Attachment Disorders Across Cultures and Contexts

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From ICD10 to ICD11

The inclusion of disorders related to early relation disruption in stress related disorders:

- A shift associated with etiological assumptions
- The Category names are at mid course between phenomenology and etiology
- Associated with the emphasis on clinical utility among cultures and contexts?

Reactive attachment disorder

Previously: Reactive attachment disorder of childhood

- Minor changes
- « Markedly disturbed and developmentally inappropriate attachment behaviours, evident before five years of age…"
- In the context of pathogenic care

Zeanah and Gleason (2011)

Rutter, Kreppner and Sonuga – Borke (2009)

Disinhibited Social Engagement Disorder

Previously: Disinhibited attachment disorder of childhood

- Minor changes
- « … the child actively approaches and interacts with unfamiliar adults »
- In the context of pathogenic care

Zeanah and Gleason (2011)

Rutter, Kreppner and Sonuga-Borkes (2009)

Future direction (not to be included in ICD11)

- "Quasi-autism" following profound institutional deprivation
- Impairment in social reciprocity and presence of circumscribed interests
- Arises after profound institutional deprivation

Rutter and Sonuga-Borke (2010)

Hokshergen, Ter Leak, Rijk, Van Dijum and Stoujeskijk (2005)

(studies in Romanian orphanages/adoptees)

Context/culture related features: in stressors

- Primary caregiver or primary caregivers?

Models of attachment may vary among cultures (nuclear vs extended families among others)

- Profound deprivation: in institutions and elsewhere? (severely traumatized parents for example)
- Co-occurrence with malnutrition in low income countries? With exposure to toxics?

Research is needed to widen the assessment frame of the early relational stressors

Context/culture related features: in symptoms

- Cultural differences in markers of social reciprocity (eye contact, adult-child verbal interactions, physical indicators of care: hugging/kissing)
- Culturally sanctioned social boundaries vary widely (calling other adults, mama or aunty, physical proximity and so on)
- Contextual differences in markers of social reciprocity (i.e. Pol Pot camps and children mutism)

Clinical implications:

Shift of childhood disorders in stress related section puts emphasis on stressors

- Important to decrease misdiagnosis (PDD related)
- Important to emphasize a public health perspective on prevention
- Potential relation to stigma needs to be considered
- Temporal dimension (evolution in adulthood) needs more attention

Clinical implications:

- Context/culture related features are overall understudied
  - "not known" or no robust evidence?
  - Clinical/qualitative data should inform clinical guidelines to insure equity in representation of low-middle income countries
  - More research is needed
- Complex relations between extreme stressors and attachment at all ages.
  - Bidirectionality needs to be studied

Post-traumatic stress disorder: Proposals for ICD-11

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Disclaimer

The author is a member of the WHO Advisory Group on Stress-Related Disorders for ICD-11. The proposals to be discussed are currently out for public consultation. Any views expressed are not those of WHO or of the Advisory Group and do not in any way represent WHO policy.

Problems with DSM-IV

- No satisfactory definition of what PTSD ‘is’ has yet been established
- The 3 DSM-IV symptom clusters are not supported - avoidance and numbing are separate. These clusters do not belong to a higher-level entity (‘PTSD’)
- There is disagreement over the stressor criterion
- There are nearly 80,000 valid combinations of symptoms
- Comorbidity is extremely high
- Diagnosis is extremely complex, reducing clinical utility
- Controversies in applying diagnosis to cancer patients etc

The ICD-10 approach

- There is no formal stressor criterion, only guidelines allowing clinicians to use their own judgement
- There is a more explicit emphasis on reexperiencing, specifically “reexperiencing in intrusive memories (‘flashbacks’), dreams or nightmares”
- There is no impairment criterion

Also to note:

- The ICD-10 version of the diagnosis has been less influential in research
- Existing studies suggest it is more lenient than the DSM-IV diagnosis

Specific problems with ICD-10

- restriction to “events which are likely to cause pervasive distress in almost everyone”
- reference to ‘typical’ diagnostic features rather than clearly distinguishing the essence of the disorder, as is done for OCD, panic etc
- ‘intrusive memories’ are now known not to be the same as ‘flashbacks’
- importance of active avoidance insufficiently emphasised
- details about course of the disorder need updating

