Does Size really matter? A multisite study of competing diagnostic criteria

Hansen, Maj; Hyland, Philip; Karstoft, Karen-Inge; Bramsen, Rikke Holm; Vægter, Henrik Bjarke; Armour, Cherie; Sternhagen, Anni; Andersen, S. B.; Larsen, Simone; Hørbye, Mette; Andersen, Tonny Elmose

Publication date: 2017

Document version
Publisher's PDF, also known as Version of record

Citation for published version (APA):

General rights
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

• Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
• You may not further distribute the material or use it for any profit-making activity or commercial gain
• You may freely distribute the URL identifying the publication in the public portal?

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.
Introduction

Clinicians and researchers are becoming increasingly aware of the difficult decision that they are likely to be making within the next years; deciding between the use of two rather different descriptions of the posttraumatic stress disorder (PTSD) diagnosis. The Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5), which describes PTSD as a diagnosis comprised of 20 symptoms belonging to four symptom clusters, and the World Health Organization’s proposed 11th revision of the International Classification of Diseases (ICD-11) set for release in 2018 in which PTSD is comprised by only 6-7 symptoms belonging to three symptom clusters. Numerous studies have supported the latent structure of PTSD according to different models of the DSM-5 and the ICD-11 proposal. The few studies investigating the ICD-11 and the DSM-5 in the same populations appear to suggest that the ICD-11 model may result in better fit than the DSM-5 based models. At the same time, there is also a tendency for ICD-11 to produce lower estimated PTSD prevalence rates than the DSM-5 criteria, which may ultimately affect who is offered treatment. Of note, it is important to stress that there is a lack of studies investigating the latent structure of the ICD-11 and DSM-5 models in the same populations using adequate measurements of both the ICD-11 and the DSM-5 PTSD. At the same time, it is important to investigate this in different trauma populations as previous research suggests that differences in prevalence rates may only exist following specific types of traumatic exposure. The aim of the present study was to investigate the latent structure of different ICD-11 and DSM-5 models of PTSD in three different trauma populations and compare the estimated diagnostic rates of PTSD based on the DSM-5 and the ICD-11, respectively.

Method

Confirmatory factor analyses (CFA) were used to test DSM-5 and ICD-11 based models of PTSD symptoms (see table 1 and 2) across data from a total of 4,656 participants drawn from 3 Danish samples using the PTSD Checklist-5 and the ICD-11-TQ. Furthermore, differences in diagnostic rates based on the two systems were compared using the z-test, while Cohen’s kappa coefficient (κ) were used to measured the level of agreement in diagnosis between the ICD-11 and the DSM-5.

Results

The CFA results of the alternative models of the ICD-11 and the DSM-5 symptoms of PTSD are presented in Table 3 and 4.

Among the university sample, the DSM-5 (14.3%) generated significantly higher rates of PTSD compared to the ICD-11 (8.0%) (Z = 8.64, SE = .01, P < .001). Agreement between the two systems was moderate (Kappa = .60, SE = .02, P < .001). No statistically significant difference between rates of DSM-5 (16.4%) and ICD-11 (17.5%) PTSD was observed in the pain sample (Z = .50, SE = .02, P = .62). Despite there being no significant difference in diagnostic rates, agreement across systems was moderate (Kappa = .60, SE = .05, P < .001). Within the military sample, rates of PTSD according to DSM-5 (9.5%) were almost twice that of ICD-11 (5.5%), but the difference was not statistically significant (Z = 1.24, SE = .03, P = .107). Agreement between the two systems was moderate (Kappa = .68, SE = .13, P < .001).

Discussion

The CFA results indicated excellent fit of the ICD-11, whereas the DSM-5 model was amongst the poorest fitting of all models tested in each sample. In relation to the diagnostic rates the DSM-5 produced a significantly higher rate among the university students but not the pain patients or soldiers. However, the Kappa values were only moderate across all samples suggesting that there were still significant differences between who met the diagnostic criteria. Thus, the extant results are generally consistent with existing research. Of note, the present study only concerns PTSD and not more complex traumatic responses as dissociative PTSD (D-PTSD) or Complex PTSD (C-PTSD). Thus, in order to fully compare the two diagnostic systems, the entire diagnostic picture needs to be included.

Conclusion

Although, the results of the two diagnostic systems cannot be directly compared per se, the shortened ICD-11 PTSD model appears to provide a simpler and satisfactory description of PTSD responses compared to the DSM-5. However, in many ways the DSM-5 can be said to be a multidomain disorder, whereas the ICD-11 PTSD is clearly not. Thus, it is important that future studies of differences between ICD-11 and the DSM-5 also includes symptoms of C-PTSD and D-PTSD.