Diagnosing Complex PTSD in ICD-11

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Diagnosing PTSD in DSM-5

The DSM-5 approach has been incremental, resulting in greater complexity and more symptom overlap with other disorders

The implicit aim appears to have been to describe the complete (chronic) syndrome as fully as possible rather than to isolate unique features or processes

The diagnosis can be earned with > 630,000 combinations of symptoms

There is disagreement over the stressor criterion

Comorbidity is extremely high

Diagnosis is extremely complex, reducing clinical utility

The ICD-10 approach to PTSD

There is no formal stressor criterion, only guidelines allowing clinicians to use their own judgement.

There is a more explicit emphasis on re-experiencing, specifically “re-experiencing in intrusive memories (‘flashbacks’), dreams or nightmares”

There is no impairment criterion

Also to note:

The ICD-10 version of the diagnosis has been less influential in research

Existing studies suggest it is more lenient than the DSM-IV diagnosis

Objectives for ICD-11 PTSD

Identify core features from knowledge of what symptoms are unique to and predictive of PTSD

Make these core features of the disorder more explicit, so as to (a) simplify diagnosis, (b) reduce qualifying combinations of symptoms, (c) reduce comorbidity, (d) provide a meaningful contrast with DSM-5 by addressing some of its shortcomings, (e) facilitate clinical utility and scientific research

Introduce impairment criterion to address possible over-leniency relative to DSM-IV and DSM-5

Definition of PTSD in ICD-11

This disorder follows exposure to an extremely threatening or horrific event or series of events (this copes more flexibly with stalking, bullying etc.)

It consists of 3 core elements: (a) Re-experiencing: vivid intrusive memories, flashbacks, or nightmares that involve re-experiencing in the present, accompanied by fear or horror; (b) Avoidance: marked internal avoidance of thoughts and memories or external avoidance of activities or situations reminiscent of the traumatic event(s); (c) Sense of threat: a state of perceived current threat in the form of hypervigilance or an enhanced startle reaction. The symptoms must also last for several weeks and interfere with normal functioning

Why *these* three elements and six symptoms?

1) Flashbacks are unique to PTSD (Bryant et al., 2011) and traumatic re-experiencing and nightmares discriminate PTSD from other conditions (Brewin et al., 2009; Gootzeit & Markon, 2011). Avoidance of reminders is logically tied to the experienced trauma.

2) Factor analyses suggest hypervigilance and startle are specific to PTSD whereas other hyperarousal and numbing symptoms reflect dysphoria (Simms et al., 2002)

3) 5 of these 6 symptoms were found to be among the most highly predictive of a PTSD diagnosis in the *DSM-IV* Field Trial (Kilpatrick et al., 1998)

4) Clinicians identified 3 of these 6 as among the 4 most characteristic symptoms of PTSD (Keane et al., 1997)

On flashbacks and intrusive memories

Intrusive memories are characteristic of many disorders – what is different in PTSD is that they involve some degree of re-experiencing **in the present**. DSM-5 symptom B3 meets this requirement but B1 does not.

The measurement of B3 (“flashbacks”) has been handicapped by lack of any definition. DSM-5 and ICD-11 now agree that they can exist on a continuum. A flashback is effectively an intrusive memory that is relived in the present, whether this is a fleeting sense of ‘nowness’ or a complete loss of awareness of the current environment.

If the person has no conscious memory of the event ICD-11 allows this criterion to be met by an emotional response to reminders of it.

Points to note

The aim is to identify the core of the disorder (what makes it unique), not to describe the typical patient. Consensus was reached by expert clinicians across the world that PTSD could be diagnosed following exposure to trauma with the combination of at least one re-experiencing, at least one avoidance, and at least one sense of threat symptom, plus functional impairment. Fewer symptoms are needed, but they are more specific, so there is no necessary increase in prevalence involved. There are only 27 qualifying combinations of symptoms. More severe presentations may be captured by a Complex PTSD diagnosis

Precursors of Complex PTSD: EPCACE

Enduring personality change, present for at least two years, following exposure to catastrophic stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterized by a hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge" as if constantly threatened, and estrangement. Although unconnected to PTSD in ICD-10, it was noted that PTSD may precede this type of personality change.

