# SIMILARITIES AND DIFFERENCES IN BORDERLINE AND OTHER SYMPTOMOLOGY AMONG WOMEN SURVIVORS OF INTERPERSONAL TRAUMA WITH AND WITHOUT COMPLEX PTSD

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Women interpersonal chronic trauma survivors are frequently misdiagnosed with borderline personality disorder (BPD) or post traumatic stress disorder (PTSD), which often results in mistreatment. Neither PTSD nor BPD adequately describes the unique character alterations observed among those exposed to prolonged early childhood trauma. Researchers suggest survivors of interpersonal and chronic trauma should be subsumed under complex PTSD (CPTSD)(MacLean & Gallop, 2003). The primary purpose of this study was to test the validity of complex PTSD as a construct. MANOVA, ANOVA, chi- Square, and independent samples *t*-Tests were utilized to test hypotheses. Results revealed that women who experienced higher frequencies of trauma met more CPTSD criteria and had higher mean base rate scores on the Major Depression, Depressive, Avoidant, Masochistic, Anxiety, PTSD, and Borderline scales of the MCMI- III than women who experienced fewer traumas. Additionally, findings suggest that the Major Depression, Depressive, Anxiety, PTSD, and Borderline scales may highlight differences among women interpersonal trauma survivors who meet five of six CPTSD criteria versus those who meet full CPTSD diagnostic criteria. Lastly, the mean Borderline scale score for women who met full CPTSD diagnostic criteria was below the cutoff for personality traits. Overall, these findings provide evidence and validation for the distinction of CPTSD from BPD and PTSD.

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TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

# CHAPTER I

# INTRODUCTION

## Introduction to the History of Trauma

The psychological aftereffects of trauma have been documented since at least the Old Testament, specifically in the book of Exodus (12:29- 30), when the Lord struck all of the firstborn in Egypt during Passover, "There was loud wailing in Egypt, for there was not a house without someone dead." Additionally, in approximately 8th century BC, Homer mentions a form of grief trauma experienced by Achilles in the *Illiad* (Homer, 1990). Although humankind has experienced trauma since the earliest writings of history, it was not until the 1800s that theories regarding the symptoms, causes, and treatment of trauma developed.

The detrimental symptoms resulting from exposure to psychological trauma received considerable attention after the American Civil War (1861-1865). However, most of the efforts resulted in ambiguous and fragmentary evidence of psychological trauma found as anecdotes in soldiers' and physicians' journals (Talbott, 1996). Physicians described symptoms of what we now know as Post Traumatic Stress Syndrome (PTSD) and attempted to predict the etiology and treatment of such symptoms (Lipton, 1994). Da Costa, an American physician who treated injured soldiers during the Civil War, noted physiological responses such as increased arousal, elevated heart rate, and irritability in those exposed to combat. Da Costa called these symptoms "Da Costa's syndrome" or "soldiers irritable heart" (Trimble, 1981).

Many theories arose about trauma, and in the mid-1890s, Freud and colleagues believed hysteria was a condition from intolerable emotional reactions of psychological trauma that produced an altered state of consciousness which was termed "dissociation" or "double consciousness" (Breuer & Freud, 1893-1895; Janet, 1889). Physicians and other theorists

thought hysteria was a "strange disease with incoherent and incomprehensible symptoms" (Herman, 1992a, p. 10). The psychiatric and medical fields adopted this approach to trauma from approximately 1895 to the end of the Vietnam War era in the United States (1962-1975) (Wilson, 1994). More knowledge and information about these symptoms arose with the advent of the First World War.

Wartime traumatic exposures and workers' compensation acts continued to increase awareness and interest for the concept of posttraumatic disorders throughout the First World War (1914-1918) (Figley, 1985). Freud theorized that war trauma "presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way, and this must result in permanent disturbances" (Freud, 1917, p. 275). The workers compensation acts provided financial compensation for the physically and psychologically injured during railroad construction and collision accidents (Figley, 1985). The increase of accidents led Myers (1915) to coin the ubiquitous term "shell shock" and suggested the condition was caused by ruptures of small blood vessels which resulted in cerebral concussions from proximity to exploding shells (Lasiuk & Hegadoren, 2006). Southard (1919) reported the psychiatric distress of 589 WWI combatants who suffered from shell shock, and made 23 detailed case reports from his observations. Physicians who dealt with trauma syndromes grew curious and speculated the etiology of the symptoms (Figley, 1985). Although most theories of the time operated from a physiological perspective, physicians and researchers began to include a focus on the ~~psychiatric~~ symptoms and may have been the precursor to what we know now as the effects of traumatic brain injury (Shephard, 2000).

The advent of World War II revived interest in trauma and the term "combat fatigue" became popular (Lipton, 1994, p. 5). Myers (1940) believed that horror and fright triggered the

physical causes of the problem, and Kardiner (1941), a prominent American psychiatrist and psychoanalyst, suggested war created a syndrome that was the same as traumatic neuroses in peacetime. Mental health practitioners evaluated and attempted to treat thousands of psychiatric sufferers during and following the Second World War (Chadoff, 1963; Kardiner, 1941). They gave sufferers a new treatment called "Amytal interviews" soon after the traumatic experience, and found cathartic story telling produced emotional discharge, which helped alleviate current and long-term symptoms in some survivors (Lipton, 1994, p. 5).

The atrocities of war and industrial accidents provided a multitude of trauma data. However, theorists, researchers, and physicians faced adversities drawing consistent conclusions for their hypotheses due to limited and biased communication. Moreover, mercurial concepts of disease and medicine influenced the field of science. Likewise, lack of reliable knowledge about the aftereffects of trauma created roadblocks to research. Nevertheless, awareness and knowledge of the psychological residue of trauma exposure, in addition to Freud's literature contributions, had profound influences on the creation of post-traumatic stress disorder (Wilson, 1994).

## The Evolution of the Construct of Post-Traumatic Stress

During the time of the Korean War (1950-1953), the American Psychiatric Association's (APA) Committee on Nomenclature and Statistics created a diagnostic category for trauma survivors with distressing symptoms (APA, 1952). This diagnosis of "gross stress reaction" (APA, 1952, p. 40), the antecedent to what we now know as PTSD, bears similarity to Freud's conceptualization of traumatic neuroses in *The Introductory Lectures on Psychoanalysis* (1917). "gross stress reaction" was added to the *Diagnostic and Statistical Manual of Mental Disorders*

(*DSM*) in 1952 under the "Transient Situational Personality Disorders" section (APA, 1952). This section included classifications of reactions to overwhelming situations, that would likely decrease when the individual was in an adaptive environment. According to the *DSM*, "Gross stress reaction" was indicated in cases involving exposure to "severe physical demands or extreme stress, such as combat or civilian catastrophe (i.e., fire, earthquake, explosion, etc.)" (APA, 1952, p. 40). The *DSM* also recognized "in many instances this diagnosis applies to previously more or less "normal" persons who experience intolerable stress" (APA, 1952 p. 40). Researchers in the 1960s, continued to study civilians who experienced natural disasters (e.g., floods, hurricanes, tornados, and earthquakes) and industrial disasters (e.g., factory and railroad accidents) and used their psychological reactions to extrapolate the anticipated reactions to combat and wartime issues (Quarantelli, 1985).

The American Psychiatric Association's Committee on Nomenclature and Statistics published the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-II*) in 1968. The "gross stress reaction" classification was omitted and replaced with "adjustment reaction of adult life" a subcategory under transient situational disturbances (APA, 1968, p. 48). According to the *DSM-II*, "transient disorders of any severity (including those of psychotic proportions) occur in individuals without any underlying mental disorders and that represent an acute reaction to overwhelming environmental stress" (APA, 1968, p. 48). Five categories of the disorder are arranged according to the victim's developmental stage: "adjustment reaction of infancy, childhood, adolescence, adult life, and late life. An example is listed under each category; however, the adjustment reaction of adult life contains three examples: 1) depression, resentment, and hostility from an unwanted pregnancy; 2) Fear in

military combat; and 3) A type of Gander syndrome associated with the death sentence which is manifested by incorrect answers to questions" (APA, 1968, p. 49).

The 16 years from the publication of the first *DSM* to the *DSM-II* was filled with numerous traumatic events (i.e., Korean and Vietnam wars, the assassination of John F. Kennedy, wars in the Middle East, and major natural disasters). However, since gross stress reaction was closely linked to warfare and combat, it is likely that the work groups did not consider other forms of trauma and only included three examples of adjustment reactions of adult life in the *DSM-II* (Andreasen, 2010). The classification demonstrated the zeitgeist of the times and fledgling trauma research. The transient situational disturbance classification did not include criteria for making a diagnosis and some believe impeded research progress for psychological trauma (Wilson, 1994).

Soon after the publication of the *DSM- II*, veterans from the Vietnam War Era (1965-1975) inundated Veterans Administration (VA) hospitals in search of help for their symptoms. These men experienced symptoms of anger, rage, irritability, mistrust of others, nightmares, painful moods, direct or symbolic behavioral repetitions, fear of loss of control over hostile impulses, and impaired social relationships (Fontana & Rosenheck, 1994; Liebman & McWhirter, 1987; Penk, Rabinowitz, Patterson, Dolan, & Atkins, 1981; Horowitz & Solomon, 1975). However, the VA staff and the fields of psychiatry and psychology were underprepared to handle the enormous need. Mental health professionals, veterans, and their family members campaigned for changes in the VA and influenced dramatic revisions to the *DSM-II* (Hegadoren, Lasiuk, & Coupland, 2006). Specifically, the APA appointed a task force to amend the *DSM-II* with the goal of operationalizing a theoretically sound construct to classify traumatic stress reactions, documented first in the *DSM- III* (Saigh & Bremner, 1999).

The *DSM-III* (American Psychiatric Association, 1980) Reactive Disorders Committee created the diagnostic criteria for what is now known as post-traumatic stress disorder (PTSD). Mental health practitioners and researchers performed extensive literature searches and prepared 265 symptomological psychiatric profiles of individuals suffering from "traumatic neuroses" (Saigh & Bremner, 1999; van der Kolk, McFarlane, & Weisaeth, 2007). Researchers such as Kardiner (1941), Andreasen, Norris, and Hartford (1971), and Krystal (1968) studied combat veterans, burn victims, and Holocaust survivors, respectively. The committee ultimately adopted a set of diagnostic criteria that was chiefly based on Abram Karinder's 1941 descriptions in *The Traumatic Neuroses of War* (van der Kolk et al., 2007). The diagnosis was well received by researchers and clinicians treating combat trauma, and it was also used to investigate other types of trauma (i.e., rape, domestic battering, child abuse, and neglect). Researchers applied the diagnostic criteria from PTSD to the various populations studied and saw effects among their research and clinical samples (Courtois, 2004). Researchers and clinicians identified additional potential posttraumatic syndromes such as rape trauma syndrome (Burgess & Holmstrom, 1974), battered women syndrome (Walker, 1984), child abuse/ sexual abuse trauma (Briere, 1984, 1987; Finkelhor, 1985), developmental trauma disorder (Pynoos, Steinberg, Wraith, 1995), and incest trauma (Courtois, 1979; Herman & Hirschman, 1977).

Through the 1970s and early 1980s police officers were taught that domestic violence was a private matter and not suited for public intervention (Buzawa & Buzawa, 1990). However, the injuries women obtained in domestic violence attacks were as serious as those suffered in violent felony crimes (Claus & Ranel, 1984). Rape in the United States was traditionally defined as intercourse with a woman other than the rapist's wife, and it was not until the 1970s that society acknowledged that rape could occur in marriage (Mahoney & Williams, 1998). The

injuries from marital rape were more severe than injuries from rape by a stranger, and marital rape survivors report higher rates of anger and depression compared to women raped by strangers. (Koss, Dinero, Siebel, & Cox, 1988). The addition of the PTSD diagnosis in the *DSM-III* (1980), was a catalyst for the rapid increase of knowledge accumulation about trauma, which helped researchers refine the construct in the proceeding editions of the *DSM* (Wilson & Raphael, 1993; Wilson, 1989).

The diagnosis of PTSD in the *DSM- III* was broadened by augmenting the first line of the description to "development of characteristic symptoms following a psychiatrically traumatic event that is generally beyond the realm of normal human experience" (APA, 1980, p. 236). This definition expanded the concept of PTSD to encompass aberrant stressors and trauma response syndromes experienced by combat survivors and civilians (e.g., victims of sexual assault, war related events, serious accidents, or disasters, as well as those with rape trauma syndrome, battered women syndrome, or abused child syndrome) (Saigh & Bremner, 1999; Hegadoren, Lasiuk, & Coupland, 2006). Due to the limited amount of empirical data on trauma research, however, researchers and clinicians drew inferences about various types of trauma from the PTSD diagnosis in the *DSM-III*, which primarily focused on men traumatized by combat (Turnbull, 1998). It is important to note that the description of PTSD in the *DSM-III* also specified that symptoms had to be more severe than common experiences such as "simple bereavement, chronic illness, business losses, or marital conflict" (APA, 1980, p.236).

The PTSD diagnosis was positioned in the anxiety disorders section of the *DSM- III* and its diagnostic criteria consisted of four sets of symptom clusters (Criteria A-D). Criterion A required mandatory exposure to extreme stress, Criterion B required the presence of one of three reexperiencing symptoms (e.g., nightmares), Criterion C required the presence of at least one of

three psychic numbing symptoms (e.g., detachment or estrangement from others), and Criterion D required the presence of at least two of six symptoms that were not apparent before the trauma (e.g., exaggerated startle response and sleep disturbance). Although the addition of the diagnosis was a landmark in trauma research, studies of various traumatized populations indicated that the diagnosis lacked the complexity to capture symptoms that resulted from long-term habituation to traumatic life experiences, particularly among people who were traumatized as children (van der Kolk, 2007).

The PTSD diagnosis provided the conceptual framework of trauma research and the detrimental effects of experiencing and witnessing traumatic events (Hegadoren, Lasiuk, & Coupland, 2006). Although the diagnosis was revolutionary for the field, revisionary efforts, began in 1983, just three years after the publication of the *DSM-III.*

The *DSM-III Revised (DSM-III-R*) was published in 1987, with numerous modifications, a set of which focused on the diagnostic criteria for PTSD. The *DSM-III-R* altered the criteria, provided detailed information regarding the expression of symptoms among youth, and specified the onset and duration of the disorder. The revised criteria are discussed first, followed by the addition of symptoms among youth and the onset and duration information.

The diagnostic criteria for PTSD in the *DSM-III- R* increased specificity and detail for each criterion (A- E). Criterion A expanded to include examples of distressing events and included witnessing distressing events. Criterion B was altered by adding an additional reexperiencing symptom, "intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event" and an example of recurrent and distressing recollections of the event for children "in young children, repetitive play in which themes or aspects of the trauma are expressed" (APA, 1987, p. 250). Criterion C was also expanded to

require at least three of seven avoidance or numbing symptoms, as opposed to the previously required one of three symptoms in the *DSM-III*. The four additional avoidance or numbing symptoms are as follows: "efforts to avoid thoughts associated with the trauma," "efforts to avoid activities or situations that arouse recollections of the trauma," "inability to recall an important aspect of the trauma," and "sense of foreshortened future" (APA, 1987, p. 250). Lastly, Criterion D was vastly modified to exclude feelings of guilt, relocated "avoidance of activities" to Criterion C, converted "hyperalertness or exaggerated startle response" into two symptoms and modified "hyperalertness" to "hypervigilance," and added a physiological reactivity example to the "exposure to events that symbolize or resemble an aspect of the traumatic event" (APA, 1987, p. 250). Lastly, Criterion E was added to include a one month duration period of the symptoms in B, C, and D criteria (APA, 1987, p. 250).

The *DSM-III-R* also included the expression of age-specific symptoms and features of PTSD. The expression of symptoms for children read, "In younger children, distressing dreams of the event, may within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others" (APA, 1987, p. 249). The *DSM-III-R* acknowledged that individuals of all ages could develop inescapable and incessant psychological disturbances from trauma exposure (Saigh & Bremner, 1999). Some examples include: "young children may not have the sense that they are reliving the past; reliving the trauma occurs in action, through repetitive play" (APA, 1987, p. 250). The expansion and specificity of the criteria helped pave the way for future trauma research.

The development of the *DSM-IV* primarily relied on scientific research from clinical trials and literature reviews (Saigh, Green, & Korol, 1996). The *DSM-IV* PTSD work group conducted clinical and community field trials. The primary goal of the trials was to examine relations

between stressors with varying magnitudes and the distinct PTSD symptoms that were induced. Moreover, researchers sought to establish the magnitude of the stressor that occurred to produce PTSD symptoms. Several secondary goals of the trial included: studying a variety of stressful events that could potentially have an effect on symptoms and their onset, the potential effect of additional symptoms on the prevalence of the disorder, and variables associated with PTSD, but independent of the type of event that produced the symptoms (Saigh & Bremner, 1999).

