

Editorial Regarding the New DSM-5 Diagnosis of PTSD in Veterans and Non-veterans

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Introduction

Post-Traumatic Stress Disorder (PTSD) is a common condition, particularly among military personnel, but its diagnostic criteria are controversial. Major changes occurred recently in the diagnostic criteria for PTSD when the DSM-IV diagnostic system was superseded by the DSM-5 system in May 2013 [1-5]. However, to date, the diagnostic criteria for PTSD in the DSM-5 diagnostic system have not been adequately assessed. In this editorial, critiques of the DSM-IV criteria for PTSD will be reviewed and a preliminary evaluation of the changes in the new DSM-5 diagnostic criteria for PTSD will be presented, citing material from a Google literature search of those topics. The implications of these changes in diagnostic criteria among veterans and non-veterans will then be discussed.

PTSD and Suicidality among Veterans

Since 2001, more than 2.2 million American Veterans have served in Iraq (Operation Iraqi Freedom, or OIF) and Afghanistan (Operation Enduring Freedom, or OEF) [6]. PTSD is the most frequently diagnosed mental disorder among OIF/OEF Veterans seeking care through the Department of Veterans Affairs [7,8]. Data from the National Comorbidity Study demonstrated that PTSD is significantly associated with suicidal ideation (adjusted odds ratio=2.79; $p<0.01$) and with suicide attempts (adjusted odds ratio=2.67; $p<0.01$) [9]. PTSD has also been shown to predict completed suicides [10]. Recent studies have demonstrated that PTSD is a significant risk factor for suicidal ideation in Iraq and Afghanistan War Veterans [11-13], and for suicide attempts [14] and completed suicide in the general population [15]. Rates of suicidal ideation have been shown to increase linearly with each increase in the number of PTSD symptoms [16]. Veterans who screened positive for PTSD are more than 4 times more likely to endorse suicidal ideation relative to non-PTSD Veterans (Adjusted Odds Ratio=4.45, 95% CI 2.58-7.67, [11,13] found that suicidal ideation was associated with PTSD in their Veteran study sample, irrespective of the presence or absence of comorbid major depression or alcohol use disorders. Since the beginning of hostilities in 2001, there has been an increase in rates of suicide among active duty soldiers deployed to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) [11]. Thus, PTSD and PTSD-related suicidality are very pressing current public health concerns among Veterans [7].

Criticisms of the DSM-IV Diagnosis of PTSD

Robert Spitzer and colleagues, who introduced the term Post Traumatic Stress Disorder (PTSD) into DSM-III, concluded that no other DSM diagnosis has generated so much controversy in the field as PTSD, including the boundaries of the disorder, diagnostic criteria, central assumption, clinical utility and prevalence in various populations [1]. In that article Spitzer and colleagues reviewed published data-based reports that contribute to questions regarding the validity of the DSM-IV PTSD diagnostic criteria, and noted the prominent non-specificity and apparent false positives of the PTSD syndrome. The authors also concluded that many suggested changes concerning PTSD in the DSM-5 are based on face validity considerations rather than empirical findings.

In response to those proposed changes in the diagnostic system for PTSD [4], in their review of the literature, noted that there are conflicting proposals on how the syndrome should be operationalized in the DSM-5 and questioned the distinctiveness and specificity of the etiology of the disorder, noting a substantial overlap between PTSD and other psychiatric disorders. Those same authors also acknowledged the "criterion creep" associated with PTSD, and the heterogeneity of the disorder. They concluded that PTSD should be relegated to the DSM-5 appendix for experimental criteria. Similar concerns were presented by [2], who questioned whether the diagnosis of PTSD could be "fixed" in DSM-5.

