

Posttraumatic Stress Disorder in *DSM-5*: New Criteria and Controversies

Mark W. Miller, Erika J. Wolf, and Terence M. Keane, National Center for PTSD at VA Boston Healthcare System, Boston University School of Medicine

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013)* featured extensive changes to the posttraumatic stress disorder (PTSD) diagnosis. PTSD was moved out of the anxiety disorders into a new class of "trauma- and stressor-related disorders," and the definition of what constitutes a traumatic experience was revised. Three new symptoms were added, existing ones were modified, and a new four-cluster organization and diagnostic algorithm were introduced. Finally, a new dissociative subtype was added to the diagnosis. We review these changes, discuss some of the controversies surrounding them, and then introduce a new debate involving a radically different conceptualization of PTSD proposed for *International Classification of Diseases, 11th edition*.

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The definition of posttraumatic stress disorder (PTSD) in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013)* features the most extensive changes made to the diagnosis since its initial appearance in *DSM-III* (APA, 1980). These revisions

were the product of a 5-year process led by a committee of experts in the field of traumatic stress. Their approach included systematic reviews of the literature, biweekly conference calls for discussion and debate, consultation with external advisors, early publication of proposed criteria, solicitation and review of feedback from the field, and psychometric studies designed to evaluate the impact of proposed changes (Friedman, 2013). In the end, changes to the PTSD diagnosis were extensive and included moving it out of the anxiety disorders section of the manual and into a new chapter titled "Trauma- and Stressor-related Disorders"; redefining what constitutes a traumatic event, including the elimination of the peri-traumatic emotion component from that definition; adding three new symptoms and revising existing ones; introducing a new four-cluster organization to the symptoms and diagnostic algorithm; and the creation of a new dissociative subtype (Friedman, Resick, Bryant, & Brewin, 2011; Friedman, Resick, Bryant, Strain, et al., 2011). The aims of this article are to review and comment on these changes and the debate surrounding some of them, discuss initial studies that have evaluated these changes, and introduce a new controversy involving a radically different conceptualization of PTSD proposed for the *International Classification of Diseases, 11th edition*.

THE MOVE OF PTSD OUT OF THE ANXIETY DISORDERS INTO THE NEW "TRAUMA- AND STRESSOR-RELATED DISORDERS" CHAPTER

The most conceptually significant change to the PTSD diagnosis was its move out of the anxiety disorders and into a chapter in the *DSM-5* meta-structure named

Address correspondence to Mark W. Miller or Terence M. Keane, National Center for PTSD (116B-2), VA Boston Healthcare System, 150 South Huntington Avenue, Boston, MA 02130. E-mail: mark.miller5@va.gov or terry.keane@va.gov.

“Trauma- and Stressor-related Disorders.” This new chapter consists of disorders defined by the onset or worsening of symptoms following an adverse life event and includes reactive attachment disorder, disinhibited social engagement disorder, PTSD, acute stress disorder, and adjustment disorders. The introduction states that it was created to better reflect the heterogeneity of psychological distress found in samples of individuals exposed to serious adverse life events.

PTSD had been conceptualized and classified as an anxiety disorder since its initial appearance in *DSM-III* (APA, 1980). However, concerns about its placement there were long-standing, as noted in the introduction to the anxiety disorders chapter of *DSM-III-R* (APA, 1987), which read: “The classification of posttraumatic stress disorder is controversial since the predominant symptom is the reexperiencing of a trauma, not anxiety or avoidance behavior” (p. 235). Subsequent studies raised further questions, leading some researchers to advocate for moving PTSD out of the anxiety disorders. For example, Resick and Miller (2009) published a review of empirical studies relevant to this question that came to four conclusions: (a) fear is just one of many emotions experienced by trauma survivors and is not necessary for the development of PTSD (Brewin, Andrews, & Rose, 2000; Rizvi, Kaysen, Gutner, Griffin, & Resick, 2008), (b) emotions other than fear or anxiety play a prominent role in the maintenance of PTSD (Andrews, Brewin, Rose, & Kirk, 2000; Ehlers, Mayou, & Bryant, 1998; Orth & Wieland, 2006), (c) laboratory studies suggest that reactivity to trauma-related cues often does not reflect pathological fear or anxiety (Carson et al., 2000; Pitman, Orr, Foa, de Jong, & Claiborn, 1987; Taft, Street, Marshall, Dowdall, & Riggs, 2007), and (d) findings of comorbidity studies are inconsistent with the current placement of PTSD among the anxiety disorders. With respect to the latter, factor-analytic studies suggest that PTSD tends to covary more strongly with disorders defined by anhedonia, worry, and rumination (i.e., the unipolar mood disorders and generalized anxiety disorder) than with diagnoses characterized by pathological fear and avoidance (e.g., the phobias, panic/agoraphobia, and obsessive-compulsive disorder; Cox, Clara, & Enns, 2002; Miller, Fogler, Wolf, Kaloupek, & Keane, 2008; Slade & Watson, 2006). Similar arguments were

