University of Chester

The British Psychological Society

Crisis, Disaster and Trauma Psychology Section

CPTSD-DIAGNOSTIC DEVELOPMENTS & THEORETICAL CONTRIBUTIONS

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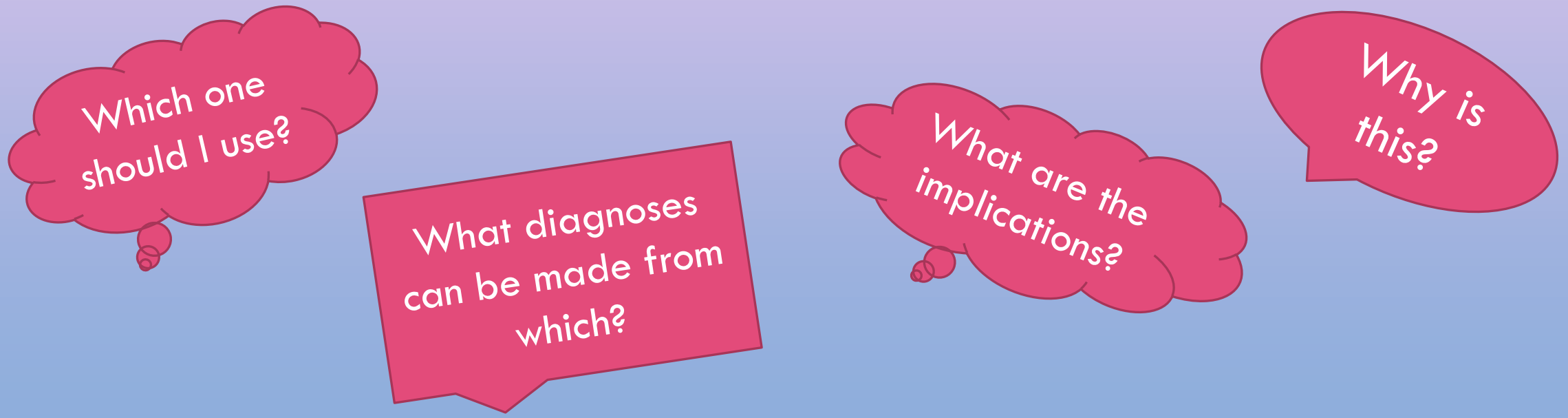
"The syndrome that follows upon prolonged, repeated trauma needs its own name. I propose to call it *complex post-traumatic stress disorder*"

