



Comparison of DSM-IV and proposed ICD-11 formulations of post-traumatic stress disorder

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Complete List of Authors:	Morina, Nexhmedin; University of Amsterdam, Department of Clinical Psychology van Emmerik, Arnold; University of Amsterdam, Department of Clinical Psychology Andrews, Bernice; Royal Holloway University of London, Psychology Brewin, Chris; University College London, Clinical, Educational & Health Psychology;
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Comparison of DSM-IV and Proposed ICD-11 Formulations of Post-traumatic Stress Disorder
among Civilian Survivors of War and War Veterans

Nexhmedin Morina^a, Arnold A. P. van Emmerik^a, Bernice Andrews^b, Chris R. Brewin^c

^a Department of Clinical Psychology, University of Amsterdam, Amsterdam, the Netherlands.

^b Department of Psychology, University of London, Egham, Surrey, United Kingdom.

^c Clinical, Educational and Health Psychology, University College London, London, UK.

Nexhmedin Morina

Department of Clinical Psychology, University of Amsterdam, Weesperplein 4, 1018 XA

Amsterdam, the Netherlands.

Tel.: +31-20-525-8607, e-mail: n.morina@uva.nl

DSM-IV and ICD-11 formulations of PTSD

Abstract

The World Health Organization recently proposed a reformulation of posttraumatic stress disorder (PTSD) for the 11th edition of the International Classification of Diseases (ICD-11), employing only six symptoms. The aim of this study was to investigate the impact of this reformulation on prevalences of current PTSD as well as comorbid major depressive episode and other anxiety disorders as compared to PTSD criteria of DSM-IV. Findings are based on interviews with 560 Kosovar civilian war survivors and a sample of 142 British war veterans. Results revealed no significant change in the prevalence of current PTSD under the criteria proposed for ICD-11. Participants who only met the newly proposed criteria showed lower rates of comorbid major depressive episode than participants who only met DSM-IV criteria. Rates of comorbid anxiety disorders did not significantly differ between participants who lost or gained a PTSD diagnosis under the proposed criteria. The diagnosis of PTSD can be effectively simplified and more clearly distinguished from major depressive episode.

Keywords: PTSD, DSM-5, ICD-11, war, traumatic events, comorbidity

DSM-IV and ICD-11 formulations of PTSD

Comparison of DSM-IV and Proposed ICD-11 Formulations of Post-traumatic Stress Disorder

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2
3 Post-traumatic stress disorder (PTSD) was first defined in the third edition of the Diagnostic
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5 and Statistical Manual of Mental Disorders (DSM-III) and later revised in its fourth edition (DSM-
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7 IV) (American Psychiatric Association, 1980 & 1994). According to the DSM-IV, the diagnostic
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9 criteria for PTSD require the onset of characteristic symptoms following exposure to an extreme
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11 event and a reaction to that event that involves fear, helplessness, or horror (Criteria A1 and A2).
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13 Post-traumatic symptoms must be present for more than one month and include at least one
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15 reexperiencing symptom (Criterion B), three avoidance/numbing symptoms (Criterion C), and two
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17 hyperarousal symptoms (Criterion D) out of a total of 17 possible symptoms. The diagnosis of PTSD
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19 has greatly influenced research and practice but has been subject to various criticisms (Rosen &
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21 Lilienfeld, 2008; Spitzer, First, & Wakefield, 2007). This article aims at presenting data on an
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23 alternative approach proposed for the 11th edition of the International Classification of Diseases
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25 (ICD-11), in which the number of qualifying PTSD symptoms is reduced from 17 to 6 (Maercker et
26
27 al., 2013).