advanced by Friedman, Resick, Bryant, Strain, et al. (2011).

Other studies with findings that bear on this issue suggest that adult psychopathology is often foreshadowed by childhood and/or adolescent problems in the same domain. Adults with anxiety disorders other than PTSD frequently have histories of childhood anxiety problems, but rarely do they report histories of juvenile externalizing disorders. In contrast, men and women with PTSD often have histories of childhood externalizing disorders (Gregory et al., 2007). Twin studies align with these findings and suggest that PTSD shares genetic influences with both internalizing and externalizing spectrum diagnoses (Wolf et al., 2010). Finally, numerous studies demonstrate that a substantial subset of men and women with PTSD exhibits a predominantly externalizing manifestation of PTSD characterized by problems in the domain of impulse control, antisociality, and substance abuse (Flood et al., 2010; Forbes, Elhai, Miller, & Creamer, 2010; Miller, Greif, & Smith, 2003; Miller, Kaloupek, Dillon, & Keane, 2004; Miller & Resick, 2007; Rielage, Hoyt, & Renshaw, 2010; Sellbom & Bagby, 2009; Wolf et al., 2010).

The move of PTSD out of the anxiety disorders into its own class of trauma- and stressor-related disorders is clearly controversial. Indeed, many early advances in the field of traumatic stress came from the diagnosis’ association with the anxiety disorders. Early theoretical conceptualizations of PTSD originated from behavioral theories of conditioned fear and avoidance (Foa, Keane, Friedman, & Cohen, 2009; Foa, Steketee, & Rothbaum, 1989; Keane, Fairbank, Caddell, & Zimering, 1989; Keane & Kaloupek, 1982), and research on the neurobiology and psychophysiology of PTSD followed suit (Malloy, Fairbank, & Keane, 1983; Pitman et al., 1987). Similarly, empirically supported treatments for PTSD were developed in parallel with exposure-based therapies applied to other anxiety disorders (Foa, Rothbaum, Riggs, & Murdock, 1991; Keane et al., 1989). In an editorial published alongside the PTSD workgroup’s initial position papers (Friedman, Resick, Bryant, & Brewin, 2011; Friedman, Resick, Bryant, Strain, et al., 2011), Zoellner, Rothbaum, and Feeny (2011) argued that because fear is central to the development of PTSD and that fear and anxiety are

the focus of effective treatments for the disorder, conceptualizing PTSD as an anxiety disorder is more defensible. Zoellner and colleagues pointed to a lack of empirical evidence supporting the existence of a distinct trauma- and stressor-related dimension of psychopathology and argued that by adding symptoms, broadening the construct of PTSD, and moving the diagnosis away from fear conditioning and extinction models, *DSM-5* would set the field back.

