Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Webinar Series

May 22, 2014; 1-2:30 p.m. (EDT)

Understanding Changes to Posttraumatic Stress Disorder and Acute Stress Disorder Diagnoses in DSM-5

Welcome and thank you for standing by. All participants will be in a listen-only mode for the duration of today's call. Today's conference is being recorded. If you have any objections you may disconnect at this time. Your host for today's conference is Commander Vythilingam. Thank you. You may begin.

Good afternoon and thank you for joining us for the webinar titled "Understanding Changes to Posttraumatic Stress Disorder and Acute Stress Disorder Diagnoses in DSM-5." My name is Commander Meena Vythilingam. I am a public health service officer and a psychiatrist at the Deployment Healthy Clinical Center. I will be your moderator for today's webinar.

It is our distinct privilege to have two top psychiatrists and PTSD experts joining us today. Dr. Matthew Friedman is from the Department of Veterans Affairs and has joined us by webcam from New Hampshire. And Dr. Charles Hoge is from the DOD and works in the Office of the Army Surgeon General. Welcome, Dr. Friedman and Dr. Hoge.

Hello.

Before I share their impressive accomplishments, let's review webinar logistics. Live closed captioning is available in the pod beneath the presentation slides. Webinar audio is not provided through the website, so please dial in using the numbers shown on the screen. Today's presentation and resource list are available for download from the "Files" box indicated on this slide.

The next few slides provide details on continuing education. Those who want to obtain a CEU certificate or a certificate of attendance must complete the post-test and evaluation at http://continuingeducation.dcri.duke.edu before next Thursday, 29th of May. Throughout the webinar you are welcome to submit technical or content-related questions via the Q&A pod located on your screen. Please do not submit technical or content-related questions via the chat pod.

The Diagnostic and Statistical Manual of Mental Disorders is a common language to discuss psychopathology and lists criteria to diagnose and classify mental disorders. The fifth edition of the DSM was published by the American Psychiatric Association last year and contains changes in the diagnostic criteria for several disorders, including posttraumatic stress disorder and acute stress disorder.

The first DSM-5 webinar we held last year was very successful, with a record 2,000 participants. We decided to have part two of the webinar of the DSM-5 discussion for two reasons. The first reason is you, the audience, wanted to hear directly from an expert who participated in the American Psychiatric Association workgroup that proposed the changes in the DSM-5 criteria. So we responded to your requests. And the second reason is we also wanted to address all the important questions that we were unable to address in the first webinar.

So, after today's webinar we hope that participants will be able to describe key changes in DSM-5 criteria for PTSD and acute stress disorder, recognize the evidence and rationale for these changes, and understand the practical and clinical indications of the new criteria for PTSD and ASD.

Now more on our speakers. Dr. Matt Friedman is a prolific psychiatric who served as the executive director of the National Center for Posttraumatic Stress Disorder in the U.S. Department of Veterans Affairs for 25 years. In addition to being extremely accomplished, he led the first major revision of the trauma and stressor-related disorders section in DSM-5. It is, indeed, a privilege to hear the rationale for the changes in DSM-5 criteria directly from the expert who led this effort. Welcome, Dr. Friedman.

Dr. Charles Hoge is a retired army colonel and psychiatrist, and is the DOD's expert in PTSD. Dr. Hoge's PTSD research has informed several DOD and army policies, and his work is regularly published in high impact journals, such as "The New England Journal of Medicine" and "JAMA." Welcome, Dr. Hoge.

While you review the disclosure information, a few words regarding our format today. First, we get to hear about DSM-5 changes from Dr. Friedman, and Dr. Hoge will then raise some questions and comments we received in the first DSM-5 webinar. And then Dr. Friedman will have one minute for a rebuttal. We hope that this interactive format keeps it interesting and engaging and ensures that we can all remember and use the DSM-5 criteria in our clinical practices.

So let's start with the big picture related to the DSM-5 before we drill down into specific changes. I'm going to start with Dr. Friedman. Dr. Friedman, can you let us know why PTSD was moved out of the anxiety disorders category in DSM-4 and placed in a completely new category in DSM-5 called "Trauma and Stressor-Related Disorders"?

Thank you very much. Yes, I think that a lot of the literature over the past 20 years or so has shown that the original concept of PTSD is a fear-based anxiety disorder really limits the scope and extent of trauma and posttraumatic reactions. Indeed, there appear to be a number of different clinical phenotypes. One is the classical fear-based anxiety disorder. One is more of a mood, an anhedonic dysphoric disorder. A third is an externalized disorder; behavioral problems, anger, aggressive behavior, recklessness. And the fourth is a dissociative disorder.

These are not necessarily mutually exclusive, but the scientific data -- and I want to emphasize that the DSM-5 was based very strongly on scientific data -- indicated that PTSD was more than an anxiety disorder and, therefore, was moved out into a category of its own, along with other disorders in which a preceding – a precipitating event can be identified that preceded the onset of symptoms. Other members of that category are acute stress disorder, adjustment disorder, a few childhood disorders, and other disorders have been under consideration, such as complicated grief.

So this slide shows where PTSD now stands. But what this shows is a part of the metastructure of the DSM-5. It's not complete. But the old anxiety disorders, which is right -- and the juxtaposition is important. So the disorders that are next door to each other are seen as being related but distinctive as well. So the old anxiety disorders, DSM-4 anxiety disorders, essentially has spawned two new chapters in DSM-5, one is the obsessive-compulsive spectrum disorders chapter where the OCD-related disorders appear to be distinctive enough from anxiety disorders as to merit a category of their own. And then next is the trauma and stressor-related disorders, which includes PTSD, as I've said. And next to this category is dissociative disorders, because dissociation has long been identified as a part of many posttraumatic reactions. But rather than having dissociative disorders as part of the trauma and stressor-related disorders, as was originally proposed, it was also moved into a chapter of its own.

Okay. So thank you for giving us the big picture. I want to give you some feedback about what we received in the last webinar. Some of the clinicians told us that they found the new DSM-5 PTSD criteria quite complex. And can you please review the major changes in DSM-5 PTSD criteria?

I'd be very happy to. I just want to say that PTSD really has not changed very much. The original 17 symptoms are still there, some of them have been re-clarified in either a small or a big way, and then three new symptoms were added. But this slide basically shows the changes. The criterion A1 trauma criterion was clarified, and I'll be going into more detail about that.

A big problem, and this was particularly relevant to military individuals, was the old A2 criterion. And if you remember in DSM-4 it wasn't enough to have been exposed to a traumatic event, but you had to respond with fear, helplessness, or horror. And many, many military personnel who would endorse all PTSD symptoms, you'd say, "Well, what did you feel?" "My training kicked in. I didn't feel anything" or "I felt angry" or whatever. And there's a lot of evidence showing that with or without the A2 criterion, PTSD would look pretty much the same in terms of its time course. So we eliminated the A2 criterion, a great deal of evidence for that.