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32 The PTSD diagnosis has been criticized on at least four fronts. First, there is debate on the
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34 utility and demarcation of the stressor criterion (Criterion A) and the overlap among separate PTSD
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36 symptom criteria (Yufik & Simms, 2010). Second, the disorder has been criticized for excessive
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38 complexity, resulting in thousands of different combinations of symptoms all leading to the diagnosis
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40 (Brewin, Lanius, Novac, Schnyder, & Galea, 2009; Spitzer et al., 2007). Third, criticisms have
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42 focused on symptom overlap and comorbidity with other mental disorders (Rosen & Lilienfeld,
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44 2008; Spitzer et al., 2007). Fourth, concerns have been raised about the broader societal
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46 consequences of the PTSD diagnosis, such as the risk of pathologizing psychological reactions to
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48 normal distress (McHugh & Treisman, 2007). DSM-5 addresses a number of these problems and
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50 following an extensive review of the evidence has modified Criterion A and the constituent symptom
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52 clusters of PTSD, further improving symptom description and adding three new symptoms
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54 corresponding to common features of the disorder (Friedman, Resick, Bryant, & Brewin, 2011).
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DSM-IV and ICD-11 formulations of PTSD

1 The World Health Organization's International Classification of Diseases first introduced the
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3 criteria for PTSD in its tenth revision (ICD-10; World Health Organization, 1992). ICD-10 also
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5 includes exposure to a stressor and symptoms from each of three symptom clusters and the onset of
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7 symptoms must be within six months. Yet, in ICD-10, there is no subjective stressor criterion and
8
9 there is a greater emphasis on re-experiencing and less on emotional numbing. To maximize clinical
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11 utility, proposals for an upcoming revision to ICD-10 (ICD-11) have included a reduction and
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13 simplification in the symptoms required for a PTSD diagnosis (Maercker et al., 2013). An important
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15 proposed innovation in ICD-11 involves specifying core elements rather than "typical features" of
16
17 PTSD. Core elements are those that on empirical or theoretical grounds most clearly distinguish
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19 PTSD from other disorders. The elements had additionally to be endorsed by clinicians working in a
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21 variety of cultural settings around the world. Following suggestions by Brewin et al. (2009), the first
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23 core element consists of reexperiencing the traumatic event(s) in the present, as evidenced by either
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25 flashbacks or nightmares, accompanied by fear or horror (see Table 1). Consistent with DSM-5,
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27 flashbacks are defined as intrusive waking memories in which reexperiencing in the present can vary
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29 from a transient sensation to a complete disconnection from the current environment. The second
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31 core element is avoidance of these intrusions, as evidenced by marked internal avoidance of thoughts
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33 and memories, or external avoidance of activities or situations reminiscent of the traumatic event(s).
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35 The third core element is an excessive sense of current threat, as evidenced either by hypervigilance
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37 or by exaggerated startle, two arousal symptoms that tend to cluster together (Yufik & Simms, 2010).
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39 PTSD is defined in terms of the presence of at least one of the two symptoms from each of these
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41 three core elements, in addition to impairment in functioning. The effect is to require the presence of
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43 at least 50% (3/6) of the specified core symptoms in place of at least 35% (6/17) of the typical
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45 features described in DSM-IV.
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52 The implications of the proposed ICD-11 criteria on the prevalence of PTSD and on its
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54 comorbidity with other disorders are unknown. To our knowledge, only one study has evaluated the
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56 impact of these criteria on the prevalence and comorbidity pattern of PTSD (van Emmerik &
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1 DSM-IV and ICD-11 formulations of PTSD
2 Kamphuis, 2011). In a sample of 170 treatment-seeking survivors of civilian traumas, no significant
3 change in PTSD prevalence was found the high comorbidity of PTSD with major depressive episode
4 (MDE) in particular was not explicable by symptom overlap alone.
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7 This study aimed to compare the prevalence of PTSD under the DSM-IV and proposed ICD-
8 11 criteria in new, non-treatment-seeking samples and using different measures of PTSD. This
9 comparison is possible since the newly proposed ICD-11 criteria for PTSD constitute a subset of the
10 PTSD symptoms specified in the DSM-IV criteria (specifically, symptoms B2, B3, C1, C2, D4, and
11 D5). Accordingly, instruments capturing the DSM-IV criteria for PTSD can be used to evaluate the
12 proposed ICD-11 criteria.
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20 21 **Method**

