

Special Communication

Unintended Consequences of Changing the Definition of Posttraumatic Stress Disorder in *DSM-5*

Critique and Call for Action

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Are changes to the definition of posttraumatic stress disorder in *DSM-5* a step forward?—No.

The 2013 *DSM-5*, the first major revision of US psychiatric nomenclature since 1994's *DSM-IV*, was coordinated by the American Psychiatric Association in a manner to ensure revisions were empirically supported and maintained continuity with previous editions.^{1,2} Although many important evidence-based changes resulted, core criteria and diagnostic language for most common conditions affecting adults remained unchanged, safeguarding continued use of treatments validated over decades.^{1,3}

A notable exception was posttraumatic stress disorder (PTSD). Criteria were added and major wording changes were made to symptoms that have been foundational clinical descriptors even before *DSM-IV*—revisions that workgroup members themselves acknowledged were controversial.^{4–6} Their rationale^{4–6} appeared to reflect selective interpretations of evidence (eg, based on nonsystematic literature review and overlooking complex neuroscience domains); cognitive theory influenced key changes, potentially lessening the emphasis of other well-established neurobiological models underlying evidence-based treatments.^{7,8} Emerging research has demonstrated that the revised definition offers no improvement in clinical utility, identifies different individuals, and excludes many individuals meeting previous criteria.^{9–11} This article details problematic changes, implications, and rationale for immediate action.

Trauma Definition: Splitting Hairs

Although *DSM-5* correctly removed the *DSM-IV* requirement for a fear-based response to the traumatic event (Criterion A2), an important modification for first responders, it also considerably tightened the scope of qualifying events to reduce “bracket creep” and “frivolous tort or compensation claims.”⁴ This effectively ties clinicians' hands in applying the trauma criterion when clinically appropriate. For example, a parent who develops disabling PTSD symptoms after losing a child to aggressive cancer can no longer be diagnosed as having PTSD because the death was nonviolent/accidental (*adjustment disorder* is recommended). A soldier symptomatic after learning of the violent death of a trusted leader cannot technically meet criteria unless they were “close friends” or the soldier experienced “repeated or extreme exposure to aversive details” occupationally.

Symptom Criteria: Unsupported Changes

Of the 17 original *DSM-IV* symptoms, 8 underwent significant edits (4 were markedly reformulated) and 3 symptoms were added. These

changes introduced complex phrasing, alterations in meaning, and exponentially increased diagnostic permutations,¹² sometimes replacing the *DSM*'s foundation of reportable, observable symptoms with nonspecific abstractions (subject to interpretations and judgments) and overlapping depressive cognitions/emotions. The most problematic changes were: (1) Replacing the fundamental *reexperiencing* term with *intrusion* and requiring intrusive memories to be “involuntary,” discounting repetitive thought/memory processes common in PTSD with intentional or habitual qualities.^{11,13} (2) Rewording “restricted range of affect” (emotional numbing), likely the most predictive *DSM-IV* symptom of chronicity and impairment,^{14,15} to “persistent inability to experience positive emotions.”¹¹ This discounts the breadth of numbing encompassing non-“positive” emotions (eg, grief) and departs from decades of evidence that many survivors of severe trauma experience alexithymia or dissociation through corticolimbic overmodulation.^{16,17} (3) Replacing another highly predictive numbing-related symptom,^{14,15} “foreshortened sense of future”—well-suited, for example, for evaluating a veteran feeling cut off from humanity because of involvement in events challenging moral or spiritual integrity—with “persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (eg, ‘I am bad,’...:‘My whole nervous system is completely ruined’).”¹¹ (4) Adding “persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others,” conflating self-blame with attributional judgments of appropriateness of blame toward others (eg, a supervisor or alleged perpetrator).¹ (5) Adding a catch-all symptom criterion, “persistent negative emotional state (eg, fear, horror, anger, guilt, or shame),” overlapping other symptoms.¹ (6) Adding “reckless or self-destructive behavior,” a nonspecific sign of impairment, as PTSD-specific symptom.¹

Symptoms in *DSM-5* were restructured into 4 clusters based on factor analyses, including new, separate requirements for active avoidance (involving only 2 of 20 symptoms) and negative cognitions/mood. However, factor analyses have produced inconsistent results (even within 4-factor solutions),^{4,18,19} and the new avoidance criterion is emerging as the most common reason for definitional discordance.^{9,20,21} Military researchers expressed concern that this will exclude personnel who learn to override avoidance through training.²²

Posttraumatic stress disorder was also moved out of anxiety disorders and into a “trauma- and stressor-related disorders” chapter in *DSM-5* with adjustment disorders (and other conditions), which have little scientific rationale for combining.²³ Adjustment disorder, recommended in *DSM-5* for subthreshold PTSD, is an ill-defined diagnosis of exclusion that does not support trauma-focused treatment and can have unintended consequences (eg, declined insurance reimbursement or separation from military without benefits).

