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

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* Postrumatic 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...
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 (Vermotten 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., Ciofret al., 2013; Frost et al., 2019; Paic 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 Greca, 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 (Ciofret 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.

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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., Olif, 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.

Brein, 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.


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.


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 from here 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 PTSD module 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.


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.


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 less 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.

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


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.12958 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., 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/trt0000408 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-v 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, A., Llosa, A. E., Rousseau, C., Somasundaram, D. J., Souza, R., Suzuki, Y., Weissecker, 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., Elkii, 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 examine 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., Jetty, 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.