In our view, Zoellner et al. (2011) were mistaken in assuming that the creation of a trauma- and stressor-related disorders chapter would render fear-acquisition, fear-extinction, and fear-circuitry models irrelevant to PTSD. To the contrary, *DSM-5* specifically states: “In some cases, [PTSD] symptoms can be well understood within an anxiety- or fear-based context” (APA, 2013, p. 265). In other words, *DSM-5* suggests that pathological fear and anxiety are more salient for some patients with PTSD than others, though necessarily applicable to all. This shift was intended to better reflect the heterogeneity of post-traumatic psychopathology and the limits of applying one conceptualization to all of its manifestations. Fear conditioning and extinction models will always be relevant, and treatments based on this approach are clearly effective for many patients with PTSD. Yet, the fact that fear is just one of many emotions experienced by trauma survivors and not necessary for the development of PTSD, that emotions other than fear or anxiety play a prominent role in the maintenance of PTSD, and that the manifestations of PTSD are heterogeneous and include an externalizing subtype as well as its distinct etiology suggests to us that PTSD is qualitatively and phenomenologically different from the other conditions subsumed under the anxiety disorders. We support the creation of the new trauma- and stressor-related disorders category and hope that it will promote new conceptualizations and approaches to its treatment while also appreciating the many advances that stem from its original placement within the anxiety disorders.

CHANGES TO CRITERION A—THE DEFINITION OF TRAUMA

DSM-5 also included important changes to the Criterion A definition of traumatic events. It now provides a more explicit description of the kinds of experiences

that are considered to be traumatic, specifically, “exposure to actual or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271). It states that exposure can occur through direct personal experience, witnessing the event in person, learning about the details of an event that happened to close others (i.e., family and friends), or through repeated exposure to disturbing details of a traumatic event, such as in the case of first responders who must frequently attend to the aftermath of violence and serious accidents. In the case of witnessing the death of a family member or friend, the death must have been “violent or accidental.” Relative to *DSM-IV*, the latter serves to further restrict the definition by excluding instances in which an individual witnessed a loved one die from a medical illness. Finally, *DSM-5* clarifies that media exposure to trauma (e.g., on TV) does not meet Criterion A unless the exposure occurs in the context of work (e.g., police repeatedly reviewing security videotapes of a violent assault in the context of collecting evidence against a perpetrator).

In *DSM-IV*, Criterion A was defined both by the characteristics of the event (e.g., Criterion A1) and by the individual’s emotional reaction to it in that the individual had to have experienced intense fear, helplessness, or horror (e.g., Criterion A2). A2 was eliminated in *DSM-5* on the basis of evidence that many individuals with PTSD do not experience these specific emotions at the time of the event (they may experience other emotions or none at all), and findings suggesting that these peri-traumatic emotional experiences predict neither who will develop PTSD nor the severity of the disorder (Friedman, Resick, Bryant, & Brewin, 2011; Karam et al., 2010; Weathers & Keane, 2007). As a result, some individuals who may have been excluded from the PTSD diagnosis due to not endorsing Criterion A2 under *DSM-IV* may now meet full criteria for PTSD in *DSM-5*.

A final change to the language of Criterion A was the explicit acknowledgment of exposure to multiple traumatic events and that symptoms may be related to more than one event. Specifically, Criterion A repeatedly and intentionally uses the term “event(s)” (APA, 2013, p. 271) to describe the types of experiences that are considered traumatic, and PTSD Criteria B–E state that the psychological symptoms must begin after the

traumatic “event(s)” occur. This language allows for symptoms to be related to more than one event such that, for example, a patient might report nightmares about a childhood trauma but have symptoms of emotional numbing that began after a subsequent trauma in adulthood. It also allows individuals to meet criteria for PTSD in response to multiple traumatic experiences even if they do not meet full criteria in reference to any single event (Kilpatrick et al., 2013). In the case of multiple combat events or repeated exposure to domestic violence, these changes obviate the expectation that the patient and the clinician can assign a particular symptom to a single event when so many events over a sustained period of time may be involved in the development of the disorder. This is important, as lifetime trauma exposure appears to have a cumulative effect on the severity of posttraumatic psychopathology (Cogle, Resnick, & Kilpatrick, 2009; McLaughlin et al., 2013). It suggests that different events can be linked to different symptoms and will hopefully stimulate further research into the cumulative effects of repeated traumatization.

