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COMMENTARY

PTSD diagnoses and treatments: closing the gap between ICD-11 and DSM-5†

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SUMMARY

The diagnostic status of 'complex' post-traumatic stress disorder (PTSD) remains controversial. The revisions to PTSD diagnostic criteria in ICD-11 and DSM-5 take opposing positions on how best to conceptualise post-traumatic presentations that include affect dysregulation, interpersonal difficulties and negative self-concept. ICD-11 carved out a separate category of complex PTSD (CPTSD) that is distinct from PTSD, whereas DSM-5 expanded PTSD to encompass such symptoms. Each approach carries problematic implications for clinical care. ICD-11 creates a dichotomy but the criteria themselves suggest a difference in severity rather than category. Furthermore, separating CPTSD perpetuates expectations that a 'simple' PTSD can be easily treated with brief trauma-focused therapy. DSM-5 complicates the PTSD diagnosis, but does not revise treatment recommendations. Both ICD and DSM need to recognise that most patients with PTSD do not reflect the clinical trial samples and do not fully recover with brief manualised therapies. Treatment guidelines should be developed that address the multiple needs and challenges of all patients with PTSD.

KEYWORDS

PTSD; complex PTSD; diagnosis; treatment.

Brewin (2020, this issue) reviews the new diagnostic category of complex post-traumatic stress disorder (CPTSD) as operationalised in ICD-11 (World Health Organization 2018). This commentary will review differences in diagnostic conceptualisations of post-trauma reactions between ICD-11 and DSM-5 (American Psychiatric Association 2013) and discuss treatment implications.

Concepts of 'complex' PTSD

The ontological status of CPTSD has dogged psychiatry since its initial proposition. In the USA there have been two camps: one promoting a diagnosis (e.g. 'disorders of extreme stress not otherwise specified', DESNOS) positing that chronic and severe interpersonal trauma can lead to pervasive emotional and interpersonal difficulties (Herman 1992; Cloitre 2012); and one arguing that PTSD alone is adequate (Resick 2012). The revisions to PTSD in ICD-11 and the DSM-5 suggest consensus that a narrowly defined, fear-based model of PTSD failed to capture the full range of trauma-related presentations. However, ICD-11 and DSM-5 have taken opposite tacks in conceptualising this diversity, each solving one problem but creating another.

ICD-11: CPTSD as a separate diagnosis

In attempting to solve the problem of codifying the CPTSD presentation, ICD-11 carved PTSD into two discrete constructs: PTSD and CPTSD. Brewin (2020) describes CPTSD as 'a diagnosis in its own right', 'separate' from PTSD. CPTSD subsumes PTSD diagnostic criteria within a broader symptom presentation that includes global problems in 'self-organisation', including affect dysregulation, difficulties with relationships and negative self-concept. The ICD-11 revision creates a dichotomy, but in fact the criteria themselves are structured as a difference in severity rather than category. Although now more clearly distinguished from borderline personality disorder, defining CPTSD as a separate diagnosis could lead to stigma for these 'complex' patients similar to that faced by patients with personality disorders, who are typically seen as treatment refractory and interpersonally difficult. If the precipitating trauma or developmental period in which it occurred is no longer determinative of diagnosis, and core PTSD symptoms are required for diagnosis, it would be more parsimonious to emphasise the similarity in conceptualisation.

DSM-5: encompassing CPTSD within the PTSD diagnosis

In contrast, DSM-5 solved the problem of defining a more pervasive or 'complex' presentation by engulfing it. DSM-5 expanded the diagnostic criteria for PTSD to four clusters with 20 symptoms, creating what statisticians have wryly observed are '636

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120 ways to have posttraumatic stress disorder' (Galatzer-Levy 2013). Under DSM-5's expansion, the symptoms captured by ICD-11 CPTSD might now be reasonably captured by the PTSD diagnosis.

Treatment implications

Although ICD-11 and DSM-5 take different approaches, a problematic subtext regarding treatment implications runs through both. Under DSM-5, the implication is that existing treatment recommendations for PTSD are adequate for this more complex presentation. The addition of 'alterations to mood and cognitions' simply brings the diagnosis more in line with the cognitive therapies that are already recommended for PTSD. This formulation remains maddeningly oblivious to the clinical reality that brief treatments will be insufficient for many (Shedler 2015; Steenkamp 2015). Current treatment guidelines (and mandates in some settings) for PTSD simply fail to adequately address challenges, including stability, emotional dysregulation, suicidality and interpersonal problems (Yehuda 2016).

Under ICD-11, the CPTSD carve-out implies two corollaries: that 'regular' or 'simple' PTSD can be fully treated with a brief manualised trauma-focused therapy; and that, in contrast, only patients with 'complex' PTSD have significant barriers to engaging in and benefiting from such treatments. Brewin (2020) notes the importance of developing a safe therapeutic relationship that counters the lack of trust and betrayal that many patients with CPTSD experience and that is a necessary prerequisite to the vulnerability of disclosure involved in trauma-focused therapy. The implication that current treatments for 'simple' PTSD are adequate is belied by the literature, which shows that only a minority of patients recover after receiving gold standard treatments recommended by multiple clinical guidelines. The need to address shame, manage dissociation and cultivate a window of tolerance for reflection on trauma material should not be special considerations only for CPTSD, but are relevant to most, if not all, treatment-seeking patients with PTSD.

Reinforcing the unsatisfactory status quo

Thus, either expanding a single definition of PTSD or delineating a discrete form of CPTSD communicates a status quo approach to PTSD treatment, while creating a silo for a subset of patients who are understood to need more attention to process, emotion regulation and stabilisation. There is a concern that both approaches reinforce clinical guidelines for PTSD that are inadequate for the majority of patients. Traumatised, treatment-seeking patients frequently have comorbidities of mood, substance abuse, medical conditions and psychosocial stressors that complicate their ability to recover using a brief manualised treatment. Patients who struggle only with re-experiencing, avoidance and hyperarousal symptoms primarily exist in the world of clinical trials (with their attendant exclusion criteria), raising concerns about the applicability of recommendations from 'evidence-based' research to clinical practice. Indeed, patients with PTSD who are both eligible for and willing to embark on brief manualised trauma-focused therapy represent a minority. Given drop-out rates as high as 50% (Schottenbauer 2008) – even for those eligible for such trials – the treatment recommendations for CPTSD are in fact relevant for most patients with PTSD.

Research implications and future progress

The more tightly defined ICD-11 diagnoses hold promise for improved biological, psychological and treatment research. The risks of the ICD approach, however, are that in reifying core PTSD symptoms as 'real' PTSD, many of those who seek care will be marginalised and stigmatised, and PTSD research will lead to findings with a rarefied sample that are clinically irrelevant. The fallacy of the big tent approach of DSM is that the increased heterogeneity makes it ever more difficult to develop a coherent science and treatment approach, while treatment guidelines for PTSD continue to neglect the reality of the needs and challenges of the majority of patients. It is a step in the right direction that both DSM and ICD have recognised that previous versions of PTSD did not adequately capture the 'complex PTSD' presentation. It is now time to bring treatment recommendations in line with this reality, starting with the need for a more comprehensive approach than is currently captured by first-line treatment recommendations.

Declaration of interest

None.

Author contributions

Both authors contributed to the conceptualisation, drafting and revising of this commentary, and both approved the final revision.

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