Reflections on PTSD’s future in DSM–V

Gerald M. Rosen, Scott O. Lilienfeld, B. Christopher Frueh, Paul R. McHugh and Robert L. Spitzer

Summary

Research findings have fuelled debate on the construct validity of post-traumatic stress disorder (PTSD). Accompanying these issues are competing suggestions to redefine PTSD’s criteria, including a recent proposal by DSM–V committee members. We review various approaches to revising the PTSD diagnosis and conclude that proposed changes should be placed in the appendix that the DSM has used for experimental criteria sets.

Declaration of interest

None.

PTSD and DSM–V

The current state of affairs surrounding PTSD is reflected in conflicting proposals for how the syndrome should be operationalised in the forthcoming and fifth edition of the DSM (DSM–V), due for publication in 2013. Proposals for how to distinguish traumatic events (Criterion A) from more ordinary stressors have included encouragements to better adhere to current definitions, modifications to current wording, and the radical suggestion that Criterion A should be eliminated entirely. It is instructive to recall that the PTSD clinical syndrome was first operationalised in DSM–III by only 12 symptoms, grouped into four clusters (intrusion, avoidance, negative affect, hyperarousal). A more sweeping alternative suggests that PTSD often results from emotions such as anger, guilt and shame, and therefore is not a sui generis construct in the DSM with regard to the expansion of diagnostic criteria. The current proposal for DSM–V, in which 21 symptoms are provided a listing of 21 possible symptoms and signs, grouped into four (rather than the current three) clusters (intrusion symptoms, avoidance, negative affect, hyperarousal). A more sweeping alternative suggests that PTSD often results from emotions such as anger, guilt and shame, and therefore is not a sui generis construct in the DSM with regard to the expansion of diagnostic criteria. The current proposal for DSM–V, in which 21 symptoms are provided a listing of 21 possible symptoms and signs, grouped into four (rather than the current three) clusters (intrusion symptoms, avoidance, negative affect, hyperarousal). It is instructive to recall that the PTSD clinical syndrome was first operationalised in DSM–III by only 12 symptoms, grouped into three clusters. This arrangement yielded 135 combinations by which an individual could meet the minimum requisite symptom criteria. In DSM–IV, 17 symptoms were grouped in the same three clusters, with minimum criteria yielding 1750 combinations. The current proposal for DSM–V, in which 21 symptoms are grouped into four clusters, allows for 10 500 ways to meet minimum requisite criteria! This expansion is beyond anything experienced for other diagnoses. Minimum criteria for diagnosing major depressive episodes, for example, allowed for 70 combinations in DSM–III, 112 combinations in DSM–IV, and essentially no new combinations in DSM–V. Minimum criteria for diagnosing generalised anxiety disorder allowed for 4 combinations in DSM–III, 20 combinations in DSM–IV, and a proposed reduction to 8 combinations in DSM–V. Once again, PTSD is sui generis in the DSM with regard to the expansion of its diagnostic criteria and continued blurry boundaries.

Three decades of research on post-traumatic stress disorder (PTSD) has informed our understanding of post-traumatic psychiatric morbidity. At the same time, the very research spurred by PTSD’s introduction in DSM–III has come to challenge almost every aspect of the construct’s originating assumptions.

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vastly increasing permitted heterogeneity at the phenotypic level, DSM–V risks increasing etiological heterogeneity, while providing no resolution to the symptom overlap conundrum.

A sound scientific alternative

Continuing controversy over how to operationalise PTSD in DSM–V has led to the suggestion that the diagnosis might best be relegated to the manual’s appendix for experimental criteria sets. A concern that such a move would lead to the construct’s demise is not warranted, as illustrated by strong interest in Spitzer’s proposal for binge eating disorder despite its placement in the appendix of DSM–IV. Yet another approach that makes use of the DSM’s appendix for experimental criteria sets is illustrated by the diagnosis of dysthymic disorder. With that diagnosis, an alternative criterion set was listed in the appendix for experimental sets, while extant criteria for dysthymic disorder remained in the main text of DSM–IV.

We believe that use of the DSM’s appendix for experimental criteria sets can operationalise PTSD in a manner that encourages research and allows for treatment of a wide range of post-traumatic reactions, while delaying scientifically premature acceptance of any specific proposal. This approach can also serve to remind clinicians that PTSD in its present form should not be reified to the status of a distinct disorder in nature, at least until such time that we better understand the full range of normal and disordered reactions that occur after traumatic and other high-magnitude stressors.7,14,15

References

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