REVISIONS TO THE SPECIFIC SYMPTOMS THAT DEFINE PTSD

The most obvious changes to the PTSD symptoms themselves were the addition of three new symptoms (for a total of 20), a new organization involving four symptom clusters (Criteria B through E) instead of the three in *DSM-IV*, and a new diagnostic algorithm that now requires the presence of a minimum of one Criterion B, one Criterion C, two Criterion D, and two Criterion E symptoms. Criterion B was left largely unchanged, though renamed from “reexperiencing” to “intrusion” symptoms to underscore an emphasis on intrusive versus ruminative processes, as evident for symptom B1 (“intrusive distressing memories of the traumatic event”). The new Criterion C, termed “persistent avoidance of stimuli associated with the traumatic event(s),” is composed of the two effortful avoidance symptoms from *DSM-IV* (C1 and C2). This revision was based on results of prior confirmatory factor-analytic (CFA) studies that emphasized the distinction between effortful avoidance and other symptoms that fell within the “numbing of general responsiveness” cluster (for a review, see Elhai & Palmieri, 2011).

Criterion D, titled “Negative alterations in cognitions and mood that are associated with the traumatic event,” lists seven symptoms. Two of them are new (i.e., D3 “distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others,” and D4 “persistent negative emotional state”) and were intended to reflect symptoms that predict chronicity, severity, and functional impairment (Dunmore, Clark, & Ehlers, 2001; Ehling, Ehlers, & Glucksman, 2008; Meiser-Stedman, Dalgleish, Glucksman, Yule, & Smith, 2009) and are a focus of cognitive-behavioral therapies for PTSD (e.g., cognitive processing therapy; Resick & Schnicke, 1992). For similar reasons, a third symptom, previously known as “sense of a foreshortened future” (D7 in *DSM-IV*), was expanded in scope and substantially revised to read “persistent and exaggerated negative expectations about one’s self, others, or the world.” Finally, on the basis of research on the nature of emotional processing abnormalities in PTSD (Litz & Gray, 2002), the *DSM-IV* symptom “restricted range of affect” was also reworked to emphasize specific deficits in the capacity to experience positive emotion.

The hyperarousal cluster from *DSM-IV* became Criterion E in *DSM-5* and was renamed “alterations in arousal and reactivity that are associated with the traumatic event(s).” This cluster features two major changes: the addition of a new symptom “reckless or self-destructive behavior” (E2), and an irritability/anger symptom that places a new emphasis on aggressive behavior, that is, “irritable or aggressive behavior” (E1). Evidence that Friedman, Resick, Bryant, and Brewin (2011) cited to support the addition of the new reckless/self-destructive item included findings showing that Israeli adolescents exposed to recurrent terrorism exhibited marked increases in risk-taking behavior (Pat-Horenczyk et al., 2007), that reckless driving is associated with PTSD (Fear et al., 2008), and that risky sexual behavior is reported in some samples of women with trauma histories (Green et al., 2005; Hutton et al., 2001). The new emphasis on aggressive behavior was also intended to reduce potential overlap with the symptom D4 “persistent negative emotional state” and to reflect evidence that aggressive behavior is a common manifestation of posttraumatic distress in various

samples of trauma survivors (Taft et al., 2009), particularly veterans with externalizing traits (Miller et al., 2004).

INITIAL STUDIES EXAMINING THE IMPACTS OF THESE CHANGES

Empirical studies examining the impacts of these changes began to appear in the published literature shortly before the publication of *DSM-5*. In one of two preliminary studies commissioned by the *DSM-5* workgroup, Kilpatrick et al. (2013) assessed event exposure and *DSM-5* PTSD symptoms in a nationally representative U.S. community sample ($N = 2,953$) and compared *DSM-IV* and *DSM-5* prevalence estimates using various diagnostic algorithms. Analyses yielded prevalence estimates for lifetime and past 6-month *DSM-IV* PTSD of 9.8% and 4.7%, respectively, while the *DSM-5* definition yielded somewhat lower estimates of 8.3% and 3.8%, respectively. Examination of cases who met criteria for *DSM-IV* but not *DSM-5* criteria revealed that 60% of such discrepancies were due to the change in the *DSM-5* trauma definition that excluded learning about the nonviolent (i.e., natural causes) death of a loved one, while the second most common reason for such discrepancies was failure to have at least one active avoidance symptom as required by *DSM-5*. In a second study using the same instrument, Miller et al. (2013) found little difference in the prevalence of PTSD using *DSM-IV* versus *DSM-5* definitions in a clinical sample of veterans. Estimates of current and lifetime PTSD prevalence using *DSM-IV* criteria were 39.9% and 74.0%, respectively, and the *DSM-5* definition yielded estimates of 38.7% for current and 75.2% for lifetime PTSD.

