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Chester

THE ICD-11 PROPOSED DIAGNOSTIC CLASSIFICATION OF COMPLEX POST- TRAUMATIC STRESS DISORDER (CPTSD)

CHRISTINA BUXTON & GORDON TURNBULL

University of Chester

AIMS OF THE PRESENTATION

- To consider the DSM-5 in light of CPTSD and to contrast with the proposed position of CPTSD in the ICD-11 classification.
- To introduce the proposed structure and content of the ICD-11 diagnostic categories of PTSD & CPTSD.
- To summarise the research evidence relating to the validity of the proposed ICD-11 CPTSD construct and symptom structure.
- To review the research evidence on prevalence, comorbidity and risk factors found with CPTSD under the ICD-11 proposals.
- To briefly consider emerging implications from the current ICD-11 CPTSD research

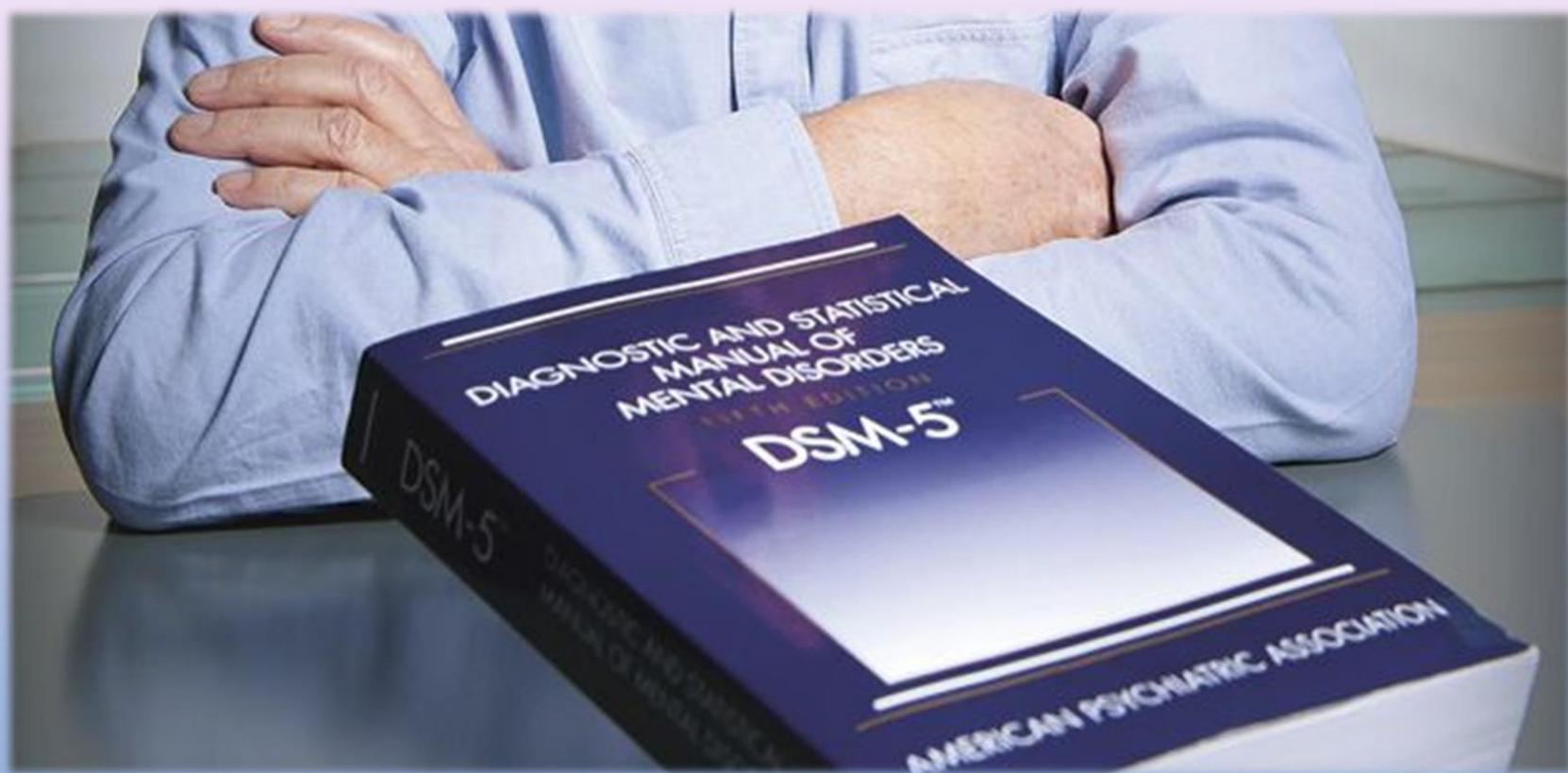


“The syndrome that follows upon prolonged, repeated trauma needs its own name. I propose to call it *complex post-traumatic stress disorder*”

Judith Herman 1992:119

From June 2018 Complex Post-Traumatic Stress Disorder will have official diagnostic recognition.

