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Review

A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD

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HIGHLIGHT

- Structural analyses suggest PTSD can be measured with 6 symptoms and 3 factors.
- Analyses distinguish a 3-factor PTSD from a 6-factor Complex PTSD.
- ICD-11 CPSTD is associated with greater functional impairment than PTSD.
- Rates of PTSD in adults under ICD-11 are likely to be lower than under DSM-5.

ABSTRACT

The World Health Organization's proposals for posttraumatic stress disorder (PTSD) in the 11th edition of the International Classification of Diseases, scheduled for release in 2018, involve a very brief set of symptoms and a distinction between two sibling disorders, PTSD and Complex PTSD. This review of studies conducted to test the validity and implications of the diagnostic proposals generally supports the proposed 3-factor structure of PTSD symptoms, the 6-factor structure of Complex PTSD symptoms, and the distinction between PTSD and Complex PTSD. Estimates derived from DSM-based items suggest the likely prevalence of ICD-11 PTSD in adults is lower than ICD-10 PTSD and lower than DSM-IV or DSM-5 PTSD, but this may change with the development of items that directly measure the ICD-11 re-experiencing requirement. Preliminary evidence suggests the prevalence of ICD-11 PTSD in community samples of children and adolescents is similar to DSM-IV and DSM-5. ICD-11 PTSD detects some individuals with significant impairment who would not receive a diagnosis under DSM-IV or DSM-5. ICD-11 CPTSD identifies a distinct group who have more often experienced multiple and sustained traumas and have greater functional impairment than those with PTSD.

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1. Introduction

The diagnosis of posttraumatic stress disorder (PTSD) was first introduced in the 3rd edition of the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association, 1980), proving immediately influential and leading to decades of important and innovative research. Subsequent editions of the DSM in 1987 and 2000 refined and improved the diagnosis, culminating in the most recent version, DSM-5 (American Psychiatric Association, 2013). Despite the popularity of the diagnosis, it has been controversial in some quarters and there have been persistent questions about whether its formulation in the DSM is optimal. The 11th revision of the World Health Organization's (WHO) International Classification of Diseases (ICD-11) is currently nearing completion (First, Reed, Hyman, & Saxena, 2015). ICD adopts a public health perspective and is organized around maximizing clinical utility for the use of diagnoses worldwide. ICD-11 has proposed a substantially different approach to diagnosing PTSD, primarily simplifying the conceptualization of disorder but also distinguishing between basic and complex forms of the condition (Maercker et al., 2013). The dissemination of these proposals has led to important discussions in the field (Miller, Wolf, & Keane, 2014). ICD-11 is scheduled for release in 2018, and in this article we review emerging evidence about the new formulation of PTSD and CPTSD that speaks to whether the proposals are useful in principle and whether revisions of this formulation may be necessary. Most of this evidence concerns adults; there are some data on children and adolescents and developmental formulations of the proposals are underway but detailed consideration of them is beyond the scope of this article.

By the time of DSM-III-R in 1987, PTSD was already one of the most complex diagnoses in the manual. It included 17 symptoms divided into three clusters, with different thresholds for each cluster, and two additional criteria concerning the nature of the stressor and the duration of symptoms. DSM-IV added another criterion, the presence of clinically significant distress or impairment. In DSM-5, the three symptom clusters were increased to four on the basis of factor analytic findings, three further symptoms were added, and a dissociative subtype was included for the first time. These successive changes resulted in a comprehensive description of the disorder, but have had several costs. One is that the diagnosis can now be based on over half a million different combinations of symptoms (Galatzer-Levy & Bryant, 2013). Another is that even with the more limited symptom combinations in DSM-IV it has proved difficult for non-specialists to confidently identify and diagnose it, which may partly account for the finding that levels of recognition among non-psychiatric physicians are poor (Brewin et al., 2010; de Bont et al., 2015; Ehlers, Gene-Cos, & Perrin, 2009; Liebschutz et al., 2007).

Many of the symptoms included as criteria for PTSD in the DSM-IV and DSM-5 overlap with other disorders: Sleep disturbance, concentration problems, and irritability are characteristic of generalized anxiety disorder (GAD); depression is characterized by these same three symptoms but also by negative beliefs about oneself and the world, self-blame, diminished interest in activities, detachment from others, and emotional numbing. It is therefore unsurprising that rates of comorbidity are very high, particularly with depression (Brady, Killeen, Brewerton, & Lucerini, 2000). Studies investigating the correlates of different latent factors of PTSD have found that symptoms characteristic of anxiety and depression appear to be more strongly related to those factors reflecting general dysphoria rather than to the more specific aspects of PTSD reflecting re-experiencing, active avoidance, and hyperarousal (Byllesby, Durham, Forbes, Armour, & Elhai, 2016; Contractor et al., 2014; Durham et al., 2015; Gootzeit & Markon, 2011).