Other studies have found slightly higher estimates of PTSD prevalence using *DSM-5* criteria compared to *DSM-IV*. For example, Calhoun et al. (2012) administered a modified version of the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995) to 185 volunteers for studies on trauma and health and found that 50% of the sample met criteria for a diagnosis of PTSD under *DSM-IV* criteria, whereas 52% met criteria under *DSM-5*. Similarly, in a sample of earthquake survivors, Carmassi et al. (2013) reported an estimated prevalence of 39.8% using *DSM-5* criteria, whereas *DSM-IV* criteria yielded a 37.5% estimate. Finally, in a

college student sample, Elhai et al. (2012) examined several different diagnostic algorithms and found that the criteria most likely to correspond to a clinical diagnosis (i.e., requiring moderate functional impairment) yielded a 4.3% prevalence estimate for *DSM-IV* and a 4.8% estimate for *DSM-5*. Thus, to summarize, preliminary studies have used a variety of samples and instruments to compare *DSM-IV* versus *DSM-5* prevalence estimates, and results have shown modest and inconsistent effects on the order of 1–2%. Together, these initial findings suggest that the changes made to the diagnosis in *DSM-5* have had no substantial or reliable effect on prevalence.

Some of the initial *DSM-5* studies included analyses that examined patterns of item endorsement and the factor structure of the new instruments. For example, Miller et al. (2013) used item-response theory (IRT) and CFA approaches to clarify the latent structure of the *DSM-5* symptom set and found that the structural model implied by the four symptom cluster criteria provided good fit to the data. Comparison with alternative models, however, suggested that one representing the dysphoria model advanced originally by Simms, Watson, and Doebbeling (2002) provided the best fit of five models tested. As in prior studies of this type, the magnitude of improvement relative to the *DSM-5* model was modest, and most importantly, the fit of the *DSM-5* four-factor solution showed a substantial improvement relative to the three-factor model that had been in place since *DSM-III*.

Miller and colleagues' (2013) examination of the pattern of factor loadings in the *DSM-5* model indicated that the amnesia symptom ("Inability to remember an important aspect of the traumatic event[s]") and new reckless/self-destructive behavior symptoms yielded relatively weak loadings on their respective factors in CFA. Similarly, Calhoun et al. (2012) found that these two items showed the lowest frequency of endorsement and the lowest correlations with other symptoms in their respective clusters. Furthermore, Miller and colleagues' (2013) IRT analyses showed that these symptoms tended to be endorsed primarily by participants with high levels of overall PTSD severity. One possible explanation for these results is that these items index manifestations of PTSD that deviate from the core syndrome in ways that may reflect comorbidity

subtypes. Other evidence suggests, for example, that the reckless/self-destructive behavior may index an externalizing form of PTSD (Miller et al., 2003, 2004, 2008), while the amnesia symptom is a marker of the new dissociative subtype (reviewed below). Future research should examine these hypotheses and further evaluate whether these symptoms are best conceptualized as core symptoms, markers of a subtype, or associated features of the disorder.

Finally, interrater reliability for the PTSD diagnostic criteria was evaluated as part of the *DSM-5* field trials at two sites: the Dallas VA Medical Center and the Houston VA/Menninger outpatient department. At both sites, kappa for a stratified sample for PTSD was good (.63 at Dallas and .69 at Houston/Menninger; average $\kappa = .67$). PTSD also had one of the highest test-retest reliabilities of any diagnosis ($\kappa = .67$; Freedman et al., 2013; Regier et al., 2013). These findings are important because they indicate that although the *DSM-5* diagnosis is broad, it can be diagnosed reliably by clinicians, even those without extensive experience with the instrument. These findings also suggest that the assessment methods developed for PTSD are as good as, or better than, those for other conditions in the *DSM*—a fact that was not always widely understood (cf. Keane, Wolfe, & Taylor, 1987).