The *DSM-IV* work group withdrew the previous specification that the stressor must have been "outside the range of normal human experience" (APA, 1987, p. 247). The specification was replaced with a new Criterion A, additional children and youth references in Criteria B, specificity to Criteria C, and the removal of a symptom in Criteria D. Criteria A was divided into two parts; A1 and A2. Criteria A1 refers to the physical threat to the self or others, "the person experienced, witnessed or was confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity to oneself or others" (APA, 1994, p. 428). Criteria A2 refers to the subjective experience of the individual requiring that the person's response "involved intense fear, helplessness or horror" (APA, 1994, p. 428). Criterion B included examples of children's responses to trauma in three of the five re-experienced symptoms, and added a physiological reactivity symptom that was previously in Criterion D of the DSM-III-R. Additional avoided stimuli examples were added to Criterion C (i.e., conversations, places, or people) and a new specification (Criterion E) was included to require the duration of the symptoms listed under Criterion B, C, and D to be apparent for at least one month. Finally, Criterion F was added to the *DSM-IV* "The disturbance must cause clinically significant distress or impairment in social, occupation, or other important areas of functioning" (APA, 1994 p. 429).

The diagnostic features section of PTSD in the in the *DSM-IV* included examples of traumatic events such as: "military combat, violent personal assault, kidnapping, taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or diagnosis of a life threatening disease" (APA, 1994, p. 424). Youth were also referenced, "sexually traumatic events may include developmental inappropriate sexual experiences without threatened or actual violence" (APA, 1994, p. 424). Examples of witnessing or learning traumatic information include "personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or close friend; or learning that one's child has a life threatening disease" was also added to the *DSM-IV* (APA, 1994, p. 424).

The PTSD diagnosis had two changes from the DSM-IV to the DSM-IV-TR, including Criterion B and the delayed onset specifier. Criterion B in the DSM-IV developed from, "the event is reexperienced in at least two ways" to specifying that the event is "persistently reexperienced in one or more ways" in the DSM-IV-TR (APA, 1994, p. 424; APA, 2000, p. 468). The delayed onset specifier also changed from at least 3 months to at least 6 months after the stressor (APA, 1994; APA, 2000). The construct of PTSD has had a long and interesting evolution; and researchers and clinicians continue to advance the knowledge and understanding of the disorder.

## Limitations of Trauma Research and the Current PTSD Diagnosis

Trauma researchers have faced innumerable obstacles since the American Civil War. Limited and fluctuating knowledge, mistaken assumptions, sparse availability of large populations affected by trauma (other than wartime populations), and social and political

influences have hindered research and are documented limitations in the field of psychology (Brett& Ostroff, 1985; Herman, 1992; Horowitz, 1986; Trimble, 1985). Women, slaves, immigrants, and children, have experienced, seen, or been confronted with traumatizing events and behavior throughout history. However, a political shift has only recently occurred to recognize the negative consequences (i.e., the potential to traumatize) of interpersonal and/or family and domestic violence, especially among these populations. Moreover, the current PTSD diagnosis is gender biased since it was primary formed from studies of men in combat and based on Kardiner's book (1941) (Hegadoren, Lasiuk, & Coupland, 2006).

According to Carlson (1997), research and clinical work related to traumatic stress is not generalizable to individuals from non-Americanized cultures because most trauma researchers have focused the majority of their attention on white, middle- and upper-middle- class Americans. The relative lack of attention to the wide variety of trauma survivors who are not combat veterans has hindered the accuracy and generalizability of research, while also restricting the understanding of the full gamut of potential outcomes of trauma (Hegadoren, Lasiuk, & Coupland, 2006; Herman, 1992a).

The current PTSD criteria evolved from studies of adult male combatants exposed to war trauma in the early 20$^{th}$ century (Courtois, 2004). The diagnosis is limited, because it does not address the ways in which women, children, and non-combatants, are affected by traumatic events, especially those that are interpersonal and chronic (Courtois & Ford, 2009; Herman, 1992; Kroll, Habenicht, Mackenzie, 1989; Horowitz, 1986; Brown & Fromm, 1986). Moreover, PTSD is represented as a unitary disorder resulting from exposure to various types of traumatic experiences, however, the diagnosis does not account for different symptomatic configurations that result from a variety of types of traumatic experiences (Becker, 2000; Lamb, 1999;

Andreason, 1995). Lastly, PTSD and dissociation are often correlated in abused samples (Stovall-MCClough & Cloitre, 2006), and research pioneers in the 19th century hypothesized an "altered state of consciousness" (e.g., Janet, 1930) was part of a post-traumatic reaction , but it is not subsumed under the current PTSD diagnosis.

## Post-Traumatic Stress Disorder and Dissociation

Pierre Janet, the first investigator to study the association between psychological trauma and dissociation, proposed the idea that experiencing trauma involves a degree of dissociation of the personality. Exposure to traumatic events often results in an inability to integrate experiences (van der Hart, Nijenhuis, & Steele, 2005; van der Kolk, 2007). Janet described his observations of dissociation, "The individual, when overcome by vehement emotions, is not himself….forgetting the event which precipitated the emotion has frequently been found to accompany intense emotional experiences in the form of continuous and retrograde amnesia" (Janet, 1909, p. 1607). The consequence of "phobia of memory" (Janet, 1925, p. 661) is that it prevents the integration or "synthesis" of traumatic events and detaches the traumatic memories from ordinary consciousness (Janet, 1889, p. 145). Evidence from 19th and early 20th century literature, clinical observations, and research findings suggest traumatization involves a degree of dissociation (van der Hart, Nijenhuis, & Steele, 2005). Dissociative experiences during the time of the trauma have been found to be the most significant long- term predictors of eventually developing PTSD (Holen, 1993; Marmar et al., 1994; Spiegel, 1991). Dissociative disorders in children and adults are often associated with traumatic histories of child abuse and neglect which can present as posttraumatic adaptations (Courtois & Ford, 2009). Trauma survivors likely

dissociate to adapt, cope, and detach from the psychological and physical effects during and after the traumatic experience (Briere, 1987).

A group of researchers (unknown to PTSD researchers) independently created a diagnostic system for dissociative disorders around the same time of the creation of the initial PTSD diagnosis in 1980 (van der Kolk et al., 2007). Initially, the two subcommittees were unaware of the commonalities among disassociation and PTSD, and upon realization of the similar symptomatology, they proposed merging both subcommittees and diagnostic criteria (Nemiah et al.,1980; van der Kolk et al., 2007). Although researchers and clinicians identified post traumatic reactions among abuse and dissociation, the task forces postponed the recommendation of combining the two groups to form an extensive diagnosis (Courtois, 2004; van der Kolk et al., 2007). They believed an independent category for dissociative disorders would describe a method of information processing, thereby switching into alternative states of consciousness, exclusive of personality disruptions that may be present during adaptations to trauma (van der Kolk, 2007). Therefore, diagnostic criteria for dissociative disorders (DDs) were included in the third edition of the *DSM*, with five distinct DDs (fugue, dissociative amnesia, depersonalization disorder, multiple personality disorder, and dissociative disorder, not otherwise specified) (APA, 1980). Alterations in attention and consciousness (i.e., dissociative symptoms) tend to be seen in children and adult survivors of prolonged and repeated interpersonal abuse (e.g., relational trauma) however, these symptoms were not adequately subsumed within the confines of the PTSD diagnostic criteria in the *DSM-III-R* (Briere, 1987; Herman, 1992a).

Although specific types of dissociation or, " dissociative flashback episodes," are classified as one of the re-experiencing symptoms of PTSD in the *DSM-IV-TR*, whereby the

individual acts or feels as if the traumatic event were recurring (APA, 2000, p. 468), a coherent and synthesized conceptualization regarding trauma and dissociation does not exist. Researchers noted "conceptual clarity regarding trauma-related dissociation is urgently needed" (van der Hart, Nijenhuis, Steele, & Brown, 2004). Moreover, an integrative concept that captures the consequences of prolonged and repeated trauma is needed to bring order to an array of symptoms that trauma survivors experience. Herman (1992a) proposed a construct which she termed, "complex PTSD." The construct (discussed at length in following pages) integrates three main symptoms (i.e., somatization, dissociation, and affect dysregulation) commonly seen in survivors of child, adolescent, and adult abuse. The concept gained recognition and was included in the *DSM-IV* field trials, however, an independent diagnosis was overruled due to lack of fit in the anxiety, dissociative, somatization, and personality disorders sections in the *DSM-IV* (Cloitre, Stolbach, Herman, van der Kolk, Pynoos, Wang, & Petkova, 2009). The reason for the overruling exemplifies the need for an integrative disorder that captures the full gamut of symptoms. Dissociation is often correlated with childhood trauma and borderline personality disorder psychopathology, and some researchers believe trauma survivors may experience personality altering symptoms similar to borderline personality disorder (Kluft, 1990).

## Borderline Personality Disorder

Similar to PTSD, borderline personality disorder (BPD) was added as an official diagnosis to *DSM-III* in 1980. BPD was included in the Axis II section as a type of personality organization which many empirical studies and psychoanalytic clinicians widely accepted (Gunderson, 1982). BPD originated by Stern (1938) who described the construct "on the border line between neurosis and psychosis" because clients did not fit within the standard psychotic or

neurotic paradigm (p. 467). More specifically,clients with BPD are often characterized or associated with patterns of unstable relationships, affect, and self- image, as well as significant impulsiveness, and distress, all of which can often lead to daily impairment in occupational and social settings (APA, 2000).

BPD is associated with a distinct stigma among society and clinicians (Gunderson, 2001). Clinicians often describe clients diagnosed with BPD pejoratively, by stating they can be "manipulative," "treatment resistant," "demanding," and "attention seeking" (Aviram, Brodsky, & Stanley, 2006, p. 250; Gallop & Wynn,1987; Hodges, 2003; Nehls, 1998; Stone, Stone, & Hurt, 1987). This stigma can lead to the devaluation of the person, and many mistake socially undesirable behaviors as the nature of the individual, not the nature of the pathology (Aviram, Brodskey, & Stanley, 2006; Katz, 1981).

Studies have shown severe childhood trauma histories among the majority (81% to 91%) of cases with BPD (Herman, 1992a; Yen, 2002). Biderman and Zimmer (1982) reported the earlier the onset and the greater severity of abuse would lead to an increased likelihood of developing BPD symptoms. Childhood trauma (i.e., abuse) may be an etiological factor of BPD, which may illuminate the significant prevalence of BPD in women (Herman, Perry, & van der Kolk, 1989; Landecker, 1992). Therefore, some clinicians may jump to conclusions and misdiagnose women exposed to prolonged and repetitive trauma with BPD before understanding the significant role of childhood trauma (Herman, 1992a). Moreover, BPD symptoms are likely adaptations to the traumatic environment and originate from severe abuse histories, not individual psychological defects (Herman, 1992a).

Even today, close to one-third (30%) of physicians and mental health professionals "blame the victim" by attributing the abusive situation to the victim's presumed underlying

psychopathology (Garimella, Plichta, Houseman, & Garzon, 2000). Some professionals conclude that victims of domestic violence are fulfilling their "masochistic needs" and identify the women's alleged personality disorder as the source of the problem. "Blaming the victim" has interfered with the psychological understanding and diagnosis of a posttraumatic syndrome, especially among women (Herman, 1992a).

BPD has been a catalyst for controversy among researchers and clinicians due to the significant symptom overlap with other disorders, lack of reliability and validity for BPD as a diagnostic construct (APA, 2012; Becker, 2000) and the heterogeneity among diagnosed individuals (Maffei, 2005). Similarly, other theorists criticize the association of BPD and PTSD.

## Clinical Controversy: PTSD or BPD?

A wide variety of viewpoints and controversy exists between the relationship of BPD and PTSD (Hodges, 2003; Lewis & Grenyer, 2009). Hodges (2003) suggests BPD and PTSD may be associated because both have symptoms that result from external forms of chronic stress. Some believe BPD should be considered a trauma spectrum disorder, which would decrease the stigma and may increase the accuracy of the diagnosis (Gunderson, 1993; Herman & van der Kolk, 1987). However, Kroll (2003) proposes that "it is impossible to know what each disorder is, let alone whether they are the same thing" (p. 70).

The diagnostic criteria for BPD and PTSD bears only partial resemblance, but client presentation can appear extremely similar. The comorbidity rate (58%) among individuals diagnosed with BPD and PTSD further illustrates the resemblance among the disorders (Zanarini, Frankenberg, Hennen, Reich, & Silk, 2004). Moreover, clients with either BPD or PTSD may present with similar disturbances resulting in related symptoms. For example,

symptoms specific to regulating affect (e.g., depression, intense anger, irritability, unable to tolerate emotional extremes, feeling empty or dead, and highly reactive to mild stressors), difficulty regulating impulse (e.g., substance abuse and self- destructive behavior), reality testing (e.g., dissociation, reality testing) problems with interpersonal relationships (e.g., intense attachment and withdrawal), and identity diffusion (Herman & van der Kolk, 1987). Although client presentation can appear similar, many regard BPD as a chronic debilitating disorder (which can be difficult to treat), whereas PTSD is viewed as a situational response to an external or environmental circumstance (Becker, 2000; Zlotnick, Johnson, Yen, Battle, Sanislow, Skodol, & Shea, 2003).

The prototypical client with PTSD likely presents with a history of healthy and stable interpersonal relationships and symptoms occurring in reaction to exposure to a recognized stressor (assault, combat, rape, natural disaster) (Gunderson & Sabo, 1993). PTSD is one of the few disorders with symptoms attributed to environmental or situational causes as the source of psychological distress (Hodges, 2003). Whereas, a prototypical client with BPD may present with a history of unstable and unhealthy interpersonal relationships and an intense need for care (Gunderson & Sabo, 1993). Although according to some researchers, reclassification of BPD as a trauma spectrum disorder or as a type of complex PTSD may decrease stigma and increase accuracy of the diagnosis, reclassification may also inaccurately assume trauma is the cause or origin of BPD rather than the interaction of social, biological, psychological, and environmental factors (Caspi, McClay, & Moffit, 2002; Lewis & Grenyer, 2009; Siever, Davis, 1991).

The complexity and comorbidity of traumatic stress disorders increases the difficulty for clinicians to accurately and efficiently diagnose and treat clients. However, careful assessment of the client's history will help to disentangle the commonalities among symptoms of PTSD and

BPD. Neither PTSD nor BPD adequately describes the unique character alterations observed among those exposed to prolonged early childhood trauma (Herman, 1992a). Furthermore, clients may be diagnosed with both PTSD and BPD, who researchers suggest should be "extricated from the diagnosis of borderline personality disorder and subsumed under that of complex PTSD" (MacLean & Gallop, 2003, p. 369).

Complex PTSD is a single syndrome alternative to an Axis I and/or Axis II diagnosis when exposure to chronic and extreme trauma has affected the sense of self and relational trust (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). The current absence of a comprehensive diagnosis (i.e., complex PTSD) elicits serious consequences for treatment due to the loss of connection between the client's present symptoms and the experience of the trauma. Therefore, attempts to fit the client into the mold of the existing diagnostic criteria most likely results in a fragmentary understanding of the problem and approach to treatment (Herman, 1992a).

## A New Construct- Complex PTSD

A wide variety of occurrences in life can be "traumatic" and how traumatic events are experienced varies across individuals. According to Carlson (1997), five factors may influence the response to traumatic event(s): " individual biological factors, developmental level at the time of trauma, severity of the trauma (i.e., number of traumatic events experienced, intensity of event(s), nature of the trauma, and duration of the trauma), the social context of the individual both before and after the trauma, and life events that occur prior and subsequent to the trauma" (Carlson, 1997 p. 37). Although the factors influence the unique response to trauma, it is likely the interaction between the individual and the factors that determine the response to trauma.

In the early 1990s researchers and clinicians recognized variations of trauma and found complex and pervasive trauma can generate multifaceted reactions and symptoms (Courtois, 2004). Lenore Terr (1991) distinguishes two types of traumatic experiences, Type I referred to as a "single, traumatic blow," and Type II referred to as the "prolonged, repeated trauma." Survivors of a single or Type I trauma may "not feel like" her or himself after the event, survivors of chronic or Type II trauma may never feel like her or himself again. Judith Herman, a prominent trauma researcher and clinician, states Type II trauma survivors, "may feel changed irrevocably and may lose the sense that he or she had any self at all" (Herman, 1992a, p. 86). Traumatic disorders and their symptom severity lie on a continuum, "ranging from the effects of a single overwhelming event to the more complicated effects of prolonged and repeated abuse" (Herman, 1997, p. 3) Type II trauma is complex and/or repetitive, (e.g., domestic violence, war, community violence, ongoing abuse, genocide, or prolonged captivity) and often occurs as multiple victimizations, and involves betrayal of trust in close relationships (Finkelhor, Ormond, & Turner, 2007; Ford & Courtois, 2009; Herman, 1992a).

