

## **Title**

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

## **Brief Title**

Risk factors and comorbidity of PTSD and CPTSD

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## Abstract

**Background:** Following the recently published 11<sup>th</sup> version of the WHO International Classification of Diseases (ICD-11), we sought to examine the risk factors and comorbidities associated with posttraumatic stress disorder (PTSD) and Complex PTSD (CPTSD).

**Method:** Cross-sectional and retrospective design. The sample consisted of 1051 trauma-exposed participants from a nationally representative panel of the UK adult population.

**Results:** 5.3% (95% 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 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 (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, co-morbid, debilitating condition compared PTSD. Further research is now required to identify effective interventions for its treatment.

**Keywords:** ICD 11 PTSD, CPTSD, risk factors, comorbidities

## **Introduction**

In 2018, the World Health Organization published the 11<sup>th</sup> version of the *International Classification of Diseases* (ICD-11); the official diagnostic system used worldwide. Substantial revisions were made to the trauma-related diagnoses in ICD-11 that are located within the parent category of ‘Disorders Specifically Associated with Stress’. The symptom profile and diagnostic requirements for Posttraumatic Stress Disorder (PTSD) were narrowed relative to the ICD-10 and the fifth edition of the Diagnostic and Statistical Manual (DSM-5: American Psychiatric Association [APA], 2013), and Complex PTSD (CPTSD) was introduced to the diagnostic nomenclature for the first time (see Table 1; Maercker et al., 2013). A multi-national field survey found that clinicians demonstrated accuracy in differential diagnoses between PTSD and CPTSD formulations (Keeley et al., 2016), and a review of the extant research indicated support for the construct validity of PTSD and CPTSD (Brewin et al., 2017).

CPTSD has been shown to occur more frequently following exposure to traumatic events that are of an interpersonal nature, that are difficult or impossible to escape from, and particularly when occurring during early development (e.g., childhood sexual abuse, torture, captivity; see Karatzias et al., 2018a). CPTSD is also a more impairing condition than PTSD (Karatzias et al., 2017) and may require enhanced interventions which are quantitatively and qualitatively different to those currently offered for PTSD (Karatzias et al., 2018b). Little is currently known about the risk factors that differentiate PTSD and CPTSD following traumatic exposure, or, how frequently other mental and physical health disorders co-occur with PTSD and CPTSD. Emerging evidence, primarily drawn from clinical samples, suggests that childhood sexual abuse, negative trauma-related cognitions, distress intolerance, and unemployment status are associated with an increased risk of CPTSD (Hyland et al., 2017; Hyland et al., 2018). Furthermore, CPTSD is more strongly associated with symptoms of

depression, anxiety, borderline personality disorder, and suicidality than PTSD (Hyland et al., 2018). Identifying risk factors and comorbidities associated with these disorders has important implications for diagnosis and subsequent treatment, as well as for prevention and early intervention. If clinicians know who is more likely to be adversely affected by a particular disorder following traumatic exposure, they can monitor individuals with a view to providing interventions before their problems become chronic. Especially in the case of CPTSD, an understanding of the risk factors will contribute to the development of theoretical models to explain its onset and course, which could ultimately lead to more focused interventions and better treatment outcomes.

#### TABLE 1 HERE

With this in mind, the current study was undertaken to: (a) identify demographic (gender, age, urbanicity, history of emigration, relationship status, number of children, employment status, and education status) and trauma-related (time passed since traumatic exposure, childhood non-interpersonal trauma, childhood interpersonal trauma, adulthood non-interpersonal trauma, and adulthood interpersonal trauma) risk factors associated with PTSD and CPTSD diagnosis; and (b) determine the comorbidity rates for PTSD and CPTSD with Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), Alcohol Use Disorder (AUD), suicidality, and the presence of a chronic illness. Based on the existing literature of the risk factors for ICD-11 PTSD and CPTSD, as well as the wider trauma literature, we expected that PTSD would be associated with being female (Tolin & Foa, 2006) and that CPTSD would be associated with exposure to an increased number interpersonal trauma types during childhood (Hyland et al., 2017). Although not yet examined in relation to ICD-11 PTSD and CPTSD, urban residence has been shown to increase the risk for multiple psychiatric disorders including mood and anxiety disorders independent of other covariates (Peen, Schoevers, Beekman, & Dekker, 2010), therefore, we