In DSM-4 there were three diagnostic clusters: re-experience of wooden snubbing and arousal. What we've done in – can I go back to the last slide, please? Can I go back to the last slide.

Sure thing.

Oh, I can – maybe I can do that. Here, okay, I've done it.

So the three clusters of DSM-4 were divided now into four clusters, because avoidance and numbing or very distinct, and so they are now split out from one another. As I said earlier, we added three new symptoms. Other symptoms were revised. In DSM-4 it was not clear, particularly for the numbing and arousal symptoms, whether they had their onset before or after the trauma event occurred. So in DSM-5 every single symptom must have either had its onset or worsened after the trauma occurred. We've added two new subtypes, and I won't be discussing those unless someone has a specific question. We've added a new dissociative subtype. And this is for people who meet all the PTSD criteria, and, in addition, exhibit either de-realization or depersonalization. And in some of the research it appears that 15% to 30% of people do meet the dissociative subtype. And we added a separate diagnostic category for preschoolers, children six and under, and, again, I'd be happy to discuss that in detail if anybody wants me to.

All right, thank you for that concise overview. Let's start moving to what trauma looks like in DSM-5. So we're going to look at the definition of criteria A. And the slide that you see right now shows the comparison between what criteria A1 looks like in DSM-4, and bottom half is what criteria A1A looks like in DSM-5. As Dr. Friedman mentioned, the criteria A2 has been deleted from DSM-5. Now, what we have done here is we have done a track change variation on a PowerPoint slide. The sections and phrases that have been deleted are indicated in the scratched piece of it. And the new additions are indicated in blue and underlined.

So I'm going to address my next question to Dr. Hoge. So, Dr. Hoge, is the criteria for defining trauma in DSM-5, do you think it's narrower or broader than it was in DSM-4? And I think, specifically, if you can give us the key differences and the rationale for some of these changes of redefining how we think about trauma, that would be great.

Yeah, I don't know if I can give you the rationale. I think Matt's probably the better person to do that. But I think it's broader in the sense of the removal of A2. I think in some ways it's narrower because – in many ways it's probably narrower, because it's trying to codify or objectify, you know, make more objectives an experience that is inherently subjective. I mean, we know that when people experience trauma they experience trauma in different ways. Some people – one person will be exposed to one type of trauma and will develop PTSD; someone else is exposed to the same trauma and doesn't. And one of the strong predictors in many studies has been the level of their subjective impression of whether that experience was traumatic or not.

So my concern with this is that it gets a little too specific, and it could lead sort of back to the path that we had previously in past years where clinicians may be inclined to sort of split hairs about whether or not a particular experience was, in fact, traumatic or meets the A criteria. Some examples might be, for instance, I lose a team member in my battalion, you know, to an accident here in garrison or down range, but he's not my family member or my personal friend. I didn't witness it, and it doesn't have anything to do with this term "aversive details of traumatic event." It's not a repeated thing. And is that traumatic? You know, I think for some people it would be. And I lose my own trial to a very prolonged bout of leukemia, for instance, and have all of the PTSD symptoms as a result of that, avoidance of hospital settings and numbing of emotions and hypervigilance and so forth, and yet technically it probably would not meet the definition here. So I think that it's a little bit problematic getting that specific. I'm concerned that it's a little too narrow.

Okay, well, I want to throw in one more scenario that was in the first webinar and then turn it over to Dr. Friedman. So one example that the attendees brought up last time was what about DOD clinicians who are repeatedly exposed to trauma narratives? We keep hearing trauma stories in a clinical practice, and does that qualify for criteria A? And the second scenario is what about drone operators or aviators who drop munitions from a high altitude?

So, Dr. Friedman, if you can help us understand the rationale behind the alterations in the definition of A criteria for trauma and help us understand some of the grey scenarios and how it fits in the DSM-5, that would be great.

I'd be happy to. Let me just say one thing. The DSM-5 is a living document, and in that sense that there's not going to – we're not going to wait until DSM-6 for the B&E revisions. As new evidence accrues, diagnoses are going to be changed. So those would be in a DSM-5.2 and a DSM-5.3, et cetera. And one of the frustrations for those of us that worked on this was that the data that we really needed and wanted to make the most informed evidence-based decisions wasn't there, and yet we had to modify the criteria. So this is a work in progress, and I'm not

going to claim that what we've come up with, which is our judgment that went through many other reviews, was the best way to go.

The A criterion has always been the biggest problem for PTSD in terms of both clinically, for compensation purposes, forensic purposes, and on and on. Where do you draw the line? And, as Charles said, and this gets into issues such as resilience and vulnerability, what's traumatic for one person is challenging for another. That's why most people exposed to any traumatic event never develop PTSD. So it's a problem. And a number of people have proposed just get rid of the A criterion, just get rid of the damn thing. And if people exhibit the symptoms then they should have PTSD. And we thought long and hard about this and felt that we couldn't eliminate the A criterion because it's really the elephant in the room. It really is the context within which all of the symptoms need to be understood.

So, given that decision, which you may not agree with, then the concern was that looking at the terminology of the DSM-4 criteria really was ambiguous. What does "confronted by" really mean? What does "threat to the physical integrity of self or others" really mean? And lawyers have had a field day with these ambiguities, as I'm sure many of you recognize. So we felt that it would be best to try to be as explicit as possible, understandably opening the door for the kinds of questions that Charles has raised. So A1 and A2 are holdovers from DSM-4, either you actually experienced the traumatic event, your life was in danger, or you were there and you witnessed it.

A3 is really our attempt to operationalize, confront it in a better way. So we said "confront it" is really learning that something happened to somebody that you love. So, yes, we specified it's got to be a close member or friend. And, furthermore, because the most frequently endorsed A criterion event in most epidemiological research, it may not be true of military research of course, but in community samples, is the sudden death of a loved one. Now, if you live long enough someone that you love is going to die. And we really felt that that was problematic. So what we tried to do was to be more specific, that that death must be violent or accidental and it must happen to a close friend. I think that research will prove whether or not we made a good decision or not. We're putting our cards on the table and now it's time to see whether or not we made a good decision. If we didn't, then there will be a revision of this. But given the data that we had, that seemed to be the best decision.

Now, A4, which is really what some of your question is about, is what about professional people who are never in danger themselves, whether it's Gray's (ph) registration, people going out and picking up body parts, photojournalists taking pictures of devastation, or therapists who are exposed day-in and day-out, or drone operators who are seeing what they're doing. And so we've tried to specify, because we felt that the data were not there to say that someone could be exposed to an A1 event, watching the World Trade Center get hit by airplanes on the television, we felt that that just opened the door. And the research that's out there about exposure through media doesn't bear out that PTSD is a likely outcome as well.

So, again, this was our attempt to provide a criterion for professionals who are exposed to this traumatic material day in, day out, never in danger themselves, but are having nightmares or are having all the other symptoms.