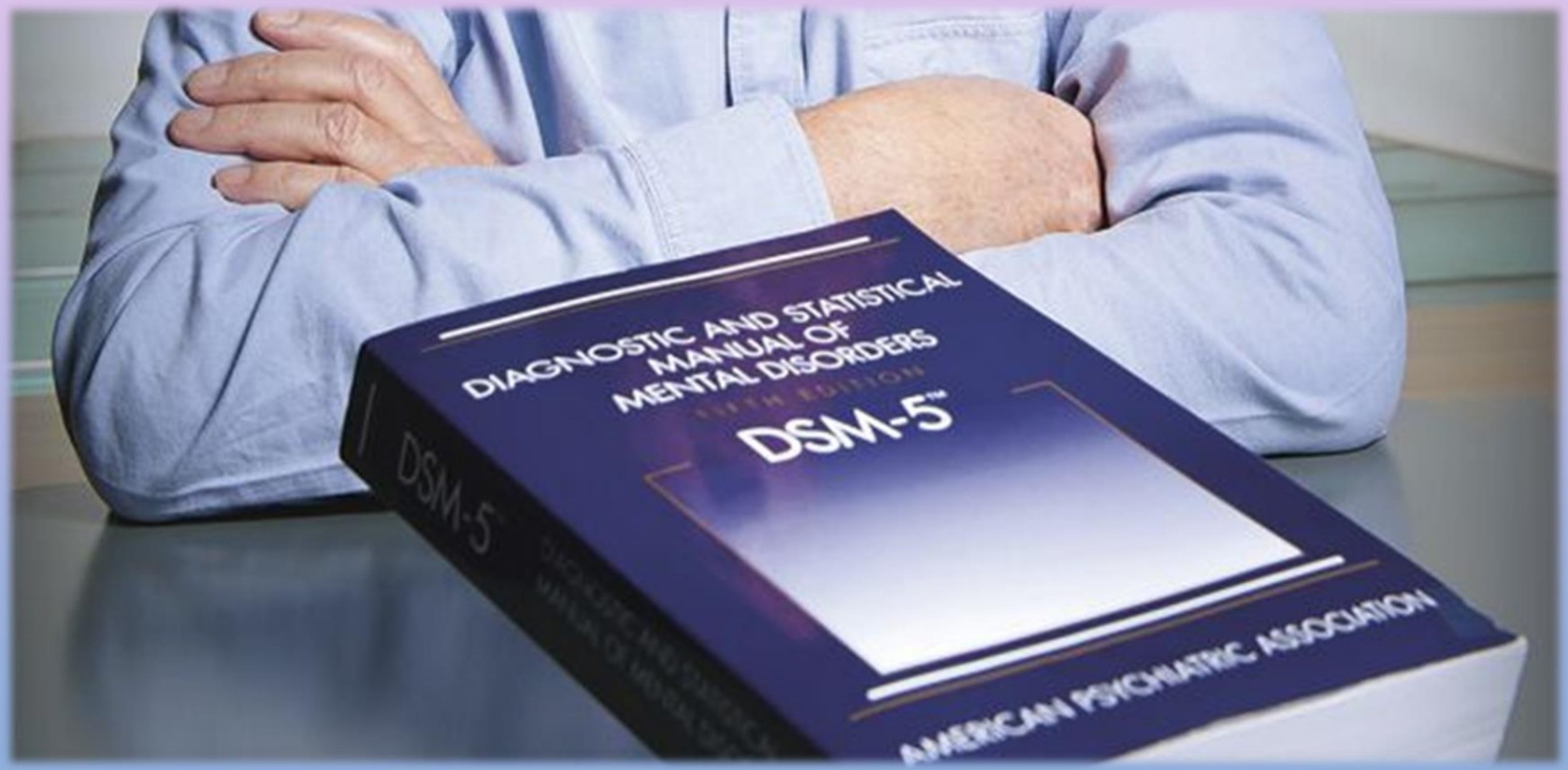
Judith Herman 1992:119

DIAGNOSTIC DEVELOPMENTS

Since the publication of the ICD-11 in June 2018 and 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.



HOW DOES THE DSM VIEW CPTSD?



DSM-5- WHY NOT CPTSD?

- Using evidence from DSM-IV field trials that found ‘nearly everyone’ meeting criteria for PTSD also met criteria for DESNOS, it was taken to indicate CPTSD did not a discrete disorder and therefore does not warrant a separate diagnostic category (Resick et al., 2012).
- DSM-5 PTSD criteria therefore aimed for a horizontal structure for maximum diagnostic sensitivity seen to more usefully provide clinicians 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) and none to have CPTSD

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

- Criterion D negative alterations in cognitions & mood (NACM) 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

