Complex PTSD: 9 Claims Debunked

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Note: This was originally written as an appendix to Dr. Scheeringa's book *The Trouble With Trauma: The Search to Discover How Beliefs Become Facts* (Las Vegas: Central Recovery Press, 2022). This was not included in the book due to length and being heavy on research detail, so it has been posted separately on Dr. Scheeringa's website.

The purpose of this section is to debunk the claims made by researchers in support of complex PTSD. All of these claims made by the stokers are not important to the relevant science. They are misdirection that has no scientific salience to the notion that complex PTSD might be a real psychiatric disorder. My purpose is to address them so that it is less easy for stokers to claim I have ignored them.

1. Claim by stokers: The current taxonomy system of comorbid disorders is an injustice to patients and a hindrance to clinicians.

Stokers claim that the current taxonomy system is fundamentally wrongly designed. In the current system, when patients meet criteria for two disorders, say, PTSD and depression, they are diagnosed as having two disorders. They are said to be comorbid disorders because they exist simultaneously. An example is when patients are diagnosed with diabetes and high blood pressure separately. The stokers claim that this causes problems to be approached "piecemeal," which causes clinicians to miss the vast system of internal disorganization present in complex PTSD. The taxonomy system itself somehow places blinders on clinicians so that they cannot think straight enough to provide treatment for more than one thing at a time. The taxonomy fails to provide guidelines for treatment.[1]

Their solution is to create a single disorder, complex PTSD, which encompasses nearly all possible combinations of disorders instead of diagnosing patients with more than one disorder. Somehow this magically focuses clinicians' mind on the right treatment. They often say this provides "parsimony," as if parsimony itself is one of the natural laws of medicine. Herman was so vexed by comorbid disorders that she believed it confused clinicians into using multiple, overlapping treatment protocols: "In practice, this leads to polypharmacy and inefficient, poorly tailored psychotherapy."[2] As usual, she had no actual case reports or research data to back that up. It is just something that everybody apparently knows.

The stokers' argument against comorbidity is wrong, not just because they have no evidence to back up their claim, but for a more fundamental reason. The purpose of taxonomies is not to provide treatment guidelines. Treatment guidelines are what clinicians learn during their training. Imagine if someone made a claim that surgeons must learn how to do surgery by reading the taxonomy of disorders that require surgery. Never mind the process of learning by experience or by reading a handbook on, say, surgical technique. Everything the stokers need to know magically comes from the taxonomy.

2. Claim by stokers: PTSD criteria do not list all of the symptoms shown by trauma survivors.

The stokers also critique the current taxonomy system because the diagnostic criteria for PTSD do not capture *all* the symptoms that can develop posttrauma.[3] They imply that because the list of symptoms in the taxonomy is too brief, somehow clinicians fail to recognize all the

important symptoms that need treatment, and they have patients trapped in a wasteland of unending misery, sort of like Odysseus wandering the seas for ten years trying to find his way home. I keep saying that stokers claim this or that happens "somehow" because they so often have failed to provide any concrete evidence to support their theories.

Again, the stokers misunderstand the purpose of taxonomies. Taxonomies are supposed to include the most important and most relevant symptoms that are the most efficient for making a diagnosis. They are not about including the most symptoms. They are about creating the most efficient list of symptoms.

The proper way for clinicians to learn about all possible symptoms is, once again, during their training, experience, and reading of other sources of information (Dean Kilpatrick criticized the supporters of complex PTSD for misunderstanding the purpose of taxonomies in his 2005 article).[4] The definition of PTSD, for example, already includes twenty possible symptoms. Studies have shown that there is no benefit to adding additional symptoms.

3. Claim by stokers: PTSD is not the most common disorder following trauma.

Stokers have often made the rather bizarre claim that we need complex PTSD because PTSD is not even the most common disorder that develops following trauma.[5] Sometimes they do not bother to explain which disorder they believe is the most common disorder, and sometimes they imply that anxiety and depression are most common following trauma, but they fail to provide any corroborating evidence.[6]

The question of which disorder is most common has been explicitly tested several times, and the answer is clearly PTSD. McMillen and colleagues showed this in an adult sample of flood survivors.[7] I showed it in both young children and their mothers who experienced Hurricane Katrina.[8] These studies also showed that anxiety and depression rarely develop in the absence of posttraumatic stress symptoms following trauma. That is, if anxiety and depression develop, it is always concurrent with posttraumatic stress symptoms.

