ICD-11 complex PTSD among Israeli male perpetrators of intimate partner violence: Construct validity and risk factors

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ABSTRACT

The International Classification of Diseases 11th Version (ICD-11) will include Complex Posttraumatic Stress Disorder (CPTSD) as a unique diagnostic entity comprising core PTSD and DSO (disturbances in self-organization) symptoms. The current study had three aims: (1) assessing the validity of CPTSD in a unique population of male perpetrators of intimate partner violence; (2) examining whether exposure to different types of traumatic events would be associated with the two proposed CPTSD factors, namely PTSD or DSO; and (3) assessing the differential association of various sociodemographic and symptom characteristics with each factor. Participants were 234 males drawn randomly from a sample of 2600 men receiving treatment at 66 domestic violence centers in Israel. Data were collected using the International Trauma Questionnaire (ITQ) – Hebrew version. Confirmatory factor analysis supported the factorial validity of ICD-11 CPTSD. Cumulative lifetime trauma and physical childhood neglect were associated with PTSD and DSO, while cumulative childhood violence exposure was associated only with DSO. Anxiety was associated only with DSO; depression more strongly with DSO than PTSD. Religious level contributed only to PTSD; compulsory military service only to DSO. The study supports the distinction between PTSD and DSO in the CPTSD construct and introduces the role of cultural variables.

1. Introduction

Two sibling trauma-based disorders have been proposed for the International Classification of Diseases 11th Version (ICD-11), to be published by the World Health Organization (WHO) in 2018 (Hyland, Shevlin, Elklit, et al., 2016). The first, Posttraumatic Stress Disorder (PTSD), is characterized by three main groups of symptoms: re-experiencing (Re), avoidance (Av), and sense of threat (Th) (Brewin et al., 2017). The WHO ICD-11 Working Group has recommended a refocus on the diagnosis of PTSD on the basis of three core elements, and the removal of non-specific symptoms that are also part of other disorders (Maercker et al., 2013), a formulation which has been supported by several factor structure analyses (Brewin et al., 2017). The second, Complex PTSD (CPTSD), describes more pervasive psychological distress that typically occurs following traumatic exposure of a chronic nature. In addition to the core symptom clusters of PTSD, the ICD-11 CPTSD definition includes three areas of disturbances in self-organization (DSO): affective dysregulation (AD), negative self-concept (NSC), and disturbances in relationships (DR) (Brewin et al., 2017). Several studies have indicated support for the construct validity of these

two diagnoses in a variety of samples (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Elklit, Hyland, & Shevlin, 2014; Hyland, Shevlin, Elklit, et al., 2016; Karatzias et al., 2016; Perkonigg et al., 2015). However, not all have shown results supporting this conceptual model (Wolf et al., 2014); thus, the need for additional testing. Moreover, the model should be tested among new community and clinical samples from a variety of cultural contexts. Of particular interest are mandated patients. These individuals may have significant levels of posttraumatic stress symptoms (Hoyt, Wray, Wiggins, Gerstle, & Maclean, 2012), as well as disturbances in self-organization, given their history of chronic exposure to traumatic events in childhood. However, because they tend not to seek help for traumatic distress, they are rarely studied in relation to CPTSD symptoms. Therefore, the purpose of this study was to evaluate the construct and discriminative validity of CPTSD in a sample of male perpetrators of intimate partner violence mandated for treatment.

In this study, confirmatory factor analysis (CFA) was used, an approach which has been used previously to test the validity of the proposed model (Hyland, Shevlin, Elklit, et al., 2016; Knefel & Lueger-Schuster, 2013; Nickerson et al., 2016; Shevlin et al., 2017) in other

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samples. The International Trauma Questionnaire (ITQ) was developed explicitly to capture the ICD-11 PTSD and CPTSD diagnoses, via self-report measures (ITQ; Cloitre, Roberts, Bisson, & Brewin, in preparation). To date, only three studies testing the content and construct validity of the ICD-11 diagnoses of PTSD and CPTSD with the ITQ have been published (Hyland, Shevlin, Brewin, et al., 2017; Karatzias et al., 2017; Murphy, Elklit, Dokkedahl, & Shevlin, 2016). There is thus a need to further test the construct validity of ICD-11 PTSD and CPTSD with the ITQ in additional samples.