For the first time since 1979, the two main international mental health diagnostic systems will not be in broad agreement over what types of PTSD exist, and the presentation of symptoms that are seen with each.



DSM-5- WHY NOT CPTSD?

- DSM-5 removed DESNOS as high co-morbidity with PTSD and significant symptom overlap between PTSD, BPD and MDD was seen to indicate CPTSD is not a discrete disorder and therefore does not warrant a separate diagnostic category (Resick et al., 2012).
- DSM-5 PTSD criteria aims for diagnostic sensitivity with symptoms that cover typical clinical presentations (Freidman, 2013).
- Using the DSM-5 criteria for PTSD there are now *636120* ways to 'have' PTSD (Galatzer-Levy & Bryant, 2013)

HOW IS CPTSD REPRESENTED IN THE DSM-5 PTSD CRITERIA?

- DIAGNOSTIC SYMPTOMS ADDED TO DSM-5 PTSD THAT ARE FREQUENTLY IDENTIFIED WITH CPTSD :
 - Criterion D negative alterations in cognitions & mood to include distorted beliefs of self and others, constricted affect & feelings of alienation from others.
 - Criterion E- hyperarousal and reactivity cluster, of externalizing irritable, aggressive, impulsive, self-destructive, and suicidal behaviours,
 - Addition of a new 'with' dissociative symptoms specifier to include depersonalisation and derealisation.

(FRIEDMAN, 2013; RESICK ET AL., 2012)

ICD-11
The Future

NEXT EXIT 

HOW IS CPTSD POSITIONED IN THE ICD-11?

- Not seen as separate from PTSD but hierarchical with PTSD as a precursor.
- Not seen as having unique aetiology but meets event based criteria for PTSD with focus on symptoms that differentiate it from PTSD
- In line with the goals of the ICD-11, CPTSD has a relatively narrow definition and limited number of symptoms providing clinical specificity.
- Based on existing clinicians taxonomies reflecting the current discourse with synonymous meaning
- Distinguishing between PTSD & CPTSD gives additional clinical utility through targeted management and treatment
 - REED (2010), SHELVIN ET.AL., (2017)