4. Claim by stokers: Treatments studied for PTSD in artificial research trials do not work for complex patients in real life.

Probably the most common claim the stokers make in support of complex PTSD is that clinicians are blinded from seeing the hidden complex PTSD and therefore give patients the wrong treatments, which are harmful. There is absolutely no evidence to suggest this is true. It is true that clinicians commonly give the "wrong" treatments to patients with all types of diagnoses, but this is not because accurate diagnoses were unavailable in the official taxonomy. Clinicians give wrong treatments because of long-standing challenges in quality control and training of therapists, which is a problem across all disorders and nearly all therapists. This argument takes several forms that keep your head swiveling to keep track of.

A representative sample of this strategy is a 2005 review paper authored by Joseph Spinazzola, with van der Kolk as a coauthor, which faulted all existing PTSD treatment trials for excluding patients with more severe, comorbid disorders from their studies.[9] Because these more severe patients were excluded, Spinazzola argued, we do not have data on how well the treatments would work for many of the PTSD patients in the real world. Ipso facto, we must create new treatments for these more severe patients, who, by the way, have the symptoms of complex PTSD. Never mind that complex PTSD has never been validated as a real disorder.

The specific severe, comorbid disorders that Spinazzola believes should be included in treatment studies include bipolar disorder, psychosis, obsessive-compulsive disorder, antisocial

behaviors, alcohol abuse, and suicide attempts.[10] What Spinazzola failed to mention is that these comorbid disorders are excluded from nearly all treatment trials because it would be impossible to treat the primary PTSD condition while those comorbid disorders are overwhelming the patient's current clinical problems.

No clinician in his or her right mind believes you can conduct the cognitive restructuring techniques needed for PTSD with patients who are hallucinating or lack sobriety. That is not only a consideration for a research study; it is exactly how real-life clinicians would handle these patients, which Spinazzola also failed to mention. This is true for all psychiatric treatment studies, not just for PTSD studies.

To stress the absurdity of Spinazzola and van der Kolk's contention, even the studies conducted by their fellow stokers to test new treatments for this population excluded these comorbid disorders.

Spinazzola argued that future studies should include more diverse samples with these more severe, comorbid disorders, so that we can have a true picture of how treatments would work in real life. This is a naïve recommendation, not just because no one in real life would treat patients that way, but also because you can never factor in all of the possible life situations that can hinder treatment. There are many nonpsychiatric issues that hinder treatment, including chronic pain, medical illnesses, the logistics of transportation, work schedules, and spousal relationship problems, to name just a handful. In terms of clinical science, Spinazzola's review paper is so unreasonable as to be amusing. But as a piece of propaganda, it is masterful for sounding like something important is being discussed and making the reader's head swivel to follow the misdirections.

5. Claim by stokers: When patients with complex PTSD are given treatments that work for PTSD, they do not get better.

Stokers argue that we must recognize complex PTSD because patients with complex PTSD do not respond well to treatments that were developed for PTSD alone.[11] The lack of logic mixed with the degree of entitled victimhood for this argument is stunning. The stokers are lamenting that no one has developed treatment protocols for complex PTSD. They blame this on a theory that the only way researchers can develop new treatment protocols is if complex PTSD is officially recognized as a disorder. The lack of logic should be obvious; researchers have never waited around for a problem to be recognized as a disorder before they develop new treatments. The sense of entitled victimhood is evident in the stokers' implication that not only are their patients being mistreated, but the researchers themselves are being mistreated and denied something vital for them to do their work.

It would be shocking if patients with complex PTSD did get better when given treatments designed for PTSD, because patients with complex PTSD have so many extra symptoms that are not trauma related. The extra symptoms of complex PTSD above and beyond those of PTSD include the "deformations of personality" such as affect regulation and self-identity, attachment, and interpersonal impairments. As I described earlier, these deformations of personality are features of personality disorders, most commonly borderline personality disorder. If these extra symptoms are actually part of a personality disorder syndrome and not trauma related, they are somewhat permanent features of individuals, and when improvement occurs in them, it is gradual and due to treatments designed specifically for personality disorders.