Proposals for ICD-11

- Update ICD-10 with recent findings, including importance of cultural variations and settings
- Make the core features of the disorder more explicit, so as to (a) simplify diagnosis, (b) reduce qualifying combinations of symptoms, (c) reduce comorbidity, (d) provide a meaningful contrast with DSM-5 by addressing some of its shortcomings, (e) facilitate scientific research
- Introduce impairment criterion to address possible over-leniency relative to DSM-IV and DSM-5

Proposed definition of PTSD

This disorder follows exposure to an extremely threatening or horrific event or series of events. It consists of 3 core elements: (a) Reexperiencing: vivid intrusive memories, flashbacks, or nightmares that involve reexperiencing in the present, accompanied by fear or horror; (b) Avoidance: marked internal avoidance of thoughts and memories or external avoidance of activities or situations reminiscent of the traumatic event(s); (c) Hyperarousal: a state of perceived current threat in the form of hypervigilance or an enhanced startle reaction. The symptoms must also last for several weeks and interfere with normal functioning.

Diagnostic guidelines

The disorder follows an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature (including, but not limited to: the *experiencing* of natural or man-made disaster; combat; serious accident; torture and other forms of ill-treatment; rape and other forms of sexual violence; terrorism, assault, or other crime; and acute life-threatening illness such as a heart attack; the *witnessing* in person of the threatened or actual injury or death of others in a sudden, unexpected, or violent context; the *confrontation with* the sudden, unexpected or violent death of a loved one. Sometimes there is a series of events that cumulatively lead to extreme threat of death or serious injury (such as being detained under harsh conditions, starvation, being stalked, or proximity to repeated bomb attacks), or to extreme horror (such as body-handling).

Diagnostic guidelines

The first core element is reexperiencing, in which the event(s) are not just remembered but are sensed as occurring again in the present. This typically occurs in the form of vivid intrusive images or memories (‘flashbacks’) accompanied by strong emotions and physical sensations. Flashbacks can vary from mild (there is a transient sense of the event occurring again in the present) to severe (there is a complete loss of awareness of present surroundings). Reexperiencing may also occur in repetitive dreams or nightmares that are thematically related to the traumatic event(s)

Diagnostic guidelines

The second core element is deliberate avoidance of reminders likely to produce reexperiencing of the traumatic event(s). This may take the form either of internal avoidance of relevant thoughts and memories, or external avoidance of people, conversations, activities, or situations reminiscent of the event(s). In extreme cases the person may change their environment (e.g. move house or job) to avoid reminders.

Diagnostic guidelines

The third core element is a perception of heightened current threat, as indicated by hypervigilance or an enhanced startle reaction to events such as unexpected noises. Hypervigilant persons constantly guard themselves against danger and feel themselves or close others to be under immediate threat either in specific situations or more generally. They may adopt new behaviors designed to ensure safety (e.g. only sit in certain places on trains, repeatedly check in vehicles' rear-view mirror).

Diagnostic guidelines

Other commonly-occurring symptoms are shared with other disorders and are not essential for diagnosis:

- Anxiety symptoms such as panic, obsessions, and compulsions
- Ruminative thoughts indicating preoccupation with the traumatic event(s)
- General dysphoria in the form of emotional blunting, anhedonia, lack of a perceived future, insomnia, irritability, and concentration problems
- Dissociative symptoms such as memory disturbances (e.g. dissociative amnesia) and pseudo-hallucinations (e.g. hearing own thoughts as voices)
- Suicidal ideation and behaviour
- Changes in interpersonal attitudes and behaviour including social withdrawal, suspicion, and distrust

Summary and contrast with DSM-5

Although guidance about what is a traumatic event is provided, this is left to clinicians' discretion (no formal Criterion A)

Definition is in terms of core elements rather than typical features

There are only 6 PTSD symptoms in all (2 reexperiencing, 2 avoidance, and 2 hyperarousal), resulting in 27 different combinations of qualifying symptoms

Although there are fewer symptoms, they are much more specific

There is no formal cutoff of 4 weeks, only a more general requirement that the symptoms last for "several weeks"