TAKEN FROM ICD-11 BETA DRAFT

IS NOT FINAL

IT IS NOT APPROVED BY WHO

THE STRUCTURE AND USER GUIDANCE MIGHT BE SUBJECT TO EDITS

FOLLOWING THE QUALITY ASSURANCE PHASE

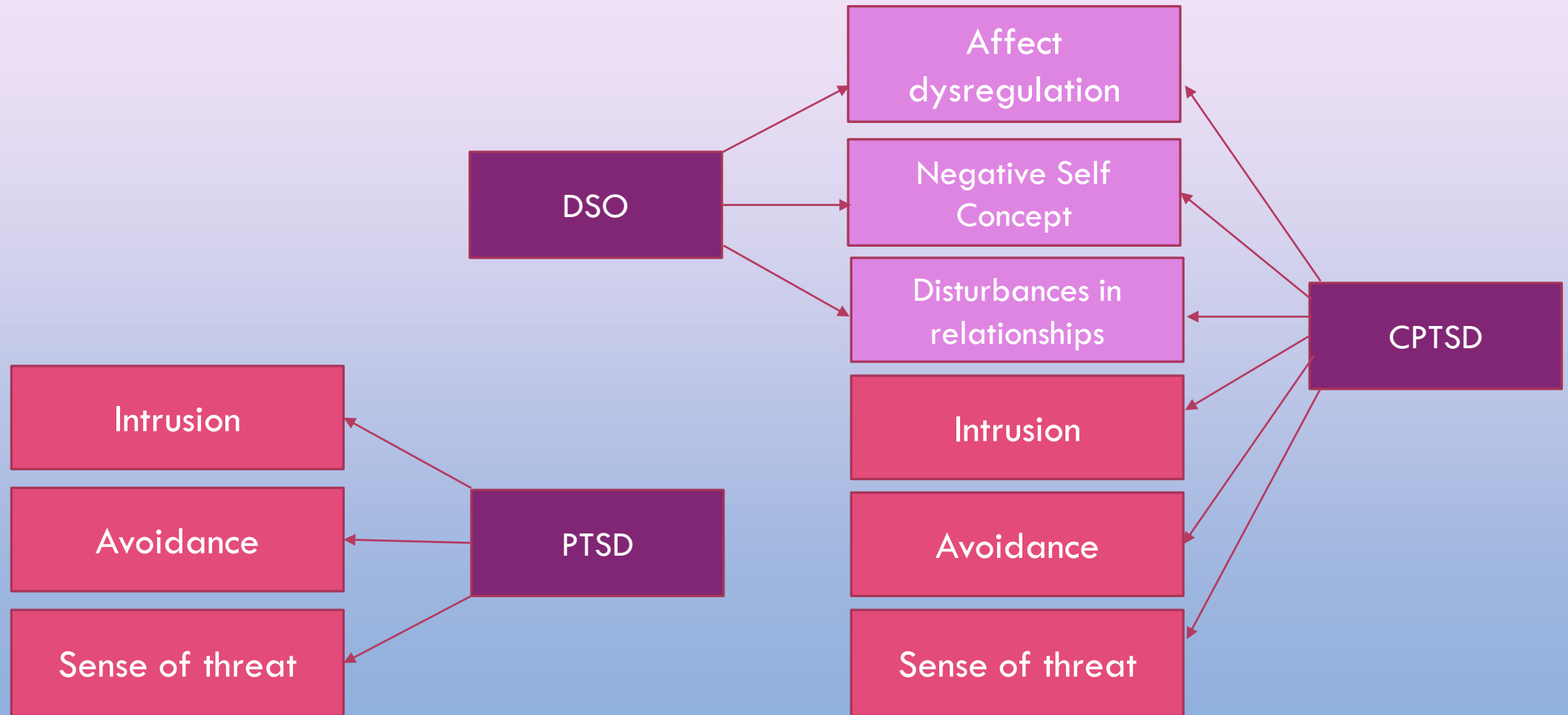
PROPOSED ICD-11 PTSD CLASSIFICATION

- Can develop following exposure to an extremely threatening or horrific event **or series of events** that is characterized by **all** of the following:
 1. Re-experiencing the traumatic event or events **in the present** in the form of vivid intrusive memories, flashbacks, or nightmares, typically accompanied strong and overwhelming emotions and strong physical sensations, or feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event (Re)
 2. Avoidance of thoughts and memories of event or events, or avoidance of activities, situations, or people reminiscent of the event or events (Av)
 3. Persistent perceptions of heightened **current threat**, as indicated by hypervigilance or an enhanced startle reaction to stimuli (Th)

PROPOSED ICD-11 CPTSD CLASSIFICATION

- May develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., Torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse).
- CPTSD is characterized by three clusters reflecting disturbances in self organisation (DSO)
 1. Severe and pervasive problems in affect regulation (AD);
 2. Persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event (NSC); and
 3. Persistent difficulties in sustaining relationships and in feeling close to others (DR).