Marylene Cloitre has been one of the most prolific researchers on new therapies for complex PTSD. She received her PhD from Columbia University in 1987. Since then, Cloitre

has conducted research in academic medical centers including Cornell Medical Center in New York City; New York University Langone Medical Center; the National Center for PTSD in Palo Alto, California; and Stanford University. Her many honors include past president of the *International Society for Traumatic Stress Studies*, associate director of research of the National Center for PTSD Dissemination and Training Division in Palo Alto, member of the scientific advisory board of the *Anxiety Disorders Association of America,* advisory committee member for the *National September 11 Memorial Museum, and* director of the Institute for Trauma and Stress at the NYU Child Study Center. She has over 150 publications, including five books.

Cloitre was well ahead of the other stokers. She was publishing treatment trials for patients with complex trauma symptoms before the complex PTSD stokers reached full stride. In 2002, Cloitre published the first trial of her new therapy, called Skills Training in Affective and Interpersonal Regulation, or STAIR.[12] STAIR consists of two phases. Phase 1 consists of eight weekly sessions of skills training in affect and interpersonal regulation. Phase 2 consists of eight sessions of modified prolonged exposure focused on PTSD symptoms. The phase-based treatment in STAIR is grounded in Cloitre's unproven theory that these patients need an extended phase of self-regulation and attachment building before being introduced to potentially overwhelming trauma-exposure therapy techniques.

A group of trauma researchers was so concerned about Cloitre's unproven beliefs that they took the unusual step of publishing a full critique of the study in 2004. Shawn Cahill and David Riggs from the University of Pennsylvania, Lori Zoellner from the University of Washington, and Noah Feeny from Case Western Reserve University wrote of their concern that Cloitre was misinterpreting the results of her own study.[13] Specifically, they disagreed with Cloitre that her phase-based treatment was needed for good outcomes of PTSD treatment. They noted that good treatments had already been proven and Cloitre had not proven that her extra steps were necessary for better outcomes. They were also alarmed that readers might take away from this study that Cloitre's extra steps were protecting patients from harm. "Similarly, we are concerned that these results will be taken as a demonstration that prior treatment with STAIR protected vulnerable patients from adverse effects attributed to exposure therapy."[14] Cahill and colleagues explained several flaws in Cloitre's study design and interpretation of the data.

In addition, Cahill and colleagues explored Cloitre's global claims that traditional PTSD treatment is commonly associated with the problems of symptom worsening and high therapy dropout rates, and that victims of childhood sexual abuse are more vulnerable to those problems than other types of victims. By presenting more thorough evidence than Cloitre had presented, they supported their concern that Cloitre's "beliefs may constitute unhelpful 'myths.'"[15]

Having read so much of the material written by stokers and listened to so many of their lectures, I am struck by how they appear to always be testing how far they can push their beliefs beyond the existing evidence before others will push back so that stokers would then need to self-correct and be more measured in their claims. Cahill's commentary represents one of the rare instances where other researchers in the trauma field pushed back, and provides an opportunity to see how willing stokers might be to self-correct their beliefs in the face of other evidence. Cloitre and her coauthors published a reply to Cahill and his coauthors in the same journal issue.[16] Cloitre did not agree with any of Cahill's concerns, and instead made an extended argument to reexplain why she believed victims of childhood interpersonal victimization are a special population of trauma victims.

This raises an alternative explanation that stokers are not interested in self-correction. It may be that the entire purpose of pushing their beliefs beyond the existing evidence is to provoke

others to push back. In other words, perhaps they were and always will be trying to get themselves attacked, because then they will have more to fight about on the road to Traumaville. After all, the road to Traumaville is not really about the destination, it is about the righteous path of fighting along the way.

Cloitre might argue that she did make an attempt at self-correction. She conducted a second treatment trial that addressed one of Cahill's criticisms. One of Cahill's criticisms about Cloitre's first study was that Cloitre claimed that the first phase of affect and skill regulation made it easier for patients to perform the second phase of working through trauma memories. Cahill noted that Cloitre did not have a control group that performed the second phase of working through trauma memories without the benefit of the first phase. In 2010, Cloitre and her colleagues published a second randomized study that included a control group that performed the second phase of working through trauma memories without the benefit of the first phase.[17] At the conclusion of treatment, those who received Cloitre's full STAIR protocol had not improved any more on PTSD symptom severity than those who had performed the second phase of working through trauma memories without the benefit of the first phase. They did not differ at six months follow-up, either. Cloitre's own study disagreed with her claim, but this appears to have had no impact on her activism.

