Complex post-traumatic stress disorder (C-PTSD) is a psychological injury that results from protracted exposure to prolonged social and/or interpersonal trauma with lack or loss of control, disempowerment, and in the context of either captivity or entrapment, i.e. the lack of a viable escape route for the victim. C-PTSD is distinct from, but similar to, posttraumatic stress disorder (PTSD). Though mainstream journals have published papers on C-PTSD, the category is not formally recognized in diagnostic systems such as DSM or ICD.[1]

C-PTSD involves complex and reciprocal interactions between multiple biopsychosocial systems. It was first referred to by Judith Herman in her book *Trauma & Recovery* and an accompanying article.[2][3] Forms of trauma include sexual abuse (especially child sexual abuse), physical abuse, emotional abuse, domestic violence or torture.[4][5]

**Contents**

- 1 Differentiating PTSD from C-PTSD
- 2 Differentiating Traumatic grief from C-PTSD
- 3 Attachment theory, BPD and C-PTSD
- 4 Child and adolescent symptom cluster
- 5 Adult symptom cluster
- 6 Treatment for adults
- 7 Treatment for children
- 8 See also
- 9 References
- 10 Further reading
- 11 External links

**Differentiating PTSD from C-PTSD**

*Main article: Posttraumatic stress disorder*

A differentiation between the diagnostic category of C-PTSD and that of posttraumatic stress disorder (PTSD) has been suggested. C-PTSD better describes the pervasive negative impact of chronic repetitive trauma than does PTSD alone.[6][7]

PTSD descriptions fail to capture some of the core characteristics of C-PTSD. These elements include captivity, psychological fragmentation, the loss of a sense of safety, trust, and self-worth, as well as the tendency to be revictimized, and, most importantly, the loss of a coherent sense of self. It is this loss of a coherent sense of self, and the ensuing symptom profile, that most pointedly differentiates C-PTSD from PTSD.[8]

C-PTSD is characterized by pervasive insecure, often disorganized-type attachment.[9] DSM-IV dissociative disorders and PTSD do not include insecure attachment in their criteria. As a consequence of this aspect of C-PTSD, when some adults with C-PTSD become parents and confront their own children's attachment needs, they may have particular difficulty in responding sensitively especially to their infants' and young children's routine distress—such as during routine separations, despite these parents' best intentions and efforts.[10] And this difficulty in parenting may have adverse repercussions for their children's social and emotional development if...
Differentiating Traumatic grief from C-PTSD

Main articles: Grief and Grief counseling

Traumatic grief\(^{11}\)\(^{12}\) or complicated mourning\(^{17}\) are conditions\(^{18}\) where both trauma and grief coincide. If a traumatic event was only life threatening then more likely the survivor will experience post-traumatic stress symptoms. If the survivor was close to the person who died, then more likely symptoms of grief will also develop. When the death is of a loved one and was sudden or violent then both symptoms coincide. This is likely in children exposed to community violence.\(^{19}\)

For C-PTSD to manifest the violence would occur under conditions of captivity, loss of control and disempowerment, coinciding with the death of a friend or loved one in life threatening circumstances. This again is most likely for children and stepchildren who experience prolonged domestic or chronic community violence that ultimately results in the death of friends and loved ones. The phenomena of the increased risk of violence and death of stepchildren is referred to as the Cinderella effect.

There are conceptual links between trauma and bereavement since loss of a loved one is inherently traumatic.\(^{20}\)

Attachment theory, BPD and C-PTSD

Main articles: Attachment theory and Borderline personality disorder

See also: Attachment in adults, Attachment in children, Attachment disorder, Attachment-based psychotherapy, Cinderella effect, Self-injury, and Emotionally focused therapy

This controversial area\(^{21}\) underlines the fragility of C-PTSD as an empirical diagnostic category separate from PTSD.\(^{22}\)\(^{23}\)

C-PTSD may have originated from observations of acute breakthrough of borderline personality (BPD) symptoms in trauma victims.\(^{\text{citation needed}}\) This could be diagnosed as PTSD with borderline features, where the symptoms of BPD were not sufficient to sustain a (hypothetical) dual diagnosis of BPD and PTSD. C-PTSD may share some symptoms with both PTSD and BPD.\(^{24}\) Judith Herman has suggested that C-PTSD be used in place of borderline.\(^{25}\)

It may help to understand the intersection of attachment theory with C-PTSD and BPD if one reads the following opinion of Bessel A. van der Kolk together with an understanding drawn from a description of BPD:

Uncontrollable disruptions or distortions of attachment bonds precede the development of post-traumatic stress syndromes. People seek increased attachment in the face of danger. Adults, as well as children, may develop strong emotional ties with people who intermittently harass, beat, and, threaten them. The persistence of these attachment bonds leads to confusion of pain and love. Trauma can be repeated on behavioural, emotional, physiologic, and neuroendocrinologic levels. Repetition on these different levels causes a large variety of individual and social suffering. Anger directed against the self or others is always a central problem in the lives of people who have been violated and this is itself a repetitive re-enactment of real events from the past. Compulsive repetition of the trauma usually is an unconscious process that, although it may provide a temporary sense of mastery or even pleasure, ultimately perpetuates chronic feelings of helplessness and a subjective sense of being bad and out of control. Gaining control over one's current life, rather than repeating trauma in action, mood, or somatic states, is the goal of healing.\(^{26}\)\(^{27}\)
Seeking increased attachment to people, especially to care-givers who inflict pain, confuses love and pain and increases the likelihood of a captivity like that of betrayal bonding[28] and of disempowerment and lack of control. If the situation is perceived as life threatening then traumatic stress responses will likely arise and C-PTSD more likely diagnosed in a situation of insecure attachment than PTSD. At what point do the complex, reciprocal biopsychosocial responses to prolonged and extreme abuse evolve into BPD? This may depend on the timing, intensity and duration of the abuse and an as yet unidentified predisposition to BPD that results in a reset of the neuroendocrinologic levels of the body[32] in a self-reinforcing pattern recognisable as the symptom cluster of BPD.

However, 25% of those diagnosed with BPD have no history of childhood neglect or abuse and individuals are six times as likely to develop BPD if they have a relative who was so diagnosed[33] compared to those who do not. One conclusion is that there is a genetic predisposition to BPD unrelated to trauma. Researchers conducting a longitudinal investigation of identical twins found that "genetic factors play a major role in individual differences of borderline personality disorder features in Western society."[29][30]

**Child and adolescent symptom cluster**

Cook and others[31][32] describe symptoms and behavioural characteristics in seven domains:

1. **Attachment** - "problems with relationship boundaries, lack of trust, social isolation, difficulty perceiving and responding to other’s emotional states, and lack of empathy"
2. **Biology** - "sensory-motor developmental dysfunction, sensory-integration difficulties, somatization, and increased medical problems"
3. **Affect or emotional regulation** - "poor affect regulation, difficulty identifying and expressing emotions and internal states, and difficulties communicating needs, wants, and wishes"
4. **Dissociation** - "amnesia, depersonalization, discrete states of consciousness with discrete memories, affect, and functioning, and impaired memory for state-based events"
5. **Behavioural control** - "problems with impulse control, aggression, pathological self-soothing, and sleep problems"
6. **Cognition** - "difficulty regulating attention, problems with a variety of "executive functions" such as planning, judgement, initiation, use of materials, and self- monitoring, difficulty processing new information, difficulty focusing and completing tasks, poor object constancy, problems with "cause-effect" thinking, and language developmental problems such as a gap between receptive and expressive communication abilities."
7. **Self-concept** - "fragmented and disconnected autobiographical narrative, disturbed body image, low self-esteem, excessive shame, and negative internal working models of self".

Source of quotes[33]

**Adult symptom cluster**

Adults with C-PTSD have sometimes experienced prolonged interpersonal traumatization as children as well as prolonged trauma as adults. This early injury interrupts the development of a robust sense of self and of others. Because physical and emotional pain or neglect was often inflicted by attachment figures such as caregivers or older siblings, these individuals may develop a sense that they are fundamentally flawed and that others cannot be relied upon.[34][35]

This can become a pervasive way of relating to others in adult life described as insecure attachment. The diagnosis of dissociative disorder and PTSD in the current DSM-IV TR do not include insecure attachment as a
Symptom. Individuals with Complex PTSD also demonstrate lasting personality disturbances with a significant risk of revictimization.[36]

Six clusters of symptom have been suggested for diagnosis of C-PTSD.[37][38] These are (1) alterations in regulation of affect and impulses; (2) alterations in attention or consciousness; (3) alterations in self-perception; (4) alterations in relations with others; (5) somatization, and (6) alterations in systems of meaning.[37]

Experiences in these areas may include:[7][8]

- Difficulties regulating emotions, including symptoms such as persistent sadness, suicidal thoughts, explosive anger, or covert anger.
- Variations in consciousness, such as forgetting traumatic events, reliving traumatic events, or having episodes of dissociation (during which one feels detached from one's mental processes or body).
- Changes in self-perception, such as a sense of helplessness, shame, guilt, stigma, and a sense of being completely different from other human beings.
- Varied changes in the perception of the perpetrator, such as attributing total power to the perpetrator or becoming preoccupied with the relationship to the perpetrator, including a preoccupation with revenge.
- Alterations in relations with others, including isolation, distrust, or a repeated search for a rescuer.
- Loss of, or changes in, one's system of meanings, which may include a loss of sustaining faith or a sense of hopelessness and despair.

