



Exploring differences between the ICD-11 and DSM-5 models of PTSD: Does it matter which model is used?



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ABSTRACT

Alternative symptom profiles for posttraumatic stress disorder (PTSD) are presented in the DSM-5 and ICD-11. This study compared DSM-5 PTSD symptom profiles with ICD-11 PTSD symptom profiles among a large group of trauma-exposed individuals from Denmark. Covariates, and rates of co-occurrence with other psychiatric disorders were also investigated. A sample of treatment-seeking adult survivors of childhood sexual abuse ($n = 434$) were assessed using self-report measures of PTSD and other psychiatric disorders. A significantly larger proportion of individuals met caseness for DSM-5 PTSD (60.0%) compared to ICD-11 PTSD (49.1%). This difference was largely attributable to low endorsement of the ICD-11 re-experiencing criteria. Replacement of the 'recurrent nightmares' symptom with the 'recurrent thoughts/memories' symptom seemed to balance the proportion of individuals meeting caseness for both taxonomies. Levels of co-occurrence with anxiety and thought disorder were higher for the DSM-5 model of PTSD compared to the ICD-11 model. Current results merit careful consideration in the selection of symptom indicators for the new ICD model of PTSD, particularly with respect to the re-experiencing symptom category.

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1. Introduction

In the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5: American Psychiatric Association [APA, 2013]), the symptom profile for posttraumatic stress disorder (PTSD) was expanded to include twenty symptoms. These symptoms are contained within four categories (intrusions, avoidance, negative alternations in cognitions and mood [NACM], and alternations in arousal and reactivity). Several studies have provided support for the latent symptom structure of the DSM-5 model of PTSD (Biehn et al., 2013; Armour, Contractor, Palmieri, & Elhai, 2014). An alternative approach to classifying and diagnosing PTSD is proposed in the upcoming 11th revision to the International Classification of Diseases (ICD-11: Maercker et al., 2013) prepared by the World Health Organisation (WHO) and set for release in 2017.

For ICD-11, the WHO emphasised clinical utility as the organizing principle in classification development including

characteristics that diagnoses should be consistent with clinician's mental health taxonomies, limited in number of symptoms, and based on distinctions important for management and treatment (Reed, 2010). The ICD-11 model includes six symptoms belonging to three categories; re-experiencing of the traumatic event(s) in the present accompanied by emotions of fear or horror (re-experiencing: 2 symptoms), avoidance of traumatic reminders (avoidance: 2 symptoms), and a sense of current threat that is manifested by excessive hypervigilance or an enhanced startle reaction (sense of threat: 2 symptoms). Initial studies testing the latent symptom structure of the ICD-11 model of PTSD have provided empirical support (Hansen, Hyland, Armour, Elklit, & Shevlin, 2015; Forbes et al., 2015; Tay, Rees, Chen, Kareth, & Silove, 2015).

1.1. DSM-5 and ICD-11: prevalence rates and comorbidity

The presence of two alternative methods of describing the same purported disorder provides a unique challenge to researchers and clinicians working with trauma-exposed individuals. Determination of the correct symptom profile for PTSD has implications for guiding research that elucidates the key etiological factors in the onset of the disorder; for refining treatment interventions that

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target the most important symptoms; and for facilitating the development of effective early interventions to prevent the onset of chronic PTSD (Elhai & Palmieri, 2011). A critical topic for research therefore is to determine whether the alternative symptom profiles of PTSD presented in the DSM-5 and the proposed ICD-11 produce discrepant prevalence and comorbidity rates.

Hansen et al. (2015) reported significantly higher rates of diagnosis according to the DSM-5 symptom profile (30.4%) compared to the ICD-11 symptom profile (22.6%) among a heterogeneous sample ($N=3746$) of trauma-exposed persons. Among a very large sample ($N=23,936$) drawn from 13 countries, Stein et al. (2014) reported similar rates of PTSD for DSM-5 (3.0%) and ICD-11 (3.2%), and marginally lower levels of comorbidity with fear and distress for ICD-11. O'Donnell et al. (2014) reported significantly higher rates of PTSD according to DSM-5 (6.7%) than ICD-11 (3.3%) in a sample of individuals hospitalised for physical injury ($N=510$) six years following trauma. However, ICD-11 rates increased to 6.1% when the re-experiencing category was expanded to include a third symptom measuring 'intrusive thoughts/memories'. Moreover, comorbidity rates with depression were found to be significantly lower according to the ICD-11 model.

Although research assessing differences in prevalence of PTSD based on the two classification systems is scarce, the available evidence suggests that the alternative diagnostic systems may affect the proportion of trauma-exposed individuals that will receive a diagnosis. Furthermore, the findings of O'Donnell et al. (2014) suggest that the ICD-11's re-experiencing category is overly restrictive and is likely the reason for observed differences in prevalence between the two diagnostic systems. Despite the possible differences in prevalence, existing findings indicate that comorbidity rates with alternative psychiatric diagnoses may be lower according to the proposed ICD-11 model of PTSD. Indeed a primary objective of the restricted symptom profile of PTSD proposed for ICD-11 is to reduce the level of comorbidity with other psychiatric disorders (Maercker et al., 2013).