6. Claim by stokers: When patients with complex PTSD are given traditional PTSD treatments, they are harmed because they drop out of treatment at unusually high rates.

The myth that patients with complex PTSD drop out of treatment at unusually high rates is a common argument from the stokers. Julian Ford and Christine Courtois wrote that traditional PTSD treatments might be "inadvertently causing harm" because patients drop out frequently.[18] They seemed certain they knew the reason why patients were dropping out. According to them, dropouts occurred because trauma treatment was moving too fast and did not prepare them adequately to process their trauma memories. The fact is, however, that we typically do not know why patients drop out of any type of psychotherapy because they drop out without telling clinicians why they drop out.

Ford created his own special treatment called Trauma Affect Regulation: Guide for Education and Therapy (TARGET), and claimed that his new phase-based treatments could do much better. In Ford's first test of his own treatment in a 2008 paper, the dropout rate in TARGET treatment was a whopping 59 percent.[19]

In Ford's next treatment study using TARGET, the dropout rate was 25 percent, which he said was "consistent with those reported in prior studies of CBT for adult PTSD," and was nearly the same as the rate for the other CBT psychotherapy used in the study (26 percent).[20]

In a study of adolescent female delinquents, Ford reported a 33 percent dropout rate for TARGET, which was actually worse than the rate for the control treatment (19 percent).[21] It seemed that Ford's special treatment had not found the secret to preventing dropouts.

As mentioned earlier, Marylene Cloitre also created her own special phase-based treatment. In Cloitre's first test of her treatment in her 2002 paper, the dropout rate in STAIR treatment was 29 percent, which she herself admitted was similar to the rate for other PTSD treatment trials.[22]

In Cloitre's next test of her treatment, she reported in 2010 that the dropout rate in STAIR treatment was only 15 percent.[23] This contrasted with a 39 percent dropout rate in individuals who received an alternative phase 1 treatment before a traditional PTSD treatment. Unfortunately, Cloitre curiously neglected to report whether people dropped out during the

alternative phase 1 or during the PTSD treatment. It was, however, a small study, and if only several more patients had dropped out in STAIR, the dropout rate of STAIR would have been the same as for other PTSD treatments.

It seems clear there is little to no evidence to support the stokers' claim that patients with complex PTSD drop out of treatment at unusually high rates when they receive traditional PTSD treatments.

7. Claim by stokers: When patients with complex PTSD are given more appropriate treatments, they improve more.

Amidst all this head-swiveling misdirection, we need to remember that neither Ford's nor Cloitre's studies diagnosed patients with complex PTSD. So, no matter what dropout rates they found, we do not know whether they apply to complex PTSD or not.

Critics of complex PTSD have recognized this and noted that there are no good treatment studies that have been conducted with patients with complex PTSD.[24] We do not know whether new treatments work better than old treatments, or vice versa, because no studies have been performed. There is only one study that required the diagnosis of complex PTSD to be included in a treatment study, and it was not randomized and had no comparison group.[25]

8. Claim by stokers: Repeated trauma triggers the toxic stress neurobiology changes.

Recall that the campaign for complex PTSD started in 1992, before the toxic stress activists launched their activism around 2000. But once the leverage capacity of neuroscience in the toxic stress campaign became obvious, the complex PTSD stokers rapidly recognized the advantages of yoking themselves to it. In fact, many of the same researchers who fronted the complex PTSD activism have become stalwart activists for the toxic stress narrative.[26]

The toxic stress narrative posited that trauma and stress cause neural alterations in the brain that are evident as PTSD and also as some of the major physical diseases such as heart disease and diabetes, the deadliest and eighth-deadliest diseases in the world. It took only a slight tweak for the complex PTSD activists to toss in a wide range of psychiatric problems such as affective regulation, attachment disorders, and "deformations of personality." When you already have convinced the world that toxic stress alters a dozen different brain centers and causes some of the leading physical diseases of the world, who is going to notice a handful of psychiatric symptoms that fit within the complex PTSD rubric? Never mind that there are absolutely zero studies that connect neurobiological changes caused by trauma to complex PTSD.