The differential diagnosis between ICD-11 PTSD and CPTSD is determined by the symptom profile rather than the individual's trauma history (Maercker et al., 2013). However, consistent with previous empirical investigations and conceptual models of complex PTSD (Ford & Courtois, 2014; Herman, 1992; Van der Kolk, 1987), the types of events associated with the risk for ICD-11 CPTSD are expected to be sustained, repeated, or multiple forms of exposure (e.g., childhood abuse, domestic violence) and are of an interpersonal nature from which escape is difficult or impossible.

Findings related to the role of trauma history variables (e.g., type of trauma, its chronicity, and number of exposures to traumatic events) as risk factors for CPTSD have been somewhat mixed. Many studies have found a positive association between chronic childhood trauma exposure and a CPTSD symptom profile (Cloitre et al., 2013; Dokkedahl, Oboke, Ovuga, & Elklit, 2015; Knefel & Lueger-Schuster, 2013). The experience of cumulative childhood exposure to various types of interpersonal trauma (Hyland, Murphy, Shevlin, et al., 2017; Karatzias et al., 2017) has been more strongly associated with CPTSD than with PTSD symptom profiles. However, one study found no relationship between childhood abuse and CPTSD (Wolf et al., 2014), and another found no relationship between other types of childhood trauma and CPTSD (Krammer, Kleim, Simmen-Janevska, & Maercker, 2015). Additionally, only two studies have examined this subject by comparing PTSD and DSO cluster symptoms as delineated by the CPTSD definition. Endorsement of childhood abuse of any type (sexual, physical, emotional) and childhood physical or emotional neglect was more strongly associated with DSO than with PTSD symptom profiles (Shevlin et al., 2017); one study among childhood sexual abuse survivors, however, found that frequency of abuse was more strongly associated with PTSD than with DSO symptom profiles (Hyland, Shevlin, Elklit, et al., 2016). Given the conflicting evidence, and the scant research that has been conducted assessing trauma history characteristics that may distinguish PTSD and DSO cluster symptoms, it is important to further study predictors and correlates that might enable a differentiation between the two.

Several studies have found that, overall, ICD-11 CPTSD is associated with a greater number of co-morbid disorders (Perkonigg et al., 2015) and greater severity of comorbid symptoms (Elklit et al., 2014; Murphy et al., 2016) than is ICD-11 PTSD. One study looked at specific differential associations of comorbid symptoms in relation to the two CPTSD factors (Hyland, Shevlin, Elklit, et al., 2016). Findings indicated that a higher level of anxiety was more strongly associated with PTSD symptoms than DSO symptoms, while a higher level of dysphoria was associated with DSO. These results are consistent with the conceptualization of PTSD symptoms arising from the experience of threat, while those of DSO are typically associated with the loss of psychological (e.g., self-efficacy) and environmental (e.g., social networks) resources that can result from repeated or sustained traumatic events.

Additional possible risk factors for CPTSD are sociodemographic. The CPTSD profile has been associated with lower educational attainment and lower socioeconomic status (Perkonigg et al., 2015), unemployment (Hyland, Murphy, Shevlin, et al., 2017), and a lower likelihood of full-time or part-time employment (Karatzias et al., 2017). It remains to be seen whether such differences will be observed in the Israeli patient population.