THE DISSOCIATIVE SUBTYPE OF PTSD

In addition to changes made to the core symptoms of PTSD, *DSM-5* includes a new dissociative subtype that applies when PTSD is accompanied by clinically significant symptoms of depersonalization (i.e., feeling as if one's body or self is not real or integrated and connected) and/or derealization (i.e., feeling as if the world is not real, as if it is dreamlike or otherwise strange or unfamiliar; APA, 2013). There is a long-standing debate surrounding the nature of the relationship between dissociation and PTSD and whether dissociation is a core feature of the disorder or a phenomenon evident only in a subgroup of individuals with the disorder. Findings of recent psychometric studies support the latter and suggest that symptoms of derealization and depersonalization are found in a subset of 15–30% of individuals with PTSD. In the first study of this type, Wolf, Miller, et al. (2012) used

latent profile analysis (a method similar to cluster analysis) to examine the relationship between PTSD and dissociation in a sample of veterans and their partners who were assessed for symptoms of PTSD and dissociation using the CAPS (Blake et al., 1995). Results yielded evidence of three distinct classes: (a) a low PTSD severity class defined by low levels of PTSD symptoms and no symptoms of derealization or depersonalization, (b) a high PTSD severity class defined by high levels of PTSD symptoms but no symptoms of derealization or depersonalization, and (c) a group defined by symptoms of severity equivalent to the second class but combined with marked derealization and depersonalization symptoms. This latter group, subsequently labeled the dissociative subtype group, comprised approximately 6% of the full trauma-exposed sample and 12% of those meeting full criteria for current PTSD. Individuals in this group also showed more frequent and intense flashbacks and were more likely to have a history of childhood and/or adult sexual abuse. These findings have since been replicated in samples of male veterans with PTSD (Wolf, Lunney, et al., 2012), female veterans and active duty service members with PTSD (Wolf, Lunney, et al., 2012), and female civilians with sexual assault histories (Steuwe, Lanius, & Frewen, 2012). Further support was provided by results of a cross-national study that found evidence for the subtype in just under 15% of individuals with probable PTSD across the globe. Specifically, Stein et al. (2012) evaluated symptoms of dissociation among individuals with PTSD from 16 different countries and found that there were no regional-specific differences in the prevalence of the subtype. The subtype was also associated with higher severity of flashbacks and psychogenic amnesia, as well as greater levels of trauma exposure, psychiatric comorbidity, suicidality, and functional impairment across the large and diverse sample.

Other evidence suggests that individuals with the dissociative subtype exhibit a unique pattern of emotional and neurobiological response to trauma cues. Specifically, studies using functional magnetic resonance imaging suggest that individuals who dissociate in response to hearing scripts describing their own traumatic experiences show lower levels of emotional activation and reduced activity in limbic brain regions (e.g., the amygdala) and increased activity in frontal

brain regions, including the medial prefrontal cortex and anterior cingulate cortex (Felmingham et al., 2008; Hopper, Frewen, van der Kolk, & Lanius, 2007; Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012). This is in contrast to other individuals with PTSD who show the more prototypical response to trauma scripts defined by high levels of emotional reactivity and responsivity in limbic brain regions with concurrent hypoactivity in frontal brain regions. On the basis of these findings, Lanius et al. (2010, 2012) suggested that those with the dissociative subtype show an over-modulated response to trauma cues such that frontal brain regions actively inhibit the limbic brain regions that are heavily implicated in emotional, and particularly fear, responsivity.

The inclusion of the dissociative subtype in *DSM-5* helps to define a more homogenous subgroup from the vast heterogeneity associated with PTSD. This should help in the evaluation of the correlates, course, and treatment of the disorder. It also provides a uniform definition of dissociation in PTSD that may allow for greater reliability in the conceptualization of dissociation across PTSD studies. The inclusion of the subtype should also alert clinicians to assess for this type of comorbidity and consider its role in case conceptualization and treatment planning. Ultimately, the utility of the dissociative subtype will be decided based upon future research that evaluates how other forms of dissociation may relate to it and how individuals with the subtype differ from those without it in regard to biology, etiology of PTSD, symptom course and correlates, and treatment response.