The impairment requirement brings PTSD more into line with DSM-5

The Clinical Utility of Complex PTSD

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Disclosures

Clinical Utility is the Organizing Principle in ICD Classification Development

Characteristics of a Diagnostic System with Clinical Utility

- Meta-structure Classification of Diagnoses
  - Consistent with clinicians mental health taxonomies
  - Based on distinctions important for management and treatment

- Diagnoses
  - Should be small in number
  - Limited number of symptoms (3-5)
  - No subtypes

Reed, 2010
Prof Psych Res Prac, 457-464

Characteristics of a *Diagnosis* with Clinical Utility

- Facilitates *communication* (among clinicians, patients, administrators)

- Has good implementation characteristics
  - goodness of fit (match to observable symptoms)
  - ease of use (limited time needed to use it)

- Useful in *selecting interventions* and making clinical management decisions

Reed, 2010
Prof Psych Res Prac, 457-464

Enduring Personality Change Associated with Catastrophic Events (EPCACE) F62.0

Following a catastrophic or excessive prolonged stress:

- Chronically feeling on edge, a sense of threat (fear activation)
- Hostile and mistrustful attitudes towards the world (relational)
- Social Withdrawal (relational)
- Estrangement: feeling different from others, out of the
- mainstream, unseen; rejected (self-relational)
- Feelings of emptiness and despair (self)
- *Symptoms must be present for at least two years*

Revision of Meta-Classification

- EPCACE removed from Personality Disorders section of ICD
- Included within the spectrum of Disorders Associated with Stress

Disorders of Stress Spectrum:

A continuum of chronicity of disorder and recalcitrance to treatment

- **Acute Stress Reaction**
- **Adjustment Disorder**
- **PTSD**
- **Prolonged Grief Disorder**
- **Enduring Changes**

Trait-like Characteristics

- Persistent across time
- Pervasive across different situations

ICD Personality Disorder: Disturbances in

- Affective
- Self
- Interpersonal

} Domains

Relationship to Classification Hierarchy

- **Rename EPCACE to "Complex PTSD"**
  - Pilot data (n=358) indicate that group scoring "yes" on the clinical cut-off for "chronic sense of threat" included nearly everyone with PTSD
  - Eliminate the "chronic threat" criterion and replace it with core PTSD spectrum symptoms (re-experiencing/avoidance/arousal)

- **Clarify role of prolonged or multiple traumas**
  - They are a **risk factor** not a requirement for Complex PTSD
  - This allows recognition of the influence of additional risk and protective factors at the individual level (genetic factors endowing either vulnerability or resilience) and the societal level (social support or disregard/stigma).

- **Define Complex PTSD by reference to symptoms:**

PTSD (core symptoms) are a prerequisite

PLUS

Symptoms representative in personality domain (persistent affective, self and interpersonal dysfunction)

PTSD and Complex PTSD in Classification Hierachy

05 F 00 "Gate" Criterion: Traumatic Stressor	
05 F 00 0 PTSD	05 F01 1 Complex PTSD
Re-experiencing	Rexperiencing
Avoidance	Avoidance
Hyperarousal	Hyperarousal
	Affect Dysregulation
	Negative Self Concept
	Interpersonal Disturbances

Complex PTSD: Proposed Revision of F62.0 EPCACE 4 Symptom Clusters

- **PTSD** core symptoms (replaces chronic feeling of threat)
- **Affect Dysregulation** – heightened emotional reactivity, violent outbursts, impulsive or reckless behaviors and dissociation (new)
- **"Defeated/Diminished" Self** marked by feeling diminished, defeated and worthless, feelings of shame, guilt, or despair (extends despair)
- **Disturbed Relationships** marked by difficulties in feeling close to others, having little interest in relationships or social engagement more generally. There may be occasional relationships but the person has difficulty sustaining them. (combines and extends detachment and social withdrawal)

ICD-11 Complex PTSD

Following the stressor and co-occurring with the PTSD symptoms, the development of persistent and pervasive impairments in affective, self, interpersonal and relational functioning including:

- **Affect problems** characterized by heightened emotional reaction to minor stressors, violent outbursts, reckless or self destructive behavior and tendency toward dissociative states when under stress. In addition, there may be emotional numbing, particularly a lack of ability to experience pleasure or positive emotions.

