

THE BEHAVIOUR INSTITUTE
Diploma in Trauma-Informed Psychotherapy

UNIT 3 • CORE READING 6 OF 6

06

Myths About PTSD and Complex Trauma

Correcting some persistent misunderstandings before Unit 4

What This Document Covers

This closing document addresses several persistent myths about PTSD, Complex PTSD, and dissociation, drawing directly on the material covered across this unit. As with earlier myth-focused documents in this course, some of these are simply inaccurate; others carry real, harmful consequences for the people affected by them.

Myth: PTSD Only Affects Combat Veterans

PTSD is strongly associated with military service in public understanding, partly for genuine historical reasons — much of the earliest clinical research, and public awareness, developed from work with veterans. But PTSD can develop following any sufficiently threatening event: accidents, assault, natural disaster, medical trauma, and, as Document 2 covered, prolonged relational trauma. Assuming PTSD is primarily a military phenomenon leads directly to under-recognition in every other population it affects.

Myth: If You Don't Remember the Event Clearly, It Wasn't Traumatic

As Document 3 covered, dissociative amnesia is a genuine, recognised feature of trauma response, not evidence that an event was insignificant or fabricated. Some of the most severe trauma produces the most significant gaps in clear, continuous memory, precisely because of the protective function dissociation serves.

Myth: Complex PTSD and Borderline Personality Disorder Are Simply the Same Thing

As Document 4 covered, these presentations share genuine overlap but are not identical, and the distinction carries real clinical weight. Treating the two as simply interchangeable risks applying a framework and treatment approach that does not accurately fit a given client's actual presentation.

Pause and Consider

Which myth in this document connects most directly to an assumption you held, or a pattern you have witnessed, before beginning this unit?

Myth: PTSD Always Develops Immediately After the Event

As Document 5 demonstrated in real depth, delayed onset is well recognised and genuinely common, sometimes emerging years after the original event, particularly following a later stressor, a change in protective life structure, or, for childhood trauma, delayed developmental readiness to process what happened. Assuming trauma-related symptoms must be temporally close to an identifiable recent event leads directly to missed diagnoses.

Myth: A Person Who Seems to Be Functioning Well Has Recovered

High-functioning presentation and genuine internal distress are not mutually exclusive. As Bilal's story in Document 5 illustrated, a person can maintain considerable external functioning for years, even decades, while carrying substantial unprocessed trauma underneath — sometimes precisely because that functioning itself is serving a containing function that will not last indefinitely.

Myth: Dissociation Is Rare and Only Occurs in Severe, Dramatic Cases

As Document 3 established, dissociation exists on a spectrum, with mild, common forms occurring in most people's ordinary experience. Clinically significant dissociation is considerably more common than the rarest, most severe presentations that tend to dominate public awareness, and it is frequently missed precisely because it does not always look dramatic.

Why These Myths Matter

As with the myths addressed in Units 1 and 2, the pattern here is consistent: each of these misunderstandings offers a simpler, more containable story than the reality this unit has actually described. It is simpler to imagine PTSD as a single, well-defined population's problem, or trauma memory as always vivid and immediate, or recovery as visible and complete once someone appears to be coping. Trauma-informed, and trauma-specific, practice depends on holding the more complicated, more accurate picture instead.

Going Further: Recommended Reading

None of the following is required, but if this unit has genuinely interested you, these are worth your time:

- “Complex PTSD: From Surviving to Thriving” by Pete Walker — a widely used, accessible account of Complex PTSD specifically, written partly from the author's own lived experience alongside his clinical practice
- Judith Herman's “Trauma and Recovery” — one of the foundational texts in this field, and among the earliest serious clinical accounts of what would later be formalised as Complex PTSD
- The ICD-11 diagnostic criteria for both PTSD and Complex PTSD, freely available from the World Health Organization, for readers who want to engage directly with the source diagnostic material referenced throughout this unit
- “The Haunted Self” by Onno van der Hart, Ellert Nijenhuis, and Kathy Steele — a more advanced, clinically detailed text specifically on dissociation, for those wanting to go well beyond this unit's introductory coverage

A Few Things to Take With You

- PTSD affects far more populations than combat veterans alone
- Memory gaps do not indicate an event was insignificant — dissociative amnesia is a genuine, recognised trauma response
- Complex PTSD and Borderline Personality Disorder are related but distinct, and should not be treated as interchangeable
- Delayed onset is well recognised and genuinely common, sometimes emerging years after the triggering event
- High functioning does not necessarily indicate resolution, and dissociation is more common, and less dramatic, than public perception often suggests

Before You Move On

- Having completed this unit, how would you now describe the relationship between PTSD, Complex PTSD, and dissociation to someone unfamiliar with any of the three?
- Which myth in this document do you think does the most harm in general public understanding, outside clinical settings specifically?
- What are you carrying forward into Unit 4, where we turn to the major therapeutic approaches used to treat trauma directly?