22 *Study 1*

23 Study 1 utilizes data from two surveys conducted in Kosovo in 2009 (Morina, von Lersner, &
24 Prigerson, 2011; Morina & Emmelkamp, 2012), 10 years after the war. The survey was conducted in
25 the municipalities of Gllogovc, Kline, Skenderaj, and Vushtrri. The interviews were conducted by
26 five female psychologists who were experienced in conducting clinical interviews for a prior project
27 (Priebe et al., 2010). In this prior project, inter-rater agreement among interviewers was assessed for
28 the MINI International Neuropsychiatric Interview in two mock interviews. Among 251 items, the
29 mean agreement rate (i.e., all interviewers gave the same answer for each item) across two sessions
30 was 90%.
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43 *Participants*

44 In accordance with the original aim of the study to investigate the impact of the war-related grief on
45 mental health, the samples consisted of bereaved and non-bereaved participants. All participants
46 reported exposure to at least one war-related traumatic event. After complete description of the study
47 to the subjects, informed consent was obtained. Participants who were 16 or 17 years old (19% of the
48 sample) were asked to provide informed consent after consulting one of their parents. The study was
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DSM-IV and ICD-11 formulations of PTSD approved by the Ethics Committee of the University of Amsterdam. Participants were compensated with five Euros for their participation.

Bereaved civilian war survivors. Lists of all families who had lost relatives during the war in the selected municipalities were provided by communal authorities. Out of 406 contacted participants, 95 did not meet the inclusion criteria. Of 311 potential participants, 27 declined to participate in the study, resulting in a participation rate of 91% (284/311). Missing values resulted in the exclusion of five participants, thus 279 bereaved participants were included in the analyses.

Non-bereaved civilian war survivors were contacted in the same localities as bereaved participants. This group was recruited using a random walk approach (Priebe et al., 2010) that involved random identification of streets in each locality where bereaved participants were contacted. All participants reported at least one potential war-related traumatic event. Out of 494 households contacted, 186 did not meet inclusion criteria. Of the remaining 308 potential participants, 21 declined to participate in the study (i.e., a participation rate of 93%). Missing values resulted in the exclusion of six participants, resulting in a total sample size of 281 non-bereaved participants.

Measures

Socio-demographic characteristics of the participants were assessed on a brief structured questionnaire. Traumatic events were measured using a checklist that assesses 18 war-related traumatic events (Morina, Rushiti, Salihu, & Ford, 2010).

MDE and anxiety disorders were assessed with the MINI International Neuropsychiatric Interview that has shown similar diagnostic sensitivity compared to the Structured Clinical Interview for DSM-III-R (Sheehan et al., 1997). The MINI is the only structured psychiatric interview translated for use among Kosovar Albanians (Morina, 2006). There is lack of information regarding psychometric properties of the Albanian version of the MINI, apart from the assessment of the inter-rater reliability among interviewers of a prior project across two sessions that was reported to be 90% (Priebe et al., 2010). To culturally adapt the instrument, the authors had applied an earlier version of the instrument to civilian war survivors in Kosovo and subsequently adjusted the

1 DSM-IV and ICD-11 formulations of PTSD
2 translation based on intense discussions with the local interviewers who had applied the MINI
3 (Morina, 2006). This interview has been used several times in the Kosovar population (Morina et al,
4 2010; Priebe et al., 2010).

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7 PTSD symptoms experienced in the past month were assessed with the Posttraumatic Stress
8 Diagnostic Scale (PDS) (Foa, Cashman, Jaycox, & Perry, 1997) that assesses the 17 PTSD
9 symptoms specified in the DSM-IV and thereby also the six PTSD symptoms proposed in the ICD-
10 11. Items are scored on a 4-point scale ranging from “never” to “5 times per week or more/nearly
11 always”. All participants indicated the war-related traumatic event that bothered them the most prior
12 to filling out the PDS in relation to that event. Foa et al. (1997) reported good reliability and
13 concurrent validity of the PDS with other PTSD measures, and that it has satisfactory agreement
14 ($kappa = 0.65$, agreement = 82%, sensitivity = 0.89, specificity = 0.75) with the PTSD module of the
15 SCID (First, Spitzer, Gibbon, & Williams, 1996). In this study, the internal consistency of the
16 Albanian version of the PDS (Morina, Bohme, Morina, & Asmundson, 2011) was $\alpha = 0.95$.