Just as the toxic stress activists concocted several catchy phrases to popularize their theory—toxic stress, biological embedding, how experience gets under the skin, weathering—the complex PTSD stokers were adept at concocting different phrases to tie complex PTSD into the toxic stress mythology. In 2002, Julian Ford embraced a "negative cascade model."[27] He did not stick with the phrase for long. In 2005, he preferred a new phrase that he invented called "developmentally adverse interpersonal trauma."[28] This term supposedly explained how interpersonal trauma during development had permanent adverse impacts on affect regulation and altered information processing. It was not explained whether this model replaced or augmented his negative cascade model. Hence, Ford's TARGET psychotherapy was not just a form of psychotherapy; it was, as he called it, an impressive-sounding "affective cognitive neuroscience-based approach to PTSD psychotherapy."[29] Spinazzola and John Briere tied complex PTSD and toxic stress together by inventing the concept of individuals who are

normoreactive because they did not experience childhood trauma, and of nonnormoreactive individuals who became biologically nonnormal due to childhood trauma.[30]

9. Claim by stokers: Surveys of experts are evidence that complex PTSD is real.

Stokers have gone to rather absurd lengths to use misdirection and keep us from looking at the quality of their research. One of their tricks is to publish studies where they send surveys to each other to collect their opinions about these issues. Then when they agree with each other, they claim this is authentic evidence that their research findings must be true.

In 2005, Spinazzola, Ford, van der Kolk, and four other coauthors sent a survey to 118 clinicians who were part of the National Child Traumatic Stress Network; sixty-two responded. Clinicians were asked to think about their caseloads and estimate the types of traumatic experiences the patients suffered, the types of symptoms they showed, and the effectiveness of the treatments they were given. Clinicians did not have to provide data from standardized, quantitative instruments. They simply had to make their best estimates from memory. The authors used this information to conclude that the "results overwhelmingly indicate that complex trauma exposure and posttraumatic adaptation involving self-regulatory impairment are prevalent," and that clinicians are not "aware of potentially effective approaches that could contribute to a multi-component intervention."[31]

In 2011, Cloitre was the first author on a paper coauthored by Christine Courtois, Bradley Stolbach, and three others. Under the auspices of the Complex Trauma Task Force of the International Society for Traumatic Stress Studies, they sent a survey to fellow clinicians.[32] The task force selected the clinicians by each member of the task force nominating ten people who they believed were complex trauma experts and ten people who they believed were PTSD experts. From these lists, they settled on twenty-five complex trauma experts and twenty-five PTSD experts. The authors concluded that the experts believed that the symptoms that victims of repeated, interpersonal trauma are likely to show are symptoms of the proposed complex PTSD syndrome. They also concluded that the experts believed that phase-based treatments were needed for complex PTSD. The circularity of the methodology is curiously brazen. It was guaranteed that believers in complex PTSD would agree that complex PTSD exists and needs treatment that is different from traditional PTSD treatment. It is doubly curious that a study this silly even got through peer review and an editor to get published.

In 2013, Ford, Spinazzola, van der Kolk, and three other coauthors sent an electronic survey to 472 clinicians.[33] They asked them to read four patient vignettes and then answer questions about their opinions on complex PTSD and existing treatment options. The authors took the clinicians' opinions as evidence that complex PTSD was a valid diagnosis and that existing treatments would not help these patients. They indicated no awareness that clinicians' opinions of hypothetical treatment outcomes do not count as scientific evidence of diagnostic validation.

In 2016, a committee working on the revisions for the International Classification of Disease taxonomy sent an online survey to 3,669 clinicians around the world and received 1,738 responses.[34] They asked participants to read eleven case vignettes. The vignettes were supposed to be based on real patients the authors had seen, but could be based on combinations of many patients. In one of their tests, the committee asked clinicians to read a case with full PTSD symptoms and another case with full complex PTSD symptoms. Not surprisingly, 93 percent correctly diagnosed the PTSD case and 83 percent correctly diagnosed the complex PTSD case, and the committee interpreted this as partial validation of complex PTSD as a real diagnosis.