Precursors of Complex PTSD: DESNOS

Disorders of Extreme Stress Not Otherwise Specified:

a pervasive pattern of maladjustment that may occur in response to persistent traumatization that occurs across settings, and frequently involves numerous types of trauma, or trauma of long duration

Mentioned in DSM-IV under “associated features” of PTSD and based on observations of “Complex PTSD” by Herman

Precursors of Complex PTSD: DESNOS

Symptom constellations:

Alteration in regulation of affect and impulses (e.g. suicidal impulses)
Alterations in attention or consciousness (e.g. dissociation)
Alterations in self-perception (e.g. permanent damage)
Alterations in relations with others (e.g. revictimisation)
Somatization (e.g. chronic pain)
Alterations in systems of meaning (e.g. loss of previously sustaining beliefs)

Precursors of Complex PTSD: DESNOS

The DSM-5 field trial investigating DESNOS revealed substantially higher rates of endorsement of symptoms representative of disturbances in affective, self, and relational domains among those with early-life chronic trauma relative to those with other types of trauma history (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The DSM-IV field trial data also found that nearly all of those who met criteria for DESNOS also met criteria for PTSD

Complex PTSD in ICD-11

Exposure: an extremely threatening or horrific event or series of events

Symptom pattern

core symptoms of PTSD (re-experiencing in the present, avoidance, sense of threat)