Trauma variations were first understood by researching child abuse victims and survivors of domestic violence since these populations were under studied regarding their relationship to trauma (Courtois, 2004). Researchers found DDs and the characteristics of complex trauma (i.e., repeated, chronic, and prolonged trauma) in children and adults with histories of severe child abuse and neglect (Courtois, 2004). Compared to other anxiety disorders and Type I traumas, persistent and prolonged exposure to stress is more damaging, resistant to treatment, and results in more severe anxieties, phobias, and panic symptoms (Norris & Slone, 2007; Herman, 1992a). Combat veterans exposed to prolonged trauma or who were held captive or imprisoned, may also experience complex trauma resulting in severe symptoms (Sutker,

Winstead, Galina, & Allain, 1991). However, although domestic violence survivors and combat veterans both experience post traumatic responses, differences exist between the groups.

Gender likely contributes to group differences; traditionally men are studied in combat veterans and women in domestic violent populations. Second, the role of the traumatized individual differs among the groups. Combatants are not only are the victims of the trauma, but may also be the agent of the trauma, whereas domestic violence survivors are commonly victims of the trauma and react to events imposed on them (Figley, 1985). The victim/ agent among combat survivors is likely to experience survivor guilt and shame, compared to the pure victim which is associated with paranoia and anxiety (Figley & Leventman, 1980). The third difference is the victim's relationship to the abuser. Survivors of domestic violence may have a strong attachment or an emotional bond to the abuser resulting in lack of trust and safety among their closest relationships (Herman, 1992a).

Intimate and domestic violence often results in relational trauma, and occurs when the victim feels trapped in a social structure, which allows abuse of a subordinate group (e.g, women) and is under the control of the perpetrator (Cloitre et al., 2009). Abused children are often psychologically and physically unable to handle the stress of the trauma, resulting in compromised development (Courtois, 2004). Herman describes the "characterlogical" features of complex PTSD among victims of child abuse, where " a child might develop within a relational matrix in which the strong do as they please, the weak submit, caretakers seem willfully blind, and there is no one to turn to for protection" (Herman, 2009, p. xiv). Furthermore, the child is often revictimized throughout the lifespan, individuals who were sexually or physically abused as children are more likely to be abused as adults (Gelinas, 1983; Herman, 1981). Additionally, child abuse is emotionally metabolized differently among men

and women. Men tend to identify with the abuser and victimize others later in life, whereas women tend to be revictimized through involvement with abusive men (Carmen, Reiker, & Mills, 1984; Jaffe, Wolfe, & Wilson, 1986). Furthermore, individuals exposed to trauma over a variety of developmental periods may suffer from an array of psychological problems not included in the PTSD diagnosis: depression, anxiety, self- hatred, dissociation, substance abuse, self-destructive and risk taking behaviors, revictimization, problems with interpersonal and intimate relationships, and medical and/or somatic concerns (Courtois, 2004).

Herman (1992a) proposed naming the syndrome that follows prolonged, repeated trauma "complex posttraumatic stress disorder' in which seven areas of diagnostic criteria have been proposed, and are as follows: 1) a history of subjection to totalitarian control over a prolonged period; 2) alteration of affect regulation; 3) alteration in consciousness; 4) alteration in self-perception; 5) alteration of perception of perpetrator; 6) alteration to relationships with others; and 7) alteration in systems of meaning ( Herman, 1992a, p. 121). These symptom clusters may result in profound changes to the sense of self, feelings of mistrust, changes to the relational style, breakdown of relationships, and feelings of grief and loss (Herman, 1992a, p. 138). The majority of relational trauma survivors experience cumulative traumas and their presentation is qualitatively different from those who experience a single traumatic event, therefore evaluating the effects of multiple traumas is imperative (Herman, 1997; Kessler, 2000).

Researchers and colleagues of Judith Herman, also believe "PTSD criteria captures only a limited aspect of post-traumatic psychopathology" (Luxenberg, Spinazzola, & van der Kolk, 2001, p. 373). Van der Kolk developed a diagnostic criteria, referred to as "disorders of extreme stress-not otherwise specified" (DESNOS), and proposed it to the *DSM-III- R* workgroup. The construct is strongly associated with experiences of prolonged trauma or stress, but DESNOS is

not officially predicated on a specific traumatic experience," therefore it is generalizable to many populations and can be the result of any "history of interpersonal victimization, multiple traumatic events, and/or traumatic exposure of extended duration" (p. 375). DESNOS addresses alterations in six domains of life as follows: 1) alteration in regulation of affect and impulses; 2) alteration in attention or concentration; 3) alterations in self- perception; 4) alterations in; and relations with others 5) Somatization 6) Alterations in systems of meaning.

The Structured Interview of Disorders of Extreme Stress (SIDES) was developed and validated during the *DSM-IV* field trials (Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997). The data from the field trails indicated prevalence of the DESNOS symptoms and was considered for inclusion as an independent diagnosis or a sub- category of PTSD in the *DSM-IV*. However, members of the taskforce held conflicting theories regarding trauma and omitted the DESNOS title and the symptoms became known as the "associated features" of PTSD (Luxenberg et al., 2001).

Comparable to Herman's complex PTSD classification, DESNOS identifies changes in mood affect regulation, concentration, self-perception, relationships with others, and systems of meaning. The constructs differ with the addition of somatization to DESNOS and the assumption of prolonged or repeated abuse in which the victim reports feeling helpless and/or controlled by the abuse or abuser in the complex PTSD criteria (Luxenberg et al., 2001). Somatization symptoms may impact the chronic trauma survivor at the biological level and result in physical complaints that challenge medical intervention and explanation (e.g., fatigue, generalized pain, digestive problems, erratic heart rate, sexual dysfunction) (van der Kolk, 2007). Exposure to chronic trauma compromises stress- response hormones, increasing the difficulty of responding to threatening situations quickly and effectively (Yehuda, 2000). Additionally,

women with histories of chronic sexual abuse in childhood may experience immune system dysfunction (Wilson, van der Kolk, Burbridge, Fisler, & Kradin, 1999). The assumption of prolonged abuse in which the victim feels helpless was omitted from the DESNOS criteria.

As previously mentioned, gender influences the types of trauma individuals experience, the way trauma encodes into meaning, and the social factors that mediate the impact of exposure (Stewart, Ouimette, & Brown, 2002). Several epidemiological studies suggest PTSD may be more prevalent among women than men (Breslau & Davs, 1992; Breslau, Kessler, Chilcoat, Schultz, Davis, & Andreski, 1998; Davidson, Hughes, Blazer & George, 1991; Helzer, Robins, & McEvoy, 1987; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Women with histories of chronic interpersonal trauma, such as assaultive violence by a significant other, often experience DESNOS or complex PTSD (Herman, 1992a). Survivors of prolonged, repeated trauma (longer than 1 month) experience considerably more complex symptoms such as, characteristic personality changes, a lack of relatedness to others, and a loss of identity that are not captured in the current PTSD diagnosis (Herman, 1992a). For example, survivors of intimate partner violence, experience the world very different from non-trauma survivors because their schemas of relationships, sex, family, and self-worth are impacted by the experience and duration of trauma (Finkelhor, 1990).

Findings from a *DSM-IV* PTSD committee authorized field trial suggested comorbidity between PTSD and complex PTSD or DESNOS was likely to occur (van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996). Despite commonalities, however, subsequent research has found PTSD and DESNOS differ in symptom presentation and functional impairment. Therefore, DESNOS could occur without meeting diagnostic criteria for PTSD (Ford, 1999). Ford (1999) interviewed 84 male veterans, who were routinely admitted to VA

specialized inpatient PTSD residential rehabilitation program and results indicate 58% met criteria for DESNOS, 26% of the respondents met criteria for DESNOS only , 29% met criteria for PTSD only, and 31% qualified for both PTSD and DESNOS, while 13% met neither diagnosis. Furthermore, approximately half of those diagnosed with DESNOS were not diagnosed with PTSD, suggesting sizeable heterogeneity between the two constructs. Survivors of extreme trauma experience symptoms that are not captured by the current PTSD diagnosis. Large proportions of trauma survivors from the *DSM- IV* PTSD field trial study who did not qualify for a PTSD diagnosis exhibited pathological dissociation (61%), somatization (47%), and affect dysregulation (34-37%). Therefore, trauma survivors who did not meet PTSD criteria exhibited considerable DESNOS symptoms (Pelcovitz et al., 1997). DESNOS-only participants were significantly more likely to report early trauma compared to the PTSD-only participants. Although the study was comprised of male participants, results indicate PTSD and DESNOS are fundamentally distinct constructs and PTSD symptoms do not account for severe symptoms from DESNOS (Ford, 1999).

Exposure to repeated, prolonged, and persistent trauma can result in a complex set of symptoms that may include PTSD symptomotology, but may also include a disruption to the affective and self-monitoring capabilities, particularly in interpersonal relationships (Cloitre, Stolback, Herman, van der Kolk, Pynoos, Wang, & Petkova, 2009). As previously mentioned, although PTSD and complex PTSD share similar symptoms (e.g., emotional numbing, anger, flashbacks) the current PTSD diagnosis does not include many elements of complex PTSD (e.g., changes in emotional regulation, consciousness, perceptions, relationships, and meaning). In a study of psychometric profiles measured by the Millon Clinical Multiaxial Inventory-III (MCMI-III) for women seeking inpatient treatment of trauma, and Huntoon (1998) found high elevations

on several personality disorder scales (Depressive, Self- Defeating, Avoidant, and Dependent), clinical syndrome scales (Anxiety, Dysthymia, and PTSD), as well as severe personality disorder scales (Borderline), and severe clinical syndrome scales (Major Depression). Allen and Huntoon's (1998) profile of participants is consistent with Herman's (1992a) multidimensional conceptualization of complex PTSD. Additionally, chronic trauma victims may also develop substance abuse disorders or major depressive disorder (Cohen & Hien, 2006; Reed & Enright, 2006; Clements & Sawhney, 2000). Prolonged and repeated exposure to trauma may result in complex symptom constellation, which may be more accurate, and less stigmatizing (Herman, 1992b) as described by complex PTSD rather than an Axis II diagnosis (i.e., Borderline Personality Disorder) (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997).

## The Purpose of the Current Study

Trauma researchers have acknowledged that trauma is not necessarily "outside the range of normal human experience" and approximately 8% of the population has PTSD (APA, 2000). Furthermore, the concept of a complex post traumatic syndrome has gained popularity over the last decade, but the review boards of the *DSM* have not yet deemed the syndrome its own title beyond the current "Disorders of Extreme Stress Not Otherwise Specified (DESNOS)" (Herman, 1992a). Although complex PTSD is not currently under review by the work groups of the American Psychiatric Association for the inclusion of the fifth edition of the DSM, the work groups have proposed the addition of a PTSD subtype with "Prominent Dissociative (Depersonaliztaion/ Derealization) Symptoms" (APA, 2012). The dissociative subtype of PTSD will likely be prevalent among survivors of prolonged and chronic trauma who may experience

detachment from traumatic memories (Chu, 2010; Lanius, Vermetten, Loewenstein, Brand, Schmahl, Bremner, & Spiegel, 2010).

A review of the literature supports the notion that women who experience complex PTSD exhibit considerably different symptoms than men diagnosed with PTSD and women diagnosed with BPD. To date, however, researchers have not explored the unique aftereffects of trauma for these women. Therefore, the purpose of the current study is to explore differences in personality characteristics and symptom profiles among women interpersonal trauma survivors diagnosed with complex PTSD when compared to similar women who were not diagnosed with complex PTSD. The study will provide a first step to understanding the distinctive symptom presentations of women who experience chronic interpersonal trauma. It is expected that women interpersonal trauma survivors with complex PTSD will differ significantly from their counterparts not diagnosed with complex PTSD in regard to symptom presentation as measured by the Millon Clinical Multiaxial Inventory- III (MCMI-III). Continued research and understanding of survivors of chronic, repeated, and prolonged trauma would help enhance and clarify the unique symptom profiles of women with complex PTSD. Additional knowledge will ultimately contribute and facilitate accurate research, assessment, and treatment of this often under recognized diagnostic entity.

The present study has three main purposes:

1. To test the following hypothesis:

   Women who meet full diagnostic criteria (i.e., meet 6 of 6 criteria on the SIDES-SR) for complex PTSD will have higher base rate scores on 10 MCMI- III scales (listed below) when compared to women who do not meet full diagnostic criteria (i.e., meet 1 of 6, 2 of 6, 3 of 6, or 4 of 6 criteria on the SIDES-SR).

| | |
|---|---|
| Clinical Syndromes | Clinical Personality Patterns |
| Anxiety | Depressive |
| Dysthymia | Masochistic |
| Post- Traumatic Stress | Avoidant |
| Somatoform | Dependent |
| Severe Clinical Syndromes | Severe Personality Pathology |
| Major Depression | Borderline |

2. To explore similarities and differences between MCMI- III profiles by describing the means, standard deviations, and ranges of base rate scores for:
    a. Women with Complex PTSD (i.e., meet all 6 criteria on SIDES- SR) vs. women who did not meet criteria for Complex PTSD (i.e., meet 1 of 6, 2 of 6, 3 of 6, or 4 of 6 criteria on the SIDES-SR).
    b. Women who meet 5 of 6 criteria for Complex PTSD on the SIDES-SR.

3. To describe trauma histories of women who meet each (criteria 1 through 6) of the SIDES- SR in an attempt to identify patterns that could inform future hypotheses.

# CHAPTER II

# METHOD

## Participants

Participants were recruited from a community clinic and shelter serving victims of intimate partner violence, sexual assault, childhood abuse, and perpetrators of intimate partner violence. Due to a small number of male victim participants ($n$ = 4), only adult women clients who sought victim services at the clinic and shelter were included in the study. The current study included 88 adult women with an average age of 34.53 years ($SD$ = 11.51) and 59.8 % self-identified as European American. The majority (30%) of the women were divorced, the mean income was $21,567.18, over half of the participants were unemployed (56.3%), and most participants reporting having (32.2%) attended "some college." Additional demographic data collected from the demographic form is reported in Table 2.

## Procedure

The Institutional Review Board approved the current study. Furthermore, permission to conduct research at the clinic was acquired by their board of directors. Participants were recruited through clinician referrals and flyers posted in the clinic waiting areas. Research assistants facilitated data collection during the clinic business hours by informing potential participants about the study. All participants signed an informed consent document and completed one of three counter balanced packets of self- report questionnaires in a quiet room in the clinic. Each packet contained 11 questionnaires, 3 of which were used in the current study. A research assistant remained in the room with each participant to answer questions and

administer items orally as needed. Participants completed the packet in 45 to 90 minutes. Upon completing the questionnaire packet, participants were compensated with $10.

## Measures

### Demographic Information

The demographic information and history form was developed for this study. The form provided a method of collecting data to describe the sample (e.g., age, ethnicity, marital and relationship status, education level, approximate income), as well as general information related to trauma history (e.g., reasons for seeking services at the clinic, frequency of experienced or witnessed trauma, age or time periods that the trauma occurred) and psychiatric diagnoses.

### Complex PTSD

The Structured Interview for Disorders of Extreme Stress- Self Report (SIDES- SR; Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997) is a self-report questionnaire designed to assess presence and/or severity of the disorders of extreme stress not otherwise specified (DESNOS). The items correspond to symptoms defined in the DESNOS diagnosis. The questionnaire measures a person's past and current (in the last month) functioning in six domains: 1) regulation of affect and impulses, 2) attention or consciousness, 3) self- perception, 4) relations with others, 5) somatization and 6) "systems of meaning" (i.e., chronically traumatized individuals may question life's purpose or the religious or ethical structures in which they were raised) (Luxenberg, Spinazzola, & van der Kolk, 2001).

The SIDES consists of 45 items that describe adverse situations and feelings; each item is followed by presence and severity questions. Participants indicate lifetime presence (i.e., this

has been true for me) and current symptom severity (i.e., how much have you been bothered in the last month?) for each item. Lifetime presence is answered as a yes/no dichotomy, whereas symptom severity ranges from 0 to 3. Presence of disturbances in all six areas of functioning and specific item endorsement is required for a DESNOS or complex PTSD diagnosis.