Research supporting the validity of the ICD-11 CPTSD construct has, to date, been conducted among quite varied clinical and community samples who have been exposed to interpersonal violence. These

include individuals who experienced both adult and childhood interpersonal violence (Cloitre et al., 2013; Karatzias et al., 2017), childhood sexual abuse victims (Hyland, Shevlin, Elklit, et al., 2016; Hyland, Shevlin, McNally, et al., 2016), survivors of institutional abuse (Knefel, Garvert, Cloitre, & Lueger-Schuster, 2015), a community sample of young adults exposed to interpersonal violence (Perkonigg et al., 2015), and a non-western (Ugandan) young adult sample exposed to civil war, including those abducted as children for soldiering (Dokkedahl et al., 2015; Murphy et al., 2016).

No studies have specifically focused on the traumatic experiences of men and, more particularly, men who have been identified as perpetrators of violence. Studies indicate that these men have usually experienced traumatic events at a greater frequency than other men in the community (Maguire et al., 2015), specifically exposure to violence by their parents (Delsol & Margolin, 2004). They also experience PTSD at higher rates than do community samples (Delsol & Margolin, 2004; Hoyt et al., 2012). Nevertheless, they have rarely been the subjects of studies in this area because they generally tend not to seek help for their traumatic distress. Consequently, they comprise a new and relevant clinical population by which to validate the ICD-11 PTSD definitions.

The first aim of the study was to test the latent structure of CPTSD symptoms via the Hebrew version of the ITQ among a special study sample of males who perpetrated intimate partner violence (IPV) and are being treated by social service agencies. The second was to examine the association between types of traumatic events and the PTSD versus DSO symptom clusters. The current study specifically examined the potential differential contributions of exposure to child abuse, physical neglect, and cumulative traumas to the risk for PTSD versus DSO, as well as the relative contribution of anxiety and depressive symptomatology. Finally, while the validation of this structural definition has been tested in several cultural contexts such as America (Cloitre et al., 2013), Denmark (Hyland, Shevlin, McNally, et al., 2016), Austria (Knefel et al., 2015), Germany (Perkonigg et al., 2015), Britain (Hyland, Shevlin, Brewin, et al., 2017; Karatzias et al., 2017), Uganda (Murphy, Elklit, Dokkedahl, & Shevlin, 2016) and Papua New Guinea (Tay, Rees, Chen, Kareth, & Silove, 2015; Silove, Tay, Kareth, & Rees, 2017), it is critical that investigations of the ICD-11 PTSD definitions continue to be tested in other cultural contexts (Hyland, Shevlin, Elklit, et al., 2016). In this study, therefore, we looked at variables that represent the Israeli cultural context, including level of religiousness and time in compulsory military service. In a previous study, both time in compulsory military service and religiousness were connected to PTSD. Time in service may be viewed as a risk factor as it is related to increased exposure to combat and other traumatic events (Solomon & Horesh, 2007). Religiosity may contribute to PTSD due to inner turmoil arising from potential conflict generated between religious principles and behavior, in addition to the already distressing fear and horror of the event (Ankri, Bachar, & Shalev, 2010). The following hypotheses were formed. First, measurement models of CPTSD that distinguish between PTSD and DSO symptoms clusters will exhibit a superior model fit. Second, the Hebrew version of the ITQ will possess satisfactory internal reliability. Third, greater exposure to traumatic events and/or child abuse and physical neglect will be a stronger predictor of the DSO than the PTSD symptom cluster. Fourth, the DSO symptom cluster will be predicted by greater severity of depression than will the PTSD symptom cluster, and the PTSD symptom cluster will be predicted by greater severity of anxiety than will the DSO. Finally, socio-demographic variables such as low level of education, income, and employment will predict the DSO symptom cluster more often than the PTSD symptom cluster. The specific cultural variable of religious level will predict PTSD more often than DSO, as religious beliefs can be shattered by traumatic events: i.e., that which once served as a source of strength may become a stressor and lead to the experience of PTSD symptoms. In addition, we hypothesize that time in the army will predict PTSD more often than DSO as time in the army brings greater exposure to combat experiences.