cause patients to seek treatment.

Fact check

Question 1

According to Friedman, Keane & Resick, (2007) complex trauma begins during adolescence and within the primary caregiving system

True/False

Chronic trauma happens over an extended period of time;

True/False

CP has a specific and easily identifiable set of symptoms

True/False

Question 2

Name 7 different types of traumatic exposure: (Can you think of any other examples?)

Reflection and analysis

Complex posttraumatic stress disorder is a relatively new concept; write a clear and concise definition that captures the essence of each of the given definitions.

3. Features of Complex Trauma

The symptom set known as Complex Posttraumatic Stress Disorder is believed to be the result of chronic and multiple traumas, especially during childhood. The nature of complex trauma leads to a difference in both the severity of symptoms and their ability to disrupt the individual's ability to display appropriate affect and interpersonal domains. The symptoms that may be presented include those of Posttraumatic Stress Disorder, but extend further to difficulties in self-regulation, particularly in the areas of affect, dissociation, anger management and socially avoidant behaviour. The effects of trauma are best understood as a result of disturbances in self-regulatory capacities, as this illustrates the numerous, diffuse and often contradictory symptoms of complex PTSD (Cloitre, et. al., 2009).

"When traumatised individuals feel out of control and unable to modulate their distress, they are vulnerable to resorting to pathological self-soothing behaviours, such as substance abuse, binge eating, self-injury, or clinging to potentially dangerous partners" (Van Der Kolk, 2002, p. 144). As with PTSD the majority of chronically traumatised clients tend to spend a large amount of time avoiding the symptoms associated with complex PTSD. This is sometimes achieved by locating a person, boyfriend, girlfriend, family member, or often a therapist, who can assist them in doing what their early caregivers, could not, which is to provide comfort and safety at critical moments (Van Der Kolk, 2002).

According to Judith Herman (1992) the features of complex trauma can be categorised into seven clusters: dysregulation of affect and impulses; alterations in attention or consciousness; alterations in self- perception and perception of the perpetrator; dysregulation in relations with others; somatisation, and dysregulation of systems of meaning (Herman, 1992).

- *Dysregulation of affect and impulses* can be categorised by persistent dysphoria, chronic suicidal preoccupation, self injury, explosive or extremely

inhibited anger and compulsive or extremely inhibited sexuality (Herman, 1992).

- *Alterations in attention and consciousness* include, but are not limited to; amnesia or hyper-amnesia for traumatic events, transient dissociative episodes, depersonalisation or derealisation, and reliving experiences with intrusive PTSD symptoms or ruminative preoccupation (Herman, 1992).
- *Alterations in self-perception* include such changes as a sense of helplessness or paralysis of initiative, shame, guilt, self-blame, a sense of defilement or stigma, a sense of alienation or isolation from others (Herman, 1992).
- There are also alterations in the *perception of the perpetrator* these can include; a preoccupation with the relationship with the perpetrator, unrealistic attribution of total power to the perpetrator; idealisation of the perpetrator or paradoxical gratitude, a sense of a special or supernatural relationship with the perpetrator and an acceptance of the belief system or rationalisation of the perpetrator (Herman, 1992).
- *Dysregulation in relations with other people* may include; isolation and withdrawal, a disruption in intimate relationships, often a repeated search for a rescuer, persistent distrust, repeated failures in self protection (Herman, 1992).
- *Dysregulation of systems of meaning* may include a loss of sustaining faith, and a sense of hopelessness and despair (Herman, 1992).

4. Treatment of Complex trauma

Due to the complicated nature of complex PTSD, the treatment itself is complex and intricate. There is no generic model for treating people suffering from this disorder. However, the literature provides guidelines set out by various therapists in different models of treatment to assist practitioners and their clients in the healing process.

“Teaching terrified people to safely experience their sensations and emotions has not been given sufficient attention in mainstream trauma treatment. With the advent

of effective medications, such as the selective serotonin reuptake inhibitors, medications increasingly have taken the place of teaching people skills to deal with uncomfortable physical sensations" (Van Der Kolk, 2002, p. 144).

Holding, hugging and rocking are some of the most natural methods people use to relax and calm themselves down when feeling anxious or overwhelmed, which appears to assist them in overcoming excessive arousal, possibly as this would aid them in feeling more grounded and present centred. This desire for physical comforting is more often than not reawakened when traumatised individuals enter relationships where these experiences of threat and abandonment are re-examined (Van Der Kolk, 2002).