27 *Study 2*

28 *Participants*

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30 Veterans were predominantly recruited from the United Kingdom Service Personnel and Veterans
31 Agency whose medical staff sent invitation letters for research participation to groups of veterans
32 receiving pensions for PTSD or for physical disabilities only (Andrews, Brewin, Stewart, Philpott, &
33 Hejdenberg, 2009). The explicit focus of the study was on veterans' general wellbeing. Of the
34 veterans at confirmed addresses 51% agreed to interview. Inclusion criteria were being in receipt of a
35 war pension, younger than 60 years, having experienced a traumatic event during military service,
36 and having suffered either from PTSD or a physical disability as a result of military service.

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38 The current report is based on 103 veterans diagnosed on the basis of our research interview
39 with PTSD at some time during the study period and 39 controls receiving war pensions for physical
40 disorders who did not report PTSD at any time. The research was approved by Research Ethics
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DSM-IV and ICD-11 formulations of PTSD

1 Committees at Royal Holloway and University College London. After complete description of the
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3 study to the subjects, written informed consent was obtained.
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Measures

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7 Retrospective DSM-IV diagnoses of current PTSD and thereby also the proposed ICD-11 diagnoses
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9 of PTSD, anchored to the time the participant was discharged from the armed services, were
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11 determined during our research interviews using the SCID for DSM-IV (First et al., 1996). As in
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13 previous studies of military samples, PTSD Criterion A2 (reporting fear, helplessness, or horror at
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15 the time of the event) was not required. In our lifetime diagnostic interviews onset and offset dates
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17 for each PTSD symptom individually were recorded, enabling us to relate each symptom to the
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19 traumatic event described by participants as affecting them most, and to determine which symptoms
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21 were present at discharge.
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26 Interviewers were trained to use the SCID and all interviews were audiotaped and transcribed
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28 verbatim. Inter-rater reliability was calculated on a subset of 27 interviews from the full 2009 sample
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30 and found to be acceptable: classification as immediate versus delayed-onset versus no DSM-IV
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32 PTSD (96% agreement, *kappa* .94).
33

Statistical Analysis

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36 First, socio-demographic and trauma-related characteristics were summarized using means and
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38 standard deviations or percentages, as applicable and available for each sample. Second, we
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40 calculated the proportions of participants in each sample meeting the PTSD diagnosis following the
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42 DSM-IV and proposed ICD-11 criteria, respectively. Two-tailed binomial approximation *z* tests for
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44 proportions were used to evaluate differences in proportions. Third, we calculated the odds ratios and
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46 their 95% confidence intervals of comorbid MDE and other anxiety disorders among civilian war
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48 survivors meeting only the DSM-IV criteria or the proposed ICD-11 criteria (numbers were too small
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50 to conduct a corresponding analysis for the sample of war veterans).
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Results**Demographic and Trauma-related Characteristics**

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Civilian war survivors. The mean age of participants was 30.56 years ($SD = 14.61$, range 16-69) and 75% were female. On average, they reported 9.55 years of school ($SD = 3.84$) and 47% of them were unemployed. Participants reported a mean of 17.59 ($SD = 13.52$) war-related traumatic events, a mean of 0.16 ($SD = 0.80$) pre-war events, and a mean of 0.16 ($SD = 1.04$) post-war events.

War veterans. The mean age was 36.27 years ($SD = 4.99$, range 22-59) and 97% were male. Education up to the age of 16 years only was reported by 58%, up to 18 years by 26%, and degree level or above by 16%. The percentage of commissioned officers was 4%, noncommissioned officers 38%, and other ranks 58%. The average length of time they had served in the armed forces was 8.50 years ($SD = 4.47$). Participants reported a mean of 3.20 ($SD = 1.55$) traumatic events.

Prevalence of PTSD

Civilian war survivors. The PTSD prevalence according to ICD-11 criteria was not significantly different from the PTSD prevalence based on the DSM-IV ($z = 1.66$, $p = 0.10$). As shown in Table 2, 48 participants (9%) met DSM-IV criteria only (and thus not ICD-11 criteria) and 22 participants (4%) met the proposed ICD-11 criteria and not the DSM-IV criteria, leaving 87% with an unchanged diagnostic status. An examination of the PTSD clusters revealed mixed results. As compared to DSM-IV criteria, significantly fewer individuals met ICD-11 criteria for intrusion and significantly more individuals met ICD-11 criteria for avoidance (both $ps < 0.01$). There was no significant difference between both sets of criteria with regard to hyperarousal ($p = 0.91$).