**Treatment for adults**

Herman[39] believes recovery from C-PTSD occurs in three stages. These are: establishing safety, remembrance and mourning for what was lost, and reconnecting with community and more broadly, society. Herman believes recovery can only occur within a healing relationship and only if the survivor is empowered by that relationship.

Complex trauma means complex reactions and this leads to complex treatments. Hence treatment for C-PTSD requires a multi-modal approach.[40] It has been suggested that treatment for C-PTSD should differ from treatment for PTSD by focusing on problems that cause more functional impairment than the PTSD symptoms. These problems include emotional dysregulation, dissociation, and interpersonal problems.[41] Six suggested core components of complex trauma treatment include:[40]

1. Safety
2. Self-regulation
3. Self-reflective information processing
4. Traumatic experiences integration
5. Relational engagement
6. Positive affect enhancement

Multiple treatments have been suggested for C-PTSD. Among these treatments are experiential and emotionally focused therapy, internal family systems therapy, sensorimotor psychotherapy, cognitive behavioral therapy, family systems therapy and group therapy.[42]
Treatment for children

The utility of PTSD derived psychotherapies for assisting children with C-PTSD is uncertain. This area of diagnosis and treatment calls for caution in use of the category C-PTSD. Ford and van der Kolk\[43\] have suggested that C-PTSD may not be as useful a category for diagnosis and treatment of children as a proposed category of DTD (developmental trauma disorder). For DTD to be diagnosed it requires a

'history of exposure to early life developmentally adverse interpersonal trauma such as sexual abuse, physical abuse, violence, traumatic losses of other significant disruption or betrayal of the child's relationships with primary caregivers, which has been postulated as an etiological basis for complex traumatic stress disorders. Diagnosis, treatment planning and outcome are always relational.'\[44\]

Since C-PTSD or DTD in children is often caused by chronic maltreatment, neglect or abuse in a care-giving relationship the first element of the biopsychosocial system to address is that relationship. This invariably involves some sort of child protection agency. This both widens the range of support that can be given to the child but also the complexity of the situation, since the agency's statutory legal obligations may then need to be enforced.

A number of practical, therapeutic and ethical principles for assessment and intervention have been developed and explored in the field:

- Identifying and addressing threats to the child's or family's safety and stability are the first priority.
- A relational bridge must be developed to engage, retain and maximize the benefit for the child and caregiver.
- Diagnosis, treatment planning and outcome monitoring are always relational (and) strengths based.
- All phases of treatment should aim to enhance self-regulation competencies.
- Determining with whom, when and how to address traumatic memories.
- Preventing and managing relational discontinuities and psychosocial crises.\[45\]

See also

- Attachment theory
- Attachment in adults
- Attachment in children
- Child Welfare
- Dyadic developmental psychotherapy
- Trauma model
- Emotional self-regulation
- Stress (biological)
- Posttraumatic stress disorder
- Dissociation
- Bipolar Disorder
- Borderline personality disorder
- Reactive attachment disorder
- Psychoneuroimmunology
- Attachment-based therapy (children)
- Child psychotherapy
- Maladaptive daydreaming
- Play therapy
- Parent-Child Interaction Therapy (PCIT)
- Psychosomatic medicine
- Dyadic Developmental Psychotherapy
- The WAVE Trust

References


15. Traumatic grief (http://www.ctsn-rcst.ca/Traumaticgrief.html)
Further reading


Herman, JL (1997). Trauma and recovery: The aftermath of violence from domestic abuse to political terror. New York: Basic Books.


External links

- Post-traumatic stress (http://www.dmoz.org/Health/Mental_Health/Disorders/Anxiety/Post-traumatic_Stress/) at the Open Directory Project
- Recommended DSM criteria (http://www.sasian.org/papers/cptsd.htm)


Categories: Stress | Abuse | Bullying | Traumatology | Anxiety disorders | Mood disorders | Psychotherapy | Death

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