1.2. The current study

The existing literature suggests that fewer trauma-exposed individuals display symptom profiles consistent with ICD-11 PTSD than DSM-5 PTSD. Tentative findings suggest that this difference may be partly attributable to low endorsement of the ICD-11 re-experiencing criteria (O'Donnell et al., 2014). Building on the findings of O'Donnell et al. (2014) therefore the current study assessed ICD and DSM PTSD taxonomic performance among a sample of Danish adult-survivors of childhood sexual abuse (CSA). First, it was predicted that there would be significant differences in the proportion of CSA victims who exhibited symptom profiles consistent with DSM-5 PTSD and ICD-11 PTSD. Second, it was predicted that endorsement variation in relation to the ICD-11 re-experiencing symptoms specifically would account for the discrepancies between the two taxonomies. Third and finally, it was predicted that both DSM-5 and ICD-11 PTSD symptom profiles, from subclinical thresholds to severe, would exhibit strong associations with a range of alternative psychiatric diagnoses.

2. Method

2.1. Participants

Participants were all victims of childhood sexual abuse (CSA; $n=434$) that attended four different Danish treatment centres for victims of CSA. The majority of participants were women (85%), and all were Caucasian. All attendees presented with distress and impairment resulting from their traumatic abuse history and

received individual psychotherapy of an eclectic nature that suited their needs. The centres are supported by the Ministry of Social Affairs. Exclusion criteria were (1) evidence of intoxication at time of visit, (2) a diagnosis of a psychotic disorder, (3) self-harming behaviour, (4) engagement in treatment elsewhere, and (5) diagnosis of a personality disorder. Ethical approval for use of data gathered from this sample was obtained from the relevant university ethical boards in Denmark. The mean age of the sample was 36.87 years ($SD=10.94$; range 18–77). Almost all (91%) had experienced CSA before the age of 15 committed by a person at least five years older than them and on an average of 23.47 years ago ($SD=12.30$). The mean age for CSA onset was 7.12 years ($SD=4.03$), and the average age at which the abuse ended was 13.44 years ($SD=4.42$). The average duration of abuse was 7.05 years ($SD=6.75$) and the mean number of experienced abuse acts was 3.34 ($SD=1.33$).

2.2. Measures

The symptoms of PTSD were assessed using the 31-item Harvard Trauma Questionnaire Part IV (HTQ-IV; Mollica et al., 1992). Designed to reflect the DSM-IV model of PTSD the HTQ-IV contains additional items that largely reflect the newly introduced PTSD symptoms in the DSM-5. The mapping of each HTQ item to the models of PTSD can be seen in Table 1. Items were rated on a four-point Likert scale (1 = 'not at all', 2 = 'a little', 3 = 'quite a bit', 4 = 'all the time'). There were two limitations associated with using the HTQ to capture the DSM-5 PTSD symptoms: (1) the B4 and B5 criteria (i.e. physiological and psychological reactivity to reminders of the traumatic event) were assessed with a single item; and (2) the E2 criterion (i.e. reckless or self-destructive behaviour) was not assessed. The Danish version of the HTQ-IV has been used in a range of trauma populations with reports of good reliability and validity (Bach, 2003). Mollica et al. (1992) reported 88% concordance between those reporting symptoms consistent with PTSD diagnostic criteria based on the HTQ-IV and a diagnostic interview. Cronbach's alpha (α) among the current sample for the 18 items used to measure DSM-5 PTSD was satisfactory ($\alpha=.83$), whereas the reliability for the 6 items used to measure ICD-11 PTSD was slightly lower ($\alpha=.69$). The slightly lower reliability estimate for ICD-11 was likely due to the limited number of items.

The DSM-5's B-E criteria were considered to be met if participants endorsed at least one symptom of intrusions, one symptom of avoidance, two symptoms of NACM, and two symptoms of arousal (see Hansen et al., 2015 for full details). The HTQ-IV does not measure criteria F-H. The ICD-11 criteria were met if participants endorsed at least one symptom of each of the three clusters of re-experiencing, avoidance, and sense of threat. Symptom endorsement in both cases was indicated by item scores 3 and above on the HTQ-IV as indicated originally in relation to the DSM-IV (see Elklit & Shevlin, 2007).

Psychiatric disorders were assessed using the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, Millon, Davis, & Grossman, 2009). The MCMI-III is a commonly used self-report measure that provides information on ten disorders (anxiety, somatoform, bipolar disorder, dysthymia, alcohol dependence, drug dependence, PTSD, thought disorder, major depression, and delusional disorder—PTSD was excluded for the purposes of this study) outlined in the DSM-IV (APA, 1994). Standardised base rate (BR) scores for each disorder can range from 0 to 115. The MCMI-III includes three threshold points to indicate the severity of the self-reported symptoms of each disorder: BR scores from 65 reflect "sub-clinical" levels of a disorder, BR scores from 75 reflect "clinical" levels of a disorder, and BR scores from 85 reflect "severe" levels of a disorder (Grove & Vrieze, 2009). The MCMI-III is intended for adults (18 and over) with at least an 8th grade reading level

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