PROPOSED HIERARCHICAL STRUCTURE OF CPTSD IN ICD-11



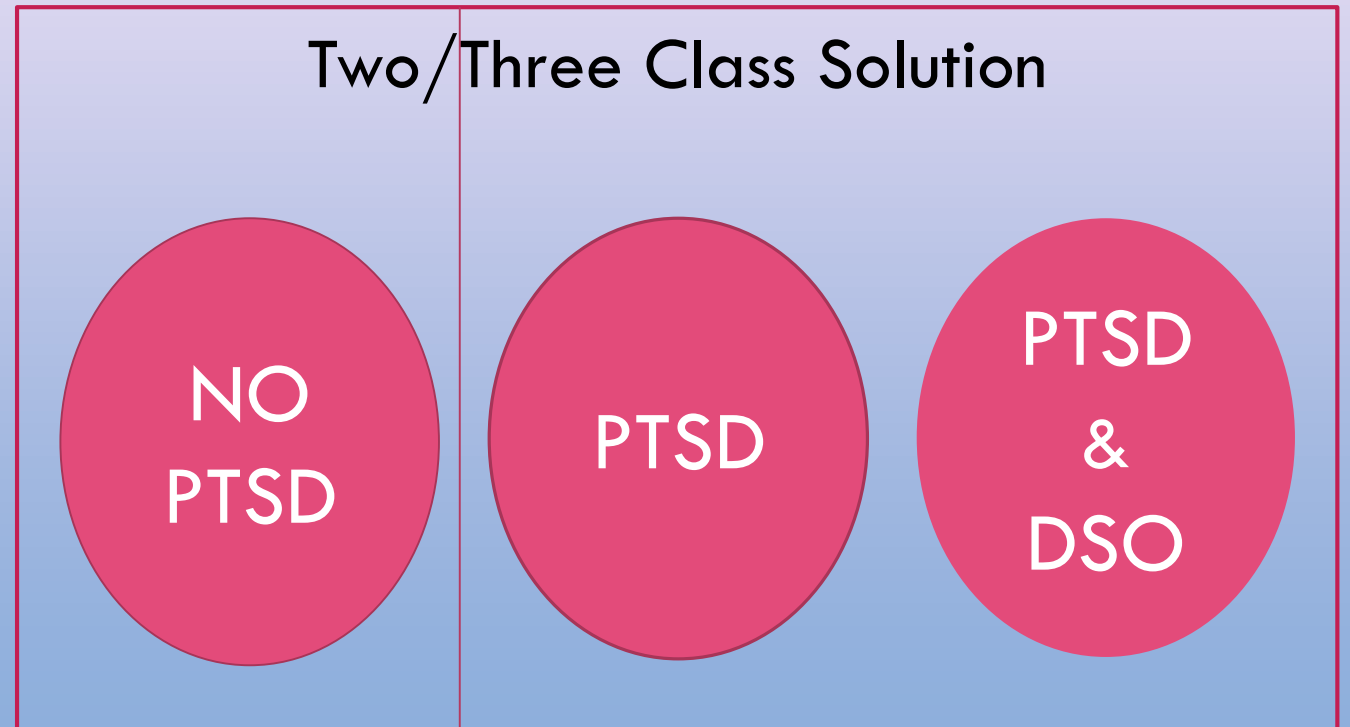
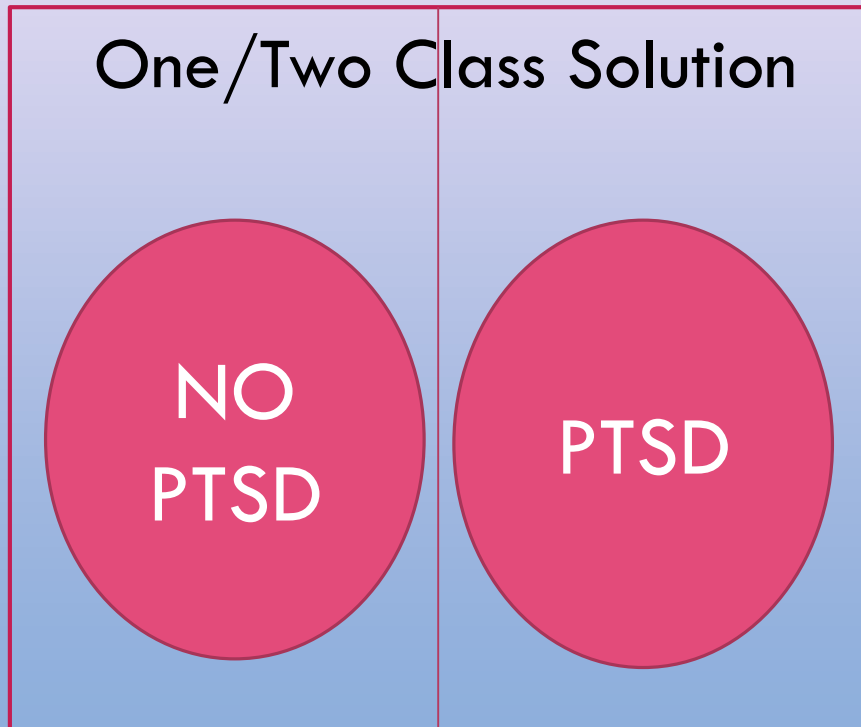
USABILITY TESTING

IN PROGRESS.