The clinician-administered or interview version of the SIDES was administered to 520 subjects as part of the original *DSM-IV* PTSD field trials (Pelcovitz et al., 1997). According to Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, and Resick (1997), inter-rater reliability as measured by Kappa coefficients was .81 and internal consistency reliability ranged from $\alpha = .53$ to $\alpha = .96$. Furthermore, internal consistency for the SIDES-SR was high ($\alpha = .93$), and in the current study, the Cronbach alpha coefficient was the same ($\alpha = .93$). According to the scale authors, five of the six subscales have adequate to good internal consistency ($\alpha = .74$ to .82), with the Somatization subscale being an exception ($\alpha = .68$). Finally, although subscale scores on the SIDES interview and SIDES-SR are generally consistent for any given participant, there are two exceptions. Specifically, clients report less affect dysregulation and better modulation of anger symptoms than their clinician raters do (Luxenberg, Spinazzola, & van der Kolk, 2001).

In the current study, three of the six (i.e., Self- Perception, Affect/ Impulse, and Somatization) subscales have adequate to good internal consistency ($\alpha = .73$ to .86). However, the remaining three (i.e., Systems of Meaning, Attention or Consciousness, and Relationships with Others) scales had inadequate internal consistency ($\alpha = .61$ to .69) (see Table 6 for Pearson correlations and alphas).

Psychiatric Symptoms

The Millon Clinical Multiaxial Inventory- III is a self- report inventory of psychological

functioning (MCMI-III; Millon, 1997*)*. The questionnaire consists of 175 true- false items that load onto a total of 24 content scales. The content scales from the MCMI- III correspond to seven clinical syndrome scales (i.e., anxiety, somatoform, bipolar, dysthymia, alcohol dependence, drug dependence, and post- traumatic stress disorder), and three severe clinical syndrome scales (i.e., thought disorder, major depression, and delusional disorder) used to assess Axis I clinical disorders. The content scales also correspond to 11 personality disorder scales (i.e., schizoid, avoidant, depressive, dependent, histrionic, narcissistic, antisocial, sadistic, compulsive, negativistic, and masochistic) and three severe personality pathology scales (i.e., Schizotypal, Borderline, and Paranoid) used to distinguish enduring Axis II disorders as described in the *DSM-IV* (APA, 1994). Additionally, the MCMI-III includes a validity scale and three Modifying Indices (i.e., Disclosure, Desirablility, and Debasement). Researchers and clinicians can assess the validity of a participant's responses and adjust scores for certain response patterns associated with specific Axis I or II disorders.

The 10 scales in the present study include four clinical syndrome scales (Anxiety, Dysthymia, Post- Traumatic Stress, Somatoform), one severe clinical syndrome scale (Major Depression), four clinical personality pattern scales (Depressive, Masochistic, Avoidant, and Dependent), and one severe personality pathology scale (Borderline).

Millon (1997) describes individuals who score high on the Anxiety scale as worrisome, apprehensive, tense, "indecisive", and "restless". Additionally they may exhibit an inability to relax, psychomotor agitation, readiness to react and can be easily startled. In terms of somatic symptoms, these individuals may experience "ill defined muscular aches", "excessive perspiration", "clammy hands", "upset stomach", "tightness", and "nausea" (p. 23). Lastly, high

scorers may indicate hyper alertness to the environment resulting in edginess and generalized touchiness.

The author described high scorers on the Dysthymia scale as involved with everyday life, however a preoccupation with feelings of "discouragement or guilt, lack of initiation, low self-esteem, and behavioral apathy" have been present over a period of years (Millon, 1997, p. 23). Tearfulness, suicidal ideation, negative outlook toward the future, difficulty concentrating, and a significant loss of interest in pleasurable activities may be present during periods of dejection (Millon, 1997). Examination of specific items endorsed may enable clinicians to discern particular present features of the dysthymic mood (e.g., low self-esteem or hopelessness).

High scorers on the Post- Traumatic Stress Disorder scale are described as experiencing an "event that involved a threat to their life in which they reacted with intense fear or feelings of helplessness" (Millon, 1997, p. 24). They may experience images or memories associated with the trauma resulting in distressing nightmares and recollections that reactivate the feelings from the original traumatic event. These individuals are likely to avoid situations associated with the trauma and demonstrate exaggerated startle response and hypervigilance (Millon, 1997).

The author (Millon, 1997) described high scorers on the Somatoform scale as expressing psychological difficulties through somatic means, such as "persistent periods of fatigue and weakness and a preoccupation with ill health" (p. 23). While some may be preoccupied with a variety of dramatic but typically nonspecific pains in unrelated regions of the body, others may interpret minor physical discomforts or sensations as signifying a serious ailment (e.g., hypochondriasis). Typically, somatic complaints are employed to gain attention. "If realistic diseases are factually present, they tend to be over interpreted despite medical reassurance" (Millon, 1997, p. 23).

High scorers on the Major Depression scale were described as expressing a "dread of the future, suicidal ideation, and a sense of hopelessness (Millon, 1997, p. 24). High scorers commonly also experience problems with "concentration, feelings of worthlessness or guilt", and "repetitive fearfulness and brooding" (Millon, 1997, p. 24). They may be incapable of functioning in a normal environment and may exhibit psychomotor agitation or retardation. Lastly, they may experience somatic disturbances such as "decreased appetite, fatigue, weight loss or weight gain, or insomnia" (Millon, 1997, p. 24).

Individuals who score high on the Depressive scale are described as expressing dread for the future, suicidal ideation, permanent pain, and a sense of hopelessness. They may also experience difficulties with concentration, feelings of worthlessness or guilt, and recurring worry. They may exhibit psychomotor retardation or agitation and somatic disturbances (i.e., decreased appetite, fatigue, weight loss or gain, and insomnia) (Millon, 1997).

High scorers on the Masochistic scale are described as "relating to others compliantly and permitting others to take advantage of them" (Millon, 1997, p.18). They may believe they deserve to be punished and shamed, which may be comforting to them. They may frequently recall their past misfortunes and assume continued hardship for the future, while also ranking themselves as inferior to others (Millon, 1997).

High scores on the Avoidant Personality scale may be on guard and ready to "distance themselves from the anxious anticipation of life's painful or negatively reinforcing experiences" (Millon, 1997, p. 16). By actively withdrawing and maintaining interpersonal distance, they "protect themselves despite their desires to relate to others (Millon, 1997, p. 16).

Individuals who score high on the dependent scale are described as assuming a passive role in interpersonal relationships. They may have a lack of initiative and autonomy, and "search

for relationships that provide nurturance, security, affection, and guidance" (Millon, 1997, p. 16). They may be likely to accept any kindness and support and willing to submit to the wishes of other to maintain affection (Millon, 1997).

High scores on the Borderline Personality scale may indicate affect dysregulation commonly expressed as unstable moods. Borderline individuals may have "recurring thoughts regarding self-mutilation and suicide," are exceedingly concerned with securing affection, exhibit an unstable sense of identity, and experience ambivalent and conflicting "feelings such as rage, love, and guilt toward others" (Millon, 1997, p. 18).

The MCMI- III was normed on 600 clinical participants and is "applicable only to individuals who evidence problematic emotional and interpersonal symptoms or who are undergoing professional psychotherapy or psychodiagnostic evaluation" (Millon, 1997, p. 6). Participants in the current study were receiving professional services, such as individual and/or group psychotherapy for interpersonal victimization

The MCMI- III uses base rate (BR) scores as the standard score from which raw scores are translated. BR scores lie on a continuum that indicates the pervasiveness and severity of a psychological characteristic. Therefore, BR scores from 0 to 74 suggest no pathology, whereas scores from 75- 84 reflect pathology at the "traits" or "features" level, and scores of 85 or higher suggest pathology at the diagnostic level. For the Axis II scales, BR at or above 75 may be viewed as indicating the presence of clinically significant personality traits, and BR at or above 85 likely indicates pervasive pathology to be called a personality disorder (Millon, 1997)

According to Millon (1997), strong internal consistency, measured by alpha coefficients, is present for the 10 scales used in the current study (Anxiety $\alpha$ = .86, Dysthymia $\alpha$ = .91, PTSD $\alpha$ = .89, Somatoform $\alpha$ = .96, Major Depression $\alpha$ = .95, Depressive $\alpha$ = .89, Masochistic $\alpha$ =

.87, Avoidant $\alpha$ = .89, Dependent $\alpha$ = .85, and Borderline $\alpha$ = .85 ). In terms of test- retest reliability, 87 participants were re-administered the test 5 to 14 days after the initial administration and results range from $r$ = .82 for Debasement to $r$ = .96 for the Somatoform scale. The median stability coefficient was $r$ = .91 which strongly indicates that the MCMI- II results are highly stable over short periods of time (Millon, 1997). Intercorrelations, alphas, means and standard deviations of base rates for the 10 proposed MCMI- III scales are reported in Table 4.

Strong internal consistency, measured by alpha coefficients, is present for the eight scales used in the current study (Anxiety $\alpha$ = .83, PTSD $\alpha$ = .89, Major Depression $\alpha$ = .87, Depressive $\alpha$ = .87, Masochistic $\alpha$ = .85, Avoidant $\alpha$ = .86, Dependent $\alpha$ = .83, and Borderline $\alpha$ = .85 ). Intercorrelations, alphas, means, standard deviations, and ranges of base rates of the eight scales from the current study sample is presented in Table 5.

Strong correlations with similar and dissimilar scales indicate support for convergent and discriminant validity (Millon, et al., 1997). A total of 67 primary clinicians participated in the MCMI- III validity study in which they were well acquainted with the MCMI test and Millon's (1990) evolutionary theory. The clinicians rated patients (who they have had at least three therapeutic or counseling sessions) severity on both Axis I and Axis II syndromes. Additionally, clinicians required their patients to complete any of several additional tests (e.g., Beck Depression Inventory (BDI; Beck & Steer, 1987), Symptom Checklist- 90- Revised (SCL- 90-R; Derogatis, 1994), and the MMPI- 2) (Millon, 1997). The MCMI- III validity has been demonstrated by significant correlations with the BDI (Beck & Steer, 1987) on the MCMI- III Depressive scale ($r$ = .56), Dependent scale ($r$ = .50), Masochistic ($r$ = .53), Borderline ($r$ = .56), Anxiety ($r$ = .61), and PTSD ($r$ = .63).

The SCL-90-R (SCL- 90-R; Derogatis, 1994) is a widely used screening tool that consists of a range of symptom clusters. The SCL-90-R Depression scale correlated with the MCMI-III Depressive scale ($r$ = .65). The SCL-90-R Anxiety scale correlated with the MCMI-III Anxiety scale ($r$ = .54). All three of the SCL-90-R Obsessive Compulsive, Interpersonal Sensitivity, and Depression scales correlated with the MCMI-III Masochistic scale ($r$ = .58). Correlations between the MCMI- III Depressive scale and the MMPI-2 Depression scale were also high ($r$ =.59) (Millon, 1997).

## Data Analyses

Prior to conducting the statistical analyses, all independent and dependent variables were examined to assess whether assumptions were met. The assumptions for MANOVA are normality, linearity, non-multicollinearity, non-singularity, and homogeneity of variance-covariance matrices. If assumptions are not met, transformations were conducted. In addition, data were explored for missing data and appropriate measures were taken to rectify the missing data.

Frequencies of all demographic variables (e.g., ethnicity, marital status, current relationship status, employment, highest degree earned, reasons for seeking services at the clinic, length in service at the clinic, length in therapy at the clinic, and number of traumatic events) were also conducted.

## Test of Hypotheses

A MANOVA was conducted to test the first hypothesis that women who meet full diagnostic criteria for Complex PTSD (i.e., meet 6 of 6 criteria on the SIDES-SR) will have

higher base rate scores on 10 MCMI- III scales (Anxiety, Dysthymia, PTSD, Somatoform, Major Depression, Depressive, Masochistic, Avoidant, Dependent, and Borderline) compared to women who do not meet diagnostic criteria (i.e., meet 1 of 6, 2 of 6, 3 of 6, and 4 of 6 criteria on the SIDES- SR). The independent variable will be the SIDES criteria (i.e., meet 1 of 6 , 2 of 6, 3 of 6, and 4 of 6) and the dependent variable will be the 10 MCMI- III scales.

To address the second aim of the study, exploring the similarities and differences between MCMI- III profiles of 2A) women with and without Complex PTSD and; 2B) women who meet 5 of 6 criteria, descriptive information (i.e., means, standard deviations, and ranges of base rates) regarding the samples were reported.

The third aim of the study, to identify patterns on the SIDES- SR among women with trauma histories, were addressed by reporting descriptive information (e.g., number of traumatic events, age at trauma(s), abused in childhood, type of abuse in childhood, etc) regarding trauma history among those who meet each of the SIDES- SR criteria (1 through 6).

# CHAPTER III

# RESULTS

## Data Preparation

Prior to analyzing the data, screening measures were used to examine the accuracy of data entry, check for missing values and outliers, and test the assumptions of multivariate analysis of variance (MANOVA), one-way analysis of variance (ANOVA), and chi-square. First, a research assistant double- checked the accuracy of data entry by comparing electronic data to the corresponding values recorded on the original survey. Then, frequencies were run to further check for data entry errors.

Next, assumptions of MANOVA-- sample size, normality, outliers, linearity, multicollinearity and singularity, and homogeneity of variance-- covariance matrices were tested by examining independent and dependent variables. The assumption of sample size was met because each cell included over 20 participants (Tabachnick & Fidell, 2007). Hypothesis 3 met the sample size assumption for ANOVA because there were more than 20 degrees of freedom and the group sizes were similar (Donaldson, 1968). The assumption of normality was tested by examining the skewness, kurtosis, and histograms of each variable. Because each of the hypotheses tested with a MANCOVA, MANOVA, or ANOVA were composed of more than 20 participants, these analyses were robust for violations of normality (Tabachnick & Fidell, 2007).

Data were then screened for multivariate outliers by calculating Mahalanobis distances to assess the distance of a particular case from the central point created by the means of all of the variables (Tabachnick & Fidell, 2007). Based on Mahalanobis distances, 27 cases were multivariate outliers, resulting in positively skewed data. Multivariate outliers were not deleted because they were expected for the variables based on the current study's sample, and

MANOVA is generally robust to such violations (Tabachnik & Fidell, 2007). To proceed with parametric analysis, standardized values (i.e., *z*-scores) were calculated to determine univariate outliers on variables relevant to hypothesis testing; *z*-scores above 3.3 that were disconnected from the distribution were determined univariate outliers (Tabachnick & Fidell, 2007). Based on z-scores, no variables relevant to hypothesis testing had univariate outliers.

Generating a matrix of scatterplots between each pair of independent and dependent variables tested the assumption of linearity. All variables met the assumption of linearity, except the data of women who met 4 of 6 ($n$ = 12) complex PTSD (CPTSD) criteria on the Structured Interview for Disorders of Extreme Stress-Self Report (SIDES- SR). The data violated the assumption of linearity on the Borderline, Avoidant, Masochistic, Depressive, and Somatoform scales, because graphs suggested curvilinear relationships between various pairs of these variables (Pallat, 2010). Furthermore, the cell size ($n$ = 12) did not ensure robustness for violations of this assumption (Tabachnick and Fidell, 2007).

To correct for these violations, participants who met 4 of 6 criteria were removed from analyses that contained the aforementioned Millon Clinical Multiaxial Inventory- III (MCMI-III) scales. The remaining participants were assigned to three groups according to the number of SIDES-SR criteria met. The following groups will be addressed throughout the remainder of the study: Women who met three or less SIDES-SR criteria are referred to as low symptom (LoSx), women who met 5 of 6 SIDES criteria are referred to as high symptom (HiSx), and women who met all 6 SIDES criteria are referred to as complex PTSD (CPTSD) (see Table 1 for group descriptions). The data of women in the LoSx group (i.e., met 1 ,2, or 3 of 6 criteria) also yielded scatter plots depicting curvilinear relationship between key variables, specifically, the relationships between Anxiety, PTSD, and Dependent scales appeared non- linear. Thus, the data

of these participants were not included in the analyses that included any combination of Anxiety, PTSD, and Dependent scores.

One- tailed Pearson *r* tests were conducted to examine multicollinearity between the proposed 10 scales of the MCMI- III (i.e., Anxiety, Dysthymia, PTSD, Somatoform, Major Depression, Depressive, Masochistic, Avoidant, Dependent, and Borderline). The tests revealed strong correlations between Somatoform and Dysthymia ($r = .77$, $p = .001$), Major Depression and Dysthymia ($r = .83$, $p = .001$), and Somatoform and Major Depression ($r = .87$, $p = .001$). To account for these redundancies across variables, the Dysthymia and Somatoform scales were removed from analyses that included the Major Depression scale. Correlations for the remaining eight scales are displayed in Table 4. Lastly, the remaining assumption for chi-square (exploratory analyses) was independence of observations (i.e., each participant is only counted once) and none of the samples violated this assumption.

