

Editorial

Problems with the post-traumatic stress disorder diagnosis and its future in DSM–V

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**Summary**

Significant issues challenge the diagnosis of post-traumatic stress disorder (PTSD). Yet, applications of the PTSD 'model' have been extended to an increasing array of events and human reactions across diverse cultures. These issues have

implications for clinical practice and for those who revise criteria in the DSM–V.

Declaration of interest

None.

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Post-traumatic stress disorder (PTSD) will undoubtedly be revised in DSM–V. When considering changes, committee members will be faced with the fact that since its inception in 1980 little about PTSD has gone unchallenged. In this context, we focus on several core issues regarding the PTSD diagnosis.

Specific aetiology?

Unlike other diagnoses in the DSM that were agnostic to aetiology, PTSD was defined as a disorder that arose after a specific set of traumatic stressors. Thus, the origins of the definition of PTSD rest on the assumption of a specific aetiology (Criterion A). This assumption, already questionable,¹ has been undermined by reports that the disorder can develop after a variety of non-life-threatening events (e.g. divorce, financial difficulties).² Further, recent studies have demonstrated the frequent occurrence of PTSD symptoms among people with depression who had not experienced Criterion A life stressors,³ and among people with social phobias who respond to failed performance situations.⁴ Even when an individual encounters horrific, life-threatening events (Criterion A), studies find that pre-incident vulnerability factors (e.g. psychiatric history) and post-incident social support contribute more to post-trauma morbidity than does the magnitude of the presumed aetiological trauma.⁵ In short, Criterion A events are neither necessary nor sufficient to produce PTSD. Instead, they appear to represent high-magnitude stressors that are otherwise indistinct from the full range of stressors that can have an impact on an individual and create risk of psychiatric morbidity. Now set apart from the general field of stress studies, PTSD might arguably be better returned to the fold.

Distinct syndrome?

In the absence of a specific aetiology, the rationale for diagnosing PTSD lies in the distinctiveness of the clinical syndrome. This is problematic when one considers that a combination of symptoms

of major depression and specific phobia fully constitutes the requisite criteria for diagnosing PTSD.⁶ This raises the concern that PTSD, at least on some occasions, is simply an amalgam of other disorders.

Consider, for example, the case of a boat captain whose fishing vessel is lost at sea, resulting in the death of several crew. Though not physically injured, the captain starts feeling 'on edge,' suffers from insomnia and begins to withdraw from usual activities. Most alien to the fisherman's self-concept, he becomes anxious when considering a return to his usual occupation. Consequently, he turns down offers to work on other vessels, and he becomes isolated from the fishing industry. Without income, this man becomes increasingly anxious and depressed. Prior to the introduction of PTSD in 1980, a psychiatrist would have conceptualised this fisherman's problems, first, as normal bereavement over lost friends who died in the incident, and second, as a phobic disorder caused by the traumatic event. A third concern would have addressed the development of situational depression as a consequence of adjustment issues and the fisherman's inability to return to sea. Now, in our post-DSM–III era, we can ask whether the introduction of PTSD has furthered our understanding of this patient's reactions to a life-threatening event.

Criterion creep

It might be expected that 'traumatologists' would be cautious in diagnosing a person as having PTSD upon realising that it lacks a specific aetiology and is possibly not a distinct syndrome. Despite that, enthusiasm for the PTSD diagnosis has not been tempered, and the PTSD 'model' has been extended worldwide to encompass an increasing array of events and human reactions across diverse cultures. Individuals no longer have to directly experience or witness a traumatic event to be thought to develop PTSD. Instead, based on the DSM–IV, the diagnosis can be provided to individuals who hear of misfortunes befalling others. Peer-reviewed articles have even discussed the possibility of developing PTSD from watching traumatic events on television.⁷ It has been suggested that rude comments heard in the workplace can lead to PTSD because a victim might worry about future boundary transgressions: the conceptual equivalent of pre-traumatic stress disorder.⁸ New diagnostic categories modeled on PTSD have been proposed, including prolonged duress stress disorder, post-traumatic grief disorder, post-traumatic relationship syndrome, post-traumatic dental care anxiety, and post-traumatic abortion syndrome. Most recently, a new disorder appeared in the professional literature to diagnose individuals impaired by insulting or humiliating events – post-traumatic embitterment disorder. Even expected and understandable reactions after

extreme events, such as anxiety and anger, are now referred to as 'symptoms'. This expansion of the PTSD model, a phenomenon referred to as 'criterion creep', highlights a critical shortcoming of traumatology: the cross-cultural medicalisation of normal human emotions.⁹ Labelling situation-based emotions and upsetting thoughts as 'symptoms' is akin to saying that someone's cough in a smoky tavern is a symptom of respiratory disease. Such illogical leaps increasingly inform our cultural narratives when we discuss human reactions to stressful events, possibly giving rise to iatrogenic misapprehensions and contributing to chronicity.

Not only has the PTSD model been expanded, but patients who present with psychiatric problems after traumatic events increasingly receive the diagnosis. Perhaps in this time of managed care, physicians have come to believe that without a PTSD diagnosis a patient's reactions to traumatic stress will be denied appropriate psychiatric attention, therapeutic intervention, and proportional compensation. Pressure for a PTSD diagnosis also may arise when patients are involved in personal injury claims. Unlike depression or other psychiatric diagnoses that can be caused by multiple stressors unrelated to a legal claim, a PTSD diagnosis is incident-specific and clearly determines causation. Unfortunately, what may be best for a lawsuit is not necessarily best for the patient. By narrowing a physician's analysis of causation to a single event, a PTSD diagnosis may downplay or even ignore crucial pathogenic features that are to be found in the broader context of a patient's personality, developmental history, and situational context.¹⁰

Implications

In light of these research and clinical considerations, psychiatrists should consider alternative perspectives and the full context of a patient's presentation when formulating their diagnosis. The diagnosis of PTSD may be appropriate in some cases, but physicians should not provide it reflexively in the aftermath of trauma. As for the DSM-V, it is unclear how current problems can best be resolved. In observing the issues that have followed PTSD since

1980, we are not dismissing the diagnosis, nor are we ignoring a wealth of research findings spurred by the construct. Rather, we are asserting that there are reasons for concern. Defining PTSD criteria in DSM-V so that they reflect current findings, while limiting the construct's susceptibility to misuse, expansion and reification, will be a difficult challenge.

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