expected that growing up in an urban area would be associated with an increased risk for both PTSD and CPTSD. Finally, based on data from clinical (Hyland et al., 2018) and internally displaced (Shevlin et al., 2018) samples, we expected that PTSD and CPTSD would be highly comorbid with the other psychiatric disorders measured in this study.

## **2 Methods**

### ***2.1 Participants and procedures***

A trauma-exposed adult sample of the United Kingdom (UK) population was used in the current study. Sample participants were drawn from an existing online research panel that was representative of the UK adult population. Panel members were randomly recruited through probability-based sampling. Inclusion criteria for the current sample were that respondents were (a) born in the UK, (b) aged 18 years or older at the time of the survey, and (c) screened positive for at least one traumatic event in their lifetime (assessed using the Life Events Checklist, described below). Ethical approval was granted by the Research Ethics Committee of the institution to which the second author was affiliated at the time of the survey. No inducements or incentives were offered for participation. In total, 2,653 panel members were contacted, and 1,051 people qualified for inclusion on the basis of meeting the inclusion criteria (selection rate = 39.6%).

The mean age of the sample was 47.18 years ( $SD = 15.00$ , range = 18-90 years), and 68.4% ( $n = 719$ ) of participants were female. The majority of respondents indicated that they did not grow up in an urban area (54.7%,  $n = 574$ ), had not emigrated in their lifetime (82.2%,  $n = 864$ ), were currently in a committed relationship (70.4%,  $n = 740$ ), did not have any children under the age of 16 years (67.5%,  $n = 709$ ), were in full- or part-time employment (58.5%,  $n = 615$ ), and had completed a college or university education (62.7%,  $n = 659$ ).

## 2.2. Measures

**2.2.1 Traumatic Exposure:** A revised version of the Life Events Checklist for DSM-5 (LEC; Weathers et al., 2013) was used to assess for childhood (“before the age of 18”) and adulthood (“at or after the age of 18”) exposure to 16 different traumatic events. Participants indicated on a ‘Yes’ (1) or ‘No’ (0) basis if they had directly experienced each traumatic event during both developmental periods. Following Ehring and Quack’s (2010) approach, we calculated summed scores for non-interpersonal trauma (natural disaster, fire or explosion, transportation accident, serious accident at work or home or during recreational activity, exposure to toxic substance, life-threatening illness or injury, severe human suffering, sudden and violent death, sudden and unexpected death of someone close to you) and interpersonal trauma (physical assault, assault with a weapon, sexual assault, other unwanted or uncomfortable sexual experiences, combat or exposure to a war-zone, captivity, serious injury and/or harm and/or death you caused to someone else) in childhood and adulthood. Scores for non-interpersonal trauma (in childhood and in adulthood) ranged from 0-9, and scores for interpersonal trauma (in childhood and in adulthood) ranged from 0-7.

**2.2.2 ICD-11 PTSD and CPTSD:** The *International Trauma Questionnaire* (ITQ; Cloitre et al., 2018) is a self-report measure of ICD-11 PTSD and CPTSD. The ITQ assess the respondent’s most distressing traumatic event and the time passed since the trauma occurred (response options: < 6 months ago, 6-12 months ago, 1-5 years ago, 5-10 years ago, 10 to 20 years ago, and > 20 years ago). The ITQ contains 12 items measuring the six PTSD ( $\alpha = .91$ ) and six Disturbances in Self-Organisation (DSO) symptoms ( $\alpha = .92$ ). There are three items measuring functional impairment (in the domains of social-life, work-life, and other important areas of life) associated with both sets of symptoms. Individuals respond to the PTSD items in terms of how much they have been bothered by each symptom over the past month, and respond to the DSO items in terms of how they typically feel, think about