Changes involving PTSD in DSM-5 PTSD

The DSM-5 manual was recently approved by the Board of Trustees of the American Psychiatric Association, and was officially released in May, 2013 [5]. The diagnostic criteria for DSM-5 PTSD include symptoms and signs grouped into five main clusters, including exposure to severe stress (Cluster A), intrusion symptoms (Cluster B), persistent avoidance (Cluster C), negative alterations in cognitions and mood associated with the traumatic events (Cluster D), and hyperarousal (Cluster E). In addition, the duration of the disorder must be more than one month (Cluster F), the disturbance must cause clinically significant distress or impairment in social, occupational or other important areas of functioning (Cluster G), and the disturbance must not be attributable to the physiological effects of a substance or another medical condition (Cluster G) [17]. The one new diagnostic cluster (Cluster D) in the proposed diagnostic system for PTSD, which was not present in DSM-IV, involves negative alteration in cognitions and mood associated with the traumatic event, as evidenced by two or more of seven listed symptoms. Thus, the diagnostic criteria for PTSD in DSM-5 have been broadened to include some depressive symptoms, such as dysphoria [18,19]. Consequently, for the first time, some depressive symptoms (which could be associated with suicidal ideations) will be part of the diagnostic criteria for PTSD in the DSM-5, though the presence or absence of suicidal ideations is not specifically mentioned in the DSM-5 criteria for PTSD. In contrast, diagnostic criteria for PTSD in the DSM-IV did not include any mention of depressive symptoms or depressive criteria, but instead only included

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symptoms associated with anxiety. Other proposed changes to the PTSD diagnosis primarily involve changes to DSM-IV PTSD's types of events satisfying the objective traumatic stressor criterion (Criterion A1 in DSM-IV), and deletion of the requirement for initial subjective reactions of intense fear, helplessness, or horror to the stressor event (Criterion A2) [18,19]. In addition, the number of symptoms required from the "avoidance" group has dropped from three in DSM-IV to one in DSM-5. These changes were primarily intended to increase the distinctiveness of the diagnosis of PTSD by minimizing overlap with other disorders and to acknowledge the importance of mood symptoms in PTSD. However, some have questioned whether the addition of depressive symptoms to the DSM-5 diagnosis of PTSD could conceivably have the opposite effect of blurring the boundary between anxiety disorders and depressive disorders.

Recent Field Test of DSM-5 PTSD

Recently, the first field trial was conducted using the DSM-5 diagnostic system. The diagnostic criteria used for PTSD in that field trial were close approximations of the final DSM-5 criteria for that disorder, but were not identical to the final DSM-5 criteria, because the final criteria were not yet available at the time that that field trial began. That field trial produced data supporting the proposed changes to the diagnostic criteria of PTSD, thereby suggesting that those proposed changes are warranted. Specifically [20], reported "very good" test-retest diagnostic reliability for the DSM-5 PTSD diagnosis in the recently conducted DSM-5 field trials, with a kappa of 0.67. In contrast, two established DSM diagnoses of major depressive disorder and generalized anxiety disorder had reliabilities in the questionable range (0.20-0.39). That field trial also found that the prevalence of DSM-5 PTSD was very similar to the prevalence of DSM-IV PTSD, which was interpreted as providing additional support for the validity of the new DSM-5 diagnosis of PTSD. Additional information regarding the methodology of those recent field trials was published recently [21]. Thus, there is recent preliminary empirical evidence from a field trial supporting the new diagnostic entity of DSM-5 PTSD and supporting the diagnostic criteria for PTSD in the DSM-5.

Conclusions

PTSD remains a controversial diagnosis, and the changes that have been introduced in that diagnostic category in the DSM-5 continue to be controversial. Empirical studies are warranted to clarify the phenomenology, predictive validity, and clinical utility of that newly revised diagnostic category, and to assess the implications of the changes contained in the DSM-5 diagnosis of PTSD among both veterans and non-veterans. Studies are also warranted to clarify the relationship between the diagnosis of PTSD and diagnoses that are commonly comorbid with PTSD, such as major depressive disorder and alcohol and other substance use disorders [22,23]. Potentially, the changes introduced in the DSM-5 diagnosis of PTSD might allow for a more clinically useful assessment of veterans and non-veterans who have been exposed to severe stress, at least in part because the diagnosis of PTSD will now include an evaluation of depressive symptoms as well as anxiety-related symptoms. Therefore, the new DSM-5 diagnostic criteria for PTSD may provide a more comprehensive and clinically useful picture of the disorder than the DSM-IV diagnostic criteria for PTSD [24-28]. The new criteria may in turn provide a better indicator for risk of suicidality and other clinical outcomes in veterans and non-veterans. Nonetheless, the potential benefits and problems associated with the new DSM-5 diagnostic system for diagnosing PTSD have not yet been fully assessed in veterans and non-veterans, so no firm

conclusions can yet be made regarding the validity and utility of the criteria for PTSD in the DSM-5 diagnostic system. Further research is clearly warranted to evaluate the new diagnostic criteria for PTSD [29-33]. Those studies should be conducted in a wide variety of populations, including both veteran and non-veteran populations, to adequately assess that new diagnosis.

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