In a therapeutic setting, patients, with histories of physical and sexual abuse, that act on those yearnings for physical comforting, are more likely to regress back to a state of confusion between what is safe and what is a violation, rather than to heal. The central therapeutic task should be to assist patients in tolerating those feelings and sensations associated with their trauma, as well as assisting them in developing and nurturing relationships in which these feelings can be safely expressed (Van Der Kolk, 2002).

Literature confirms that treatment of complex trauma should initially be symptomatic, dealing with current issues such as dysregulation of emotion or alterations in relations with others, before engaging in trauma exposure, as these symptoms are more likely to interfere with daily functioning (Van der Kolk et. al, 2005).

Connor and Higgins (2008) developed the "HEALTH" model for the treatment of Complex PTSD, which had two major influences: Connor and Higgins' own personal experiences with dealing with survivors of complex trauma and people suffering from complex PTSD (Connor & Higgins, 2008) as well as Herman (1992) writing on the matter. The treatment program guidelines for treating Complex PTSD are presented here as a broad framework, rather than as a prescriptive step-by-step therapeutic process. However, within the framework, there is scope for catering for individual needs. The guidelines are based on a 6-stage model of treatment.

4.1. The six stages form the acronym ‘‘HEALTH’’:

- 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).

Each stage is explained below (Connors and Higgins, 2008):

Stage 1: Having a supportive and experienced therapist

Having a therapist who is skilful in building rapport and providing a supportive environment for vulnerable clients is important for survivors of Complex Trauma. The therapist, should have extensive experience in working with sufferers of long-term and multiple forms of trauma, adhere to relevant codes of professional and ethical codes for conduct and will also need to be available on a regular basis and over a long period of time to allow for sufficient “ego strengthening” to take place. Supervision is recommended for clinicians who are new to the field of trauma by professionals who have extensive experience in the field.

Stage 2: Ensuring personal Safety

“The inclusion of an initial stage, which ensures that the client develops effective safety strategies, is vital to the success of all ongoing work”. It has been found that survivors of childhood abuse are likely to become involved in a range of self-destructive and dysfunctional behaviours. Self-mutilation (non-lethal) is common, as is substance abuse, eating disorders and addiction to risk-taking behaviours in

survivors of childhood abuse. Re-victimisation (i.e. further experiences of childhood abuse and/or sexual assault in adulthood) is also very common.

Inadequate self-care through both self-destructive behaviour and vulnerability to re-victimisation needs to be controlled prior to the beginning of exploratory therapy, if this does not occur, the likelihood of serious self-harm when traumatic material is re-visited, is high. Thus, it is important that abuse survivors create an environment of personal safety prior to any therapeutic work relating to past abuse. It is also important that the therapist assists the client in developing a comprehensive safety plan so that he/she can feel free from harm or the immediate threat of harm in five areas: physical, emotional, psychological, sexual and spiritual.

Stage 3: Assisting with Daily Functioning

Once the client has developed a safety plan and committed to principles of self-care that he/she developed with the therapist, it is important to assist them in certain aspects of their daily functioning. Normal day-to-day functioning has been over shadowed by the reality of trauma and the re-experiencing of that trauma by clients who have suffered long-term or multiple experiences of trauma. Maintaining an appropriate level of functioning is imperative to the success of the therapy. Therefore, regular activities such as hobbies, social events and a job should be encouraged by the therapist to help provide a much-needed daily structure as well as to assist with social networking opportunities.

The therapist should also offer relaxation tips or advice as well as sleep-enhancing strategies to assist the client in resting and relaxing effectively which will in turn assist the client in maintaining an adequate level of functioning.

Stage 4: Learning to Manage Core PTSD Symptoms (Self-regulation)

It is vitally important that once the client has reached an adequate level of functioning, that the therapist assists with modulating and controlling the symptoms

of PTSD. Symptoms of core PTSD include re-experiencing the trauma (in the form of flashbacks, intrusive thoughts, and nightmares), amnesia, dissociation, depersonalisation, de-realisation, abrupt state changes, hyper-vigilance and hyperarousal. Through a range of behavioural interventions, such as grounding, self-regulation, relaxation and stress reduction, control of these symptoms can be achieved.