Thank you so much, Dr. Friedman. It sounds like the group really struggled with criteria A. And it sounds like you feel that it may not be the perfect answer, but let's put it in DSM-5 and let the data speak for itself. Did I get that right?

Let the data speak for itself, that's right.

Okay. Let's move on to B criteria. And so we're going to go through the individual symptoms. So the next slide that you're seeing right now shows the DSM-5 wording for the B cluster, and compares it to DSM-4. So, Dr. Friedman, why was the term "re-experiencing" changed to "intrusion symptoms"? Could you explain that to us?

Yes, I'd be happy to. So another real concern about PTSD, particularly in regard to what were the numbing symptoms, is the overlap with depression. Real confusion there and lots of -- you know, one of the most frequent comorbid disorders with PTSD is depression. And there's research that's been done now, a fair amount, showing that depressed people also ruin A, also have re-experiencing symptoms in terms of thinking about what happened, the bad stuff that occurred. And so it felt, to us, based on the research, and our semantic considerations that it would be cleaner if we clarified that the intrusion symptoms, these are symptoms that are not voluntarily called up as in depression, but they barge into your thoughts. So you're trying to listen to a webinar and you can't stop thinking about the domestic violent episode you were just exposed or the firefighter, whatever. So we felt that intrusion was a better characterization of what we were trying to specify in PTSD and to distinguish from similar kinds of symptoms in depressed and other individuals.

Thank you. So I know Dr. Hoge, you had several concerns about this change, from re-experiencing to intrusion. So can you share with us your concerns and some of the comments from the first webinar.

You know, this definition has stood the test of time for over 25 years since DSM-3R. The term "re-experiencing" is so ingrained in clinicians' perspective on PTSD. And this idea that you can somehow separate PTSD from depression just simply by changing the term from "re-experiencing" to "intrusion" or view these symptoms as purely involuntary is just, you know, not really the way these experiences are experienced by people who undergo trauma.

So I think it's unfortunate that we're losing the term "re-experiencing." I think that it's still the better term. And I think you can make arguments that there are involuntary intrusive symptoms from depression. And I'm not sure – and I think as we'll see later, I think there's a lot of issues with the overlap of depression, and this certainly doesn't solve the problem.

Okay, so it sounds like the crux of the issue is is it involuntary or voluntary. Dr. Friedman, you have one minute to rebut what Dr. Hoge said.

So, two things. Number one, the term "intrusion" has been in the terminology as long as "re-experiencing." "Intrusive recollections" has been there as long "re-experiencing," so this is not a radical shift. Secondly, this is true for any diagnosis. Terms that may have been there originally and were even cherished terms sometimes do go by the wayside with new information. So that's my rebuttal.

All right, great. Thank you for keeping it under one minute. So let's move on to the rest of the B criteria. If you can walk us through the rest of the B and tell us what's changed and what's the same, that would be fantastic.

Okay. So B2 is traumatic nightmares, and that really hasn't changed very much, except that particularly for children who really can't verbalize what the nightmare is but it's clear that the

child is having a nightmare. So we added that it could be content or affect of a dream in terms of what they can recollect. But it's really not much of a change at all.

B3 is flashbacks, and that really hasn't changed very much, except that based on research we've basically specified that a flashback is a dissociative reaction that can occur on a continuum, everything from a little thing, of a reliving to an instant replay where you're totally immersed in the event. I think that the whole issue of dissociation is something that's been around since the 19th Century, but I think that, hopefully, there's going to be a lot more good research on dissociation in posttraumatic situations, including PTSD.

B4 and B5, which in many respects, I think, are extremely important, are that stimuli. Recollections of the traumatic event can trigger either emotional distress, psychological distress, that's B4; or physiological reactivity; racing pulse, sweating, what have you. And, of course, these symptoms are the hallmark of so much of the research. You know, we expose people to these reminders and we put them in an MRI scanner and we can see what happens to the amygdala, what have you. Prolonged exposure therapy is really using these symptoms to expose people in a therapeutic context to the reminders and then therapeutically helping them extinguish the fear conditioning or other kinds of aversive conditioning caused by the symptoms. But the symptoms themselves have not changed.

All right. Well, thank you for that summary of changes in the B criteria. Let's move on to the avoidance cluster. And the slide that you see right now, there is avoidance criteria in DSM-4 and 5. And there's a key shift in how C cluster has been conceptualized. So the persistent avoidance and numbing in cluster C has now been split up into C cluster that contains only avoidance symptoms, and the new D cluster, called "negative alterations in cognitions and mood." Dr. Friedman, could you very briefly talk about the C because I want to make sure we have enough time to spend on the D criteria?

Yes, I'll try to be very brief. There have been probably over 20 confirmatory factor analytic studies of the DSM-4 criteria. And in no study were the avoidance and the numbing symptoms linked together. They always, always disaggregated, because they're really different symptoms. And so this is really an evidence-based decision; that avoidance really should not be linked. And part of the issue is also that in DSM-4 all you needed was three of the avoidance numbing seven symptoms. So you could have PTSD without a single avoidance symptom. And based on the data, we felt that that was not – that this was a better way to conceptualize it.

Now, I must say that this is probably one of the most significant changes from DSM-4 to DSM-5 because in DSM-4 you could have PTSD without a single avoidance symptom, in DSM-5 you cannot. And some of the preliminary research that's already been done indicates that either having or not having an avoidance symptom is really the key to whether or not an individual is going to meet PTSD criteria.

All right. So it's really important to talk about this new D cluster of symptoms called "Alterations in Cognition and Mood." So help us understand what's changed, what's new, what was altered, and why were all these changes made. You mentioned the factor analysis and mentioned how the avoidance symptoms really separate out from the numbing and the mood symptoms. So if you could walk us through the next couple of slides, and then we'll take a break to get Dr. Hoge's input after the next two slides.

So, first of all, and I'll say it now rather than later, the term "numbing" is no longer used in PTSD. It's sort of like the old term "neurosis," which was also a time-honored term that we don't use

anymore because of new data, and that's because there's a lot of research now showing that people with PTSD are not completely shut down emotionally. They're very capable of experiencing negative emotions; sadness, grief, guilt, shame, as well as fear and anger. And so we felt that we wanted to remove the term "numbing." And so what the research has looked at has shown that people with PTSD have negative alterations in mood, as well in some of their cognitions. And so that's really the background for the change in the naming and the reason why, as I said earlier, the reason why these old numbing symptoms are split off into a category of their own is because they belong in a category of their own. These symptoms basically are linked together and are quite distinct from the avoidance symptoms. So, to go through this quickly –

If you could just go through the next slide, the slide 26, "DSM-5 Criteria D," and then we'll take a break to get input. Do you have anything else to add on the D1 through D7?

Me? Yes, I do.

Okay, go ahead.

