



Research paper

Evidence of distinct profiles of Posttraumatic Stress Disorder (PTSD) and Complex Posttraumatic Stress Disorder (CPTSD) based on the new ICD-11 Trauma Questionnaire (ICD-TQ)

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ABSTRACT

Background: The WHO International Classification of Diseases, 11th version (ICD-11), has proposed two related diagnoses following exposure to traumatic events; Posttraumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD). We set out to explore whether the newly developed ICD-11 Trauma Questionnaire (ICD-TQ) can distinguish between classes of individuals according to the PTSD and CPTSD symptom profiles as per ICD-11 proposals based on latent class analysis. We also hypothesized that the CPTSD class would report more frequent and a greater number of different types of childhood trauma as well as higher levels of functional impairment. **Methods** Participants in this study were a sample of individuals who were referred for psychological therapy to a National Health Service (NHS) trauma centre in Scotland (N=193). Participants completed the ICD-TQ as well as measures of life events and functioning.

Results: Overall, results indicate that using the newly developed ICD-TQ, two subgroups of treatment-seeking individuals could be empirically distinguished based on different patterns of symptom endorsement; a small group high in PTSD symptoms only and a larger group high in CPTSD symptoms. In addition, CPTSD was more strongly associated with more frequent and a greater accumulation of different types of childhood traumatic experiences and poorer functional impairment.

Limitations: Sample predominantly consisted of people who had experienced childhood psychological trauma or been multiply traumatised in childhood and adulthood.

Conclusions: CPTSD is highly prevalent in treatment seeking populations who have been multiply traumatised in childhood and adulthood and appropriate interventions should now be developed to aid recovery from this debilitating condition.

1. Introduction

Two ‘sibling disorders’ have been proposed for ICD-11; Posttraumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD) (Maercker et al., 2013). The organizing principles for the ICD-11 revisions were that diagnoses should be consistent with clinicians’ mental health taxonomies, limited in the number of symptoms

included, and based on distinctions important for management and treatment (Reed, 2010). The ICD-11 model of PTSD includes symptoms reflecting three clusters: (1) re-experiencing of the trauma in the present (Re), (2) avoidance of traumatic reminders (Av), and (3) a persistent sense of threat that is manifested by increased arousal and hypervigilance (Th). These symptoms define PTSD as a response characterised by some degree of fear or horror related to a specific

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traumatic event. In contrast, the symptom profile of CPTSD includes the core PTSD symptoms plus three additional symptoms that identify ‘disturbances in self-organization’ (DSO): (1) affective dysregulation (AD), (2) negative self-concept (NSC), and (3) disturbances in relationships (DR).

The DSO component of the ICD-11 model is consistent with the plethora of research findings that indicate how prolonged interpersonal trauma, particularly of an early relational type, can result in the development and maintenance of negative and denigrating view of self, and fearful and threatening interpretation of others. Childhood sexual abuse has been shown to be associated with shame (Andrews, 1998), guilt (Street, Gibson, and Holohan, 2005), adoption of defensive submissive strategies (Gilbert, 2000), perceptions of low self-worth (Kucharska, 2015), self-directed disgust (Badour et al., 2014) and fearful attitudes toward relationships (Harris and Valentiner, 2002). Furthermore, the role of interpersonal trauma in emotional dysregulation is well established (Dvir et al., 2014). Therefore, the concept of DSO can be seen as a convenient summary of the multitude of deleterious effects of prolonged interpersonal trauma.

More formally the distinction between PTSD and Complex PTSD was first articulated by Herman (1992) who proposed that prolonged interpersonal traumatic stressors (e.g., childhood abuse, domestic violence, being a prisoner of war) negatively impacted self-organization, independent of PTSD symptoms. Data from the DSM-IV field trials indicated that those with chronic trauma exposure reported high rates of symptoms representative of disturbances in affective, self and relational domains compared to those with other types of trauma histories (Roth et al., 1997). Since that time, data has been accumulating indicating the presence of salient disturbances in these domains as particularly associated with childhood trauma (e.g., Briere and Rickards, 2007; Cloitre et al., 1997; Kaltman et al., 2005) and some data indicating disturbances in these domains in samples defined by adult-onset sustained interpersonal violence such as civilians exposed to war (e.g., Morina and Ford, 2008).