THE INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)— DEFINITION OF PTSD

Historically, the *DSM* has held the dominant position in defining mental disorders for research, clinical practice, clinical training, policy, and law throughout the world. However, for the past 20 years, the *International Classification of Diseases*, currently in its 10th edition (*ICD-10*), has also included a definition of PTSD that differs substantially from the *DSM-IV* diagnosis. These distinctions have received relatively little research attention to date because use of the *ICD* system has historically been limited to the World Health Organization's (WHO) collection and analysis

of international health statistics. This has the potential to change in the near future given policy developments that may dramatically increase the use of the *ICD* system in the United States and elsewhere (Reed, 2010). The U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996, best known for setting new standards for patient privacy, also mandated that *ICD* codes be used for all billing and reimbursement transaction covered by the law, and the U.S. Centers for Medicare and Medicaid Services now plan to require *ICD-10* coding for all services as of October 1, 2014. Further, the U.S. government, as a participating member of the WHO, is obligated to implement *ICD-11* when it is finalized in 2015, and, as others have noted, it would be problematic for the United States to not use the medical diagnostic classification system adopted by the rest of the world (Reed, 2010).

Recently, the WHO's working group on the Classification of Disorders Specifically Associated with Stress published papers outlining their proposal for revisions to the PTSD diagnosis in *ICD-11* (Maercker et al., 2013a, 2013b). Parts of their proposal paralleled changes evident in *DSM-5* (e.g., moving PTSD out of the anxiety disorders and into its own class of stress-related conditions), while other modifications would further accentuate the differences between the two systems. Specifically, Maercker and colleagues' (2013a, 2013b) proposal (outlined also by Brewin, 2013) targets and seeks to reduce the large number of "nonspecific symptoms" of PTSD shared with other disorders. They proposed to narrow the scope of the construct by focusing on just six symptoms organized under three core elements: re-experiencing of the trauma, avoidance, and heightened threat and arousal. Specifically, the proposed *ICD-11* PTSD diagnosis would require (a) exposure to a qualifying event accompanied by (b) at least one re-experiencing symptom (specifically, flashbacks and/or nightmares), (c) one avoidance symptom (avoidance of internal and/or external cues associated with trauma), (d) one "sense of threat" symptom (hypervigilance and/or exaggerated startle), and (e) functional impairment. Thus, in comparison with the *DSM-5* diagnosis, the *ICD-11* proposal would omit three intrusion symptoms, all seven of the "negative alterations in cognitions and mood" symptoms, and four of the "alterations in arousal and reactivity"

symptoms. Although empirical studies of the potential impact of the proposed changes are yet to be published, it seems likely that narrowing the scope of possible symptoms will reduce the prevalence of PTSD in the population and change the clinical composition of patients with the diagnosis.

THE ICD-11 COMPLEX PTSD PROPOSAL

In addition to the markedly reduced criteria set proposed for *ICD-11*-defined PTSD, the *ICD-11* proposal includes the addition of a new complex PTSD (CPTSD) diagnosis. The proposed CPTSD diagnosis is defined as meeting full criteria for *ICD-11* PTSD and evidencing at least one symptom from each of three symptom clusters: affect dysregulation, negative self-concept, and interpersonal disturbances (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Maercker et al., 2013a, 2013b). Cloitre et al. (2013) suggested that the affect dysregulation cluster encompasses symptoms of emotional reactivity, dissociation, anger, aggression, and emotional numbing; the negative self-concept cluster includes negative beliefs about the core value of the self along with feelings of guilt and shame; and the interpersonal disturbances cluster includes avoidance of relationships, estrangement, and lack of emotional intimacy in relationships. Many of these symptoms are represented in the *DSM-5* definition of PTSD, particularly in symptom clusters D and E. The symptoms that define *ICD-11* CPTSD are thought to be enduring and stable and to be more likely to occur following severe and/or protracted traumatic experiences (Maercker & Perkonig, 2013; Maercker et al., 2013a).