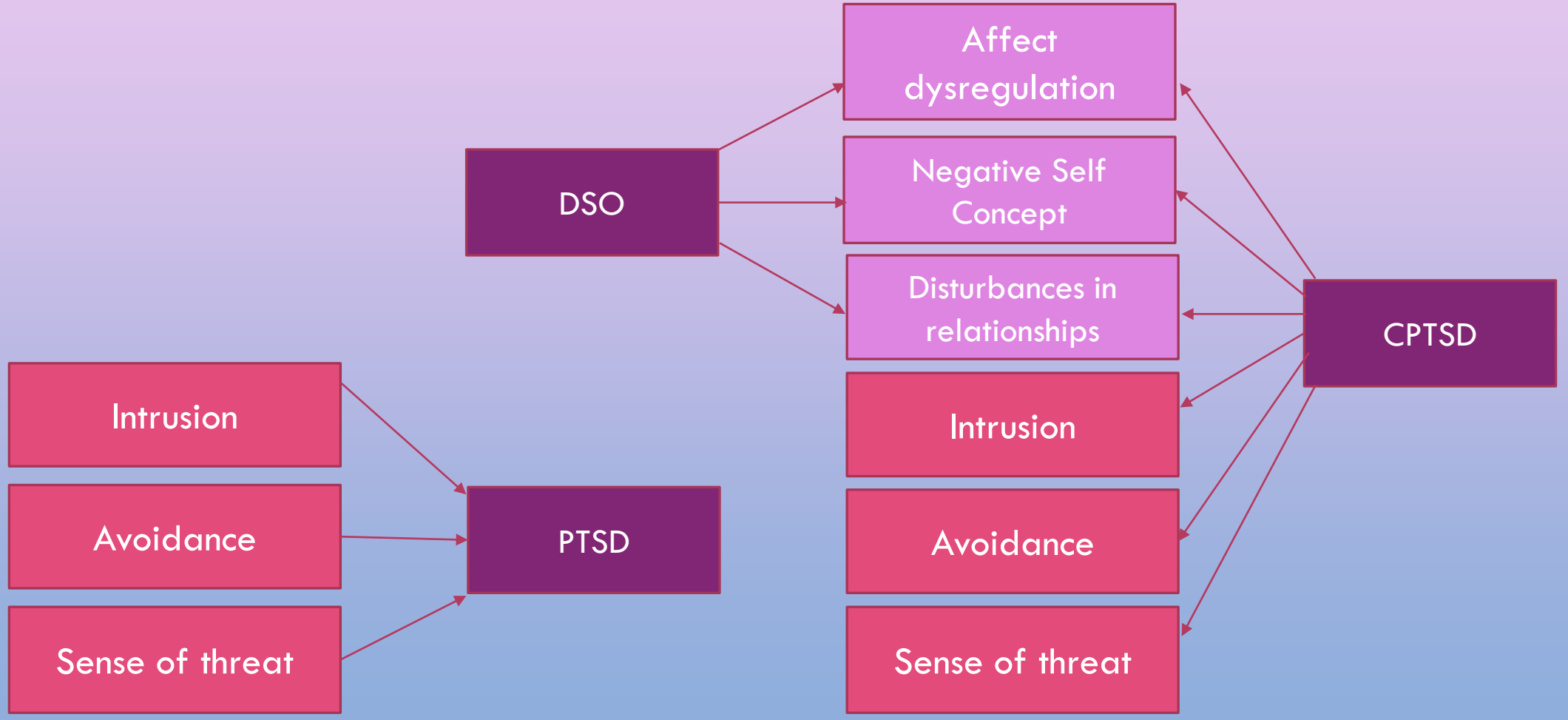
(FRIEDMAN, 2013; RESICK ET AL., 2012)

HOW DOES THE ICD-11 VIEW CPTSD?

HOW IS CPTSD POSITIONED IN THE ICD-11?

- Not seen as discrete or separated from PTSD but hierarchical in structure 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 is limited in the number of symptoms to provide clinical specificity.
- Based on existing clinicians taxonomies reflecting the current discourse in use with synonymous meaning
- Distinguishes more clearly between PTSD & CPTSD giving additional clinical utility through opportunity for targeted management and treatment
    - REED (2010), SHELVIN ET.AL., (2017)

