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Literature on *DSM-5* and *ICD-11*: An Update

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In 2014, Matthew J. Friedman published a *PTSD Research Quarterly* article reviewing the 11th edition of the International Classification of Diseases (*ICD-11*; World Health Organization [WHO], 2018) and the fifth version of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013) versions of PTSD. At that time, *ICD-11* had not been published, although its PTSD criteria had been in the literature since at least 2009 when they were proposed by Brewin and colleagues. Further, the new diagnostic criteria for *DSM-5* PTSD had been published only the year before. Consequently, little research comparing *ICD-11* and *DSM-5* PTSD had been published. In the last six years, though, many empirical comparisons have emerged, necessitating an update of the literature. Brewin and colleagues (2017) provided a thorough review of the early research. In the present article, we highlight some of the same articles covered in the Friedman and Brewin et al. reviews and point the reader to new findings that have emerged in the last three years. To orient the reader, we begin by discussing the contrasting approaches taken by *DSM-5* and *ICD-11* to defining PTSD, and how these approaches laid the groundwork for two divergent, rival conceptualizations of PTSD. We then present a select review of the literature, focusing on implications for prevalence of PTSD and four main aspects of the *ICD-11* rationale for diverging from both *DSM* and earlier versions of *ICD*: ease of diagnostic application, inclusion of only core symptoms, reduction of comorbidities, and greater inclusion of symptomatic individuals.

DSM-5 Versus *ICD-11*: Approach to Revisions and Resultant Diagnoses

The revisions made to the PTSD diagnosis by the *ICD-11* working group shared important similarities to those made by the *DSM-5* Posttraumatic and Dissociative Disorders Sub-Work Group (SWG). For example, both groups opted to move PTSD from the anxiety disorders category to a new stress-related disorders category to retain the three symptom clusters included in the fourth version of the *DSM* (*DSM-IV*; APA, 1994); and to include diagnostic criteria that were both evidence-based and optimized clinical utility (Friedman, 2013). Beyond these similarities, however, the two work groups diverged substantially. The *DSM-5* PTSD SWG took a conservative approach, only changing criteria when justified by strong empirical evidence. In stark contrast, the *ICD-11* working group relied upon conceptual considerations and the overarching goal of simplifying PTSD. As a result, whereas the *DSM-5* process was more restrained and incremental, the *ICD-11* process had the latitude to make radical changes, leading to two vastly different conceptualizations of PTSD.

On the one hand, *DSM-5* conceptualizes PTSD as a multifaceted syndrome, with twenty characteristic symptoms grouped into four clusters: 1) intrusive symptoms associated with the traumatic event(s) (e.g., unwanted memories, nightmares, and dissociative flashbacks); 2) avoidance of internal and external reminders of the trauma(s); 3) negative alterations in cognitions and mood (e.g., persistent negative beliefs and emotions); and 4) increased

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arousal and reactivity (e.g., hypervigilance, exaggerated startle). The symptoms must share as their etiology an event (or series of events) involving life threat, serious injury, or sexual violence that was directly experienced, witnessed, learned about, or which involved exposure to aversive details. To meet diagnostic criteria, at least one intrusion symptom, one avoidance symptom, two symptoms consistent with negative alterations in cognition and mood, and two arousal symptoms must be endorsed. The symptoms must have persisted for at least one month after exposure to the trauma(s) and must cause clinically significant distress and/or functional impairment. *DSM-5* PTSD includes two specifiers: delayed onset (i.e., full diagnostic criteria are not met until at least 6 months after the traumatic event[s]); and with dissociative symptoms (i.e., in addition to meeting full criteria for *DSM-5* PTSD, individuals also endorse experiencing depersonalization and/or derealization in response to the trauma[s]).

On the other hand, *ICD-11* introduced two "sibling disorders": PTSD and complex PTSD (CPTSD; Karatzias et al., 2017). Unlike the PTSD diagnoses presented in *DSM-IV*, *DSM-5*, and *ICD-10*, the *ICD-11* working group eliminated all "non-specific" symptoms from *ICD-11* PTSD. As a result, the diagnosis includes only three core elements : 1) re-experiencing the traumatic event, as evidenced by intrusive memories, flashbacks, and/or nightmares; 2) avoidance of traumatic reminders, as evidenced by the avoidance of internal and/or external stimuli; and 3) a persistent sense of threat, evidenced by hypervigilance and increased startle. One symptom from each category is required, and the symptoms must have persisted for several weeks and cause significant impairment in functioning. In short, *ICD-11* is restricted to seven potential PTSD symptoms (rather than the 20 in *DSM-5*) and lowers the minimum diagnostic threshold to three symptoms (rather than the six in *DSM-5*).

The *ICD-11* diagnosis of CPTSD requires meeting criteria for PTSD as well as for three additional features evidencing "disturbances in self-organization" (DSO): 1) affective dysregulation (e.g., trouble calming down, numbing); 2) negative self-concept (e.g., worthlessness); and 3) disturbed relationships (e.g., difficulty feeling close to others). Whereas the etiology of PTSD is thought to be general exposure to an extremely threatening or horrific event or series of events, Herman's (1992) original conceptualization of CPTSD posited that the etiology was exposure to prolonged or repetitive events from which escape is difficult or impossible. Although *ICD-11* CPTSD does not require the event be prolonged or repetitive, it notes that it often stems from such. Moreover, the developers note that regardless of the nature of the stressor, the diagnosis of PTSD versus CPTSD is determined by the symptom profile (e.g., Cloitre et al., 2013).

Importantly, although the inclusion of a CPTSD diagnosis was considered by the *DSM-5* SWG, the proposal for inclusion was ultimately rejected due to insufficient empirical support (Friedman et al., 2011). Instead, the *DSM-5* definition of PTSD incorporates aspects of CPTSD, to some degree within the core diagnosis, and more broadly in the discussion of associated features. For example, dissociation is included in two of the core PTSD symptoms (amnesia and flashbacks) and the two symptoms of the dissociative subtype (depersonalization and derealization). Further, pervasive negative mood, negative beliefs about oneself, distorted negative cognitions, inappropriate blame of self or others, and reckless behavior, which may align with some conceptualizations of CPTSD, were also added to the *DSM-5* PTSD diagnostic criteria itself (Friedman, 2013; Wolf et al., 2015). In addition, in the discussion of associated features, the *DSM-5* text notes that prolonged trauma may result in affective dysregulation, trouble maintaining stable interpersonal relationships, or dissociative symptoms, all of which are core aspects of CPTSD in Herman's (1992) seminal formulation.

