PTSD should not be retained in DSM V

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How should a psychiatric disorder be defined?

- It should have internal coherence, with the relevant symptoms having positive predictive value.
- It should be distinct from other groupings, with minimal overlap.
- Ideally, there should be some therapeutic or research advantage to the classification.
- It should not be an arbitrary sub-set which leads to tautological self-confirmations.
How should one measure the impact of life events in psychiatry?

• Ideally, by prospective samples studied before and after an index event, compared with those who did not experience the index event
• This has been done for depression and schizophrenia, and anxiety should be no exception
• Usually the result is a stress/diathesis model, vulnerability making a significant contribution
One must distinguish between Stressors, Stress Reactions and Feelings

- Stressors = *things* which can cause harm
- Stress reactions = heart rate, blood pressure, sweating (GSR), breathing, behaviour
- Feelings = verbal reports about emotional states
A model of anxiety
Rachman (2004)
Threatening Stimuli

- Sudden
- Intense
- Dangerous
- Unpredictable
- Uncontrollable
- Irregular
- Long duration
- Instinctive

- Signalled
- Mild
- Safe
- Predictable
- Controllable
- Regular
- Short duration
- Unprepared fears
Generic problems with DSM

1. Neither diagnostic nor statistical, just a stamp collection
2. No cluster analysis, so disorders are poorly differentiated and poorly supported
3. Does not give statistics of symptom frequency for each diagnosis
4. Categorical, not dimensional, which is against the evidence.
5. Too many disorders, many of them overlapping
6. Diagnostic categories are over-inclusive and pathologize ordinary life
7. Not purely scientific, but manipulated by interest groups
Dr Allen Frances, Chairman DSM IV

• Dr Allen Frances has resigned from DSM V in dismay, explaining:
• “So long as psychiatric diagnosis is stuck at its current descriptive level, there is little to be gained and much to be lost in frequently and arbitrarily changing the system. Descriptive diagnosis should remain fairly stable until, disorder by disorder, we gradually attain a more fundamental and explanatory understanding of causality”.
• Essentially, he believes that DSM as a whole is likely to generate many false positives, as specialist interest groups stretch their inclusion criteria too widely.
Specific problems with DSM PTSD

1. Omits some actual post-trauma reactions, unfairly elevates a particular sub-set of responses
2. Too highly co-morbid with other disorders
3. Bundles together very different symptom frequencies
4. Allows a “pick and mix” of symptoms
5. Does not occur after most events
6. Can occur without a life-threatening event
7. Is not unique, but is the extreme end of normal stress
Do all those exposed to life threat get PTSD?

• Most, but not all.
• For example, after the London bombings 72% did so, and other exposed subjects got other diagnoses.
• Brewin 2008
Diagnoses of London bombing survivors referred for treatment

- PTSD 72%
- Travel phobia 8%
- Adjustment disorder 9%
- Generalised anxiety disorder 3%
- Complicated grief 4%
- Depression 2%
- Other diagnosis 3%

Brewin 2008
DSM III pick and mix

- 1 out of 4 re-experiencing
- 3 out of 7 avoidance
- 2 out of 6 arousal
DSM IV and TR pick and mix

- 1 out of 5 for Intrusion
- 3 out of 7 avoidant/numbing
- 2 out of 5 hyper-arousal
DSM V “pick and mix” (proposed)

• 1 out of 5 intrusion,
• 1 out of 3 avoidance,
• 3 out of 4 negative cognitions
• Unsatisfactory, results in heterogeneity of symptoms and patients, reveals that the diagnosis is poorly defined.
• For example, thoughts and recollections count towards avoidance and not negative cognitions.
Is PTSD really unique?

- PTSD is the one psychiatric disorder for which DSM claims to know the cause.
- If you have all the features of PTSD, but did not experience Criterion A, then you cannot be diagnosed with PTSD.
- A fundamentalist disorder, admits of no multi-causality. Many ways of becoming anxious or depressed or psychotic, but only one way to become traumatised.
PTSD and vulnerability

- Dunedin Study, prospective, longitudinal, civilians
- Adults exposed to trauma rarely got PTSD unless they had received another psychiatric diagnosis earlier in life.
- 100% of those diagnosed with past-year PTSD, and 93.5% of those with lifetime PTSD at age 26, had met criteria for another mental disorder in adolescence.
- Of new cases of PTSD arising between ages 26 and 32, 96% had a prior mental disorder.