Other evidence for non-specificity comes from studies that have examined whether PTSD symptoms are more common following events that, according to the successive definitions adopted by the DSM, are traumatic as opposed to distressing (but non-traumatic). The option of removing the requirement that one be exposed to a traumatic event was contemplated by the DSM-5 Work Group (Friedman, Resick, Bryant, & Brewin, 2011). Although this committee recognized that PTSD symptoms can develop following non-traumatic events, it decided to retain the traumatic event as a gatekeeper criterion for the diagnosis because “intrusion and avoidance symptoms are incomprehensible without prior exposure to a traumatic event” (p. 754). However, a recent meta-analysis (Larsen & Pacella, 2016) showed that PTSD symptoms were only slightly more common following events defined as traumatic versus non-traumatic according to the DSM, and this advantage disappeared if subjective ratings of fear, helplessness, and horror (required in DSM-IV but not in DSM-5) were omitted. Moreover, the structure of DSM-5 PTSD symptoms is essentially the same whether or not individuals have experienced events meeting the criteria for a trauma (Zelazny & Simms, 2015).

One implication that has been drawn is that many of the PTSD symptoms included in the DSM are general reactions to adversity rather than specific reactions to trauma (Brewin, 2003). This non-specificity in the clinical picture painted by the DSM is possibly one of the reasons why, although much is known about the biological correlates of PTSD, there are as yet no specific biomarkers for the condition (Lehrner & Yehuda, 2014). For example, reductions in brain volume associated with PTSD have not been able to be distinguished from similar patterns associated with depression (Kroes, Rugg, Whalley, & Brewin, 2011).

Such observations have led previous authors to question whether comorbidity would be reduced with a smaller symptom set consisting of those more specific to PTSD such as flashbacks, nightmares, startle, and hypervigilance (Davidson & Foa, 1991). Another proposal (Spitzer, First, & Wakefield, 2007) involved eliminating a symptom considered to be of doubtful validity (impaired recall of the trauma) as well as symptoms shared with depression and GAD (irritability, insomnia, difficulty concentrating, and markedly diminished interest). The effect of this suggested change on comorbidity with a variety of disorders was tested in three studies, two of which showed no significant differences relative to DSM-IV (Elhai, Grubaugh, Kashdan, & Frueh, 2008; Grubaugh, Long, Elhai, Frueh, & Magruder, 2010) whereas the third, conducted with an adolescent sample, suggested less comorbidity with depression associated with the Spitzer et al. symptom set (Ford, Elhai, Ruggiero, & Frueh, 2009). In these studies, however, the samples meeting the DSM-IV versus the Spitzer et al. criteria for PTSD overlapped to a considerable extent, with most of the PTSD cases appearing in both. A clearer picture would be given by comparing non-overlapping samples who met the DSM-IV but not the Spitzer et al. criteria, or vice versa.

A final suggestion to decrease the symptom set (Brewin, Lanius, Novac, Schnyder, & Galea, 2009) proposed requiring at least one of two symptoms specifically reflecting re-experiencing of the traumatic event in the present (corresponding to the DSM items assessing flashbacks or nightmares), at least one of two symptoms specifically reflecting active avoidance (corresponding to the DSM items assessing avoidance of internal thoughts or external reminders), and at least one of two symptoms (hypervigilance or exaggerated startle) reflecting the continuing sense of threat identified as characteristic of PTSD (Ehlers & Clark, 2000). Under this proposal there are only 27 combinations of qualifying symptoms. As with the Davidson and Foa (1991) proposal, the intention was to include those symptoms that best discriminated PTSD from other disorders. A more detailed rationale for the choice of symptoms can be found elsewhere (Brewin, 2013; Brewin et al., 2009).

2. ICD-11 proposals for PTSD and complex PTSD

A modified version of the Brewin et al. (2009) formulation, along with many other changes to ICD-10 PTSD, have been incorporated in the proposed diagnostic requirements for PTSD in ICD-11 (Maercker et al., 2013). Exposure to trauma, defined as an extremely threatening or horrific event or series of events, is required. The essential feature of