themselves, and relate to others. All items are measured using a five-point Likert scale ranging from 0 (“Not at all”) to 4 (“Extremely”). Diagnostic requirements are presented in Table 1, and a symptom was considered present based on a score of  $\geq 2$  (“Moderately”). Importantly, the ICD-11 diagnostic rules only permit a diagnosis of PTSD or CPTSD, not both. The psychometric properties of the ITQ, and the diagnostic rates of PTSD and CPTSD, were demonstrated in a prior study based on this exact sample (Cloitre et al., 2018). The diagnostic rates are presented below in the results section.

**2.2.3 Major Depressive Disorder (MDD):** The Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is a nine-item, self-report measure of MDD that aligns to the diagnostic criteria of the DSM-5 (APA, 2013). Individuals are instructed to respond to each item in terms of how much they have been bothered by that symptom over the past two weeks using a four-point Likert scale ranging from 0 (“Not at all”) to 3 (“Nearly every day”). The PHQ-9 has demonstrated strong psychometric properties (Manea, Gilbody & McMillan, 2015) and the internal reliability among the current sample was excellent ( $\alpha = .94$ ). Scores range from 0 to 27 and scores  $\geq 10$  are indicative of a diagnosis of MDD (Kroenke et al., 2009).

**2.2.4 Generalized Anxiety Disorder (GAD):** The Generalized Anxiety Disorder 7-Item Scale (GAD-7; Spitzer, Kroenke, Williams & Lowe 2006) is a seven-item, self-report measure of GAD. Individuals are instructed to respond to each item in terms of how much they have been bothered by each symptom over the past two weeks using a four-point Likert scale ranging from 0 (“Not at all”) to 3 (“Nearly every day”). The GAD-7 has demonstrated good psychometric properties (Kertz, Bigda-Peyton & Bjorgvinsson, 2013) and the internal reliability among the current sample was excellent ( $\alpha = .95$ ). Scores range from 0 to 21 and scores  $\geq 10$  are indicative of a diagnosis of GAD (Spitzer et al., 2006).

**2.2.5 Alcohol Use Disorder (AUD):** The presence of an AUD was measured using the AUDIT-C, a brief self-report measure comprised of the first three questions of the *Alcohol Use Disorders Identification Test* (Saunders, Aasland, Babor & de la Fuente, 1993). The clinical utility of the AUDIT-C has been demonstrated in multiple sample including the general population (Nayak, Bond, Cherpitel, Patel & Greenfield 2009), military veterans (Bradley et al., 2003), and hospitalised patients (Kelly, Donovan, Chung, Bukstein & Cornelius 2009). Scores on the AUDIT-C range from 0-12, and based on a nationally representative sample of adults from the United States, scores  $\geq$  four effectively capture a DSM-5 diagnosis of AUD (Dawson, Smith, Saha, Rubinsky, & Grant 2012).

**2.2.6 Suicidality / Self-harm:** Suicidality was measured using two items taken from a self-report measure of Borderline Personality Disorder symptoms. These questions asked respondents: “*Have you tried to hurt or kill yourself or threatened to do so?*” and “*Have you ever cut, burned, or scratched yourself on purpose?*” These items were responded to using a ‘Yes’ (1) or ‘No’ (0) response format. A person was deemed to screen positive for lifetime suicidality if they answered ‘Yes’ to either question.

**2.2.7 Chronic Illness:** The presence of a chronic illness was assessed using the first item of the Charlson Comorbidity Index (Charlson, Pompei, Ales & MacKenzie, 1987). This item asks the respondent “*Do you suffer from any chronic illness?*” using a ‘Yes’ (1) or ‘No’ (0) response scale. Respondents are subsequently asked to indicate the specific type of chronic illness they have been diagnosed with.