Koenen (2008)
In combat, does vulnerability matter?

- Even in real combat, prior vulnerability still has a major effect.
- Vietnam veterans with a family history of psychiatric illness, anti-social behaviour, and substance abuse had more depressive symptoms regardless of combat exposure, and particularly at the highest levels of combat exposure (Helzer 1981).
Single traumas or cumulative stress?

- PTSD assumes single traumas lodged in memory, a luxury of safe societies. Civilians in conflict zones, and soldiers experience many stressors.
- In WWII soldiers broke down after an average of about 3 months of continual combat (Jones and Wessely, 2005). Which then was the trauma?
- This is much more in line with the usual dose-response relationship in psychiatric disorder.
Criterion A

• A fundamental difficulty with the nosological status of the diagnosis
• Is it a unique diagnosis defined by an extreme event, or is it yet another psychiatric diagnosis in which vulnerability plays a major role?
The defining Criterion A over the years

**DSM III (1980)**

a recognizable stressor that would evoke significant symptoms of distress in almost anyone."

**DSM III-R (1987)**

a psychologically distressing event that is outside the range of usual human experience (i.e., outside the range of such common experience as simple bereavement, chronic illness, business losses, and marital conflict). The stressor producing this syndrome would be markedly stressing to almost anyone, and is usually experienced with intense fear, terror and helplessness.
The defining criterion continued

DSM IV (1994) and DSM IV TR (2000)

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) 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

(2) the person's response involved intense fear, helplessness, or horror.
Proposed DSM V

The person was exposed to the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:

- Experiencing the event(s) him/herself
- Witnessing the event(s) as they occurred to others
- Learning that the event(s) occurred to a close relative or close friend
- Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g. first responders collecting body parts; police officers repeatedly exposed to details of child abuse)

Note: Witnessing or exposure to aversive details does not include events that are witnessed only in electronic media, television, movies or pictures, unless this is part of a person’s vocational role. Exposure to aversive details of death applies only to unnatural death.
Separate the stressor from the reaction

• Criterion A in DSM-IV currently requires not only that there be a stressor, but that the patient should have a particular stress reaction. These should be kept logically distinct.
Criterion over-inclusiveness

- The widened range of permitted Criterion A stressors has watered down the diagnosis to the point of absurdity. A concept which originally applied to combat has been generalised to everyday threats.
- Whether a stressor can cause PTSD ought to be an empirical matter, not something defined in advance.
- In fact, PTSD symptoms can be caused by a wide range of everyday threats. Hence the uniqueness of PTSD is revealed to be false. It is the end point of a dimension, and not a unique category.
Criterion over-inclusiveness

- Because of the expanding and over-inclusive nature of the definition of trauma 90% of adults in Michigan qualify for a PTSD diagnosis.
- PTSD status has been granted to patients having wisdom teeth removed (de Jongh 2008), mothers giving birth to a healthy baby after routine delivery (Olde 2006) and even being told rude jokes at work (MacDonald 2003).
- This watering down may not have been intended by the originators of the criterion, but it was implied. Because PTSD is a psychiatric diagnoses with positive connotations (no blame, and victim status) over-diagnosis is endemic.
Criterion over-inclusiveness: the virtual world

- The problem of “informational exposure” in DSM IV Criterion A.
- 4% of Americans who watched the Twin Towers collapse on television get the same PTSD diagnosis as those who ran down the stairs of the real burning building: PTSD of the virtual kind (Schlenger 2002).
ICD 10

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.

Predisposing factors, such as personality traits or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence.

continued…. 
Typical features include episodes of repeated reliving of the trauma in intrusive memories, dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia.
Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change.
In conclusion

- DSM has made a mess of psychological trauma. They have chopped and changed their criteria in response to pressure groups. They should withdraw from the field.
- The evidence suggests that trauma is an extreme case of normal anxiety. Clinicians should judge the relative contributions of real stressors and patient vulnerability on the merits of the individual case.
- In the meantime, if you want, use the more focussed and modest description provided by ICD 10.