
COMMENT

Simplifying Complex PTSD: Comment on Resick et al. (2012)

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Although constructs related to complex posttraumatic stress disorder (CPTSD) have been discussed for many years, the field still lacks reliable and standardized definitions to guide research in this field. This comment responds to the article by Resick et al. (2012), who conclude that CPTSD lacks sufficient support to be recognized as a diagnosis. Even though there is no doubt that research is lacking, this comment argues that the key to progressing the field is introducing a standardized definition that will allow researchers to understand CPTSD in relation to other trauma-related disorders, identify key mechanisms driving the condition, and further treatment programs specifically for patients with CPTSD.

Resick and colleagues (2012) provide a timely overview of the merits and flaws with the construct of complex posttraumatic stress disorder (CPTSD), with particular emphasis on whether we know enough to warrant its recognition in *DSM-5*. The underlying problem in this debate is the definition of CPTSD. It does not exist as a diagnostic category, has not been formally defined as a set of symptoms, and no standardized measurement tools exist. This creates problems for the evaluation of the construct; in fact, this problem is reflected throughout the review by Resick et al. (2012). Although this critique criticizes the construct for being poorly defined, it nonetheless draws on a very broad range of evidence on the basis of search terms that included CPTSD, disorders of extreme stress, not otherwise specified (DESNOS), complex trauma, posttraumatic personality disorder, and personality change after a catastrophic event; these terms encompass many constructs and some of the evidence cited is not directly applicable to the issue of CPTSD. It seems ironic that the authors criticize the construct of CPTSD for its lack of clarity; nevertheless, they proceed to rely on loosely related evidence drawn from a body of work that is not directly defined as CPTSD to make their case. The reliance by these authors on these terms, however, reflects how our field has not empirically operationalized the construct adequately.

Although Resick et al. (2012) recognize the need to understand these more complicated cases better, they conclude that (a) there is not enough evidence to validate the construct as a

separate entity, (b) we do not know enough about CPTSD to warrant inclusion in *DSM-5*, and (c) current treatments appear equally valid for less and more complicated presentations of PTSD.

In terms of the first point, the authors appear to miss a fundamental point that is central to the argument for this condition; it is a *variant* of PTSD (Cloitre et al., 2011). They note that there is much overlap between CPTSD and other disorders, including PTSD, major depressive disorder (MDD), and borderline personality disorder (BPD). They point out that CPTSD lacks discriminant validity insofar as there is much overlap between PTSD and CPTSD—of course there is overlap because CPTSD requires PTSD to be present: It is a complex variant of PTSD. They are critical of the overlap of emotion dysregulation in PTSD, MDD, and BPD. Emotion dysregulation can in fact be present in nearly every psychiatric condition, but it is not essential. The distinguishing feature of CPTSD is that it *requires* emotion dysregulation to be a primary problem in association with PTSD presentations, and it is this presentation that distinguishes it from other PTSD presentations. Similarly, although PTSD symptoms are common in BPD, they are not central or necessary in BPD. This is an important distinction between CPTSD and BPD. Having said that, Resick and colleagues (2012) do make a cogent argument that the clear conceptual and operational distinctions between CPTSD and BPD have yet to be empirically clarified.

This raises a pivotal issue in terms of whether CPTSD is ready for diagnostic status. Can we define it in a standardized way so we understand what its underlying constructs, mechanisms, and distinctiveness from related conditions are? One of the problems in which these authors address this issue is the emphasis they place on the nature of the traumatic event in defining and validating CPTSD, to the point of highlighting that because multiple prior traumatic events (including

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childhood ones) have been shown to be a risk factor for the current PTSD diagnosis, there is a need to demonstrate that this form of trauma leads to qualitatively different symptom patterns not captured by current diagnoses. Given what we now know about the variable responses of trauma exposure, including childhood abuse, it seems inappropriate to place such emphasis on an historical event rather than symptom presentation when defining the syndrome. Although certain characteristics seem to be associated with development of CPTSD, such as prolonged uncontrollability, there is no doubt that these factors interact with genetic and constitutional variables to influence final symptom presentation. Any diagnostic framework must be based on empirically established *symptoms* rather than a simple linear link to a number of types of traumatic events. Initial work done in this area largely arose from observations of the pervasive effects of childhood abuse on development, and so it appears that childhood abuse has taken on the role of being a defining cause of CPTSD presentations. More recent work has noted CPTSD can occur following a range of adult experiences, including war, civil conflict, torture, and other experiences involving pervasive loss of control over aversive consequences. Defining the constellation of symptoms is essential for CPTSD to be properly categorized in relation to both its underlying features, mechanisms, and relationship to other disorders.

Resick et al. (2012) argue correctly that the argument for a construct of CPTSD rests largely on the utility for treatment options. They conclude, however, that there is no evidence that treatments specifically designed for CPTSD have been shown to be effective. This argument is based largely on the premise that treatment studies have not used appropriate entry criteria to identify patients as suffering from CPTSD. As noted above, this is the problem underpinning the debate. The authors dismiss the importance of the Cloitre et al. (2010) study, which tailored cognitive-behavioral therapy (CBT) by preparing PTSD survivors of childhood sexual abuse with skills to compensate for emotion dysregulation. This study found that not only did preparing CBT with skills result in superior treatment gains relative to standard CBT, it actually assisted patients to not deteriorate in the period following treatment. Although it is true

that this study did not formally recruit patients with CPTSD, this is a difficult task when the formal criteria do not actually exist. This trial, however, provides powerful evidence that survivors of CSA (half of whom had Axis II disorders), benefited more from a treatment that targeted the hypothesized dysfunction in CPTSD than those receiving standard CBT. It needs to be understood that this population can be resistant to treatment, and interventions that address their difficulties in responding to traditional PTSD therapy is an important public health issue.

There is little doubt that the conclusion by Resick et al., (2012) that there are numerous gaps in our knowledge about CPTSD, is correct. One of the first priorities is to determine a standardized definition for it to be studied by various teams around the world to understand its relationship to PTSD, BPD, and other trauma-related conditions. We cannot dismiss the emerging evidence, however, that does attest to the additive gains to efficacy of treatments that target emotion dysregulation in more complicated cases of PTSD. As we have learned from many previous conditions, it is often only when we recognize a condition that research can progress and we can understand its features, mechanisms, distinctiveness, and treatment needs. Stating that “we need more research” is not enough; we need a formal definition of CPTSD, even it is not a *DSM-5* category, to ensure that researchers can study these PTSD presentations in standardized ways so that field progresses empirically rather than relying on clinical experience or expert opinion.

References

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