It is useful to think of the treatment of core PTSD symptoms listed as a form of self-regulation. Self-regulation is a term that is used to describe the process of becoming more aware of feelings and emotions and other internal experiences, and managing the intensity of these feelings and emotions so that they do not dominate the clients' life. Self-regulation is really self-management, as the skills learned can help the client tolerate (or ''sit with'') and control the emotions that may have previously led to avoidance. This will in turn, help to reduce the frequency and intensity of traumatic stress symptoms and experiences. Self-regulation is included as a separate stage of treatment to ensure that when clients reach this stage, they are able to achieve their goals more easily, due to increased feelings of safety and improved daily functioning.

Stage 5: Treating CP symptoms

Treating the complex PTSD symptoms is the main focus of the model of treatment. The focus of the work and the speed and order in which an individual proceeds will depend on the needs of the individual in therapy. Areas that may need further work include: affect regulation, self-perception, perception of the perpetrator, interpersonal relations, somatic concerns and systems of meaning.
Clients need to prioritise their symptoms through discussing them and their prevalence. From there, the treatment guidelines can be drawn up so that the client is aware of the process that is to follow. This is an important part of the HEALTH model as it provides the client with information as well as helps in creating a safe and secure environment between therapist and client.

Stage 6: Having patience and persistence in enabling ‘‘ego strengthening’’

Often when clients experience setbacks in the treatment process, they feel discouraged and the prospect of change in their lives diminishes. Thus, it is important for therapists to re-assure clients that change often only occurs after a number of therapy sessions and that setbacks can happen. By reminding the client of the changes that have already taken place since the start of their therapy sessions, as well as the fact that becoming healthier and stronger will take time, the therapist can help to counteract any discouragement felt by the client due to a setback.

> “Self-analysis is a useful starting point in ‘‘ego strengthening’’ and can be used to help clients examine and identify their strengths and weaknesses and gain a healthy self-knowledge. Affirmations can be used to assist clients reinforce positive self-messages and these can be reinforced with hypnotherapy. Cognitive strategies such as cognitive restructuring or cognitive reframing are also appropriate in assisting clients provide themselves with self-appraisals that are more realistic. Assisting clients with taking a more pro-active role in changing behaviours that they see as undermining their capacity to move forward can also be useful in gaining a sense of empowerment when a change takes place” (Connors and Higgins, 2008, p300).

Cook et al. (2007) listed six core components for the treatment of complex PTSD in children and adolescents:

1. *Safety:* Creating a home, school, and community environment in which the child feels safe and cared for.
2. *Self-regulation:* Enhancing a child’s capacity to modulate arousal and restore equilibrium following dysregulation of affect, behaviour, physiology, cognition, interpersonal relatedness and self-attribution.
3. *Self-reflective information processing:* Helping the child construct self-narratives, reflect on past and present experience, and develop skills in planning and decision making.

4. *Traumatic experiences integration:* Enabling the child to transform or resolve traumatic reminders and memories using such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behaviour.
5. *Relational engagement:* Teaching the child to form appropriate attachments and to apply this knowledge to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social empathy, and the capacity for physical and emotional intimacy.
6. *Positive affect enhancement:* Enhancing a child's sense of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, and competence, mastery-seeking, community-building and the capacity to experience pleasure.

There are a number of similarities between the HEALTH model and the core components as set out by Cook et al. (2007). A few key themes are present in the two models these being: establishing a safe environment for the client, and restoring self-regulation and ego strengthening or positive affect enhancement.

5. Differential Diagnoses

"Histories of childhood physical and sexual assaults are associated with a host of other psychiatric problems in adolescence and adulthood: substance abuse, Borderline and Antisocial Personality, as well as eating, dissociative, affective, somatoform, cardiovascular, metabolic, immunological and sexual disorders" (Van Der Kolk et. al, p. 390, 2005).

Complex Posttraumatic Stress Disorder and Borderline Personality Disorder share a number of symptoms. Both of these disorders tend to arise out of traumatic

experiences. However, there is a distinct difference between these disorders. Complex PTSD occurs as a result of chronic and repeated abuse, often in a situation of captivity, such as kidnappings, prisoner of war camps, domestic abuse, and child abuse (Herman, 1992), while Borderline personality disorder is most commonly associated with child abuse (Borderline Personality Disorder Help, 2010).