So, D1 is psychogenic amnesia. It's no different than DSM-4. D2 is a major change in what used to be "foreshortened future." And it's really interesting that many clinicians interpreted "foreshortened future" primarily as feeling that your life is going to be shortened, et cetera, but what it really is is about your perception, your appraisal of your future, "My future I had before the traumatic event is no longer available to me." A lot of literature on Robert Lifton calling it the "broken connection" or "shattered assumptions" between the pre-trauma world of the individual and the post-trauma world.

So the focus here in D2 is really on how my perception, my expectations of the future have really changed. D3 and D4 are new. D3 is a negative cognition, negative cognitions that people with PTSD appear to develop as a result of their exposure. It's a grist for the mill for any cognitive therapist in the audience, you know that this is what you're working on, these distorted cognitions about myself and the world.

D4 is persistent negative emotional state, as I said earlier. Not just fear, helplessness, and horror, but shame, guilt, sadness, things of that sort. D5 and 6 are the same, diminished interest and feelings of detachment. D7 is the old numbing criteria, and we've changed that based on a lot of data now, and what I said earlier, because of D4 people can experience negative emotions. What the real problem for PTSD people is that they can't experience positive emotions, and that's often the kiss of death to a marriage, to friendships, to other kinds of relationships, to self-esteem.

Okay, well thank you for that very quick overview. We're going to get a few comments from Dr. Hoge before we drill down into the D criteria, because this is really, as you said Dr. Friedman, this is really the biggest shift in the criteria, so it's worth spending some time on it. Dr. Hoge.

Well, two things. One is that these, really, on the surface, look to me like depressive cognitions and emotions, and, you know, we've certainly talked a bit about whether or not this new definition is going to help distinguish people who have depression versus PTSD, or the combination. And I think that what we're seeing in the initial data suggests that, in fact, the new definition is really not any more specific than the old definition in terms of its overlap and likelihood of overlap of depression. I think this is part of the issue.

In terms of – we'll get into it, I think, in a later slide – in terms of the idea of removing the term "numbing," you know, previously it was actually "restricted range of affect," and the patients who we've all treated often talked about being shut down emotionally. It's a major fundamental symptom of PTSD, numbing of emotions or restricted range of affect. And it's not just for positive emotions, it's also for, for instance, for grief. Oftentimes, grief is also bottled up like the rest of the emotions that individuals are experiencing. So I think that you know, removing that term is certainly -- I don't consider numbing to be like the term "neurosis," for goodness sakes.

All right, so we have a good debate going here. So, you know, we have the DSM-5 clearly introduced two new symptoms in the D cluster of negative alterations in cognitions and mood -- sorry, distorted cognitions and persistent negative emotional state.

And I think it's helpful to look at some of the specific wording change as we go through this.

Yes. So, Dr. Friedman, do you want to drill down into the D criteria and then we can take each of them one by one?

Sure.

All right. Let's go ahead to the next slide, please.

So, okay. So, actually, I forgot I had all these slides behind me. I tried to do it all with the last slide. So basically this is the old -- this is really unchanged, essentially, from DSM-4, except that, again, we've specified that it's really a dissociative amnesia, it's not due to a TBI or alcohol or other drugs. As I said earlier, this is D2, and this is the old foreshortened future and this is "persistent and exaggerated negative beliefs and expectations about one's self." Again, this is about the future. "I now feel I'm a bad person and I can't trust anyone. The world is dangerous." "My nervous system is ruined" is a cross-cultural variant of this. This is a kind of elaboration that one sees in more traditional cultures. That's another thing about the DSM-5, whereas in DSM-4 all the cross-cultural stuff was thrown into an appendix that nobody read. We've tried to incorporate cross-cultural issues within some of the criteria themselves. Moving on --

Before you move on, I think that -- if you could go back to DSM -- I don't think this really is about the future. This is about one's beliefs right now. Yes, it includes expectations, but it really doesn't -- you know, it's not in any way, shape, or form the same construct as foreshortened future. And I think that some of these examples, you know, "I'm bad," "The world is completely dangerous," "My whole nervous system is completely ruined," is not really the way patients talk. This is a different construct. This is pretty classic depressive construct -- depressive cognitions right here.

So I think the key issue on the table, Dr. Friedman, is how much of this is overlapping with depressive cognitions versus specific cognitions unique to PTSD? So I'm assuming you've got a couple of more cognitions before you address this distinction.

Well, again, I think that -- I mean, I disagree with Charles. It's obvious that he and I don't agree on a lot of this stuff. These kinds of negative cognitions, this is grist for the mill in treating, particularly because the context within which these cognitions have evolved is the traumatic event, things that people did or didn't do in the course of that event. So, again, it's an empirical question, and I look forward to the research. Based on the research that's been done, we came to a very different conclusion than Charles has come to. We believe that these are distinctive to PTSD and they're very useful and that this is an improvement over the "foreshortened future,"

which, from what I can gather, was never consistently interpreted. A lot of confusion on the part of clinicians in terms of how they interpreted that symptom. I agree with Charles that we have changed, that this is not "foreshortened future." This is, in my opinion, a much better item.

Well I think unfortunately we do not have the poll function, which we had in the first webinar, so we do not have the opportunity to get feedback directly from the audience. But in the interest of time let's move on to D3 and D4, which are two completely new symptoms that have been added in. And, again, let's question whether this is part of depressive cognitions, PTSD cognitions, and how does it apply to our patients that we are treating.

Can I jump in here before you comment on this, Matt? I think that, you know, blame and guilt -- or, you know, self-blame and guilt are fundamentally one of the most important symptoms. I think they're really the same. It's the cognitive process of guilt is self-blame and one of the toughest nuts to crack when you're doing clinical work with clients. So I applaud the addition of guilt and self-blame. The problem is that it's been conflated with blame of others, which is very complex when you're talking about traumatic events, and also a bunch of other symptoms, including the fear and harm in the A2 criteria. So I would have preferred, and I think the literature would support me in this, that it would have been helpful to have a single guilt item on there.

Let's hear from Dr. Friedman about your thoughts in response to the single guilt item that Dr. Hoge refers to.

Well, you know, guilt is an interesting one, because in the original DSM-3 PTSD survivor guilt was an item. It was removed in DSM-4 because it was felt to be a non-specific and maybe too much of depression. The literature indicates that this is very, very consistent. One of the interesting debates, and it's really coming out in the new ICD-11. The World Health Organization is now going to create an ICD-11. And what they have concluded -- what they've done is they have a very, very simple PTSD construct with about eight different symptoms. And they have gotten rid of any symptoms that they feel is not purely found in PTSD. So that doesn't just include guilt, like we've been discussing. It includes things like insomnia, things like irritability, things like cognitive blunting, things like social distancing. And so they've basically eliminated those things.