### **2.3 Data Analysis**

Hierarchical binary logistic regression analysis was used to examine the associations between each risk factor and meeting diagnostic criteria for PTSD and CPTSD, respectively. Eight demographic variables were entered into the model at step 1 and these were: sex (0 = Male, 1 = Female), age (measured years), having grown up in an urban area (0 = No, 1 =

Yes), history of emigration (0 = No, 1 = Yes), relationship status (0 = Not in a committed relationship, 1 = In a committed relationship), number of children under the age of 16, employment status (0 = Employed, 1 = Unemployed), and attendance of college/university (0 = No, 1 = Yes). Five trauma-related variables were entered into the model at step 2 and these included: the time passed since trauma (1. < 6 months ago, 2. 6-12 months ago, 3. 1-5 years ago, 4. 5-10 years ago, 5. 10 to 20 years ago, 6. > 20 years ago), childhood non-interpersonal trauma, childhood interpersonal trauma, adulthood non-interpersonal trauma, and adulthood interpersonal trauma. The comorbidity rates for PTSD and CPTSD with MDD, GAD, AUD, suicidality, and chronic illness were evaluated using the Pearson chi-square tests. There was very little missing data present (0.19%) and the default listwise deletion method in SPSS was used in all analyses.

### **3. Results**

#### ***3.1 Life events and common mental health problems***

The most common traumatic event in childhood was physical assault (32.4%, n = 340) and the most common traumatic event in adulthood was the sudden and unexpected death of a loved one (47.4%, n = 498). The sudden and unexpected death of a loved one was most commonly reported as the 'most distressing traumatic event' (29.4%, n = 309). With respect to the time passed since the trauma, the most common response was 'more than 20 years ago' (40.1%, n = 421). The mean number of childhood non-interpersonal trauma types was .84 (SD = 1.31, range = 0-9) and the mean number of childhood interpersonal trauma types was also .84 (SD = 1.20, range = 0-7). The mean number of adulthood non-interpersonal trauma types was 1.43 (SD = 1.49, range = 0-9), and the mean number of adulthood interpersonal trauma types was .82 (SD = 1.27, range 0-7). Bivariate correlations between the different types of trauma were all statistically significant ( $p < .001$ ) and ranged

from .26 (between childhood interpersonal trauma and adulthood non-interpersonal trauma) to .52 (between childhood interpersonal trauma and childhood non-interpersonal trauma).

As reported in Cloitre et al. (2018), the PTSD diagnostic criteria were met by 56 respondents (5.3% [95% CI = 4.0% - 6.7%]) and the CPTSD diagnostic criteria were met by 136 respondents (12.9% [95% CI = 10.9% - 15.0%]). Furthermore, based on the recommended cut-off scores of  $\geq 10$  for the PHQ-9 and GAD-7, respectively, 368 respondents (35% [95% CI = 32.1% - 37.9%]) had a probable MDD diagnosis and 300 (28.5% [95% CI = 25.8% - 31.3%]) had a probable GAD diagnosis. Additionally, 353 (33.6% [95% CI = 30.7% - 36.4%]) participants had a probable AUD diagnosis based on the recommended cut-off score of  $\geq 4$  for the AUDIT-C, 329 (31.3% [95% CI = 28.5% - 34.1%]) reported a history of suicidality, and 322 (30.6% [95% CI = 27.8% - 33.4%]) reported having been diagnosed with a chronic illness.

### ***3.2 Risk factors for PTSD and CPTSD***

The results of the two binary logistic regression analyses for PTSD and CPTSD are presented in Table 2. In the case of meeting diagnostic criteria for PTSD, step 1 of the model (which included the demographic variables) was statistically significant ( $\chi^2(8) = 23.03, p = .003$ ), and growing up in an urban area (OR = 2.02) and being in a committed relationship (OR = 2.30) were significantly associated with PTSD. The trauma variables were entered at step 2 and did not significantly improve the model ( $\chi^2(5) = 5.68, p = .339$ ). The full model was statistically significant ( $\chi^2(13) = 28.71, p = .007$ ) and, when adjusting for all demographic and trauma factors, four variables were significantly associated with a diagnosis of PTSD: being female (OR = 2.08), having grown up in an urban area (OR = 2.05), being in a committed relationship (OR = 2.30) and less time having passed since trauma (OR = .81).