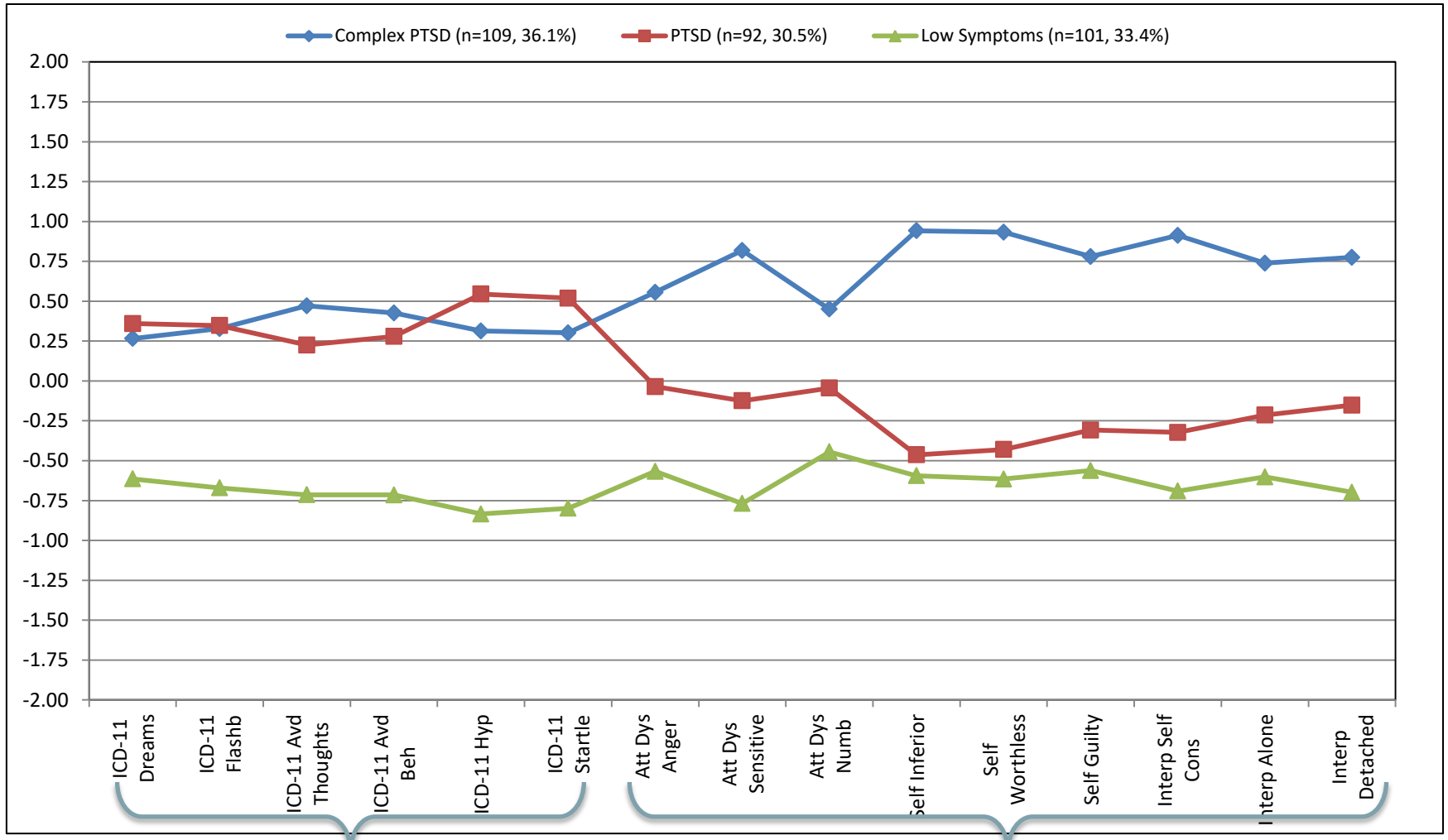
plus

persistent and pervasive impairments in:

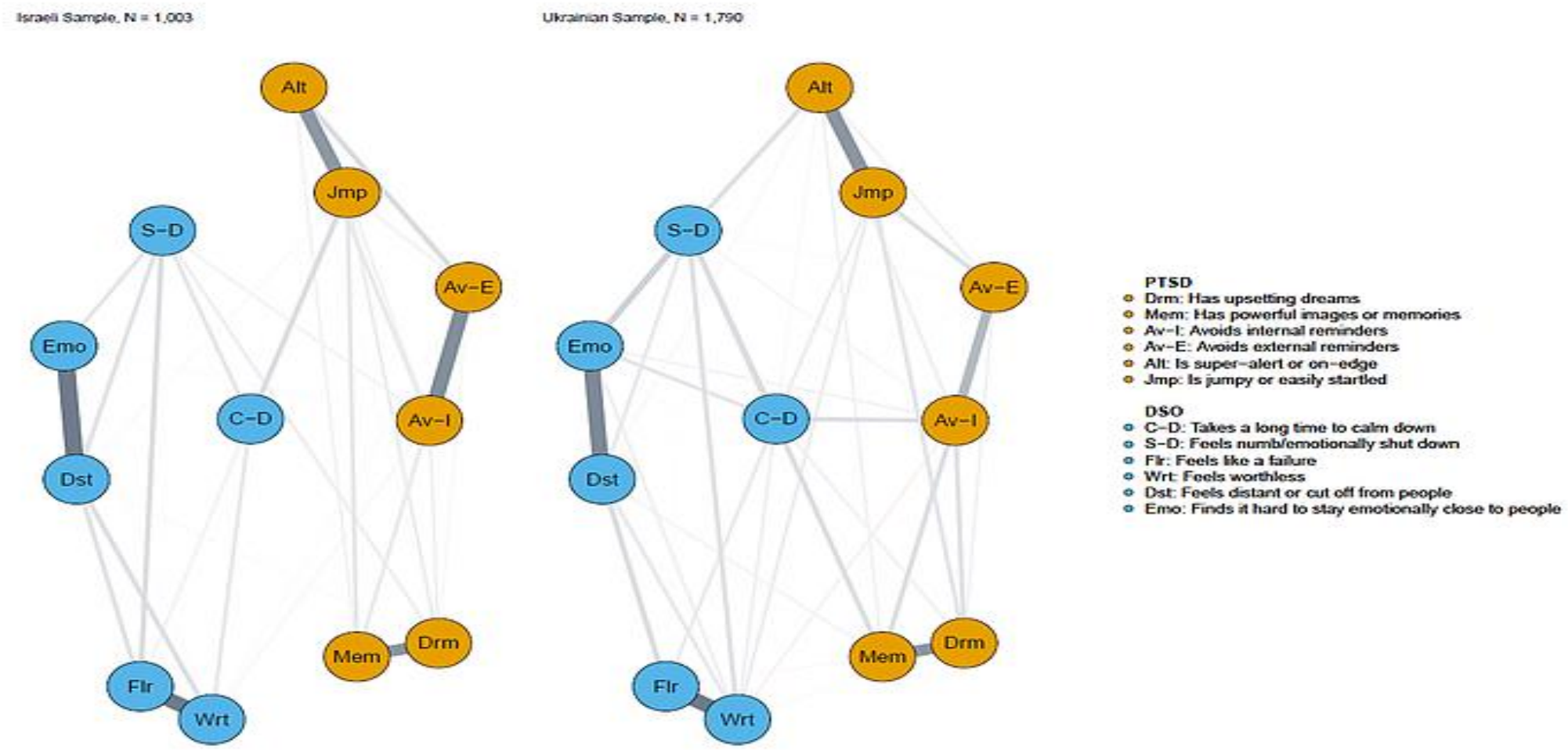
- **affective functioning**: Affect dysregulation, heightened emotional reactivity, violent outbursts, tendency towards dissociative states when under stress
- **self functioning**: Persistent beliefs about oneself as diminished, defeated or worthless; pervasive feelings of shame, guilt
- **relational functioning**: Difficulties in sustaining relationships or feeling close to others