In 2019, a group of nine authors including van der Kolk, Spinazzola, and Ford sent surveys to clinicians and asked them to rate symptoms of real patients in their caseloads based on their progress notes and memories of the patients. They found that 17.5 percent of the cases met some criteria for complex PTSD but not the full criteria for PTSD. They interpreted this as evidence that complex PTSD was a distinct and real disorder.[35]

Can you imagine this in other fields of science? What would we think if astronomers sent surveys to each other to ask, “Do you believe the shift in orbits of planets near the Sagittarius A black hole is probably evidence of a wormhole?” When the astronomers report that they believe it is definitely evidence of a wormhole, then the researchers conclude, without any reservations, that wormholes exist (which is not proven) and time travel is possible (which it is probably not). Wouldn’t somebody point out that opinions are not real evidence?

Notes

1 Van der Kolk, "Developmental trauma disorder"; Van der Kolk & Courtois, "Editorial Comments"; John Briere & Joseph Spinazzola. "Phenomenology and psychological assessment of complex posttraumatic states," *Journal of Traumatic Stress* 18 (2005): 401-412.

2 Herman, “CPTSD is a distinct entity,” 257.

3 Van der Kolk & Courtois, "Editorial Comments"; Briere & Spinazzola. "Phenomenology and psychological assessment.”

4 Kilpatrick, “A special section on complex trauma.”

5 Wendy D'Andrea, *et al*., "Understanding interpersonal trauma in children: why we need a developmentally appropriate trauma diagnosis," *American Journal of Orthopsychiatry* 82 (2012): 187-200.

6 Briere & Spinazzola, “Phenomenology and psychological assessment”; Bessel A. van der Kolk, *et al*., "Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma," *Journal of Traumatic Stress* 18 (2005): 389-399.

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10 Van der Kolk & Courtois, “Editorial Comments”; Spinazzola, Blaustein & van der Kolk, “Posttraumatic Stress Disorder Treatment.”

11 Van der Kolk, “Developmental trauma disorder”; Herman. "Complex PTSD"; Ford & Kidd, "Early childhood trauma"; Cloitre, "Commentary on De Jongh et al."

12 Marylene Cloitre *et al*., "Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse," *Journal of Consulting and Clinical Psychology* 70 (2002): 1067-1074.

13 Cahill *et al*., "Sequential Treatment for Child Abuse."

14 Cahill *et al*., "Sequential Treatment for Child Abuse," 544.

15 Cahill *et al*., "Sequential Treatment for Child Abuse," 547.
16 Marylene Cloitre *et al*. “Treating Life-Impairing Problems Beyond PTSD: Reply to Cahill, Zoellner, Feeny, and Riggs (2004).” *Journal of Consulting and Clinical Psychology* 72 (2004):549-551.
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19 Linda K. Frisman *et al*., "Outcomes of trauma treatment using the TARGET model," *Journal of Groups in Addiction and Recovery* 3 (2008): 285-303.
20 Julian D. Ford, Karen Steinberg & Wanli Zhang. "A randomized clinical trial comparing affect regulation and social problem-solving psychotherapies for mothers with victimization-related PTSD," *Behavior Therapy* 42 (2011): 560-578.
21 Julian D. Ford *et al*., "Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency," *Criminal Justice & Behavior* 39 (2012): 695-724.
22 Cloitre *et al*., "Skills training.”
23 Cloitre *et al.*, "Treatment for PTSD.”
24 Resick et al., “A Critical Evaluation.”
25 Ethy Dorrepaal *et al.*, "Stabilizing group treatment for Complex Posttraumatic Stress Disorder related to childhood abuse based on psycho-education and cognitive behavioral therapy: A pilot study," *Child Abuse and Neglect* 34 (2010): 284-288.
26 Van der Kolk, “The Body Keeps the Score,” retrieved from www.youtube.com.; Julian D. Ford. "Traumatic victimization in childhood and persistent problems with oppositional-defiance," *Journal of Aggression, Maltreatment & Trauma* 6 (2002): 25-58.
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35 Jonathan DePierro *et al.* "Beyond PTSD: Client presentations of developmental trauma disorder from a national survey of clinicians," *Psychological Trauma: Theory, Research, Practice and Policy* (2019 Dec 19).

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