HIERARCHICAL STRUCTURE OF CPTSD IN ICD-11

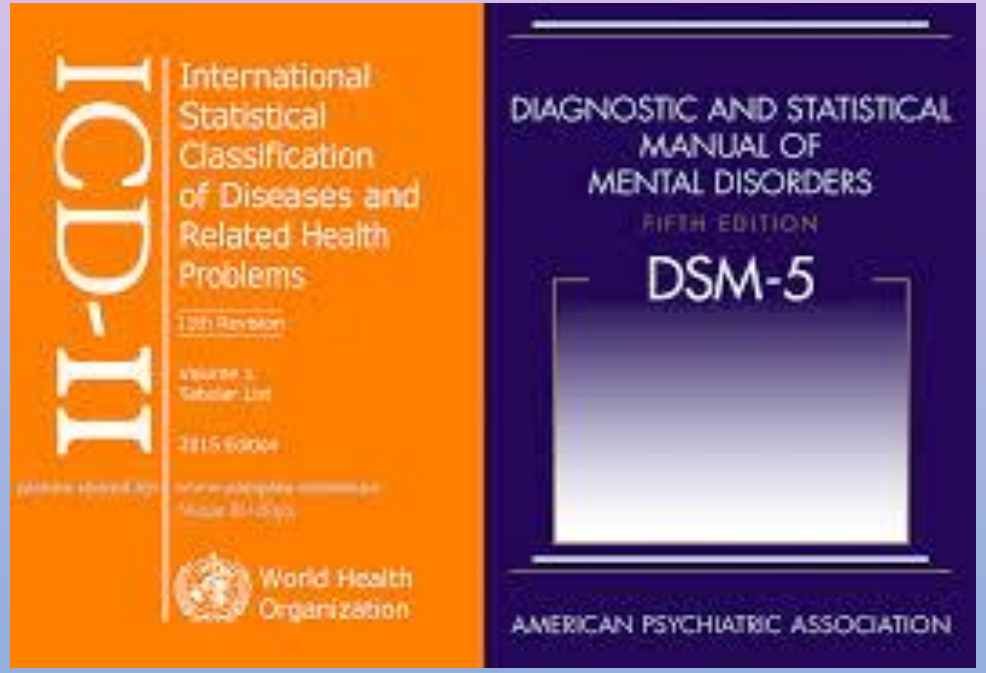


ICD-11 CPTSD CLASSIFICATION

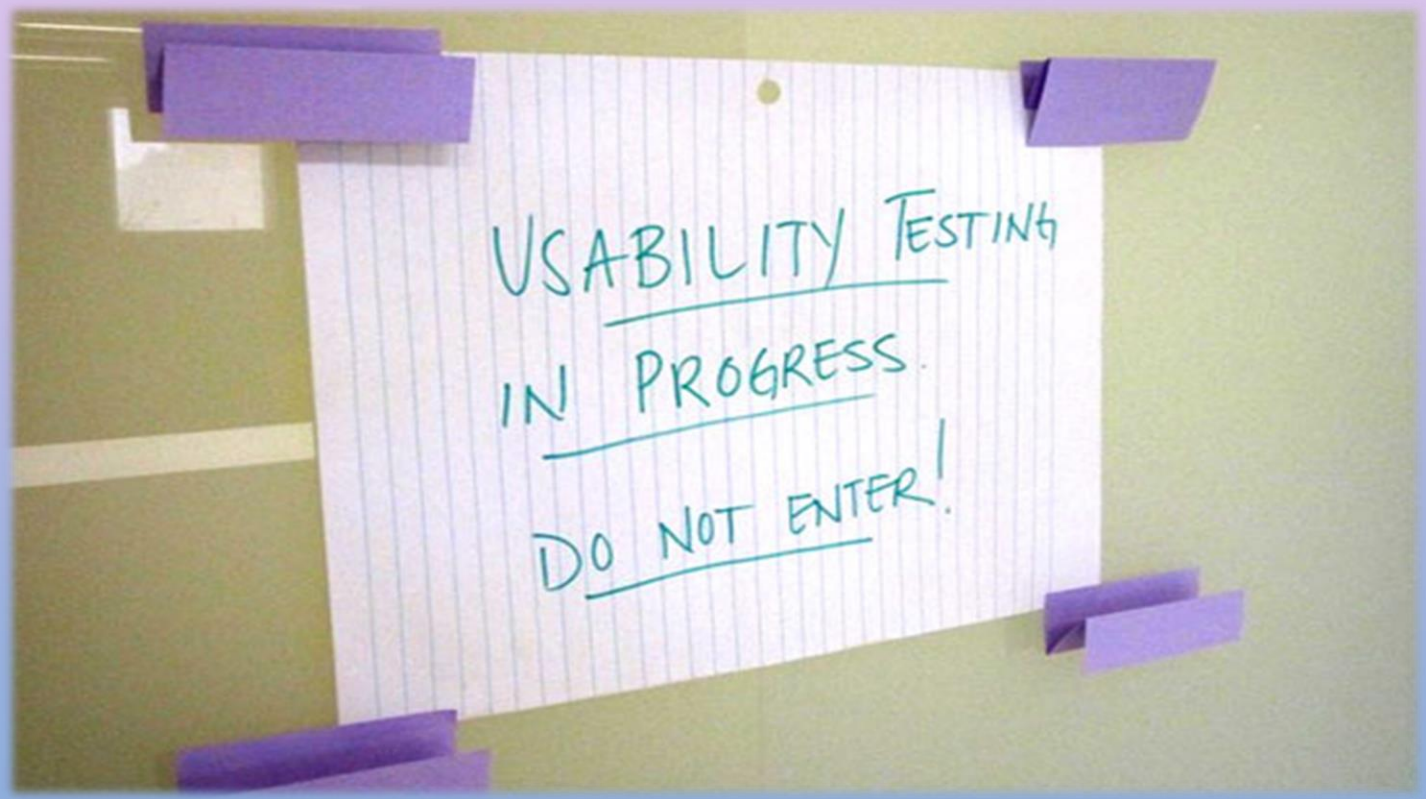
- May develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., Torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD
- 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).