In my opinion, that's like eliminating fever because fever occurs in so many infectious diseases, or eliminating edema because we see edema in so many different, whether it's cardiac or pulmonary or allergic or what have you kinds of things. So, but I think it's a fundamental and very important question that, again, we've take a stand on it. We're happy to let the games begin and let the research show whether we're wrong or right. But it really gets down to do you want to have a set of diagnostic criteria that characterize the symptom that you're seeing, whether or not some of those symptoms are also seen in other disorders, or do you want to take the ICD-11 approach and only include symptoms that are only found in PTSD?

It's a very, very important question, and I think that because of the difference between the DSM and the ICD-11 that's coming out next year, that the research will show us. It's a question that, frankly, hasn't really been on the table before. Now it's right smack in the middle of the table. And so I think the discussion that Charles and I are having about guilt is we could be talking about insomnia -- I don't know what Charles thinks about insomnia in PTSD -- or some of these other symptoms. So this is much bigger than the D4 criterion of PTSD.

Okay. So, in the interest of time, I just want to say to all the researchers in the audience, you know, please take this into account when you're doing your research. Do you want to do the DSM-5 approach or do you want to do the ICD-11 approach? I think the data is going to be very important in trying to, ultimately, come up with DSM-6. So let's move on to --

It looks like the experts can't agree on what PTSD is.

Well, you know, it certainly looks like that could be an issue. But I think the bottom line is the new data has to validate if DSM-5 is going to be a valid construct, or whether we need to go the ICD-11 way. We don't know the answer.

And I think there's two other things here. One is that -- and I offer this not defensively, but contextually -- that the two differences between DSM-5 and ICD-11, the DSM-5 was basically a very conservative process. In other words, there had to be a great deal of strong evidence to eliminate any symptoms, and there was that strong evidence to get rid of A2. But other symptoms, frankly, for which the evidence is mixed, like insomnia -- I'm sorry -- forgetting, being unable to remember, amnesia, the evidence wasn't strong enough to get rid of it, even though we seriously thought that it really might not be a good symptom, so the conservatism and these very strong empirical base. ICD-11 is not bound by either of those rules. There's no conservatism and they're not as strongly empirically based. So some of it, Charles, is not about experts agreeing or disagreeing, but about the rules of engagement. You change the rules you're going to get different outcomes.

All right, well, thank you, Dr. Friedman. I want to keep my eyes on the clock here. We have two more D symptoms, and one of them that Dr. Hoge mentioned was we have deleted restricted range of affect and we have focused on the persistent inability to experience positive emotions. So can you tell us what have we sacrificed by getting rid of in ability to experience negative emotions, Dr. Friedman?

I don't think I have anything to add in the interest of time. I think I've made the argument of why we got rid of it. There's lots of data showing that people with PTSD can experience, maybe not all of them, but in general can experience negative emotions.

This is one of the symptoms that is most impairing. It's the thing that leads to social relationship problems the most. It's the thing that I hear from spouses all the time, that we all hear from spouses all the time. You know, "He doesn't seem to love anymore. He seems to be shut down. He's numb. He doesn't seem to have emotions." So I really think that this is a bit of a travesty to have dropped restricted range of affect from the symptoms. I hate to say that, but I do feel that way.

I think the example you gave supports my argument.

Well, good, I'm glad we can use the same data that way.

I actually see that you folks are agreeing with each other.

Yeah.

Because it sounds like, Dr. Friedman, what you're saying is spouses complain about the inability to feel love and other positive emotions, and that becomes the relationship point. But I think I hear what Dr. Hoge is saying, he's saying, "Hey, what about grief? What about guilt?" There

may be a restricted ability for PTSD patients to feel sadness and grief, so to be continued in the question and answer session.

There's two fundamental emotions of PTSD, it's shutting down emotions, numbing, and it's anger. Those are the two fundamental emotions of PTSD. And to start to -- I don't know.

Well, we're going to get to the anger. We are going to get to the anger and irritability, so let's get to that. So I think we're going to go on to the E1 criteria, in fact, it will be great segue to move to the E criteria, which includes irritability and outbursts of anger. So, Dr. Friedman, could you walk us through the E1 – E criteria, which used to be the D cluster?

So in DSM-4, anger, the emotion, and anger, the behavior, were conflated. What you have in this slide is irritability, which is an emotion or outburst of anger, which is a behavior. And we felt that this was confusing to diagnosticians. So irritability or angry feelings, and agreeing with Charles, saying that anger is an important component of PTSD, is now in the D4 criterion that we've already discussed, the negative emotions. Angry behavior, irritable behavior, angry outbursts, so that the E cluster, which used to be hyperarousal, we renamed "hyperarousal" and "reactivity" because so many of these symptoms are behavioral reactions. So this is more -- whereas the D cluster is more of the emotional component of PTSD, the E cluster is more of a behavioral one. So this is about irritable behavior or angry outbursts with little or no provocation, which may be expressed in verbal or physical aggression. So that's really what D1 is all about.

All right. So I think we've heard Dr. Hoge's point here. We'll come back to the shutting down emotion in the discussion period. But if you can walk us through the rest of this.

I have one quick comment on anger. One of the concerns is anger is now in two symptoms, or possibly even three if you consider D4 and E1 and reckless or self-destructive behaviors that are resulting from anger. So, I mean I think that that's problematic when we start being able to meet three criteria with the price of one.

So, Dr. Friedman, can you give these three possible different places that irritability and anger could come and help make the distinction, because I know you made the distinction between emotion, going in D, and behavior, going in E? So could you try and de-conflict it in a clear way for the audience?

I thought I already had done that. I tried to do that. I mean, people feel anger without expressing it in an aggressive way. I think that E1, frankly, one of the problems with PTSD, it is related to angry behavior. I don't agree, Charles, that the next symptom, E2, which is reckless or self -- this is a new symptom. This is the only new symptom in this cluster. This includes self-destructive behavior, reckless, unprotected sex, driving while intoxicated. It's not constructed as an angry symptom at all. That would be E1. Just to finish the slide, all the rest of these symptoms are pretty much the same as DSM-4.

Okay. So the key distinction here is separating the mood from the behavior.

Correct.

And mood goes into cluster D, and then the behavior, irritability and anger, stays in cluster E.

Right.

All right. Is there a third part that you wanted to say, Dr. Hoge, that you said irritability and the anger, and there's a third part with the symptom anger shows up.

I don't recall if I had anything else to say.

All right. Perfect. Perfect. Thank you. So let's move on to adjustment disorders, because this is probably a huge shift. You know, adjustment disorders has been removed from the category it was in and is now in the same category as PTSD. So, Dr. Friedman, can you walk us through why this decision was made and whether the criteria are the same, different, and how to think about adjustment disorders?