The mean scores of the eight MCMI- III scales used in the current study are displayed for women in groups HiSx and CPTSD in Figure 3. Lastly, the mean scores for all MCMI-III scales and for all Groups (i.e., women meeting 1-6 SIDES- SR Criteria) are displayed in Figure 4 and 5. Refer to Table 15 for a depiction of results.

## Hypothesis Testing

### Hypothesis 1

A MANOVA was conducted to test the first hypothesis states that the mean Base Rate scores for the Anxiety, PTSD, and Dependent scales of the MCMI- III would be higher for women with CPTSD (i.e., met 6 of 6 criteria) than women in the HiSx (i.e., met 5 of 6 criteria) group. Results of the MANOVA showed that the effect of number of Complex PTSD criteria

met was statistically significant at the multivariate level, $F(3, 42) = 3.44$, $p = .025$; Wilks' $\lambda = .80$; partial eta squared = .20. When evaluating dependent variables separately at the univariate level, statistically significant group differences were found on the Anxiety and PTSD scales. Namely, women in the CPTSD group ($M = 87.28$, $SD = 16.34$) scored significantly higher on the Anxiety scale $F(1, 44) = 4.97$, $p = .031$, partial eta square = .102 than their HiSx peers ($M = 73.71$, $SD = 24.67$). Further, women in the CPTSD group ($M = 78.20$, $SD = 17.37$) scored significantly higher on the PTSD scale $F(1, 44) = 9.91$, $p = .003$, partial eta square = .184 than their HiSx peers ($M = 60.05$, $SD = 21.75$). There were no significant group differences, however, on the Dependent scale $F(1, 44) = 2.73$, $p = .106$, partial eta square = .058. Although not statistically significant, the variance accounted for by scores on the Dependent scale was notable. The effect sizes were 10% and 18% for the Anxiety and PTSD scales respectively, and accounted for a meaningful amount of variance (see Table 6 for Means and Standard Deviations and Table 8 for MANOVA results).

Hypothesis 2

The second hypothesis states that the mean scores for the Major Depressive, Depressive, Avoidant, and Masochistic scales would significantly differ for women in all three groups (e.g., LoSx, HiSx, and CPTSD). Another, one- way between groups MANOVA was conducted to investigate differences in mean Base Rate scores on four MCMI- III scales. Results of the MANOVA showed that the main effect of number of CPTSD symptoms met was statistically significant at the multivariate level, $F(8, 128) = 4.68$, $p < .001$; Wilks' $\lambda = .60$, partial eta squared = .23.

When the results for the dependent variables were considered separately at the univariate level, statistically significant group differences were found for women in the LoSx, HiSx, and CPTSD groups on the Major Depression scale $F(2, 67) = 19.17$, $p < .001$, partial eta squared = .36. Specifically, women in the LoSx group ($M = 38.80$, $SD = 27.51$) are significantly different than women in the HiSx group ($M = 62.24$, $SD = 20.04$, $p = .005$) and women in the CPTSD group ($M = 81.64$, $SD = 20.04$, $p < .001$). Moreover, women in the HiSx group are significantly different than women in the CPTSD group ( $p = .023$). Group membership accounted for a meaningful amount of variance in Major Depression scores.

Furthermore, results revealed statistically significant group differences for women in the LoSx, HiSx, and CPTSD groups on the Depressive scale, $F(2, 67) = 11.64$, $p < .001$, partial eta squared = .26. More specifically, women in the LoSx ($M = 51.83$, $SD = 24.70$) are significantly different than women in the CPTSD group ($M = 83.20$, $SD = 16.00$, $p < .001$). Women in the HiSx group($M = 66.00$, $SD = 27.07$) are significantly different than women in the CPTSD group ( $p = .035$). However, women in the LoSx group are not significantly different than women in the HiSx group ( $p = .102$). Moreover, group membership accounted for a meaningful amount of variance for symptoms of self- blame, guilt, feelings of sadness, emptiness, and pessimism.

Likewise, significant group differences were found for women in the LoSx, HiSx , and CPTSD groups on the Avoidant scale, $F(2, 67) = 6.90$, $p < .001$, partial eta squared = .17. Particularly, women in the LoSx group ($M = 43.42$, $SD = 26.90$) were significantly different than women in the CPTSD group ($M = 71.32$, $SD = 28.05$, $p = .001$). Women in the LoSx group were not significantly different than women in the HiSx group ($p = .123$) and women in the HiSx group were not significantly different than women in the CPTSD group ($p = .263$). Group membership accounted for a considerable amount of variance in Avoidance scores.

The homogeneity of variance assumption was violated for the Masochistic scale, $F(2, 67) = 7.08$, $p = .002$, therefore, the corrected model was reported and revealed significant group differences for women in the LoSx, HiSx, and CPTSD groups, $F(2, 67) = 10.96$, $p < .001$, partial eta squared = .25. For instance, women in the LoSx group *(*$M = 49.88$, $SD = 29.01$) were significantly different than women in the HiSx group ($M = 67.90$, $SD = 24.03$, $p = .030$), and CPTSD group ($M = 80.80$, $SD = 14.58$, $p > .001$). However, women in the HiSx group did not significantly differ from women in the CPTSD group ($p = .153$). Group membership accounted for a meaningful amount of variance in the Masochistic scores.

These results revealed that women in the CPTSD group had significantly more Major Depression, Depressive, Avoidant, and Mashochistic symptoms than women in the HiSx or LoSx groups. Results suggest women who meet more CPTSD criteria (i.e., HiSx or 3) experience greater Major Depression, Depressive, Avoidant, and Masochistic symptoms (see Table 9).

Hypothesis 3

The third hypothesis states that the mean Base Rate score for the Borderline scale would significantly differ for women in all three groups. To test this hypothesis, an ANOVA was performed to test mean score differences on the Borderline scale, as measured by the MCMI- III. Based on Levene's *F* tests, the homogeneity of variance assumption was violated, $F(2, 67) = 5.77$, $p = .005$. Subsequently, Dunnett T3 pairwise post hoc tests of the three groups indicated that women in the CPTSD group ($M = 72.88$, $SD = 16.14$) had significantly more Borderline symptoms than women in the HiSx group ($M = 52.95$, $SD = 25.89$, $p = .013$). Likewise, women in the CPTSD group had more Borderline symptoms than women in the LoSx group ($M = 19.67$,

*SD* = 19.67, $p$ = .001). Lastly, women in the HiSx group had significantly more Borderline symptoms than women in the LoSx group ($p$ = .037). Overall, these findings support hypothesis 3 (see Table 10).

## Exploratory Analyses

The third aim of the study, to identify patterns on the SIDES- SR among women with differing trauma histories, was addressed by running frequencies of trauma history (e.g., number of traumatic events, age at trauma(s), abused in childhood, and type of abuse in childhood) among those who meet each of the SIDES- SR criteria (see Table 7a and 7b). Additionally, several chi-square tests, independent samples *t*-tests, frequencies, and an ANOVA were run to compare various demographic and trauma history information. The relationships between type of abuse, perpetrators, various demographic variables, and CPTSD are presented first, followed by exploratory analyses of SIDES- SR Criteria I and the MCMI- III Borderline Scale.

### Chi-Square Tests

The first chi- square test was run to examine the relationship between adult sexual assault and CPTSD. The test (with Yates continuity correction) did not reveal a statistically significant relationship between adult sexual assault and CPTSD, $\chi^2$ (1, $n$ = 75) = 1.37, $p$ = 2.42, phi = .17. A second chi- square test was run to examine the relationship between childhood abuse and CPTSD. The test revealed (with Yates continuity correction) a statistically significant relationship between CPTSD and childhood abuse, $\chi^2$ (1, $n$ = 81) = 5.62, $p$ = .018, phi = .29. To further explore the relationship of childhood abuse and CPTSD, several chi- square tests were run to examine the association between types of childhood abuse and CPTSD. The chi- square

tests (with Yates continuity correction) revealed statistically significant associations between the following types of childhood abuse: sexual, $\chi^2$ (1, $n$ = 78) = 7.66, $p$ = .006, phi = .34, physical $\chi^2$ (1, $n$ = 77) = 5.42, $p$ = .020, *phi* = .29, and emotional $\chi^2$ (1, $n$ = 78) = 4.43, $p$ = .035, *phi* = .27. It is notable that sexual childhood abuse has the strongest association with CPTSD among the three types of significant childhood abuse.

Furthermore, chi- square tests were conducted to examine the association between the perpetrator of the childhood abuse and CPTSD. The Chi- square tests (with Yates continuity correction) did not reveal statistically significant relationships between mother/ female guardian, $\chi^2$ (1, $n$ = 75) = .33, $p$ = .568, *phi* = .10 or Father/ male guardian, $\chi^2$ (1, $n$ = 74) = .00, $p$ = .962, *phi* = .04, or "Other family member" perpetrator, $\chi^2$ (1, $n$ = 76) = 3.50, $p$ = .061, *phi* = .24 and CPTSD. The chi- square test for Sibling and Stranger perpetrators did not meet the assumption for sample size because less than 80% of the cells included five or more participants (Pallant, 2010).

Chi-square tests were run to further examine the relationship between additional demographic variables and CPTSD. The test (with Yates Continuity Correction) did not reveal statistically significant relationships between Secondary Trauma, $\chi^2$ (1, $n$ = 75) = .99, $p$ = .321, *phi* = .15 or "Romantic Partner was abused", $\chi^2$ (1, $n$ = 74) = 1.60, $p$ = .207, *phi* = -.18 and Complex PTSD. The chi- square test for "My [participant's] child was abused", did not meet the assumption for sample size because less than 80% of the cells included five or more participants (Pallant, 2010).

Independent Samples *t*-Tests

An independent- samples *t*-test was conducted to compare the age of participants and

CPTSD diagnosis according to the SIDES-SR. There was no significant difference in age of women with Complex PTSD ($M$ = 31.74, $SD$ = 9.18) and without CPTSD ($M$ = 35.35, $SD$ = 12.04), $t(53) = -1.45$, $p = .153$. The magnitude of the differences in the means (mean difference = -3.61, 95% *CI*: -8.61 to 1.38) was small (eta squared = .026).

An independent samples *t*-test was conducted to compare the age of participants and SIDES-SR Criteria I. There was no significant difference in age of participants who met ($M$ = 34.84, $SD$ = 11.82) and did not meet SIDES-SR Criteria I ($M$ = 33.63, $SD$ = 10.86), t (78) = .472, $p = .638$. The magnitude of the differences in the means (mean difference = 1.21, 95% *CI*: -3.91 to 6.33) was small (eta squared = .003).

To compare mean score differences on the Borderline scale for women who met and did not meet the diagnostic criteria for CPTSD, an independent samples *t- test* was run. The test revealed statistically significant differences in mean Borderline scores for women who met ($M$ = 72.88, $SD$ = 16.14) and did not meet the CPTSD diagnosis ($M$ = 41.09, $SD$ = 24.07) t (67) = 7.01, $p = .001$. The magnitude of the differences in the means (mean difference = 31.79, 95% *CI:* 22.74 to 40.85) was large (eta squared = .381).

Finally, to further examine the relationship between BPD and CPTSD, an independent samples *t-test* was conducted to compare the mean Borderline scale score and SIDES-SR Criteria I. There was a medium, negative correlation between BPD and Criteria I, $r = -.375$, $n = 82$, $p = .001$, with high scores on the BPD scale associated with lower levels of Criteria I (coded: 1 = yes, 2 = no). The test revealed significant differences in mean Borderline scores for participants who met ($M$ = 59.26, $SD$ = 26.51) and did not meet SIDES-SR Criteria I ($M$ = 39.40, $SD$ = 21.70) t (80) = 3.62, $p = .001$. The magnitude of the differences in the means (mean difference = 19.86, 95% *CI*: 8.93 to 30.77) was large (eta squared = .147).

Frequencies

Frequencies were run to assess if there were participants in the sample who scored high on the Borderline scale (≥75) but did *not* meet criteria for a CPTSD diagnostic criteria. Results revealed 16 (20% of the total sample) of the participants scored ≥75 on the Borderline scale. Of those 16 women, 10 (63%) met CPTSD diagnostic criteria and six (38%) did not meet CPTSD diagnostic criteria. Furthermore, the means and standard deviations for the MCMI- III scales with scores ≥75 for the 16 participants who scored ≥75 on the Borderline scale are displayed in Table 13.

Frequencies were run and explored to investigate and compare the data from women who did not meet criteria for a CPTSD diagnosis, but reported similar trauma histories to those who did meet a CPTSD diagnosis. Frequency results reveal presence of women who report having experienced similar types of trauma histories but do not meet criteria for a CPTSD diagnosis. However, women who met diagnostic criteria for a CPTSD diagnosis endorsed types of abuse (e.g., sexually assaulted, abused in childhood, physical childhood abuse, sexual childhood abuse, emotional childhood abuse, physical childhood neglect, and emotional childhood neglect) an average of 27% more than those without a CPTSD diagnosis. Furthermore, the unequal sample sizes should be noted (see Table 14 for Frequencies).

# CHAPTER IV

# DISCUSSION

The primary aim of this study was to assess the validity of complex post traumatic stress disorder (CPTSD) as a construct distinct from borderline personality disorder. Specifically, women trauma survivors who met and did not meet criteria for CPTSD on the SIDES- SR, were compared on the Anxiety, PTSD, Dependent, Major Depression, Depressive, Avoidant, Masochistic, and Borderline scales on the MCMI- III. It is important to describe the unique aftereffects of interpersonal trauma these women experience because they are frequently misdiagnosed and mistreated (Herman, 1992a).

Consistent with previous research (Herman, 1992a), which originally characterized CPTSD as a result of chronic and prolonged trauma beginning during the early stages of life, results from the current study revealed a statistically significant relationship between abuse in childhood and CPTSD. Significant relationships between childhood sexual, physical, and emotional abuses were found with CPTSD. These findings are in keeping with previous research that a history of childhood sexual abuse is significantly related to symptoms of CPTSD (i.e., somatization, dissociation, anxiety, hostility, alexithymia, social dysfunction, maladaptive schemas, self- destruction, and adult victimization) (Jackson, Nissenson, & Cloitre, 2010; Zlotnick et al., 1996). Additionally, childhood physical and sexual abuse are risk factors for developing CPTSD among women, and those who experience a combination of childhood physical and sexual abuse are at a greater risk than physical abuse alone (Roth, et al., 1997).

Women with a CPTSD diagnosis have an average of 27% higher frequency of childhood abuse than women without a CPTSD diagnosis, suggesting the salience of repeated incidences of trauma rather than the presence of abuse history alone. These results are consistent with the

theoretical conceptualization of CPTSD as an early onset and long duration trauma that are commonly found in survivors of childhood abuse (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazola, 2005). Furthermore, current results suggest that those who met the CPTSD diagnostic criteria experienced a higher incidence of trauma compared to those who met fewer CPTSD diagnostic criteria. Similarly, the number of traumatic events experienced was positively associated with SIDES- SR criteria met. Lastly, results support hypothesis one, which stated that women who met more SIDES criteria would have higher mean scores on all eight MCMI- III scales used in the current study. These findings provide evidentiary support for the validity and theoretical conceptualization of CPTSD.

## MCMI- III Scales

Women with histories of interpersonal trauma were grouped according to the number of SIDES- SR criteria met. Women who met three or fewer SIDES- SR criteria are referred to as Low Symptom (LoSx), women who met 5 of 6 SIDES criteria are referred to as High Symptom (HiSx), and women who met all 6 SIDES criteria are referred to as Complex PTSD (CPTSD). Significant differences were found on the Major Depression scale when comparing women across all three groups. Similarly, significant differences were found on the Depressive scale when comparing women in the HiSx vs. CPTD group as well as LoSx vs. CPTSD group. However, no significant differences were found on the Depressive scale when comparing women in the LoSx vs. HiSx group. Both Major Depression and Depressive scales for women who meet CPTSD diagnostic criteria had mean scores above 80. Additionally, 52% and 56% of women with CPTSD had mean Major Depression and Depressive scores $\geq$85, respectively. These

findings suggest that the majority of women with CPTSD experience comorbid Major Depression and Depressive symptoms.