The WHO working group decision-making process that led to the introduction of the *ICD-11* sibling disorders was guided by the organizing principle of clinical utility, defined as ease of use in non-specialist, low-resourced, non-English speaking settings (Maercker & Perkonigg, 2013). The working group members have argued that the introduction of these two sibling disorders, following from the parent category of traumatic stress disorders, exemplifies this principle in that these diagnoses demonstrate simplicity in classification, clear differences in conceptual organization, and limited symptomatology (Cloitre et al., 2013). Consistent with this, the six symptoms chosen for inclusion in the PTSD diagnosis were selected based on the assumptions that they were core to the entity of PTSD and not shared by other psychiatric disorders (Cloitre et al., 2013; Maercker et al., 2013). Because of this, the simplified version was designed not only to reduce the high comorbidity associated with broader definitions, but also to be responsive to evidence that a broader taxonomy excludes symptomatic individuals who do not have all the required symptoms (i.e., the large number of individuals who meet criteria for partial PTSD under the *DSM* taxonomy; Brewin, 2013). Advocates of *ICD-11* PTSD argue that requiring many symptoms is not only exclusionary, it is unnecessary (i.e., short screeners which assess only a few symptoms are excellent at classifying individuals as PTSD positive versus PTSD negative; Brewin, 2013).

However, the *ICD-11* conceptualization is not without detractors. Critics have argued that the *ICD-11* approach to PTSD is problematic because it eliminates symptoms that were core in *ICD-10* and *DSM-IV* and were retained in *DSM-5*. They further argue the decision to conceptualize symptoms in a hierarchical manner (thus eliminating "non-specific" symptoms) is not only a contrast to the requirements of all the other mental disorders described, but also problematic because it has the unintended consequence of depriving symptomatic individuals of a diagnosis (Vermetten et al., 2016). Additional study was therefore needed to examine the two diagnoses empirically.

Comparison of the *DSM* and *ICD* Diagnoses: Prevalence and Rationale

ICD-11's radically different approach to conceptualizing PTSD sparked interest in how this shift might impact who receives a trauma-related disorder diagnosis. In general, findings have suggested that *ICD-11* PTSD is substantially less common than either *ICD-10* or *DSM-5* conceptualizations (e.g., Brewin et al., 2017; Haravuori et al., 2016; Shevlin et al., 2018), with low levels of overlap across diagnoses (e.g., La Greca et al., 2017). For CPTSD, rates tend to vary as a product of the sample examined, with clinical samples demonstrating higher rates of CPTSD than *ICD-11* PTSD, and non-clinical samples demonstrating the opposite pattern (e.g., Karatzias et al., 2017). The few studies that have examined rates of *ICD-11* CPTSD in comparison to *DSM-5* PTSD have found that CPTSD tends to be the less common of the two (e.g., Hyland et al., 2018).

Research has also begun to test whether the rationale for the *ICD-11* sibling disorders has been borne out empirically (Brewin et al., 2017). For example, research has examined whether the *ICD-11* approach has indeed improved the ease of applying these diagnoses. Some support for this claim has come in the form of latent profile analyses; the majority of studies conducted suggest that individuals assessed for *ICD-11* PTSD and DSO symptoms can be reliably sorted into at least two symptomatic trauma-exposed classes: one class that is high on PTSD symptoms and low on DSO symptoms (the PTSD class), and a second that is high on both PTSD and DSO symptoms (the CPTSD class; e.g., Cloitre et al., 2013; Frost et al., 2019; Palic et al, 2016). However, other research has suggested that the distinction between PTSD and CPTSD may be one of severity, rather than a representation of separate classes of disorders (Wolf et al., 2015). Further, the finding that the *DSM-5* PTSD diagnosis had one of the highest reliabilities of any *DSM-5* diagnosis in the *DSM-5* field trials (Regier et al., 2013), makes the necessity of simplifying the diagnosis for ease of use questionable.

Other research has explored whether the symptoms included in the *ICD-11* PTSD diagnosis are truly core to the diagnosis. Support for this claim has come from empirical evidence suggesting that the procedure used by the *ICD-11* working group to choose the core symptoms was sound (Kliem et al., 2016). In contrast, network analyses have found that only a portion of the *ICD-11* PTSD symptoms are central to the PTSD network, raising questions about whether the symptoms chosen by *ICD-11* are indeed central to the diagnosis. For example, Mitchell and colleagues (2017) found that, of the 20 symptoms included in *DSM-5* PTSD, the six most central symptoms are persistent negative emotions, avoidance of external reminders, avoidance of internal reminders, inability to experience positive emotions, nightmares, and unwanted memories; only four of the six are represented in *ICD-11* PTSD.

The *ICD-11* working group highlighted that a key goal for the revision was to reduce the comorbidity associated with broader conceptualizations of the disorder, like that of *DSM-5*. Findings regarding the success of the *ICD-11* working group in this endeavor have been equivocal. Whereas, some studies have suggested that *ICD-11* PTSD demonstrates lower rates of comorbidity than either CPTSD (Karatzias et al., 2019) or *DSM-5* PTSD (La Greca et al., 2017), other research has found that *ICD-11* PTSD is associated with higher rates of comorbid psychopathology than both *ICD-10* (Barbano et al., 2019) and *DSM-5* (Green et al., 2017; Shevlin et al., 2018). Still other research has found that there is no difference in comorbidity between *ICD-11* PTSD and *DSM-5* PTSD (Wisco et al, 2016). Interestingly, one study found that the presence of additional symptoms in the *DSM-5* taxonomy, particularly those associated with depression, may mask a biomarker that confers risk for both *ICD-11* and *DSM-5* PTSD (Danzi & La Greeca, 2018). Although this study used the preschool criteria for both diagnoses, it does provide preliminary evidence that reducing comorbidity may be an important goal in any taxonomy.

Finally, investigators have explored whether the *ICD-11* approach is more inclusive of symptomatic individuals than broader taxonomies. Although there is some evidence that *ICD-11* PTSD can detect individuals with significant impairment who would not be diagnosed using *DSM* criteria (Brewin et al., 2017), other research has suggested that the use of the *ICD-11* PTSD taxonomy excludes individuals with clinically significant symptoms (e.g., Stein et al., 2014). For example, Barbano et al. (2018) found that although *ICD-11* PTSD did identify the more severe cases of individuals, individuals who met for *ICD-10* but not *ICD-11* still had moderate PTSD symptoms according to a clinical interview. Further, research has found that *ICD-11* PTSD is associated with lower functional impairment than *DSM-5* PTSD among children (Danzi & La Greca, 2016).

Conclusions

In the decade that the field has known of both the *DSM-5* and the *ICD-11* proposals, an impressive body of literature examining the impact of two differential diagnoses has been amassed. However, research on the conceptualization put forth by *ICD-11*, and how it compares to that advocated for by *DSM-5*, is still nascent. Any conclusions about the impact of these diagnoses is preliminary, however, due to improvements in methodology that have occurred while research has been ongoing. Indeed, one of the most important advances has been the development of the International Trauma Questionnaire (ITQ) and International Trauma Interview (ITI) for assessing *ICD-11* PTSD and CPTSD (Cloitre et al., 2018; Roberts et al., 2018). Having *ICD-11*-based measures greatly facilitates and disambiguates comparisons between *ICD-11* and *DSM-5* PTSD. Prior to the availability of these measures, *ICD-11* criteria were typically assessed by using *ICD-11*-correspondent items embedded in *DSM-5* measures. This embedded approach is not ideal, owing to differences in wording and context, so may not provide an accurate comparison between *ICD-11* and *DSM-5* criteria. Availability of *ICD-11*-dedicated measures, however, will allow direct, unambiguous comparisons.