War veterans. The prevalence of PTSD was not significantly different regarding the two criteria sets (see Table 3). Three participants (2%) met DSM-IV criteria only (and thus not ICD-11 criteria) and nine participants (6%) met the proposed ICD-11 criteria and not the DSM-IV criteria, leaving 92% with an unchanged diagnostic status. As compared to DSM-IV criteria, significantly more individuals met ICD-11 criteria for avoidance ($p < 0.05$). There was no significant difference between both sets of criteria with regard to intrusion or hyperarousal (both $ps > .10$).

Comorbidity of PTSD with MDE and anxiety disorders

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Civilian war survivors. Table 4 presents rates of comorbidity among participants meeting PTSD criteria according to both criteria sets. An examination of participants meeting DSM-IV criteria only and participants meeting ICD-11 criteria only revealed that rates of comorbidity were generally lower in the ICD-11 group but differed significantly only with respect to MDE, fewer participants in this group reporting the diagnosis ($p = 0.01$). Numbers were too small to conduct a corresponding analysis for the sample of war veterans.

Discussion

Our results indicate that the new approach proposed for ICD-11 need not make a substantial difference to PTSD prevalence. This finding held across two samples that differed markedly in gender and composition (civilian vs. military), and are consistent with van Emmerik and Kamphuis (2011). This finding is in some ways surprising given the attempt to define the core features of the disorder more narrowly, requiring a minimum of only three symptoms. Although fewer symptoms are required for the diagnosis, the corresponding reduction in the number of qualifying symptoms (from 17 to 6) appears to have preempted any tendency to inflate diagnosis rates. Our findings are in line with evaluations of other proposals to reduce the number of PTSD symptoms (Spitzer et al., 2007), which have similarly found few changes in prevalence (Grubaugh, Long, Elhai, Frueh, & Magruder, 2010) and suggest that the 17 symptoms described in DSM-IV are not all required to assess PTSD.

One effect of the ICD-11 proposals, which was observed in both datasets, was to decrease the number of individuals meeting the re-experiencing criterion. This was to be expected given that repetitive intrusive memories, once thought to be unique to PTSD, are now known to be found in many other disorders (Brewin, Gregory, Lipton, & Burgess, 2010). Moreover, under DSM-IV re-experiencing symptoms included intrusive thoughts about the trauma, which may be more characteristic of depressive rumination (Friedman et al., 2011). Among civilian war survivors, more participants met the DSM-IV re-experiencing criterion than the ICD-11 criterion (i.e., distressing dreams and flashbacks). This was mainly due to the finding that these two symptoms were the two

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1 least prevalent re-experiencing symptoms. However, as this did not lead to a significant difference on
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3 the prevalence of overall PTSD (87% of individuals in the civilian sample who met ICD-11 criteria
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5 for PTSD also fulfilled DSM-IV criteria for PTSD), this result might support the notion that
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7 distressing dreams and flashbacks represent the core re-experiencing symptoms. Thus, individuals
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9 reporting either distressing dreams or flashbacks were very likely to also meet the other PTSD
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11 criteria. Among war veterans, however, there was no difference between the DSM-IV and ICD-11
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13 prevalence of the re-experiencing criterion. In this sample, 54% of individuals reported distressing
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15 dreams, which is double as much as in the civilian sample and might suggest that distressing dreams
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17 might be more characteristic of combat trauma. Yet, the difference might also be a result of different
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19 measurements (PDS vs. SCID).
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24 Perhaps the most substantial effect of the changes was to increase the number of individuals
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26 meeting the avoidance/numbing criterion. Our data support this notion as in both samples the number
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28 of individuals meeting the avoidance criterion was higher for the ICD-11 system than for the DSM-
29
30 IV system. This is most plausibly a result of the reduced threshold whereby three out of seven
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32 avoidance symptoms must be present to meet the DSM-IV avoidance criterion as compared to one
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34 out of two symptoms following the ICD-11. One potential implication is that previously a substantial
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36 proportion of individuals diagnosed with PTSD showed active avoidance of internal or external
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38 stimuli that reminded them of their trauma but failed to meet the criterion because other symptoms in
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40 this cluster were lacking. Substantial literature shows that the active avoidance symptoms are
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42 functionally distinct from the other Criterion C symptoms in DSM-IV (e.g., social withdrawal, loss
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44 of interest in activities) (Yufik & Simms, 2010). Recent analyses support the position that requiring
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46 active avoidance (proposed both for ICD-11 and DSM-5) is likely to refine the PTSD diagnosis and
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48 reduce spurious diagnoses being applied to individuals who are primarily suffering from depression
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50 (Forbes et al., 2011).
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55 Relatedly, the reduced set of symptoms led to significantly less comorbidity with major
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57 depression. The removal of symptoms a number of which are now known to be characteristic of
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DSM-IV and ICD-11 formulations of PTSD depression (e.g., intrusive memories, distressing recollections, social withdrawal, foreshortened future) may have improved the specificity of the remaining symptoms sufficiently to reduce comorbidity, as was the intention. Alternatively, the reduced comorbidity with major depression may be viewed as a correlate of lower symptom severity in participants meeting the proposed ICD-11 criteria for PTSD compared to participants meeting the DSM-IV criteria. Interpretation of our findings will differ depending on whether ICD-11 is perceived as having a more lenient avoidance/numbing criterion as compared to DSM-IV or whether these symptoms are perceived as being part of a separate condition.