TABLE 2 HERE

In the case of meeting diagnostic criteria for CPTSD, step 1 of the model was statistically significant ( $\chi^2(8) = 65.52, p < .001$ ), and age (OR = .96), growing up in an urban area (OR = 1.96), and having emigrated (OR = 1.62) were significantly associated with CPTSD. The inclusion of the trauma variables at step 2 significantly improved the model ( $\chi^2(5) = 67.70, p < .001$ ), and the model as a whole was significant:  $\chi^2(13) = 133.25, p < .001$ . When adjusting for all demographic and trauma factors, four variables were significantly associated with a diagnosis of CPTSD: younger age (OR = .97), growing up in an urban area (OR = 1.72), childhood interpersonal trauma (OR = 1.52), and adulthood interpersonal trauma (OR = 1.20).

### **3.3 ICD-11 PTSD and CPTSD comorbidities**

The comorbidities for PTSD ranged from a low of 30.4% with GAD to a high of 60.0% with AUD (see Table 3). Meeting criteria for PTSD was significantly (all  $ps < .05$ ) associated with an increased likelihood of having a probable MDD diagnosis (OR = 1.79), a chronic illness (OR = 1.90), an AUD (OR = 2.04), and a history of suicidality (OR = 3.13). The comorbidities for CPTSD ranged from a low of 45.6% with chronic illness to 89.0% with MDD. Meeting criteria for CPTSD significantly increased the likelihood of having every other condition (all  $ps < .01$ ) including being approximately 25 times more likely to have a probable MDD diagnosis and being 22 times more likely to have a probable GAD diagnosis. The associations between CPTSD and AUD, suicidality, and chronic illness, respectively, were of a similar magnitude to those observed for PTSD.

TABLE 3 HERE

## **4. Discussion**

### **4.1 Main findings**

Our results showed that physical abuse and the unexpected death of a loved one were the most common traumatic events during childhood and adulthood, respectively. We also

found that PTSD was independently associated with being female, being in a committed relationship, and less time having passed since traumatic exposure. In contrast, CPTSD was independently associated with younger age, having experienced a higher number of different childhood interpersonal traumas, and having experienced a higher number of different adulthood interpersonal traumas. A shared risk factor associated with PTSD and CPTSD was growing up in an urban environment. High rates of comorbidity were observed for PTSD and CPTSD however in the cases of MDD and GAD, CPTSD was substantially more strongly associated with these disorders than was PTSD. Presence of PTSD and CPTSD increased the likelihood of suicidality by more than three times, and an AUD and a chronic illness by approximately two times.

#### ***4.2 Comparison with other studies***

In this trauma-exposed community sample of the UK population, we found that CPTSD was a more common diagnosis than PTSD. This is in contrast to findings from a nationally representative sample of the Israeli population that reported higher rates of PTSD (9.0%) than CPTSD (2.6%) (Ben-Ezra et al., 2018), and findings from a nationally representative sample of the United States population that reported similar rates of PTSD (3.4%) and CPTSD (3.8%) (Cloitre et al., in press). It is probable that the trauma-exposed inclusion criteria used in this study selected for more distressed members of the general population. Consequently, while prior studies suggest that PTSD may be as or more common than CPTSD in the general population, the current findings suggest that CPTSD may be the more common diagnosis among members of the general population that are trauma-exposed. This is an important discovery given the 70% of the world's population has experienced at least one traumatic life event (Benjet et al., 2016).

Our findings regarding the risk factors for PTSD and CPTSD are generally consistent with much of the theoretical and empirical psychotrauma literature. In the current study, females were twice as likely as males to experience PTSD and this aligns with a substantial body of evidence relating to DSM-based models of PTSD (Tolin & Foa 2006). Such differences have been predominantly attributed to biological factors (e.g., hormonal factors; Kajantie & Phillips, 2006). The same applies for the observed association between less time having passed since traumatic exposure and the increased risk for PTSD. This association has been explained in terms of increased amygdala activity in the aftermath of traumatic exposure and thus an increased risk for fear-based responses (Ganzel, Casey, Glover, Voss & Temple, 2007).