The CPTSD construct has been debated since the time of the *DSM-III-R* (APA, 1987; for a review, see Bryant, 2012; Goodman, 2012; Herman, 2012; Lindauer, 2012; Resick, Bovin, et al., 2012; Resick, Wolf, et al., 2012). It was first described by Herman (1992) to denote impairing and severe posttraumatic symptoms that were not included in the *DSM-III-R* PTSD criteria set; a similar construct, termed disorders of extreme stress not otherwise specified (DESNOS; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997), was considered for inclusion in *DSM-IV* but ultimately rejected over concerns about its validity.

To our knowledge, only one published study has empirically evaluated the relationship between the

proposed *ICD-11* CPTSD and PTSD diagnoses. Specifically, Cloitre et al. (2013) used self-report measures of PTSD symptoms and general psychopathology to examine the relationship between the proposed *ICD-11* diagnoses in a treatment-seeking, trauma-exposed sample. Latent profile analyses revealed a low severity group with minimal symptoms of PTSD and CPTSD, a group with high PTSD and low CPTSD symptom severity (the PTSD group), and a group with high PTSD and CPTSD symptom severity (the CPTSD group); factor-analytic models yielded moderate to strong associations between latent variables reflecting *ICD-11* PTSD and CPTSD. Cloitre et al. (2013) concluded that results provided support for the discrimination between the two diagnoses.

Further evaluation of CPTSD is necessary to determine its utility and construct validity. Overlap between symptoms proposed for CPTSD and symptoms included in *DSM-5* Criteria D and E raises questions about whether the CPTSD symptoms simply reflect greater severity of PTSD as opposed to a distinct diagnosis. It is also unclear to what extent there is overlap between the CPTSD diagnosis and the dissociative subtype of *DSM-5* PTSD or whether dissociation is a reliable marker of affect disturbance. Keane and Najavits (2013) highlighted the many limitations in the evidence base for CPTSD, including the fact that no measure of CPTSD has undergone proper psychometric evaluation and that the discriminant validity of this condition relative to related ones has yet to be demonstrated. Thus, in our view, the CPTSD proposal generates more questions than answers, and additional work is needed to determine whether the inclusion of the CPTSD diagnosis aligns with the broader goals of the WHO in reformulating the *ICD*.

CONCLUSIONS

PTSD has been surrounded by controversy since at its conception, and the *DSM-5* features the most extensive revisions to the diagnosis since its initial appearance in *DSM-III* (APA, 1980). Although preliminary studies suggest that these changes have not had a substantial effect on estimates of PTSD prevalence or the reliability of clinical assessment, critics have voiced concern over the increase in the number

of mathematically possible ways by which people can be diagnosed with PTSD (Galatzer-Levy & Bryant, 2013). The radically different proposal advanced in reaction to *DSM-5* by the *ICD-11* PTSD committee has the potential to ignite new controversies and introduce new challenges to the field of traumatic stress. Although it remains unclear to what extent, when, or where the *ICD-11* definition of PTSD will be adopted, the existence of two diagnoses with the same name but different symptoms and that applies to different groups of patients has potential to introduce significant confusion for researchers, clinicians, patients, and policy makers alike. Proponents of the *ICD-11* diagnosis should bear the empirical burden-of-proof to support their proposal with evidence for its theoretical, empirical, and practical superiority relative to the *DSM-5* diagnosis. Ideally, evidence should show that the proposed changes accomplish the stated aims of improving clinical utility and reducing comorbidity while at the same time not dramatically altering the number, or clinical characteristics, of individuals who meet criteria for the disorder.

These developments should stimulate research into an array of new and important topics. New assessment measures must be developed, refined, and validated. The creation of the trauma- and stressor-related disorders chapter raises questions about whether the diagnoses contained therein constitute a true spectrum of mental illness or simply a collection of constructs with a common theme. The new dissociative subtype may bring the topic of dissociation more into the mainstream of clinical psychology and encourage a new level of scientific inquiry into its mechanisms and treatment. Whatever the outcome of this work, PTSD will undoubtedly remain a major public health concern and a key condition in the pantheon of mental disorders that clinical psychology and related disciplines must continue to explore.

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