SUMMARY OF KEY DIFFERENCES FOR PTSD IN THE DSM-5 & C/PTSD IN THE ICD11

- DISSOCIATION
- TIMELINE
- STRUCTURE
- NOMENCLATURE
- SCOPE
- SYMPTOMS

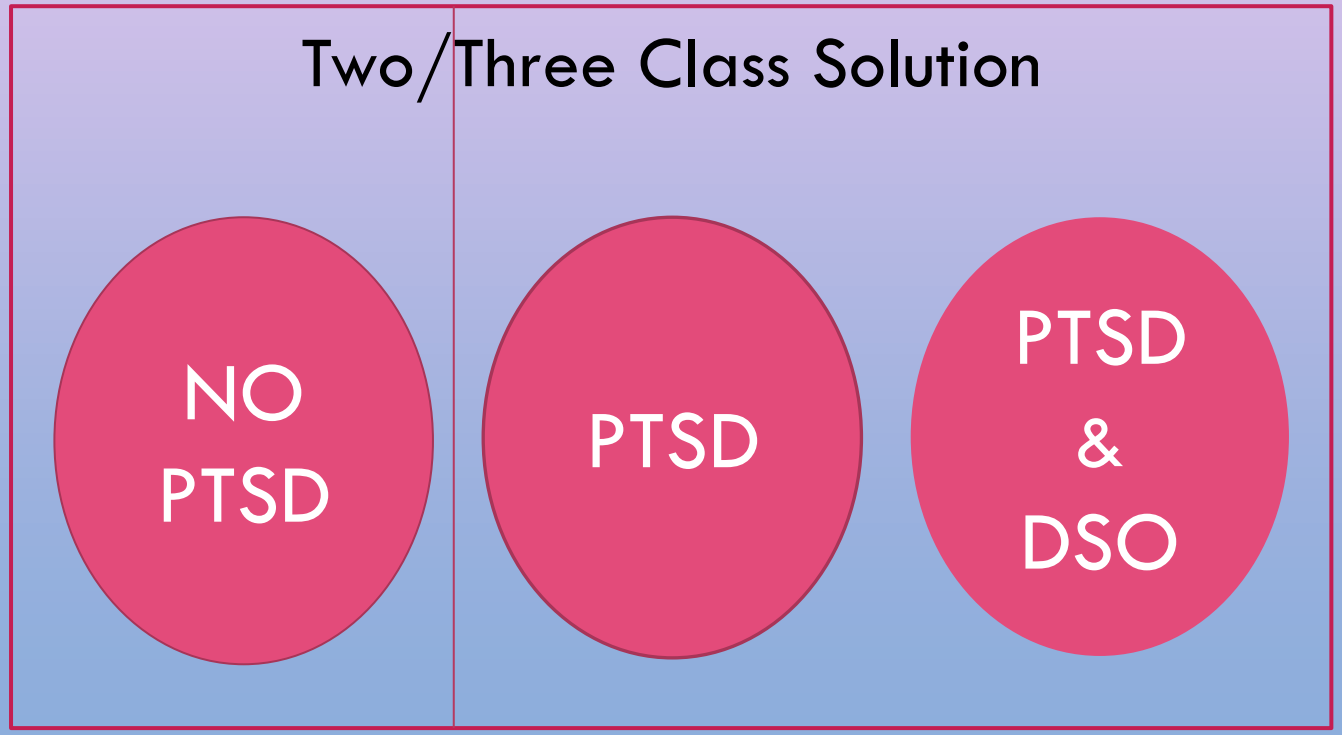


HOW DO I KNOW CPTSD IS A VALID CONSTRUCT?



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?



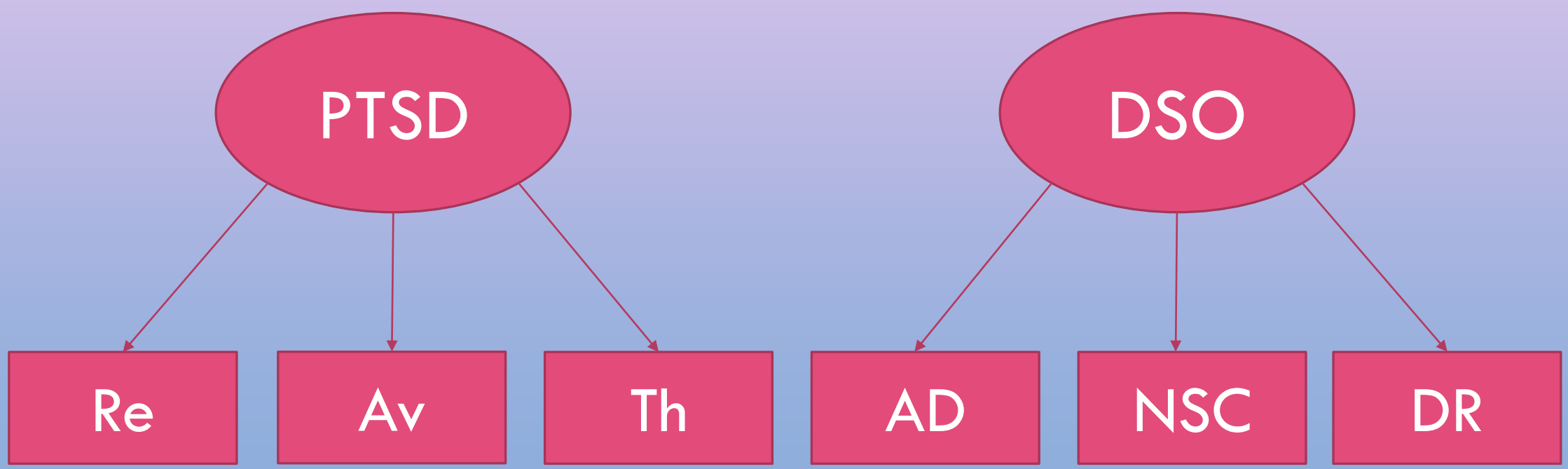
IS ICD-11 CPTSD A VALID CONSTRUCT?

"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 reposting 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.

THEORETICAL CONTRIBUTIONS

PREVALENCE & SENSITIVITY OF ICD-11 CPTSD

Prevalence Rates: General Population Samples

	USA	Israel	Ireland	UK^**	Germany*	Ghana	Kenya	Nigeria
PTSD diagnosis	3.4%	6.7%	5.0%	5.3%	1.5%	17.6%	20.3%	17.4%
CPTSD diagnosis	3.8%	4.9%	7.7%	12.9%	0.5%	13.0%	13.7%	19.6%
Total	7.2%	11.6%	12.7%	18.2%	2.0%	30.6%	34.0%	37.0%

^Trauma exposure was a criterion for inclusion.

*Very narrow definition of trauma exposure applied.