Evidence of Flawed Consensus Processes

Although the PTSD workgroup followed the extensive American Psychiatric Association processes, there were no a priori scientific standards for evaluating the many proposed changes or feedback received.⁴⁻⁶ For example, PTSD criteria were significantly loosened after initially drafting the definition, based essentially on observational prevalence data (to match *DSM-IV* prevalence).^{24,25} In parallel, a major revision was being undertaken for *International Statistical Classification of Diseases, Eleventh Revision (ICD-11)*.²⁶ However, diametrically different conclusions were reached as to what was necessary, with the workgroup for *DSM-5* producing the most complex PTSD definition to date (20 symptoms and 4 clusters) and the workgroup for *ICD-11* producing the simplest (6 symptoms and 3 clusters).^{1,26} These divergent conceptualizations derived through parallel processes (even involving some of the same members) epitomize (and solidify) disagreement across the field and highlight limitations with consensus processes relying on expert opinion.²⁷

Head-to-Head Comparisons

Studies comparing *DSM-IV* criteria and proposed *DSM-5* criteria were conducted largely in nonrepresentative convenience samples (eg, Internet surveys and research registries) using nonindependent measures (eg, *DSM-IV* instruments appended with *DSM-5* items), biasing concordance estimates.^{20,21,24,25} The only clinician test-retest evaluation of the PTSD definition in *DSM-5* showed higher reliabilities than other conditions (κ s, 0.63-0.69).²⁸ However, half of PTSD diagnoses were discordant, and results are nongeneralizable given uncharacteristically high prevalence in the veteran-specific study samples (47%-50%).²⁸ Since the publication of *DSM-5*, several studies⁹⁻¹¹ have confirmed high discordance between the definitions of PTSD in *DSM-IV* and *DSM-5* (even using nonindependent measures^{10,11}) and, more importantly, have found no evidence for improved clinical utility based on comparable impairment and comorbidities. One well-controlled head-to-head comparison⁹ showed that 30% of combat soldiers who met *DSM-IV* symptom criteria failed to meet *DSM-5* criteria. Discordance among those who met either criteria was nearly 50% and would have been higher had trauma criterion revisions been considered; discordance was also high comparing item-by-item wording changes.⁹ A psychometric comparison of the original and revised PTSD checklists in a convenience sample of college students²⁹ found discordance comparable to the infantry study⁹; item-by-item discordance (κ s) was likely also comparable, based on reliability correlations presented.²⁹ The *ICD-11* definition offered no clinical advantages and even greater discordance.³⁰ One multinational study¹⁰ scored diagnostic interviews according to *DSM-IV*, *DSM-5*, *ICD-10*, and *ICD-11* criteria; concordance across all 4 definitions was so low, with comparable impairment, that this research team (which included *DSM-5* and *ICD-11* PTSD workgroup

chairs) even suggested using all 4 definitions for future epidemiological studies. Such a recommendation essentially throws out the definitional foundation altogether (and doubles prevalence).

Clinical Evaluation: Reinventing the Wheel

The revision undermines our ability to generalize the extensive research base and creates a circular requirement for an entirely new foundation of instrumentation, neurobiological, genetic, and interventions research. Furthermore, 3 years after the publication of *DSM-5*, validation studies remain absent for the Clinician-Administered PTSD Scale (CAPS-5) compared with the original CAPS or other diagnostic instruments. The CAPS-5 not only revised phrasing for *DSM-5* but also completely altered structure, response options, and scoring and introduced illogical and disquieting questions—for example, patients are asked to remember the number of important parts of an event they cannot remember, the percentage of time they “felt ... strong negative beliefs,” the number of times they experienced unwanted memories in the past month (with twice per month deemed “moderate”), how “convinced you are that you or others are truly to blame,” and “why” questions—yet is promoted as the new gold standard.^{31,32} Serious concerns with CAPS-5 were raised in a landmark Vietnam veterans study.^{33,34} Thus, CAPS-5 cannot be recommended.

Conclusions and Recommendations

The purpose of revising a psychiatric definition is to enhance diagnostic accuracy, clinical utility, and communication. The *DSM-5* definition of PTSD provides no improvement in these areas. This has profound implications for patients with PTSD per *DSM-IV* for whom well-established treatments exist and for patients with impairment meeting *DSM-5* criteria for whom treatments may not generalize. Psychiatric case definitions are not implemented in health care settings as hypotheses, and there are screening, insurance, disability, and forensic ramifications. Essentially, what the new definition appears to have accomplished is a disruption of the long chain of links, established through epidemiological, neurobiological, and treatment studies, providing the foundation of current practice for patients with PTSD. Expedited reconsideration or revision is required.

Meanwhile, in the interests of patient care, continued use of the *DSM-IV* formulation and corresponding instruments is necessary. Research proposals enrolling patients with PTSD should be closely scrutinized if their design does not encompass *DSM-IV* criteria. Patients who meet *DSM-IV* criteria should continue to be diagnosed as having PTSD and not denied trauma-focused treatment or entitlements based on the *DSM-5* definition. We cannot assume that established neurobiological or treatment paradigms apply to patients identified only under *DSM-5* (or *ICD-11*).

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