

THE BEHAVIOUR INSTITUTE

Diploma in Trauma-Informed Psychotherapy

UNIT 3 • CORE READING 4 OF 6

04

Diagnosis in Practice

Assessment, differential diagnosis, and the overlaps that trip people up

What This Document Covers

The previous three documents covered PTSD, Complex PTSD, and dissociation as distinct clinical presentations. In real practice, these conditions often overlap with each other, and with several other diagnoses, in ways that genuinely complicate assessment. This document covers how that assessment actually happens, and where the most common points of confusion arise.

What Good Assessment Actually Involves

A thorough trauma assessment goes well beyond simply asking whether someone has experienced a traumatic event. It typically involves a detailed history of the event or events, including the factors covered in Unit 2 — escapability, duration, developmental timing, and available support at the time — alongside a structured review of current symptoms against the specific criteria covered in Documents 1 and 2. Standardised assessment tools exist for this purpose, though they supplement rather than replace a genuine, attentive clinical conversation.

Equally important, and easy to underweight, is a careful history of the period before and after the identified trauma — prior mental health, prior trauma exposure, and current life circumstances all shape both the clinical picture and the appropriate treatment approach considerably.

Where Diagnoses Overlap and Get Confused

PTSD and Complex PTSD

As Document 2 covered, these are related but distinct diagnoses. A careful assessment looks specifically for the additional three clusters — emotional dysregulation, negative self-concept, relational disturbance — rather than assuming standard PTSD criteria alone capture the full picture, particularly where the trauma history involves prolonged or repeated, inescapable circumstances.

Complex PTSD and Borderline Personality Disorder

This is one of the most clinically significant, and most debated, areas of overlap. Complex PTSD and Borderline Personality Disorder share genuine surface similarities — emotional dysregulation, relational difficulty, an unstable sense of self — and a considerable proportion of people diagnosed with one have a history that could equally support the other diagnosis. The distinction matters clinically: Complex PTSD centres the presentation around identifiable trauma and its aftermath, while a Borderline Personality Disorder framework, though also trauma-informed in modern practice, is structured somewhat differently. Careful, trauma-informed assessment considers both possibilities directly, rather than defaulting to whichever diagnosis a particular service or clinician happens to be more familiar with.

Dissociation and Attention or Mood Presentations

As Document 3 noted, dissociation can be mistaken for inattention, disengagement, or a primary mood disorder, particularly when a clinician is not specifically listening for it. A careful assessment asks directly about the specific experiences covered in Document 3 — depersonalisation, derealisation, gaps in memory —

rather than relying on a client to volunteer these experiences unprompted, which, given their often confusing and sometimes shame-laden nature, frequently does not happen without being asked.

Pause and Consider

Why do you think a client experiencing dissociation, or the additional features of Complex PTSD, might be reluctant to raise these experiences unprompted, even in an otherwise trusting therapeutic relationship?

The Role of Comorbidity

PTSD and Complex PTSD frequently co-occur with other conditions — depression, anxiety disorders, and substance use are all common alongside a trauma-related diagnosis, sometimes developing as a direct consequence of attempting to manage trauma symptoms without adequate support. A genuinely trauma-informed assessment holds this possibility in view from the outset, rather than treating a co-occurring presentation, such as substance use, as a separate, unrelated problem to be addressed only after trauma work has concluded. In practice, these presentations are often best addressed together, in a coordinated way, rather than sequentially.

Why Careful Assessment Matters So Much

Getting this picture right has real consequences. A missed Complex PTSD diagnosis, mistaken for standard PTSD alone, risks leaving significant parts of a client's presentation unaddressed, as Document 2's case example illustrated. A missed dissociative presentation, mistaken for disengagement, risks a client being labelled as unmotivated or resistant, when the reality is an involuntary protective response. And genuine diagnostic uncertainty between Complex PTSD and Borderline Personality Disorder, handled without care, risks a client receiving treatment structured around the wrong underlying framework entirely.

None of this means diagnosis needs to be resolved with total certainty before any treatment begins — in practice, understanding often deepens over the course of the work itself. It does mean holding genuine curiosity and openness to revision, rather than settling prematurely on the first diagnostic label that seems to fit.

What's Next

The next document addresses a related, practical challenge: presentations where trauma symptoms do not emerge until well after the event itself, sometimes making the underlying connection considerably harder to recognise, for the client and the clinician alike.

A Few Things to Take With You

- Thorough trauma assessment includes detailed history, structured symptom review, and attention to circumstances before and after the trauma, not simply confirmation that a traumatic event occurred
- PTSD, Complex PTSD, and Borderline Personality Disorder share real overlap and require careful, deliberate differentiation
- Dissociation is easily mistaken for inattention or mood disturbance unless specifically asked about directly
- Comorbidity with depression, anxiety, and substance use is common, and is best addressed in a coordinated way rather than sequentially
- Diagnostic understanding often deepens over the course of treatment itself, and should remain genuinely open to revision

Before You Move On

- Why do you think the overlap between Complex PTSD and Borderline Personality Disorder is described as clinically significant and debated, rather than simply resolved?
- How might treating a co-occurring substance use presentation as entirely separate from trauma work risk undermining both?
- What would you want to ask, specifically, in an assessment to avoid missing a dissociative presentation?