Given the potential for ICD formulations to become the primary diagnostic classification system used in the field of psychotraumatology (Wolf et al., 2015), a thorough empirical assessment of the ICD-11 models of trauma-based disorders is required. The ICD-11 model of CPTSD predicts that there should be evidence of qualitatively different patterns, or profiles, of symptom endorsement and these different profiles should be related to the nature of the trauma exposure. Such evidence is usually provided by the results from mixture models that identify different homogeneous sub-populations that share similar patterns of symptom endorsement. Specifically, it is predicted that there would be evidence of PTSD characterised by high endorsement of PTSD symptoms and low endorsement of DSO symptoms. CPTSD would be characterised by high endorsement of both PTSD and DSO symptoms. Also, the CPTSD profile of symptom endorsement should be more strongly associated with sustained, repeated, and multiple forms of traumatic exposures. It is also possible to find other profiles, such as low endorsement of all symptoms, without invalidating the CPTSD model.

There have been several studies that have tested the ICD-11 model of CPTSD using mixture models, most commonly using latent class analysis (LCA) and latent profile analysis (LPA). These studies and their findings are summarised in Table 1.

The six studies that employed mixture models, utilizing seven trauma samples found support for the distinction between ICD-11 PTSD and CPTSD while one study has called this into question (Wolf et al., 2015). Overall, the research evidence for the ICD-11 model of CPTSD is largely supportive as the findings from the mixture models support the qualitative distinction between PTSD and CPTSD.

The present study aimed to determine if there are qualitatively different groups of participants, or classes, with symptom endorsement that reflect PTSD and CPTSD using the only self-report scale (i.e. ICD-11 Trauma Questionnaire (ICD-TQ); Cloitre, Roberts, Bisson, and

Brewin, 2014) that has been developed to measure CPTSD as proposed by the ICD-11. Analyses were based on data from a sample of outpatients seeking psychological treatment for distress following traumatic events. It was predicted that (1) separate classes representing PTSD (high probabilities of meeting diagnostic criteria for the three PTSD symptom clusters and low probabilities of meeting diagnostic criteria for the three DSO symptom clusters) and CPTSD (high probabilities of meeting diagnostic criteria for the three PTSD and three DSO symptom clusters) would be found, (2) the CPTSD class would report higher rates of childhood trauma (individual and cumulative) and stressful life events, and (3) the CPTSD class would report higher levels of functional impairment (home management, social leisure activities, private leisure activities and relationships with others). The study also aimed to examine differences between the PTSD and CPTSD classes on a range of socio-demographic variables.

2. Method

2.1. Participants and procedure

Participants in this study were individuals who were referred by general practitioners, psychiatrists or psychologists for psychological therapy to a National Health Service (NHS) trauma centre in Scotland. All 230 new patients over the 18 month recruitment period were sent a letter and invited to complete a set of standardised measures. Twenty-two did not respond and 13 provided unusable data due to large amounts of missing responses, and 2 had missing scores on the ICD – TQ which resulted in a final sample size of 193.

The mean age of the sample was 41 years (SD=12.4) and there were more females (65.1%) than males. Most of the sample were born in the United Kingdom (88.7%) and of these most were from Scotland (79%). The highest level of academic attainment was varied: school (38.5%), College (30.2%), and University (30.2%). Approximately one third of the sample was in employment (full-time 20.2%, part-time 13%), 38.9% were unemployed, 7.3% were retired, and 5.7% were in voluntary work (15% reported ‘None of these’). Almost half of the sample were single (48.2%), 22.3% were married, 12.4% were divorced, and 9.8% were co-habiting. Most participants were either living with partner or with their family (41%), 34.7% were living alone (and 24.4% reported ‘Other’).

2.2. Measures

2.2.1. ICD 11 Trauma Questionnaire (ICD-TQ; Version 1.2, Cloitre et al., 2014)

The ICD-TQ is a 23-item self-report measure for the screening of ICD-11 PTSD and CPTSD symptomatology. Six items represent the three clusters of PTSD including Re-experiencing (RE) (items P1-P2), Avoidance (AV) (items P3-P4), and Sense of Threat (Th) that is manifested by increased arousal and hypervigilance (items P5-P6). CPTSD includes PTSD as well as three clusters reflecting DSO. Sixteen items represent the three DSO clusters including affective dysregulation (AD, items C1-C9), negative self-concept (NSC, items C10-C13), and disturbances in relationships (DR, items C14-C16). Symptom endorsement is scored on a Likert scale, indicating how much a symptom has been bothersome in the past month, with scores ranging from 0 (not at all) to 4 (extremely). The scale can be used to estimate a self-report ICD-11 PTSD or CPTSD diagnosis by recoding the Likert scores into six binary variables representing each of the 3 PTSD and DSO symptom clusters based on the following cut-off scores. A diagnosis of PTSD requires a score of ≥ 2 (moderately (2), quite a lot (3), extremely (4)) for at least one symptom in each of its three clusters. A diagnosis of CPTSD requires PTSD and the following scores for each of the three DSO clusters. As for PTSD component, an item requires a score of ≥ 2 to be positive. The proposed algorithm for each DSO cluster requires a sum that is half of the total possible score. AD requires a

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