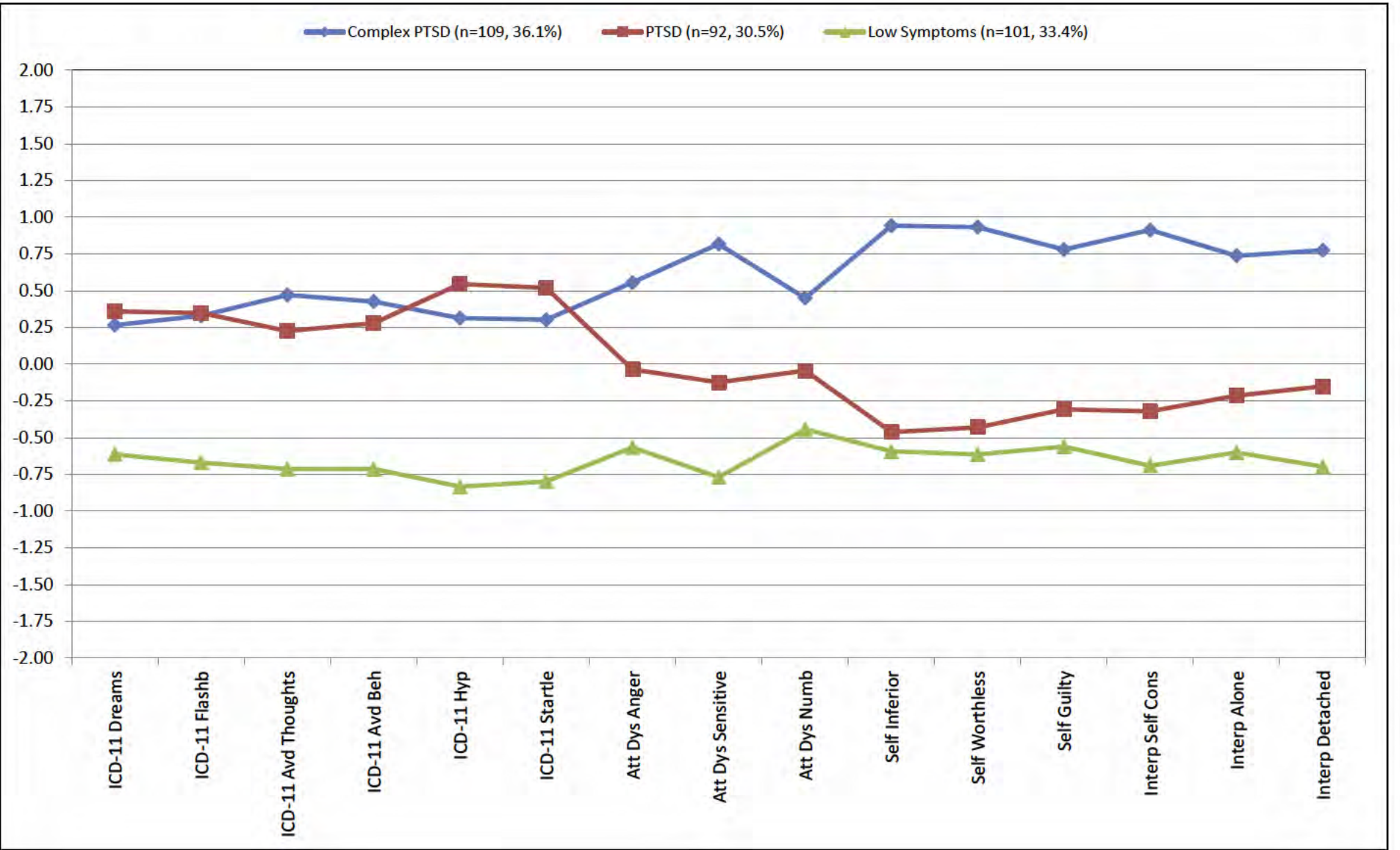
- **A disturbed sense of self**. The individuals also develops persistent beliefs about himself or herself as diminished, defeated or worthless accompanied by deep and pervasive feelings of shame, guilt or failure related to, for example, not having escaped from or succumbing to the adverse circumstance, or not having been able to prevent the suffering of others.

- There are also **persistent difficulties in sustaining relationships.** This may present in a variety of ways and is characterized primarily by difficulties in feeling close to others. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally. Alternatively there may be occasional intense relationships but the person has difficulty sustaining them.