Consistent with theoretical models of CPTSD (Cloitre, Garvert, Brewin, Bryant & Maercker, 2013), and findings from clinical (Karatzias et al., 2017, Hyland et al., 2018) and general population (Cloitre et al., in press) samples, we showed that interpersonal trauma is an independent risk-factor for CPTSD. Interpersonal trauma exposure, particularly in childhood, tends to be more toxic with regard to its effects on health and well-being predominantly because it compromises a child's ability to successfully master certain developmental tasks (e.g., affect regulation, secure attachments; Cicchetti & Toth, 1995). Interpersonal trauma also compromises the development of neurobiological systems involved in regulating arousal, emotion, stress responses, and reward processing (McLaughlin, Fox, Zeanah, & Nelson, 2011), which are all related to the development of traumatic stress. Current findings are also in-line with the broader scientific literature, which indicates that urban dwelling increases risk of multiple forms of psychiatric diagnoses, particularly those characterised by anxiety and mood problems (Peen, Schoevers, Beekam & Dekker, 2010). Possible explanations for this effect include differences in social support, stressful life events, and familial liability (Peen & Decker, 2004).

### ***4.3 Strengths and limitations of the study***

A notable strength of the current study is that it is the first to empirically assess the risk factors and comorbidities associated with the ICD-11 diagnoses of PTSD and CPTSD in a community sample of trauma-exposed adults. Nonetheless, there were several limitations. The community sample was drawn from a nationally representative panel, however, it cannot be ensured that the trauma-exposed participant sample itself was nationally representative, especially considering the high levels of comorbidities reported. Second, diagnoses were based on self-report measures rather than clinician-administered interviews and should therefore be interpreted cautiously. Third, the current study did not include children or adolescents, therefore, it is unknown if the current findings are relevant for younger persons exposed to trauma. However, it is important to highlight that many reported exposure to trauma as a younger person. Finally, the sample in the present study was the same as in Cloitre et al. (2018) although in the study by Cloitre et al. (2018), a more extended version of the ITQ was used.

### ***4.4 Implications for clinicians and future research***

Clinicians should be acutely aware of the symptom profiles of ICD-11 PTSD and CPTSD, and consider a diagnosis of CPTSD to be especially pertinent in cases where there is a history of interpersonal trauma (in childhood or in adulthood). It is critical that clinicians are cognizant of, and accurately diagnose, CPTSD given that it is (a) so highly comorbid with a range of life-threatening conditions, and (b) may require enhanced interventions distinct from those currently offered for PTSD (Karatzias et al., 2018b). Work is ongoing to test the efficacy and acceptability of specific clinical interventions for CPTSD (Karatzias et al., 2018b) however, accurate recognition of CPTSD in general practice, and referral for appropriate interventions, will facilitate recovery from the deleterious effects of CPTSD.

### **Declaration of Interest**

Marylène Cloitre participated as member of the World Health Organization Working Group on the Classification of Disorders Specifically Associated with Stress, reporting to the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. However, the views expressed reflect the opinions of the authors and not necessarily the Working Group or Advisory Group and the content of this article does not represent WHO policy.

### **Author Contribution**

TK and PH conceptualized the manuscript. MS, PH, AB conducted the statistical analysis and wrote the first draft of the manuscript. All authors contributed to and have approved the final manuscript.

### **Data Sharing**

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Table 1.

Symptom and diagnostic profile for ICD-11 PTSD and CPTSD.