What is clear from the literature to date is that having two distinct, widely used diagnoses for understanding the impact that trauma-exposure can have, presents a range of challenges for clinicians and researchers alike. This is particularly true if the different diagnoses do indeed represent low overlap across individuals. Additional research is needed to clarify the best way to understand trauma-related psychopathology, so that individuals suffering from these debilitating disorders can receive the help they need and deserve.

Featured Articles

Barbano, A. C., van der Mei, W. F., Bryant, R. A., Delahanty, D. L., deRoon-Cassini, T. A., Matsuoka, Y. J., Olff, M., Qi, W., Ratanatharathorn, A., Schnyder, U., Seedat, S., Kessler, R. C., Koenen, K. C., & Shalev, A. Y. (2018). **Clinical implications of the proposed ICD-11 PTSD diagnostic criteria.** *Psychological Medicine, 49*(3), 483–490. doi:10.1017/S0033291718001101

Background. Projected changes to PTSD diagnostic criteria in the upcoming *ICD-11* may affect the prevalence and severity of identified cases. This study examined differences in rates, severity, and overlap of diagnoses using *ICD-10* and *ICD-11* PTSD diagnostic criteria during consecutive assessments of recent survivors of traumatic events. *Methods.* The study sample comprised 3,863 survivors of traumatic events, evaluated in 11 longitudinal studies of PTSD. *ICD-10* and *ICD-11* diagnostic rules were applied to the Clinician-Administered PTSD Scale (CAPS) to derive *ICD-10* and *ICD-11* diagnoses at different time intervals between trauma occurrence and 15 months. *Results.* The *ICD-11* criteria identified fewer cases than the *ICD-10* across assessment intervals (range -47.09% to -57.14%). Over 97% of *ICD-11* PTSD cases met

concurrent *ICD-10* PTSD criteria. PTSD symptom severity of individuals identified by the *ICD-11* criteria (CAPS total scores) was 31.38–36.49% higher than those identified by *ICD-10* criteria alone. The latter, however, had CAPS scores indicative of moderate PTSD. *ICD-11* was associated with similar or higher rates of comorbid mood and anxiety disorders. Individuals identified by either *ICD-10* or *ICD-11* shortly after traumatic events had similar longitudinal course. *Conclusions.* This study indicates that significantly fewer individuals would be diagnosed with PTSD using the proposed *ICD-11* criteria. Though *ICD-11* criteria identify more severe cases, those meeting *ICD-10* but not *ICD-11* criteria remain in the moderate range of PTSD symptoms. Use of *ICD-11* criteria will have critical implications for case identification in clinical practice, national reporting, and research.

Barbano, A. C., van der Mei, W. F., deRoon-Cassini, T. A., Grauer, E., Lowe, S. R., Matsuoka, Y. J., O'Donnell, M., Ollf, M., Qi, W., Ratanatharathorn, A., Schnyder, U., Seedat, S., Kessler, R. C., Koenen, K. C., Shalev, A. Y., & International Consortium to Prevent PTSD. (2019). **Differentiating PTSD from anxiety and depression: Lessons from the ICD-11 PTSD diagnostic criteria.** *Depression and Anxiety, 36*(6), 490–498. doi:10.1002/da.22881 *Objective:* PTSD is frequently associated with depression and anxiety, but the nature of the relationship is unclear. By removing mood and anxiety diagnostic criteria, the *ICD-11* aims to delineate a distinct PTSD phenotype. We examined the effect of implementing *ICD-11* criteria on rates of co-diagnosed depression and anxiety in survivors with recent PTSD. *Method:* Participants were 1,061 survivors of traumatic injury admitted to acute care centers in Israel. *ICD-10* and *ICD-11* diagnostic rules were applied to the Clinician-Administered PTSD Scale for *DSM-IV*. Co-occurring disorders were identified using the Structured Clinical Interview for *DSM-IV* (SCID). Depression severity was measured by the Beck Depression Inventory-II (BDI-II). Assessments were performed 0–60 ("wave 1") and 90–240 ("wave 2") days after trauma exposure. *Results:* Participants identified by *ICD-11* PTSD criteria were equally or more likely than those identified by the *ICD-10* alone to meet depression or anxiety disorder diagnostic criteria (for wave 1: depressive disorders, OR [odds ratio] = 1.98, 95% CI [confidence interval] = [1.36, 2.87]; anxiety disorders, OR = 1.04, 95% CI = [0.67, 1.64]; for wave 2: depressive disorders, OR = 1.70, 95% CI=[1.00, 2.91]; anxiety disorders, OR=1.04, 95% CI=[0.54, 2.01]). *ICD-11* PTSD was associated with higher BDI scores (M = 23.15 vs. 17.93, $p <$ 0.001 for wave 1; M = 23.93 vs. 17.94, $p <$ 0.001 for wave 2). PTSD symptom severity accounted for the higher levels of depression in *ICD-11* PTSD. *Conclusions:* Despite excluding depression and anxiety symptom criteria, the *ICD-11* identified equal or higher proportion of depression and anxiety disorders, suggesting that those are inherently associated with PTSD.

Brewin, C. R. (2013). **'I wouldn't start from here'—An alternative perspective on PTSD from the ICD-11: Comment on Friedman (2013).** *Journal of Traumatic Stress, 26*(5), 557–559. doi:10.1002/jts.21843 This commentary briefly summarizes some of the criticism directed at the diagnosis of PTSD according to the *DSM-5*including the issues of complexity and comorbidity, and offers a rationale for attempting a simpler approach to diagnosis that can be used in minimally resourced, non-English-speaking countries. Rather than describe comprehensively the features of PTSD, the World Health Organization in its upcoming edition of the *ICD-11* has opted to define a much smaller number of symptoms that will effectively discriminate PTSD from other related conditions. Parallel research on the two approaches to diagnosis promises to add greatly to our understanding of the condition.

Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., Humanyun, A., Jones, L. M., Kagee, A., Rousseau, C., Somasundaram, D., Suzuki, Y., Wessely, S., van Ommeren, M., & Reed, G. M. (2017). **A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD.** *Clinical Psychology Review, 58,* 1–15. doi:10.1016/j.cpr.2017.09.001 The World Health Organization's proposals for PTSD in the *ICD-11* scheduled for release in 2018, involve a very brief set of symptoms and a distinction between two sibling disorders, PTSD and CPTSD. 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 six-factor structure of CPTSD symptoms, and the distinction between PTSD and CPTSD. 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.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). **Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis.** *European Journal of Psychotraumatology, 4*(1), Article 20706. doi:10.3402/ejpt.v4i0.20706 *Background:* The WHO *ICD-11*, has proposed two related diagnoses, PTSD and CPTSD within the spectrum of trauma and stress-related disorders. Objective: To use latent profile analysis (LPA) to determine whether there are classes of individuals that are distinguishable according to the PTSD and CPTSD symptom profiles and to identify potential differences in the type of stressor and severity of impairment associated with each profile. *Method:* An LPA and related analyses were conducted on 302 individuals who had sought treatment for interpersonal traumas ranging from chronic trauma (e.g., childhood abuse) to single-incident events (e.g., exposure to 9/11 attacks). *Results:* The LPA revealed three classes of individuals: (1) a CPTSD class defined by elevated PTSD symptoms as well as disturbances in three domains of self-organization: affective dysregulation, negative self-concept, and interpersonal problems; (2) a PTSD class defined by elevated PTSD symptoms but low scores on the three self-organization symptom domains; and (3) a low symptom class defined by low scores on all symptoms and problems. Chronic trauma was more strongly predictive of CPTSD than PTSD and, conversely, single-event trauma was more strongly predictive of PTSD. In addition, CPTSD was associated with greater impairment than PTSD. The LPA

analysis was completed both with and without individuals with borderline personality disorder (BPD) yielding identical results, suggesting the stability of these classes regardless of BPD comorbidity. *Conclusion:* Preliminary data support the proposed *ICD-11* distinction between PTSD and CPTSD and support the value of testing the clinical utility of this distinction in field trials. Replication of results is necessary.

Danzi, B. A., & La Greca, A. M. (2016). **DSM-IV, DSM-5, and ICD-11: Identifying children with posttraumatic stress disorder after disasters.** *Journal of Child Psychology and Psychiatry, 57*(12), 1444–1452. doi:10.1111/jcpp.12631 *Background:* Different criteria for diagnosing PTSD have been recommended by the *DSM-5* and the proposed *ICD-11*. Although children are vulnerable to PTSD following disasters, little is known about whether these revised criteria are appropriate for preadolescents, as diagnostic revisions have been based primarily on adult research. This study investigated rates of PTSD using *DSM-IV*, *DSM-5*, and *ICD-11* diagnostic criteria, and their associations with symptom severity, impairment, and PTSD risk factors. *Methods:* Children (7–11 years) exposed to Hurricanes Ike (*n* = 327) or Charley (*n* = 383) completed measures 8–9 months post-disaster. Using diagnostic algorithms for *DSM-IV*, *DSM-5*, and *ICD-11*, rates of 'probable' PTSD were calculated. *Results:* Across samples, rates of PTSD were similar. However, there was low agreement across the diagnostic systems, with about a third overlap in identified cases. Children identified only by *ICD-11* had higher 'core' symptom severity but lower impairment than children identified only by *DSM-IV* or *DSM-5*. *ICD-11* was associated with more established risk factors for PTSD than was *DSM-5*. *Conclusions:* Findings revealed differences in PTSD diagnosis across major diagnostic systems for preadolescent children, with no clear advantage to any one system. Further research on developmentally sensitive PTSD criteria for preadolescent children is needed.

Danzi, B. A., & La Greca, A. M. (2018). **Genetic pathways to posttraumatic stress disorder and depression in children: Investigation of catechol-O-methyltransferase (COMT) Val158Met using different PTSD diagnostic models.** *Journal of Psychiatric Research, 102*, 81–86. doi:10.1016/j.jpsychires.2018.03.014 The catechol-O-methyltransferase (COMT) Val158Met polymorphism has been linked to PTSD, although findings have been inconsistent. Recently, different diagnostic criteria for PTSD have been introduced by *ICD-11* and *DSM-5*, including separate criteria for adults and for young children (i.e., the preschool criteria). The preschool criteria may be applicable to older children as well. This study is the first to examine COMT associations with depression and PTSD, using new diagnostic models, in school-age children (7–11 years) exposed to a natural disaster. Children (*n* = 115) provided saliva samples for genotyping and completed measures assessing disaster exposure, posttraumatic stress, and depressive symptoms. COMT Met allele carriers were at risk for PTSD, but only when using *ICD-11* (OR = 6.99) or the preschool criteria (OR = 4.77); there was a trend for *DSM-IV* and no association for *DSM-5* (adult criteria). However, all children agreed upon as having PTSD by both *DSM-5* and *ICD-11* were Met allele carriers. The genetic association between the COMT Met allele and PTSD seemed primarily driven by arousal symptoms, as a significant relationship emerged only for the PTSD arousal symptom cluster. In contrast, COMT Val allele homozygosity was associated with depression (OR = 4.34). Thus, findings suggest that opposing COMT genotypes increased vulnerability to depressive versus arousal-based clinical presentations following trauma exposure. As a result, the heterogeneity of the *DSM-5* PTSD criteria and its inclusion of depressive symptoms may mask COMT associations with *DSM-5* PTSD. Future research should consider how the use of different diagnostic models of PTSD may influence genetic findings.

Friedman, M. J. (2013). **Finalizing PTSD in DSM-5: Getting here from there and where to go next.** *Journal of Traumatic Stress, 26*(5), 548–556. doi:10.1002/jts.21840 The process that resulted in the diagnostic criteria for PTSD in the *DSM-5* (American Psychiatric Association; 2013) was empirically based and rigorous. There was a high threshold for any changes in any *DSM-IV* diagnostic criterion. The process is described in this article. The rationale is presented that led to the creation of the new chapter, "Trauma- and Stressor-Related Disorders," within the *DSM-5* metastructure. Specific issues discussed about the *DSM-5* PTSD criteria themselves include a broad versus narrow PTSD construct, the decisions regarding Criterion A, the evidence supporting other PTSD symptom clusters and specifiers, the addition of the dissociative and preschool subtypes, research on the new criteria from both Internet surveys and the *DSM-5* field trials, the addition of PTSD subtypes, the noninclusion of CPTSD, and comparisons between *DSM-5* versus the World Health Association's forthcoming *ICD-11* criteria for PTSD. The PTSD construct continues to evolve. In *DSM-5*, it has moved beyond a narrow fear-based anxiety disorder to include dysphoric/anhedonic and externalizing PTSD phenotypes. The dissociative subtype may open the way to a fresh approach to CPTSD. The preschool subtype incorporates important developmental factors affecting the expression of PTSD in young children. Finally, the different approaches taken by *DSM-5* and *ICD-11* should have a profound effect on future research and practice.