plus functional impairment related to these symptoms

Distinguishing PTSD and Complex PTSD (Cloitre et al., 2013)



Network analysis of ICD-11 PTSD/CPTSD (McElroy et al., 2019)



Points to note

- Unlike the DESNOS (Disorders of Extreme Stress Not Otherwise Specified) diagnosis included in the DSM-IV Appendix, Complex PTSD does not *require* prolonged or chronic trauma, although it is expected this is the most common aetiology. It is based on symptom pattern.
- Also unlike DESNOS and EPCACE, the core pattern of PTSD symptoms is required, to distinguish it from other chronic disorders associated with early trauma such as borderline personality disorder

How borderline personality disorder differs

Unlike Complex PTSD, it:

- Does not require PTSD symptoms such as re-experiencing
- Is characterised by being frantic about being abandoned, having an unstable sense of self, having unstable relationships, impulsiveness, and self-harm and suicidal behaviour
- Is not characterised by an extremely negative sense of self, and avoidance of relationships

Conclusions from initial studies on 4 continents

Factor structure of ICD-11 PTSD generally fits the data well and outperforms DSM-5 in several comparisons. This is partly because its structure is simpler and was informed by previous factor analyses. There may be some specific samples (accident victims, incest survivors) where the fit is not so good

A taxometric analysis has suggested that cases and non-cases are distinct in ICD-11 whereas a DSM PTSD diagnosis represents more of a continuum. This is potentially very helpful for studies of biological markers

Conclusions from initial studies on 4 continents

7/8 studies with adults, and 2/2 studies with children, have replicated the proposed distinction between PTSD and Complex PTSD using latent profile or latent class analyses, and there is preliminary evidence Complex PTSD can be successfully differentiated from Borderline Personality Disorder