In Complex PTSD victims are often exposed to their perpetrators' belief systems and ideals, and more often than not are able to understand and sympathise with the perpetrator. As a result of the situation of captivity and trauma, victims come to idealise the perpetrator seeing them initially as bad, but after long term exposure their perception of the perpetrator becomes more positive (Herman, 1992).

This set of perceptions tends to be completely reversed in people with Borderline Personality Disorder, as these people are more likely to initially perceive other people as good, until they are disappointed by the individual, who they will then perceive more negatively. As is common with people with Borderline personality disorder perceptions of others range from one extreme to the other often with no in-between (Borderline Personality Disorder Help, 2010).

Patients suffering from both Borderline Personality disorder and Complex PTSD hold the belief that they are special somehow. However, they differ in the sense that people with Borderline Personality Disorder are found to be more narcissistic, while persons with Complex PTSD believe or feel that they are special because they have an in-depth understanding of their perpetrator (Borderline personality disorder help, 2010).

Other similarities between Borderline Personality Disorder and Complex PTSD include, but are not limited to, self-mutilation, suicidal ideation, suicide attempts, mood swings, aggression and aggressive behaviour, depersonalisation, dissociative amnesia, derealisation, depression, disrupted relationships, disturbances and distortion in self-image, self-blame and guilt (Borderline personality disorder help, 2010).

Most people present with depression and anxiety initially after experiencing a traumatic experience. However, people with Complex PTSD are more likely to become aggressive following this initial reaction, whereas people with Borderline Personality Disorder are more likely to be depressed (Borderline personality disorder help, 2010).

Fact check

Question 1

Traumatised individuals who feel out of control can resort to self-soothing behaviour such as substance abuse and binge eating

True/False

Victims of complex PTSD can never understand their perpetrators system of beliefs and are unable to identify with them

True/False

There is only one way to treat childen and adlescence who have been eposed to complex trauma and that is through Cook et al. (2007) six core components for the treatment of PTSD.

True/False

Question 2

List the 7 clusters of features of complex trauma and explain them briefly;

What are the 6 stages of the “HEALTH” model?

Reflection and analysis

List the similarities and differences between Borderline personality disorder and Complex Posttraumatic Stress Disorder:

Similarities	**Differences**

6. Complex Trauma and DSM-V

Very little attention has been given to the relationship between PTSD, Complex PTSD and multiple other symptoms associated with early and prolonged trauma. Research has shown that the effects of multiple or repeated forms of trauma in childhood, tend to be both more severe and qualitatively different in their presentation to single incident traumas, as chronic trauma affects multiple affective and interpersonal domains (Van Der Kolk, 2005).

Van Der Kolk, recognising the impact that chronic trauma can have on people, especially repeated and long term trauma beginning in early childhood, has proposed a new diagnostic category, Developmental Trauma Disorder, to account for the complex symptom profiles of chronically traumatised children (Cloitre, et. al, 2009).

Miller, Resick and Keane (2009) believe that the most appropriate location for PTSD in the DSM-V is not under the Anxiety Disorders as it is currently in the DSM-IV. They argue that PTSD should be part of a class of disorders precipitated by serious and negative life events. This would include Complex PTSD, Acute Stress Disorder, Adjustment Disorder and a Traumatic Grief or bereavement-related diagnosis. Their argument for this placement is that the majority of disorders currently in the DSM-IV-TR are classified descriptively as opposed to aetiologically. PTSD is one of the most obvious exceptions to the descriptive classification as PTSD, by definition, specifies a causal relationship between trauma exposure and symptom development. These disorders are collectively a result of an environmental pathogen, or traumatic stressor that can have a unique affect on people, depending on their vulnerability to psychopathology (Miller, Resick & Keane, 2009).

Conclusion

Complex Posttraumatic Stress Disorder carries with it issues of both diagnosis and treatment of the disorder. This is as a result of the similarities between Complex PTSD and other disorders such as PTSD and Borderline Personality Disorder. The similarities and differences between these disorders have been highlighted in this course. The definitions of Complex PTSD as viewed by a variety of authors have been discussed, as well as the features of the disorder and the treatment options. Also proposals of Complex PSTD for inclusion in the DSM-V have been discussed.

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