Green, J. D., Annunziata, A., Kleiman, S. E., Bovin, M. J., Harwell, A. M., Fox, A. M. L., Black, S. K., Schnurr, P. P., Holowka, D. W., Rosen, R. C., Keane, T. M., & Marx, B. P. (2017). **Examining the diagnostic utility of the DSM-5 PTSD symptoms among male and female returning veterans.** *Depression and Anxiety, 34*(8), 752–760. doi:10.1002/da.22667 *Background:* PTSD diagnostic criteria have been criticized for including symptoms that overlap with commonly comorbid disorders, which critics argue undermines the validity of the diagnosis and inflates psychiatric comorbidity rates. In response, the upcoming *ICD-11* will offer PTSD diagnostic criteria that are intended to promote diagnostic accuracy. However, diagnostic utility analyses have not yet assessed whether these criteria minimize diagnostic errors. The present study examined the diagnostic utility of each PTSD symptom in the *DSM-5* for males and females. *Methods:* Participants were 1,347 individuals enrolled in a longitudinal national registry of returning Veterans receiving care at a Department of Veterans Affairs (VA) facility. Doctoral-level clinicians assessed all participants using the PTSDmodule of the Structured Clinical Interview for *DSM*. *Results:* Of the 20 symptoms examined, the majority performed in the fair to poor range on test quality indices. Although a few items did perform in the good (or better) range, only half were *ICD-11* symptoms. None of the 20 symptoms demonstrated good quality of efficiency. Results demonstrated few

sex differences across indices. There were no differences in the proportion of comorbid psychiatric disorders or functional impairment between *DSM-5* and *ICD-11* criteria. *Conclusions:* *ICD-11* PTSD criteria demonstrate neither greater diagnostic specificity nor reduced rates of comorbidity relative to *DSM-5* criteria and, as such, do not perform as intended. Modifications to existing symptoms or new symptoms may improve differential diagnosis.

Karatzias, T., Cloitre, M., Maercker, A., Kazlauskas, E., Shevlin, M., Hyland, P., Bisson, J. I., Roberts, N. P., & Brewin, C. R. (2017). **PTSD and Complex PTSD: ICD-11 updates on concept and measurement in the UK, USA, Germany and Lithuania.** *European Journal of Psychotraumatology, 8*(Sup 7), Article 1418103. doi:10.1080/20008198.2017.1418103 The 11th revision to the World Health Organization's *ICD-11* proposes two distinct sibling conditions: PTSD and CPTSD (CPTSD). In this paper, we aim to provide an update on the latest research regarding the conceptual structure and measurement of PTSD and CPTSD using the ITQ as per *ICD-11* proposals in the USA, UK, Germany and Lithuania. Preliminary findings suggest that CPTSD is common in clinical and population samples, although there may be variations across countries in prevalence rates. In clinical samples, preliminary evidence suggests that CPTSD is a more commonly observed condition than PTSD. Preliminary evidence also suggests that the ITQ scores are reliable and valid and can adequately distinguish between PTSD and CPTSD. Further cross-cultural work is proposed to explore differences in PTSD and CPTSD across different countries with regard to prevalence, incidence, and predictors of PTSD and CPTSD.

Karatzias, T., Hyland, P., Bradley, A., Cloitre, M., Roberts, N. P., Bisson, J. I., & Shevlin, M. (2019). **Risk factors and comorbidity of ICD-11 PTSD and complex PTSD: Findings from a trauma-exposed population based sample of adults in the United Kingdom.** *Depression and Anxiety, 36*(9), 887–894. doi:10.1002/da.22934 *Background:* Following the recently published 11th version of the WHO *ICD*-11, we sought to examine the risk factors and comorbidities associated with PTSD and CPTSD. *Method:* Cross-sectional and retrospective design. The sample consisted of 1,051 trauma-exposed participants from a nationally representative panel of the UK adult population. *Results:* A total of 5.3% (95% confidence interval [CI] = 4.0–6.7%) met the diagnostic criteria for PTSD and 12.9% (95% CI = 10.9–15.0%) for CPTSD. Diagnosis of PTSD was independently associated with being female, being in a relationship, and the recency of traumatic exposure. CPTSD was independently associated with younger age, interpersonal trauma in childhood, and interpersonal trauma in adulthood. Growing up in an urban environment was associated with the diagnosis of PTSD and CPTSD. High rates of physical and mental health comorbidity were observed for PTSD and CPTSD. Those with CPTSD were more likely to endorse symptoms reflecting major depressive disorder (odds ratio [OR] = 21.85, 95 CI = 12.51–38.04) and generalized anxiety disorder (OR = 24.63, 95 CI = 14.77–41.07). Presence of PTSD (OR = 3.13, 95 CI = 1.81–5.41) and CPTSD (OR = 3.43, 95 CI = 2.37–4.70) increased the likelihood of suicidality by more than three times. Nearly half the participants with PTSD and CPTSD reported the presence of a chronic illness. *Conclusions:* CPTSD is a more common, comorbid, debilitating condition compared to PTSD. Further research is now required to identify effective interventions for its treatment.

Kliem, S., Kröger, C., Foran, H. M., Mößle, T., Glaesmer, H., Zenger, M., & Brähler, E. (2016). **Dimensional latent structure of PTSD-symptoms reporting: Is it adding by subtracting?** *Psychological Assessment, 28*(12), 1663–1673. doi:10.1037/pas0000287 Although PTSD is used as a distinct diagnosis in clinical practice, its symptoms were characterized as a dimensional structure in several taxometric analyses. However, a categorical latent structure of PTSD could be superimposed by using indistinct PTSD symptoms that can appear within the framework of other trauma-induced syndromes (e.g., depression, anxiety disorders). For that reason, in revising the *ICD-11*, a core set of cardinal symptoms that determine the presence of PTSD as selectively as possible will be used. To determine whether the latent status of a recommended core set of PTSD symptoms is dimensional, the authors analyzed the latent status of PTSD symptoms reported by participants who had experienced at least one traumatic event during their lifetime in two nationwide surveys of the German population (*N* = 1,212). Using the Posttraumatic Diagnostic Scale (PDS), they applied three popular taxometric *Methods:* maximum eigenvalue, mean above minus below a cut, and latent mode factor analysis, using the core set and PTSD symptom clusters of previous taxometric studies. Although the analysis replicated findings of previous taxometric analyses using symptom clusters, the item core-set approach indicated a categorical solution of PTSD cardinal symptoms. These results seem to support the procedure used by the *ICD-11* expert group.