Well, I mean adjustment disorder has traditionally been a wastebasket diagnosis for people that seemed clinically distressed but didn't conform to any diagnostic criteria -- any other diagnostic criteria. We've re-conceptualized adjustment disorder as a stress response syndrome where the stressor may or may not be traumatic. It could be divorce or a failure of one sort or another, not necessarily life-threatening but potentially life-changing. And so we felt that by moving adjustment disorder into this category in which the membership is contingent upon specifying that something bad, an aversive event, not necessarily traumatic event, preceded the onset of these symptoms was really an advance.

We also felt that it would stimulate much needed research on adjustment disorders, which right now is -- you know, it's got so many different phenotypes, depressive phenotype, an anxious phenotype, a conduct disorder phenotype, that it would -- number one, biologically, do we see the same kinds of HPA changes in people with an adjustment disorder that we might see in PTSD, although it might be quantitatively, not qualitatively different? We know that people with sub-threshold PTSD right now often receive an adjustment disorder diagnosis. So putting it in the same playground or cluster or DSM-5 chapter, along with PTSD and the other diagnoses, we felt, was very useful, would stimulate a lot of creative clinical thought, research that can help us move further.

All right, well I know that Dr. Hoge has a lot of thoughts about adjustment disorder. I want to make sure we have time to address his thoughts.

Well, you know, granted the DSM can be a springboard for research, right, but when you have such a fundamental difference where you take a category that is a diagnosis of exclusion and really doesn't have symptom criteria, you can't really call it a syndrome. And to think that it's in any way neurobiologically similar to PTSD, it may have some overlap like a ton of other disorders, but do we really think that adjustment disorder is neurobiologically more akin -- or PTSD more akin to adjustment disorder than it is to anxiety disorders? And to take PTSD out of the anxiety disorders section and put it in with adjustment disorders, I think there are a lot of potential problems with that. And also -- and we'll talk about subclinical PTSD, but in the DSM it recommends the use of adjustment disorder for subclinical PTSD, and I think that's hugely problematic for a lot of reasons.

Right. So I think, Dr. Hoge, you raise a very important point, and it reminds me of what Dr. Inso (ph) was proposing, you know, [inaudible], the way you really use biological abnormalities to classify disorders rather than symptom clusters. And maybe we might be there, you know, the next 10 years, 15 years, hopefully in time for the DSM-6.

This is such an empirical question, and to put it in the same chapter which then codifies and sort of forces clinicians to start to utilize it in that particular way when it's not supported by the research is problematic, to say the least.

All right. Dr. Friedman, you have a minute for rebuttal. I know that's a tight rebuttal, but go ahead.

If you agree, and you've already said that you do, that it's difficult to know where to draw the line between what's a criterion A event and a non-criterion A event, if you have an individual who may be just on the wrong side of that line but has all the other PTSD symptoms, adjustment disorder is one of the diagnoses that has been used traditionally. There's another one, or anxiety NOS, which has a different name in DSM-5. So I don't agree with you, Charles. I think that this is a very appropriate thing to be doing at this particular time. We don't know. It was not neurobiological considerations that led to the movement of adjustment disorder, but to move adjustment disorder out of the cellar of default diagnoses that it's occupied and put it out there so people can address these questions.

You may be right. You may not be right. But at least it gives -- first of all, it gives clinicians an opportunity to understand that aversive events don't always produce PTSD; they produce other kinds of phenotypes, and really giving both clinicians and researchers the challenge to come up with this. Where this is going to go, I don't know. Adjustment disorder, there may not be any such things as adjustment disorder in DSM-6, but if it's not there it's because the research that's been lacking up to now will have done.

Okay, well I think, you know, hopefully the new DSM is going to be informed by biological research that can augment some of the decision-making that we've struggled with based on the class of -- I mean, based on the psychopathology research we've had up until now. So let's move on to sub-threshold PTSD. That's something that I've struggled with. Where do you put sub-threshold PTSD in the new category -- in the new classification system?

Well we struggled with it also. And, you know, at least at the time we completed our work, there were 60 different articles on sub-threshold PTSD, and I've contributed to about four or five of them. The problem is that sub-threshold PTSD in one paper is not sub-threshold PTSD in another. There's never been a standard definition so that we couldn't really merge all of this very interesting information and draw some conclusions about whether there is a sub-threshold PTSD, what symptoms should be included, what should be excluded, et cetera, et cetera, et cetera. So, because of that, we were unable to have a sub-threshold PTSD in the DSM-5.

As a result, we're really stuck with either adjustment disorder, which would be a legitimate diagnosis within the first six months of a chronic adjustment disorder, or this new diagnosis, 309.89, which is the old anxiety disorder NOS, essentially sub-threshold PTSD. And I think, Charles, you've been involved in some of these discussions, that I know VA is recommending that for sub-threshold PTSD this be the diagnosis, not adjustment disorder for sub-threshold PTSD. I don't know what DOD has finally decided. I thought that they were in agreement with this statement, this policy statement.

So, Dr. Hoge, can you tell us how DOD thinks about sub-threshold PTSD and chronic adjustment disorder?

Well, I mean, there's sort of two issues. One is what's the right terminology for subclinical -- for sub-threshold PTSD or the right diagnostic category for it or term to use, label to use. And the

other is we have issues with coding now that are just very real for clinicians in terms of using, for instance, 309.89. It really doesn't show up as a trauma specified -- you know, as a trauma other specified condition. It shows up as an "other adjustment disorder." And so it essentially gets put into the adjustment disorder category, not the trauma category. So we've got a little bit of an issue there.

Chronic adjustment, if you want to go back a slide, I think it was a slide on chronic adjustment disorder that I saw pop up there for a minute. And, you know, unless the APA is going to come out and issue a statement -- I mean, I guess DOD -- we haven't made a decision in DOD, but DOD and VA can certainly come out with a policy statement on what code we think is most appropriate for subclinical PTSD, but that doesn't necessarily mean that every clinician is going to follow that. They might be more inclined to follow the letter of the law, which has traditionally been the DSM, which now recommends chronic adjustment disorder as the term to use. And I think there's issues with that. I mean, with chronic adjustment disorder you have to have a persistence of the stressor or its enduring consequences, and I don't think you can argue that the symptoms themselves enduring after a traumatic event are the enduring consequences, because then you're basically saying that the definition of chronic adjustment disorder is the persistence or the chronicity of the symptoms.

That's right.

And so it's a circular argument. So I think we have problems. I think we have problems with chronic adjustment disorder. In DOD adjustment disorder has a pejorative connotation. It can be lead to administrative separation, you know, without medical benefits. Chronic adjustment disorder is medically compensable, but acute adjustment disorder isn't, and it's a diagnosis of exclusion. So I think we have problems right now with the sub-threshold PTSD.

Do you have any solutions for the next round, Dr. Hoge? What would you recommend for the next round of DSM?