**Karatzias et al. (2019) Depression and Anxiety

Prevalence Rates: Treatment Seeking Samples

	Welsh patients	Scottish patients	Syrian refugees	Mixed refugees in Switzerland
PTSD diagnosis	10.9%	37.0%	25.2%	19.7%
CPTSD diagnosis	53.6%	53.1%	36.1%	32.8%
Total	64.5%	90.1%	61.3%	52.5%

Karatzias et al. (2017) Journal of Affective Disorders

SENSITIVITY OF ICD-11 CPTSD

- TRAUMA EXPOSED SAMPLES
  - Comparing DSM-5 to ICD-11, a UK trauma exposed sample showed diagnostic rates for ICD-11 CPTSD **and** PTSD of 64.5%, with diagnostics rate for DSM-5 PTSD of 76.1%.
  - Using the ICD-11 measures rates for PTSD alone were 10.9% whilst CPTSD alone was 53.6% (Hyland et al., 2017).
  - Comparing ICD-10 and ICD-11 an Austrian sample of adult survivors of childhood institutional abuse found ICD-10 PTSD had a diagnostic rate of 52.8% whilst the combined ICD-11 PTSD and CPTSD rate was 34.8%.
  - When measured separately ICD-11 PTSD dropped to 17% and ICD-11 CPTSD accounted for 21.4% of the sample (Knefel & Lueger-Schuster, 2013).

CO-MORBIDITY & FUNCTIONAL IMPAIRMENT WITH ICD-11 CPTSD

CO-MORBIDITY & FUNCTIONAL IMPAIRMENT

- Impairment in functioning in all areas of psychopathology (depression, anxiety, dissociation, somatisation, interpersonal sensitivity & aggression) (Elklit, Hyland & Shevlin, 2014: Cloitre et al., 2013), but particularly with regard to relationships with others (Karatzias et al., 2017).
- Association with depression, anxiety, dissociation, and three times more likely in those with histories of self harm, & suicidal ideation (Hyland, Shevlin, Fyvie & Karatzias, 2018).
- Correlated with negative view of self and attachment anxiety (Karatzias et al., 2018), and lower tolerance of distress (Hyland et al., 2017).
- CPTSD found with higher levels of depression, dissociation, and with EUPD symptoms (Hyland et al., 2018), however EUPD also been found to co-occur with CPTSD, PTSD and Non PTSD groups (Cloitre et al., 2013).

RISK FACTORS FOR CPTSD UNDER ICD-11

RISK FACTORS FOR CPTSD UNDER ICD-11

- TRAUMA HISTORY
  - Childhood trauma found have significant effect on likelihood of developing CPTSD (Karatzias et al., 2017; Shevlin et al., 2017). More specifically both childhood interpersonal trauma & adulthood interpersonal trauma was found to be associated with CPTSD (Karatzias et al,. 2019)
  - Increased likelihood where there is a greater frequency of childhood traumas with just one violent childhood traumatic event doubling the risk of CPTSD (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 identified with different single T adult trauma's at prevalence ranging from 10% to 21% with PTSD in the same sample between 25% and 43% (Elklit, Hyland & Shevlin, 2014).

RISK FACTORS FOR CPTSD UNDER ICD-11

- 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 most predictive of CPTSD in combination with CSA and childhood physical abuse (Hyland et al., 2017).

RISK FACTORS FOR CPTSD UNDER ICD-11

- SOCIODEMOGRAPHIC CHARACTERISTICS
  - Being unemployed (Hyland et al., (2017), 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 & Karatzias et al., 2019).
  - Educational attainment has not shown any predictive value however younger age and growing up in an urban area were found to be associated with CPTSD in particular (Karatzias et al., 2019).

STORY SO FAR…….

- The conceptual distinction between PTSD and CPTSD is supported by research in a range of populations investigating both contract validity & symptom structure showing a clear distinction as two distinct but related disorders.
- A pattern of lower overall prevalence rates using ICD-11shown 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 it is also associated with multiple & single instance adult trauma endorsing childhood trauma as a risk factor rather than a requirement.


ANY
QUESTIONS?