La Greca, A. M., Danzi, B. A., & Chan, S. F. (2017). **DSM-5 and ICD-11 as competing models of PTSD in preadolescent children exposed to a natural disaster: Assessing validity and co-occurring symptomatology.** *European Journal of Psychotraumatology, 8*(1), Article 1310591. doi:10.1080/20008198.2017.1310591 *Background:* Major revisions have been made to the *DSM* and *ICD* models of PTSD. However, it is not known whether these models fit children's posttrauma responses, even though children are a vulnerable population following disasters. Objective: Using data from Hurricane Ike, we examined how well trauma-exposed children's symptoms fit the *DSM-IV*, *DSM-5* and *ICD-11* models, and whether the models varied by gender. We also evaluated whether elevated symptoms of depression and anxiety characterized children meeting PTSD criteria based on *DSM-5* and *ICD-11*. *Method:* Eight-months post-disaster, children (*N* = 327, 7–11 years) affected by Hurricane Ike completed measures of PTSD, anxiety and depression. Algorithms approximated a PTSD diagnosis based on *DSM-5* and *ICD-11* models. *Results:* Using confirmatory factor analysis, *ICD-11* had the best-fitting model, followed by *DSM-IV* and *DSM-5*. The *ICD-11* model also demonstrated strong measurement invariance across gender. Analyses revealed poor overlap between *DSM-5* and *ICD-11*, although children meeting either set of criteria reported severe PTSD symptoms. Further, children who met PTSD criteria for *DSM-5*, but not for *ICD-11*, reported significantly higher levels of depression and general anxiety than children not meeting *DSM-5* criteria. *Conclusions:* Findings support the parsimonious *ICD-11* model of PTSD for trauma-exposed children, although adequate

fit also was obtained for *DSM-5*. Use of only one model of PTSD, be it *DSM-5* or *ICD-11*, will likely miss children with significant post-traumatic stress. *DSM-5* may identify children with high levels of comorbid symptomatology, which may require additional clinical intervention.

Maercker, A., & Perkonigg, A. (2013). **Applying an international perspective in defining PTSD and related disorders: Comment on Friedman (2013).** *Journal of Traumatic Stress, 26*(5), 560–562. doi:10.1002/jts.21852 We address the general perspective of the World Health Organization towards the classification process of the *ICD-11*; give a short description of the *ICD-11* proposals related to "disorders specifically associated with stress" and the differentiation between posttraumatic stress disorder, complex posttraumatic stress disorder, and prolonged grief disorder; and comment on the most important aim of classifying mental disorders—to provide the best treatments available.

Mitchell, K. S., Wolf, E. J., Bovin, M. J., Lee, L. O., Green, J. D., Rosen, R. C., Keane, T. M., & Marx, B. P. (2017). **Network models of DSM–5 posttraumatic stress disorder: Implications for ICD–11.** *Journal of Abnormal Psychology, 126*(3), 355–366. doi:10.1037/abn0000252 Recent proposals for revisions to the *ICD-11* PTSD diagnostic criteria have argued that the current symptom constellation under the *DSM-5* is unwieldy and includes many symptoms that overlap with other disorders. The newly proposed criteria for the *ICD-11* include only six symptoms. However, restricting the symptoms to those included in the *ICD-11* has implications for PTSD diagnosis prevalence estimates, and it remains unclear whether these six symptoms are most strongly associated with a diagnosis of PTSD. Network analytic methods, which assume that psychiatric disorders are networks of interrelated symptoms, provide information regarding which symptoms are most central to a network. We estimated network models of PTSD in a national sample of Veterans of the Iraq and Afghanistan wars. In the full sample, the most central symptoms were persistent negative emotional state, efforts to avoid external reminders, efforts to avoid thoughts or memories, inability to experience positive emotions, distressing dreams, and intrusive distressing thoughts or memories (i.e., three of the six most central items to the network would be eliminated from the diagnosis under the current proposal for *ICD-11*). An empirically defined index summarizing the most central symptoms in the network performed comparably to an index reflecting the proposed *ICD-11* PTSD criteria at identifying individuals with an independently assessed *DSM-5* defined PTSD diagnosis. Our results highlight the symptoms most central to PTSD in this sample, which may inform future diagnostic systems and treatment.

Shevlin, M., Hyland, P., Vallières, F., Bisson, J., Makhashvili, N., Javakhishvili, J., Shpiker, M., & Roberts, B. (2018). **A comparison of DSM-5 and ICD-11 PTSD prevalence, comorbidity and disability: An analysis of the Ukrainian internally displaced person's mental health survey.** *Acta Psychiatrica Scandinavica, 137*(2), 138–147. doi:10.1111/acps.12840 *Objective:* Recently, the American Psychiatric Association (*DSM-5*) and the World Health Organization (*ICD-11*) have both revised their formulation of post-traumatic stress disorder (PTSD). The primary aim of this study was to compare *DSM-5* and *ICD-11* PTSD prevalence and comorbidity rates, as well as the level of disability associated with each diagnosis. *Method:* This study was based on a representative sample of adult Ukrainian internally displaced persons (IDPs: *N* = 2203). Post-traumatic stress disorder prevalence was assessed using the PTSD Checklist for *DSM-5* and the International Trauma Questionnaire (*ICD-11*). Anxiety and depression were measured using the Generalized Anxiety Disorder Scale and the Patient Health Questionnaire-Depression. Disability was measured using the WHO Disability Assessment Schedule 2.0. *Results:* The prevalence of *DSM-5* PTSD (27.4%) was significantly higher than *ICD-11* PTSD (21.0%), and PTSD rates for females were significantly higher using both criteria. *ICD-11* PTSD was associated with significantly higher levels of disability and comorbidity. *Conclusion:* The *ICD-11* diagnosis of PTSD appears to be particularly well suited to identifying those with clinically relevant levels of disability.

Stein, D. J., McLaughlin, K. A., Koenen, K. C., Atwoli, L., Friedman, M. J., Hill, E. D., Maercker, M. D., Petukhova, M., Shahly, V., van Ommeren, M., Alonso, J., Borges, G., de Girolamo, G., de Jonge, P., Demyttenaere, K., Florescu, S., Karam, E. G., Kawakami, N., Matschinger, H., Okoliyaski, M., . . . Kessler, R. C. (2014). **DSM-5 and ICD-11 definitions of posttraumatic stress disorder: Investigating "narrow" and "broad" approaches.** *Depression and Anxiety, 31*(6), 494–505. doi:10.1002/da.22279 *Background:* The development of the *DSM-5* and the *ICD-11* has led to reconsideration of diagnostic criteria for PTSD. The World Mental Health (WMH) Surveys allow investigation of the implications of the changing criteria compared to *DSM-IV* and *ICD-10*. *Methods:* WMH Surveys in 13 countries asked respondents to enumerate all their lifetime traumatic events (TEs) and randomly selected one TE per respondent for PTSD assessment. *DSM-IV* and *ICD-10* PTSD were assessed for the 23,936 respondents who reported lifetime TEs in these surveys with the fully structured Composite International Diagnostic Interview (CIDI). *DSM-5* and proposed *ICD-11* criteria were approximated. Associations of the different criteria sets with indicators of clinical severity (distress-impairment, suicidality, comorbid fear-distress disorders, PTSD symptom duration) were examined to investigate the implications of using the different systems. *Results:* A total of 5.6% of respondents met criteria for "broadly defined" PTSD (i.e., full criteria in at least one diagnostic system), with prevalence ranging from 3.0% with *DSM-5* to 4.4% with *ICD-10*. Only one-third of broadly defined cases met criteria in all four systems and another one third in only one system (narrowly defined cases). Between-system differences in indicators of clinical severity suggest that *ICD-10* criteria are least strict and *DSM-IV* criteria most strict. The more striking result, though, is that significantly elevated indicators of clinical significance were found even for narrowly defined cases for each of the four diagnostic systems. *Conclusions:* These results argue for a broad definition of PTSD defined by any one of the different systems to capture all clinically significant cases of PTSD in future studies.