DO NOT ENTER!

IS ICD-11 CPTSD A VALID CONSTRUCT?

DOES THE ICD-II CPTSD MODEL SHOW AN ABILITY TO REFLECT DIFFERENT GROUPS OR CLASSES OF INDIVIDUALS WHO DIFFER FROM THOSE WITH PTSD IN THE TYPE AND NUMBER OF SYMPTOMS?



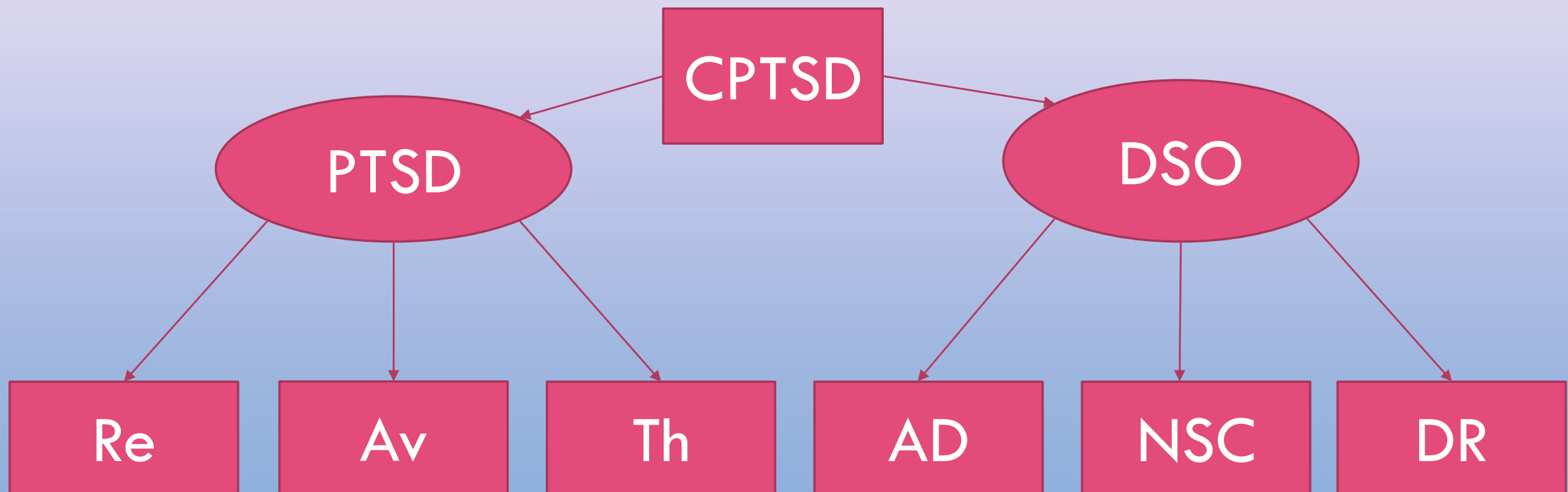
IS ICD-11 CPTSD A VALID CONSTRUCT?

“To date 10 studies have been published and 9 of them have identified the presence of at least two distinct symptom profiles, one describing a group of individuals endorsing high levels of CPTSD in all six symptom clusters, and another reporting high levels of PTSD symptoms but low levels of symptoms related to DSO”

Brewin et al., (2017:5)

IS THE ICD-11 CPTSD SYMPTOM STRUCTURE SUPPORTED?

IS THE SIX FACTOR FIRST ORDER MODEL OF CPTSD SUPPORTED BY TWO CORRELATED HIGHER ORDER FACTORS OF PTSD AND DSO ?



IS THE ICD-11 CPTSD SYMPTOM STRUCTURE SUPPORTED?

Four studies have specifically investigated the possible models for symptom structure, all four supported a structure of CPTSD as consisting of two higher order factors of PTSD & DSO, each supported by three first order factors representing the conceptual distinctions made in the CPTSD model.

PREVALENCE & SENSITIVITY OF ICD-11 CPTSD



PREVALENCE & SENSITIVITY OF ICD-11 CPTSD

- NATIONAL SAMPLES

- Israeli prevalence of PTSD was 9% & CPTSD 2.6% (Ben-Ezra et al 2018), Danish PTSD prevalence was 3% & CPTSD prevalence 1% (Hyland et al., 2017).