As previously noted, however, comorbidity was not reduced by these means in a treatment-seeking sample (van Emmerik & Kamphuis, 2011). Yet, this dataset was modest in size, and the groups meeting ICD-11 and DSM-IV criteria overlapped substantially. The current analyses use much larger numbers and permit the most appropriate comparison, namely between individuals meeting DSM-IV but not ICD-11 criteria, and vice versa. Replication of these findings is nevertheless needed. Other strengths of the study include the use of disparate samples that differ markedly in gender, age, culture, and training for exposure to war trauma and that data resulting from both samples yielded similar results regarding the prevalence of PTSD. This is consistent with growing evidence for the cross-cultural validity of the PTSD construct (Hinton & Lewis-Fernandez, 2011).

Limitations include the focus on war trauma only and the low rates of some comorbid anxiety disorders. Additionally, the PDS used in the civilian sample measures the frequency of PTSD symptoms only and not the level of impairment. Further, the use of a self-report in the civilian sample might represent a less accurate recording of PTSD symptoms as opposed to the use of clinical interviews. However, a potential overrepresentation of PTSD symptoms is not likely to have impacted the current results as such an overrepresentation should be present in both formulations of PTSD (i.e., DSM-IV and ICD-11). The use of a self-report in the first sample and a structured interview in the second sample might also represent a strength of this study given the similar results

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1 in both samples. In addition, reliance on previously collected data prevented us from testing
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3 proposed ICD-11 against DSM-5 diagnoses. Although the participation rate in the veteran sample
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5 was only around 50%, the specific analyses we have reported do not require a representative or
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7 unbiased sample, so this is unlikely to be a serious limitation. Further research is needed to examine
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9 to what extent the ICD-11 criteria and DSM-IV criteria demarcate different forms of
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11 psychopathology, despite yielding comparable prevalences of PTSD. Additionally, as ICD-11 criteria
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13 include only one symptom that lends itself to objective measurement (exaggerated startle response),
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15 future research needs to also investigate potential scientific and clinical implications of the reduced
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17 number of the required PTSD objective symptoms
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21 The symptoms selected for ICD-11 are those which appear at present to distinguish PTSD
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23 most clearly from other disorders, i.e. the re-experiencing of the traumatic event(s), the deliberate
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25 avoidance of reminders of the traumatic event(s), and certain hyperarousal symptoms. Five of the six
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27 symptoms selected to assess PTSD in ICD-11 were found to be among the most highly predictive of
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29 a PTSD diagnosis in the DSM-IV Field Trial (Kilpatrick et al., 1998). The ICD-11 criteria aim at
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31 maximizing clinical utility, leading to more reliable diagnosis in non-specialized settings such as
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33 primary care, and more efficient diagnosis after large scale traumatic events. If the current results are
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35 replicated another benefit may be a reduction in comorbidity with depression, allowing researchers to
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37 measure and study a narrower and more clearly defined phenotype corresponding to this particular
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39 response to extreme stress. Thus ICD-11 may under certain circumstances offer a useful alternative
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41 to the DSM-5 PTSD diagnosis, which remains true to DSM-IV in offering a detailed and
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43 comprehensive clinical picture of the disorder for mental health practitioners.
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Conflict of interest