Wisco, B. E., Miller, M. W., Wolf, E. J., Kilpatrick, D., Resnick, H. S., Badour, C. L., Marx, B. P., Keane, T. M., Rosen, R. C., & Friedman, M. J. (2016). **The impact of proposed changes to ICD-11 on estimates of PTSD prevalence and comorbidity.** *Psychiatry Research, 240,* 226–233. doi:10.1016/j.psychres.2016.04.043 The

World Health Organization's PTSD work group has published a proposal for the forthcoming edition of the *ICD-11* that would yield a very different diagnosis relative to *DSM-5*. This study examined the impact of the proposed *ICD-11* changes on PTSD prevalence relative to the *ICD-10* and *DSM-5* definitions and also evaluated the extent to which these changes would accomplish the stated aim of reducing the comorbidity associated with PTSD. Diagnostic prevalence estimates were compared using an United States national community sample and two VA clinical samples. The *ICD-11* definition yielded prevalence estimates 10 to 30 percent lower than *DSM-5* and 25 and 50 percent lower than *ICD-10* with no reduction in the prevalence of common comorbidities. Findings suggest that by constraining the diagnosis to a narrower set of symptoms, the proposed *ICD-11* criteria set would substantially reduce the number of individuals with the disorder. These findings raise doubt about the extent to which the *ICD-11* proposal would achieve the aim of reducing comorbidity associated with PTSD and highlight the public health and policy implications of such a redefinition.

Wolf, E. J., Miller, M. W., Kilpatrick, D., Resnick, H. S., Badour, C. L., Marx, B. P., Keane, T. M., Rosen, R. C., & Friedman, M. J. (2015). **ICD–11 complex PTSD in U.S. national and veteran samples: Prevalence and structural associations with PTSD.** *Clinical Psychological Science, 3*(2), 215–229. doi:10.1177/2167702614545480 The *ICD-11* is under development and current proposals include major changes to trauma-related psychiatric diagnoses, including a heavily restricted definition of PTSD and the addition of CPTSD. We aimed to test the postulates of CPTSD in samples of 2,695 community participants and 323 trauma-exposed military Veterans. CPTSD prevalence estimates were 0.6% and 13% in the community and Veteran samples, respectively; one-quarter to one-half of those with PTSD met criteria for CPTSD. There were no differences in trauma exposure across diagnoses. A factor mixture model with two latent dimensional variables and four latent classes provided the best fit in both samples: classes differed by their level of symptom severity but did not differ as a function of the proposed PTSD versus CPTSD diagnoses. These findings should raise concerns about the distinctions between CPTSD and PTSD proposed for *ICD-11*.

Additional Citations

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Brewin, C. R., Lanius, R. A., Novac, A., Schnyder, U., & Galea, S. (2009). **Reformulating PTSD for DSM-V: Life after Criterion A.** *Journal of Traumatic Stress, 22*(5), 366–373. doi:10.1002/jts.20443 Early proposal recommending substantial changes to the *DSM-IV* PTSD diagnosis to address three major criticisms: the pathologizing of normal events, the limitations of Criterion A, and the high overlap with other disorders. Although originally proposed as a model for *DSM-5* PTSD, this eventually became the scaffolding for the *ICD-11* PTSD diagnosis.

Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., Karatzias, T., & Hyland, P. (2018). **The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and complex PTSD.** *Acta Psychiatrica Scandinavica, 138*(6), 536–546. doi:10.1111/acps.12956 In this diagnostic study, the authors finalized and validated the ITQ, a measure of the *ICD-11* PTSD and CPTSD. The authors used item response theory, to select 12 optimal symptom indicators that were ultimately included in the ITQ, and then conducted confirmatory factor analysis to evaluate the measure's factor structure. Results of confirmatory factor analysis showed that a two-factor second-order model was the best fit for the data, which aligns with the structure of the joint diagnoses of PTSD and CPTSD in *ICD-11*.

Friedman, M. J. (2014). **Literature on DSM-5 and ICD-11.** *PTSD Research Quarterly, 25*(2), 1–10. Retrieved from https://www.ptsd.va.gov/publications/rq_docs/V25N2.pdf In this PTSD Research Quarterly, Friedman reviews the major literature on *DSM-5* and *ICD-11*. He provides a summary of the rationale for the changes to *DSM-5*, proposed *ICD-11* criteria and rationale, criticisms of *DSM-5*, and research to date on *DSM-5* and *ICD-11* criteria, while highlighting the contrast in the revision processes of *DSM-5* and *ICD-11*.

Friedman, M. J., Resick, P. A., Bryant, R. A., & Brewin, C. R. (2011). **Considering PTSD for DSM-5.** *Depression and Anxiety, 28*(9), 750–769. doi:10.1002/da.20767 This article is the first to put forth the proposed *DSM-5* PTSD diagnostic criteria. The article reviews the empirical literature concerning the *DSM-IV*, text revision (TR) diagnostic criteria and ties the proposed diagnostic changes specifically to issues thoroughly studied empirically. In addition to the new criteria, the article reviews other relevant responses to trauma exposure that are not directly addressed in the diagnosis (e.g., CPTSD).

Frost, R., Hyland, P., McCarthy, A., Halpin, R., Shevlin, M., & Murphy, J. (2019). **The complexity of trauma exposure and response: Profiling PTSD and CPTSD among a refugee sample.** *Psychological Trauma: Theory, Research, Practice, and Policy, 11*(2), 165–175. doi:10.1037/tra0000408 One of the more recent examinations of the structure of *ICD-11* PTSD and CPTSD, this paper examined the latent dimensional and categorical structure of the diagnoses within a refugee sample. Using factor mixture modeling (FMM), the authors identified 5 latent classes, two of which were consistent with *ICD-11* PTSD and CPTSD; the remaining classes reflected nonspecific variation across dimensions. The PTSD and CPTSD classes were distinguishable by trauma type, with PTSD being associated with situational trauma and CPTSD being associated with interpersonal trauma.

