Journal of Traumatic Stress
June 2012, *25,* 256–257

ISTSS International Society for Traumatic Stress Studies

COMMENT

CPTSD is a Distinct Entity: Comment on Resick et al. (2012)

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The concept of complex posttraumatic stress disorder (CPTSD) is both conceptually and clinically useful. This distinct entity is highly prevalent, across different cultures, in survivors of prolonged, repeated trauma. Recognition of this entity as part of the spectrum of traumatic disorders would promote development of effective treatment.

Although a comprehensive and even-handed review of the literature on complex posttraumatic stress disorder (CPTSD) would be very timely and useful, unfortunately, in my opinion, the Resick et al. (2012) review is neither comprehensive nor even-handed. Rather, it reads like a position paper, marshaling whatever arguments it can against inclusion of CPTSD as a distinct subtype in the *DSM-5*. The authors arbitrarily set a standard for inclusion that requires a very high level of research development, and then predictably, demonstrate that their chosen standard has not been met.

There is no dispute as to the need for more sophisticated research, both in measure development and in treatment outcome especially. The question is whether, as a practical matter, such research can be expected ever to develop without recognition of CPTSD as a distinct entity. The history of the field to date would suggest that such recognition is generally a precondition for development of the kind of research that all agree is needed.

A comprehensive review of the CPTSD literature would also require consideration of three major issues that are not addressed at all in the Resick et al. (2012) review. The first concerns the estimated high prevalence of CPTSD. It is now generally recognized that the majority of trauma patients are multiply traumatized (Kessler, 2000). CPTSD symptoms are common in trauma populations (Ford & Smith, 2008; Zlotnick et al., 1996). In the *DSM-IV* field trials, a multisite study of subjects with histories of trauma, the lifetime prevalence of PTSD alone was 20%, but the prevalence of PTSD and CPTSD was 34%. CPTSD was specifically associated with early onset and long duration of trauma; it was very rarely found in survivors of natural disasters, and very commonly found in survivors of childhood abuse (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). These symptoms are recognized cross culturally, with high prevalence in postconflict settings (De Jong, Komproe, Spinazzola, van der Kolk, & van Ommeren, 2005) and among survivors of mass violence (Hinton & Lewis-Fernandez, 2011).

A second consideration is the clinical significance and utility of the CPTSD concept. It has been well documented that CPTSD symptoms account for much of the functional impairment in survivors of prolonged and repeated trauma, above and beyond the impairments attributable to PTSD alone (Cloitre, Miranda, Stovall-McClough, & Han, 2005). Treatments proven to be effective for PTSD alone may be inadequate, or possibly even harmful, for CPTSD (Ford & Kidd, 1998; Hembree, Street, Riggs, & Foa, 2004; McDonough et al., 2005; Schnurr et al. 2007). On this point, the review is particularly selective, citing only those studies that would seem to indicate that existing exposure-based treatments are both sufficient and benign. Even within this restricted literature, however, it is unclear whether the existing treatments cited were indeed effective for CPTSD symptoms because outcomes were commonly assessed by measures of PTSD alone.

A recent well-controlled study provides strong evidence that a staged treatment, one that addresses CPTSD symptoms of affect dysregulation and problems in interpersonal relationships before engaging in trauma-focused exposure, proves more effective in sequence than either component separately (Cloitre et al, 2010). The results of this study would suggest that recognition of CPTSD as a distinct entity leads to clinically significant advances in effective treatment for a broader population (e.g., Bryant, 2010). Rather than acknowledging the promise of this study, however, the authors are remarkably dismissive.

Third and last, there is the matter of conceptual utility. The CPTSD concept is more parsimonious than the concept of multiple comorbidities. Although CPTSD shares some features

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DOI: 10.1002/jts.21697

with several other psychiatric disorders, it is not congruent with any one. The Venn diagram in the Resick et al. (2012) article illustrates this concept nicely (though it lacks an overlapping circle representing the dissociative disorders).

Although the authors briefly touch on the issue of parsimony, they do not begin to address the practical clinical problems that arise from a failure to recognize CPTSD as a single diagnostic entity. The alternative to one parsimonious diagnosis is multiple comorbid diagnoses and multiple overlapping treatment protocols. In practice, this leads to polypharmacy and inefficient, poorly tailored psychotherapy. To suggest that this problem would be solved by better training for clinicians is to miss the point entirely.

The authors do acknowledge that the PTSD diagnosis alone may fail to capture the heterogeneity of adaptation to trauma. Another way of formulating this idea might be to recognize a spectrum of posttraumatic disorders. A number of recent studies develop the concept of a dissociative "subtype" of PTSD (Ginzburg et al., 2006; Lanius et al., 2010). Recognition of CPTSD as a subtype of PTSD might expand the dimensional concept of a posttraumatic spectrum. This might be a fruitful path toward the development of consensus.

Recognition of CPTSD as a discrete entity, within a spectrum of posttraumatic disorders, would also be likely to expand research in exactly the domains that Resick et al. (2012) recommend: more precise descriptive definition of the disorder, including symptom thresholds, more precise and well-validated measures, and ultimately the development of more gold-standard treatments.

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