I mean, I'm not confident. Judging by how long these things happen, I mean, maybe there will be a DSM-5.1, 5.2, 5.3, and, you know, every six months we'll have a new DSM. You know, that might be great. But I doubt it. I seriously doubt it. I think it will be years before we see any fundamental changes to it. And so I think we're going to have to come up with a solution. What I'm doing currently with my patients, I'm using anxiety disorder NOS because the code is there and it clearly identifies it as an anxiety disorder, and clinicians think of an anxiety disorder and they treat an anxiety disorder different than they do an adjustment disorder. And so I think it's the better code. But I'm sure there's other clinicians within DOD and maybe policymakers who don't agree with me on that.

Well, actually, this calls -- and Dr. Friedman, we have heard from you how the VA is handling it. Do you want to add anything else before we maybe talk about how the DOD and VA should probably come together and discuss the policy consideration?

Well, just to say that the other specified does specifically mention sub-threshold PTSD, so it's not correct that adjustment disorder is the only diagnosis that the DSM-5 recommends for --

Is that an online change, because it's certainly not part of the printed edition?

I believe it is in the printed edition.

It's not.

We can check that, but I think the bottom line is it sounds like the way DOD clinicians may be coding it may be different from the VA clinicians. This is something that we should take it up the chain and try to come up with ways we can be on the same page with the VA and other DSM conceptualizes it.

My last comment is that anxiety NOS is now -- there is not NOS in DSM-5, so anxiety NOS is "other specified anxiety disorder." And if you think it's a posttraumatic origin, I think that it's a mistake to code that when you have other specified traumatic or stressor-related disorder. That diagnosis is specifically there to distinguish the posttraumatic presentation from a panic or an agoraphobic type of presentation that you would -- or a GAD presentation that you'd see in other specific anxiety disorders. So I --

Yeah, but those codes aren't available now, that's the problem.

[Cross-talking].

I don’t know why they're not available. They should be.

And it's available at the VA, Dr. Friedman?

Yes. And, you know, VA has basically had training on DSM-5 and we have specifically encouraged people to use 309.89 for sub-threshold PTSD rather than chronic adjustment disorder and rather than other stress-defined anxiety. We think it's not great, but I think, given the other options, it's the best thing to use right now.

Okay, well, you know, clearly DOD, we've got to figure out the coding and the training much more than what we offer in the webinar. So we're running out of time, so I want to make sure you have time to cover the acute stress disorder and PCL, and then have time for -- we'll probably have time for a couple questions.

Okay, so I'll try to be very brief. I'll try to be brief, but there's a lot to talk about.

That's right.

So the biggest problem in DSM-4, as far as acute stress disorder, was that you had to have three dissociative. You had to have three dissociative symptoms, three out of five possible, then re-experiencing one avoidance, one arousal symptom. And the reason for that was that, first of all, it was the dissociative disorders group in DSM-4 that put together the ASD criteria rather than the PTSD group. And at that time there was a belief that peritraumatic dissociation was a major component. Well there's been a lot of excellent research since then showing that people who have had acute traumatic exposure with or without dissociative symptoms look no different from one another.

So what we did was we analyzed all of the world's databases that had longitudinally follow people who had been exposed to a traumatic event -- most of these databases, the point of origin was an emergency room -- and followed them, and setting a 20% based on other data suggesting that 20% of those developing ASD was a reasonable guestimate. Again, we had to do this because no prospective studies have been specifically designed to answer the questions that we had to address for DSM-5.

So, based on that, it looked like 9 symptoms, 9 out of the 14 symptoms, would come up with about 20%. Now, you can argue that we didn't have all the cohorts and on and one, and we didn't, but we did the best we could. So what the new acute stress disorder criteria recognizes as thus PTSD that posttraumatic symptoms may be very variable, may look very different in different people, may be primarily depressive or anxious or dissociative or externalizing. And so there are six different clusters. They got four intrusion symptoms, one negative mood, two dissociative, two avoidance, and five arousal. If you have nine of these, with or without a dissociative symptom, you've got PTSD. And so that's how we made the decision. I think it's an improvement. Can we do better? I'm sure we can. And we look forward to more research.

Thank you.

So let me go on.

Go ahead, sir.

So, just to wrap it up, I was asked to say a few things about the PCL and the CAPS. So at the National Center we have revised the CAPS and we've revised the PCL for DSM-5. And my next slide will tell you how you can get the exposure to them. So on the left column, talking about PCL -- there were three different PCLs in DSM-4, a civilian, a military, a general. There's only one PCL in DSM-5. The factor structure, et cetera, looks pretty much the same.

One of the things that we changed, because it was confusing, is it's a five-point scale, but instead of going from one to five, it goes from zero to four so that with -- and so by adding the 14 symptoms, the highest you can get is an 80, zero to 80. And on this Likert scale, if an item scores two or higher it's counted as a positive symptom. Similarly, we've revised the CAPS. It's a 30-item structure. The big difference is, in the CAPS-4 there were separate assessment for the frequency and the intensity ratings for people. And for CAPS-5 we don't do that anymore. So each item has one score, basically you take both frequency and intensity into consideration and come up with one item. Again, on a zero to four severity rating there's scoring anchors. There's a training video that we've developed at the National Center, et cetera.

So, go to the next slide. The cut points, so if you remember, since the PCL that Charles has used in all of his research was one to five, and now the PCL is zero to four, the highest score you can get is much lower. So what was a cut score of 50 in the DSM-4 is now 38, the best we can gather from our data and for PCL-5. There have been a couple of studies looking at this. Moderate, as you can see on the slide and I saw -- showing the PCL-4 equivalence to PCL-5, so moderate would be 31 compared to 44 in DSM-4, and 28, et cetera. So the final slide is, if you want this information, contact us, contact the National Center, here's the address, and we can make that information available to you.

All right. Well thank you so much, Dr. Friedman and Dr. Hoge. That was a great discussion. And I think the key take-home points here are DSM-5 is going to be rolled out in the DOD, I think probably October or so, and I'm not sure where it stands in the VA.

It's October.

Sorry?

It's October.

October. So, you know, it is going to be the law of the land, but, again, the debate we heard today with Dr. Hoge raising several issues with the criteria and some of the audience raising several points, you know, makes us question whether it's applicable to our patients. So, please, get actively engaged, write down your thoughts and comments, and pass it on to Dr. Friedman or even the APA so that it can be taken into consideration during the next revision. Of course, the researchers out there, you know, please be paying attention to some of the issues that have come up in this webinar today. And, of course, the final lesson, before we go to the question and answer session, is from a DOD standpoint we have a lot of work to do with regards to coding and rollout of DSM-5 training across the DOD.

So let's move on to the question and answer session. The next couple of slides do have references that you can use in case you're inspired to go back and read more about this topic. And let's move on to the question and answer session. We've had a lot of questions come in, but looking through some of the questions that have come in by the email, there seems to be a recurrent theme here, and the big concern that several clinicians seem to have is what if the patients are diagnosed and continued to treat based on DSM-4 – criteria, what if my patients no longer meet criteria for PTSD using the DSM-5 criteria? So what should clinicians do if this happens, Dr. Friedman?