Haravuori, H., Kiviruusu, O., Suomalainen, L., & Marttunen, M. (2016). **An evaluation of ICD-11 posttraumatic stress disorder criteria in two samples of adolescents and young adults exposed to mass shootings: Factor analysis and comparisons to ICD-10 and DSM-IV.** *BMC Psychiatry, 16,* Article 140. doi:10.1186/s12888-016-0849-y This study examined the factor structure of *ICD-11* PTSD and compared it to PTSD as defined by *ICD-10*, *DSM-IV* and *DSM-5* in terms of prevalence and diagnostic agreement in samples of adolescents and young adults who had

been experienced school-based mass shooting incidents. Results indicated that *ICD-11* PTSD symptoms represented two rather than three factors. In addition, the *ICD-11* criteria are more restrictive compared to the *ICD-10* criteria, and there were some differences in the clinical characteristics of the PTSD cases identified by *ICD-11*, when compared to *ICD-10* and *DSM-IV*.

Herman, J. L. (1992). **Complex PTSD: A syndrome in survivors of prolonged and repeated trauma.** *Journal of Traumatic Stress, 5*(3), 377–391. doi:10.1002/jts.2490050305 This article proposes introducing a syndrome referred to as Disorders of Extreme Stress Not Otherwise Specified (DESNOS) – a complex form of PTSD observed in survivors of prolonged, repeated trauma – to the upcoming *DSM-IV*. Herman argues that this diagnosis – CPTSD – is needed because the current conceptualization of PTSD is based on individuals who have experienced a single traumatic event. Herman argued that additional symptoms, including somatization, dissociation, affective changes, relational instability, identity disturbance, and self-injurious behavior would better reflect individuals who had experienced chronic trauma than would simple PTSD.

Hyland, P., Shevlin, M., Fyvie, C., & Karatzias, T. (2018). **Posttraumatic stress disorder and complex posttraumatic stress disorder in DSM-5 and ICD-11: Clinical and behavioral correlates.** *Journal of Traumatic Stress, 31*(2), 174–180. doi:10.1002/jts.22272 The authors evaluated the prevalence of PTSD using *DSM-5* versus *ICD-11* criteria, as well as correlates and diagnostic associations between *ICD-11* PTSD versus CPTSD and *ICD-11* CPTSD versus *DSM-5* PTSD. Results indicated that *DSM-5* PTSD was more prevalent than *ICD-11* PTSD, and that *ICD-11* CPTSD was more prevalent than *ICD-11* PTSD. *ICD-11* CPTSD had significantly higher levels of dissociation, depression, and symptoms of borderline personality disorder than *ICD-11* PTSD, and significantly higher levels of depression, anxiety, and suicidal ideation and self-harm than *DSM-5* PTSD.

Maercker, A., Brewin, C. R., Bryant, R. A., Cloitre, M., Reed, G. M., van Ommeren, M., Humayun, A., Jones, L. M., Kagee, Aw., Llosa, A. E., Rousseau, C., Somasundaram, D. J., Souza, R., Suzuki, Y., Weissbecker, I., Wessely, S. C., First, M. B., & Saxena, S. (2013). **Proposals for mental disorders specifically associated with stress in the International Classification of Diseases-11.** *The Lancet, 381*(9878), 1683–1685. doi:10.1016/S0140-6736(12)62191-6 This manuscript provides an early description of the WHO working group's proposed diagnostic changes to disorders associated with stress for the upcoming *ICD-11*. The decision to move these disorders into a unique category, as well as a discussion of the diagnoses that will be contained within (including the sibling disorders of PTSD and CPTSD) are discussed briefly. The authors conclude with a brief discussion about how their proposal differs from the *DSM-5* PTSD diagnosis that had recently been introduced.

Palic, S., Zerach, G., Shevlin, M., Zeligman, Z., Elklit, A., & Solomon, Z. (2016). **Evidence of complex posttraumatic stress disorder (CPTSD) across populations with prolonged trauma of varying interpersonal intensity and ages of exposure.** *Psychiatry Research, 246,* 692–699. doi:10.1016/j.psychres.2016.10.062 This latent class analysis examined *ICD-11*'s PTSD and CPTSD across populations with prolonged trauma to evaluate the claim that CPTSD applies to other repeatedly traumatized samples beyond child abuse. The authors identified both a four- and a five-class solution; both included a PTSD class, a CPTSD class, a non-pathological class, and an Anxiety class, and the five-factor solution also included a Dissociative PTSD-subtype class. Results indicated that both the CPTSD and Anxiety classes were both associated with prolonged trauma, but the CPTSD class was associated with highest frequency of work-related functional impairment.

Regier, D. A., Narrow, W. E., Clarke, D. E., Kraemer, H. C., Kuramoto, S. J., Kuhl, E. A., & Kupfer, D. J. (2013). **DSM-5 field trials in the United States and Canada, Part II: Test-retest reliability of selected categorical diagnoses.** *American Journal of Psychiatry, 170*(1), 59-70. doi:10.1176/appi.ajp.2012.12070999 This article describes the one aspect of the *DSM-5* field trials; specifically, analyses examining the reliability of the categorical diagnoses – including PTSD – obtained by two independent clinicians using their usual clinical interviews followed by use of a computer-assisted checklist to document the presence or absence of the symptomatic criteria needed to support their clinical diagnosis. Results indicated that *DSM-5* PTSD was one of the most reliable of the diagnoses, was highly comparable to *DSM-IV* PTSD, and demonstrated overlap with major depressive disorder, generalized anxiety disorder, and alcohol use disorder.

Roberts, N. P., Cloitre, M., Bisson, J., & Brewin, C. R. (2018). *International Trauma Interview (ITI) for ICD-11 PTSD and complex PTSD* (Test Version 3.1). This citation represents the International Trauma Interview, the first interview measure designed explicitly to assess for *ICD-11* PTSD and CPTSD. The semi-structured clinical interview is divided into two parts: part one, which is based on the Clinician Administered PTSD Scale for *DSM-5* (Weathers, Blake, et al., 2013), assesses for PTSD symptoms; part two assesses for the additional symptoms of DSO required for a CPTSD diagnosis. Although a validation study of the English language version has not yet been published, a Swedish version has been validated (interested readers are directed to Bondjers et al., 2019).

Vermetten, E., Baker, D. G., Jetly, R., & McFarlane, A. C. (2016). **Concerns over divergent approaches in the diagnostics of posttraumatic stress disorder.** *Psychiatric Annals, 46*(9), 498–509. doi:10.3928/00485713-20160728-02 This review article describes both the ongoing debate about how to define PTSD, and the associated consequences of divergent diagnostic systems. In particular, the authors detail their concerns regarding aspects of the *ICD-11* working group's approach to revisions and ultimate changes to the PTSD diagnosis. The authors conclude with a discussion of how the development of a stringent and universal revision process can reduce divergence in future iterations of the diagnosis.

World Health Organization. (2018). *International statistical classification of diseases and related health problems* (11th Revision).