Childhood physical or sexual abuse, particularly within the family, is more strongly related to CPTSD than PTSD. CPTSD is also associated with higher levels of psychiatric burden than PTSD, including greater depression and dissociation

Conclusions from initial studies on 4 continents

In adults PTSD prevalence rates according to the DSM-IV and DSM-5 are broadly comparable with rates of PTSD + CPTSD in ICD-11 although there are consistently slightly lower rates under ICD-11. ICD-11 is more stringent than ICD-10

Rates for community samples of children and young people appear very similar in DSM-IV/5 and ICD-11 (PTSD + CPTSD). ICD-11 identifies quite a lot of cases missed by DSM-5. The simpler formulation may be particularly appropriate here

Nationally representative surveys have found:

ICD-11 PTSD 1.5% CPTSD 0.5% (Germany)

3.4% 3.5% (USA)

9.0% 2.6% (Israel)

Assessing comorbidity

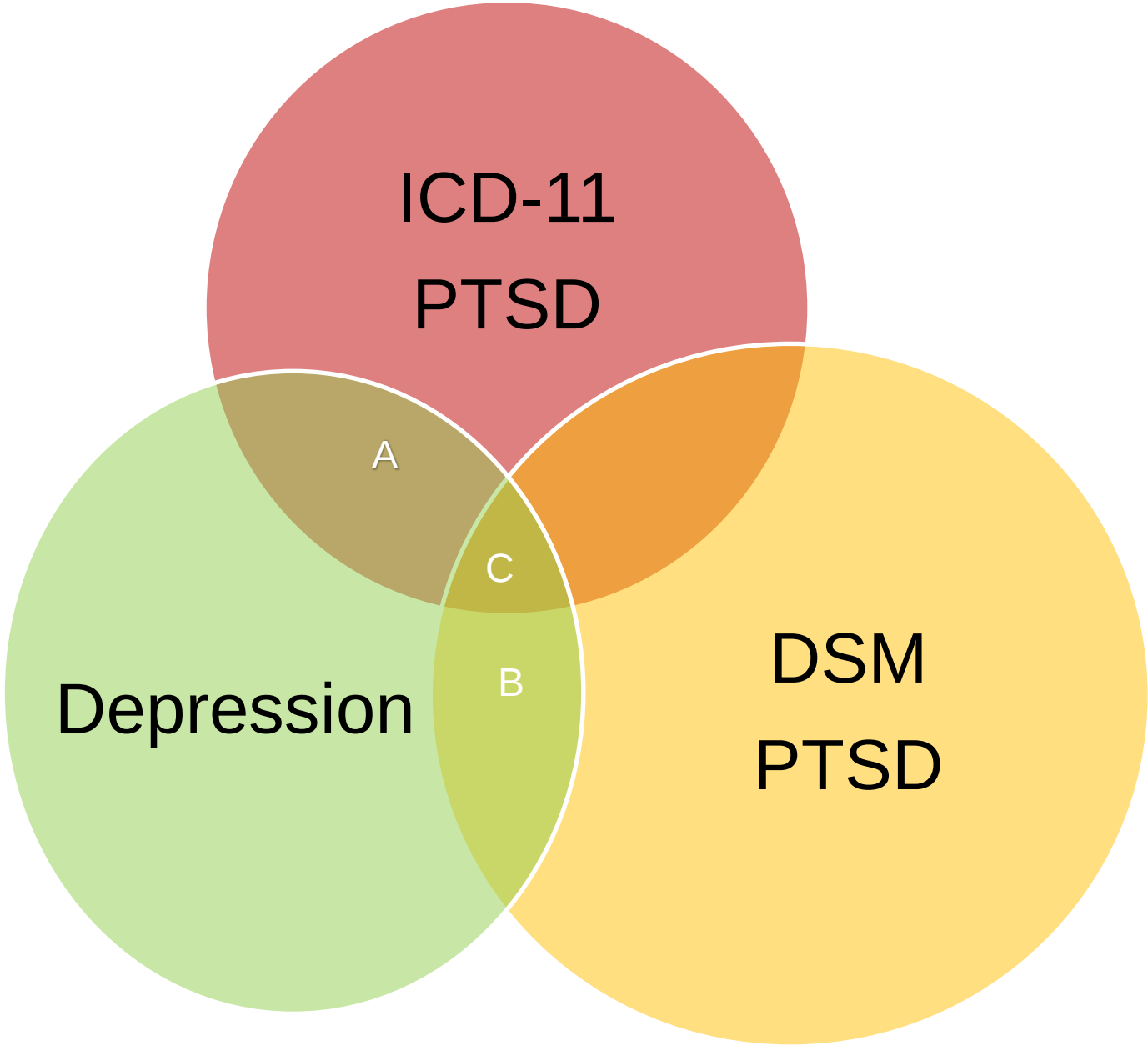
What not to do:

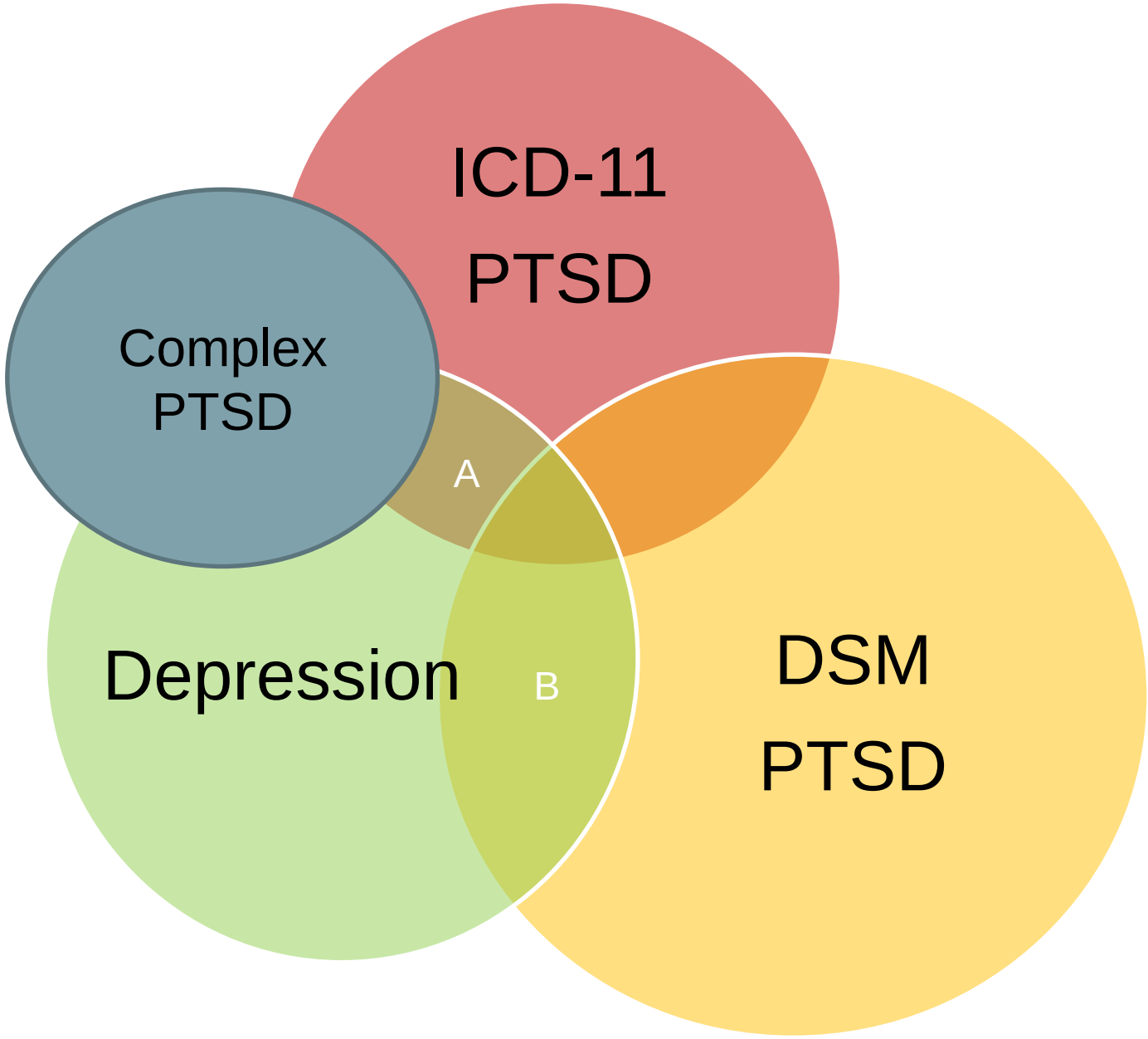
Compare those meeting criteria for ICD-11 PTSD with those meeting criteria for DSM PTSD. Problems: overlap between cases; ICD-11 PTSD group will include some with CPTSD