You know, this is not just a PTSD issue. I mean, for example, the criteria for hypertension keep changing, is it a diastolic of 90s, diastolic of '85? At least in VA people that have a PTSD diagnosis will be grandfathered. And so moving forward the diagnostic criteria will apply.

And what about DOD, Dr. Hoge, how would it work in the DOD?

I think the same. You know, the research that I've seen comparing DSM-4 to DSM-5, the reality is the DSM-5 definition has been calibrated to the DSM-4 definition, and not surprisingly the prevalence that you find with the DSM-4 versus DSM-5 or with the two PCL versions are comparable. But they're not the same people. And there's a fairly sizable number of people who meet DSM-4 criteria who won't meet DSM-5 criteria, and vice versa, though the overall prevalence appears to be pretty similar from the preliminary data that we've seen in several studies. So I think that it does call into question whether or not the new group of people who are identified are – which group is more accurately reflects the diagnosis of PTSD or which definition more accurately reflects. It's just essentially a matter of convention in this case. I'm not convinced the science necessarily supports the new definition being better than the old definition, and certainly I wouldn't start turning around and saying that people that met the criteria in the previous definition don't have the disorder now. But it remains to be seen.

Okay.

I'd like to – can I respond for a minute.

Yes, absolutely, Dr. Friedman.

I think that the question that nobody knows, which really has a huge bearing on this very important issue, is what are effective treatments for sub-threshold PTSD? The problem is that in most clinical trials people who don't meet the criteria don't get included. So we don't know whether or not they would respond to the psychotherapies or the medications or what have you. And so we need to start – we need a case definition of sub-threshold PTS, and then we need to -- because I don't know what the rest of you do, but if I have a patient who fails to meet the

PTSD criteria because of a symptom or two, you know, I'm going to treat them. It's not in the practice guidelines, but I'm going to treat them as if they had PTSD. I'm going to offer them cognitive behavioral treatments or I'm going to offer them SSRIs or Venlafaxines or Prazosin or what have you. And we have a lot of catching up to do.

So my guess is that if I – when a clinicians says to me, "Well, I got a guy who looks very much like PTSD, would have made it in DSM-4, doesn't make it in 5. What should I do," I would suggest that they treat them as if they have the PTSD. The perfect is the enemy of the good. And I think that that's a reasonable approach until we know better, until we know that the treatments for PTSD don't work as well for sub-threshold PTSD. Instead of using Drug X you got to use Drug Z or Drug W. So it's an immensely important question. We can't begin to answer it because we don't know, because we just haven't – we don't have any research on this and we need to get some.

But the bottom line take-home message here is if you've diagnosed patients with PTSD based on DSM-4 and they don't meet the checklist for DSM-5, don't stop treatment.

Don't stop treatment.

Don't stop treatment and don't tell them they don't have PTSD.

That's right.

Those are the take-home points. Okay. So let's move on to another question that came through. So one clinicians pointed out that, within code, many of the de-criteria mapped onto cognitive processing therapy. And I know that Dr. Resick was on the committee." That's Pattie Resick who developed the cognitive processing therapy. "Makes me wonder if this will inflate the success rate of CPT over prolonged exposure and other treatments." What do you think of this, Dr. Friedman?

I think it's an empirical question. I think that most of the literature we have shows that PE and CPT are pretty comparable in terms of their results. We don't right now know where to – whether a round peg should get PE and a square peg should get CPT. There's a big cooperative study that Dr. Paula Schnurr, my colleague, is starting where there's going to be 900 veteran with PTSD randomized to either PE or CPT. Maybe that will help us understand who ought to get what. But both treatments are superb and both treatments work equally well. I don't think this is going to tilt the balance one way or the other. That's my own opinion.

Okay. I think a related question – and actually, Dr. Hoge, do you want to respond to the CPT versus PE comment/question?

No, I mean, I do think that the changes were heavily influenced by cognitive processing therapy based on the wording of things. And I think that some of the changes were – if you look at major depressive disorder and panic and generalized anxiety disorder and ADHD and a host of other disorders throughout DSM-5, you know, there were some small changes made, but not changes fundamental changes on the wording of a number of symptom items that have stood the test of time for many years. So, you know, I think that that was the case of PTSD and I'm not sure that they completely reflect the broad literature on PTSD.

So we hear your comments loud and clear. We got it. We got it. Okay, let's – there was one question that seems to be – another question that seems to be coming up repeatedly that

seems to be tied into our diagnosis question, but I do want to bring it up because it's very relevant to the veterans and service members we treat. "What thought has been given to how many veterans have qualified for disability under the previous criteria and will no longer qualify according to the new criteria?" Dr. Friedman?

Yeah, I don't think it's a useful question because anyone who received a PTSD diagnosis is not going to lose their diagnosis. So where it's going to make a difference is going forward. As Charles said, the prevalence rates are comparable, but there are people who meet four and don't meet five criteria, people who meet five and don't meet four criteria. The main reasons are the A2 criterion, which you had to have in four and don't need in five. You must have an avoidance criterion in five, didn't need it in four. And sudden death, unless it's specifically violent or accidental, which would have been met in four, won't meet in five. So, as Charles said earlier, the criteria have both broadened and narrowed that the PTSD construct. I agree with that statement.

Okay. Well, it's time to wrap up this lively debate. I think both Dr. Hoge and Dr. Friedman have given us a lot of food for thought. But the DSM-5, it is what it is, it is what we have to use in our clinical practice. What I do know from after this debate is I would remember the nuances a lot better than sitting and reading the criteria all my myself in the office. So, thank you so much to both of you for participating and being open enough to spar intellectually and not take this personally. I thought this was incredible the way we were able to discuss – have an honest discussion. So thank you, Dr. Hoge. And thank you, Dr. Friedman.

So today's presentation will be archived in the monthly webinar section of the DCoE website. After the webinar, for those interested in continuing education certification, please feel free to complete the post-test and evaluation, and download your certificate. And we are very, very interested in your feedback to help us improve future webinars. Is this format an interesting format? Do you prefer the usual format with a speaker speaking first and then questions to the end? Is this interactive format distracting or useful? So, please complete the feedback tool that will open in a separate browser on your computer.

And, finally, the chat function is going to remain open for an additional ten minutes after the conclusion of the webinar. So feel free to continue to network and chat after we sign off, and get your thoughts of your colleagues way after we are done. Just a few announcements regarding the next few webinar topics. So June is "Unique Male Risk Factors for Mild TBI." And we have another psych health topic which is in June, which is "Depression and Men in the Military."

And I want to end by extending my gratitude, again, to both of you. This has been an incredible learning experience for me. Thank you very much for attending. And thank you very much to both of you again. And thank you for the fantastic webinar team who made all this happen. Have a great day.

Thank you.

Thank you. This concludes today's conference. Participants, you may disconnect at this time.