Although LoSx vs.HiSx women differed on the Major Depression scale, they did not differ on the Depressive scale. One possible explanation for these findings is that the mean Depressive scores were higher than the mean Major Depressive scores for women in LoSx vs. HiSx groups. That is, women in this sample tended to endorse personality prototypical items related to chronic worrying, self- blame, guilt, feelings of emptiness, and suicideality, but HiSx women reported significantly more current vegetative symptoms, crying spells, and withdrawn behavior than did the LoSx women.

The results comparing LoSx vs. HiSx women indicate that women who meet more SIDES- SR criteria experience significantly more Major Depression and Depressive symptoms. Furthermore, the Major Depression and Depressive scales could differentiate HiSx from LoSx women. That is, these findings provide evidence for the construct of CPTSD by illuminating the presence of statistically significant differences on the Major Depression and Depressive scales for women who meet and do not meet CPTSD criteria. One possible explanation for the significant differences between women in HiSx vs .CPTSD and LoSx vs. CPTSD women on the Major Depressive scale is the prevalence of depression among trauma survivors. As Walker (1979) articulated, Major Depression is the most common disorder among chronically traumatized individuals, and depression tends to be embedded in a history of interpersonal trauma (Allen, et al., 1998).

Herman and van der Kolk (1987) observed that affect regulation, impulse control, reality testing, interpersonal relationships, and self-integration are common disturbances experienced in both BPD and CPTSD. However, one of the crucial differences between the disorders is the

etiology. As previously mentioned, PTSD is the only disorder to date which assumes trauma as the primary cause, whereas trauma could be one of many etiologies for BPD (Zanarini, Williams, & Lewis, 1987).

Empirical evidentiary support is needed to provide evidence that the two constructs are in fact distinct. In light of this dilemma, two exploratory analyses were conducted. The mean score for CPTSD women was three points below the cutoff for Borderline personality traits. That is, the prevalence of unstable mood, obstreperous behavior and reactions, and labile emotions (Millon, 1997) was not clinically significant among the current population. Furthermore, subsequent analyses suggest 10 of 25 (40%) women who met diagnostic criteria for CPTSD scored $\geq$75 and 15 of 25 (60%) scored $\leq$ 75 on the Borderline scale of the MCMI- III. These findings provide further evidentiary support for the distinctiveness of CPTSD and BPD, and that meeting CPTSD diagnostic criteria may be indicative of a BPD diagnosis only 40% of the time.

The finding that the Borderline scale was significantly different when comparing HiSx vs. CPTSD women, suggests that the Borderline (BPD) scale distinguishes between women who meet five of six CPTSD criteria and women who meet full CPTSD diagnostic criteria. One possible explanation for this finding is that the BPD scale was significantly correlated with three SIDES Criteria: Criteria I, ($p$ = .001) (alterations in regulation of affect and impulses), Criteria III, ($p$ = .001) (alterations in self- perception), and Criteria V ($p$ = .001) (Somatization). That is, as participants' BPD score increased, they were also likely to meet SIDES criteria I, III, and V. A closer look at Criteria I illustrated that women who met and did not meet SIDES- SR Criteria I were significantly different on their Borderline scores, and women who met SIDES- SR Criteria I had higher mean scores on the Borderline scale. These findings illustrate the clinical controversy and confusion regarding the distinction of CPTSD and BPD, the extensive symptom

overlap, but yet the heterogeneity of the individuals considered for both diagnoses (Maffei, 2005).

Significant differences were found on the Masochistic scale when comparing women in the LoSx vs. HiSx groups, but women in the HiSx vs. CPTSD group did not significantly differ on the Masochistic scale. One explanation for this finding is that the women in the HiSx and CPTSD groups met more SIDES criteria therefore, also experienced a higher number of traumatic events throughout their lifetimes. Furthermore, previous research (Herman 1992a) suggests interpersonal trauma survivors may reenact traumatic relationships in the form of self-defeating and/or masochistic behaviors, thus increasing Masochistic characteristics. Lastly, an additional possible explanation is that women in the LoSx group are higher functioning and have less psychological pathology, as measured by the MCMI- III, compared to women in the CPTSD group.

Comparisons of women in the LoSx vs. CPTSD group were not significantly different on the Masochistic scale, which suggests these women are likely to be more similar in terms of their self- concept, the number of traumatic events experienced, and their self- defeating thoughts and behaviors. This finding also suggests that the Masochistic scale does not necessarily differentiate women who almost meet five of six CPTSD diagnostic criteria and those who meet full diagnostic CPTSD criteria. However, the Masochistic scale may differentiate women who meet less than three CPTSD criteria versus women who meet either five or six criteria.

The Avoidant scale results reveal only significant differences between women in the LoSx vs. CPTSD group. As previously mentioned, the mean Avoidant score for women in the CPTSD group was below the cutoff of 75, indicating its low prevalence among the current sample, especially those who met CPTSD diagnostic criteria. This finding contradicts previous

research (Allen et al., 1998), which suggests the majority of inpatient women trauma survivors show features of Avoidant personality. However, one possible explanation for these findings is that 26% of the current sample self-reported that they never married, and according to Bartholomew (1990), they could be exhibiting fearful avoidance of intimacy, which is characterized by a view of themselves as undeserving of love and support. Lastly, high scorers on the Avoidant scale may be less likely to seek help at a community trauma clinic.

The Anxiety, PTSD, and Dependent scales were compared among women in the HiSx vs. CPTSD group. Results revealed significant differences for the Anxiety and PTSD scales, but not the Dependent scale, with women in the CPTSD group experiencing significantly higher levels of Anxiety and PTSD than women in the HiSx group. The mean Anxiety score was not only the highest among the PTSD and Dependent scales, but it was also the highest average mean score of all eight scales used in the current study. This finding indicates that the majority of the women in the current sample likely experience symptoms such as worrisomeness, an uneasy sense that problems are imminent, hypervigilance to one's environment, and a generalized state of tension (Millon, 1997).

Elevated Anxiety scores in a sample of trauma survivors is consistent with previous literature, particularly (as previously mentioned in the literature review) the fact that PTSD has been positioned in the anxiety disorder section since the DSM- III (APA, 1980). The current findings are consistent with the nosology of anxiety disorders, and they are also consistent with previous literature (Norris & Slone, 2007; Herman, 1992a) which suggests persistent and prolonged exposure to stress is more damaging and results in more severe anxieties than exposure to a single trauma. Furthermore, Allen et al., (1998) reported the anxiety scale had the

second highest mean score to the Major Depression scale on the MCMI- III when studying psychological pathology among women inpatient trauma survivors.

Contrary to the Anxiety and PTSD scales, the Dependent scale was not significantly different when comparing women in the HiSx vs. CPTSD group. Additionally, the mean Dependent score was one point below the cut off for women who met diagnostic criteria for CPTSD, indicating women in the current sample did not frequently endorse a lack of initiative and autonomy. Specifically, questions from the Dependent scale reflect a naïve cognitive style, an inept self- image, and a willingness to submit to the wishes of others. This finding contradicts the historically common misconception that women survivors of complex trauma have been described as inherently dependent (Herman, 1992a). A possible explanation for this finding is that women in the current study sought help from a community clinic, which demonstrates a level of initiative and autonomy, and desire to separate from a traumatic, abusive relationship or lifestyle; characteristics that are not likely present among high scorers of the Dependent scale. This finding illustrates that the Dependent scale does not distinguish women who met full CPTSD diagnostic criteria from those who met five of six diagnostic criteria.

The finding that women in the HiSx vs. CPTSD significantly differ on the Anxiety and PTSD scales indicate that both scales discriminate between women who met full CPTSD diagnostic criteria and those who met five of six diagnostic criteria. These findings suggest a distinction in symptomology of CPTSD as a discrete diagnosis.

## Conclusions

As hypothesized, women who met more SIDES-SR criteria had higher mean base rate scores on the Major Depression, Depressive, Avoidant, Masochistic, Anxiety, PTSD, and

Borderline scales of the MCMI- III than women who met fewer SIDES- SR criteria. For both HiSx women and women with CPTSD, the Anxiety scale of the MCMI-III was their highest MCMI score, signifying the prevalence of anxiety symptoms among this population and the appropriateness of classifying CPTSD as a type of Anxiety Disorder. Findings from the current study suggest the Major Depression, Depressive, Anxiety, PTSD, and Borderline scales may highlight differences among women interpersonal trauma survivors who meet five of six CPTSD criteria versus those who meet full CPTSD diagnostic criteria.

In addition to the five scales, which may help clarify the CPTSD construct, women who met full diagnostic criteria for CPTSD scored below the cutoff for BPD personality traits, suggesting a distinction of the two constructs. Lastly, the experience of childhood abuse (specifically, sexual, physical, emotional) was also associated with CPTSD.

## Clinical Implications

These findings provide support for the clinical significance and distinction of CPTSD among a sample of women interpersonal trauma survivors. Overall, these results will raise clinician's awareness that women who have experienced frequent trauma with an early onset will likely present with more severe Major Depression, Depressive, Anxiety, PTSD, and Borderline symptoms, which emphasizes the importance of assessing for these types of symptoms from the onset of treatment. Furthermore, based on the current study's findings, women survivors of interpersonal trauma who meet full CPTSD diagnostic criteria likely experience particularly high and distressing levels of anxiety. These findings also highlight the importance of administering a comprehensive intake assessment especially regarding childhood trauma, the presence of sexual, physical, and emotional trauma, relationship to the perpetrator, and age and longevity of trauma.

Although the distinction of BPD and CPTSD remains equivocal, clinicians need to be cognizant that continued research will further clarify questions in the coming years, and that women who represent with BPD symptoms may not necessarily have BPD, but may rather be more clearly diagnosed with CPTSD.

## Limitations

There are several limitations to the current study that warrant discussion. First, self-report measures were utilized to collect data, which may result in under-reporting, over-reporting, or other self- presentational biases. For example, the questionnaires included many items that women might consider highly sensitive and personal (e.g., "You were sexually assaulted," "you were abused in childhood," " list all of the ages or time periods when you experienced trauma," and " estimate how many traumatic events you have encountered over the course of your life") which might result in underreporting and/or overreporting these effects. Additionally, due to the sensitivity of the subject matter, women might also have varied how they interpreted and answered questions. For instance, some women may not have been psychologically aware (at the time of participation in the study) that they experienced what is considered "child abuse," but rather thought it was normal. Lastly, some participants expressed confusion regarding the instructions on the SIDES-SR, which could have impacted results as well.

The second limitation to the study was the small sample size. The small sample size limited the types of analyses that could be conducted and questions that could be asked. For instance, many inferential statistics could not be conducted to examine various demographic variables and their relationship to CPTSD because these analyses violated the lowest expected

frequency needed in each cell. To increase group sizes for the main analyses women were grouped according to how many SIDES- SR criteria they met. Therefore, data could not be specifically analyzed based on each criteria met. In the future, recruiting a larger sample will allow researchers to tease apart more of the intricacies of CPTSD.

## Future Research

There is a critical need for more sophisticated research on the conceptualization, measurement, and treatment outcomes of CPTSD. Thus, a comprehensive evaluation of possible stressful experiences and exposures over the lifespan (e.g., natural disasters, interpersonal traumas, combat exposure, serious injuries, and captivity) found on the Life Events Checklist (Gary, Litz, Hsu, & Lombardo, 2004) would be helpful to understand the wide range of traumatic experiences among those with and without CPTSD.

Furthermore, a closer look at the longitudinal history and course of trauma would be helpful in distinguishing trauma history for those with BPD and those with CPTSD. The stigma of BPD among society and clinicians has been well documented; therefore it would be helpful to closely examine the differences of several demographic variables that are typically included in the BPD stigma (e.g., employment longevity, quality of life and relationships, level of functioning, and response to treatment, particularly Dialectical Behavioral Therapy) to those with CPTSD. An exploration of the impact of the developmental phase in which trauma occurred while also exploring differences in attachment styles among women with and without CPTSD and BPD. The ultimate goal of CPTSD research is to establish valid diagnosis and effective treatment. Working towards a parsimonious diagnosis can help to accomplish this goal, but

questions remain regarding the best pathway and methodology to validly diagnose, effectively treat, and work against social stigmas of CPTSD.

Table 1

*Groups for the Current Sample*

| Group | Number of SIDES- SR Criteria |
|---|---|
| LoSx( *n* =24) | 1, 2, and 3 of 6 |
| HiSx ( *n* =21) | 5 of 6 |
| CPTSD ( *n* = 25) | 6 of 6 (i.e., Complex PTSD) |

Table 2

*Descriptive Statistics for the Sample*

| Variable | *M* | *SD* | Range |
|---|---|---|---|
| Age in years | 34.53 | 11.51 | 18 – 62 |
| Yearly income | 21,567.18 | 34,580.98 | 0 - 250,000 |

Table 3
*Descriptive Frequencies for Sample*

| Variable | | *n* | Percent |
|---|---|---|---|
| Ethnicity | African American | 15 | 18.8 |
| | Caucasian | 48 | 60 |
| | Hispanic | 8 | 10 |
| | Biracial | 8 | 10 |
| | Other | 1 | 1.3 |
| Marital Status | Never Married | 21 | 25.9 |
| | Married/ Partnered | 12 | 14.8 |
| | Separated | 17 | 21 |
| | Divorced | 25 | 30.9 |
| | Widowed | 3 | 3.7 |
| | Other | 3 | 3.7 |
| Current Relationship Status | Single, Not Dating | 36 | 44.4 |
| | Single, Dating Casually | 11 | 13.6 |
| | Single, but Dating Seriously | 6 | 7.4 |
| | Living Together/ Engaged | 8 | 9.9 |
| | Married/ Partnered | 10 | 12.3 |
| | Separated | 10 | 12.3 |
| Employed | Yes, Part-time | 12 | 14.5 |
| | Yes, Full-time | 23 | 28 |
| | No | 47 | 57.3 |
| Student | Yes, Part-time | 5 | 6.2 |
| | Yes, Full-time | 14 | 17.3 |
| | No | 62 | 76.5 |
| Highest Degree | $9^{th}$ grade | 3 | 3.7 |
| | $10^{th}$ grade | 2 | 2.4 |
| | $11^{th}$ grade | 11 | 13.4 |
| | High School Diploma or GED | 15 | 18.3 |
| | Some College | 27 | 32.9 |

*(table continues)*

Table 3 *(continued)*.

| Variable | | *n* | Percent |
|---|---|---|---|
| Highest Degree | Technical/ Trade School Diploma | 6 | 7.3 |
| | Community College | 7 | 8.5 |
| | University Degree | 8 | 9.8 |
| | Other | 3 | 3.7 |
| Domestic Violence Victim | Yes | 68 | 85 |
| | No | 12 | 15 |
| Abused in Childhood | Yes | 51 | 63 |
| | No | 30 | 37 |
| Sexually Assaulted | Yes | 33 | 44 |
| | No | 42 | 56 |
| Someone close to you was abused or assaulted | Yes | 36 | 48 |
| | No | 39 | 52 |
| Referred by CPS for parenting classes | Yes | 19.4 | |
| | No | 80.6 | |
| How Long Attending service at FOF | 3 Months or Less | 44 | 55 |
| | 3-9 Months | 16 | 20 |
| | About 1 year | 10 | 12.5 |
| | 2 years | 3 | 3.8 |
| | 3+ years | 6 | 7.5 |
| | N/A | 1 | 1.3 |
| How Long in Therapy Service | 3 Months or Less | 42 | 53.2 |
| | 3-9 Months | 15 | 19 |
| | About 1 year | 9 | 11.4 |
| | 2 years | 2 | 2.5 |
| | 3+ years | 3 | 3.8 |
| | I am not attending therapy | 8 | 10.1 |

*(table continues)*

Table 3 *(continued)*.

| Variable | | *n* | Percent |
|---|---|---|---|
| Number of Traumatic Events over Course of Life | 1 | 6 | 8 |
| | 2 | 3 | 4 |
| | 2.5 | 1 | 1.3 |
| | 3 | 4 | 5.3 |
| | 3.5 | 3 | 4 |
| | 4 | 6 | 8 |
| | 4.5 | 1 | 1.3 |
| | 5 | 7 | 9.3 |
| | 7 | 1 | 1.3 |
| | 7.5 | 2 | 2.7 |
| | 8 | 2 | 2.7 |
| | 8.5 | 1 | 1.3 |
| | 9 | 2 | 2.7 |
| | 10 | 4 | 5.3 |
| | 11 | 1 | 1.3 |
| | 12 | 1 | 1.3 |
| | 12.5 | 1 | 1.3 |
| | 15 | 1 | 1.3 |
| | 20 | 8 | 10.7 |
| | 25 | 1 | 1.3 |
| | 30 | 2 | 2.7 |
| | 43 | 6 | 8.0 |
| | 45 | 1 | 1.3 |
| | 50 | 4 | 5.3 |
| | 300 | 3 | 4 |
| | 500 | 3 | 4 |