Better:

Compare those meeting criteria for ICD-11 PTSD but not DSM PTSD with those meeting criteria for DSM PTSD but not ICD-11 PTSD: In 4/4 studies less comorbidity with depression under ICD-11

Best: Compare those meeting criteria for ICD-11 PTSD but not CPTSD or DSM PTSD with those meeting criteria for DSM PTSD but not ICD-11 PTSD/CPTSD


ICD-11
PTSD
A
C
Depression
B
DSM
PTSD


ICD-11
PTSD
Complex
PTSD
A
Depression
B
DSM
PTSD

Assessing ICD-11 PTSD and Complex PTSD

Available measures that approximate ICD-11 Complex PTSD:

Litvin et al. (2017, Journal of Traumatic Stress): The Complex Trauma Inventory (20 symptom items + 9 functional impairment items)

Dorr et al. (2018, Psychotherapie Psychosomatik Medizinische Psychologie): Das Screening zur kPTBS – revised (SkPTBS) (16 symptom items)

Questionnaire for ICD-11 PTSD and CPTSD:

Cloitre et al. (2018, Acta Psychiatrica Scandinavica): The International Trauma Questionnaire (12 symptom items + 6 functional impairment items)

Treating Complex PTSD

NICE PTSD Guideline (2018) suggests extra sessions needed

Controversy over whether phase-based treatments are necessary:

phase 1: stabilisation; phase 2: trauma processing; phase 3: reintegration

Lack of direct evidence, especially about phase 3

A few trials indicate that immediate trauma-focussed treatment (i.e., bypassing phase 1) could be effective for many patients with histories of multiple traumatisation, including child abuse

However, a child abuse history does not guarantee a person has CPTSD

Patients entering trials may not be representative

Complications in Treating Complex PTSD

- Dissociation
  - Temporary loss of awareness or fugue states may put patients in danger
  - Imaginal or in vivo exposure may be disrupted
  - Both may require stabilisation work based on grounding as well as changes to exposure protocols
- Voice-hearing
  - Internal voices give instructions and are difficult to challenge
  - Discover the number of voices, their role, and the relationship with them
  - Cognitively challenge unhelpful voices with Socratic questioning

Summary

Diagnostic formulations are best examined against competing alternatives

For the first time there is an alternative to the DSM that is also based on empirical evidence but is much simpler and promises less comorbidity

This runs the risk that clinicians and patients will be confused

It has the advantage that it allows us to examine untested assumptions and to see whether there are patients who are missed by the DSM formulation

The distinction between PTSD and CPTSD already has considerable support

We need to understand more about this difference and about patients who meet DSM but not ICD criteria or vice versa

It is much too early to say if one system is “better” than the other

General references

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