

## Introduction to the Special Feature on Complex PTSD

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This issue contains a Special Feature—an example of the changes I pledged when I took over editorship of the *Journal of Traumatic Stress* (*JTS*; Weiss, 2011)—a discussion and analysis of the current status of complex posttraumatic stress disorder (CPTSD) with regard to the *DSM-5*. Spurred by a report on best practices for clinicians from the International Society for Traumatic Stress Studies (ISTSS) Task Force for CPTSD (Cloitre et al., 2011), I invited Resick et al. (2012a) to submit a comprehensive review of the literature about CPTSD. The reviews of that manuscript that I solicited evolved into a set of comments (Bryant, 2012; Goodman, 2012; Herman, 2012; Lindauer, 2012) and, as is *JTS* policy, Resick et al. (2012b) were offered and accepted the chance to craft a reply.

The status of CPTSD is controversial, and as the contributions note, the controversy is not new. My goal in placing the articles in *JTS* was to stimulate discussion and thought about CPTSD, the nature of evidence, the nature of mental health diagnosis and mental health disorder, and finally the role that official and organized institutions (the American Psychiatric Association [APA] and the World Health Organization [WHO]) play in the advancement of understanding and in the shaping of research and scientific agendas. At the very least, I have been successful in that goal in one case: As I edited the contributions my thinking about these matters stimulated my decision to craft the Editorial included in this issue. I am hopeful that authors of empirical work addressing one or more of the many questions raised in this set of articles will help *JTS* present these issues to our readership and the field over the next several years.

I want to make explicit that the appearance of the extended review by Resick et al. (2012a) does not constitute either an endorsement or rejection of its conclusion, any more than the appearance of the comments represent an endorsement or rejection of their conclusion(s). I have my own thoughts about the conceptual approach, and these are set forth in the Editorial, but

they are my own and not to be taken in any way as an official position of ISTSS.

I would be remiss, however, not to offer one observation here about the ripeness of CPTSD to be included in the *DSM-5*. If the standards for the evidence base and established measures that Resick et al. (2012a) appear to require for CPTSD had been applied during the *DSM-III* APA committee meetings of the late 1970s to the decision to include PTSD in the *DSM-III*, it could not have been included. At that time, there was not a single published measure of PTSD symptoms; the earliest, the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979), had not yet appeared. A search of PsychINFO<sup>®</sup> and PILOTS fails to show a single article prior to 1980 with PTSD (or its variants) in the title. As well, there was only a small somewhat disconnected and scattered literature on stress response syndromes and their more event-specific exemplars such as rape trauma (see van der Kolk, 2007). The advance in the *DSM-III* was to foster just the solidification in the evidence that Resick et al. describe. As a consequence, subsequent revisions of the *DSM* used that evidence to modify the criteria based on the literature that had been spawned by its inclusion. The same process could happen for CPTSD. As of this writing, the alpha version of the current revision of the WHO (n.d.) *International Classification of Diseases*, the 11th revision, includes two traumatic stress disorders: post-traumatic [sic] stress disorder and complex post-traumatic stress disorder.

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