Table 4

*Correlation Matrix of MCMI-III Scales*

| Scale | A | D | R | H | CC | 2B | 8B | 2A | 3 | C |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Anxiety (A) | 1.00 | | | | | | | | | |
| 2. Dysthymia (D) | .46 | 1.00 | | | | | | | | |
| 3. Post- Traumatic Stress (R) | .66 | .53 | 1.00 | | | | | | | |
| 4. Somatoform (H) | .44 | .61 | .41 | 1.00 | | | | | | |
| 5. Major Depression ( CC) | .46 | .71 | .52 | .76 | 1.00 | | | | | |
| 6. Depressive ( 2B) | .44 | .62 | .56 | .41 | .48 | 1.00 | | | | |
| 7. Masochistic ( 8B) | .36 | .49 | .41 | .31 | .36 | .55 | 1.00 | | | |
| 8. Avoidant ( 2A) | .30 | .44 | .31 | .30 | .34 | .52 | .49 | 1.00 | | |
| 9. Dependent (3) | .37 | .40 | .32 | .30 | .34 | .40 | .50 | .42 | 1.00 | |
| 10. Borderline (C) | .44 | .55 | .55 | .34 | .46 | .58 | .53 | .38 | .40 | 1.00 |
| Alpha | .86 | .88 | .89 | .86 | .90 | .89 | .87 | .89 | .85 | .85 |
| Mean | 63.6 | 56.7 | 50.8 | 49.2 | 59.3 | 57.4 | 52.0 | 53.4 | 62.9 | 54.7 |
| SD | 33.8 | 34.2 | 29.2 | 28.9 | 36.7 | 31.8 | 29.6 | 30.5 | 27.1 | 28.0 |

Table 5

*Pearson Correlations, Alphas, Means, Standard Deviations, and Ranges Associated with MCMI-III Scales From the Current Sample*

| Scale | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 1. Anxiety | 1.00 | | | | | | | |
| 2. Post- Traumatic Stress | .79* | 1.00 | | | | | | |
| 3. Dependent | .67* | .60* | 1.00 | | | | | |
| 4. Major Depression | .62* | .72* | .61* | 1.00 | | | | |
| 5. Depressive | .63* | .69* | .67* | .76* | 1.00 | | | |
| 6. Masochistic | .55* | .58* | .61* | .67* | .84* | 1.00 | | |
| 7. Avoidant | .49* | .57* | .60* | .59* | .67* | .63* | 1.00 | |
| 8. Borderline | .63* | .66* | .58* | .72* | .69* | .66* | .48 | 1.00 |
| Alpha | .83 | .89 | .83 | .87 | .87 | .85 | .86 | .85 |
| Mean | 68.12 | 60.63 | 60.04 | 58.39 | 64.02 | 63.24 | 57.22 | 50.78 |
| SD | 29.46 | 24.42 | 27.83 | 30.12 | 28.13 | 27.93 | 29.56 | 26.35 |
| Possible Range | 0-115 | 0-115 | 0-115 | 0-115 | 0-115 | 0-115 | 0-115 | 0-115 |
| Sample Range | 0-115 | 0-108 | 0-104 | 0-106 | 0-107 | 0-107 | 0-113 | 0-106 |

*Note:* * Correlation is significant at the .001 level.

Table 6

*Pearson Correlations and Alphas of the SIDES- SR Criteria for the Current Sample*

| Criteria | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1. Alterations in Regulation of Affect and Impulses | 1.00 | | | | | |
| 2. Alterations in Attention or Consciousness | .30** | 1.00 | | | | |
| 3. Alterations in Self- Perception | .26* | .49** | 1.00 | | | |
| 4. Alterations in Relationships with Others | .03 | .37** | .33** | 1.00 | | |
| 5. Somatization | .33** | .41** | .44** | .22 | 1.00 | |
| 6. Alterations in Systems of Meaning | .20 | .16 | .32** | .20 | .17 | 1.00 |
| Alpha | .83 | .68 | .73 | .67 | .86 | .61 |

*Note:* ** Correlation is significant at the .01 level.
* Correlation is significant at the .05 level.

Table 7

*Means and Standard Deviations of MCMI- III Scales According to Number of SIDES-SR Criteria Met*

| | CPTSD (*n*= 25) | | HiSx (*n*= 21 ) | | LoSx (*n*=24 ) | |
|---|---|---|---|---|---|---|
| | 6 of 6 | | 5 of 6 | | ≤3 of 6 | |
| | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| 1. Anxiety | 87.28 | 16.34 | 73.71 | 24.67 | -- | -- |
| 2. PTSD | 78.20 | 17.37 | 60.05 | 21.75 | -- | -- |
| 3. Dependent | 74.40 | 20.19 | 63.67 | 23.88 | -- | -- |
| 4. Major Depression | 81.64 | 20.04 | 62.24 | 24.80 | 38.79 | 27.51 |
| 5. Depressive | 83.20 | 16.00 | 66.00 | 27.07 | 51.83 | 24.70 |
| 6. Masochistic | 80.80 | 14.58 | 67.90 | 24.03 | 49.88 | 29.01 |
| 7. Avoidant | 71.32 | 28.05 | 59.05 | 23.33 | 43.42 | 26.90 |
| 8. Borderline | 72.88 | 26.14 | 52.96 | 25.89 | 34.75 | 19.67 |

Table 8

*Trauma History Frequencies and Percentages for 1, 2, and 3 of 6 SIDES-SR Criteria*

| Variable | 1 of 6 ( *n*= 6) | | | 2 of 6 (*n*= 6) | | | 3 of 6 (*n*= 12) | | |
|---|---|---|---|---|---|---|---|---|---|
| | *n* | Yes | No | *n* | Yes | No | *n* | Yes | No |
| Abused in childhood | 6 | 1 (16.7%) | 5 (83.3%) | 6 | 0 (0%) | 6 (100%) | 11 | 6 (54.5%) | 5 (45.5%) |
| Physical childhood abuse | 5 | 1 (20%) | 4 (80%) | 6 | 0 (0%) | 6 (100%) | 11 | 4 (36.4%) | 7 (63.6%) |
| Sexual childhood abuse | 6 | 1 (16.7%) | 5 (83.3%) | 6 | 0 (0%) | 6 (100%) | 11 | 5 (45.5%) | 6 (54.5%) |
| Emotional childhood abuse | 6 | 1 (16.7%) | 5 (83.3%) | 6 | 0 (0%) | 6 (100%) | 11 | 7 (63.6%) | 4 (36.4%) |
| Physical childhood neglect | 6 | 0 (0%) | 6 (100%) | 6 | 0 (0%) | 6 (100%) | 11 | 3 (27.3%) | 8 (72.7%) |
| Emotional childhood neglect | 6 | 0 (0%) | 6 (100%) | 6 | 1 (16.7%) | 5 (83.3%) | 11 | 4 (36.4%) | 7 (63.6%) |
| Mother/ female guardian abused you in childhood | 6 | 1 (16.7%) | 5 (83.3%) | 6 | 1 (16.7%) | 5 (83.3%) | 11 | 4 (36.4%) | 7 (63.6%) |
| Father/ male guardian abused you in childhood | 6 | 1 (16.7%) | 5 (83.3%) | 6 | 0 (0%) | 6 (100%) | 11 | 5 (45.5%) | 6 (54.5%) |
| Sibling abused you in childhood | 6 | 0 (0%) | 6 (100%) | 6 | 0 (0%) | 6 (100%) | 11 | 2 (18.2%) | 9 (81.8%) |
| Stranger abused you in childhood | 6 | 0 (0%) | 6 (100%) | 6 | 0 (0%) | 6 (100%) | 11 | 1 (9.1%) | 10 (90.9%) |
| Secondary Trauma | 6 | 3 (50%) | 3 (50%) | 6 | 3 (50%) | 3 (50%) | 12 | 8 (66.7%) | 4 (33.3%) |

Table 9

*Trauma History Frequencies and Percentages for 4 of 6 through 6 of 6 SIDES-SR Criteria.*

| Variable | 4 of 6 ( *n*= 6) | | | 5 of 6 (*n*= 6) | | | 6 of 6 (*n*= 12) | | |
|---|---|---|---|---|---|---|---|---|---|
| | *n* | Yes | No | *n* | Yes | No | *n* | Yes | No |
| Abused in childhood | 12 | 8 (66.7%) | 4 (33.3%) | 21 | 15 (71.4%) | 6 (28.6%) | 25 | 21 (84%) | 4 (16%) |
| Physical childhood abuse | 12 | 6 (50%) | 6 (50%) | 19 | 12 (63.2%) | 7 (36.8%) | 24 | 18 (75%) | 6 (25%) |
| Sexual childhood abuse | 12 | 7 (58.3%) | 5 (41.7%) | 20 | 12 (60%) | 8 (40%) | 23 | 19 (82.6%) | 4 (17.4%) |
| Emotional childhood abuse | 11 | 6 (54.5%) | 5 (45.5%) | 20 | 16 (80%) | 4 (20%) | 24 | 20 (83.3%) | 4 (16.7%) |
| Physical childhood neglect | 10 | 2 (20%) | 8 (80%) | 19 | 8 (42.1%) | 11 (57.9%) | 21 | 10 (47.6%) | 11 (52.4%) |
| Emotional childhood neglect | 12 | 5 (41.7%) | 7 (58.3%) | 19 | 12 (63.2%) | 7 (36.8%) | 21 | 14 (66.7%) | 7 (33.3%) |
| Mother/ female guardian abused you in childhood | 11 | 4 (36.4%) | 7 (63.6%) | 19 | 11 (57.9%) | 8 (42.1%) | 22 | 11 (50%) | 11 (50%) |
| Father/ male guardian abused you in childhood | 11 | 6 (54.5%) | 5 (45.5%) | 18 | 12 (66.7%) | 6 (33.3%) | 22 | 11 (50%) | 11 (50%) |
| Sibling abused you in childhood | 11 | 1 (9.1%) | 10 (90.9%) | 17 | 6 (35.3%) | 11 (64.7%) | 20 | 4 (20%) | 16 (80%) |
| Stranger abused you in childhood | 11 | 2 (18.2%) | 9 (81.8%) | 16 | 3 (18.8%) | 13 (81.8%) | 22 | 9 (40.9%) | 13 (59.1%) |
| Secondary Trauma | 12 | 10 (83.3%) | 2 (16.7%) | 21 | 18 (85.7%) | 3 (14.3%) | 25 | 21 (84%) | 4 (16%) |

Table 10

*MANOVA Comparing Groups 2 and 3 Criteria and the Anxiety, PTSD, and Dependent scales of the MCMI- III*

| Source Variance | *df* | SS | MS | *F* | *p* | Partial Eta Square |
|---|---|---|---|---|---|---|
| Multivariate group effects | | | | | | |
| Groups 2 and 3 | | | | 3.44 | .025 | 0.20 |
| Univariate group effects | | | | | | |
| Anxiety | 1, 44 | 2100.33 | 2100.33 | 4.97 | .031 | 0.10 |
| PTSD | 1, 44 | 3760.70 | 3760.70 | 9.99 | .003 | 0.18 |
| Dependent | 1,44 | 1314.83 | 1314.83 | 2.73 | .106 | 0.06 |
| Error | 44 | 56470.95 | 1283.43 | | | |
| Total | 46 | 63646.81 | 8459.29 | | | |

*Note.* Base Rates $\geq$ 75 indicate personality traits and $\geq$85 indicate personality disorder (Millon, 1997).

Table 11

*MANOVA Comparing Groups 1,2, and 3 and Major Depressive Disorder, Depressive, Avoidant and Masochistic MCMI- III Scales*

| Source Variance | *df* | SS | MS | *F* | *p* | Partial Eta Square |
|---|---|---|---|---|---|---|
| Multivariate group effects | | | | | | |
| Groups 1, 2 and 3 | | | | 4.68 | .001 | 0.23 |
| Univariate group effects | | | | | | |
| Major Depressive Disorder | 2,67 | 22518.32 | 11259.16 | 19.17 | .001 | 0.36 |
| Depressive | 2,67 | 12096.95 | 6048.48 | 11.64 | .001 | 0.26 |
| Avoidant | 2,67 | 9562.42 | 4781.21 | 6.90 | .002 | 0.17 |
| Masochistic | 2,67 | 11785.01 | 5892.50 | 10.96 | .001 | 0.25 |
| Error | 67 | 156591.52 | 2337.19 | | | |
| Total | 70 | 192287.22 | 32655.73 | | | |

*Note.* Means within each row whose subscripts differ are different at $p < .05$.

Base Rates $\geq$ 75 indicate personality traits and $\geq$85 indicate personality disorder (Millon, 1997).

Table 12

*Independent Sample* t *Tests: Difference between Groups 1 and 2 and Groups 2 and 3 on the Borderline Scale*

| | Groups 1 and 2 | | Groups 2 and 3 | |
|---|---|---|---|---|
| Variable | *t* | *p* | *t* | *p* |
| Borderline | 3.06 | .004 | 2.68 | .011 |

Table 13

*Comparison of Women on Six MCMI- III scales who Scored ≥75 on the Borderline Scale Who Met and Did Not Meet CPTSD Criteria*

| | Met CPTSD Criteria (*n*= 10) | | Did not meet CPTSD Criteria (*n*= 6 ) | |
|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* |
| 1. Debasement | 85.30 | 10.34 | 76.33 | 5.54 |
| 2. Paranoid | 86.60 | 17.55 | 76.83 | 19.30 |
| 3. Negativeistic | 82.50 | 16.32 | 78.00 | 9.84 |
| 4. Anxiety | 89.89 | 20.50 | 78.33 | 17.42 |
| 5. Borderline | 86.20 | 10.10 | 78.33 | 2.81 |
| 6. Disclosure | 89.80 | 8.56 | 83.33 | 13.35 |

*Note.* Base Rates ≥ 75 indicate personality traits and ≥85 indicate personality disorder (Millon, 1997).

Table 14

*Trauma History Frequencies and Comparison for Women With and Without a CPTSD Diagnosis*

| Variable | No CPTSD Diagnosis | | | CPTSD Diagnosis | | | "Yes" Percent Difference |
|---|---|---|---|---|---|---|---|
| | *n* | Yes | No | *n* | Yes | No | |
| Sexually Assaulted | 54 | 21 (39%) | 33 (61%) | 21 | 12 (57%) | 9 (43%) | 18% |
| Abused in Childhood | 56 | 30 (54%) | 26 (46%) | 25 | 21 (84%) | 4 (16%) | 30% |
| Physical Childhood Abuse | 53 | 23 (43%) | 30 (53%) | 24 | 18 (75%) | 6 (25%) | 32% |
| Sexual Childhood Abuse | 55 | 25 (46%) | 30 (55%) | 23 | 19 (75%) | 4 (17%) | 29% |
| Emotional Childhood Abuse | 54 | 30 (56%) | 24 (44%) | 24 | 20 (83%) | 4 (17%) | 27% |
| Physical Childhood Neglect | 52 | 13 (25%) | 39 (75%) | 21 | 10 (48%) | 11 (52%) | 23% |
| Emotional Childhood Neglect | 54 | 22 (41%) | 32 (59%) | 21 | 14 (67%) | 7 (33%) | 26% |
| Mother/Female Guardian Abused you in Childhood | 53 | 21 (40%) | 32 (60%) | 22 | 11 (50%) | 11 (50%) | 10% |
| Father/Male Guardian Abused you in Childhood | 52 | 24 (46%) | 28 (54%) | 22 | 11 (50%) | 11 (50%) | 4% |
| Sibling Abused you in Childhood | 51 | 9 (18%) | 42 (82%) | 20 | 4 (20%) | 16 (80%) | 2% |
| Stranger Abused you in Childhood | 50 | 6 (12%) | 44 (88%) | 22 | 9 (41%) | 13 (52%) | 29% |
| Other Family Member Abused you in Childhood | 52 | 15 (29%) | 37 (71%) | 24 | 13 (54%) | 11 (46%) | 25% |

Table 15

*Results Table*

| Scale | **LoSx** vs. HiSx | **HiSx** vs. CPTSD | LoSx vs. **CPTSD** |
|---|---|---|---|
| Anxiety | -- | *M* = 73.71, *SD* = 24.6<br>Partial Eta Squared = .102 | *M* = 87.28, *SD* = 16.34 |
| Depressive | *M* =51.83, *SD* = 24.70<br>*p* = .102 | *M* = 66.00, *SD* = 27.07<br>*p* = .035 | *M* = 83.20, *SD* = 16.00<br>*p* = .000 |
| Major Depression | *M* = 38.79, *SD* = 27.51<br>*p* = .005 | *M* = 62.24,*SD* = 24.80<br>*p* = .023 | *M* = 81.64, *SD* = 20.04<br>*p* = .000 |
| PTSD | -- | *M* = 60.05, *SD* = 21.75<br>Partial eta squared = .184 | *M* = 78.20, *SD* = 17.37 |
| Dependent | -- | *M* = 63.67,*SD* = 23.88<br>Partial eta squared = .058 | *M* =74.40, *SD* =20.19 |
| Borderline | *M* = 34.75, *SD* = 19.67<br>*p* = .037 | *M* = 52.96, *SD* = 25.89<br>*p* = .013 | *M* = 72.88, *SD* = 26.14<br>*p* = .001 |
| Avoidant | *M* = 43.42, *SD* = 26.90<br>*p* = .123 | *M* = 59.05, *SD* = 23.33<br>*p* = .263 | *M* = 71.32, *SD* = 28.05<br>*p* = .001 |

*Note:* Shaded cells indicate significant difference. Means and Standard deviations are listed for Bolded Group.