<b>PTSD</b>	<b>CPTSD</b>
Traumatic exposure (required)	All PTSD diagnostic requirements necessary and disturbances in self organisation (DSO)
<b>Re-experiencing in the here and now (1 of 2 required)</b>	<b>Affective dysregulation (1 of 2 required)</b>
1. Upsetting dreams	7. Emotional reactivity
2. Flashbacks	8. Emotional numbing
<b>Avoidance of traumatic reminders (1 of 2 required)</b>	<b>Negative self-concept (1 of 2 required)</b>
3. Internal reminders	9. Failure
4. External reminders	10. Worthless
<b>Sense of threat (1 of 2 required)</b>	<b>Disturbances in relationships (1 of 2 required)</b>
5. Vigilance	11. Cut-off from people
6. Hyperarousal	12. Hard to stay close to others
Functional impairment associated with these symptoms (required)	Functional impairment associated with these symptoms (required)

Table 2.

Hierarchical binary logistic regression models for PTSD and CPTSD diagnosis.

	ICD-11 PTSD	ICD-11 CPTSD
	OR (95% CI)	OR (95% CI)
<b>Step 1</b>		
Sex (female)	2.02 (.97, 4.20)	.74 (.49, 1.14)
Age	.99 (.97, 1.01)	.96 (.94, .97)***
Grew up in an urban area	2.02 (1.15, 3.58)*	1.96 (1.34, 2.88)**
History of emigration	1.22 (.61, 2.45)	1.62 (1.03, 2.54)*
In a relationship	2.30 (1.05, 5.02)*	.92 (.60, 1.42)
Number of children	1.14 (.87, 1.49)	1.07 (.88, 1.29)
Unemployed	.98 (.55, 1.74)	1.37 (.93, 2.02)
University education	1.17 (.64, 2.15)	.79 (.53, 1.17)
<b>Step 2</b>		
Sex (female)	2.08 (.99, 4.36)*	.88 (.55, 1.40)
Age	1.00 (.97, 1.02)	.97 (.95, .98)***
Grew up in an urban area	2.05 (1.15, 3.64)*	1.72 (1.15, 2.58)**
History of emigration	1.16 (.56, 2.40)	1.02 (.61, 1.70)
In a relationship	2.30 (1.05, 5.03)*	.93 (.60, 1.45)
Number of children	1.12 (.85, 1.48)	.92 (.74, 1.14)
Unemployed	.98 (.55, 1.77)	1.39 (.92, 2.10)
University education	1.21 (.65, 2.23)	.94 (.61, 1.44)
Time since trauma	.81 (.66, 1.00)*	.92 (.79, 1.07)
Childhood non-interpersonal trauma	.88 (.67, 1.15)	1.03 (.86, 1.22)
Childhood interpersonal trauma	1.04 (.78, 1.39)	1.52 (1.27, 1.83)***
Adult non-interpersonal trauma	1.05 (.83, 1.32)	1.08 (.92, 1.26)
Adult interpersonal trauma	1.07 (.82, 1.39)	1.20 (1.01, 1.43)*

Note: N = 1049; OR (95% CI) = Odds Ratio with 95% confidence intervals; \* p < .05, \*\* p < .01, \*\*\* p < .001.

Table 3.

Proportion of those with PTSD and CPTSD meeting probable diagnosis for other disorders.

	% with MDD	% with GAD	% with AUD	% with Suicidality	% with Chronic Illness
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
PTSD	48.2%	30.4%	60.0%	57.1%	44.6%
	1.79 (1.04 – 3.07)*	1.10 (0.61 – 1.97)	2.04 (1.02 – 4.08)*	3.13 (1.81 – 5.41)***	1.90 (1.10 – 3.27)*
CPTSD	89.0%	86.0%	58.8%	56.6%	45.6%
	21.82 (12.51 – 38.04)***	24.63 (14.77 – 41.07)***	2.07 (1.36 – 3.15)**	3.43 (2.37 – 4.70)***	2.11 (1.46 – 3.05)***

Note: PTSD = Posttraumatic stress disorder; CPTSD = Complex PTSD; MDD = Major depressive disorder; GAD = Generalized anxiety disorder; AUD = Alcohol use disorder; OR (95% CI) = Odds ratio (95% confidence intervals); statistical significance = \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$ .