

From DSM-IV-TR to DSM-5: Changes in Posttraumatic Stress Disorder

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One of the biggest changes in the *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition* (DSM-5)¹, released in May 2013, involves the classification and conceptualization of posttraumatic stress disorder (PTSD). PTSD is no longer classified as an anxiety disorder, but instead falls under a new chapter, “Trauma- and Stressor-Related Disorders.”

Classification

Previously grouped under anxiety disorders beginning in the DSM-III², PTSD shares many similar symptoms with other types of anxiety disorders. For example, all of the anxiety disorders have some aspect of re-experiencing (e.g., distress of reminders in panic disorder), avoidance (e.g., numbing in social phobia) and arousal (e.g., concentration deficits in generalized anxiety disorder)³. However, for some individuals the depressed mood associated with PTSD is more salient than the anxiety symptoms⁴. Comorbidity between PTSD and depression, a mood disorder, has ranged between 9% and 31% in soldiers following return from combat, depending on the criteria used⁵. The re-classification of PTSD as a trauma- and stressor-related disorder in DSM-5 is based on a common etiology (i.e. exposure to a traumatic event), rather than symptoms, which is similar to how other medical fields label diagnoses⁴. Other disorders that share the classification include reactive attachment disorder, disinhibited social engagement disorder, acute stress disorder, adjustment disorders and other specified and unspecified trauma- and stressor-related disorders.

Criteria

The DSM-5 also reflects many changes to PTSD criteria. Revisions include changes to the language in Criterion A, in which a traumatic event is now more clearly defined than it was in the DSM-IV-TR⁶. The DSM-5 specifies examples of experiencing or witnessing a traumatic event, such as sexual assault or the repeated indirect exposure to adverse events, such as in the case for professionals (e.g., first responders), and requires being explicit about how the event was experienced (i.e., directly or indirectly).

The DSM-IV-TR criteria were more general, stating “the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others.” Further, the DSM-5 definition rules out such events as the unexpected death of a family or close friend due to natural causes, as well as indirect non-professional “...exposure through electronic media, television, movies, or pictures¹.” Examples of events that would qualify for Criterion A include learning about a family or close friend’s suicide, serious accident or assault. Some studies have reported that viewing images of traumatic events, such as the September 11

attacks on television, do not typically result in increased PTSD symptoms for people not directly affected by the event (e.g., lost a friend in the attack)^{7,8}; however, job-related exposure (i.e., police officers exposed to graphic details of rape) has been shown to lead to increased rates of PTSD⁹. Also, in regard to Criterion A, the requirement that “the person’s response to the event must involve intense fear, helplessness, or horror” has been removed. The DSM no longer requires this explicit subjective emotional reaction to a traumatic event. It was originally thought that requiring an intense emotional reaction would result in distinguishing between those individuals who experienced traumatic from less severe events. However, several studies have found that the DSM-IV-TR’s Criterion A2 did not improve diagnostic accuracy (see Friedman et al., 2011, for review)⁹; for example, military personnel, who are trained for combat encounters, may not experience an immediate emotional reaction following trauma¹⁰.

Symptom Clusters

In the DSM-5, an additional cluster was added and some others were reorganized based on the results from several factor analytic studies (see Elhai & Palmieri, 2011, for review)¹¹. *Intrusion symptoms* (formerly re-experiencing) and *alterations in arousal and reactivity* (formerly arousal) remain as clusters, while *avoidance and numbing* have been split into two clusters, *avoidance* (Criterion C) and *negative alterations in cognitions and mood* (Criterion D).

It is common for individuals to develop maladaptive appraisals and catastrophic thinking in reaction to a traumatic event. While these cognitions are not unique to PTSD, they are useful to include in the criteria due to their association with impairment¹². For example, such posttraumatic cognitions as negative self-cognitions, negative world cognitions, and self-blame cognitions were related to PTSD via a structural equation model¹². Evidence-based treatments for PTSD, such as cognitive-behavioral therapy and cognitive processing therapy, address these cognitions in therapy. As a result of recent research findings, two new symptoms were added to Criterion D – distorted blame of self or others for causing the traumatic event or for resulting consequences, and persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., “I am bad.” “The world is completely dangerous.”).

There have been some inconsistencies regarding the best fit for symptom clusters. For instance, several studies have advocated for a dysphoria, vice numbing, fourth cluster; further investigation revealed that the conflicting results over numbing or dysphoria might be due to the measurement used (e.g., Clinical-Administered PTSD scale vs. self-reported PTSD checklist)¹¹. Support for an alternative cluster – dysphoria (e.g., irritability, concentration difficulties, loss of interest) – has been found in a sample of veterans serving in the Iraq or Afghanistan wars, presenting to primary care. However, symptoms in this dysphoric cluster also matched equally well under the alterations in arousal and reactivity cluster¹³. With the adoption of the new clusters, more work will be done to identify the best model for organizing

symptoms.

Specifiers and Subtypes

Modifications have also been made to the PTSD specifiers. In the DSM-IV-TR, specifications of diagnoses included both acute and chronic PTSD. Acute PTSD was specified if symptoms lasted between one and three months, while chronic PTSD was defined as symptoms lasting longer than three months.

Both acute and chronic specifications have been removed from the new DSM. Instead, a diagnosis is given if symptoms last at least one month and no differentiation is made between acute and chronic PTSD. For symptoms that last from three days to one month following exposure to one or more traumatic events, a diagnosis of acute stress disorder is given. Delayed expression (i.e., DSM-IV-TR's Delayed Onset PTSD), for full diagnosis not met until at least six months after the trauma, remains. Two subtypes of PTSD have been added, the preschool subtype (PTSD in children younger than six) and the dissociative subtype (PTSD with prominent dissociative symptoms). Research supports theoretical models for a dissociative component to PTSD¹⁴, including studies using cross-national samples¹⁵.

Implications

Researchers and practitioners must be aware of how the changes in the disorder will affect assessment. Plans to transition to measures reflecting the DSM-5 criterion of PTSD should occur for best practices, though it may take some time for the system to accommodate and reflect these changes. According to the National Center for PTSD, the Clinician-Administered PTSD Scale (CAPS), the Primary Care PTSD Screen (PC-PTSD) and the PTSD Checklist (PCL) are currently undergoing revision and validation. It is anticipated that researchers will continue to evaluate the adapted measures' validity for several years to come.

While the DSM-5 reflects changes in the PTSD classification and criteria, prevalence rates of the disorder are not expected to be greatly affected^{16,17}. Further research needs to be conducted in order to better understand the implications of the changes to the DSM, including whether the changes do, in fact, lead to improvements in diagnostic accuracy.

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