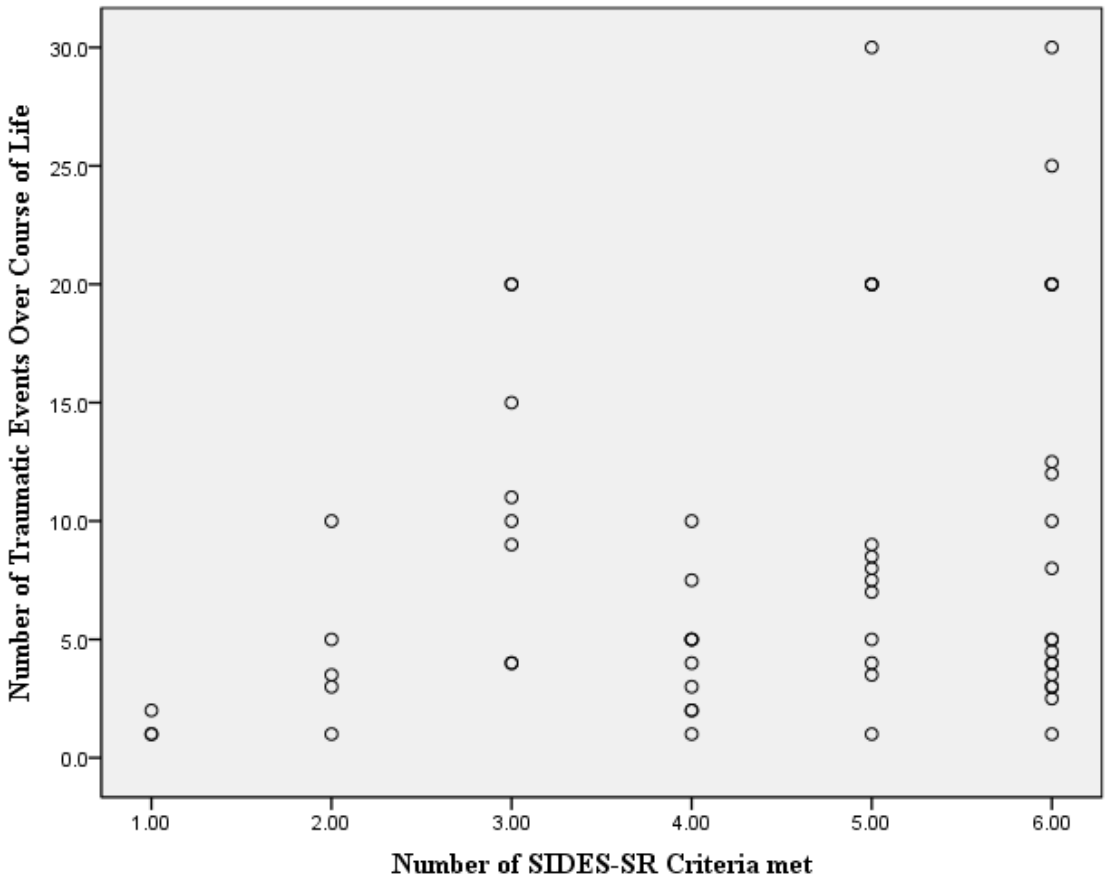



*Figure 1*. Number of traumatic events by number of SIDES-SR criteria met.

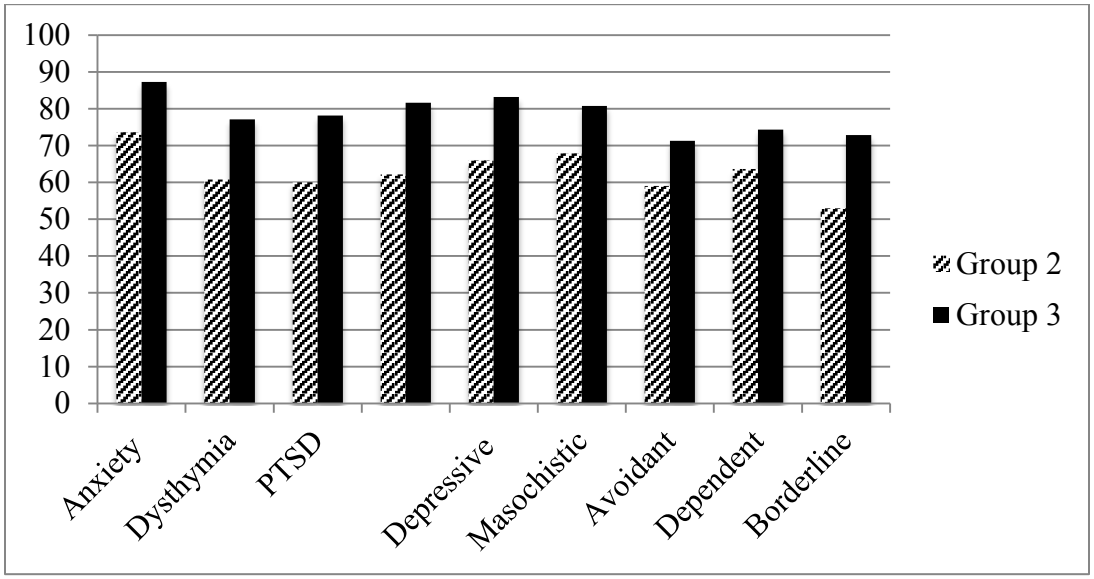
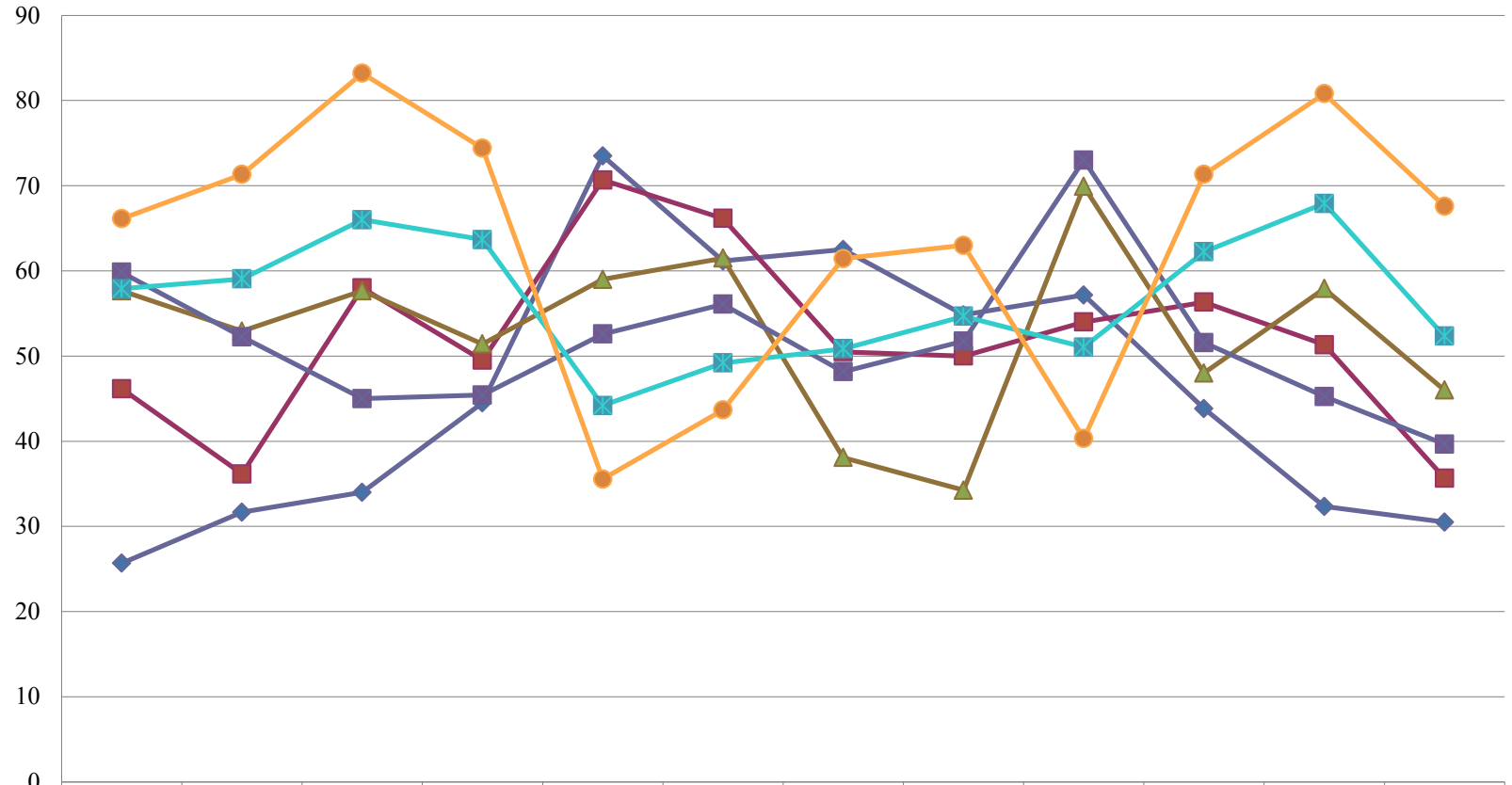
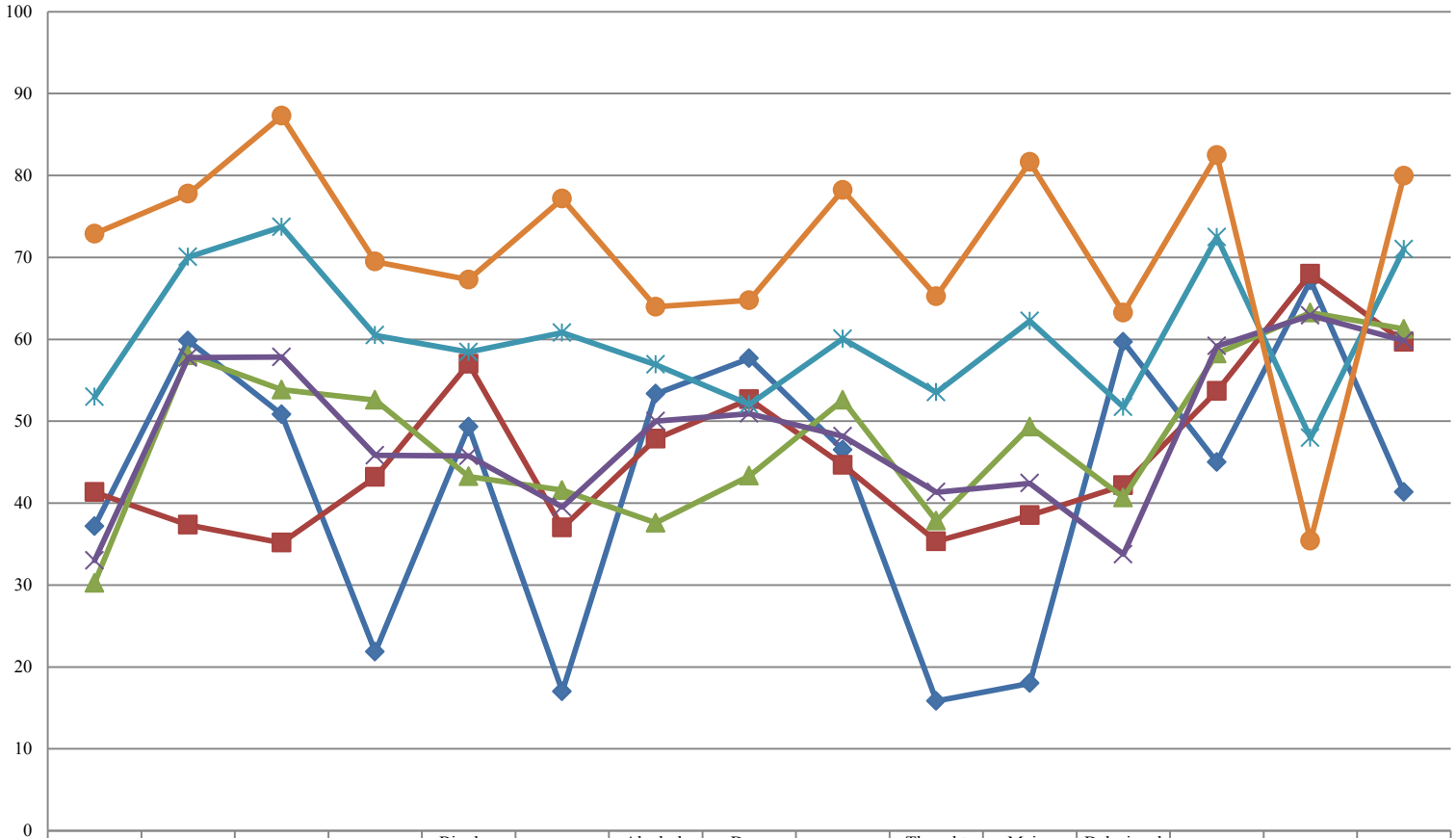



*Figure 2*. MCMI- III Mean Scores for Groups 2 and 3.




| | Schizoid | Avoidant | Depressive | Dependent | Histrionic | Narcissistic | Antiscocial | Sadistic | Compulsive | Negativistic | Masochistic | Schizotypal |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 of 6 | 26 | 32 | 34 | 45 | 74 | 61 | 63 | 55 | 57 | 44 | 32 | 31 |
| 2 of 6 | 46 | 36 | 58 | 50 | 71 | 66 | 51 | 50 | 54 | 56 | 51 | 36 |
| 3 of 6 | 58 | 53 | 58 | 51 | 59 | 62 | 38 | 34 | 70 | 48 | 58 | 46 |
| 4 of 6 | 60 | 52 | 45 | 45 | 53 | 56 | 48 | 52 | 73 | 52 | 45 | 40 |
| 5 of 6 | 58 | 59 | 66 | 64 | 44 | 49 | 51 | 55 | 51 | 62 | 68 | 52 |
| 6 of 6 | 66 | 71 | 83 | 74 | 36 | 44 | 61 | 63 | 40 | 71 | 81 | 68 |

*Figure 3.* Mean Base Rate Scores on the MCMI-III for Groups 1-6




| | Borderline | Paranoid | Anxiety | Somatoform | Bipolar: Manic | Dysthymia | Alcohol Dependence | Drug Dependence | PTSD | Thought Disorder | Major Depression | Delusional Disorder | Disclosure | Desirability | Debasement |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 of 6 | 37 | 60 | 51 | 22 | 49 | 17 | 53 | 58 | 47 | 16 | 18 | 60 | 45 | 67 | 41 |
| 2 of 6 | 41 | 37 | 35 | 43 | 57 | 37 | 48 | 53 | 45 | 35 | 39 | 42 | 54 | 68 | 60 |
| 3 of 6 | 30 | 58 | 54 | 53 | 43 | 42 | 38 | 43 | 53 | 38 | 49 | 41 | 58 | 63 | 61 |
| 4 of 6 | 33 | 58 | 58 | 46 | 46 | 40 | 50 | 51 | 48 | 41 | 42 | 34 | 59 | 63 | 60 |
| 5 of 6 | 53 | 70 | 74 | 60 | 58 | 61 | 57 | 52 | 60 | 54 | 62 | 52 | 72 | 48 | 71 |
| 6 of 6 | 73 | 78 | 87 | 69 | 67 | 77 | 64 | 65 | 78 | 65 | 82 | 63 | 82 | 35 | 80 |

*Figure 4.* Mean Base Rate Scores on the MCMI-III for Groups 1-6.

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