- TRAUMA EXPOSED SAMPLES

- Comparing DSM-5 to ICD-11, UK trauma sample rates for ICD-11 CPTSD & PTSD were 64.5%, rate for DSM-5 PTSD was 76.1%. When separated, rates for ICD-11, PTSD were 10.9% & CPTSD 53.6% (Hyland et al., 2017).
- Comparing ICD-10 and ICD-11, Austrian trauma sample rates for ICD-10 PTSD were 52.8%, for ICD-11 PTSD & CPTSD rates were 34.8%. When separated, rates for ICD-11 PTSD were 17% and ICD-11 CPTSD 21.4% (Knefel & Lueger-Schuster, 2013).

CO-MORBIDITY & FUNCTIONAL IMPAIRMENT WITH ICD-11 CPTSD



CO-MORBIDITY & FUNCTIONAL IMPAIRMENT WITH ICD-11 CPTSD

- General functional impairment in all psychopathology (Elklit, Hyland & Shevlin, 2014; Cloitre et al., 2013), particularly in relationships with others (Karatzias et al., 2017).
- Associations with depression, anxiety, dissociation, self harm, & suicidal ideation (Hyland, Shevlin, Fyvie & Karatzias, 2018), and with BPD symptoms (Hyland et al., 2018).
- Correlated with negative view of self and attachment anxiety (Karatzias et al., 2018), and lower tolerance of distress (Hyland et al., 2017).

RISK FACTORS FOR CPTSD UNDER ICD-11 PROPOSALS



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- TRAUMA HISTORY

- Experiences of childhood trauma increase likelihood of developing CPTSD (Karatzias et al., 2017; Shevlin et al., 2017).
- Increased likelihood where there is a greater frequency of childhood traumas (Hyland et al., 2017).
- CPTSD risk increased where there is a greater number of different types of childhood traumas (Karatzias et al., 2017).
- Risk increased for multiple traumas in adulthood (Clotire et al., 2013; Karatzias et al., 2016), CPTSD also identified with different single T adult traumas (Elklit, Hyland & Shevlin, 2014).

RISK FACTORS FOR CPTSD UNDER ICD-11 PROPOSALS

- NATURE OF THE TRAUMA
 - Childhood abuse most predictive of CPTSD rather than PTSD (Cloitre, et al., 2013), however CSA has been found to be the greatest predictor (Hyland et al., 2017).
 - CPTSD shows strongest correlation with childhood emotional and physical neglect (Shevlin et al., 2017).
 - Adult physical assault was predictive of CPTSD in combination with CSA and childhood physical abuse (Hyland et al., 2017).

RISK FACTORS FOR CPTSD UNDER ICD-11 PROPOSALS

- SOCIODEMOGRAPHIC CHARACTERISTICS
 - Being unemployed, unmarried, living alone & taking psychotropic medication each show increased risk (Karatzias et al., 2017).
 - Females appear at twice the risk (Hyland et al., 2017) and show greater association with DSO symptoms (Knefel & Lueguer-Schuster 2013), however being female was also found to more strongly predict PTSD rather than DSO (Hyland et al., 2017).
 - Age and educational attainment have not shown any predictive value (Karatzias et al., 2017).

EMERGING IMPLICATIONS FROM ICD-11 BASED CPTSD RESEARCH

- High functional impairment, higher number of symptoms and greater types of symptoms may require longer treatment course with different interventions (Karatzias et al., 2017).
- Clear links to dissociation, depression, symptoms of BPD highlights need for targeted and more specialised interventions (Hyland et al., 2018).
- Given relationship with attachment anxiety and NSC there is a need to understand how useful relational and attachment based approaches may be (Karatzias et al., 2018).

IN SUMMARY.....

- The conceptual distinction between PTSD and CPTSD is supported by research in a range of populations investigating both construct validity & symptom structure showing a clear distinction as two distinct but related disorders.
- A pattern of lower overall prevalence rates using ICD-11 shown in clinical populations together with a differential diagnosis demonstrates clinical specificity and an ability to consider differentiated treatments.
- Whilst childhood trauma is strongly associated with CPTSD under the ICD-11 proposals it is also associated with multiple & single instance adult trauma endorsing childhood trauma as a risk factor rather than a requirement.
- Further research is needed to understand the relationship between CPTSD & other symptom related disorders in addition to clarifying presentations of CPTSD in children and adolescents.



THANK
YOU!