Items selected for LPA based on Face Validity and EFA: 4 Symptom Clusters

Construct	Item	Content
ICD-11 PTSD	PSS-SR2	Nightmares
	PSS-SR3	Flashbacks
	PSS-SR5	Avoid thoughts
	PSS-SR6	Avoid people places activities
	PSS-SR15	Hypervigilance
	PSS-SR16	Startle
Emotion Regulation Problems	BSI20	Feelings easily hurt
	BSI13	Uncontrollable outbursts of anger
	BSI33	Numbness
Negative Self-Concept	BSI22	Feeling inferior to others
	BSI50	Feelings of worthlessness
	BSI52	Feelings of guilt
Interpersonal Problems	BSI42	Very self-conscious with others
	BSI44	Never feeling close to others
	PSS-SR9	Feelings of detachment

Pilot data distinguishing PTSD and Complex PTSD: NYC Trauma Sample (n=302)



Characteristics of the Classes

Characteristics	Class 1 Complex PTSD	Class 2 PTSD	Class 3 Low Symptoms	Significance test
Female	91.2%	90.2%	85.15	ns
Ethnicity (% white)	47.7%	53.9%	85.1%	ns
Employment(full or part-time)	62%	62%	67%	ns
9/11 Tx Seeking	27%	44%	40%	p = .03
Any Childhood IPV	88%	81%	75%	NS
Childhood IPV Total (4 possible events)	1.48 (.82)	1.27 (.84)	1.17 (.86)	p = .04
ICD-11 PTSD total 6 items (0-4)	14.61	14.84	5.57	P < .01 1 ,2 > 3
Affect Dysregulation 3 items (0-4)	7.13 (2.32)	4.28 (2.22)	2.08 (1.75)	P < .01 1 > 2 ,3 ; 2> 3
Self-Concept 3 items (0-4)	9.30 (2.19)	3.60 (2.18)	2.75 (2.53)	p < .01 1 > 2 ,3 ; 2 > 3
Interpersonal Problems 3 items (0-4)	9.27 (2.08)	4.89 (2.32)	3.08 (2.12)	p < .01 1 > 2 ,3; 2>3
Functional Impairment (SAS-SR)	2.77 (.48)	2.34 (.39)	2.13 (.36)	p < .01 1 > 2 ,3; 2>3

Is Chronic Sustained Trauma a Risk Factor for Complex PTSD? Yes

Logistic Regression (outcome = Complex PTSD vs. not)

	Beta	STD Error	Wald Chi-square	Odd Ratio	Odds Ratio (95% CI)	p
Childhood IPV (yes/no)	0.359	0.173	4.313	2.05	1.04 - 4.04	.038

Is Adult Onset Trauma a risk factor for Complex PTSD? No

Logistic Regression: Outcome = Complex PTSD vs. PTSD

	Beta	STD Error	Wald Chi-square	Odd Ratio	Odds Ratio (95% CI)	p
9/11 as "worst trauma"	-0.42	0.199	4.49	0.43	0.20 - .94	.034

Do the Complex PTSD Symptom Clusters Contribute to Functional Impairment (SAS-SR) (n=309)

Variables	Standardized Beta	t	P-value
Gender	-.072	-1.5	.13
Age	.113	2.35	.02
PTSD Sx	.124	2.17	.03
Affect Dysregulation	.15	2.21	.03
Self-Concept	.17	2.58	.01
Interpersonal Disturbances	.30	4.14	<.01
Final Model: $F(4, 277) = 30.84$, $p < .01$; $R^2 = .402$ $p < .01$			

Summary on ICD-11 Complex PTSD

- Intuitively placed in meta-categorization scheme as "sibling" to PTSD
- Types of symptoms conceptually, intuitively organized
- Number of symptoms limited
- Different classes of patients identified
- Different antecedents (type of trauma hx as risk factor)
- Different levels of functional impairment
- Different treatment duration ?
- Different types of interventions ?

Next Steps: Testing Clinical Utility

- Are CPTSD and PTSD easy to distinguish from one another ?
- Are the symptoms easy to communicate?
- Is the CPTSD diagnosis easy to implement?
- Does the diagnosis have value in guiding treatment and prognosis?