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51 Dr. Brewin was an advisor to the DSM-5 sub-workgroup on trauma and dissociation and is a
52
53 member of the World Health Organization (WHO) International Advisory Group for the Revision of
54
55 ICD-10 Mental and Behavioural Disorders. Any views expressed are not those of the American
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Psychiatric Association (APA), WHO, or any Advisory Group and do not in any way represent APA or WHO policy. The authors report no other competing interests.

For Peer Review

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DSM-IV and ICD-11 formulations of PTSD

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DSM-IV and ICD-11 formulations of PTSD

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Table 1

*Diagnostic Criteria for PTSD Proposed for ICD-11**Reexperiencing.* Either:

- (i) recurrent distressing dreams related to an event now perceived as having severely threatened someone's physical or psychological well-being, from which the person wakes with marked fear or horror, or
- (ii) repeated daytime images related to an event now perceived as having severely threatened someone's physical or psychological well-being, experienced as recurring in the present and accompanied by marked fear or horror

Avoidance. Either:

- (i) efforts to avoid thoughts, feelings, conversations, or internal reminders associated with the reexperienced event(s), or
- (ii) efforts to avoid activities, places, people, or external reminders associated with the reexperienced event(s)

Hyperarousal. Either:

- (i) hypervigilance, or
- (ii) exaggerated startle response

Impairment. The symptoms must last for at least several weeks and cause significant impairment in functioning.

Table 2. Proportion of civilian war survivors ($N = 560$) meeting DSM-IV and proposed ICD-11 criteria for PTSD

	DSM-IV		ICD-11		Changes in diagnostic status under ICD-11 criteria						<i>Z</i>	<i>p</i> -value
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	No longer present		Unchanged		Newly present			
					<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>		
Reexperiencing	339	61 ^{1,b}	221	39 ²	118	21	442	79	0	0	7.05	<.001
Criterion B												
B1. Distressing recollections	308	55	n.a.	n.a.								
B2. Distressing dreams	146	26	146	26								
B3. Flashbacks	170	30	170	30								
B4. Psychological reactivity	283	51	n.a.	n.a.								
B5. Physiological reactivity	229	41	n.a.	n.a.								
Avoidance	223	40 ¹	277	49 ²	7	1	492	88	61	11	-3.25	.001
Criterion C												

1													
2													
3													
4	C1. Avoiding	262	47	262	47								
5	internal reminders												
6													
7	C2. Avoiding	216	39	216	39								
8	external reminders												
9													
10													
11	C3. Specific	117	21	n.a.	n.a.								
12	amnesia												
13													
14	C4. Diminished	180	32	n.a.	n.a.								
15	interest												
16													
17	C5. Detachment	128	23	n.a.	n.a.								
18													
19	C6. Restricted	180	32	n.a.	n.a.								
20	affect												
21													
22	C7. Foreshortened	186	33	n.a.	n.a.								
23	future												
24													
25	Hyperarousal	303	54 ¹	305	54 ¹	23	4	512	91	25	4	0.12	.90
26	Criterion D												
27													
28	D1. Difficulty	217	39	n.a.	n.a.								
29	sleeping												
30													
31	D2. Irritability	264	47	n.a.	n.a.								
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D3. Difficulty concentrating	243	43	n.a.	n.a.								
D4. Hypervigilance	241	43	241	43.0								
D5. Exaggerated startle response	238	43	238	43								
PTSD Diagnosis	195	35 ¹	169	30 ¹	48	9	490	87	22	4	-1.66	.10

Note: PTSD = Posttraumatic Stress Disorder; n.a. = not applicable (indicates symptoms which are not included in the ICD-11 criteria); b = Different superscripts (1, 2) in the DSM-IV and ICD-11 columns indicate significant differences between adjoining proportions ($p < .01$).

Table 3. Proportion of war veterans ($N = 142$) meeting DSM-IV and proposed ICD-11 criteria for PTSD at discharge

	DSM-IV		ICD-11		Changes in diagnostic status under ICD-11 criteria						<i>Z</i>	<i>p</i> -value
	<i>n</i>	%	<i>n</i>	%	No longer present		Unchanged		Newly present			
					<i>n</i>	%	<i>n</i>	%	<i>n</i>	%		
Reexperiencing	91	64 ^{1,b}	82	58 ¹	9	6	133	94	0	0	1.09	<.27
Criterion B												
B1. Distressing recollections	73	51	n.a.	n.a.								
B2. Distressing dreams	77	54	77	54								
B3. Flashbacks	56	39	56	39								
B4. Psychological reactivity	54	38	n.a.	n.a.								
B5. Physiological reactivity	59	42	n.a.	n.a.								
Avoidance	67	47 ¹	88	62 ²	1	1	119	84	22	15	-2.50	.02
Criterion C												

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C1. Avoiding	82	58	82	58									
internal reminders													
C2. Avoiding	46	32	46	32									
external reminders													
C3. Specific	21	15	n.a.	n.a.									
amnesia													
C4. Diminished	46	32	n.a.	n.a.									
interest													
C5. Detachment	73	51	n.a.	n.a.									
C6. Restricted	50	35	n.a.	n.a.									
affect													
C7. Foreshortened	27	19	n.a.	n.a.									
future													
Hyperarousal	98	69 ¹	98	69 ¹	10	7	122	86	10	7	0	1.0	
Criterion D													
D1. Difficulty	79	56	n.a.	n.a.									
sleeping													
D2. Irritability	76	54	n.a.	n.a.									

D3. Difficulty concentrating	56	39	n.a.	n.a.								
D4. Hypervigilance	81	57	81	57								
D5. Exaggerated startle response	76	54	76	54								
PTSD Diagnosis	58	41 ¹	64	45 ¹	3	2	130	92	9	6	0.72	.47

Note: PTSD = Posttraumatic Stress Disorder; n.a. = not applicable (indicates symptoms which are not included in the ICD-11 criteria); b = Different superscripts (1, 2) in the DSM-IV and ICD-11 columns indicate significant differences between adjoining proportions ($p < .01$).

Table 4. Proportion of civilian war survivors with PTSD meeting criteria for comorbid depression or anxiety disorders.

	DSM-IV PTSD (<i>n</i> = 195)		ICD-11 PTSD (<i>n</i> = 169)		DSM-IV PTSD only (<i>n</i> = 48)		ICD-11 PTSD only (<i>n</i> = 22)		ICD-11 PTSD only vs. DSM-IV PTSD only		
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>OR</i>	[95% <i>CI</i>]	<i>p</i> -value
Major Depressive Episode (MDE)	102	52	84	50	21	44	3	14	0.2	[0.05, 0.78]	0.01
Panic Disorder without Agoraphobia	2	1	2	1	0	0	0	0	n.a.	n.a.	n.a.
Panic Disorder with Agoraphobia	12	6	13	8	1	2	2	9	4.7	[0.40, 54.84]	0.18
Agoraphobia	54	27	48	28	10	21	4	18	0.8	[0.23, 3.06]	0.80
Social Phobia	23	11	18	11	7	15	2	9	0.6	[0.11, 3.08]	0.52
Obsessive-Compulsive Disorder	7	4	8	5	1	2	2	9	4.7	[0.40, 54.83]	0.18
Generalized Anxiety Disorder	63	32	57	34	7	15	1	4	0.3	[0.03, 2.42]	0.22
MDE or an anxiety disorder	134	69	112	67	28	58	6	27	0.3	[0.09, 0.81]	0.02

Note: PTSD = Post-Traumatic Stress Disorder; DSM-IV PTSD or ICD-11 PTSD = individuals meeting criteria for PTSD according to DSM-IV or ICD-11 criteria, respectively; n.a. = not applicable. Odds Ratios (ORs) were conducted with individuals only meeting ICD criteria for PTSD, as compared to individuals only meeting DSM-IV criteria for PTSD.